Institute of Actuaries of Australia

Technical Development of Appropriate Claims File Loads

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Presented to the Institute of Actuaries of Australia
XIth Accident Compensation Seminar 1-4 April 2007
Grand Hyatt Melbourne, Australia

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Introduction

File loads are integral to claims management and those adopted by insurers and/or claims agents may be a very significant differentiator in key performance indicators. In some cases little technical attention is given to establishing appropriate file loads - in many cases benchmarking against the competition forms the basis. In this paper we present a model methodology to establish appropriate file loads for different claim types and claims streams, concentration on long-tail. The cost benefit effect of reducing file loads is demonstrated by the trade off between increased management expenses and the value achieved through the improvement in claims outcomes.

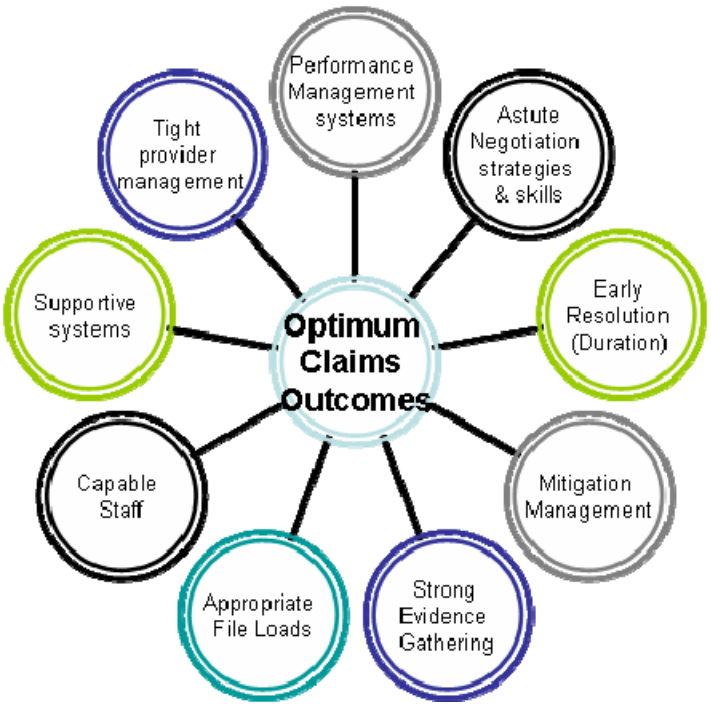
Claims Best Practice Attributes

In many lines of insurance business, the quickest, most effective and most enduring manner of improving financial results is through enhanced claims cost outcomes.

Claims cost outcomes can be influenced by external factors – weather, crime rates, other natural phenomena – and by internal factors – application of deductibles, risk selection criteria and claims management effectiveness. This paper concentrates upon claims management effectiveness and in particular one factor of claims management – file loads handled by claims officers for long tail classes. These can include both first party and third party lines.

We believe there are many separate, yet related, business drivers that influence standards of claims management and resulting claims cost outcomes. They include each element of the following figure.

Figure 1 – Best Practice Attributes



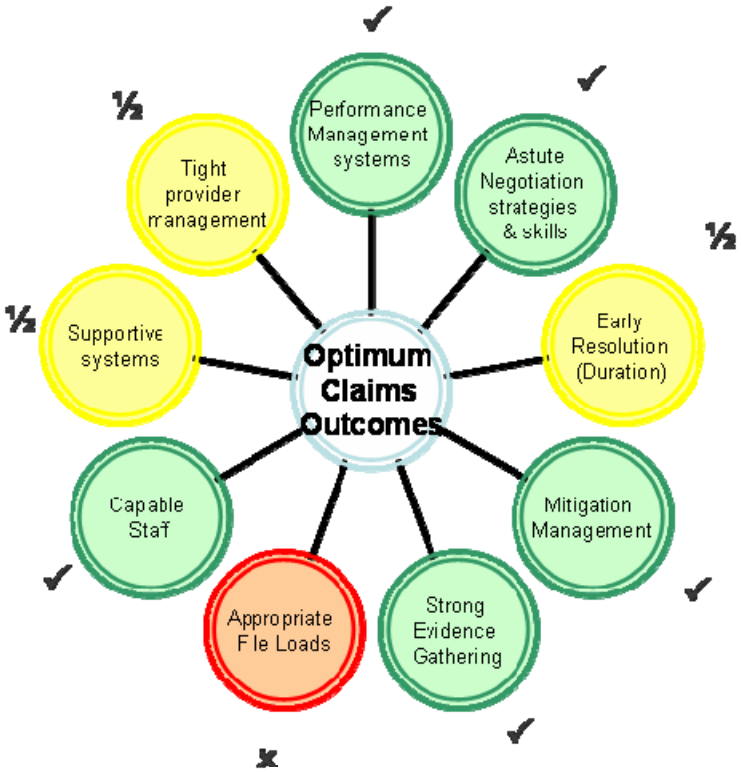
The purpose of this paper is not to explore each such business outcomes driver, but rather those that can be seen often to be detrimental to results.

Some Identified Deficiencies in Claims Management

The potential for improved claims cost outcomes through investment in and adoption of "best practice" (that is, dedication to each of the drivers illustrated in Figure 1) may be significant – possibly in the order of 15% of claim costs or even more at the extreme. We have observed across CTP, Workers Compensation and Income Protection businesses that on balance sufficient focus is not given to all of these drivers all of the time.

Typically the level of focus given to the required management attributes is as depicted as follows in Figure 2 below.

Figure 2 – State of Application of Best Practice



Some specific deficiencies we have observed include:

1. **Early resolution – in particular with personal injury:** Little evidence of focused management towards the expected durations of injuries. The insurer/agent not effectively emphasising and setting upfront expectations for claims duration and outcome. Also not working toward those duration and outcome goals which have been established based on objective clinical standards.

2. **Provider management:** Control systems over providers that do not provide for accountability for outcomes in claim results. Focus is typically on soft measures such as

turn-around times; too often hard measures such as success in an investigation activity or financial results against expectations are ignored.

3. **Supportive computer systems**: *Process management* (workflow and imaging systems) are generally well implemented. However, *decision-support tools* embedded in systems are often missing. These tools enable the claims operative to utilise the collective knowledge and capability of their company or the industry through programmed systems functionality designed to drive outcomes (as distinct from processes).

4. Appropriate file loads. This issue is the principal subject of this paper.

Appropriate File Loads

We assert that in a best practice model claims resources' efforts positively affect the outcome of claims. That is, they should not have the sole objective of paying as quickly as possible to optimise customer service. Outcomes are optimised by claims resources when they are able to:

- satisfy themselves as to indemnity and liability issues and where satisfied
- ensure that the policy responds only to the financial extent necessary, given the claimant's real loss.

If we accept this then having sufficient time to exercise their professional capabilities and execute on the company's policies and procedures will help claims resources effectively influence the claims outcome.

Smaller file loads are not necessarily optimal. File loads can be excessive but they can also be insufficient. Implications of inappropriate file loads that affect the opportunity for the claims operation to perform effectively, include:

- If insufficient file loads, unnecessary costs and an inefficient use of resources.
- If excessive:
  - poor customer service
  - delays in resolution
  - poor prioritisation and avoiding the difficult cases. That is, "processing" and rolling over tasks to another day, rather than taking effective actions at appropriate times
  - lack of time or inclination for positive initiatives
  - non-compliance with company and potentially regulatory requirements
  - outsourcing (abrogating) to third party providers – further costs and lack of accountability and control
  - staff disillusionment and turn-over.

Where the claims resolution is a lengthy process anyway (particularly third party insurance) these issues can manifest over a long time period, by the end of which, levels of significant ongoing damage have occurred.

Similar issues apply to short tail business, but our observation is that file load issues in short-tail business are more short-lived, as first party client input serves to signal issues at an early stage.

As a corollary, having appropriate file loads:

- complements the investment in all other critical aspects of the company's claims management and business models
- enables an insurer/agent to be proactive in claims management – managing rather than processing
- has the potential to have high impact on the culture of the business
- presents recognition to staff that excessive work loads "don't occur here" and provides the opportunity for committed staff to have the time to act professionally in their roles.

Response by Insurers/Agents to File Load Issues

Insurers/claims agents inherently understand these issues; within reason lower file loads, all else being equal, will tend to produce superior outcomes. But how do they establish those file loads?

Our experience is quite broad, but by no means universal. It suggests that the principal approach by insurers in regard to file loads, is either:

- benchmark against competitors, who in all likelihood are doing the same thing against them but who may be employing different business models
- use trial-and-error to achieve a felt-fair level - see where the levels "seem comfortable" – for example, complaints from claimants and staff diminish to an acceptable level or at least balance each other.

Our View

Our view is that as well as benchmarking and "feeling fair", insurers and claims agents should establish their own appropriate file loads by analytical assessment:

- in recognition of the specifics of their own business model and business line requirements
- to be variable by claim cohort type, and
- recognising the particular portfolio characteristics.

A Way to Do It

One possible strategy could be to take the following steps to establish file loads by analytical means:

1. Portfolio/business assessment

   Identify the existing scheme or business requirements, and existing procedures and allocation of responsibilities to confirm the key business requirements. If being undertaken external to the company, this enables the consultant to recognise the key business drivers.

   Identify any obvious efficiency measures that can be taken (if the file load assessment is part of a broader operational review of performance, this aspect, of course, takes on greater significance).

2. Identify discrete cohorts of claims

   Identify and isolate homogeneous cohorts of claims, based on similarity of characteristics at different points of their life cycle. The identification of each cohort must be practical – those demonstrating similar rather than precise characteristics.

   Here one would determine that the identified cohorts may be similar throughout their life cycle or that claims may move into different cohorts through the cycle.

   For example, apparent low complexity claims may commence in a single cohort. Some of those claims resolve in that manner as simple claims. Others take on higher complexity later in their life, such as moving from being legally unrepresented even to litigated.

   The path that each identified cohort takes would also be established in this step.

3. Operational processes

   Identify operational processes for each officer type involved with each identified cohort (number of iterations of each process and length of each iterations). This should be done by taking suitable averages where there is some variation in timeframes or number of iterations involved (but which are nevertheless still worthy of being considered a single cohort).

4. Outsourced processes

   Identify elapsed times in any outsourced claims management processes (such as legal, investigative or compulsory conference requirements) which has a tangible effect on duration.

5. Undertake available time assessment

   Deduct reasonable (and essential) non-productive time per officer type. This time could include talks around the coffee bar through to extraneous business phone interruptions to scheduled regular meetings.

6. Operational timeframes

   Identify the ideal operational time, number of iterations and elapsed waiting time for each operational step for each cohort based on the current business approach (but with recognition of any distortions that current constraints produce).

   This should be established by a combination of accepting the resources' views on the issue (they do it every day and understand the barriers to effective outcomes) and the modeller's value assessment, based on experience or judgement.

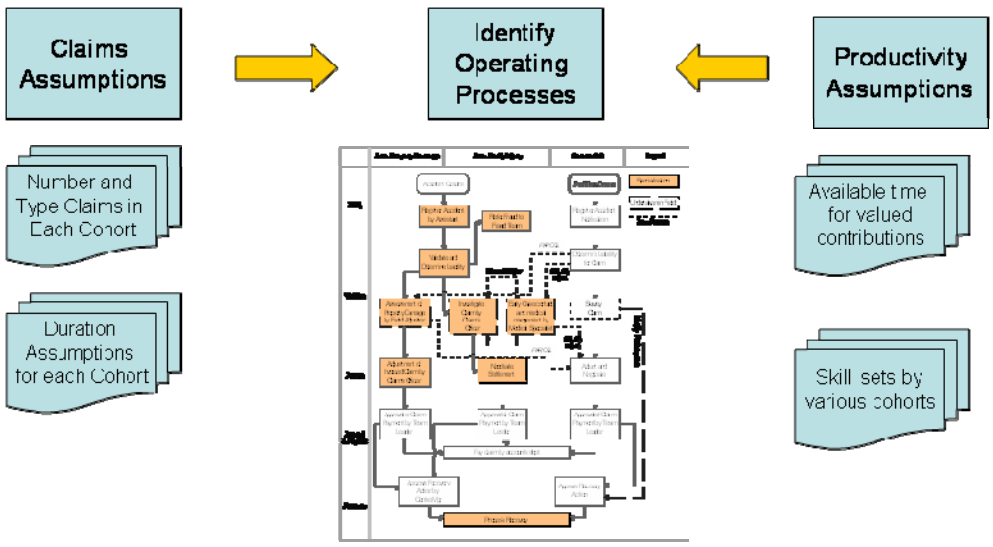
   This is arguably the most important and complex aspect of the modelling approach.

7. Durations

   Establish through analysis the average duration of each cohort of claims identified and the likely duration if operational constraints were removed and "best practice" deployed.

Figure 3 depicts the steps to date.

Figure 3 – State of Application of Best Practice



Model a claims build-up and run-off pattern using the assumptions established.

The result is a potential file load for each identified discrete cohort.

	File loads		Number Staff		Total Number Claims
	Claims	Admin	Claims	Admin	
Cohort 1	150	600	12	3	1800
Cohort 2	90	300	5	1.5	450
Cohort 3	60	200	3	0.90	180
Total	122	450	20	5.4	2430

Business Case

Once proposed staff numbers emerge from the analysis (including all supporting infrastructure), the claims operation should develop a cost-benefit analysis of the overall impact of any proposed changes.

Any additional costs are quite obvious. The benefit side of the equation needs to take account of estimated improvement in claims costs. This could be by:

- Surveying staff as to the potential effect of the file load reforms proposed (as well as any accompanying business improvement initiatives proposed) on duration, for example.
- Considering any evidence from other sources of the effect of similar reforms undertaken.

The results of the above approach can be incorporated directly into a business case into the changes needed. Our experience, where we have confronted significantly excessive file loads through such studies, is that the business case identifies significant net cost improvements.

For example:

Current scenario
- Annual Incurred Claim Cost - $300m
- Claims operative staff numbers - 100
- File loads -130
- Staff costs - $15m

Projected scenario
- Determination that best practice does not apply but that it would derive claims cost savings of 5% (to be conservative):
  - the main tangible investment is a file load reduction to 110
  - this will increase operatives to 120 at a staff cost of $1.4 million
- Simple cost benefit: Increase in staff costs of 1.4/15 = 9%
- Claims cost savings: $300m x 5% = $15m
- Thus return on investment can be predicted as 15:1.4 or 11:1

File Load Outcomes

The overall potential outcomes and advantages from pursuing this analytical approach to file load assessment and the associated background work, include:

i. Establishing the optimal claims handling (claims outstanding) capacity for each staff type for each identified cohort of claims.

ii. Alternatively or additionally, establishing the optimal number of new claims for each staff type for each cohort – this is more a throughput measure and is most relevant to simple, short-duration classes.

iii. As a corollary, establishing the required complement of staff based on claim file loads for each cohort.

   This, in turn, gives rise to an assessment of support and managing staff and thus an overall staff cost.

iv. Identification of efficiency gains available by modifying resource allocations, job descriptions and procedures – best practice models.

v. Identification of discrete cohorts of claims, which in time can assist in the establishment of specific strategies for each particular cohort.

vi. Cost benefit opportunities from undertaking particular claims management initiatives.

vii. Identification of any existing inherent backlogs and possibly under-utilisation of resources.

Application of this Approach

From our direct experience, this approach has been adopted in CTP and Income Protection businesses as part of broader claims reform initiatives. Management has accepted the business cases and the results of the initiatives, of which file load reform has been one and therefore unable to be isolated and specifically measured by us, have included significant improvements in claim loss ratios. Importantly, there has been staff recognition that the resultant file loads "make sense" to them and allow them to fulfill their responsibilities in the manner intended.