Benchmarking the customer service standard by Regulator - The missing links

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Customer is sovereign

"A customer is the most important visitor on our premises. He is not dependent on us. We are dependent on him. He is not an interruption of our work. He is the purpose of it. He is not an outsider of our business. He is part of it. We are not doing him a favour by serving him. He is doing us a favour by giving us the opportunity to do so."

Thus articulated Late Mahatma Gandhi, the father of nation, while inaugurating one of the business establishments in South Africa more than 100 years back when many popular concepts of today's marketing like customer service, customer satisfaction or customer delight etc were not even coined. However what Mahatma Gandhi could visualise long back about customer supremacy or centrality in the operation of a business, yet many organizations barring a few exceptions have not been able to internalize it as part of their working DNA despite some commendable progression made in the sphere of customer servicing.

Gone are days of yore of mute, servile and strapped customers who would accept anything or everything without even a mild protest. Today's customers on the contrary, are armed with choices and literally dictate terms and get what they want or need in the bargain. Customers today are sovereign (Mahatma Gandhi was indeed very close to the reality) as we witness Corporates fiercely scramble about to seize the opportunity provided by the customers for their success.

The unpalatable experience of the pre-liberalization period

The customer servicing before liberalization was not only antiquated in its approach but also in execution. A small claim of a scooter would take about two months time to be settled. The claim would get stuck for months for such frivolous documents as a tax token which had no bearing on the claim settlement. It was not only archaic but also callous at time. The assured benefit of a life insurer would not pass on to him even after the last premium was paid well on time. Most insured would not get the basic documents like a policy for days and months. The claimant of a Maruti car accident once narrated a very touching anecdotes about the functioning of an insurance company. His car met with a fatal accident in early 80s and he lost his only child who succumbed to injuries. It was a total loss case. The insurance company took about six months time to settle this claim which was considered reasonably fast in those days. A beaming branch manager asked about the quality of the customer service. The customer not amused at all, said that he was not very sure which accident was more grievous to negotiate –the one which took place in the road some six months back or the ones he had to negotiate in the office of the insurance company to get his claim. He maintained that every time, he visited the office, he was reminded of an incident which he didn't want to remember and, therefore, he felt those numerous encounters in the office were more difficult to handle. The above anecdotes clearly summed up the sentiments of a grieving father and the near diabolic treatment given to customer servicing in those days. If insurance penetration in India didn't pick up, one reason was insurance companies failed to create favourable customer experience collectively. As a result, customer going for insurance cover seeking financial protection didn't percolate down the Indian psyche.

Consumer Protection Act / Insurance Ombudsman- the dawn of a new era

The enactment of The Consumer Protection act in 1986 was a big leap towards addressing genuine customer grievances. The system worked well & the awards of the courts were binding on the insurance companies. It brought a sense of responsibility to the organization. The only hitch was most consumers did not want to move the court for addressing their problems. India even today is not a litigant society.

The concept of Ombudsman was in a way an extension

of the grievance redressal mechanism. Though the forum has lost some of its sheen, primarily because of the delayed appointments & resource constraints, yet, it helped a lot in infusing a sense of transparency & empathy in the claim settlement process and service related activities of insurance companies. Since most of the Ombudsmen were industry veterans, their observations / decisions were well received by the insurance companies and the aggrieved customers.

Citizen Charter in mid 90s - a sincere PSU initiative

Designed on the lines of successful UK model, even Govt. of India initiated the concept of Citizen Charter in late 90's. The then fully owned government insurance companies, were part of that process. For the first time in India, the customers experienced pro-active approach by companies to connect with their client base with a promise of a guaranteed level of service, thereby, setting a benchmark. The Charters were expected to incorporate the following elements :- (Vision and Mission Statement; (ii) Details of business transacted by the organisation; (iii) Details of clients; (iv) Details of services provided to each client group; (v) Details of grievance redress mechanism and how to access it; and (vi) Expectations from the clients.

Customer service post liberalization

The first major initiative by the insurance regulator in India was undertaken in the year 2002, when the regulation on 'Protection of Policyholders' Interests' was introduced to safeguard the interests of insurance customers in India. The regulation was a modest initiative at that stage, to streamline and consolidate the insurance business vis-a-vis the customer expectation in the wake of liberalisation in India. The scope of this regulation was limited and possibly didn't capture the growing requirements of Indian insurance customers .It clarified certain definitions ,and came out with guidelines for point of sale, proposal for insurance ,grievance redressal mechanism, matters to be stated in life and non –life policies ,claims procedure in life and general insurance claims and policyholders servicing. The regulation for the first time set the tone for speedy disposal of policies and claims related issues in some cases with specific time frame.

In 2017, the regulator came out with the Protection of Policyholders' Interests (PPHI) Regulations which is much wider in its scope and has much more clarity. The regulation for the first time came out with three specific objectives. The first objective dwells upon how to ensure that interests of insurance policyholders are protected. The second objective wants to ensure that insurers, distribution channels and other regulated entities fulfil their obligations towards policyholders and have in place standard procedures and best practices in sale and service of insurance policies and the third objective wants to ensure policyholder-centric governance by insurers with emphasis on grievance redressal. The objectives at the first instance would give an impression that the entire regulation is very customer centric and customer focussed but in reality, at the ground level things are very different .The intention of the regulator is well on place but the execution by the industry left much to be desired. Customers continue to suffer from miscommunication and as a result mis-selling is rampant .

It is, however, also true that post liberalization, the industry witnessed a great deal of improvement in servicing and in particular claim settlement. Despite the fact that some efforts were made by some companies to create favourable customer impressions, the negative perception continues to dominate the minds of the customers. In spite of the fact that life insurance companies settle close to 97-98% of their claims, most customers even today have suspicion about the intent of the companies at the point of lodging claims. The majority of the general insurance companies report high incurred claims and fail to register underwriting profit. Even then, they are perceived by customers as entities who don't want to pay claims and even if they pay, they don't pay adequately. The discontentment continues – a trend that needs to be reversed immediately.

Distinctive features of the IRDAI Protection of Policyholders' Interests Regulations, (PPHI) 2017 – formation of Policyholder Protection Committee(PPC) & induction of a customer representative

The IRDAI PPHI Regulations 2017 mandated a Board approved policy for protection of policyholders' interest for every company by instructing them to articulate steps for customer awareness, service standard, grievance handling and steps to stop mis-selling and unfair practices. It also demanded setting up of service parameters & turnaround times. The other important step was the compulsion for the companies to form a Policyholder Protection Committee (PPC) as a part of the Corporate Governance guidelines issued by IRDAI to ensure the compliance to "protection of policyholders' interests" as per their mission statements. This committee headed by a non-executive director on the board is to have as its member the senior official dealing with the customer centric

department and also a representative of the customer as an invitee. This ensures that insurers' internal systems are monitored effectively at the highest level of the company, that is, the Board.

Good step in right direction – An impetus to customer service

The IRDAI PPHI Regulations 2017,while being prescriptive creates an onus on insurers to ensure that the customer interests are always protected and not compromised in any manner at any time. Further, it creates an onus on the insurer to ensure transparency as per the expectations of Policyholders' protection Committee, which in turn, oversees the functioning of the company and ensures that all services are rendered with the interests of the customers in mind.

PPHI Regulations try to evolve standardisation in servicing customers across the industry. It is a customer focussed and driven initiative and aims at developing transparency in customer handling. It provides a vibrant structure and framework for servicing and covers every nuance of policy life cycle- from issuance of policy to servicing and claims settlement , communications including policy documents and letters to be sent (what and when) and grievance redressal framework. It is indeed a guiding principle for all companies.

The regulator through its guidelines has ensured governance of just not only of turnaround times of processing/servicing/refunds/settlements but also around accuracy of such monetary amounts wherever applicable and compensating the customer with standardised penal interest in all cases of delay be it inadvertent or otherwise.

Good Service – the missing clarity

Every company has to come out with steps, elucidating the measures taken to avoid mis-selling and unfair business practices at the point of sale and service rendered. **But have any of them taken care in the first place to define what is meant by Good services?** The first encounter of a customer on most occasions takes place when he seeks a claim for an unfortunate event. Good services are defined by moments of truth. This encounter of the customer with the insurer or his representatives often leaves an indelible imprint in his/her mind –difficult to eradicate. Even at a time, a claim which has been settled well on time as per the insurer's perspective may well fall short of expectations of the customer. The customer was expecting something more or different. **A customer centric company first looks for delivering services at 'Basic Threshold Quality Level' by undertaking an extensive survey of customer expectations it wants to serve and then goes on to improve its services to stay ahead in competition. If a company doesn't know the basic threshold level of its customers** –is either over-spending or under spending its resources –both at its own peril. Even if a company is over spending, chances are there, that the service may well fall short of the customer expectations or providing high quality services not called for. At the same time, if a company spends less than the basic threshold level, it may well go the way of dinosaurs. Most companies come out with 'Turn Around Time' for settling claims based on their sweet whims without any concrete empirical evidence based on research. How can a company even think of delivering services at 'Enhanced Threshold Quality' or at 'Incremental Quality', when it has no idea of basic threshold level of expectations of its customers? Therefore, the whole exercise of putting these pieces of information without concrete substantiation is just eyewash and nothing beyond that. Good companies with customer focus want to work beyond mere customer satisfaction for they know that satisfaction suffices but delight dazzles. They want to deliver services at incremental quality level i.e. exceeding the expectations of their customers. Only then they can delight the customers.

Good service includes bespoke service offerings and standards mostly delivered through bespoke claims services. Customers vary in their service preferences and can't be considered one cohort as such .Therefore, bespoke service for different cohorts or segments has become necessary for a company to remain competitive. In this context, developing a standard service procedure and best practices in sale and service of insurance policy catering to the expectations of varied customer segments remains a big challenge. A gentleman working with an organization enjoyed group mediclaim policy issued by a standalone health insurance company .He also had another individual policy from a standalone company for Rs. 5 lakh. His wife needed some surgery and was admitted to a hospital. The estimate of expenditure was 1 lakh The company issuing the group mediclaim policy gave a preauthorization of Rs. 30,000 and the other company preauthorized the same case for Rs.70000/. The hospital remained the same in both the cases. The gentleman wanted to utilise the group mediclaim policy instead of the individual for the obvious reason. However, the preauthorization was so low that he was

unsure of the full claim. This is bizarre case of absence of standardised procedure in preauthorization. The Policy of Protection of policyholders' interest must come out with a guideline to address such issues as this or else the industry as a whole would suffer.

The other moot point here is whether the service of insurance policies includes claims servicing as well. It is not clear for neither the word service nor the word service deficiency has been defined in the regulation. We presume that claims servicing is included in insurance policy servicing.

The best practice in delivering excellence in insurance claims handling involves many components. Every company should develop excellent culture and philosophy of claims servicing that should be entirely customer focussed. If today, you ask a customer to deposit salvage parts of damaged motor vehicle in the office of an insurer, he would not prefer to do so. However it was a common practice 10 years back.

The PPHI Regulations describe in detail the time frame for settling claims in life, general and health insurance policies. It also imposes penalty on insurers in the event a claim is not settled within a stipulated period. The above measure (penalty) is counterproductive as it clearly shows the emphasis is more on punishment and not on the quality of claim services delivered. The PPHI Regulations should have instead come out with a guidelines of best practices in delivering excellence in claims servicing with the focus on building effective communications with the customers, hiring or developing skilled people with empathy and humanoid touch, building robust IT Infrastructure, client initiated and driven claims procedures and effective grievance resolution mechanisms. This would help develop a culture of excellent client services .This would also develop a proactive culture of Good Services –thus creating its own benchmark in the process.

In a customer driven company, the strategic plan revolves around their customers. This means that the procedures for customer protection should be dynamic to accommodate changes in customer expectations. Right kind of information should be made available to customers to help them taking right decisions. Optimize use of market data and congenial regulatory processes also enhance consumer protections.

Stringent and non conducive policy contracts

The general principles governing general and health insurance policies allow insurers to categorise policy conditions in five broad types with a view to give clarity and understanding of policy conditions to a policyholder. Most non-life insurers avoid conditions precedent to contract and instead use condition precedent to liability. They do so with a view to giving the man opportunity to settle claims rather leniently & in the interest of customers. The effect of condition precedent to contract is not conducive from a customer's point of view. A mere misrepresentation, misdescription or non –disclosure can make the policy void. All the above three are violation of utmost good faith and forms part of implied conditions. If violated, as stated above, the policy becomes void. Therefore, we find that in a fire insurance policy, it is lifted from the implied conditions and made an expressed condition with 'condition precedent to liability'.This is so in motor insurance policy as well. The effect is that the impaired claim (the claim affected by all above or one) becomes voidable at the insurer's option. However in most health policies, the insurer use condition precedent to contract for misrepresentation, misdescription or concealment. Even at a slight or minor misrepresentation or concealment on the part of insured, the insurer can not only reject the claim but also avoid the policy as well. This is against the spirit of fair customer treatment.

It may be noted here that the principle of utmost good faith hinges around three legal guidelines – representation, warranty and concealment. In today's customer friendly ambience ,no company chooses to use warranty barring a few cases as it is a very harsh legal doctrine- even a minor or non material breach of warranty may allow the insurer to reject a claim. Nowadays, statements made by applicants of insurance are considered representation and not warranty. The legal ramification of a representation is that the insurance contract is voidable at the option of the insurer if the representation is material, false and depended upon by the insurer. A representation whether innocent or fraud but material and relied upon by the insurer makes the contract voidable.

However what we find that in a health insurance policy that even a representation which is not material and not relied upon can make the contract void. This simply doesn't protect the interest of the policyholders.

Prickly challenges

In the current scenario, no exceptions have been provided while imposing a penalty i.e. in cases where the delay is not attributable to the insurer, like non updating the communication address or contact number and / or is not approachable during the death

claim investigation. It could also be a case of customer not providing complete documents for processing the claim.

The prescribed claims procedure is not in sync with Section 45 of the Insurance Act, for example if in a policy, a claim is intimated at the completion of 2 Year and 11 month from the commencement date of the policy, the insurer will get only one month to investigate which contradicts the regulation.

The reduction of timeline in death claim investigation (from 180 days to 90 days) is a short timeline to complete the investigation especially in the rural areas where the information isn't readily available and the probability of fraud also is high.

There is a regulatory requirement that insurance policies be issued within 24 hours of receipt of premium – this poses practical challenges in terms of geographical reach and time taken to deposit the premium collected at a local branch as well as completion of documentation necessary for issuance of a policy. There is a need to make it little lenient to ensure reasonable TAT for such POS policies

There is a requirement in PPHI Regulations to ensure that maturity policies are settled on the same date of maturity irrespective of processing time or time taken for completion of documentation by the policyholder or irrespective of the product type. In ULIP policies, this poses a problem as the NAV redemption happens overnight and the value is available on the next day followed by minimum processing time to release the payout.

Section 45 in itself poses practical challenge for the insurer as the right to call the policy in question after 3 years form the date of commencement of the policy /reinstatement of the policy on any ground is no longer available. This allows persons with fraudulent intent to file the death claim after a period of 3 years of lapsation irrespective of early death within 3 years thereby preventing the insurer from taking concrete action in terms of investigation and overrule fraud, if any.

As stated above, the condition applied in health policies need to be changed keeping in mind the genuine misrepresentations or nondisclosures that are not material and not relied upon by the insurer.

The co-pay provision of health insurance policies for senior citizens must be revisited for they are unduly high – thus doesn't protect the interest of senior citizens.

Way Forward

PPHI Regulations are the right starting point and instead of waiting for the revision of the same the industry should voluntarily adopt minimum standards of service and should continue to set the bar higher with each passing day. Now the focus has shifted onto customer outcomes more than before although cost and efficiency still can too heavily influence the thinking and discussions.

Since the notification of the PPHI Regulations, 2017, there has been limited progress in the journey. It should have evolved towards creating a wider customer awareness eco-system, thus benefiting the customers at large. There is no mechanism of sharing experiences across the industry.

It is also felt that the existing composition of Policyholders Protection Committee (PPC) having a single external representative for essaying customers' point of view is grossly insufficient and needs to be increased

There is also a need to shift the focus from transactional service matters dominating the servicing of customers need to wider aspects of simplicity, understanding & fairness. With the growth in digital economy, even greater emphasis is needed to protect the privacy of data sharing.

Conclusions

As mentioned earlier, the intent of the regulator is to heighten the customer service by protecting the interests of the insurance policyholders. The regulator has indeed taken great care to broaden the scope of protection of the policyholders by strong mandates but the execution on the part of insurers, distribution channels, and insurance intermediaries, fall well short of the expectations of the customers. The need of the hour is to develop a robust monitoring system, enabling the effective compliance to the PPHI Regulations in letter and spirit. The time has also come to strengthen the data management and the authenticity of the data provided by service providers. The real test lies in making insurance a reliable tool of risk management in the minds of the common man, for which the entire industry has to work in tandem to build confidence and trust in the minds of the policyholders.

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