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Controlling workers' compensation claim costs: 3 things every self-insured should know

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The observed increase in workers' compensation claim liabilities and ultimate losses is partially attributable to external factors—those outside the control of risk management, such as medical inflation. Elizabeth Bart's article, "Ever-increasing unpaid claim liabilities: When does the growth stop?"[1] explores such external factors.

This article also explores the topic of increasing workers' compensation claim costs, with a focus on how claims practices can influence claims costs and contribute to the increasing liabilities, and discusses what self-insureds can do to better manage practices in an effort to control costs.

The management of a workers' compensation claim incorporates several key areas, all of which interact and combine to influence the claim's outcome (e.g., initial handling, investigation, reserving, medical management, etc.). It can be challenging to understand whether a workers' compensation claim is well managed and whether optimal outcomes are being achieved. This is particularly true for self-insured entities, which often delegate claims management responsibilities to an outside third-party claims administrator (TPA).

The result of using TPAs for claims administration is that the self-insured entity itself maintains little if any expertise in the area of sound claims management practices. Moreover, the TPA will often delegate certain functions to other vendors such as case management and medical and legal bill review, further removing the oversight of these services from the self-insured's reach. Finally, many self-insured/TPA contracts focus on the quick resolution of a large volume of smaller dollar claims, with little consideration for the efforts and resources needed to resolve large claims. Therefore, the management of larger claims may not be well understood or outlined in these arrangements.

Improving three often misunderstood or underestimated claims handling areas could result in a significant improvement in claims outcomes and have a material impact on liabilities:

- Initial activities
- Information and data collection
- Change in case reserving practices

Basic knowledge of these essential claims handling activities will enable the self-insured to effectively work with its TPA to avoid common pitfalls and to proactively manage the TPA. This, in turn, will mitigate or avoid unnecessary cost increases.

Initial activities

Activities undertaken by the claims handler immediately after a claim is reported are often thought of as administrative tasks—no more than an intake exercise whereby the handler runs through a checklist of scripted questions. These activities include assessing immediate medical management needs, making three-point contact (i.e., contact with the employer, the injured worker, and the medical provider), assigning to the appropriate adjuster, taking statements, and gathering documents (e.g., medical authorizations, photos, police reports, and wage statements).

And in truth, activities that occur in the early stages of a claim may not be terribly significant for the large number of reported workers' compensation claims that resolve quickly. However, for that small percentage of claims upon which the majority of the costs are ultimately expended, proper claims management from the outset is crucial to achieving optimal claims outcomes.

For example, a claimant who has had previous injuries or prior surgeries, or who otherwise presents with certain characteristics such as chronic pain, is more likely to require medical management from the outset to ensure optimal medical outcomes, which in turn reduces costs. For a small number of high-severity claims, if the medical aspects are not understood and well controlled at the outset, the claimant often does not improve and the claim can adversely develop into a larger-than-anticipated and larger-than-necessary claim—a lifetime pain management claim perhaps involving multiple surgeries, and costing hundreds of thousands or even millions of dollars without optimal medical outcome or endpoint for the claimant.

Thus, it is important upon receipt of a claim to investigate all prior injuries, surgeries, prescriptions, and comorbidities (i.e., health issues that are not work-related but nonetheless could impact the treatment of the injury). In many cases, the best practice of making three-point contact has devolved in practice into two-point contact (the employer and the injured worker) and in some cases even one-point contact (the employer). This can leave basic medical questions unanswered for weeks or months. For a small percentage of claims that have the potential for developing into the highest-severity losses, these delays could be critical.

Another key initial activity is adjuster assignment. Assignment to the appropriate adjuster can be particularly important for some claims—for example, those where the claimant reports injuries to nonspecific or multiple body parts, such as "neck, shoulder, arm." These claims present an element of subjectivity, uncertainty, and potential complexity. It is important that the adjuster thoroughly investigate precisely how the injury occurred and communicate with the medical providers about the types of injuries that can result from that activity.

This means that the adjuster needs to have the proper background and expertise to ask the right questions. If injuries or body parts are reported that are not medically connected to the work-related injury, the adjuster may only have a short period of time within which to deny those unrelated claims. An inexperienced adjuster may not identify or attempt the valid denial, in which case that injury and all subsequent treatment may be deemed accepted for the duration (perhaps for the life of the claimant), with no further opportunity to deny. In a large number of cases, this missed opportunity will not have a significant impact on the outcome, but for that small population of high-severity claims, such an error will be costly.

As a final example, the initial investigation is important to assess the claimant's ability or motivation to return to work based on one or more subtle aspects of the claim, such as educational level, child support status, disability status of the claimant's spouse, ability of the employer to accommodate the claimant's limitations, proximity of claimant's home to job opportunities, or other factors.

It is important for the handler at the outset of the claim to immediately contact the employer, the injured claimant, witnesses, and medical providers to ask pertinent questions. Equally important is the need for the handler to listen carefully to the answers and follow up on unusual or inconsistent information. Inexperienced claim handlers often appear to be following a list of predetermined questions and may hesitate to go "off script." Many times, the claims that adversely develop are those that, in retrospect, could have been controlled had certain information been collected and had the investigation been thoroughly completed and thoughtfully assessed early in the life of the claim.

Information and data collection

Increasing claim costs are also associated with the inability to easily locate and evaluate the information gathered on the file. A claim may be assigned to an adjuster with the appropriate level of expertise, and that adjuster may undertake a prompt and thorough investigation. However, the pertinent information emanating from that investigation is not captured in discrete data fields in one location in the file system. Rather, that information is buried throughout the "notes" section of the claim system—along with numerous immaterial or administrative entries. This impedes the ability of the self-insured to easily identify claims that have the potential to be large and work with the TPA to effectively control costs.

For example, a large volume of the "notes" section of a claim file may include entries such as the date of a reserve review, an adjuster's failed attempt to contact a party, the payment of a bill, the date a processing decision was made, the scanning of a document into the file, or the receipt of a police report with no substantive commentary. Even entries related to the status of a claim—one that on its face would appear to be highly relevant and current—are often simply "copy/pasted" from prior status entries.

Thus, including in the claim notes pertinent information vital to making prompt and reasonable strategic decisions can lead to inefficiencies and suboptimal outcomes. The amount of stale, outdated, repetitive, and sometimes misleading information makes it exceedingly difficult to identify and assess the pertinent facts, issues, and activities in the file, and impedes the adjuster's (and supervisor's) ability to make informed decisions. In many claim operations, reviewing the file is so time-consuming and difficult that the supervisor is only able to randomly select a small sample to audit at regular intervals. If that supervisor does not by chance select the "right" files, important issues might not be identified and key strategic opportunities might be missed.

The problem is compounded when information is entered incorrectly. Common errors can lead to costly repercussions. For example, assume that the medical records all clearly identify a right shoulder injury. If the handler inadvertently references the "left shoulder" injury in the claim notes, all subsequent actions might be based upon that. A supervisor or newly assigned adjuster may not have the time, or may believe it is unnecessary, to confirm that information by checking the original medical records. Body parts and treatments could be implicitly accepted and additional costs expended for injuries that are not work-related.

Similar types of errors can be made with wage information or rate calculations, and can go unnoticed for long periods of time, resulting in costlier claims. Finally, as more and more claims departments are outsourcing medical bill review functions to third-party vendors, some of that key medical information is not captured in the claim system at all, which can also distort the true picture of the potential exposure.

Thus, it is important that the self-insured verify that the TPA, or other claims-handling entity, develops a system of meaningful data capture, whereby key pieces of information are systematically downloaded or manually entered into consistent discrete fields in as few screens as possible. Many claims systems already have these capabilities, but handlers are not required to enter the data and the fields remain blank. Such a data capture would allow representatives at the self-insured entity the ability to obtain a current and comprehensive snapshot of the development on the claim. Discrete data fields also ensure consistency, facilitate fact-checking, and support the creation of meaningful metrics and management information reports. Self-insureds should ensure that they have full access to the claims system and that they understand all the features of that system.

Change in case reserving practices

The onset of conservative case reserving practices can lead to unnecessary increases in ultimate losses. This may not be intuitive. Many people may think that inadequate case reserves lead to increasing ultimate losses, because over time the case reserve (which was initially set "too low") needs to increase to cover actual payments. While this is true, the ultimate losses may not be affected by the development of inadequate case reserves, because the actuary may have taken the case reserve practices into account in estimating the actuarial reserve.

Thus, even if the case reserves were "too low," the actuarially estimated additional reserves would have compensated, resulting in a total reserve (case plus actuarial), or "ultimate," of "just right." As case reserves increase, actuarial reserves may decrease (all else being equal), and the ultimate will not change. In that way, inadequate case reserves do not necessarily result in increasing ultimate losses.

An important aside: We must remember that inadequate case reserves are not necessarily the result of poor claims handling or intentionally suppressing case reserves. When we say that case reserves are inadequate, we mean that, despite best efforts to set a case reserve that reflects the ultimate value of the claim at any given point in time, there are a few claims that will develop adversely in unanticipated ways (i.e., in ways that could not be foreseen by the claims handler when the prior case reserve was established).That is in part what the actuarial reserve is intended to estimate—the unanticipated development—and is outside the purview of the claims handler.

Changing case reserving practices by making them "higher" or "more conservative," however, can result in increasing ultimate losses. Consider, hypothetically, a TPA that decides to institute a new practice of establishing a case reserve reflecting the worst case scenario, or adding an arbitrary amount (e.g., 25%) on top of the best estimate of case reserves. That change could result in higher ultimate losses, for two reasons:

- First, if the actuary is unaware of this change, it will not be incorporated into the actuarial estimates. This could result in higher actuarial estimates. When added to the already increased case reserves, the ultimate losses increase substantially.
- Second, raising case reserves on a claim can lead to overpayments by the adjuster, a phenomenon commonly referred to as "leakage." In this case, the additional case reserves are believed, either explicitly or subconsciously, to be available to make payments. Efforts to reduce costs and manage the claim to its optimal result may be tempered by the knowledge that there is "extra" money with which to negotiate. This change in case reserving practices can lead to overpayments and rising claims costs.

Conclusion

In this article, we explored a concept mentioned but not developed in Elizabeth Bart's article, "Ever-increasing unpaid claim liabilities: When does the growth stop?" Specifically, we discussed three basic claims practices that could result in increasing workers' compensation costs. Understanding and recognizing the importance of these practices will enable the self-insured to effectively manage the TPA to control increasing costs.

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1 Elizabeth Bart. Ever-increasing unpaid claim liabilities: When does the growth stop? Retrieved on May 23, 2013 from http://insight.milliman.com/article.php?cntid=8328.