An Analysis of Claims Settlement and Insurance Companies' Profitability in Nigeria (1981-2022)

Francis Aniefiok Bassey
Email: basseyfrancis757@yahoo.com

Ubong Esang Ankoh
Email: ubongankoh@gmail.com

Boniface Christopher Ekanem
Department of Insurance and Risk Management
Faculty of Management Sciences,
University of Uyo, Uyo, Nigeria.
Email: bonifacekanem@gmail.com

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Abstract

This study analyzed claims settlement and insurance companies' profitability in Nigeria (1981-2022). Problems arise when there is a claim report. The problems range from non-payment of claims, even when paid, it is not settled promptly and only a negligible proportion of claims are settled. On many occasions, disputes arise in claims settlement between the insured and the insurer. Violation of policy provisions can vitiate an insurance contract and is also capable of hindering claims settlement. The study is an empirical research and the secondary data used for the study were obtained from the Central Bank of Nigeria (CBN) Statistical Bulletin and Annual Report of NAICOM. The regression method was used to test the hypothesis. The finding revealed that there are significant influences of total expenditure and total income on the profitability of the Nigerian insurance companies while total claims settlement and total premium income have no significant influences on profitability. It was recommended that there is a need for the insurance industry to carry out sensitization and awareness campaigns on loss control devices for the insured. This reduces the loss frequency and claims amount considerably for sustainable profit. Managers of claims and the holders of policies should be educated in reporting claims processes such as loss minimization, claims verification, investigation, evaluating the degree of the damage preceding any replacement or repair and loss evaluation. This reduces claims report frequency and enhances the profitability and premium income of insurance companies. Insurance income generated in terms of premiums should be reinvested to upsurge insurance companies' profits.

Keywords: Total expenditure, Total income, Profitability, Insurance companies, Total claims settlement, Total premium income

1.1 Introduction

Settlement of claims is the central affair in the association between insurance firms and holders of policies. Claim settlement is a practice to display that the periods spent in paying premiums were substantial in the expenditure. Butler & Francis (2010) avowed that payment of claims denotes the major cost to underwriters and 80% per cent of premiums are disbursed on payment of claims and related expenditures. Redja (2008) added that management of claims entails all management decisions and procedures vis-à-vis claims settlement in agreement with insurance contract terms. Nevertheless, firming up claims unit, agreeing with OECD (2004) encompasses effective claim processes or tasks, which comprise claims valuation, claims reporting, claim processing, fraud discovery, grievances and disputes/conflicts settlements.

According to Ubom (2014), claims settlement remains a key issue in the performance and growth of the insurance industry as well as the profitability of insurance companies. The essence of insurance is for the insurer to restore the insured to his earlier position, even after he must have suffered a loss, by settling his claims promptly. Unachukwu et al., (2015) posited that when claims are promptly settled, it gives insurance the best advertisement. But when they are delayed or denied, the essence of insurance is defeated, which breeds erosion of confidence in the sector. Isimoya (2003) opined that there are varying perceptions from different people as regards how reliable claims settlement situation is. Claims settlement could be regarded as the mechanism by which insurers provide financial succour to the insured that had suffered losses. Also, Irukwu (2003) opined that one of the principal functions of an insurance company is claims settlement.

1.2 Statement of the Problem

Since the existence of the insurance industry in Nigeria in 1921 and the establishment of the Royal Exchange Assurance Company, the insurance industry has not been without some problems. The problems range from non-payment of claims, even when paid, it is not settled promptly and only a negligible proportion of claims are settled.

On many occasions, disputes arise in claims settlement between the insured and the insurer. This often stems from either the amount to be paid as compensation or refusal of payment or claims, which often lead to litigation. Violation of policy provisions can vitiate an insurance contract and is also capable of hindering claims settlement. Dealing with claims efficiently is a multifaceted task. Notwithstanding its several stages and disparities in every procedure, some underwriters in Nigeria still scuffle to unswervingly advance claims procedures. This probably is not unconnected with unfortunate claims procedure and lack of recognition accorded to the industry claims department staff. Since the experience gotten from claims settlement is a prime trigger of satisfaction of policyholder, a need arises for a mannish claims unit controlled by an experienced staff to bring high-quality services to reality as well as cost-effectiveness. For cost-effectiveness to be feasible, the practice of cutting costs by separating authentic claims reports from fraudulent claims reports must be present. Fake claims reports are one of the chief operational risk sources of underwriters and form a substantial ratio of losses. As provided by Dionne (2000), there are several aims for claims deception such as alterations in morality, intermediaries' behaviours, poverty, insurer's approach and insurance contract nature. Anchored on these anomalies, and to properly align these augments, this paper seeks to analyze claims settlement and insurance companies' profitability in Nigeria from 1981 to 2022.

1.3 Objectives of the study

The leading aim of this paper is to analyze claims settlement and insurance companies' profitability in Nigeria from 1981 to 2022. Explicitly, this paper aims to analyse the influences of total claims settlement, total premium income, total expenditure, and total income on profitability of the Nigerian insurance companies.

1.4 Research Hypothesis

H_{o1}: There are no significant influences of total claims settlement, total premium income, total expenditure, and total income on profitability of the Nigerian insurance companies.

2.0 Literature Review

2.1 Conceptual Clarifications of Insurance

Insurance is a prescribed bond between holders of policies and underwriters, where the underwriters undertake to compensate the holders of policies in the occasion of a loss enclosed in exchange for premium payment, based on the terms and conditions of the contract (Thoyts, 2010). Insurance is a contract of fortuitous events, which are anchored on incidents unforeseeable, and beyond the control of the holders of policies (Blunden & Thirlwell, 2010). The insurance industry is an essential economic

sector because it accelerates risk cost shifting away from the assured to an underwriter in interchange for premium payment (Ericson & Doyle, 2004). Principally, insurance is a mechanism for risk transfer; hence, aiding risk transfer from assured to underwriters (Fadun, 2013). Additionally, this becomes possible because an underwriter has further exposure with a diversified portfolio, which aids in reducing unanticipated losses.

2.1.2 Overview of Claims Settlement

Claims settlement involves the financial settlement of claims by the insurer to the insured after due process (Unachukwu et al., 2015). Claims payment is the reason behind the insurance contract. If a loss occurs, the insured must be paid by the terms of the policy. Therefore, claims are the tangible result of insuring (Isimoya, 2003). There are four generally accepted procedures to follow in claims settlement. However, the insurer and the insured are required to comply with these procedures. These actions are claims notification, investigation, proof of loss and payment or denial of claims.

Claims notification: The claim procedure starts when an insured notifies the insurer that an insured event has occurred leading to claims. It is necessary that the insurer is notified of any accident or loss that involves claims as soon as possible and that the notification of a claim is the responsibility of the insured. The insurer will want speedy notification of the claim and will often lay down time limits within which the insurer should be intimated of claims. Though the notification requirement differs from one policy to another the contract requires that the notice be given immediately or as soon as practicable (Vaughan & Vaughan, 2014). The authors further stated that "all insurance policies require notification in writing immediately or as soon as practicable after a loss has occurred. Notification may be made through an agent or broker or directly to the insurance company. Some policies stipulate that the notice must be sent to the insurers within a specified number of days. Failure to give the notice within the stipulated number of days is a breach of the terms of the policy, which might entitle the insurer to repudiate liability".

Claims Investigation: The insurer may start an investigation on the accident or loss but should avoid creating the impression at this stage that he has accepted liability under the policy. The insurer needs to wait for a completed claims form to ascertain whether or not the claim is within the scope of the policy and to help the insurer establish whether or not the policyholder or other party entitled to indemnity is legally liable to any third party, before telling the insured. On receipt of the completed form, the insurer should always check whether: the premiums have been paid dully, whether the policy has any special endorsement, and whether the policyholder complied with the warranties if any (Isimoya, 2003).

A series of other questions must be answered before a claim is approved. Normally, loss adjusters are employed to investigate the loss (Rejda, 2008). When an insurer carries out a careful investigation of claims using experts from different fields, it helps to provide education and enlightenment programmes to the potential insured and the existing policyholders. This measure will help to provide loss prevention and control devices to the insuring public, thereby having a positive effect on the performance of the economy and enhancing economic growth.

The primary essence of investigating a claim is to ascertain whether the insured is qualified for indemnity or not, or whether the amount specified in the claim form is unreasonable. Vaughan & Vaughan (2014) referred to this stage as the verification stage. He stated that "verification of records is to ensure that there was cover at the time of the loss against the peril that caused the loss. This involves an examination of records in the insurer's office to ascertain that the relevant policy was in force at that material time and that the policy covers the event that led to the loss".

Proof of loss: Unachukwu et al., (2015) opined that the applicant must provide loss proof. He must prove to the insurer that a loss has been sustained by an insured peril. The insurer is however expected to be liberal in the interpretation of what constitutes proof unless he is in doubt of the integrity of the insured. A proof of loss is a sworn statement by the insured that substantiates a loss. The principle of utmost good faith is very important at this point. Isimoya

(2003) observed that the insured is required to provide all information with evidence about the subject matter and the loss. Vaughan & Vaughan (2014) added that "the onus is on the insured to prove his loss. The claimant has to convince the Insurer not only that a loss has occurred, but that the loss was caused by an insured peril. If the insured fails to prove their loss, the claim may fail. The policyholder must also prove the quantum or the extent of their loss".

Negotiation*:* Vaughan & Vaughan (2014) opined that "most claims are settled using negotiation between the parties without the need for such formal procedures as arbitration or litigation. This is, of course, the fastest and most economical method of adjustment. In most claims, there may be nothing over which to negotiate and the claim may be paid almost immediately. When negotiation does not work out, the contract may itself prescribe some other procedure to be followed, such as arbitration and litigation.

i. Arbitration: *"*Where negotiations break down or fail to achieve the desired objectives, the other option available is arbitration. It is the settlement of a dispute by the decision of one or more persons called arbitrators. The decision of an arbitrator is called an award and it can be enforced by legal process in the same way the judgment of a law court could be enforced" (Holyoake & Weipers, 2005).

ii. Litigation is an additional technique of settling insurance disputes where "the aggrieved party goes to the law court to seek redress. This option is chosen where negotiation and arbitration fail. In practice, insurers are reluctant to go to court to protect their image. In most cases, insurers always get problems solved before it gets out of hand or resort to litigation" (Holyoake & Weipers, 2005).

Claims Payment or Denial: The final stage in the claims procedure is the actual monetary settlement or denial (Holyoake & Weipers, 2005). The claim has been notified, all parties have carried out their perspective duties and all that remains is for the claim to be settled. Rejda (2008) observed that the claim can be paid, the claim may be denied or there may be a dispute about the amount to be paid. Normally, the claim is paid according to the terms of the policy. It may be denied if the policy may specify how the dispute is to be resolved.

2.1.3 Claim Settlement Methods

There are four ways of settling insurance claims (Akpan et al., 2021). First, cash payment is the most common way of settling claims. As a matter of fact, with liability claim, this is the only practicable method available, if payment is made to the policyholder in reimbursement of outlays to third parties.

The replacement method is used because there are times when an insurer finds it more convenient to replace an article than pay cash. Also, the insurer might opt to repair the insured object, for instance, in motor insurance where the insurer chooses to repair the vehicle involved in the accident. Reinstatement is mainly applicable to fire insurance. In this case, the insurer tries to restore or rebuild the premises to their former condition. Akpan et al., (2021) added that "when all activities associated with adjustment of the loss are completed and the amount of loss is determined and agreed upon, the insured is entitled to receive payment. There are at least four methods of payment, which insurers can employ in providing claim settlements. They are as follows: Cash Payments, Repair, Replacement, and Reinstatement". Ex-gratia occurs "when a client suffers a loss or incurs some liability for which the insurer cannot be held liable, under the policy. This client may be a valued client to the insurer and the insurer may want to identify with him during his misfortune. In such situations the practice of insurance allows for the payment "out of grace" (ex-gratia) of monies to the insured. Therefore, this is a claim payment made by the insurer out of favour even though there is no legal obligation" (Chiejina, 2004).

2.1.4 The Image of Insurance Industry via Prompt Claims Settlement

A ubiquitous consensus exists among practitioners of insurance businesses all over West African nations, that the present insurance industry does not enjoy encouraging public image in comparison with other emerging and developed economies globally. Operators of insurance businesses are sometimes seen as scammers and extortionists who exploit people devoid of giving considerably in return except intermittent claims, which they are duty-bound to pay either out of fear of being taken to court and exposed or discredited, losing their clients to another syndicate (Unachukwu et al, 2015). “The claim unit is a window shop of the insurer where an insurer will be judged” (Roff, 2004).

Lijadu (2002) stated that “the insurance industry in Nigeria and of course in the West African sub-region is bogged down by unwholesome public perception. The insurance industry is aware of the public’s misconstrued image of the insurance sub-sector. The insurance industry is perceived as quick to collect premiums, slow to pay claims, using small prints to confuse you, providing poor services and engaging in sharp practices. It is interesting to note that this perception still lingers on in Nigeria,whiles the story remains different for other parts of the world”.

2.1.5 Claims Settlement and Insurance Companies’ Profitability

Policyholders’ satisfaction is seen to be one of the essential outcomes of all marketing actions in a market-oriented firm and becomes the vital predictor of behavioural intention in the future (Huber &Herman 2001). Many studies affirmed that prompt claims settlement influences organizational profitability significantly. For example, Butler & Francis (2010) found that prompt claims settlements have a positive and significant relationship with insurance performance in terms of customer loyalty and satisfaction. Underwriters need to take their claim-handling functions more seriously because if a claim is handled well the resultant effect is higher customer retention but if the reverse is the case, lose confidence in the insurer by policyholders and this may damage its most valued reputation. Omar (2005) evaluated consumers’ attitudes towards life insurance patronage in Nigeria and found that there is a lack of trust and confidence in the insurance companies due to a lack of or slow claims settlements. The foremost reason for this attitude is a lack of knowledge about life insurance products. These findings mean that even if the share capital of insurance is increased in multiples, the profitability of the industry may probably still be distorted by the Nigerians’ attitudes. One of the reasons for the low penetration of insurance business in the country is due to insurers’ delay in settling claims. The insurance business is grounded on trust but is troubled with fraud as committed by the many players in this sector in Nigeria. Daniel (2013) likewise revealed that claims settlement failure and delayed claims settlement are the causes of insurance failure in Nigeria.

Profitability is the primary goal of all business ventures. The profitability of insurance companies is the excess of income over expenditure. Without profitability, an insurance business will not survive in the long run. So measuring current and past profitability and projecting future profitability is very important. Profitability is measured with income and expenses. Income is money generated from the activities of the business. Expenses are the cost of resources used up or consumed by the activities of the business (Momoh & Ukpong, 2013).

Profitability is measured with an “income statement”. This is essentially a listing of income and expenses during a period (usually a year) for the entire business (Pandy, 2010). Whether you are recording profitability for the past period or projecting profitability for the coming period, measuring profitability is the most important measure of the success of the business. A business that is not profitable cannot survive. Conversely, a highly profitable business can reward its owners with a large return on their investment.

One of the most important profitability metrics is the return on equity. It is the ratio of net profit to shareholders' equity also called book value, net assets or net worth and expressed as a percentage. According to Pandy (2010), profitability is a measure of how well a company uses shareholders' funds to generate a profit. Return on equity (ROE), is a financial ratio that measures the return generated

on stockholders'/shareholders' equity, the book or accounting value of stockholders'/shareholders' equity which reflects the accumulation over time, of amounts received by the company from stock/share issues plus the profits/earnings retained by the company, i.e., not yet distributed in dividends (accounting value of shareholders' equity is also equal to a company's net assets, i.e., assets minus liabilities).

2.2 Theoretical Framework

This research is based on two theories: risk theory and modern financial intermediation theory.

2.2.1 Risk Theory

This theory was propounded by Borch Karl in 1960. To illustrate this theory, the author began by studying a very simple model. He considered all insurance company which holds a portfolio of insurance contracts, all of which will expire before the end of a certain period. We assume that the premium for all contracts has been paid to the company in advance. The risk situation of the insurance company is then determined by the following two elements: F (x) = the probability that the total amount of claims being made under the contracts in the portfolio shall not exceed x. S = the funds which the company holds, and which it can draw upon to pay claims. At the end of the period, the company will hold the amount $y = S - x$, where y is a variate with the probability distribution $G(y) = I - F(S - y)$ where $-\infty \leq y \leq S$. It is convenient to refer to G (y) as the profit distribution associated with the risk situation (S, F (x)).

2.2.2 Financial Intermediation Theory

Merton & Bodie (1995) developed a theory called the modern theory of financial intermediation which comprises traditional theory and the changes in the financial environment. The modern theory of financial intermediation emphasizes six core functions of insurance: provision of means for clearing and settling payments to facilitate the exchange of goods and services; provision of mechanism for polling resources; resources allocation; risk management; provision of price information to help in coordinating decentralized decision making in various sectors of the economy and provision of means to tackle the problem of moral hazard, physical hazard and information asymmetry. For this study, the enumerated functions by Merton & Bodie (1995) could be expressed as resource accumulation, resource allocation, managing various risks and facilitation of exchange. It is by realizing these functions that the insurance sector contributes to economic growth. The channels to growth model tries to link the financial intermediation function of insurance companies to economic growth. The growth theory states that well-developed financial intermediation can promote economic growth through marginal productivity of capital, efficiency of channelling savings to investment, savings rate and technological innovations. The insurance company by promptly settling of claims of their client could lead to customer retention and even attract more new customers, this could lead to resource accumulation which can further be allocated to different areas of the economy that need the resources, which can lead to the growth of the economy.

2.3 Review of Empirical Studies

Some empirical studies have been conducted to examine the nature of how claims management leads to insurance industry performance or profitability. In this subsection, we provide a summary of the findings of the existing literature.

Afolabi (2018) examined the effect of claims payments on the profitability of the Nigerian insurance industry. Using descriptive statistics and multiple regression techniques aided with SPSS version 23, the author found that the independent variable loss ratio (LR) and the net claims (NC) had an indirect relationship with the dependent variable return on assets (ROA) but a direct relationship with the expense ratio (ER), while net claims (NC) regressed with loss ratio (LR), had a significant positive relationship. The author recommended that for the insurance companies to be profitable, the

Nigerian insurance industry must strive to effectively manage its claims processes by reducing the cost of risk (that is the number of claims paid for every premium earned).
Fadun (2023) studied the impact of insurance claims settlement on the economic growth of Nigeria. Using gross domestic product (GDP) as the dependent variable and insurance claims (INSCLM), the research design used was ex-post facto with a time series of 28 years (that is, 1992-2019). From the results, the INSCLM had a negative significant effect on the GDP. The results were surprising as one would expect the settlement of claims should result in economic growth. Therefore, the researcher recommended that insurers should pay close attention to their claim management processes.

Green & Segal (2004) in Kasturi (2006) maintained that an insurance company's profitability relies mainly on the net premium earned per year. Also, independent variables such as proceeds from the underwriting function, annual turnover, return on investment as well equity profits of the companies as well as investors if well managed thereby providing security to the insureds. This assertion agrees with the study of Yusuf & Dansu (2014) that profit remains important to the management as evidence of growth and to the investors as a source of dividends, while also providing security to business owners (policyholders) against insolvency.

Olarinre et al., (2020), while investigating the effects of claims management on the profitability of insurance companies in Nigeria, used net claims (NC), expense ratio (ER) and loss ratio (LR) as independent variables regressed on the dependent variable return on asset (ROA) of listed insurance companies within the span of 8 years (2010-2018). Regression analysis involving ordinary least square estimation techniques was employed to analyse the data. The results indicated that while net claims have a significant (direct) effect on ROA, expense ratio had a positive though insignificant effect on the said dependent variable, while loss ratio recorded an indirect insignificant effect on ROA of the insurance companies used for the study. The researcher concluded that claims management promotes a positive influence on insurance companies' profitability. Therefore, it was recommended that all efforts should be made to pay genuine claims promptly as this boasts and increases the confidence of the general public about insurance and the industry as a whole.

Hewitt (2006) also found that prompt claims settlement by insurance companies influenced customer loyalty in advanced countries. However, the findings of Bates & Atkins (2007) and Ndubuisi (2008) conflicted with previous studies. They discovered that claims payment could be very costly as claims constitute the largest cost of an insurer and that this has contributed to poor performance of insurance companies.

3.0 Methodology

To achieve the aim of this research, the researcher adopted an empirical research design. According to Ndiyo (2005), empirical research involves the actual interaction with experience and data. It is rooted in a first-hand observation of phenomena and gathering of data to describe, explain and predict events. Data obtained from the secondary sources cover total insurance claims, total expenditure of insurance companies, total income of insurance companies and the profitability of insurance companies (excess of total income over expenditure of insurance companies). Data used in this study were obtained from secondary sources such as textbooks, the Central Bank of Nigeria (CBN) Statistical Bulletin, and the Annual Report of the National Insurance Commission (NAICOM).

In testing the research hypothesis, the multiple least square regression method was used. The multiple linear regression model is specified as: $PRFT = \beta_0 + \beta_1 TCLP + \beta_2 TPIN + \beta_3 TEXP + \beta_4 TINC + u_t$

Where:
PRFT = Profitability of insurance companies (Total Income minus Total Expenditure)
TCLS = Total claims settlement
TPIN = Total premium income
TEXP = Total Expenditure
TINC = Total Income

u_t is the stochastic error term.
$\beta_0 - \beta_4$ are regression constants.

The *apriori* expectation provides expected signs and significance of the values of the coefficient of the parameters under review on the part of the empirical evidence and theoretical assertions. The incorporated variables in the modified model are expected to have positive (+) or negative (-) signs, which means a positive or negative relationship. The *apriori* expectation is that claims settlement and expenditure will have negative signs while premium and income will have positive signs.

4.1 Empirical Analysis and Results

In this section, the hypothesis earlier formulated is tested with the aid of the SPSS computer package. The hypothesis was that there are no significant influences of total claims settlement, total premium income, total expenditure, and total income on the profitability of the Nigerian insurance companies. The summary of the empirical results is presented below:

Table 1: Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.993[a]	.586	.481	27.434	2.071

a. Predictors: (Constant), TOINC, TEXP, TCLS, TPIN

b. Dependent Variable: PRFT

Table 2: ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	7.331E10	4	1.833E10	2.435E7	.000[a]
	Residual	20320.703	38	752.619		
	Total	7.331E10	42			

a. Predictors: (Constant), TOINC, TEXP, TCLS, TPIN

b. Dependent Variable: PRFT

Table 3: Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	6.653	6.127		1.086	.287
	TCLS	-.002	.002	.000	-.883	.385
	TPIN	.000	.001	.000	.880	.387
	TEXP	-.998	.002	-.519	-571.772	.000
	TOINC	1.001	.001	1.426	1449.534	.000

a. Dependent Variable: PRFT

Sources: SPSS computer output by the researcher

Since the calculated p-values of 0.00 and 0.00 for total expenditure and total income were less than 0.05 level of significance, it was found that there are significant influences of total expenditure and total income on profitability of the Nigerian insurance companies while total claims settlement and total premium income have no significant influences on profitability.

4.2 Discussion of Findings

From the first hypothesis, the regression result revealed that a regression coefficient of 6.653 indicates that TCLP, TPIN, TEXP and TINC have a positive relationship with the profitability of insurance companies (*PRFT).* The coefficient of determination (R2) was 0.586 which implies that about 58.6% variations in PRFT were caused by TCLP, TPIN, TEXP and TINC.

The unstandardized coefficient represents the amount by which the dependent variable changes if we change the independent variable by one unit keeping other independent variables constant. Unstandardized coefficients should not be used to drop or rank predictors (independent variables) as it does not eliminate the unit of measurement. From the above table, a beta value of -0.002 indicates a decrease in TCLS by N0.2 billion causing PRFT to increase by N1 billion, given that the other independent variables in the model are held constant. Also, a beta value of 0.000 indicates that if TPIN is held constant together with other variables, PRFT will still increase by N1 billion. The unstandardized beta coefficient of -0.998 indicates a decrease in TEXP by approximately N1 billion causing PRFT to increase by N1 billion, given the other independent variables in the model are held constant. A beta value of 1.001 indicates an increase in TOINC by N1 billion causes PRFT to increase by N1 billion, given the other independent variables in the model are held constant. The overall unstandardized beta coefficient of 6.65 indicates that activities of the independent variables have caused the profitability of insurance companies in Nigeria to increase by N6.65 billion.

On the other hand, standardized coefficients are mainly used to rank predictors (or independent or explanatory variables) as they eliminate the units of measurement of independent and dependent variables). We can rank independent variables with the absolute value of standardized coefficients. The most important variable will have a maximum absolute value of standardized coefficient. The standardized coefficient is measured in units of standard deviation. A beta value of 1.43 indicates that a change of one standard deviation in the independent variable (TOINC) results in a 1.43 standard deviation increase in the dependent variable (PRFT). While a beta value of -0.519 indicates that a change of one standard deviation in the independent variable (TEXP) results in a 0.519 standard deviation decrease in the dependent variable (PRFT). Beta values of 0.00 and 0.00 indicate that a change of one standard deviation in the independent variables (TPIN) and (TCLS) respectively result in a constant standard deviation in the dependent variable (PRFT). An F-statistic of 2.435 indicates that the model has a good fit while Durbin-Watson of 2.071 shows that the model does not suffer from autocorrelation error. This is because the Durbin-Watson of 2.071 is greater than the traditional benchmark of 2.00. The finding showed that there are significant influences of total expenditure and total income on profitability of the Nigerian insurance companies while total claims settlement and total premium income have no significant influences on profitability.

This study seems to agree with that of Olarinre et al., (2020) as well as that of Afolabi (2018). Though different dependent variables were used as to that of the above-mentioned studies. This study showed some independent variables such as expense ratio (used as total expense in this work) among others having a significant relationship or impact on the profitability of insurance companies except for Fadun (2023), which concluded that insurance claims payment does not impact economic growth of Nigeria, though the researcher acknowledges that this insignificance could be as a result of several factors that may not have been taken into consideration by the researcher.

5.0 Conclusion and Recommendations

Claims settlements are often carried out by claims personnel that include managers, supervisors, claims representatives, customer service representatives, special investigation unit personnel, in-house counsel and third-party administrators. The claims handling process includes acknowledging and assigning the claim, identifying the policy, contacting the insured or the insured's representative, investigating and documenting the claims, determining the cost of loss amount and concluding the claims this is, claims payment or repudiation. Claims settlement has an inverse relationship with profitability. This is because a firm's financing decision is different from its financial structure meaning that the various means used to raise funds (both short-term and long-term) represent the firm's financial structure, while its financing decision represents the proportionate relationship between its long-term debt and equity capital. Based on the findings, it is concluded that claims settlement has no significant influence on the profitability of Nigerian insurance companies.

Based on these, there is a need for the insurance industry to carry out sensitization and awareness campaigns on loss control to the insured. This will help reduce the frequency of loss occurring and the amount of claims paid to the insureds to enhance insurance companies' profitability. Claims managers can also be trained in claims reporting processes like minimization of losses, investigation, verification of claims, loss evaluation and assessing the extent of the damage before any repair or replacement. This will help reduce the frequency of claims reports and enhance the profitability and premium income of insurance companies. Insurance premium income generated should be reinvested into the Nigerian economy to increase the profitability of insurance companies.

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