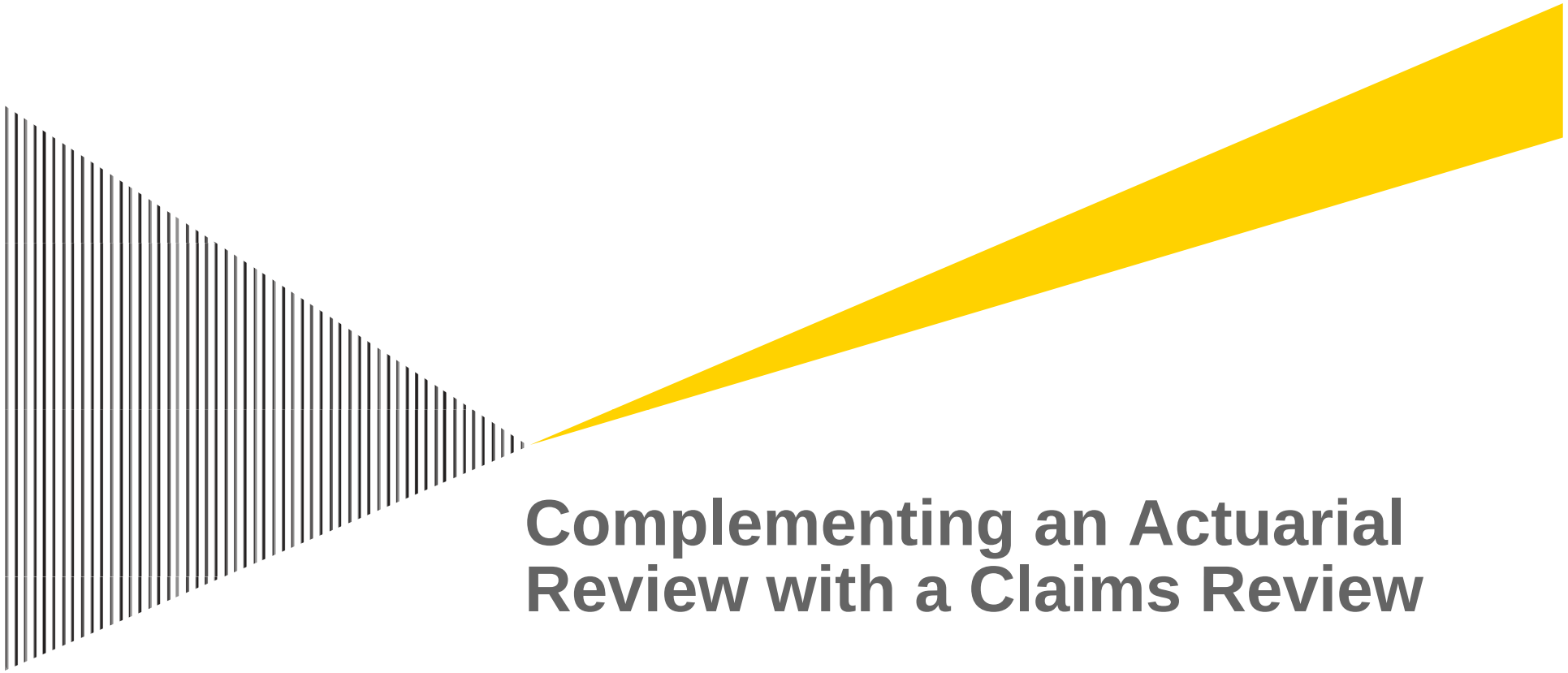

Complementing an Actuarial Review with a Claims Review

2011 Casualty Loss Reserving Seminar

September 16, 2011

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Presenters

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Introduction

- What is a claims review?
- Why should an actuary consider requesting one?
- Who in the audience has been involved in one?

Overview

1. Trigger for a claims review from the actuary's perspective
2. Basic process for a claims review
3. How to consider findings in actuarial analysis
4. Potential value of claims review beyond the actuarial review

Triggers for a claims review from an actuary's perspective

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- Several possible triggers exist that you can be looking for
  - Findings from questioning of claims department or TPA
  - Data diagnostics performed before or during the analysis
  - Unexplained adverse of favorable development
- These things are often elementary, but may not be viewed through the lens of a possible claims review

Findings from questioning with claims department/TPA

- Asking the right questions early on can point to issues
  - What specific objectives and guidelines does your department have in setting unpaid case?
  - Have there been any significant changes in the guidelines for setting and reviewing unpaid case during the last year(s)?
  - Are any special procedures or guidelines applied in the reserving of large or catastrophic claims? If so, please describe.
  - Has the size of the caseload of the average claims adjuster changed significantly in the past several years?
  - When, in the sequence of events, is a claim file established?
  - Have there been any noticeable changes in the rate of settlement of claims recently?
  - Has there been any shift from the employment of company adjusters to independent adjusters?
  - Could you provide copies of recent claim audits?

Data diagnostics

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- Take the time to perform the traditional data diagnostics every year, and do so early in the process
- Two general types of diagnostics
  - Loss and claim count diagnostics
  - Average claim diagnostics
- Review for consistency relative to your claims interviews

Data diagnostics

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- Loss and claim count diagnostics
  - **Ratio of paid-to-reported claims:** may indicate changes in case outstanding adequacy or settlement patterns
  - **Ratio of paid claims to on-level earned premium:** may indicate changes in speed of claims payment or in underwriting results
  - **Ratio of closed-to-reported claim counts:** may indicate changes in the settlement rate of claims
- Important: Understand any changes in deductibles, limits, coverages, or mix of business/claims

Data diagnostics

- Average claim diagnostics (inflationary trends expected)
  - **Average reported claim (report loss/reported claim count):** may indicate either changes in payments or case outstanding
  - **Average paid claim (paid loss/closed claim count):** may indicate change in payment speed
  - **Average case outstanding (case/open claim count):** may indicate change in case reserve adequacy
- Important:
  - Understand definition of reported and closed claims (may have $0 claims)
  - Beware of large claims that may distort diagnostics (either remove or limit)

Unexplained adverse or favorable development

- Performance of an "actual vs expected" or "hindsight" analysis at each review may also be a trigger
- Consistent adverse or favorable development could be indicative of a shift in claims practices, or in a mismatch between assumptions and exposure being analyzed
- Beneficial to review experience not just in total for each class, but by accident year as well
- The result of the claims review may also help you decide whether to give weight to the experience or not

Understanding the review triggers – baseline operational review

- Who is the client?
- What is driving the current environment?
- High-level Client Operational Review – Establishing a Baseline
  - Organizational changes
  - Loss trends
  - Level of risk retention
  - Loss allocation methodology
  - Divisional/location structure
  - Workforce analysis
  - Client staffing & expertise/Roles & responsibilities
  - Internal claim management guidelines

Understanding the review triggers – baseline operational review

- Agreed Reason for Claims Review
  - Audit or review?
  - In most cases, review should focus on vendor leading practices in claim management
- Claims Vendor - Program Review
  - Length/depth of program with client
  - Pricing/incentives
  - Special account instructions
  - Vendor interviews
  - Vendor stewardship
  - Vendor claim management leading practices
  - Vendor stability

Deeper dive into the claims metrics

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- Program Trending
  - Overall + rate-adjusted where available
  - Frequency
  - Severity
  - Lost Work Days/OSHA
  - Corporate, divisional, key locations
- Key Vendor Metrics
  - Claim closure
  - Expense management
  - Indemnity vs. Medical
- Vendor Performance

Establishing guidelines and logistics; setting expectations

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- Finalize Goals of Review
- Depth of Review
- Client Involvement
- Vendor Involvement
- Determine Expected Output of Review
  - Report
  - Metrics
  - Action planning
  - Corrective Action/Follow-Up
- Logistics
- Timetable

Building or choosing the review tool

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- Review Tool Format
  - Usually Access-based
  - Pre-populated with claim selections
  - Should allow for pre-formatted reporting based on findings
- Review Tool Content
  - Focus areas
  - Baseline questions by coverage line
  - Ability to modify based on specific client needs/goals
  - Weighting element – Scoring
- Review Tool Example

Review Tool – Screen Shot Sample

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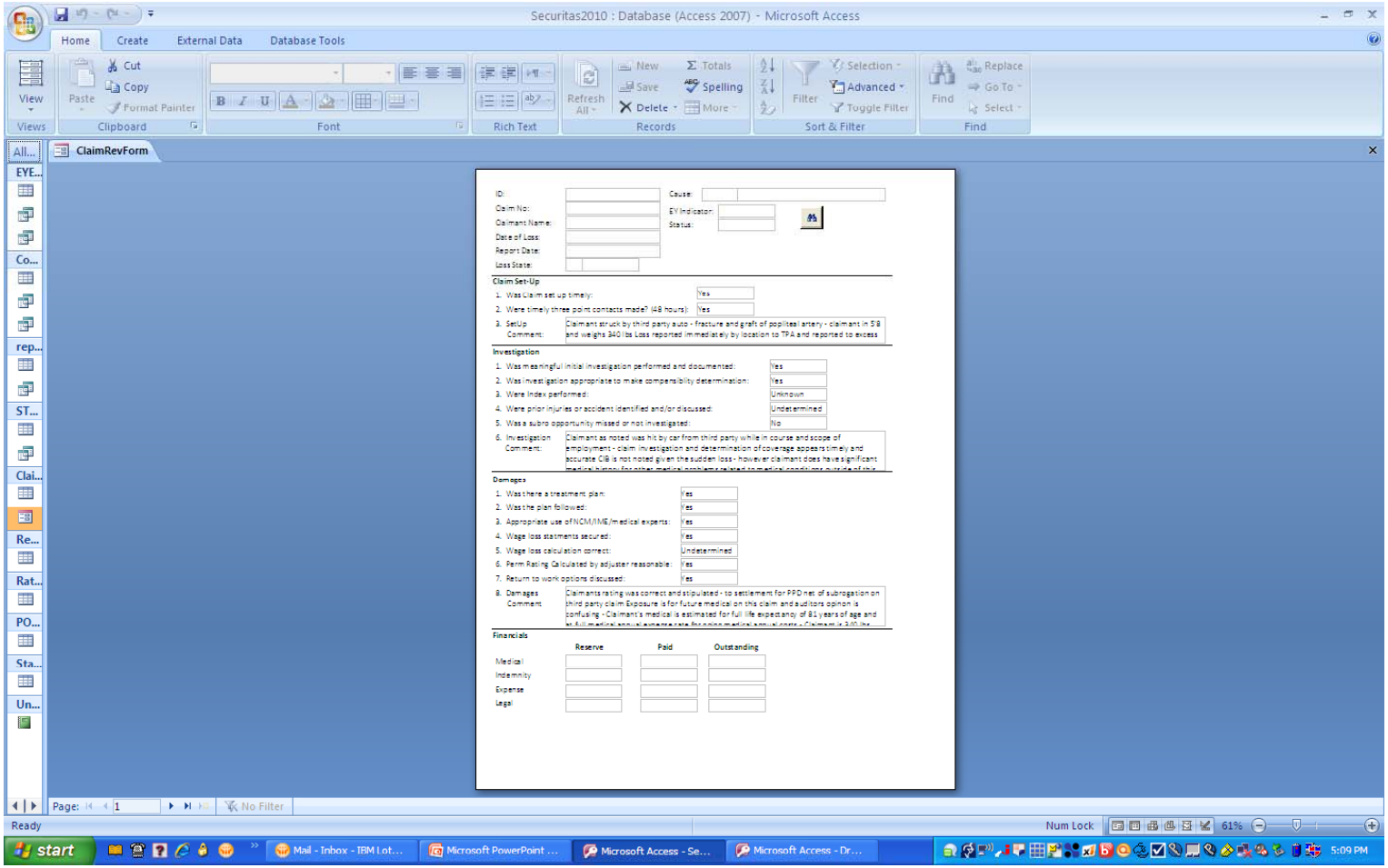

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Claim selection process

- Claim Selection – Statistical Significance
- Forced Selection – Agreed Parameters
  - Open or closed
  - Age of claim
  - Type of claim
  - Severity of claim
  - Jurisdictional representation
  - Business unit representation
  - Vendor claim office representation
  - Litigated claims
- Vendor Involvement/Cooperation

Inside the claim review

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- Pre-Audit/Team Consistency
- Quality Assurance
- Location of Review
  - Vendor
  - Client
  - Remote/Web
- Complex Claim Review & Concurrence
- Daily Team Discussion/Wrap-Up
- Notes/Trends

Communication with key stakeholders

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- Project Kick-Off
- Client Involvement
- Vendor Communication/Feedback
  - Daily issue discussion
  - Claim-specific concerns/questions
  - Jurisdictional or expert guidance
- Actuarial/Base Team Communication
- Preliminary Audit Results

Report & Metrics

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- Instant Reporting – Quantitative Results
- Final Quality Assurance
- Detailed Written Report Interpreting Findings
  - Review results by category, claim office, overall
  - Key qualitative trends
  - Identify Improvement opportunities for vendor, client
  - Suggested action plan/training needed
- Additional Review Needed?
- Review Results Tied Back to Key Metrics

Process Improvement and ongoing review process

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- Key Review Findings
- Vendor Feedback
- Additional or Deeper Review/Audit Required?
- Identify Specific Action Steps/Training
  - Vendor
  - Client
- Quantify Value of Improvement – Metrics & Actuarial Impact
- Timelines for Next Steps

May suggest adjustments or partitions of the data

- The claims review may indicate that subsets of the exposures are driving significantly different results from a claims perspective
  - State differences
  - Class differences

- Or, specific individual claims may be identified as unique and subject to different development behavior
  - Latent claims (asbestos, environmental, construction defect)
  - Large losses at limit
  - Hurricane losses

May provide assumptions or sources of assumptions

- Expected loss ratios
  - May indicate which historical period should be relied on
  - May be a basis for making an adjustment to industry
  - May be a basis for making adjustments to current year
- Loss development patterns
  - Again, may indicate which historical period to rely on
  - May result in exclusion of some specific claims
  - May result is restatement of case reserve levels (e.g. B-S)
- Also, often valuable to get claims input on reasonability of assumptions, especially if relying on industry

May suggest which methods are more appropriate

- Consistency of settlement and case reserving practices may point you towards one method or another
- In cases where methods are deemed not reliable, claims input may allow for adjustment and improvement
- In cases where there are a limited number of open claims and limited potential for additional reporting, the claims review may yield an actual IBNR estimate to consider

May inform on the reasonable width of the range

- Often times an actuary's range is based on a benchmark width or rule of thumb
- Discussion of these low and high IBNR estimates with the claims professional may indicate that one of the ends of the range is not realistic or reasonable
- In cases where different "reasonable" assumptions and methods were used to determine range, claims input on low and high assumptions and methods can be considered, as was discussed on the last two slides

Window into client organization

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- Identify Client Issues
  - Verify trends identified in actuarial analysis
  - Claim reporting
  - Return-to-work
  - Medical provider relationships
  - Vendor relationships
  - Divisional/location issues
  - Union – employee relations issues
  - Guidelines/changes needed?

Identify vendor improvement opportunities

- Quantify Critical Claims Vendor Issues
  - Account instruction compliance
  - Data quality
  - Data security
  - Reserving accuracy
  - Quality of field office claim staff
  - Claim supervision & field office management
  - Process vs. rigor
  - Claim leakage
- Vendor Commitment to Client
- Introduce Formal Claim Review/Audit Process

Opportunity to introduce performance and outcome-based metrics into the organization, centered around loss-cost mitigation

- Create Value for Client
- Outcomes-based Metrics
  - Loss-cost reduction
  - Rate-adjusted metrics
  - Ability for claims vendor to impact
- Vendor Contracting – Procurement
  - Performance guarantees/incentives
  - Loss costs – overall severity, lost work days, medical $
  - Outcomes vs. process
  - Penalty/bonus
  - Timing/length of measurement
- Build Long-term Partnership

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