

**EFFECT OF FORENSIC ACCOUNTING PRACTICES ON CLAIM  
SETTLEMENT EFFICIENCY IN HEALTH INSURANCE SECTOR  
IN KENYA**

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**16/03323**

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## DECLARATION

### **Declaration by the Student**

I declare that this dissertation is my original work and has not been previously published or submitted elsewhere for award of a degree. I also declare that this project contains no material written or published by other people except where due reference is made and author acknowledged.

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## **DEDICATION**

I would like to dedicate this research study to my cherished family members, all of whom have been instrumental in ensuring that I complete all of the requirements for this program. It has been a really challenging process, but I am thankful that they provided me with reasons to keep pushing through until we reached the end.

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## **LIST OF ABBREVIATION/ACRONYMS**

<b>A.C.F.E</b>	Association of Certified Fraud Examiners
<b>C.A.I.F</b>	United States of America, the Coalition against Insurance Fraud
<b>IRA</b>	Insurance Regulatory Authority
<b>NAFA</b>	National Association of Forensic Accountants
<b>NHIF</b>	National Health Insurance Fund
<b>NHIS</b>	National Health Insurance Scheme
<b>WIBA</b>	Work Injury Benefit Act

## OPERATIONAL DEFINITION OF TERMS

<b>Claim Settlement Efficiency</b>	It is the payment of the proceeds of an insurance policy to the insured under the terms of an insurance contract with the least amount of resources, time, and errors.
<b>Dispute Resolution Practices</b>	It is the process of settling a dispute or disagreement between two or more people. Dispute resolution is important because it can be used to solve a problem without going to court.
<b>Forensic Accounting Practices</b>	It is using accounting skills to find evidence of fraud or theft and to analyze financial data for use in court.
<b>Fraud Investigation Practices</b>	The goal of the exercise was to protect and give justice to the victim of a fraud, as well as to punish the fraudster who committed the crime.
<b>Health Insurance</b>	A kind of insurance that pays for medical bills that come up because of illness. These costs could be related to going to the hospital, buying medicine, or seeing a doctor.
<b>Litigation Support Practice</b>	The process of helping lawyers with their current and future cases by giving them advice and support. They may build and manage databases, look over documents, get records, and make materials for court presentations.

## ABSTRACT

The vast majority of insurance plans include common statement indicating that in the event of a fraudulent claim, all policy benefits are null and void. The fraudulent insurance claims have the ability to destabilize the economy, bankrupt financial and banking institutions, damage government operations, disrupt tax-funded development efforts, and erode public trust in government administration. The purpose of this research was to determine the effect of forensic accounting techniques on the efficiency of claim settlement in Kenya's health insurance sector. Among the specific goals was to investigate the effect of fraud detection technologies, litigation support strategies, and dispute resolution practices on claim settlement efficiency in Kenya's health insurance sector. The study is significant to insurance companies, Insurance Regulatory Authority of Kenya and future, academics and researchers. The study was anchored on Occupational Fraud Theory, Moral Hazard Theory and White-Collar Crime Theory. The study adopted descriptive research design. The population of interest constituted administrative staff from head offices of medical insurance companies. The study adopted census design whereby all the 32 medical insurance providers were involved in the study. The questionnaire was the main primary data collection method. The data was quantitatively analyzed aided by SPSS package to generate percentage ratings, frequencies inferential statistics. Presentation was done in form of tables. The study found that in fraud investigation, it could be easier to monitor and keep trail of any fraud if it arises considering that systems of claims settlement are in place. In litigation support, clients might receive assistance from insurance companies to reduce the cost effect of the risk of legal action while others claim that insurance companies may not necessarily engage in helping clients on various legal engagements. Lastly, in dispute resolution, settling a dispute about claims can be done through court of laws, thus, providing documented evidence for claim processing. However, this may amount to notable inefficiency as court proceedings may last longer than the claimants anticipate. The study recommends that policy makers in the insurance companies should ensure that fraud investigations are properly documents and be carried out in the shortest time possible to fulfill expected efficiency in claim settlement. Still, the companies should be obligated enough to invest own funds to take care of legal claims in relations to litigations. The management of the insurance firms should ensure that they put in place dispute resolution mechanism that is workable and that can support quick settlement of complaints on claims.

## CHAPTER ONE

### 1.0 INTRODUCTION

#### 1.1 Background of the Study

Claims settlement is an important component of the insurance industry, which is a service company whose success is dependent on the services it provides to its customers. It is critical for the insurance company to preserve and protect the policyholders' interests. The distribution of insurance policy proceeds to the insured in accordance with the provisions of the insurance contract is known as claim settlement (Drechsler & Jütting, 2015). The only way to officially apply for benefits under an insurance policy is to file a claim, but it will remain a claim until the insurance company has examined the facts. For insurance firms, the efficiency metric is claim settlement (Mohapatra & Tiwari, 2019).

Claims settlement is still a major topic of interest and concern in the insurance industry, as it has a considerable effect on both customer satisfaction and the insurer's bottom line. Claims have a significant effect on the development and pricing of various insurance policies (Insurance Claim, 2020). A well-managed claims process, according to Machui (2015), is regulated by a written corporate philosophy that specifies the overall approach for providing high-quality service. It describes the type of claims service provided at each level, the pace with which claims are processed, and the responsibilities connected with each stage. The precision, promptness, and efficacy of claims settlement have a significant effect on the relationship between an insurer and a client (Mahlow et al, 2016).

The hurdles and problems that insurance fraud investigators encounter in the United States were explored by Cole and McCullough (2017). According to the survey, claims departments believe it is critical to investigate because if a falsified claim is paid, the insurer loses a considerable amount of money to fraudsters. Furthermore, if a fraudster gets away

with his or her crime, he or she may be more likely to commit it again in the future. According to Mohapatra and Tiwari (2019), the claim function in India comprises the timely and effective processing of claims while preventing fraud. A hurried claim settlement can result in increased fraud costs. Slow fraud detection, on the other hand, can lengthen the claim cycle. Customers was happier and more likely to stay loyal if claims are processed swiftly and efficiently.

According to Sodzi-Tettey (2017), there has been no formally recorded research in Ghana focusing on the hurdles that account for provider payment delays and claims denial. As a result, concerns were raised about the administrative and organizational issues connected with managing claims as part of the National Health Insurance Scheme strategic purchasing (NHIS). The majority of schemes lacked a well-defined organizational structure, as well as job descriptions and responsibilities for their permanent personnel. There was no set professional promotion system in any of the programs.

The Insurance Regulatory Authority (IRA), Kenya's insurance market regulator, classifies medical insurance as a high-risk class in terms of claim payment. Providers are rewarded in a variety of ways for both outpatient and inpatient care (Chuma & Maina, 2017). It is clear that when the accident facts are ambiguous, claims departments are more ready to consider a claim. Claimant advocates and agents/brokers are the most likely to conduct fraud. Furthermore, the leading causes of claim payout delays were found as late claim reporting and severe staff workload (Omondi, 2018).

Medical classes make up 31.5% of the general insurance business (IRA, 2018). Net earned premium was KES 91.08 billion in 2018, representing 70.7% of gross premium income and a 0.2% decline from KES 91.30 billion earned in 2017 (IRA, 2018). However, general insurance premiums grew by 2.2% in 2018. This is much lower than the sector's four-

year average annual growth rate of 8.7%. The Claims Ratio is an indicator of a company's capacity to pay claims. For example, an 80% claims ratio means that for every KES 1,000 in premiums collected during a certain accounting period, KES 800 is paid out in benefits (Korir, 2020).

According to the journal Policy Bazaar (2020), a higher claim ratio indicates lower profitability. A claim ratio of 85%, for example, shows that 85% of the premiums collected by the insurance company are spent on claims. The profit margin is represented at 15%. If this ratio rises to 90% in the following year, the insurer's profit would fall from 15% to 10%, which is could be considered bad news to the organization. A ratio larger than 100 percent indicates that the company is losing money since the premiums collected are insufficient to cover the claims. As a result, the insurer is almost certainly using its reserves to pay claims, which is bad news.

### **1.1.1 Forensic Accounting Practices**

A forensic audit is when the financial records of a business or person are looked at and judged. During a forensic audit, the auditor looks for proof that could be used in court. A forensic audit is used to find illegal behavior like fraud or theft (Mahlow & Wagner, 2016). Forensic audit investigations are done with the help of experts who know how to investigate in a way that allows the results to be used as evidence in court. The auditor should use a method that takes into account both the chance of fraud and the chance that it may not happen.

According to Crumbley (2015), forensic accounting is the process of finding, recording, extracting, settling, sorting, reporting, and verifying financial data related to past or other accounting activities in order to settle current or future legal disputes, or using such past data to evaluate possible financial data for settling legal disputes.

The National Association of Forensic Accountants (NAFA) assert that insurance companies, lawyers, and businesses need more forensic accountants (NAFA, 2017). The goal of forensic accounting in insurance claims is to figure out how much money was lost in each case. It's important to note that forensic accountants don't usually focus on figuring out who did what. Instead, their main job is to figure out how much damage was done (Atube, 2020).

Association of Certified Fraud Examiners A.C.F.E. did a study in 2016 in Austin, Texas, which found that firms lose an average of 5% of their annual income to fraud, which is about \$3.5 trillion around the world. Insurance fraud, which includes premium diversion, policy twisting, asset theft, and employer pay-off fraud, costs more than \$40 billion a year. So, insurance fraud causes insurance rates to go up, puts pressure on the financial stability of insurance companies, and makes it harder for people to get insurance. The Coalition against Insurance Fraud C.A.I.F. (2017) in Washington, DC, United States of America, found that 10% of annual insurance losses and loss adjustment charges are due to fraud. Based on the same survey, fraudsters steal \$80 billion every year from all types of insurance. Fraud can hurt the insurance industry's efficiency, productivity, and ability to come up with new ideas because it forces resources to be spent on things that aren't productive. This hurts an organization's ability to grow.

The conclusion was drawn by Okunbor and Obaretin (2017) that the Nigerian businesses that used forensic accounting did not contribute much to criminal activities in the region. In a different study, Islam, Hosan, and Rahaman (2018) assert that forensic accounting as a way to find corporate crimes was important because it seemed to be one of the key tools for fighting these kinds of crimes. This was said when forensic accounting was brought up as one of the strategic instruments. In a second study, Boritz, Kotchetova, and Robinson (2020) assert that to forensic accountants and auditors to find out what it would be

like to have fraud specialists help make audit plans that would help South African public sector firms find fraud. These plans would make it easier for these organizations to find fraud. They found that doing forensic audits this way, instead of just consulting with fraud experts, would lead to better results.

According to Mahinda (2016), there is 66% occupational fraud in Kenya, which is about double the global average of 34%. It is a common practice among a wide range of government and non-government groups, especially those that provide financial services. Stopping the widespread and long-standing auditing mistakes in Kenya could hurt the economy and level of development in the country as a whole (Warutere, 2016). Due to how important this issue is, forensic accountants are required to take part in all stages of risk assessment and audit plan development, rather than just giving advice (Boritz, Kotchetova, & Robinson, 2018).

Forensic processes and forensic equipment are used to find out if fraud has been committed and gather facts to back up the conclusion. The tool was made to help protect and support digital evidence during computer forensics and incident response activities (Omondi, 2018). According to Sudti (2018), forensic accountants are capable of developing fraud profiles based on existing trends in the database. An investigator could find proof of fraud if they looked at these patterns. Using this method also gives you the chance to make warning signs that can find outliers in data that is otherwise consistent.

Litigation support is the process by which certified public accountants with experience in business cases get in touch with lawyers and give them advice or help while they bring or defend a case in court (Singleton & Murey, 2018). After a legal dispute has been settled, in some cases it may be necessary to estimate how much money was lost, while in other cases it may be enough to provide relevant information and documents. Forensic

accountants must be able to testify in court as credible witnesses about whether or not fraud has been committed. This is the most important skill needed to help with legal cases (Omoniyi, 2019).

Dispute resolution is an example of forensic audit practice. This is the process of getting people to settle their differences in ways other than going to court (Feinman, 2020). Rae and Subramaniam (2018) claim that conflict resolution is better than traditional litigation because it protects both parties' corporate reputations, makes it easier and less expensive to settle disputes, and gives people a way to avoid litigation altogether. Most fraud cases are settled through mediation or arbitration.

### **1.1.2 Forensic Accounting Practices and Claim Settlement Efficiency**

The claim settlement and the way the insurance industry works has caused payouts to be significantly delayed, with some claims reporting delays of up to 90 days. Normal business practice does not take into account the fact that the number of insurance services is growing and that insurance claims are always changing. This means that urgent insurance claims are useless to the business (Mwangi & Murigu (2015). Kiana noticed in 2010 that there are delays in insurance claims because most health service providers and insurance service providers still process most claims by hand and don't have a good accounting system that records every insurance transaction. In the insurance business, people still want good systems. The insurer's actions during the claims process must be looked at, and a defense was given if there are good reasons to disagree with a particular claim. On purpose, it has been left unclear what is reasonable in this situation, but insurers have enough time to look into legitimate concerns.

Using these factors, Muriuki (2018) asserts that there is a clear difference between handling claims and managing claims well. Claims management includes more than just

processing. It also includes strategy, service, cost monitoring, and the role of the person handling the claim. Yusuf and Dansu (2014) claim that good claims management should be proactive in recognizing and paying legitimate claims, reporting regularly, estimating accurately the reserve associated with each claim, minimizing unnecessary costs, treating claimants with respect, avoiding long legal disputes, and processing claims quickly.

The insurance industry is regulated by the Insurance Regulatory Authority. A parliamentary act from 2007 told the government to set up this self-governing government department to take the place of the department of insurance. The board of directors and the insurance commissioner, who is also the CEO, are in charge of running the company (Kiana, 2016). The main goal of the Insurance Regulatory Authority (IRA) is to regulate, monitor, and grow the insurance industry in Kenya. As of the end of 2013, there were 48 insurance companies in Kenya. Of these, 25 focused on non-life insurance, 12 on life insurance, and 7 did both (AKI, 2015).

According to the numbers, the rate of penetration is 3.44 percent, and since 2012, revenue has grown by 17.1 percent. KPMG did a poll in 2015 and found that more Kenyans than people from any other East African country liked insurance fraud. The false claim makes Kenyan insurance companies raise their rates by a quarter of a percentage point. According to the first study of its kind to be done in the area, Kenya has higher rates of insurance fraud than Uganda, Tanzania, Burundi, Rwanda, and Ethiopia. These rates are similar to those seen in the banking industry.

According to Chudgar and Asthna (2018), claims that insurance fraud is one of the biggest problems for both customers and the government agencies that oversee the insurance industry. According to the research, these kinds of insurance fraud have a direct effect on the total cost of insurance policies and the cost of insurance premiums for policyholders. It

includes a wide range of illegal actions and behaviors in their different forms. Morley and Ormerod found in 2016 that effective risk management is becoming more and more important in the insurance market. Risk management is getting more attention because the insurance business is always changing. Insurance companies need risk management systems that can both assess the risk of fraud and stop it.

### **1.1.3 The Health Insurance Sector in Kenya**

Historically, the medical insurance industry has consistently underperformed, with individual companies and brokers sustaining huge losses (Nair, 2016). Claims are investigated extensively in an effort to reduce these losses, and it takes a long time to settle a claim due to the manual nature of the procedure and the lack of control on both sides (Nandi, Ashok, & Laxminarayan, 2018). Kenya's government pioneered health insurance in 1967, when it established the National Health Insurance Fund (NHIF) to offer health care to Kenyans. Since then, the sector has grown tremendously due to industrial liberalization and rising medical costs. Health insurance is provided in Kenya by both government and private insurers.

According to AKI research (2015) on the uninsured market in Kenya, the medical industry's investment revenue ratio has averaged 5.2% during the last five years. From 2015 to 2019, the top five medical providers' investment income ratio averaged 4.6%, while all other providers averaged 6.7%. The medical insurance industry had the largest market share, accounting for 34.4% of total gross direct premiums. Previously, the auto insurance industry was the largest class. The medical insurance sector has always been unprofitable due to price undercutting and fraudulent claims. However, there was an increase in underwriting profitability in the medical insurance market for 2020 with the release of COVID-19. The net loss ratio is 74.7% on average. To minimize loss ratios, it was proposed that insurance

companies employ data and predictive analytics to detect fraud. Management expense ratios average 22.8%. It is believed that insurance businesses should optimize their operational models and automate their insurance procedures in order to reduce costs in a sustainable manner. With the spread of COVID-19, there is prediction of various changes in medical insurance trends. It is anticipated there being an increase in the number of medical claims as a result of COVID-19.

The Insurance Regulatory Authority (IRA), Kenya's insurance market regulator, classifies medical insurance as a high-risk class in terms of claim payment. Providers are rewarded in a variety of ways for both outpatient and inpatient care (Chuma & Maina, 2015). The method is heavily influenced by the quantity of money involved. The majority of outpatient service payments are made with cash, debit/credit cards, and, more recently, mobile money such as MPESA. According to Haas and Nagarajan (2017), the latter has played a critical role in improving access and closing the financial gap for rural healthcare providers. Inpatient treatments, regardless of quantity, are likewise decided utilizing the aforementioned techniques.

The Kenyan health insurance sector were investigated by Korir (2020). The investigation was carried out using secondary data from the IRA website, journals, and publications. A claim ratio of 50 to 100 percent indicates that the insurance company compensates claims proportionately in relation to the total premium collected. In most cases, such an insurance company has a promising future because of its financial stability and the likelihood that it will no longer deny claims in the future. However, for client insurance, the acceptable claim ratio should be between 60% and 90%. Claim ratios less than 50% imply that a company either charges a high premium or has customers that have a low risk profile in comparison to competitors. There is a risk that this posture may not change in the near

future, which is good for the company but bad for its customers. When choosing a medical insurance provider, such companies should be avoided.

Fraud in the healthcare and insurance industries costs a lot of money and is a serious problem. In 2009, the European Healthcare Fraud and Corruption Network stated fraud wastes 5.59 percent of all money spent on health care around the world. All over the world, insurance companies are aware of the problem and are working hard to find a solution. Schiller (2016) says that about US\$260 billion of the \$4.7 trillion spent on health care around the world is lost to waste, fraud, and mistakes. Since insurance companies deal with huge amounts of data that can only be processed successfully with the help of automation, it has been suggested that a fraud management system is the most realistic way to solve this problem.

Authorities and medical insurance providers in Kenya have paid a lot of attention to fraud control and good governance because insurance costs are going up. Add to that the competition and pressure from financial institutions like banks that have entered the medical insurance market to offer cheaper, more flexible alternatives to traditional insurance. Also, the rise in insurance fraud and the fact that corporations can get health care on their own terms has made medical insurance less profitable (IRA, 2015). In Kenya, the loss ratio for medical insurance is high, which may be why it is not primarily underwritten. For example, AAR Health Services and Resolution Health East Africa started out as HMOs when they got into the Kenyan market, but they have since expanded into other types of insurance (Isoe, 2019).

## **1.2 Statement of the Problem**

The success of both large and small businesses operating in the insurance market depends critically on the effectiveness of their claims management processes. According to Nair (2016), who addressed the determinants of Enrollment in Comprehensive Health Insurance Scheme and Implementation Challenge, major components of the claims handling process include developing strategies to cut costs and reduce fraud while keeping customers satisfied. This was shown to be an important aspect of the claims handling process. According to Schneider, Kass, and Piotrowski (2018), the time it takes to process a claim is comprised of multiple steps, the first of which is the filing of a claim by an individual. The subsequent steps determine whether or not a claim is legitimate, as well as the amount that an insurance provider will pay out.

In spite of this, the problem of claim settlement was shown by Korir (2020) who conducted a comparative study of Jubilee Insurance Company's Claim Ratio with Other Insurance Companies in Kenya. According to the IRA, non-life insurance companies paid KES 56.93 billion in claims. The automotive category received the most claims (49%) followed by the medical segment (36%). The insurance regulating authority reports a substantial number of fraud claims in the Kenyan insurance sector each year. The automotive segment has had the most fraud claims, followed by the medical segment. There have been numerous reports of faked surgery in the country. In this case, healthcare professionals submit incorrect billing codes to insurers in order to receive exaggerated compensation.

There are also instances where a normal delivery is performed yet medical practitioners state that a Caesarean section was performed. As a result, insurance firms face hefty claim costs. Still, an investigation of insurance settlement challenges in Kenya that was carried out by Ernst and Young (2013-2015) found that forty percent of all claim payments

were fraudulent. According to the annual report that AKI published in 2015, the total amount of net claims paid out was 40.07 billion Kenyan shillings, of which 40 percent, or 6.02 billion, were judged to be fraudulent (Owojori, 2018).

There are studies addressing the subject of insurance claims; Crocker and Tennyson (2021) investigated various aspects of insurance fraud as well as the most productive approaches to the resolution of claims at Michigan State University while Lakshmi and Ganesh (2016) conducted research into the function of forensic accounting in relation to the prevention of corporate fraud and the provision of legal assistance to Indian firms. In Tanzanian Insurance Industry, Yusuf, Tajudeen and Adebawal (2018) examined the Roles of Claims Manager in the Claims Handling Process. Gisairo (2016) conducted a study on the effectiveness of biometric technologies in preventing fraud in Kenyan medical insurance companies. According to the research, the health insurance industry had the greatest loss rate at 81.5%, followed by the private auto insurance industry at 74.9%. While Abdinasir (2017) examined the influence of Forensic Audit Services on Fraud Detection Among Commercial Banks in Kenya. This study's purpose was to analyze the effect of the forensic audit services given by commercial banks in Kenya; suspicious occurrences and recurring costs associated with the Anti-money laundering service. The study discovered a negative correlation between fraud detection and investigation services and lawsuit assistance. Njuguna (2019), made an effort to figure out the response plan that Kenyan commercial banks do when they discover fraud. It was established that commercial banks in Kenya implement a variety of measures to combat fraud including preventative, training, detection, prosecution, and investigation methods.

Despite the studies that have been undertaken to address the subject of claim settlement, there is no specific study that narrowed to forensic accounting practices and

settlement of health insurance and same time adopting fraud investigation practices, litigation support practice and of dispute resolution practices. Other studies focused on financial institutions such as banks whereas the current study focuses on insurance firms. Further to this, gaps are also observed on the study covered in Tanzania and in a public organization whereas the current study focused on Kenyan Insurance firms. This resulted in research gaps that this study sought to cover. Therefore, in order to fill the research gaps, this current study sought to establish effect of forensic accounting practices on claim settlement efficiency in health insurance sector in Kenya.

### **1.3 Objectives of the Study**

The study was guided by the following;

#### **1.3.1 General Objectives**

The general objective of the study was to examine effect of forensic accounting practices on claim settlement efficiency in health insurance sector in Kenya

#### **1.3.2 Specific Objectives**

- i. To assess the effect of fraud investigation practices on claim settlement efficiency in health insurance sector in Kenya.
- ii. To assess the effect of litigation support practice on claim settlement efficiency in health insurance sector in Kenya.
- iii. To determine the effect of dispute resolution practices on claim settlement efficiency in health insurance sector in Kenya.

### **1.4 Research Questions**

- i. How does fraud investigation practices affect claim settlement efficiency in health insurance sector in Kenya?

- ii. To what extent does litigation support practice affect claim settlement efficiency in health insurance sector in Kenya?
- iii. How does dispute resolution practices affect claim settlement efficiency in health insurance sector in Kenya?

### **1.5 Significance of the Study**

The findings of this study will be useful in contributing to the formulation of insurance sector policy in Kenya, particularly with regard to the responsibilities and functions of forensic auditors. In addition to this, it will provide concrete evidence regarding the influence that forensic accounting has on the prevention of fraud, which will contribute to the creation and administration of health insurance policies. Because it will offer guidance on the internal controls that can be implemented by insurance companies during the occurrences of health care claims and will also elaborate on forensic accounting services. In addition, it will provide advice on the internal controls that can be implemented by insurance companies during the occurrences of health care claims.

The study will provide the Insurance Regulatory Authority of Kenya with assistance in developing guidelines for improving the efficiency of forensic accounting techniques in the hopes of lowering the number of instances of financial fraud that occur within the insurance industry. It is intended to encourage Kenyan forensic professionals to participate in the activities that led to the development and modification of various accounting procedures, thereby making those procedures more applicable and adoptable in the insurance sector. This will be accomplished by pushing for their participation.

Insurance Firms: This study will make an effort to inform insurance businesses through the development of risk assessment tools and training for capacity-enhanced staff on

fraud-related activities and how to minimize them. These goals will be accomplished through the research described in this paragraph.

In the future, academics and researchers who intend to continue their investigation into the same subject will use the findings of the study as a reference when conducting their work. The findings will also help researchers in identifying areas that require greater research; the broad empirical literature will help in identifying study gaps. The research will contribute significantly to the development of forensic accounting strategies in the insurance sector.

### **1.6 Scope of the Study**

The purpose of this study was to examine effect of forensic accounting practices on claim settlement efficiency in health insurance sector in Kenya. This was on reference to insurance firms in Nairobi. The study sought to target selected administrative staff to address the subject of fraud investigation practices, litigation support practice and dispute resolution practices on claim settlement efficiency in health insurance sector. The study was carried out within a period of six months to completion.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter offers a review of the pertinent literature that was deemed important in order to assist in better comprehending the research investigation. The theoretical orientation, the empirical review, and the conceptual framework are all discussed.

#### **2.2 Theoretical Review**

The current study is anchored on the following theories;

##### **2.2.1 Occupational Fraud Theory**

In 1995, Timothy William Bergsma founded the Occupational Fraud Theory. Schemes that involve occupational fraud involve an employee defrauding their employer by exploiting the confidence they have earned from their employer for their own personal gain. The purposeful misuse or misapplication of the employing organization's resources or assets for the goal of personal benefit is the official definition of occupational fraud. Occupational fraud is a form of white-collar crime.

Further, Grenier, Mackay and Morrissey (2018) state that the Association classifies occupational fraud into one of three categories. Corruption can take several forms, including conflicts of interest (schemes involving buying and selling), bribery (including invoice kickbacks and bid rigging), illegal gratitude, and economic coercion. Asset misappropriation includes both the loss of cash (theft of cash on hand or cash receipts) and the misuse of inventory and other assets for the purpose of obtaining personal advantage.

Both overstatement and understatement of assets or revenues on financial statements are considered fraudulent practices. Examples of each include "timing differences," "fictitious revenues," "concealed expenses and liabilities," "improper asset valuation," and

"improper disclosures" (Timing differences, understated revenues, overstated expenses and liabilities, improper asset valuation). Fraud in the workplace takes many forms, including theft of company property, bribery, and the presentation of false financial information. This ubiquitous problem affects nearly all companies, regardless of their size, location, or field of operation.

The argument by Isaac, Adotey and Kwashi (2019) were based on the notion that employee theft is essentially a consequence of workplace conditions in the setting of conventional firms. Employee theft is highly connected with job dissatisfaction. Employee dissatisfaction has been found to connect with dysfunctional behavior, according to study on occupational dishonesty. These investigations shed light on some key linkages between the criminals and the scams they have perpetrated, including the following: There was a lack of responsibility separation, placing undue reliance in key employees, imposing unachievable expectations, and operating on a crisis basis, all of which were pressures or weaknesses associated with fraud.

Those who disagree with the Occupational Fraud Theory argue that it may be improved by include a fourth factor, which they refer to as capacity. There is a possibility that the criminal possesses a position as well as sufficient expertise. According to Dorminey et al. (2015), the opportunity, pressure, and rationalization that bring the perpetrator closer to the door to fraud all bring the perpetrator closer to the door. However, the perpetrator needs to be able to recognize the presence of opportunity in order to take advantage of it and commit fraudulent acts.

Drechsler and Jütting (2015) explains that there are a lot of other things that come together to make fraud such a challenging problem. Nevertheless, they assert that even when robust internal controls are in place, there are still instances of fraud committed by employees

who find ways to get around those protections. This is the case even when strong internal controls are in place. If management has a comprehensive awareness of the possibilities, pressures, and rationalizations that lead to fraud in organizations, they will have an easier time identifying areas that are susceptible to fraud and will be better able to strengthen such areas. Fraudsters will only commit their crimes when they believe they will make a profit from their activities. Possibilities include an unstable board of directors, insufficient internal controls, and the capacity to conceal fraudulent activities in complex webs of related organizations. All of these factors contribute to the possibility of fraud.

The theory is applicable in the study because it helps to explain aspect of fraud investigation and why any employee might be motivated to defraud the employer and it also reveals how incentives and opportunities appear to interact with one another. For years, occupational fraud has been the primary topic of discussion when discussing white-collar crimes in the accounting field. Auditor's use of the Fraud as a technique for observing the motivations of fraud perpetrators is another area in which it is useful. The theory states that people have a tendency to be greedy and dishonest by nature, which makes them the primary source of risk inside an organization.

### **2.2.2 Moral Hazard Theory**

A moral hazard happens when someone is responsible for the interests of another person but has a reason to put their own needs first (Holmstrom, 1979). Moral hazard is a term that has been used to talk about insurance for more than 200 years. It means that there is a chance that insurance could cause the insured to take on more risk in a way that could not be managed. Moral hazard is also used in mainstream analyses that focus on rational behavior, usually in relation to the fact that not everyone has the same amount of information. The

theory of moral hazard is based on four main ideas: perverse incentives, bad examples, norms, and provocation.

It is opportunistic to take advantage of a situation for your own gain, even if it hurts other people. So, moral hazard is the risk that a person or group will act in an immoral way, breaking moral rules and breaking trust. Moral hazard is the difficulty of getting people to choose the right hidden acts, and adverse selection is the difficulty of getting people to tell the truth about hidden information (Schneider *et al.* 2018).

The claims made by Kocs (2015) reveal that moral hazard has both good and bad parts. From a traditional moral hazard point of view, more use by insured patients is usually seen as wasteful. But moral hazard spending can save a person's life if they are in a situation that could kill them. So, people who buy insurance to transfer income in case they get sick will have to pay a portion of their premiums based on the usual moral hazard effect. But it is efficient because the consumer is willing to pay more than the care's marginal cost. Moral hazard is the idea that a healthy person shouldn't be able to use health services for things like cosmetic surgery or unneeded outpatient visits just because they can.

Having access to health care services is ideal because everyone is exposed to health risks. Purchasing health insurance is one way to protect yourself from this type of danger. People need health insurance to cover the high costs of medical care, especially those incurred by hospitalization or long-term medical conditions. It safeguards financial resources. Many people struggle financially because of the high cost of medical care, whether from an unexpected illness or injury or from a long-term condition requiring ongoing treatment. Exorbitant health care prices are another reason why people put off getting medical help. Consequently, having health insurance is crucial (Jarque, 2010).

Considering that expenses are borne by other policyholders, proponents of the moral hazard hypothesis claim that it is understood to apply to incentives for patients to abuse healthcare services. In other words, policyholders have an incentive to utilize more services than those upon which their premiums are based. Still, there are two more stakeholders to health insurance besides policyholders: insurers and health care providers. In a direct or perverted manner, all three are susceptible to moral dangers (Schneider *et al.* 2018).

The critique of the theory of moral hazard as provided by Morley and Ormerod (2016) revealed that it is regarded an economic problem since it leads to poor resource allocation. It does so because one side imposes a greater cost on the other, which, if applied to the economy as a whole, would result in extremely high expenses. Consequently, when insured persons bear a lesser portion of their medical care costs, they are more inclined to utilize more care. The term for this is "moral hazard." Moreover, when selecting an insurance plan, persons who are more likely to require medical treatment prefer to choose for more generous coverage.

In the legal context of health insurance, moral hazard is frequently used to describe the possibility that insurance coverage, by reducing the marginal cost of care to the individual, may promote healthcare utilization. The dispute resolution practices may be required in cases where moral hazard may result in personal, professional, and economic legal liability when persons or corporations in a transaction engage in hazardous activity because the other parties are contractually obligated to bear the unfavorable outcomes, thus, a need for dispute resolution practices.

### **2.2.3 White Collar Crime Theory**

The theory of white-collar crime is traced to Ross (1907), who introduced the concept of white-collar crimes. Ross (1907), coined the term *crimanoloid* to describe a person who

exploits societal flaws but does not fit the profile of a typical criminal. This theory was explored further by Sutherland (1949) as an extension of old beliefs that maintained poverty-related criminality. White-collar crime is financially motivated and non-violent, including business and government professionals.

According to Sutherland (1949), the "white-collar crime" is a crime done by a person with a good reputation and high status in a certain job. These crimes are both planned and carefully put together on purpose. White-collar criminals don't think of themselves as breaking the law and don't look like a typical criminal. Since most white-collar cops are not poor, poverty isn't a factor in these crimes. White-collar crimes include things like fraud, bribery, cybercrime, embezzlement, and money laundering.

Sutherland tried to show a link between white-collar crime and business and economic operations in 1949. The status of professionals in a society creates an atmosphere of both awe and fear, so people in the community both respect professionals and do not go to court against them out of fear. This means that white-collar crimes get light punishments or none at all. White collar crime is more complicated and less obvious than violent crime because the effects of the crime can last for a long time. Some people may claim that fraud is a good thing and share this information with people who think that fraud is bad. People are less likely to think that white-collar crimes do not hurt anyone and are a big deal when they hurt more than one socioeconomic group (Schneider, Kass and Piotrowski, 2018).

The idea of white-collar crime has been criticized by scholars. Friedrichs says that Sutherland put too much emphasis on individualistic social psychological factors and didn't pay enough attention to social structures like economic cycles, profit rates, and capitalism (2002). He is also criticized for not being able to tell the difference between white collar crimes and other crimes and for not taking into account the role of companies in legislative

and regulatory processes. In the past few years, the idea that professionals would get better legal punishments has also changed.

Understanding the causes of white-collar crime through litigation support practice is crucial for the development of effective intervention and preventive programs. Effectively preventing white-collar crime may need an increase in security measures effective litigation support practice demanding more energy to beat criminals and presenting a greater risk of capture, according to the theory. The simplification of laws and regulations can prevent commercial abuses such as bankruptcy fraud and insurance fraud.

### **2.3 Empirical Literature**

This section indicates various studies carried out in relation to fraud investigation practices, litigation support practice and dispute resolution practices on claim settlement efficiency in health insurance sector.

#### **2.3.1 Fraud Investigation Practices and Claim Settlement Efficiency**

Research was carried out at Michigan State University by Crocker and Tennyson (2021) on various aspects of insurance fraud as well as the most productive approaches to the resolution of claims. In order to arrive at such conclusion, a factor analysis and a variance analysis were utilized. The statistical hypothesis testing and cross-tabulation techniques were utilized in order to investigate the interdependence of claims across user groups and industries. In addition, the authors of this study make use of a multiple regression in order to investigate the connection that exists between these parameters and the various market subsets. An indemnification profile was used as the settlement mechanism in this case because it was determined that claims auditing was ineffective as a means of discouraging fraudulent activity. This was done to ensure that the amount of money paid out by the insurance company was proportionate to the amount of loss that was declared. A decent indemnity

profile will contain some degree of systematic underpayment of claims on the margin in order to dissuade loss exaggeration. The amount of underpayment will be restricted by anticipated litigation costs and potential bad-faith claims, however.

A Critical Review of Insurance Claims Management: Olalekan, Ajemunigbohunb, and Gbenga (2019) delivered a presentation entitled "A Study of Selected Insurance Companies in Nigeria. The metropolitan region of Lagos served as the location for this research, which was carried out using a descriptive survey design, random sampling, and a structured questionnaire in order to collect data. Claim managers and other staff members from the companies polled were included in the sample population to represent the public at large. In order to examine the gathered information, a single sample T-test was applied. According to empirical research, the numerous processes that are used to handle claims have a significant influence on the processes that are utilized by insurance companies for claims management.

The findings of the study provide evidence that the numerous processes involved in the treatment of claims are significant to the claims management of insurance firms in Nigeria. As a result of this, it is strongly suggested that claims managers build strategic plans in order to guarantee that insurance claims complaint files are effectively stored, monitored, and managed in preparation for future demands. In addition, cutting-edge training mechanisms ought to be put into place so as to bolster and enhance the working pattern of a claim officer, which has the potential to influence the organizational effectiveness of insurance companies in terms of claim administration.

In Tanzanian Insurance Industry, Yusuf, Tajudeen and Adebawal (2018) examined the Roles of Claims Manager in the Claims Handling Process. The purpose of this study was to investigate the responsibilities of claim managers in Tanzanian insurance claims

processing. Using a structured questionnaire and a basic random sample technique, the study utilized an exploratory research design. The Chi-square test was performed to evaluate the data in order to discover whether or not there is a significant association between the variables in each hypothesis. The research indicated a significant correlation between claims operation and efficient claims management. It also demonstrates a significant connection between fraud detection and efficient claims management. In order to improve these roles, it is suggested that the head of claims should be a member of the top management team, that workers in the claims department be subjected to training, and that insurance companies embrace their organizational philosophy towards the claims handling process.

As stated by Odhiambo (2017), based on evaluation on the fraud management measures employed by insurance companies in Kenya in his study. A survey was undertaken among 25 of the 50 insurance companies to determine particular fraud management measures in use and to evaluate their efficacy. The collection, coding, descriptive statistical analysis, and presentation of data. The study determined that insurance companies utilize standard internal control systems to manage fraud, including internal and external audit functions, underwriting, claims administration, information technology, and management committees. The study determined that the measures employed by insurance firms to combat fraud are unsuccessful, resulting in a rise in fraud cases and costs. This vulnerability is exploited by fraudsters who take advantage of the fact that most businesses avoid examining and prosecuting suspected false claims.

The study by Kimeli (2018) was based on the investigation about the role of the Fraud Investigation Unit in the management of crimes in the capital markets industry in Nairobi County, Kenya. The study's aims were to identify fraud manifestations, explore the techniques used by the Capital Market Fraud Investigation Unit for managing fraud in the

sector, and identify the challenges the unit encounters in carrying out its mandate. A descriptive survey design was used, which included questionnaires and in-depth interviews with key informants. The study included personnel from capital market players as well as important industry insiders. Employees were sampled using stratified random sampling, whilst key informants were sampled using a purposive sampling design. To collect primary data, questionnaires and semi-structured interviews were employed. The data was evaluated qualitatively utilizing themes and content analysis approaches.

The study discovered that fraud management techniques benefited Nairobi County's capital markets. Misaligned incentive structures and inadequate cultural norms, on the other hand, have resulted in reputational loss and mistrust among capital market businesses. The investigation concluded that the capital markets' Fraud Investigations Unit had adopted a number of detection methods, the most essential of which were the surveillance system and information sharing.

According to Chudgar and Asthna (2018), insurance fraud is one of the most significant concerns affecting customers, firms that provide insurance, and government agencies that oversee the insurance industry. According to the findings of the research, instances of insurance fraud like these have a direct influence on the total cost of insurance policies as well as the cost of insurance premiums for policyholders. It comprises a wide range of unlawful practices and actions in their many forms. Morley and Ormerod (2016), revealed that the importance of effective risk management is rapidly expanding in the sector of the insurance industry. Due to the ever-changing nature of the insurance sector, an increased focus has been placed on risk management. Insurance companies need risk management systems that combine both the assessment of fraud risk and the prevention of fraud.

### **2.3.2 Litigation Support Practice and Claim Settlement Efficiency**

Lakshmi and Ganesh (2016) conducted research into the function of forensic accounting in relation to the prevention of corporate fraud and the provision of legal assistance to Indian firms. In order to gather the necessary information for the study, interviews with forensic accountants in India were conducted between 2013 and 2015. In order to shed light on the theoretical concept, nature, practice, need, and function of forensic accounting in the prevention of fraud, as well as the practical challenges faced by forensic accountants, the goal of the research was to conduct the investigation described above. The research offered a helpful opportunity to have a deeper understanding of the significance of forensic accounting as well as its scope. It also highlighted the obstacles they faced in a more physical sense, such as the lack of centralized databases in the Indian environment, which made it impossible to access all important data. This was one of the issues that was addressed in the report. The demands made by the clientele are occasionally laughable.

Lyimo (2019) did research on Insurance Claims and Claims Settlement in Tanzania, looking at both the legal and practical problems that can occur as a result of these processes. This study focuses on the claims and settlements procedure within the Tanzanian insurance market. It investigates both the legal and the practical components of this process. There is a widespread perception that the laws that govern insurance claims and payouts are unfairly weighted in favor of insurers. Three different insurance companies, namely the National Insurance Corporation (NIC), Phoenix Insurance, and Jubilee Insurance, were chosen specifically for the purpose of conducting this research.

Lyimo (2019) notes that a combination of in-depth interviews with workers in the insurance sector (insurers), focus groups with clients of insurance companies (insureds), and document examination and analysis were used to acquire the data for this study. The data

provided support for the idea that the regulations that control insurance claims and settlements are weighted heavily in favor of insurance companies. The first reason why people who have health problems aren't required to have insurance is because the regulations that govern insurance claims and claim settlement typically require a lengthy waiting period between the insured person and the insurance company before the insured person is compensated for their insured losses. This is why people who have health problems aren't required to have insurance. While insurers remain silent in the face of policy violations that result in legal duties and penalties, insureds are held accountable.

The study by Angima and Mwangi (2017) focused on the influence of underwriting and claims management on the performance of East African property and casualty insurers. Multiple linear regression analysis was applied to primary and secondary data gathered from general insurers in Kenya, Uganda, and Tanzania. The findings indicate that some litigants seek litigation finance or pay their legal fees case-by-case since, without it, they would be unable to launch a lawsuit at all. However, firms are no longer required to invest and risk their own resources in order to fund legal claims. The FISCUS is the funding package that insurance firms can offer clients to assist in mitigating the financial risk of litigation and removing the associated costs off their balance sheets.

The analysis undertaken by Njuguna (2019) addressed the effectiveness of the Legal and Institutional Framework in Preventing Automobile Insurance Fraud in Kenya. The study employed a longitudinal design. In the study, a sample size of 10 was utilized. The study utilized secondary data found on the website of the Insurance Regulatory Authority in Kenya. Using descriptive and inferential statistics, the data given in tables and graphs was analyzed. The study determined that auditing necessitates a variety of inquiries on liabilities in general, which may include consideration of prospective lawsuits and claims the audited entity may

face. To conduct this portion of the audit, auditors typically request representation letters from the company's attorneys. These letters affirm an estimate created by management, which is then submitted straight to the auditors.

According to Bundi (2019), an analysis on the role of third-party administrators in establishing legally managed health care systems: a case study of Henner Groupe Kenya was carried out. The research employed a descriptive design. This study's intended participants were insurance companies with headquarters in Nairobi. The research used both primary and secondary data sources. The research produced qualitative and quantitative data. The descriptive statistics method of data analysis was applied to both quantitative datasets. The study concludes that the revelation of facts or estimations of the financial repercussions anticipated by the corporation in relation to the litigation for auditing purposes may influence the litigation's outcome. The reported estimate may differ from the amount the corporation may have offered to settle the dispute, thereby complicating settlement negotiations. The outcome demonstrated that audited entities cannot tell their attorneys not to submit information about actual or continuing litigation, as requested by their auditors, in order to maintain the confidential character of such material. This might result in the auditor's providing comments on the financial statements or maybe issuing a modified audit opinion.

Resolving medical malpractice claims: a critical analysis of disciplinary proceedings in Kenya was the topic of study by Lifanya's (2017). In addition to archival material and newspaper articles, an explanatory case study methodology was used for the study. The study discovered that the concept of insurance litigation for medical malpractice claims is predicated on the notion that an insurance company owes a specific level of care to policyholders. As a genuine insurance business, it should acknowledge its duty to defend a claim that is presented in accordance with the provisions of the policy and its duty of

indemnification, to pay a judgment against the policyholder up to the maximum of coverage by reducing the number of days-to-resolution.

### **2.3.3 Dispute Resolution Practices and Claim Settlement Efficiency**

As a case study in the search of enhanced consumer dispute resolution, Schwarcz (2021) investigated the disparities between the techniques taken in the United Kingdom and the United States to disputes about medical insurance claims. Within the scope of the study were components of both quantitative and qualitative research approaches. Participants ranged from legal and judicial officials to those working in the medical field. According to the findings of the research, the insurance industry has actively encouraged the use of mechanisms or institutions that have the potential to lead to the out-of-court resolution of disputes or disagreements that may arise between the insured and insurance companies. This has been done in an effort to reduce litigiousness in the processing of claims and discourage litigation in general.

Kajwang (2022) conducted research on the factors that influence the productivity of Uganda's insurance industry, namely loss adjustment methods and dispute settlement. In addition to doing a desktop literature review, we carried out a systematic search with the use of Google Scholar, Semantic Scholar, and Research Gate in order to accomplish this objective. For the purpose of the study, relevant articles that were published between 2015 and 2022 were integrated. According to the findings of the researchers, effective loss adjustment methods are essential to the growth and profitability of insurance companies in both financial and non-financial aspects. It was discovered that there was a correlation between the existence of an established and management-approved method for paying out *ex gratia* claims and the occurrence of fewer financial risks. It was also noted that insurance companies might increase their earnings by regularly examining their policies for the

management of claims in order to adapt to the patterns of developing markets. The research also discovered that the financial and non-financial results of insurance businesses are affected by quality reviews of claims to determine whether or not they are handled properly and appropriately. This was found to be the case for both types of results.

The review by Isoe's (2019) was based on the Alternative Dispute Resolution (ADR) for Insurance Disputes: A Comprehensive Review of the Legislative Framework in Kenya. The data reported in the article were collected as part of an investigation of the viability of health insurance in Kenya. A cross-sectional household survey and focus group talks were used to obtain data. According to the findings, mediation success rates are determined by a neutral third party (the mediator) who assists conflicting parties in reaching an agreement. Notably, the mediator has no authority to compel the parties to reach a settlement. Instead, his or her objective is to help the parties discover common ground.

The analysis by Gachohi (2016) focused on the factors that influence the adoption of health insurance programs among Kibera Informal Settlement Dwellers in Nairobi, Kenya. The study employed a census survey approach in which a structured questionnaire was provided to four reinsurance businesses in the country that handle claims. The study indicated that policyholders who purchase an insurance policy do so with the expectation that the insurer will behave in good faith and do its best to achieve Mediation success rates when it comes time to make a claim. When insurers fail to fulfill their responsibilities, they are sometimes called into question and become entangled in insurance lawsuits.

The study by Cheluget and Kitaka (2020) focused on the Factors Affecting Disputed Insurance Claims Payments in Kenya: A Case Study of Assurance Company Limited. The study was founded on expectancy and goal setting ideas. The population of 120 "A" Assurance Company Limited employees was the focus of this study, which used a descriptive

research approach. A representative sample of the target population was acquired using stratified proportional sampling. To collect data for this study, questionnaires were mostly used. Prior to distribution to the intended population, the surveys were pilot-tested. Descriptive statistics were used to analyze the data. The study made extensive use of means, averages, and percentages. According to the report, legal settlements can be obtained in or out of court. Insurance claim disputes are often resolved outside of court by negotiations between the insurer and the insured, notably the settlement of claims at the insurer's discretion (*ex gratia*) as an act of good faith on the part of the insurer/policyholder.

According to Awino and Kathanga (2016), they conducted a study on the compensation issues confronting Kenya's insurance sector growth: a survey of selected insurance firms. A descriptive survey methodology was used in the study. A descriptive survey method was used. There are a total of 43 insurance firms available. A sample of 21 enterprises (representing 50% of the population) was chosen from the population. This was accomplished through the use of a random sampling approach. The collected data was analyzed using the statistical package for social science (SPSS) software for data analysis employing tables, frequencies, and percentages. Using questionnaires and analyzing data with descriptive statistics based on the findings, it was determined that parties can engage in the decision-making process regarding the resolution of the disagreement. The function of the mediator is to listen to all parties' arguments and aid them in reaching a resolution. In addition, the findings highlighted that the procedure may be a waste of time and money if one of the parties does not approach it with the proper mindset.

A study on Legal Strategies Affecting the Performance of Health Insurance Companies in Kenya: A Case Study of Jubilee Insurance Company in Nairobi was carried out by Mugo (2017). The study employed a descriptive research design in which quantitative

and qualitative research methods were employed to acquire a deeper understanding of the outcomes. This study's initial population selection was limited to Jubilee Insurance Company of Kenya Limited. The selection of the sample was based on non-probability sampling methods, namely judgment and convenience. Respondents were administered open- and closed-ended questionnaires to collect primary data. Using means, standard deviations, and frequencies, descriptive analysis was conducted using the descriptive statistical tool Statistical Package for the Social Sciences (SPSS). In contrast, the quantitative data obtained were analyzed using Anova and regression analysis to identify the relationship between performance and other variables, and the results were presented in tables. The findings indicated that the standard rules of evidence used in court may not be properly applied in arbitration procedures, making it considerably simpler to provide evidence. Discovery, the time-consuming and costly process of taking and responding to interrogatories, depositions, and requests to produce documents, may be significantly reduced in arbitration.

#### **2.3.4 Claim Settlement Efficiency**

The nature and difficulties of cost claims management by reinsurance enterprises in Kenya were examined by Machuhi (2016). The census survey approach was utilized in this study to distribute a structured questionnaire to four reinsurance businesses in the country that handle claims. According to the research, the biggest impediments to reinsurers' ability to execute their claims management requirements are incorrect claims cushioning and late payment of reinsurance premiums by cedants. The efficiency of an insurance company's Claims Department employees is one element that may influence the time it takes to settle a claim. Inadequate inbound data collection methods, poor information exchanges between claims adjusters and underwriters, and the claims adjuster's inability to triage or prioritize incoming

claims all reduce insurance claim employees' productivity and, as a result, the time spent settling claims.

The subject of Mwangi's (2018), analysis was the Operations Decision-Making Efficiency of Kenyan Insurance Companies. The research was guided by the resource-based perspective theory, the behavioral choice theory, and the industrial organization theory. The investigation employed a descriptive methodology. The researcher utilized primary data for the aim of this study. Using a questionnaire, data was gathered via an experience survey. The respondents were the operational managers from each of Kenya's 52 direct insurers. As impractical as it may sound, the study revealed that customers anticipate claims to be settled as soon as they notify the insurance carrier of a loss or damage. However, the length of time required to settle a claim varies widely from firm to company. It is not advisable for the insurance company to take too long to settle a claim, as this reduces customer satisfaction and exposes the insurance firm to lawsuit risks.

An analysis carried out by Mudaki and Wanjere (2020) was on the Effects of Operational Efficiency on Organizational Performance in Kenya's Insurance Industry. The study's goal was to evaluate how operational difficulties affect insurance company performance. The study used a descriptive census survey format. The research was carried out in Nairobi, and the population consisted of insurance companies that were registered as of August 2017. Using descriptive statistics and inferential statistics, the data was analyzed. Some staff can process 10 claims per day, while others can process only one per day, according to the findings of the study. Once managers have identified the source of the insurance claim processing productivity issue, they was in a better position to take the necessary next steps, such as firing unproductive staff who do not reach claims processing quotas.

The investigation by Wambia and Jagongo (2020) were on the effect of working capital management practices on the financial performance of Kenyan insurance firms. The study used a descriptive research design. It is targeted underwriting managers, chief accountants, and finance managers at Kenya's 47 insurance companies. A sample size of respondents was determined using a systematic sampling procedure. Data was collected through a questionnaire, which was then analyzed using the Statistical Package for the Social Sciences. Because insurance companies exist to make a profit, having profitability linked to inefficient insurance claim processes that raise the cost per claim can be detrimental to the bottom line. As previously said, claims adjusters can reduce errors by spending more time processing claims; however, taking too much time may cost the business money and alienate clients due to lengthy claim cycle times.

According to Mugo (2017), when it comes to making payments on insurance claims, many insurance firms are required to proceed with a high degree of caution so that they do not become victims of insurance fraud. In order to successfully defend themselves against erroneous claims, it is essential for every insurer to have access to a skilled legal team that can investigate the possibility of fraud and misrepresentation across the entirety of their insurance company. There are a variety of approaches that may be used to investigate a claim in order to determine whether or not it is valid when an insurance company has reason to believe that it may have been the recipient of a fraudulent or inflated claim.

#### **2.4 Summary**

Claim settlement inefficiency is caused by a multitude of variables, including insurance fraud, according to research results. It is asserted that institutions lacking a suitable forensic accounting procedure for tracking claims payment will incur payment delays. Literature reviewed for this study indicates that the concepts of fraud investigation techniques, litigation

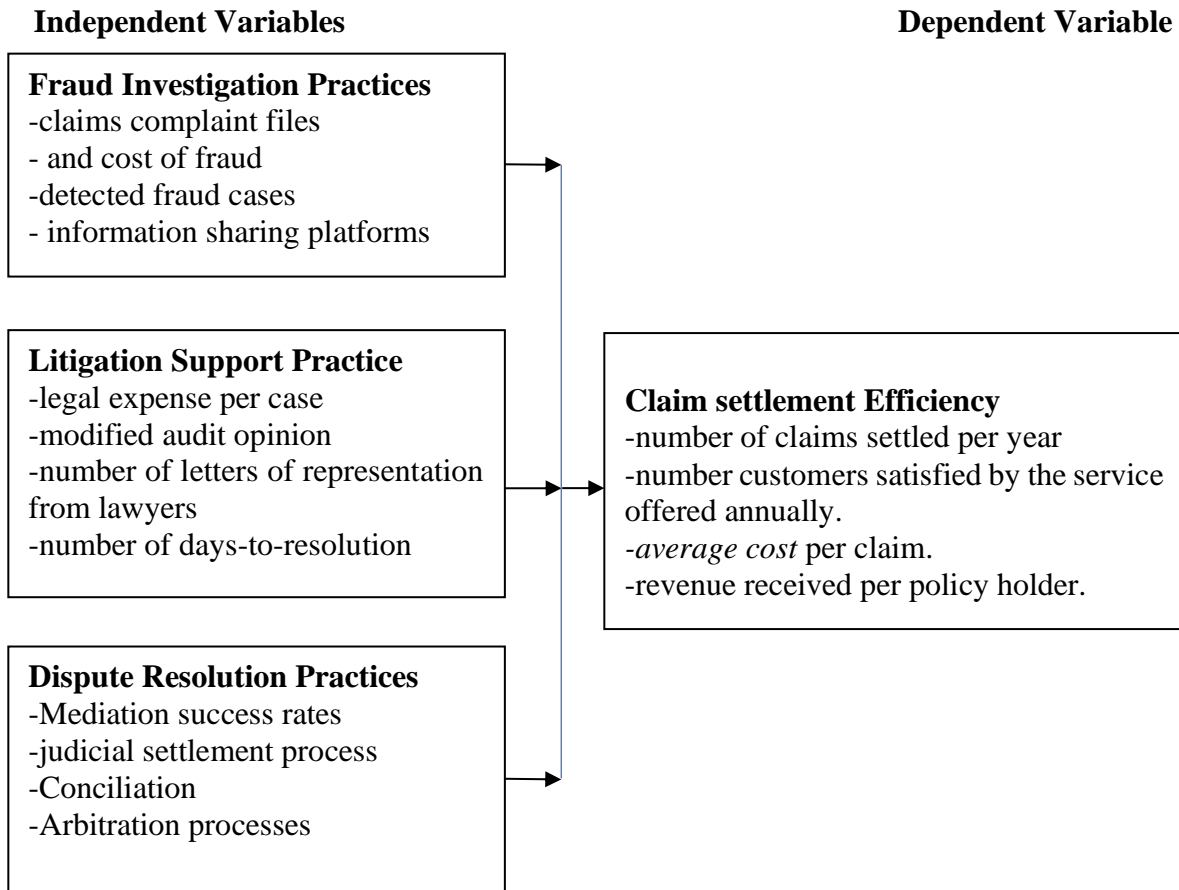
support methods, and dispute resolution practices are connected to the efficiency of claim settlement in the health insurance industry. In addition, the literature review has shown a number of hypotheses that support the necessity of embracing such characteristics.

Investigations into insurance fraud almost always concentrate their attention on the policyholders who are responsible for filing false claims. Claims that are either false or exaggerated cannot be accepted. According to reports compiled by the Coalition Against Insurance Fraud, fraudulent insurance claims result in annual payouts of approximately \$80 million. Because of the infusion of cash, the insurance market will be thrown into disarray, and premiums will go up as a direct result. Insurance fraud can occur in a variety of contexts, including those pertaining to health, disability, disaster, automobile, homeowners, and business insurance, to name a few.

The findings of empirical studies conducted both locally and internationally reveal conceptual, contextual, and methodological flaws. The bulk of studies have been quantitative or qualitative in nature. Furthermore, past research has interpreted concepts from many perspectives by using a number of theories and variables to develop deductive arguments, which cannot be fully accepted in this study. Diverse procedures were used by different researchers in terms of research design, population, sample design, research instruments, and data processing techniques. Unlike previous studies that used causal, longitudinal, and cross-sectional research methods, the current study will use quantitative survey research. Second, each study was conducted in a variety of environments, ranging from insurance businesses to universities. The current study, on the other hand, will focus on the effect of forensic accounting techniques on the efficiency of claim settlement in Kenya's health insurance system.

## 2.5 Conceptual Framework

A conceptual framework is a type of analytical tool that comes in a variety of configurations and contexts. It is used to draw conceptual distinctions and organize concepts that capture something actual in an easily-remembered and applicable manner (Shamoo & Resnik, 2018).



Source: Researcher (2022)

Figure 2.1 Conceptual Framework

## 2.6 Operationalization of Variables

**Table 2.1 Operationalization of Variables**

<b>Objectives</b>	<b>Variables</b>	<b>Indicators</b>	<b>Scale</b>	<b>Data Collection Instrument</b>
To assess the effect of fraud investigation practices on claim settlement efficiency in health insurance sector	fraud investigation practices	-claims complaint files - and cost of fraud -detected fraud cases - information sharing platforms	Ordinal scale	Questionnaire
To assess the effect of litigation support practice on claim settlement efficiency in health insurance sector	litigation support practice	-legal expense per case -modified audit opinion -number of letters of representation from lawyers -number of days-to-resolution	Ordinal scale	Questionnaire
To determine the effect of dispute resolution practices	dispute resolution practices	-Mediation success rates -judicial settlement process -Conciliation -Arbitration processes	Ordinal scale	Questionnaire

To analyze claim settlement efficiency in health insurance sector in Kenya.	efficiency in health insurance	-number customers satisfied by the service offered annually. -average cost per claim. -revenue received per policy holder.	Ordinal scale	Questionnaire
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**Source: Research Data (2022)**

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

The methodology of research is the systematic examination and application of processes employed in scientific investigation or a specific research study. The term methodology refers to the research design, data gathering methods, and data analysis techniques adopted to accomplish the research objectives.

#### **3.2 Research Design**

The study adopted descriptive research design. The design of the study included a detailed overview of the approaches and procedures that was used for collecting data and analyzing it. According to Kothari (2008), the purpose of descriptive research investigations was to gather relevant and accurate information on the current state of a problem or phenomenon and, whenever it is possible to do so, to draw valid generalizations based on the facts acquired. In a descriptive survey, the who, what, when, where, and how questions are answered. The descriptive approach commonly employs visual aids such as graphs and charts to assist the reader in comprehending the data. The researcher was able to obtain knowledge on the phenomenon with the assistance of this method by drawing inferences from the facts that are based on the effect of forensic accounting practices on claim settlement efficiency in health insurance sector in Kenya.

#### **3.3 Target Population**

A population is an identified total group or collection of components relevant to the specified information problem and of interest to a researcher as stated by Hair (2013). Determining the demographic from which the researcher draws the sample is part of the process. Salkind (2012) asserts that the population is an accurate representation of particular categories as a

whole or entire group of persons being studied. The target population comprised of 32 registered insurance offering medical covers in Nairobi (IRA, 2021). This was provided on the appendix III, as a list of registered medical insurance companies.

### **3.4 Sampling Size and Sampling Technique**

The study adopted census survey whereby all the 32 medical insurance providers were involved in the study. The medical insurance providers consist of the personal accident cover, medical cover and workmen injury benefits compensation act, (WIBA) which substantially covers medical expenses paid by insurance providers on behalf of the insured clients. Therefore, one (1) representative from each of the 32 medical insurance firms constituted the respondents to participate in the research exercise.

### **3.5 Data Collection Instruments**

A questionnaire is a series of written questions intended to elicit respondents' opinions on a certain subject (Lyon, 2014). In this study, data was gathered using questionnaire. The questionnaires were divided between structured/closed-ended questions that provided a range of possible responses. According to Williamson (2015), the advantage of employing questionnaires is that the procedure is relatively inexpensive for some since once questionnaires are distributed to willing respondents, the researcher only waits for the respondents to respond in their own time.

The questionnaire was divided into two sections: Part A, which comprised of general information about the respondents, and Part B, which comprised of specific questions about claim settlement efficiency in health insurance sector.

### **3.6 Data Collection Procedures**

According to Glass and Hopkins (2018), data collection is the process of acquiring specific information for the purpose of establishing or disproving certain truths. The data collection procedural exercise adopted a drop-and-pick-later approach where accessible respondents were given questionnaires to fill in. The inaccessible ones with the help of email addresses enabled easier access and also gave respondents adequate time to complete the questions. While Kothari (2008), emphasized that the response alternatives for a closed-ended question were exhaustive and mutually exclusive in order to allow the respondent to provide a more in-depth response.

### **3.7 Pilot Study**

The study validated questionnaires by carrying out reliability and validity tests as shown;

#### **3.7.1 Reliability of Research Instruments**

According to Kothari (2008), reliability is the degree to which a test instrument consistently generates the same results when administered to the same group across time. Reliability permits the researcher to discover obscure and missing data collection tool components. A pilot study was conducted using consultants in the health Insurance Industry. At the conclusion of the exercise, however, adjustments were made to the primary questionnaires prior to their distribution to the whole respondents in insurance companies that were targeted.

#### **3.7.2 Validity of Research Instruments**

The extent to which a research instrument measures what it claims to measure is its validity still, it is the degree to which a survey method accurately evaluates what it is intended to evaluate (Kothari, 2008). Before data collection, content validity was determined by having the researcher and supervisor discuss the data collection instrument. This was done to determine the appropriateness of the questions to be asked and the language to be adopted

in the questionnaires in order to assess the complexity of the instrument's content validity.

The researcher adopted the internal consistency of the instruments to test reliability. According to Ary, Razavieh and Soorensen (2020), an instrument should have a Cronbach alpha value of above 0.7 if it is to be considered to have good internal consistency. The researcher used the results of the pilot study to calculate the Cronbach's Alpha Coefficient at a confidence interval of 95%. The results of the pilot study were fed into a computer and the Cronbach's alpha calculated using SPSS version 23. The questionnaire that was found to have a Cronbach's alpha value of above 0.7 was deemed reliable for use with the sample without modification.

### **3.8 Data Analysis and Presentations**

Data analysis is the technique of ordering and organizing raw data in order to extract usable information from it. This requires data cleansing and data coding so that the researcher can generate findings (Glass & Hopkins, 2019).

Before analysis, data was examined for precision, uniformity, logical completeness, and consistency. Data was analyzed using descriptive statistics, such as mean, mode, percentage, and standard deviation, with the use of Statistical Package for the Social Sciences (SPSS) version 26. The analyzed data was presented by use of tables.

To establish the level of relationship of the variables, correlation analysis was used as a statistical tool. To examine the associations between the independent and dependent variables, a correlation matrix was created. A correlation value of zero indicates that no relationship exists between the dependent and independent variables. A correlation of 1.0, on the other hand, indicates that there is a perfect positive or negative relationship. The values ranged from 0 (no relationship) to 1.0 (strong relationship) (perfect relationship).

Regression analysis was used to establish effect of forensic accounting practices on claim settlement efficiency in health insurance sector in Kenya.

The regression analysis was used to establish the combined effect on the study variables. The regression analysis model is specified as follows;

$$Y = \alpha + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon;$$

**Where;**

Y = is the dependent variable, claim settlement efficiency in health insurance sector;

Whereas, X is a set of independent variables of forensic accounting practices measured against the dependent variable, claim settlement efficiency.

X<sub>1</sub> = fraud investigation practices;

X<sub>2</sub> = litigation support practice;

X<sub>3</sub> = dispute resolution practices,

α = constants term, i.e., the claim settlement efficiency does depend on variables under study.

β<sub>1</sub>, β<sub>2</sub>, β<sub>3</sub>, = regression coefficients of X<sub>1</sub>, X<sub>2</sub>, and X<sub>3</sub> while ε = error item.

### **3.9 Diagnostic Tests of Significance**

Prior to performing regression analysis, the researcher checked the independent variables for multicollinearity, homoscedasticity, normality and linearity tests.

#### **3.9.1 Multicollinearity Test**

Both of the multicollinearity tests were carried out by the researcher. The phenomenon known as multicollinearity occurs when there is an inter-correlation among the variables that are being used for explanation (Mugenda & Mugenda, 2003). Multicollinearity renders the estimation of the regression coefficient impossible in its most extreme manifestation (that is, if the correlation between two independent variables is either 1 or -1), and renders the estimation of the regression coefficient unreliable in all other manifestations of the phenomenon. The researcher determined the degree of multi-collinearity present in the

sample by comparing the numerous R<sup>2</sup> values that were obtained and selecting the one that is highest among those values (with few significant t ratios).

### **3.9.2 Heteroscedasticity Diagnostics**

Heteroscedasticity diagnostics are statistical tests of the null homoscedasticity hypothesis against the alternative that a function of the variance can be linearly or non-linearly related to a set of variables (Bray & Maxwell, 2012). Normality tests are used to determine if a data set is well-modelled by a normal distribution and to compute how likely it is for a random variable underlying the data set to be normally distributed (Sekaran & Bougie, 2013). To achieve this, this study utilized the Karl Pearson's coefficient of correlation. The correlation coefficient ranges from - 1 to +1. A value of r near 0 indicates a little correlation between the attributes while a value near +1 or -1 indicates a high level of positive and negative correlation respectively.

### **3.9.3 Normality Tests**

The idea that data should be normally distributed is fundamental to the practice of multivariate analysis (Hair et al., 2010). There is the presumption of a uniform distribution of errors in the value that is predicted for Y, which is the dependent variable. In order to verify that the data are normally distributed, an improved version of the Shapiro-Wilk test was carried out. As a result of the higher power features it offers, the improved Shapiro-Wilk test is frequently utilized in regression research as a method for determining whether or not data follows a normal distribution (Mendes & Pala, 2016). If the results of the tests show out to be significant, then the assumption of normalcy is also invalidated. If the p-values for the K-S test and the S-W test are both greater than 0.5, then the data are judged to be normal.

### **3.9.4 Linearity Tests**

It is presumed that the relationship between the independent variable and the dependent variable is linear. The degree to which the value of the dependent variable shifts in response to shifts in the values of the predictor variables is what's meant by the term "linearity" (Hair et al., 2010). In order to determine whether or not there is a linear relationship between the independent variables and the dependent variables, the study made use of scatterplots.

## CHAPTER FOUR

### DATA ANALYSIS AND PRESENTATION OF FINDINGS

#### 4.1 Introduction

In data analysis, this chapter also addresses the presentation of findings. The interpretations covers the background information about respondents, descriptive and inferential statistics are also covered.

#### 4.2 Response Rate

**Table 4.1 Response Rate**

Category	Frequency	Percentage (%)
Response	31	97
Non-Response	1	3
<b>Total</b>	<b>32</b>	<b>100</b>

**Source: Research Data (2022)**

The presentations shown on table 4.1 provides the response rate. The analysis revealed that 97% of questionnaires were returned against 3% that were not returned. Majority of returned questionnaires symbolized that there was good response to be used in the final interpretations.

#### 4.3 Reliability Test

Reliability of tests were presented in the table as shown.

**Table 4.2 Reliability Test**

Variables	Number of Items	The Cronbach Alpha Values $\alpha > 0.7$	Recommendations
Fraud Investigation Practices	6	0.970	Reliable
Litigation Support Practice	6	0.970	Reliable
Dispute Resolution Practices	6	0.964	Reliable
Claim Settlement Efficiency	5	0.924	Reliable

**Source: Research Data (2022)**

Reliability analysis was carried out to establish the reliability of the used questionnaire. The study used the Cronbach's Alpha. Gliem and Gliem (2008) established the Alpha value threshold at 0.7, thus forming a benchmark for the study. The findings as shown in table 4.2 indicate that fraud practices had an alpha value of 0.970, Fraud support had an alpha value of 0.970 as well whereas dispute resolution had an alpha value of 0.964 and lastly, claim settlement efficiency had an alpha value of 0.924. From the presentation, all items adopted in the study were having Cronbach's Alpha values of more than 0.7. An indication that variables were reliable.

#### **4.4 Demographic Analysis**

The study addressed the personal information about respondents involved in this research exercise

##### **4.4.1 Gender of Respondents**

Gender of respondents were analyzed as follows;

**Table 4.3 Gender of Respondents**

<b>Category</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Male	16	51.6
Female	15	48.4
<b>Total</b>	<b>31</b>	<b>100</b>

**Source: Research Data (2022)**

The presentation shown on table 4.3 was based on the age of respondents. The analysis revealed that 51.6% of respondents involved in this study were male whereas 48.4% of respondents were female respondents. This was a revelation that there was fair gender representation in this research exercise.

#### 4.4.2 Work Experience of Respondents

The work experience of respondents were summarized in the table as follows;

**Table 4.4 Work Experience of Respondents**

Category	Frequency	Percentage (%)
Less than 1 year	1	3.2
1-4 years	3	9.7
5-8 years	3	9.7
9-12 years	12	38.7
Over 12 years	12	38.7
<b>Total</b>	<b>31</b>	<b>100</b>

**Source: Research Data (2022)**

Table 4.4 comprised of work experience of respondents involved in this research exercise. From the presentation, it was noted that a total of 3.2% of respondents were having working experience of less than 1 year. The study further established that 9.7% of respondents were having 1-4 years of work experience whereas 38.7% of respondents had a working experience of 9-12 years. This is also reflected to those over 12 years of work experience were also rated as 38.7%. This revealed that majority of respondents were highly experienced going by the percentage response. Hence, expected to furnish adequate data to this study.

#### 4.4.3 Highest Level of Education of Respondents

The presentation based on Highest Level of Education of Respondents was presented in the table as follows;

**Table 4.5 Highest Level of Education of Respondents**

Category	Frequency	Percentage (%)
O-Level	2	6.5
Diploma Level	6	19.4
Bachelor's degree	16	51.6
Postgraduate degree	4	12.9
Other Qualifications	3	9.7
<b>Total</b>	<b>31</b>	<b>100</b>

**Source: Research Data (2022)**

Table 4.5 comprised of summary of respondents' education level. The presentation revealed that 6.5% of respondents had only 0-level of education. The analysis further revealed that

19.4% of respondents had diploma level of education although majority being 51.6% of respondents had bachelor's degree. Still, a total of 12.9% of respondents had postgraduate degree while 9.7% of respondents had other qualification. The all-round interpretation revealed that respondents were well learned to participate in this study.

## 4.5 Descriptive Statistics

### 4.5.1 Fraud Investigation Practices and Claim Settlement Efficiency

The analysis was based on the influence of fraud investigation practices on claim settlement efficiency in health insurance sector.

**Table 4.6 Fraud Investigation Practices**

Statement	SD	D	N	A	SA	Mean	Std dev
Claims managers make plans to make sure that insurance claims complaint files are well kept.	(4)12.9%	(2)46.5%	(4)12.9%	(8)25.8%	(13)41.9%	3.77	1.40
Polycymakers do come up with long-term plans on insurance claims	(3)9.7%	(5)16.1%	(2)6.5%	(11)35.5%	(10)32.3%	3.64	1.35
Modern training methods are used to strengthen and improve a claim	(1)3.2%	(2)6.5%	(2)6.5%	(14)45.2%	(12)38.7%	4.09	1.01
Fraud detection has been picked out as a way to deal with claims management.	(7)22.6%	(5)16.6%	(10)32.3%	(4)12.9%	(5)16.1%	2.83	1.36
This insurance company keeps fraud in check	(2)6.5%	(2)6.5%	(1)3.2%	(10)32.3%	(16)51.6%	4.16	1.18
The steps that an insurance company takes to stop fraud works	(2)9.7%	(2)6.5%	(1)3.2%	(11)35.5%	(14)45.2%	4.00	1.29

**Source: Research Data (2022)**

The presentation of findings on Table 4.6 was based on the analysis showing the influence of fraud investigation practices on claim settlement efficiency in health insurance sector. The study established that claims managers make plans to make sure that insurance claims

complaint files are well kept. From the response majority disagreed with the statement whereas 41.9% of respondents agreed as 12.9% of respondents were neutral. This was supported by (mean, 3.77 & Std. Dev. 1.40). The analysis also showed that policymakers do come up with long-term plans to make sure that insurance claims complaint files are handled in a way that takes into account what was needed in the future. This was supported by 35% of respondents who agreed whereas 6.5% were neutral as 9.7% strongly disagreed. Majority were in support towards this statement, thus, evidenced by (mean, 3.64 & Std. Dev. 1.35). The study further sought to establish whether modern training methods are used to strengthen and improve a claim officer's way of working. From the responses, it was found that 45.2% of respondents were in agreement, 6.5% were neutral as 3.2% of respondents strongly disagreed. Majority of respondents were a confirmation that there was effect, thus, evidenced by (mean, 4.09 & Std. Dev. 1.36).

From the presentation, respondents were also tasked to confirm whether fraud detection has been picked out as a way to deal with claims management. Going by the percentage response, majority being 32.3% were not sure about these assertions, however, 22.6% of respondents strongly disagreed and 16.1% of respondents strongly disagreed. This was evidenced by (mean, 2.83 & Std Dev 1.36). The presentation further revealed that the insurance company keeps fraud in check with standard internal control systems. From the responses, the study confirmed from 51.6% of respondents were strongly agreeing to the statement whereas 3.2% were neutral and 6.5% of respondents strongly agreed. Going by the majority of respondents were in agreement as evidenced by (mean, 4.16 & std dev 1.18). Lastly, the presentation revealed that the steps that an insurance company takes to stop fraud works successfully. As per study findings, 45.2% of respondents were in total support however, 3.2% of respondents were neutral and 9.7% of respondents strongly disagreed. This

showed that majority were in agreement with the statement as evidenced by (mean, 4.00 & Std. Dev, 1.29).

#### 4.5.2 Litigation Support Practice and Claim Settlement Efficiency

The analysis was based on the influence of litigation support on claim settlement efficiency in health insurance sector.

**Table 4.7 Litigation Support Practice**

Statement	SD	D	N	A	SA	Mean	Std dev
Firms are no longer obligated to invest and risk their own funds to pay legal claims.	(1)3.2%	(1)3.2%	(3)9.7%	(9)29.0%	(17)54.8%	4.29	1.00
Clients might receive assistance from insurance companies to reduce the cost	(6)19.47%	(11)35.5%	(1)3.2%	(7)22.6%	(6)19.4%	2.87	1.47
Insurance companies can provide their clients assistance.	(4)12.9%	(2)6.5%	(1)3.2%	(5)16.1%	(19)61.3%	4.06	1.45
The insurance lawsuit for medical malpractice claims	(3)9.7%	(2)6.5%	(1)3.2%	(9)29.0%	(16)51.6%	4.06	1.31
The insurance company recognizes its obligation to defend a claim	(5)16.1%	(1)3.2%	(1)3.2%	(4)12.9%	(20)64.5%	4.06	1.52
Auditing calls for a range of investigations through broad litigation	(2)6.5%	(2)6.5%	(4)12.9%	(11)35.5%	(12)38.7%	3.93	1.18

**Source: Research Data (2022)**

The presentations shown on table 4.7 comprises of findings that were intended to show the influence of litigation support on claim settlement efficiency in health insurance sector. The

study revealed that firms are no longer obligated to invest and risk their own funds to pay legal claims as supported by majority of respondents who were 54.8%. The study also showed that 9.7% of respondents were neutral whereas 3.2% of respondents strongly disagreed by the statement. Going by majority of respondents, it was evidenced that they strongly agreed as shown by (mean, 4.29 & Std. Dev. 1.00). Other analysis revealed that clients might receive assistance from insurance companies to reduce the cost effect of the risk of legal action. It was however not supported by majority of respondents who were 35.5% although, 22.6% were in agreement and only 3.2% were neutral. It was thus confirmed that respondents were not in support as shown by (mean, 2.87 & Std. Dev. 1.47).

The presentations further revealed that insurance companies can provide their clients assistance in reducing associated costs from their balance sheets. This was supported by 61.3% of respondents. However, only 3.2% were not sure whereas 12.9% did not agree. Majority were in support of this statement and was evidenced by (mean, 4.06 & Std. Dev. 1.45). Further analysis revealed that the insurance lawsuit for medical malpractice claims is based on the idea that an insurance company owes policyholders a certain degree of care. From percentage responses, a total of 51.6% of respondents were in agreement however, 3.2% were neutral as 6.5% of respondents did not support the idea. As per majority of respondents, it was confirmed that they were in total support as shown by (Mean, 4.06 & Std. Dev. 1.31). Lastly, the study sought to establish whether auditing calls for a range of investigations through broad litigation support for liabilities. From the responses, it was confirmed that 38.7% of respondents were in agreement although 12.9% were neutral to the statement and 6.5% of respondents strongly disagreed. The interpretation drawn from the study confirmed that auditing calls for a range of investigations as evidenced by (Mean, 3.93 & Std. Dev. 1.18).

### 4.5.3 Dispute Resolution Practices and Claim Settlement Efficiency

The analysis was based on the influence of dispute resolution practices on claim settlement efficiency in health insurance sector.

**Table 4.8 Dispute Resolution Practices**

Statement	SD	D	N	A	SA	Mean	Std dev
A mediator is a third person who acts impartially	(6)19.4%	(1)3.2%	(1)3.2%	(12)38.7%	(11)35.5%	3.67	1.49
The mediator cannot force the parties to	(5)16.1%	(3)9.7%	(1)3.2%	(2)6.5%	(20)64.5%	3.93	1.61
The expectation of policyholders is that the insurer	(13)41.9%	(7)22.6%	(2)6.5%	(3)9.7%	(6)19.4%	2.41	1.58
When insurers do not meet their obligations,	(8)25.8%	(5)16.1%	(1)3.2%	(14)45.2%	(3)9.7%	2.96	1.44
Judicial settlements can be reached in or outside of court	(4)12.9%	(1)3.2%	(1)3.2%	(6)19.4%	(19)61.3%	4.12	1.40
Arbitration proceedings correctly apply the same rules	(2)6.5%	(5)16.1%	(1)3.2%	(13)41.9%	(10)32.3%	3.77	1.25

**Source: Research Data (2022)**

The presentations of findings shown on table 4.8 was intended to bring out the assessment of the influence of dispute resolution practices on claim settlement efficiency in health insurance sector. From the findings, it was established that 38.7% of respondents agreed to the statement, while 3.2% were neutral and 19.4% did not agree to the idea that a mediator is a third person who acts impartially and helps disputing parties come to a resolution, and

their success rates in mediation are measured. This was confirmed by those who were in support (mean 3.67 & Std. Dev. 1.49). The study also sought to establish whether the mediator cannot force the parties to come to an agreement. His or her goal is to assist the parties in finding common ground instead. From the responses, it was noted that 64.5% of respondents were strongly agreeing, 3.2% were neutral whereas only 16.1% strongly disagreed. As per the findings, the analysis revealed that majority were in support as shown by a mean of 3.93 & Std. Dev. of 1.61).

Respondents were also tasked to show whether the expectation of policyholders is that the insurer will act in good faith and make every effort to increase the success rates of mediation. Going by the percentage responses, it was established that 41.9% of respondents strongly disagreed while 6.5% were neutral and 19.4% of respondents strongly agreed. Majority did not support the idea and this was revealed by (Mean, 2.41 & Std. Dev. 1.58). Further analysis showed that when insurers do not meet their obligations, they are occasionally questioned and involved in insurance lawsuits. From the responses, it was confirmed by 45.2% of respondents who were in support while 3.2% were neutral and 25.8% of respondents were not in support. As per majority of respondents, it was a confirmation that they were in support as shown by (Mean, 2.96 & Std. Dev. 1.44). There was need to establish whether judicial settlements can be reached in or outside of court. From the responses, 61.3% of respondents agreed while 3.2% were neutral and 12.9% strongly disagreed. Majority of respondents strongly agreed and it was evidenced by (Mean 4.12 & Std. Dev. 1.40). Lastly, there was need to establish whether arbitration proceedings correctly apply the same rules of evidence used in court, making it easier to present evidence. In the analysis, it was found that 41.9% of respondents agreed to the statement while 3.2% were

neutral and lastly 16.1% did not agree. From the majority of respondents, it was confirmation that there was influence. This was provided by (Mean 3.77 & Std. Dev. 1.25).

#### 4.5.4 Claim Settlement Efficiency

The analysis was based on the need to examine the state of claim settlement efficiency in health insurance sector.

**Table 4.9 Claim Settlement Efficiency**

Statement	SD	D	N	A	SA	Mean	Std dev
The amount of time needed to resolve a claim varies greatly from company to company	(3)9.7%	(1)3.2%	(2)6.5%	(2)6.5%	(23)74.2%	4.32	1.32
The insurance company must first investigate the claim	(9)29.0%	(5)16.1%	(2)6.5%	(7)22.6%	(8)25.8%	3.00	1.63
Adjusters of claims can limit the number of errors	(1)3.2%	(2)6.5%	(4)12.9%	(15)48.4%	(9)29.0%	3.93	0.99
Long claim cycle times can cost the company money and drive away clients	(1)3.2%	(1)3.2%	(3)9.7%	(11)35.5%	(15)48.4%	4.22	0.99
Institutions that do not have a competent forensic accounting	6)19.4%	(8)25.8%	(1)3.2%	(3)9.7%	(13)41.9%	2.38	1.58

**Source: Research Data (2022)**

The presentation shown on table 4.9 was drawn from a study examining the state of claim settlement efficiency in health insurance sector. It was established that a total of 74.2% of respondents strongly agreed that the amount of time needed to resolve a claim varies greatly from company to company. While 6.5% of respondents were neutral whereas 3.2% being the least respondents disagreed. In relations to the percentage response, majority agreed and it was evidenced by (Mean, 4.32 & Std. dev. 1.32. The study also established that the

insurance company must first investigate the claim to ascertain whether the circumstances are covered by the client's policy. This was not supported by 29.0% of respondents who were majority and strongly disagreed. However, 6.5% were neutral and 25.8% strongly agreed. Going by the majority of respondents, it was a confirmation that respondents were in disagreement as shown by (Mean, 3.00 & Std. Dev. 1.63). The study further sought to establish whether adjusters of claims can limit the number of errors they make by devoting more time to the processing of claims. Going by number of respondents, it was found that 48.4% of respondents agreed to the statement, 12.9% were neutral and 3.2% strongly to the statement. Majority of respondents were used to confirm that there was influence as evidenced by (Mean 3.93 & Std. Dev. 0.99).

Further analysis revealed that long claim cycle times can cost the company money and drive away clients, especially if the company takes too much time to process claims. This was strongly supported by 48.4% of respondents while 9.7% were neutral and only 3.2% claimed that they strongly disagreed. This was shown by (Mean, 4.22 & Std. Dev 0.99). Lastly, results of the findings were drawn from the study that sought to establish whether institutions that do not have a competent forensic accounting mechanism in place for monitoring the payment of claims will experience delays in payment. As per the study findings, a total of 41.9% strongly agreed to the statement, however, 3.2% did not agree and 25.8% disagreed. From the majority of respondents, they aided in confirming that there was influence as evidenced by (Mean, 2.38 & Std. Dev. 1.58).

## 4.6 Inferential Analysis

The researcher performed a correlation and multiple regressions analysis as follows;

### 4.6.1 Correlation Analysis

The Pearson Product Moment correlation coefficient was used in the study to determine the degree of linear relationship on bivariate factors that are thought to have an effect on claim settlement efficiency. In a specific study, a Pearson coefficient of less than 0.3 indicates a weak correlation, whereas a correlation of 0.5 indicates a significant correlation among the examined variables. Table 4.10 displays the findings of the correlation analysis.

**Table 4.10 Correlation Analysis**

		Claim Settlement Efficiency	Fraud Investigation Practices	Litigation Support Practices	Dispute Resolution Practices
Claim Settlement Efficiency	Pearson Correlation	1			
	Sig. (2-tailed)				
	N	31			
Fraud Investigation Practices	Pearson Correlation	.897**	1		
	Sig. (2-tailed)	.000			
	N	31	31		
Litigation Support Practices	Pearson Correlation	.876**	.895**	1	
	Sig. (2-tailed)	.000	.000		
	N	31	31	31	
Dispute Resolution Practices	Pearson Correlation	.897**	.948**	.841**	1
	Sig. (2-tailed)	.000	.000	.000	
	N	31	31	31	31

\*\* . Correlation is significant at the 0.01 level (2-tailed).

The presentations on table 4.10 were designed to demonstrate the correlation analysis. The study used a correlation analysis to assess the direction of strength in terms of the relationship that exists between the various variables assumed to have an influence on claim settlement efficiency. As a result, at the 1% level of significance, the association between fraud investigation techniques and claim settlement efficiency was determined to be  $r=0.897$ . A further examination of the relationship between litigation assistance practice and claim settlement efficiency revealed a positive correlation with  $r= 0.876$  at the 1% level of

significance. Nonetheless, the researcher discovered a strong positive association between dispute resolution techniques and claim settlement efficiency ( $r=0.897$  at 1% significance level).

#### 4.6.2 Multiple Regression Analysis

In this study, a multiple regression analysis was used to determine the significance of the relationship between the dependent variable, claim settlement efficiency, and the independent variables, fraud detection practices, litigation support techniques, and dispute resolution methods. This was done in order to determine whether or not there was a significant correlation between the two. The purpose of the study was to ascertain whether or not the independent variables had any influence on the variable that was being investigated.

The model summary was presented on the 4.11.

**Table 4.11 Multiple Linear Regression Analysis Model Summary**

Model Summary <sup>b</sup>										
Model	R	Adjusted R Square	Std. Error of the Estimate	Change Statistics				Sig. F Change	Durbin-Watson	
				R Square Change	F Change	df1	df2			
1	.925 <sup>a</sup>	.856	.53144	.856	53.287	3	27	.000	.498	

a. Predictors: (Constant), fraud investigation practice, dispute resolution practices, and litigation support practice

b. Dependent Variable: Claim settlement efficiency

The results from the model summary indicated that adjusted R square of 83.9% in the variations on claim settlement efficiency in the insurance firms could be explained by the fraud investigation practices, dispute resolution practices and litigation support practice. Therefore, the percentage remaining could be explained by other factors that are not in the model which were contributed by 16.1%.

### 4.6.3 Analysis of Variance

In this study, ANOVA-Analysis of Variance is used to reveal how well the model fits for use. The findings are summarized on the table 4.12.

**Table 4.12 Analysis of Variance (ANOVA)**

ANOVA <sup>a</sup>						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	45.149	3	15.050	53.287	.000 <sup>b</sup>
	Residual	7.626	27	.282		
	Total	52.774	30			

a. Dependent Variable: claim settlement efficiency

b. Predictors: (Constant), fraud investigation practices, litigation support practice and dispute resolution practices

In the analysis in table 4.12, it was found that the variables fraud investigation practices, dispute resolution techniques, and litigation support practices all had a substantial influence on claim settlement efficiency. As a result of the analysis, it was discovered that the regression model had a significance level of 0.000%, proving that the data in this study was adequate for drawing conclusions about the population parameters because the level of significance was less than 0.005. The static F (53.287) is the regression mean divided by the residue mean. The significance value of 0.000 is less than the approximated value of 0.005, indicating that the data was significant for drawing conclusions, i.e., the predictor variables of fraud investigation practices, litigation support practices, and dispute resolution practices show variation in the dependent variable of claim settlement efficiency.

**Table 4.13: Regression Coefficient Results**

		<b>Coefficients</b>				
		Unstandardized Coefficients		Standardized		
Model		B	Std. Error	Beta	t	Sig.
1	(Constant)	.228	.491		.464	.647
	fraud investigation practices	.091	.264	.097	.345	.733
	litigation support practice	.508	.216	.386	2.348	.026
	dispute resolution practices	.427	.205	.480	2.079	.047

a. Dependent Variable: claim settlement efficiency

The regression analysis model developed is specified as follows;

$$Y = \alpha + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon$$

**Where**

Y = claim settlement efficiency ;

X<sub>1</sub> = fraud investigation practices ;

X<sub>2</sub> = litigation support practice ;

X<sub>3</sub> = dispute resolution practices,

α = constants term, i.e. the claim settlement efficiency does depend on variables under the study.

β<sub>1</sub>, β<sub>2</sub>, β<sub>3</sub> = regression coefficients of X<sub>1</sub>, X<sub>2</sub> and X<sub>3</sub>. ε = error item.

$$Y = 0.228 + 0.091X_1 + 0.508X_2 + 0.427X_3$$

From the analysis, it was noted that there was a positive and insignificant relationship between fraud investigation practices and claim settlement efficiency in health insurance firms (β) 0.228, t= .345, p value <0.05). The analysis implied that a unit change in fraud investigation practices improved claim settlement efficiency by 0.345 units when holding other factors constant.

The findings revealed that there was a positive and significant relationship between litigation support practice and claim settlement efficiency in health insurance firms ( $\beta$  0.91,  $t=2.348$ ,  $p$  value  $<0.05$ ). The analysis implied that a unit change in dispute resolution practices affected level of claim settlement efficiency by 2.348 units when holding other factors constant.

It was established that there was a positive and significant relationship between dispute resolution practices and claim settlement efficiency in health insurance firms ( $\beta$  0.427,  $t=2.348$ ,  $p$  value  $<0.05$ ). The analysis implied that a unit change in dispute resolution practices improved level of claim settlement efficiency by 0.399 units when holding other factors constant.

## CHAPTER FIVE

### SUMMARY, CONCLUSION AND RECOMMENDATIONS

#### 5.1 Introduction

This chapter constitutes the summary drawn from the findings, there is conclusion and lastly recommendation and limitations of the study. The summary was based on effect of forensic accounting practices on claim settlement efficiency in health insurance sector in Kenya.

#### 5.2 Summary

##### 5.2.1 Fraud investigation practices and claim settlement efficiency

The summary derived from the study showed that fraud investigation practices had insignificant influence on claim settlement efficiency in health insurance sector. It was noted that claims managers do make plans to make sure that insurance claims complaint files are well kept. However, being a coordinated effort, it was deduced that some of the staff may jeopardize the efficiency process which may amount to slow service delivery and lack of open accountability as shown by mean, 3.77 and Std. Dev. 1.40.

Further analysis showed that policymakers do come up with long-term plans to make sure that insurance claims complaint files are handled in a way that takes into account what would be needed in the future. Since majority were in support, the findings implied it could be easier to monitor and keep trail of any fraud if it arises considering that systems of claims settlement are in place. Hence, any deviation may arise to establishing lack of accountability in the claim process. This was evidenced by mean of 3.64 & Std. Dev. 1.35. It was also noted that training methods are used to strengthen and improve a claim officer's way of working, as a result, it was expected that well trained administrative staff in claim settlement roles were still expected to deliver on their mandate with minimal or no case of inefficiency of claim settlement as evidenced by mean, 4.09 & Std. Dev. 1.36. In light of

these results, Olalekan, Ajemunigbohunb, and Gbenga (2019) found that claims managers need to make strategic measures to keep insurance claims complaint files safe and ready for use when the time comes. In addition, cutting-edge training mechanisms ought to be put into place so as to bolster and enhance the working pattern of a claim officer.

### **5.2.2 Litigation support practice and claim settlement efficiency**

The summary drawn from the findings showed that litigation support practices had a significant contribution towards claim settlement efficiency in health insurance sector. The study revealed that firms are no longer obligated to invest and risk their own funds to pay legal claims as supported by majority of respondents. This implied that claims that are considered fraudulent are not completely settled an indication that firms are investing in litigation systems to counter such practices. Hence, this shown by mean, 4.29 & Std. Dev. 1.00. The summary also revealed that clients might receive assistance from insurance companies to reduce the cost effect of the risk of legal action.

From the analysis, respondents were totally not in support, implying that insurance companies may not necessarily engage in helping clients on various legal engagements, hence, a revelation that insurance companies seek to remain accountable to internal funds with minimal dispersal to legal cases for their clients. This is shown by mean, 2.87 & Std. Dev. 1.47). From the analysis, it was noted that auditing calls for a range of investigations through broad litigation support for liabilities. Majority were in support of this statement, implying that regular audits would enable the insurance firms to identify areas weakness that are limiting efficient service delivery about claim settlement in healthcare sector. This as evidenced by Mean, 3.93 & Std. Dev. 1.18).

Still, summary showed that insurance lawsuit for medical malpractice claims is based on the idea that an insurance company owes policyholders a certain degree of care. This was

summary by majority of respondents. The findings were considered similar to Lifanya's (2017) who established that the concept of insurance litigation for medical malpractice claims is predicated on the notion that an insurance company owes a specific level of care to policyholders. As a genuine insurance business, it should acknowledge its duty to defend a claim that is presented in accordance with the provisions of the policy and its duty of indemnification.

### **5.2.3 Dispute resolution practices and claim settlement efficiency**

From the summarized data, the study established that dispute resolution practices had notable influence on claim settlement efficiency in health insurance sector. Respondents were in total support that a mediator is a third person who acts impartially and helps disputing parties come to a resolution, and their success rates in mediation are measured as confirmed by mean 3.67 & Std. Dev. 1.49. The summary implied that insurance claim settlement representative had an obligation to ensure total accountability is enforced for claimants to receive claims efficiently or timely. The summary also confirmed that mediator cannot force the parties to come to an agreement, thus, their goal is to assist the parties in finding common ground instead. From the analysis, the study showed that the expectation of policyholders is that the insurer will act in good faith and make every effort to increase the success rates of mediation as affirmed by Mean, 2.41 & Std. Dev. 1.58.

The summary revealed that arbitration proceedings correctly apply the same rules of evidence used in court, making it easier to present evidence, this was provided by (Mean 3.77 & Std. Dev. 1.25). Thus, implied that settling a dispute about claims can be settled through court of laws, thus, providing documented evidence for claim processing. However, this may amount to notable inefficiency as court proceedings may last longer than the claimants anticipate. These findings relates to those provided by Mugo (2017) who found

that standard rules of evidence used in court may not be properly applied in arbitration procedures, making it considerably simpler to provide evidence. Discovery, the time-consuming and costly process of taking and responding to interrogatories, depositions, and requests to produce documents, may be significantly reduced in arbitration.

### **5.3 Conclusion**

The study concluded that fraud investigation practices had a significant influence on claim settlement efficiency in health insurance sector. The results showed that some of the staff may jeopardize the efficiency process which may amount to slow service delivery and lack of open accountability. Thus, it could be easier to monitor and keep trail of any fraud if it arises considering that systems of claims settlement are in place. In claim settlement, well trained administrative staff were still expected to deliver on their mandate with minimal or no case of inefficiency of claim settlement.

In conclusion, litigation support practices had a significant contribution towards claim settlement efficiency in health insurance sector. This shows that claims that are considered fraudulent are not completely settled and indication that firms are investing in litigation systems to counter such practices. Further, to this insurance companies may not necessarily engage in helping clients on various legal engagements, hence, a revelation that insurance companies seek to remain accountable to internal funds with minimal dispersal to legal cases for their clients. Lastly, regular audits would enable the insurance firms to identify areas weakness that are limiting efficient service delivery about claim settlement in healthcare sector.

The conclusion drawn from the study revealed that insurance claim settlement representative had an obligation to ensure total accountability is enforced for claimants to receive claims efficiently or timely. Still, the expectation of policyholders is that the insurer

will act in good faith and make every effort to increase the success rates of mediation. Settling a dispute about claims can be settle through court of laws, thus, providing documented evidence for claim processing.

Due to the nature of the risks involved in providing medical care, insurance premiums tend to be rather costly. Due to the high cost of insurance, this deters many potential customers. Risk factors mean that most medical insurance brokers only accept annual premium payments and do not extend credit. The inflexibility of premium payment discourages many would-be policyholders. Most medical insurance companies (brokers) offer a wide selection of coverage options, and individual plans can be tailored to meet the needs of policyholders by offering a wide range of benefits.

#### **5.4 Recommendations**

The following comprises of recommendations from the study.

##### **5.4.1 Fraud investigation Practices**

The study recommends that policy makers in the insurance companies should ensure that fraud investigations are properly documents and be carried out in the shortest time possible to fulfill expected efficiency in claim settlement. This can be achieved by empowering managers in the insurance companies to keep well or document fully all the files with complaints. This will ensure that any time that a point of reference is required to be made while processing the healthcare claims is easily accessed. The management should ensure that all culprits associated with slow processing of claims and compounded by any unethical practice should subjected to legal proceedings to weed out insurance policy administrators. This will ensure that total accountability is attained and minimal cases of forensic audits experienced.

#### **5.4.2 Litigation Support Practices**

The study recommends that for litigation practices, the management of insurance firms should ensure that adequate resources are allocated to address the issue of litigation. That is, the companies should be obligated enough to invest own funds to take care of legal claims. However, claims that are considered fraudulent are should not be settled as this would amount to losses that will be identified though forensic audits. There is also need to ensure that regular audits are carried out so that it enable the insurance firms to identify areas weakness that are limiting efficient service delivery in relations to claim settlement efficiency in the in healthcare sector.

#### **5.4.3 Dispute Resolution Practices**

The study recommends that since insurance claim settlement representative had an obligation to ensure total accountability is enforced for claimants to receive claims efficiently or timely. The management of the insurance firms should ensure that they put in place dispute resolution mechanism that is workable and that can support quick settlement of complaints on claims. Since the mediators in dispute resolution cannot force the parties to come to an agreement and their goal being to assist the parties in finding common ground instead, the managers should therefore identify most competent team to undertake such roles. This is in the context that the expectation of policyholders is that the insurer will act in good faith and make every effort to increase the success rates of mediation pace for amicable settlement of insurance claims.

### **5.5 Limitations of the Study**

Private organization have tendency to put in place measures to bar non-staff members from accessing inside information regarded as private or sensitive information to the public. However, the researcher overcame this challenge by assuring the management that the study was for academic purposes only and not for any other commercial purposes.

The researcher initially faced the challenges related to confidentiality of data. This is because some respondents had initially failed to disclose enough information considered as confidential. The researcher assured the staff that all the information they would disclose would not be used for other purpose other than academic purposes.

### **5.6 Suggestions for Further Study**

The study recommends that further research may be carried out by other researchers to address the similar area of study. However, since the current study was only limited to three objectives or variables comprising of Fraud Investigation Practices, Litigation Support Practice and Dispute Resolution Practices. Other researchers should consider carrying additional studies by adopting other independent variables that associated with forensic audit practices. This will enable attainment of a comprehensive research on this subject.

## REFERENCES

- Abdinasir, G. A. (2017). The Effect of Forensic Audit Services on Fraud Detection Among Commercial Banks in Kenya: *European Journal of Accounting Auditing and Finance Research*, 3(4), 69-85.
- AKI report (2011): Annual report. Nairobi. Kenya.
- AKI report, (2015): Understanding the uninsured market. BO research Kenya. Retrieved <https://actserv.co.ke/wp-content/uploads/2021/06/Medical-Research-Final.pdf>
- Angima, C. & Mwangi, M. (2017). Effects of Underwriting and Claims Management on Performance of Property and Casualty Insurance Companies in East Africa. *European Scientific Journal*; Vol.13, No.13 ISSN: 1857 – 7881 (Print) e - ISSN 1857- 7431.
- Awino, Z. & Kathanga, W. (2016). The compensation challenges facing the growth of insurance sector: a survey of selected insurance companies in Kenya: *Journal of Business and Strategic Management*. Vol.1, Issue No.1, pp 1 - 15, 2016
- Bundi, G. (2019). Role of third-party administrators in setting up legally managed health care systems: a case of Henner Groupe Kenya. *European Observatory on Health Care Systems Series*, 23(5), 194-199.
- Chelugot, J. & Kitaka, M. (2020). Factors Affecting Disputed Insurance Claims Payments in Kenya: A Case Study of “A” Assurance Company Limited. *International Journal of Research and Innovation in Social Science (IJRISS)* |Volume IV, Issue VII, July 2020.
- Gachohi, L. (2016). Factors influencing the uptake of health insurance schemes among Kibera Informal Settlement Dwellers, Nairobi, Kenya: *East African Medical Journal*, 34(45-77).
- Crocker, K. and Tennyson, S. (2021). Insurance Fraud and Optimal Claims Settlement Strategies in Michigan State: *University of Michigan Cornell University Press Journals*, 4(9) 77-81.
- Drechsler, D., & Jütting, J. P. (2015). Is there a role for private health insurance in developing countries? (No. 517). DIW Discussion Papers.
- Feinman, J. M. (2020). The Law of Insurance Claim Practices: Beyond Bad Faith. *Tort Trial & Insurance Practice Law Journal*, 693-740.
- Gisairo B. (2016). Effectiveness of use of biometric technology to curb fraud in medical insurance firms in Kenya: Retrieved on July 5, University of Nairobi; <http://erepository.uonbi.ac.ke/bitstream/handle/11295/98395/Final%20Project%2>

- OBarnabas%20Updated%207.11.2016.pdf?sequence=1&isAllowed=y
- Isoe, B. (2019). Alternative Dispute Resolution (ADR) for Insurance Disputes: a comprehensive review of the Legislative framework in Kenya. *The BMC Health Services Research*: Vol 13, 474 (2019).
- Jarque, A. (2010). Repeated moral hazard with effort persistence. *Journal of Economic Theory*, 145(6), 2412-242.
- Kajwang, B. (2022). The Role of Loss Adjustment Practices and Dispute Resolution on The Performance of Insurance Sector in Uganda. *International Journal of Business Strategies*, 7(1), 32 - 47.
- Kiana, M. W. (2016). Challenges in management of general insurance claims in Kenya (Doctoral dissertation, School of Business, University of Nairobi).
- Kimeli, S. (2018). Role Of Fraud Investigation Unit in Management of Crimes In Capital Markets Industry in Nairobi County, Kenya. *Journal of Economic Theory*, 145(6), 2412-242.
- Korir, K. (2020). A Comparative Study of Claim Ratio of Jubilee Insurance Company with Other Insurance Companies in Kenya. *International Journal of Innovative Science and Research Technology*, 5(9), 23-29.
- Lakshmi P., and Ganesh, M. (2016). Forensic Accounting: A Checkmate for Corporate Fraud and Legal Support in Indian Firms. *Journal of Modern Accounting and Auditing*, 12 (9), 453-460.
- Lifanya, A. H. (2017). Resolving medical malpractice claims: a critical study of disciplinary proceedings in Kenya. *Research Journal of Finance and Accounting*; Vol.4, No.6.
- Lyimo, H.C. (2019). *Legal and Practical Problems Relating to Insurance Claims and Settlement of the Claims in Tanzania*. Master's thesis, The Open University of Tanzania.
- Machuhi, W.M. (2016). Nature and challenges of cost claims management by reinsurance companies in Kenya. *Strategic Management Journal*, 25(2), 139-165.
- Mahlow, N., & Wagner, J. (2016). Process landscape and efficiency in non-life insurance claims management: An industry benchmark. *The Journal of Risk Finance*, 17(2), 218-244.
- Mohapatra, S., & Tiwari, M. (2019). Using Business Intelligence for Automating Business Processes in Insurance. *IJACT: International Journal of Advancements in Computing Technology*, 1(2), 92-98.

- Morley, N. J., & Ormerod, T. C. (2016). How the detection of insurance fraud succeeds and fails. *Psychology, Crime & Law*, 12(2), 163-180.
- Mshimba, H. A. (2018). Forensic accounting and its relevance in Tanzania, a case of national audit office, Tanzania: The University of Dodoma, institutional repository.
- Mudaki, L. and Wanjere, D. (2020). Effects of Operational efficiency on Organizational Performance in Kenyan Insurance Industry. *International Journal of Business and Social Science*: Vol. 3 No. 17.
- Mugo, M. (2017). Legal Strategies Affecting Performance of Health Insurance Companies in Kenya: A Case of Jubilee Insurance Company in Nairobi. *Strategic Management Journal* 1(8), pp.19-2.
- Mwangi, G. (2018). Operations Decision Making Efficiency in Insurance Companies in Kenya. *International Journal of Management and Social Sciences Research*. 2(4), pp. 1-9.
- Nair, D. (2016). Determinants of Enrollment in Comprehensive Health Insurance Scheme and Implementation Challenges: A Study in Kerala, South India. *Health Science Journal*.
- Njuguna, W. (2019). Motor Insurance Fraud in Kenya: An Analysis of the Effectiveness of the Legal and Institutional Framework in Curbing Insurance Fraud. *International Journal of Social Sciences and Entrepreneurship*, 1 (11), 467-490.
- Odhiambo, T. (2017). Evaluation of fraud management strategies adopted by insurance companies in Kenya: *Journal of Social Science & Medicine*, 72(2), 157-165
- Olalekan Y., Ajemunigbohunb, S. & Gbenga, N. (2019). A Critical Review of Insurance Claims Management: A Study of Selected Insurance Companies in Nigeria. *The SPOUDAI Journal of Economics and Business*, Vol.67 (2017), Issue 2, pp. 69-84.
- Schneider, S. K., Kass, S. J., & Piotrowski, C. (2018). Customers' Views Toward the Insurance Industry Response Post-Hurricane. *Organization Development Journal*, 29(4), 33.
- Schwarcz, T. (2021). Redesigning consumer dispute resolution: A case study of the British and American approaches to medical insurance claims conflict. *Journal of Economic Theory*, 145(6), 2412-242.
- Wambia, W. O. & Jagongo, A. (2020). The effects of working capital management practices on the financial performance of insurance companies in Kenya. *International Academic Journal of Economics and Finance*, 3(5), 103-120.

Yusuf O. Tajudeen, O. & Adebawal, (2018). Investigating the Roles of Claims Manager in Claims Handling Process in the Tanzania Insurance Industry. *Journal of Business and Finance*; 22: 234-256.

## APPENDICES

### Appendix I: Letter of Introduction

**Dear Sir/Madam,**

**Ref: Request for Data Collection**

I am James Tama Musyoka, a Master of Science (Finance and Accounting) student at KCA University. I'm doing research on the "**Effect of Forensic Accounting Practices on the Efficiency of Claim Settlement in the Health Insurance Sector in Kenya.**"

I'm writing to extend an invitation to take part in the research project by submitting your responses to the questionnaire. It ought to take approximately thirty minutes to finish. Your participation in this survey is entirely optional and you will remain anonymous throughout the process. Any information that you provide with me will be treated with the utmost discretion.

Please respond to all the questions to enhance successful completion of this exercise.

I really look forward to receiving your support.

James Tama Musyoka

Reg. no. 16/03323

## Appendix II: Research Questionnaire

I am undertaking academic research on the "Effect of Forensic Accounting Practices on Claim Settlement Efficiency in Health Insurance Sector in Kenya."

Please attempt the question in the way the instructions require.

### SECTION A: GENERAL INFORMATION

Please answer the question in the way the instructions require.

#### 1. Gender of Respondents

Male [    ]

Female [    ]

#### 2. How long have you worked in the insurance company?

Less than 1 year [    ]

1-4 years [    ]

5-8 years [    ]

9-12 years [    ]

Over 12 years [    ]

#### 3. Highest level of education attained

O- level [    ]

Diploma level [    ]

Bachelor's degree [    ]

Post graduate degree [    ]

Other qualifications [    ]

**Tick on the statement you agree with based on a scale of 1-5 in which 1-strongly disagree, 2-disagree, 3 neutral 4-agree and 5 strongly agree.**

**SECTION B: FRAUD INVESTIGATION PRACTICES AND CLAIM SETTLEMENT EFFICIENCY**

<b>Statement</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Claims managers make plans to make sure that insurance claims complaint files are well kept.					
Policymakers do come up with long-term plans to make sure that insurance claims complaint files are handled in a way that takes into account what was needed in the future.					
Modern training methods are used to strengthen and improve a claim officer's way of working.					
Fraud detection has been picked out as a way to deal with claims management.					
This insurance company keeps fraud in check with standard internal control systems.					
The steps that an insurance company takes to stop fraud works successfully					

**SECTION C: LITIGATION SUPPORT PRACTICE AND CLAIM SETTLEMENT EFFICIENCY**

<b>Statement</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Firms are no longer obligated to invest and risk their own funds to pay legal claims.					
Clients might receive assistance from insurance companies to reduce the cost effect of the risk of legal action.					
Insurance companies can provide their clients assistance in reducing associated costs from their balance sheets.					

The insurance lawsuit for medical malpractice claims is based on the idea that an insurance company owes policyholders a certain degree of care.					
The insurance company recognizes its obligation to defend a claim brought in accordance with the policy requirements in order to pay a judgment against the policyholder.					
Auditing calls for a range of investigations through broad litigation support for liabilities.					

**SECTION D: DISPUTE RESOLUTION PRACTICES ON CLAIM SETTLEMENT EFFICIENCY**

<b>Statement</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
A mediator is a third person who acts impartially and helps disputing parties come to a resolution, and their success rates in mediation are measured.					
The mediator cannot force the parties to come to an agreement. His or her goal is to assist the parties in finding common ground instead.					
The expectation of policyholders is that the insurer will act in good faith and make every effort to increase the success rates of mediation.					
When insurers do not meet their obligations, they are occasionally questioned and involved in insurance lawsuits.					
Judicial settlements can be reached in or outside of court					
Arbitration proceedings correctly apply the same rules of evidence used in court, making it easier to present evidence.					

**SECTION E: CLAIM SETTLEMENT EFFICIENCY IN HEALTH INSURANCE  
SECTOR**

<b>Statement</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
The amount of time needed to resolve a claim varies greatly from company to company.					
The insurance company must first investigate the claim to ascertain whether the circumstances are covered by the client's policy.					
Adjusters of claims can limit the number of errors they make by devoting more time to the processing of claims.					
Long claim cycle times can cost the company money and drive away clients, especially if the company takes too much time to process claims.					
Institutions that do not have a competent forensic accounting mechanism in place for monitoring the payment of claims will experience delays in payment.					

**Thank you for your Participation**

### **Appendix III: List of Medical Insurance Companies**

1. Heritage insurance company
2. AAR Insurance Kenya Limited
3. African Merchant Assurance Company Limited
4. AIG Kenya Insurance Company Limited
5. Alliance Insurance Company of Kenya Ltd
6. APA Insurance Limited
7. Appolo Life Assurance Limited
8. Britam Insurance Compant
9. Cannon Assurance Company
10. CIC general Insurance Limited
11. Continental Reinsurance Limited
12. Corporate Insurance Company Limited
13. Directline Assurance Company Limited
14. East Africa Reinsurance Company Limited
15. Fidelity Shield Insurance Company Limited
16. First Assurance Company Limited
17. GA Insurance Company Limited
18. Gateway Insurance Company Limited
19. Geminia Insurance Company Limited
20. ICEA Lion General Insurance Company Limited
21. ICEA Line Life Assurance Company Limited
22. Intra Africa Assurance Company Limited
23. Invesco Assurance Company Limited
24. Kenindia Assurance Company Limited
25. Kenya Orient Insurance Limited
26. Liberty Life Assurance Company Kenya Limited
27. Madison Insurance Company Limited
28. Mayfair Insurance Company Limited
29. Mercantile Insurance Company Limited
30. Metropolitan Life Insurance Company Limited
31. Occidental Insurance Company Limited
32. Pacis Insurance Company Limited