

Lost Contact

Best Practice Considerations for Telephone Adjusting Operations
by Don H. Donaldson

What are Best Practices? Are there identifiable practices within the insurance industry associated with superior operating results, policyholder approval and loyalty, and employee retention and satisfaction? If so, how has the transition from a predominantly outside or field adjusting workforce to an inside or telephone claims staff affected the claims administration process? Has the virtual elimination of personal, face-to-face contact with the insured or claimant created unique or specialized considerations for Best Practices companies? These are serious questions which are part of larger issues affecting the traditional insurance market and its future. A growing body of research has identified some common characteristics of successful and *profitable* claims operations and provides revealing insights about the public perception of the claims function.

Public Opinion & Perception

No business is immune from the perceptions held by its customers. Understanding and responding to the perceptions of its customers is the first element in every highly effective, customer driven company. There are generally only two principal interactions between any policyholder and an insurance company. The first is at the time of purchase/renewal. The second and most crucial interaction occurs when a claim is reported. In an insurance transaction, trust is the critical factor in the purchase decision. The fulfillment of the aleatory promise made by the insurance company in exchange for the insured's premium dollar is claim service. The claims function, therefore, serves as the demonstration of commitment and integrity of an insurance company to adhere to the contractual promise made to the insured. While the effect of pricing, marketing and underwriting cannot be dismissed, it is fair to suggest the bulk of the insurance industry's public image relates to the successful operation, or lack thereof, of the claims function.

As a general matter, the entire insurance industry suffers from a high degree of institutional mistrust which is common across race, age and geographic boundaries. Institutional mistrust is the tendency of the consuming public to view all large businesses as faceless, self interested machines with little or no concern for anything except profitability. Personalization throughout the insurance transaction, but most especially in the claims function, can make a significant improvement in the public's opinion. Figure 1 reflects a 1996 study of the insurance industry's image¹ and the correlation between personalization and public opinion.

Figure 1

% of Public having favorable opinion of public image of ALL Insurance Companies – 50%
% of Public having favorable opinion of public image of THEIR OWN Company -- 80%

During the eighties, the widely accepted rationale for centralizing the claims function into large regional centers and the corresponding rise in claim department workloads was centered on the need for improved efficiency and processing. Certainly there were significant improvements in automation and workflow during the past decade resulting in reduced costs and better processing. The period from 1993 to 1996 was one of the most intensive periods of insurance industry

automation since its inception. Measuring the developed cost or benefit of these changes requires looking beyond the short term, operational savings alone. While the industry was busy singing the praises of intranets, voice mail, and email, the tide of unpopularity and distrust among the general public about the overall fairness of the claims process during the same period increased substantially. The data in Figure 2² reflects the overall decline in the public's trust in the claims process and the disturbing relationship between attorney involvement and this declining confidence:

Figure 2

	<u>1993</u>	<u>1996</u>
Public believing fair settlement <u>without</u> an attorney is unlikely	31%	49%
Public believing a higher settlement likely with an attorney	42%	66%
% believing hiring an attorney will speed up the claim process	35%	53%.

Clearly, the improvements in industry automation and the development of intelligent systems failed to check the rising level of dissatisfaction with the claims process among personal and commercial insurance consumers.

Factors Influencing Communications in the Claims Process

Personalization in an insurance setting involves overcoming the public's natural tendency to consider insurers as faceless, nameless entities. Recent studies of the human factors which influence the decision making process in children and adults reveal the relationship between direct, personal contact and effective communication. **Body language** is responsible for approximately 55% of decision criteria; **tone** or **delivery of words** make up about 38%; and the actual **words** used in conveying information account for around 7% of decision formulation. Face-to-face communication has the inherent advantage of incorporating body language into the interaction and offers positive or negative reinforcement of the spoken word. The loss of this one critical element in any communication can impair the entire process by over fifty percent.

It is not surprising that the industry trend toward centralized claim processing centers totally dependent upon written and telephone interactions with insureds and claimants has had a negative impact on the insurance industry in several ways. Impaired or faulty communication creates fertile ground for suspicion and doubt in business or personal relationships. Removing the face-to-face contact between the adjuster and the insured or claimant has been a major factor in the rise of institutional distrust, attorney involvement, and fraud.

The adjusting process involves decision making by both the insured\claimant **and** the claims technician. The human factors in decision making have the same, if not greater, influence on the individuals employed by the companies to adjust and process claims as they do on the claimant. By removing face-to-face interactions from the claim adjustment process, a dynamic of **mutual** distrust and non-cooperation becomes virtually assured.

To overcome these inherent obstacles associated with inside adjusting, ongoing special training and emphasis is needed to improve the quality and methods of interacting with claimants which remain available to the inside adjuster. To maximize the possibilities of a mutually informative and beneficial interchange, the claim technician must be highly skilled in verbal and written communication. The studies on effective communication confirm the telephone adjuster should

choose words and a method of delivery in every interaction which enable the insured or claimant to visualize not only the issue but also promote a sense of trust and respect. If face-to-face meetings are not possible, the tone and delivery of each communication must overcome the absence of body language. Approach each claim with a demonstration of honesty, concern for claimant's situation, and a willingness to provide as much as possible as quickly as possible in the way of information and support. The claims technician or independent adjuster should always take the initiative to offer the olive branch of trust and respect. Adjusting is about helping people in crisis. *Each new claim presents a person or persons who have just been involved in a very unpleasant, potentially catastrophic event.* An insurance professional charged with claims responsibilities must be capable and skilled at defusing the anger, confusion and distrust presented in virtually every case that crosses their desk.

Without direct contact, the chief ingredient required to enable all of these divergent factors to come together successfully is **time** – time for the adjuster to be readily available to respond to the insureds and claimants – time to complete a full and thorough investigation (with the understanding of the inherent limitations on the scope of an inside versus outside investigation) – and time to compile and evaluate the information gathered at the conclusion of this process. Structuring a Best Practices claims operation around telephone adjusting units means incorporating an awareness of time requirements into a combined system of reasonable workload guidelines*, proper resource allocation, and ongoing staff development. Each piece of the puzzle must fit together correctly so that the lack of **time** does not become the enemy to the process.

Workload Guidelines

Along with the trend to centralize claim functions in regional processing centers, there has been a steady increase in the workload guidelines for claim technicians in most U.S. companies during the past two decades. In the middle seventies, the average pending workload of most adjusters was approximately 50 claims per month. In today's work place, this number has increased to an average minimum of 150 pending claims. Many companies feel comfortable with each claims representative carrying 200 to 250 pending claims. Only two decades ago, a typical adjuster would receive 10-12 new claims per month. The current day figure is around 50 to 75 new claims per month.

As the average month contains only 22 working days, the modern day adjuster must initiate an average of 3 new claims per working day compared to 1 claim every other day just 20 years ago. To maintain a given level of pending claims, the adjuster must close one existing file for every new file received. This translates into closing an average of 3 files each workday in order to avoid increasing the total number of claims pending each month. Concurrent with the dramatic increase in workloads over the past 20 years, there has been a wave of statutory and administrative duties and obligations which have added to the traditional responsibilities associated with claims handling. Some states' consumer protection laws or insurance code provisions have mandated minimum standards of responsibility or timeframes for performance which have aggravated this issue by imposing time compression on the claims process.

* avg. number of newly assigned claims/month; avg. number of unresolved (pending) cases carried/month

During the transition to an inside workforce, most companies did not foresee or respond to the delays associated with the U.S. Mail and the telephone as the sole or primary means of investigation and communication. Consider the delay introduced in the typical claim by requesting and receiving medical records via postal service versus personal adjuster visit. This also applies to police reports, inventories, land or public records, automobile titles and just about every documentary item one might expect to see in a claim file. What about the ever-present frustration and delay of telephone tag with the insured, claimant, medical provider, appraiser, or legal counsel? Organizations which have failed to account for these factors in staffing and operational planning have seen a marked decrease in the overall efficiency of claims administration and staff retention.

Allocation of Resources – Commitment to Quality

The Ward Financial Group, Inc.'s 1997 Best Practices Survey results identified common threads among the top 50 P&C insurers, which typically averaged 5.8% lower combined loss ratios, significant increases in policyholder retention and a marked reduction in the number of suits filed against the company as compared to their non-best practices counterparts:

- Allocating human resources to accounts and geographic areas with high frequency/high severity where the greatest financial exposure existed to both the insureds and the carrier,
- A mentoring program to train and provide continuing education and cross training for all employees,
- Cross departmental communication without management or supervisory approval, and
- Systems and programs designed to include the insured and the insured's employees, the agent and underwriting in the claims process.

There is a growing concern shared by many industry observers that highly experienced and knowledgeable claims personnel are not valued or retained by many insurers. A large percentage of this highly experienced workforce has moved from traditional carrier based claims operations to independent adjusting firms or TPA operations – some have been lost entirely as available resources. The gulf of experience and training which exists between the newly recruited claims handler and their most seasoned counterparts is one of the most urgent issues requiring the immediate attention of U.S. insurance executives. Salary and compensation considerations must be addressed to allow the most skilled and experienced members of claims departments to remain in place to coach, mentor and set a professional standard of conduct for their co-employees and industry peers.

Other issues of allocation involve very fundamental changes to bring the claims function into the modern age of customer driven services. The overwhelming majority of auto accidents (in terms of frequency) occur during peak driving times, i.e., early morning or late evening hours. The insurance purchasing public places a great value on the availability of qualified personnel during these periods of high claims frequency. Despite this clear preference among its consumers and the obvious benefits of time shifting in auto claims units, a significant number of auto insurers do not maintain operational business hours to coincide with the greatest period of consumer demand.

Prompt Response – The Benefits of Proper Staffing

A growing body of research data coming from the study of Workers' Compensation claims throughout the United States points to the substantial benefits to be gained by reducing the amount of time which elapses from the date of accident/injury to first contact by the adjuster, the employer, or a primary medical provider. One such study of W/C claims reported average savings of \$3500 per claim by lowering the number of days between the date of loss and first contact from 16 days to 10 days. The results for OTC and PD claims showed similar reductions in final settlement costs.³ Figure 3 reflects some of the other findings in W/C claims as part of the same study:

Figure 3

CLAIMS HANDLING AND SEVERITY COSTS BASED ON D\A* TO D\R**

<u>Days</u>	<u>Total Claims Settlement Costs</u>
0-10	\$12,082
11-20	15,582
> 31	17,920

EFFECT OF TIMELY LOSS REPORTING ON LITIGATION RATE

<u>Days to Report</u>	<u>Litigation Rate -- % of Cases Litigated</u>
0-10	22%
>30	47%

A 1997 Gallup Organization study of 500 W/C lost time cases nationwide indicated that injured employees contacted by company representatives, an insurance adjuster, or seen by a medical provider within 1 day of the injury producing event were **40% less likely to sue their employers.**

Those not falling into this group:

- returned to work later;
- achieve a higher disability or impairment rating;
- were less likely to remain employed by employer (at time of injury) over the next 5 years.

The proper and ongoing training of claims staff, allocation of staff resources to maximize availability to the insured, and maintaining realistic workload guidelines are key essentials in the ability to promote prompt adjuster interaction after each loss. Short-term budget reductions achieved by staffing cuts cannot be justified when weighed against the improvements in loss ratios and customer satisfaction/retention associated with a fully trained, well compensated and adequately populated claims department.

Wake Up Call

Successful administration of the claims process through inside adjusting techniques requires an acknowledgement of their inherent limitations. Overcoming these obstacles involves providing the necessary staffing and training to ensure substantially lower workloads than typically exist today. Consistent, customer driven administrative, operational and staffing polices will continue

* Date of Accident

** Date of Report

to be the cornerstone of the highly profitable segment of the traditional insurance marketplace. Consumers have demonstrated a growing demand for customer focus. The cost savings which may be achieved from the total reliance on telephone adjusting, premature reductions of claims staff, and increasing workload guidelines must be balanced with a corporate awareness of the fundamental importance of the claims function and a realistic assessment of the complex and difficult responsibilities placed upon the loss adjustment staff as a result of the shift to centralized, inside adjusting.

Any policy or procedure that improves the image and relationship of our industry to its customers and consumers is a Best Practice. One of the greatest educators and visionaries of modern insurance, Dr. Edwin S. Overman, CPCU, in describing the future of our industry said it this way, "The real test of whether the insurance business develops leaders and an educated work force will be the public's response to our business in the future." The companies which will lead our industry into the 21st century will have a corporate philosophy which considers expenditures for maintaining reduced workloads, ongoing training and development, and maintaining highly experienced, customer driven claims professionals as a practical necessity.

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¹ Insurance Research Council, 1997 *Fairness & Balance Survey of 2011 P&C Policyholders*

² Insurance Research Council, 1996 *Public Attitude Monitor Survey*

³ First Notice Systems, 1995 Survey of 256,000 policyholders

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