RISK MANAGEMENT NOTES #216

Practical Risk Management
June 2006

A Note from the Publisher

As you know, IRMI has become publisher of Practical Risk Management. As president of IRMI, it is my pleasure to welcome you to our subscriber family.

Since we have been around quite a while, odds are that you are familiar with IRMI. Just in case you are not, however, here are some quick facts about our company.

- We have a 28-year track record of publishing the finest risk management and insurance reference manuals, newsletters, and books. We don't engage in any other activities, such as consulting or expert witness work, that would distract us from our mission.
- The IRMI reference library is comprised of more than 30,000 pages of insightful and practical risk management and insurance information.
- Our 11-person research/editorial team is dedicated to keeping you on the leading edge of risk management and insurance with practical strategies and tactics. The IRMI research analysts have years of industry experience and hold advanced degrees and industry designations (e.g., CPCU and ARM).
- We also rely on a vast network of risk management and insurance practitioners as advisers and contributing authors to assure that our work remains relevant to you.
- A customer-focused client services team stands ready to help you with any problems you encounter when doing business with us.

For many years we have greatly respected Practical Risk Management and we are immensely proud to include it in our product line. We believe in this publication and promise to do everything in our power to maintain its crisp writing style and—most importantly—expert, practical treatment of the many important risk management issues with which you must deal.

Again, welcome to the IRMI subscriber family. If you have any questions about the approach we will be taking with Practical Risk Management, feel free to phone me directly at (972) 687–9320. We look forward to serving your information needs in the future. If you have any questions or concerns about your subscription, please call our client services staff toll free at 800–827–4242.

—Jack P. Gibson, CPCU, CRIS, ARM

In this Supplement

Supplement 216 updates two topics of importance to all risk professionals and two topics of interest to those in the nonprofit and association sectors. The fallout from last year's hurricane season has caused renewed focus on insurance for the flood peril. As many businesses and public entities seem to have underestimated the catastrophic potential of this peril—and the nuances of insuring it—this is important. Thus, you will find the newly updated discussion of flood to be a timely one.

It could be said that the overall objectives of risk management are to assure the continuation of the organization following a catastrophe and control the cost of risk. Since the first topic focuses on a catastrophe issue, it is only

appropriate that the second focuses on the cost of risk. The discussion of this topic as an important reporting and benchmarking tool is now up to date.

We have updated the discussions of association pools and the special risk management needs of public entities, two areas in which the consultants of ARM Tech who prepared these updates have particular expertise.

Lastly, this is an expanded issue of *Risk Management Notes,* covering the elements of claims best practices.

The Future of *PRM*

Our intention is to utilize industry practitioners to update the existing topics in Practical Risk Management and add discussions of many new topics. We will maintain the concise, crisp writing style with a practical, action-oriented focus on the important points and issues for each topic.

In choosing the topics to update we will consider the age of the current discussion, the importance of the topic to risk managers, and current trends and concerns. Some of the topics that will be updated in the next few supplements include the following.

1. Risk Identification
2. Reports to Management
3. Marketing a Large Account
4. Enterprise Risk Management
5. Business Continuity Planning
6. Emergency Planning
7. Risk Financing
8. Mergers & Acquisitions

We are currently developing a list of topics to add and will announce our plans in the near future. If you would like to suggest a topic to add or update, please do so through the "Contact Us" Web page on IRMI.com. Mention that you are suggesting a *PRM* topic to add to the manual that should be forwarded to Jack Gibson.

Claims Best Practices

Every risk manager is responsible for effective claims administration. This is true whether the program is self-funded and self-administered, administered through a third-party administrator, or insured through an insurer. This issue of Risk Management Notes focuses on self-insured programs, which present the greatest opportunity to control outcomes.

Effective claims administration includes:

- Managing loss and expense within realistic budgets
- Managing the desired level of service provided to employees and third-party claimants

The risk manager with a self-administered claims program achieves these objectives by hiring competent staff, setting objectives, and monitoring performance to expected outcomes.

Where third-party administration is involved, the risk manager must not only select the best, most cost-effective administrator but must ensure the contract requires the administrator to achieve performance standards representing claims best practices. Some risk managers include performance incentives that guarantee the administrator a bonus when achieving better-than-expected results and penalize them when results are less than

expected.

Through a regular audit program, the risk manager can monitor best practices compliance.

Best Practices Defined

Claims handling best practices are those ethically sound processes and procedures that lead to optimum outcomes. As these methods have been proven over time, they have been integrated with claims handling practices by many organizations.

Who defines best practices? No single individual or organization. These practices evolve from:

1. **Mandated industry standards defined through regulations such as *Fair Claims Practices Acts.*** These regulations include standards for:

    a. **Timeliness in acknowledging communications from claimants.** Many regulations require the administrator to acknowledge communications within mandated time frames.

    b. **Investigating and processing claims.** These regulations usually place limitations on time required to investigate the circumstances of the claim.

    c. **Settling claims.** When liability is reasonably clear, regulations often require the administrator to make a "good faith" effort to resolve the claim.

    d. **Communication.** Various penalties can be applied if the administrator intentionally misleads claimants.

While many states exempt public entities from compliance with Fair Claims Practices Acts, compliance often makes sense from a practical and ethical standpoint. Organizations subject to these regulations may be liable for penalties for violations by the claims administrator.

2. **Policy and procedure manual updates.** Claims administrators continually update their policy and procedure manuals to incorporate evolving best practices.

3. **Competition.** Since applying best practices will theoretically achieve the best outcomes, competition is a major driver in determining industry standards. Administrators strive to differentiate themselves by providing more value to the customer. While many aspects of claims handling are basic, opportunities for differentiation exist in areas such as litigation and recovery management, cost containment, communication, and information systems. As new ground is broken that achieves cost savings, these changes become the industry standard.

In defining their best practices, administrators must look at claims in terms of:

1. **What needs to be done?**

    a. **Claims resolution.** Activities required to conclude the client's liability include contacting the claimant, investigating the claim, assessing liability and damages, determining whether there is subrogation potential, determining whether there are other parties who share liability, and managing litigation. Finally, the claim must be evaluated and settled at the most favorable cost and terms.

    b. **Claims file documentation.** The administrator must determine what documentation will be required in the claims file. Documentation can consist of evidence and adjuster notes. The claims file can be an electronic file, paper file, or a combination. If the electronic file is available to the client, it must be easy to understand.

2. **When and by whom.** Contacting the claimant sooner rather than later will almost always lead to a more favorable outcome. The less time it takes to complete an investigation, the more quickly the adjuster can evaluate liability and damages. Early evaluations lead to earlier, less costly settlements. If there is subrogation potential, the sooner the adjuster places the responsible party on notice, the better the chance

for recovery.

Decisions made on who is involved at what point in the claims process directly impact cost outcomes. Costs are affected when decisions are made to use outside firms to conduct an investigation, rather than having the staff adjuster perform the task. Similarly, using attorneys to investigate claims is much more expensive than using adjusters. The level of automation can determine whether processing is performed by an adjuster or by a clerical associate. The key is to avoid duplication of work while ensuring tasks are completed in a timely manner.

3. **How performance is to be measured.** Once the best practices are defined, procedures are developed to measure performance. This process involves determining what acceptable performance will look like and what will be required to achieve superior performance. Developing differentiation between acceptable and superior performance is similar to developing an employee's job performance appraisal.

For example, it may be acceptable for an adjuster to contact an injured claimant within 5 days of assignment of the claim, to establish rapport and obtain information while memories are fresh. An adjuster who contacts the injured party within 1 day will more effectively accomplish these objectives, which are vital to successful conclusion of the claim. The latter exemplifies superior performance.

Applicability to Property and Casualty Claims

This section discusses components commonly measured when reviewing for compliance with claims best practices and describes requirements for acceptable performance.

1. **Property and casualty claim components:**

a. **Claims setup, processing, and closing.** Best practices require the claim be assigned to an adjuster immediately and set up within 7 days of receipt. Payments should be processed accurately and made no later than 15 days after receipt of documentation requiring the payment. Closings should be processed promptly, with reserves adjusted during the month of closure.

b. **Coverage.** Best practices require any coverage dispute to be identified within 24 hours of receipt of the loss or other factual development. Resolution of any dispute depends on the contract involved and requires investigation to allow the client to make the decision.

c. **Claims investigation.** Best practices require the extent of the investigation to be related to the claim exposure or other public policy factors. If appropriate, investigation should include written or recorded statements, police reports, and photographs. Outside firms should be retained only if necessary and cost-effective. Investigation reports should be timely and thorough. Index bureau reporting should be completed on all bodily injury claims. Investigation should be substantially completed within 15 days of assignment and fully completed within 30 days. Necessary investigation that cannot be completed within this time should be documented and subject to an action plan.

d. **Liability determination.** Best practices require a clear methodology to evaluate both bodily injury and property damage claims. The methodology should include obtaining evidence of duty owed, duty breached, and damages resulting from the breach. This evidence may be derived from pictures, diagrams, contracts, medical reports, and bills or appraisal reports and/or repair estimates or bills. Liability determination also requires an assessment of comparative negligence (if any), a determination as to whether the other party took proper action to mitigate damages, and a monetary evaluation range.

e. **Damages evaluation.** For injury claims, special damages and general damages should be delineated. For property claims, scope of damages should be completed and the value of damaged items verified.

f. **Claims settlement evaluation.** Best practices require documentation of proper closing techniques, timeliness of settlement evaluations, and authorization requests.

g. **Claims reserving.** Best practices require that initial reserves be reasonable based on information provided with the initial report. Any adjustments should be made within 30 days of receipt of information suggesting that revision is warranted. Current reserves should be accurate based on the most probable ultimate outcome. The reserve should be reviewed on each diary date and the claim

file documented as to its accuracy at least biannually.

h. **Litigation management.** Best practices require:

- Establishing a panel of defense attorneys approved by the client.
- Promptly assigning cases that present disparities between investigation and medical findings to the defense attorney for development of evidence supporting disputes, recommendations to resolve disputes, and hearing preparation.
- Developing a litigation plan and budget with examiner participation to complete activities within the examiner's scope, such as requesting copy service activities and scheduling medical exams.

i. **Recovery management.** Best practices require that subrogation, salvage, and contribution be identified as early as possible. In cases of subrogation or contribution, investigation should be promptly completed to maximize recovery and responsible parties placed on notice within 30 days of recognition. Follow-up activities should ensue until contact with the responsible party is completed, details of coverage obtained, and any potentially relevant contracts identified and acquired. Salvage should be identified, evaluated, and disposed of promptly using an independent bidding process. Recoveries must be credited within 5 days to the client's account.

j. **Cost containment.** Best practices require a methodology in place to control costs. Reasonableness of fees should be checked against work product submitted by service providers. Bill review services should be engaged, if necessary. If fee agreements are in place, bills should be checked for compliance.

k. **Communication.** Best practices require return calls be made within 1 working day, all incoming correspondence be date-stamped, and response to written correspondence within 5 working days of receipt. Claim file documentation should be clear and allow the client to efficiently manage the delivery of claim services. Claim files must display action plans, and supervisory intervention may be required where execution activities are lacking.

l. **Data accuracy.** The claims information system allows the client to manage efficient and effective delivery of claims administration services and generate reports for senior management. To do so, financial as well as nonfinancial information must be entered accurately and promptly.

2. **Claim components specific to workers compensation:**

a. **Medical utilization review.** Medical treatment billings (physician, pharmacy, hospital, physiotherapist, etc.) will be matched to the file, reviewed for correctness, approved for payment, and paid within the time required. A bill review process should be utilized wherever possible. There should be participation in a Preferred Provider Organization (PPO) whenever possible.

b. **Disability management.** In cases involving loss of time from work, the attending physician's office will be contacted within 5 working days of notice of claim. Such contact will continue as needed during the continuation of temporary disability to assure treatment is related to a compensable injury or illness.

c. **Rehabilitation.** Injured workers will be notified of any rights according to local regulations. Implementation of medical or vocational rehabilitation activities will be considered where it can favorably impact loss costs.

Measuring Performance

Claim reviews with the administrator are essential to measure ongoing performance. This process involves the client selecting individual claims and meeting with the administrator to discuss the current status and raise any questions. The client and the administrator should reach agreement on the time limits for response to any concerns.

Independent audits should be considered where required by government ordinance, for accreditation of risk pools (where applicable), or where questions raised during claim reviews do not receive a satisfactory response. The audit firm should have experience with the type of claims being reviewed and the type of entity whose claims are being audited.

Performance results should be classified according to a scale that measures variance from the acceptable baseline. An example of a four-point scale is:

- **Superior.** Performance that *significantly exceeds* the acceptable level.
- **Commendable.** Performance that *exceeds* the acceptable level.
- **Acceptable.** Performance that *meets* the acceptable level.
- **Needs improvement.** Performance that *does not meet* the acceptable level.

Using the Knowledge

Once the best practices are defined and the administrator's performance is measured, the risk manager is able to:

- **Evaluate competencies.** The risk manager can review performance and evaluate whether the administrator is meeting the necessary requirements to effectively manage loss and expense and deliver the expected level of claims service.
- **Set performance standard and targets.** The risk manager can use audit performance results to set the performance standard, identify gaps in the administrator's current performance, and identify targets and time frames to meet those targets.
- **Implement financial incentives.** There is significant competition among claim administrators and many risk managers to incorporate financial incentives in the claims administration contract. While an administrator who fails to achieve acceptable performance should not be guaranteed the full amount under the contract, one who significantly exceeds agreed performance standards should have the opportunity to earn a bonus. When incentives are applied, we recommend an independent auditor be involved in assessing performance.

Applying claims best practices works. Organizations applying them have consistently better results. Risk managers meet their responsibility for effective claims administration by demanding and ensuring their claims organization meets or exceeds acceptable best practices. Continued measurement provides new performance targets and continuous organizational improvement.
