Assurances

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Claims Audits

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Volume 60, Number 3, 1992

URI: https://id.erudit.org/iderudit/1104905ar
DOI: https://doi.org/10.7202/1104905ar

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Publisher(s)

HEC Montréal

ISSN

0004-6027 (print)
2817-3465 (digital)

Explore this journal

Cite this document

Quinly, K. (1992). Claims Audits. *Assurances*, *60*(3), 425–439. https://doi.org/10.7202/1104905ar

Article abstract

Un service des sinistres bien géré nécessite, comme une automobile, un entretien périodique; ainsi en est-il de la vérification périodique des sinistres. Les assureurs et les autoassurés dépensent des milliers de dollars chaque année pour des vérifications comptables par des firmes externes. Mais, chose étonnante, ils ne pensent presque jamais à prévoir un budget pour la vérification des services de règlement. Le client peut avoir l'impression qu'il reçoit un bon service, mais comment peut-il en être certain ? Dans cet article, l'auteur démontre l'importance d'une vérification périodique des sinistres, les avantages et les désavantages lorsqu'elle est effectuée soit à l'interne ou soit par une firme externe, les aspects divers d'une telle vérification et, en dernier lieu, l'évaluation de la vérification, une fois le travail accompli.

Claims Audits*

by

Kevin M. Quinly**

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The "flight to quality" is an off-head expression these days, usually referring to insurance buyers seeking stable and solvent sources of insurance coverage, It has equal application to seeking—and keeping—top-flight loss adjusting services.

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* Reprinted from *The Risk Report,* April 1992, with the permission of the publisher, International Risk Management Institute, Inc., Dallas, Tx.

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Having picked the right claim service provider, clients hope that matters will proceed smoothly. Unfortunately, though, much can go wrong even with the most careful selection. Communications break down. Service deteriorates. Expenses blow budgets.

Like cars, well-managed claim programs need periodic tweaking and maintenance to keep them running well. Here enters the periodic need for a claims audit. Insurers and self-insureds spend thousands of dollars a year on outside accounting audits, but when it comes to their annual investment in adjusting

services, surprisingly they may give little thought. A client may believe it is receiving good service, but how does it really know? A periodic claims audit answers this question.

This article examines the need for claims audits, considerations for whether to go outside or stay in-house to have it performed, how to select an auditor, points the audit should encompass, and how to evaluate the audit and auditor once accomplished.

Warning Signs Flashing

When is a claims audit needed? No hard and fast rules exist. Like red lights on a car's dashboard, various indices may signal a need for a claims audit, such as those shown in Figure 1.

Audits can be preventive, spotting problems before they occur. While ideal, in reality, many audits are reactive and event-driven. Audits are not usually undertaken because a risk manager or service buyer is happy with the status quo.

Do-It-Yourself?

Clients may opt to conduct the audit themselves. There is some logic for this choice. They undoubtedly have greater familiarity with the adjusting company and know where to look for areas of strength or weakness. There is less wasted time when risk manager take it upon themselves to audit and adjusting company.

Figure 1

Audit Indicators

- Recent turnover occurs in account adjuster personnel.
- Over 2 years have elapsed since the last audit.
- A recent surge in complaints about the claims process or problems in claims handling occur.
- Consideration is given to soliciting bids from competing claim service providers.
- A signal needs to be sent to the adjusting company that the current level of service is unacceptable.
- The client plans to discharge the current claim service provider and wishes to document the reasons.
- A reinsurer or excess insurer wishes to assure themselves that adjusters are handling claims in a thorough, competent, and professional manner.
- Turnover occurs within the client's risk management staff. For example, the incumbent risk manager is about to leave or retire, and management desires some benchmark comparison of claim service.
- A claim audit may precede a merger or acquisition. A merging or acquiring company wants to look closely at the liabilities it may purchase. Therefore, as part of the "due diligence" process preceding an acquisition or merger, a claims audit is a prudent if not necessary step.

Expense is another advantage. Hiring an outside consultant to conduct a claims audit can be expensive. Depending on the ize and scope of the project, an audit usually costs between $1,000 and $10,000. Using staff resources to conduct and audit has obvious appeal due to cost savings.

Speed is another bonus. Hiring an outside party for an audit puts one at the mercy of the consultant's schedule. The consultant may have two large projects ahead of the client's. If

internal staff is used, the wait for an audit may not be as long. Bottom line: the project may get started sooner.

While a do-it-yourself approach to claims audits has appeal, there are advantages to having an outside consultant conduct the claims audit. Objectivity is one advantage. Consultants may have fewer preconceptions about the adjusting company, good or bad. This aids their objectivity. Clients may have biases that undermine an audit's objectivity and usefulness. If, for example, the risk manager picked the third-party claims
 administrator, how likely is it that she will give the adjusting service low marks? She may fear this will reflect poorly on her judgment. Hence, to validate her selection, she may soft-pedal criticisms. To do otherwise might adversely reflect on her choice.

Specialization and expertise are another advantage. Odds are that the risk manager does not conduct claims audits very often. Once a year may be the limit. Consultants conducting claims audits regularly, on a full-time basis, are more apt to be adept at it than those who dabble in them as a sideline. An experienced consultant knows what to look for, how to probe deeply into claim practices, and how to compare one claim operation to another. A seasoned auditor will also likely be more efficient in conducting and completing audits than one who audits only sporadically.

Another bonus of using an outside party is credibility. Audit results may have more credibility with actuaries, auditors, reinsurers, or excess insurers if an outside consultant specializing in such activities performs the job. No publicly held company would state in its annual report that it audited its own financial statements and they were in good shape! The imprimatur of an outside accounting firm, often a "Big Six" outfit, is S.O.P. Without it, the numbers lack credibility. To an extent, the same holds true with do-it-yourself versus professional claim audits.

Selecting the Auditor

Assuming a firm decides to hire an outside auditor, the next step is selecting the auditor. Unfortunately, virtually anyone can grab some stationery and anoint themselves as claims auditor as easily as Jethro Bodine can call himself a "double-ought" spy. There are no standardized requirements that individuals must meet to become claim auditors. Such practitioners have no trade association to police themselves, nor any credentialing process. The term "GIGO"—garbage in, garbage out—applies here. R.L. Stinchcomb of Golden Gate Insurance Adjusters of Los Angeles writes that some claims auditors:

> ...are competent investigators and average adjusters who have become incompetent auditors. Never before have so many audits been performed on upper management. This is being done by use of claims auditors who are primarily investigators and many who have never worked in claims. These auditors were promoted basically through the "Peter Principle". (*Claims*, September 1991).

Avoid "Peter Principle" auditors who have never "gotten their hands dirty" with real field and claims adjusting work.

Many insurance brokerage firms, particularly the "alphabet houses", have full-time claims people on staff. Risk managers should check with their agents or brokers to see if they are capable of conducting claims audits. Clients may be able to get this service included in exchange for the commission or fee paid to the broker.

What qualities should risk managers seek in a claims auditor? A few considerations to weigh follow.

References

Request at least three. Get names and phone numbers of contact people and check them out. Were they satisfied with the auditors' work? Was it completed on time? Would they use the auditor again? Do they still use the auditor? Was the work performed competently? Was it reasonably priced?

Experience

Seek a consultant who has been doing claims audits full-time for a number of years. How long has the person been an auditor? Is it a sideline or a full-time vocation? An ideal background might include someone who worked within an independent claims adjustment company. Former claims managers from insurance company departments would also be prime candidates. Most reinsurers maintain a brisk trade in claims audits, since they must make sure that their reinsureds are doing a good job of handling losses. Excess insurers have personnel who specialize in auditing the files of primary insurers below them. Former corporate/self-insured risk or claim managers should also be adept at conducting claims audits. These are ideal experience profiles of top-flight candidates.

Credentials

A jumble of letters after one's name does not guarantee expertise. On the other hand, not having any professional designations inspires little confidence. Claims consultants and auditors come from varied backgrounds. Some of the insurance industry credentials indicating a qualified auditor are Chartered Property Casualty Underwriter (CPCU), Associate in Risk Management (ARM), and Associate in Claims (AIC). These designations, while no guarantee of quality, do signify that consultants have the motivation and determination to complete a lengthy course of study, much of it on their own. Drive, intelligence, insight, persistence, and an ability to be a quick study—these are qualities of a successful claims auditor worthy of one's business.

Occasionally claims auditors with legal degrees or the Certified Public Accountant (CPA) designation are encountered. A legal background is a plus, but few attorneys are claims auditors. It is best if the attorney has hands-on experience in claims handling to avoid an ivory-towered orientation. The strength of an accounting education is clearly in quantitative

analysis, but increasingly accounting firms are moving into the "fuzzier" areas of management consulting.

Aiming at the Target

Once the firm picks an auditor, the next step is to scope out the job and report. Do more than tell the consultant, "Conduct a claim audit". Be specific. What do you want the auditor to zero in on—reserves, investigation thoroughness, draft errors? Flag problem areas for the auditor to focus on. Do you want the auditor to focus on files only, or do you desire a comprehensive review of the entire account, including management systems? The latter will be more expensive and will entail the auditor spending time with adjusters, examiners, and supervisors handling the account. A file review alone will be less expensive. Some file reviews may be done off-site, thus trimming the auditing fees. For example, the client can ask the claims office to pack up and ship out selected files to the auditor. This way, the auditor consumes less travel time, and the client saves some money.

Having made these decisions, on what areas should a claims audit focus? Discussing claims audits is like being the proverbial mosquito at a nudist colony: it knows what to do, but hardly knows where to begin! Whether a client picks an outside consultant, or opts for a do-it-yourself approach, many components go into a good claims audit. While the topic could consume dozens of pages, in the interest of economy, let us focus on a few dimensions of a quality claims audit.

Coverage

At least from the perspective of insurers, some observers state that the three most important aspects of claims handling are, in order, coverage, coverage, and coverage (of course, a risk manager of a self-insured organization will emphasize other aspects of the claims function). Auditors should check claims files to see if the adjusters are recognizing coverage issues. Are adjusters sending reservation of rights letters? After adjusters

reserve rights, do they try to reach agreements on coverage? Claims representatives must not keep insureds "in the dark". Reservation of rights letters are time-sensitive.

Do adjusters seek the advice of coverage attorney? Adjusters should realize when they are over their heads on a coverage matter and need counsel's advice. Failure to seek such advice on coverage can invite bad faith claims.

Investigations

Do adjusters have an investigative plan? Do they grasp what needs to be done to investigate claims? Was it done? If not, was this for reasons beyond the adjuster's control? Are investigations tailored to case severity, with files neither over- nor under-investigated? Are the right tasks accomplished, and are they done right? Here are some of the highlights to examine when auditing investigations.

- Do the files have signed or recorded statements, or merely "interviews"? The latter may be worthless if a claim ever progresses to the courtroom. Statements are the backbones of the investigative file.
- Has the adjuster judiciously used photos and diagrams? Adjusters should display color photographs of 35mm quality on special mounting sheets, with brief legible explanations of what they purport to show. Good diagrams, considered by many to be a lost art among adjusters, complement photographs.
- The auditor should see that adjusters fully investigate and *verify* the claimant's damages. This includes: obtaining signed medical and wage authorizations; spot-checking medical service providers or employers to verify treatments or employment earnings; arranging independent medical exams to authenticate a claimant's complaints; and conducting activity checks, and even arranging for a surveillance firm to film that back-injury claimant hooking his drive on Fairway Fourteen.

- Was the investigation completed within a reasonable amount of time? Given a year, any adjuster can do a thorough investigation. Few claims allow that luxury, though. Usually, time frames are more compressed.

Reporting

Do adjusters provide status reports at regular intervals? For some cases, clients might need reports every 14 days. For other files, every 90 days may suffice. Set reporting standards and grade the outside claim service. Must the client constantly prod adjusters for status updates? That is a bad sign. Do adjusters have cases on a diary system? Or do they simply report when clients turn up the heat? If a file is replete with client letters requesting status updates, that too is a danger sign.

Reporting involves quality as well as quantity. Disdain "weather reports" that simply tell clients little, nothing, or what they already know. Do reports contain meaningful information? Do they give recommendations and a to-do list? Is there a standard report format that the client requires or the adjusting company has which adjusters follow? Are reports legible and typed, or handwritten and scrawled? Do reports go by Federal Express or FAX when there is no urgency? Are topic headings captioned to flag important points? Are requests for decisions and authority displayed prominently for the client's attention, or are they buried in paragraph three, page seven? Are significant dates—trials, hearings, etc.—highlighted?

File Documentation

Ideally, files should speak for themselves. They should reflect the basis for adjusters' decisions—settlement evaluations, reserve judgments, authority requested, grounds for payment and denial, documentation of authority given and offers extended, etc. Claims representatives should document phone conversations on a log or "claim progress" sheet. This is critical, given epidemic turnover of personnel in claim offices. The new person handling the file should be able to pick up where the prior

adjuster left off. Like a medical record, the claim should be "charted", with key decisions, activities, and work documented. Significant time lapses between entries indicate a lapse in file documentation.

Reserves

Since under-reserving is a leading cause of insurer insolvency, this function is key to any successful operation. Clients have an interest in seeing that their losses are neither over - nor under-reserved.

Check the auditor's reserve philosophy. One large independent adjusting firm, for example, believes in reserving to "injury exposure". This means reserving according to the severity of the claimant's injury. It does *not* factor in liability or lack of it. If a client's cases typically involve serious injuries but rarely any liability, however, such "injury reserves" may warrant significant discounting due to the defensible liability.

How often do supervisors review reserves? This may depend upon the type of case. Reserves should receive a review with every diary date. At minimum, this should be every 90 days or quarterly. This does not necessarily mean that reserves should be changed four times a year, though some cases may warrant this. See if the file notes or status reports reflect attention to reserve adequacy.

Is more than one person reviewing reserves? The claims examiner, supervisor, or even branch manager should periodically check reserve adequacy. Some claim departments have stratified levels of reserve authority. For example, any adjuster wishing to raise a reserve above $100,000, for example, must obtain a supervisor's approval. Reserve changes over $250,000 may require a branch manager's approval. Any change over $500,000 may require home office approval. Without getting too bureaucratic, a system of checks and balances is a key quality control tool in a well managed claim office.

Figure 2

Warning Lights During the Audit

Claim auditors should beware of the following "early warning" signals which may flag developing management problems with outside adjusting services.

Overworking files. Some neophyte adjusters over-investigate small claims, either out of zeal, ignorance, or to stretch to meet their billing quotas. Whenever the auditor or client spots overworking of claim files—much more common when billings are on a time-and-expense basis—they should try to nip it in the bud.

Underworking files. More common than overworking losses, this occurs when:

- Adjusters narrowly responding to issues the clients raise, without suggesting other investigative avenues or claim resolution techniques.
- Adjusters taking an ultra cautious approach to all proposed initiatives, such as, "We recommend against further investigation, lest we stir up a claim".
- Adjusters cutting corners in investigations, paying claims without adequate documentation of liability or damages.

Poor staff selection. Request that claims be handled at the lowest professional level, consistent with the quality required. It may be in a client's best interest to have a trainee or 2-year adjuster handle basic collision losses or slips and falls. Adjusters commanding higher hourly rates should be reserved for the most serious losses.

"Handoffs". Do *not* allow the adjusting service to substitute another adjuster for one who has already gained substantial familiarity with your account or claims, unless there is a very good reason. If the adjusting service cannot avoid such a substitution, ask them to write off the time the new person spends learning bout the client's claims, file, or account.

Pyramiding. Make sure the adjuster or adjusting service has not assigned a "team" of adjusters to work on a file, unless this has been cleared with the client and the justifications clearly spelled out. This type of staffing pyramid, which can inflate allocated loss adjusting expenses, should be for the exceptional case.

Are reserves holding steady, unchanged, for prolonged periods? This may signal inattention on the part of the adjuster. Resolved claims staying open for many months after settlement is a tip-off that someone is asleep at the wheel. Other tip-offs reflecting weak reserving practices include the following.

- A case reserved for $150,000 settles for $75,000 but the reserve remains $150,000 until the file closes 60 days later.
- An adjuster reserves a fatality at $15,000 since the first week it was reported and the reserve remains unchanged 10 months later.
- Defense counsel evaluated a claim reserved at $25,000 to be worth $200,000 6 months ago, but the adjuster only changed the reserve last week.
- Radical reserve jumps on the eve of trial.

All of these are "warning lights", signals that adjusters may not be paying attention to reserves, and that the individual case reserves are either under - or overstated. Other warning lights are shown in Figure 2.

Compare final payments with initial reserves. Avoid comparing final payments with final reserves. That is too easy! By the time the adjuster enters the final reserve, he probably knows close to the penny how much the claim will cost. Instead, how reliable are the *initial* reserves? Are the cases priced at a very rosy and unrealistic level, only to be hiked up later when bad news hits? Are adjusters trying to look like heroes in setting low reserves, hoping that they will get a transfer, get reassigned, or get accepted to law school before a major claim "meltdown" occurs?

How many reserve changes does the claims staff make over the life of files? This allows the auditor to conclude that, "on average, reserves were changed once per X number of months". This tells clients how often or infrequently adjusters are *really* examining reserves. For a slow developing medical malpractice

loss, a reserve change once every 5 months may be adequate. For a serious automobile liability claim, this is clearly inadequate.

Audit Report, Findings, and Follow-up

A thorough claims audit does not end with an intensive file review. Ideally, it includes a *management examination* of the claims staff handling claims files. The auditor should spend time talking with adjusters, supervisors, and manager(s) handling the client's account. This rounds out impressions formed through file reading.

Part of what clients pay for should be a final written report with the auditor's findings and recommendations. An auditor should offer specific, concrete, and practical suggestions on improving the claims handling and management system. Ideally, an audit report should contain the following.

- The *body* of the report, discussing in detail the aspects of claim operations.
- An *appendix:* work sheets on each file that the auditor examined. Typically, the auditor's sheets will grade each file according to specific criteria, with some free space for remarks.
- An *executive summary* with specific recommendations. Busy professionals will likely not have time to slog through a 20-page single-spaced report. They want "bottom line" recommendations, preferably accompanied by cost estimates.

Once an audit is finished, it should not simply be put on the shelf or briefly circulated. To make it worth the investment of time and money, the audit recommendations must be implemented, or there should be compelling reasons for not doing so. This is not to say that everything auditors suggest will be valid or practical. The client should not feel bound to implement every audit suggestion. On the other hand, if the client ignores an audit's recommendations, he had better have a

Figure 3

How to Survive a Claims Audit

How about when risk managers and clients are the subject of a claims audit? Here are some tips on surviving with flying colors when on the receiving end.

Get an advance list of files. Try to get a maximum amount of advance notice, so that you can locate and pull all files on the audit list. This also gives the claims staff the chance to review files pre-audit and anticipate any problems.

Review the files in advance. Check for rocks in the channel. Anticipate problems and prepare for areas of likely criticism, and formulate your response.

Do some housecleaning. Tidy up to make a good impression. Organize the file contents under brads. Make each file user-friendly.

Have a preaudit discussion to preempt problems. Be candid about problems the auditor is likely to see. Explain your claims philosophy. Do not boast, "Our files are in tip-top shape", even if you believe this to be true.

Prepare the playing field. Have all files ready and a conference room reserved. Be conversant with the cases. Have available an organizational chart, short biographies of key account people and technical/support staff available to answer questions or help out.

Show an interest. Poke your head in the door periodically and ask, "How is it going?" Are there any questions? Anything you can help with? Some problems and misunderstandings can be addressed on the spot.

Accept constructive criticism. Do not react like a hothead. Listen attentively. Admit problems, and the candor can be disarming. View the audit as a way to get an outsider's view of your operation, as an opportunity for improvement.

Challenge fault findings. If you strongly disagree with an audit report, go "on record" with a rebuttal. Do not overlook the obvious. The best way to sail through an audit is to have claims files in good shape: prompt and thorough investigations; sturdy reserves; sufficient file documentation so that files speak for themselves.

good reason for doing so and, preferably, should document the reasons.

Some auditors succumb to an ivory-towered outlook that makes their recommendations impractical. If, for example, the auditor suggests a doubling of claims staff during a hiring freeze, that is clearly unrealistic. The client may be able to use the report, however, to lobby against the freeze, to have the freeze lifted, or to justify some increase in claims department staffing.

Audits are a waste of time and money if reports become mere window dressing. A doctor can administer a physical checkup and suggest losing 15 pounds. If the patient keeps eating Twinkies and gaining weight, the checkup did little good. The same reasoning applies to a claims audit. The auditor can suggest, but it is up to the client to implement. Like a checkup, the audit can be an effective diagnostic and preventive tool, keeping a claims program in the pink of health!