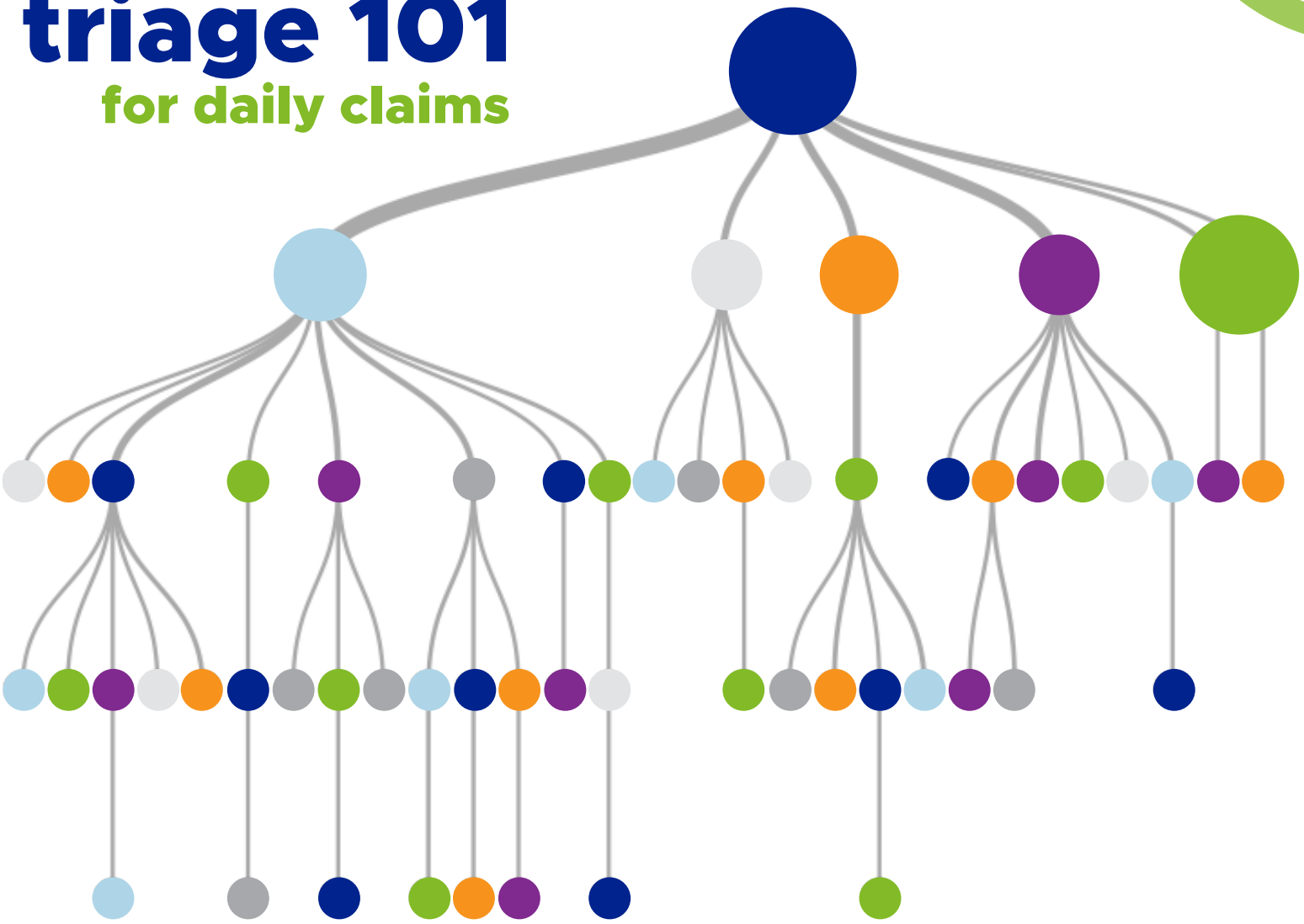
triage 101

for daily claims



ias CLAIM SERVICES | *for what's ahead*

Triage 101 for daily claims

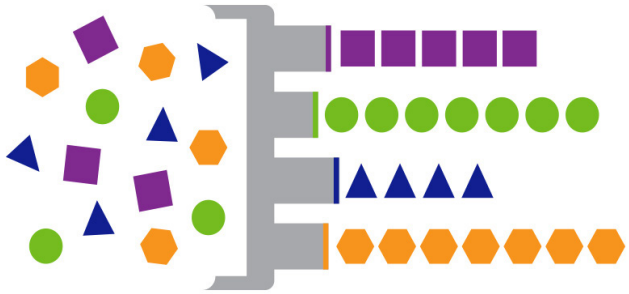
triage

[tree-ahzh]

(noun) the determination of priorities for action.

The origin of the word triage comes from the French verb “trier”, meaning to short, shift or select, and for most of us likely conjures up images of battlefields or disaster response sites. Historically, the term has been used in the medical field to define the process where patients are prioritized based on the severity of their condition and/or likelihood of recovery. In medical contexts, the goal is usually to identify and organize patients to optimize treatment processes that provide the maximum good for the maximum number of people.

These days, the term is increasingly gaining popularity in other fields where large numbers of quick decisions need to be made, such as the insurance claims industry. In these cases, the term is used mostly the same way – to define a set of processes and organization that move the incoming needs into proper channels that will provide the best possible outcomes, while most effectively utilizing resources.



Some of the most common reasons for triaging property claims in the insurance industry include:

- Quantifying and segmenting claims for proper assignment
- Reduction of loss expense
- Reduction of claim handling expense
- Increasing customer (policyholder) satisfaction

For property focused IA firms, there are multiple places where claim triage can affect their business for daily claims: the first being claim routing at the carrier level; and the second being how the IA firm makes internal decisions in handling their processes and assignments.

Below we'll look at both levels of triage, and discuss high level practices, policies, and potential results of an effective triage program including claim sorting, resource organization, processing models, and implementation.

PROPERTY CLAIM TRIAGE AT THE CARRIER LEVEL

For an IA firm's carrier partners, claim triage is an everyday fact of life, and can often result in both great cost-saving benefits, and also increased customer satisfaction scores if done properly.

Carriers may vary on the specifics, but at the most basic level, most of them will start claim triage with a series of questions, which may include:

- Is anyone injured?
- Is there the possibility of ongoing damage (standing or running water, fire potential, structural damage)?
- Is the home livable?

For a major carrier's property claims FNOL team, a "yes" answer to questions 1 or 2 will many times keep the claim internal to the carrier, and an outside IA firm will never see it. This is often the first step in the carrier's claims triage process – to assign the most "high-risk" claims to their teams designated specifically to deal with exactly these scenarios. A carrier may typically feel more comfortable in providing the additional levels of customer service that are required by claims with immediate need or ongoing damage potential, or that are more likely to be longer-term, high-touch cases.

Worthy of note however, is that each carrier is limited to processing the amount of claims their internal teams are able to reasonably handle, so during a carrier's triage process, there are still may times these high-touch, high-risk claims are by necessity assigned to an outside IA firm.

Once a claim has moved through the initial injury / ongoing damage / adjuster capacity test and the determination has been made to involve an IA firm, carriers are then faced with additional triage choices that determine which of their IA partners they are going to assign the claim to. These choices often include:

- How many partners do we have / what are our partner assignment ratios?
- What is each partner's current individual workload?
- Which partners have the highest performance scores?
- Which partners are known to have the adjuster coverage needed in the claim areas?
- Which partners have proven they are able to scale up capacity during emergencies?
- Which partners have the expertise to handle the claim types currently in process?

As you can see, there are potentially a large number of factors that carriers may use in determining which of their IA partners to assign claims to, and these factors affect not only catastrophe claim situations, but also daily claim assignments.

In order to be the best partner possible for its carriers, it's important for an IA firm to have a deep understanding of each carrier's individual needs and goals throughout the triage process, and to be able to respond accordingly. Obviously, cycle times and claim quality are some of the most important factors, but an IA

can also provide additional benefits to their partners (and potentially get more claim volume) by focusing on other key areas as well. For example, ramping up adjuster coverage in areas where your carriers are known to have PIF, and adding the ability to cover additional claim types can be just as important in building your relationships with your carrier partners.

IA FIRM TRIAGE FOR DAILY CLAIMS

Let's face it, whether they call it that or not, all IA firms do some form of triage. Even simple manual decisions like "What adjusters do we have available for this claim in XX city?", and "We're giving this large loss claim to XXXX because he's got 20 years of experience and can handle it.", count as triage in the technical sense. But let's dive a little deeper into some of the steps and processes the best firms are putting in place, how they get there, and the results they might expect.

Process 1: Claim sorting & prioritization

It's hard to say any one step is more important than the others in the process, but if we're going to pick one as the single most important indicator of success in a triage plan, this one would be it. Identifying all the variables surrounding a claim is crucial to being able to implement a successful triage execution plan, and is essential in enabling the other steps of the process. And re-qualifying, and re-categorizing claims if they change throughout the process can be just as important as the initial categorization.

This process can be challenging however, and relies on both outside and internal partners to be done effectively.

Some of the common challenges include determining:

- How much claim data is provided by your partners upon receipt?
- How and where in the process do you confirm this data with the policyholder?
- How does the carrier require the claim to be handled? (ex: field, desk, self-service?)
- Are there additional carrier requirements that impact how claims should be handled? (specific adjuster training requirements, faster than usual response expectations, unique customer service instructions, etc)
- How do you categorize and classify your internal teams and outside IA resources?
- How do you utilize technology to automate the processes?

After gathering answers to the above questions, you should be able to start formulating your triage plan. While every IA firm will have unique requirements, and the steps will vary in usage and order, a general field process will typically look something like this:

Step 1: Identify claims by location. (Region, city, zip)
Step 2: Prioritize claims by severity and/or response expectation.
Step 3: Classify claims by claim type. (wind/hail, fire, large-loss, flood, commercial, etc)
Step 4: Identify adjusters in required regions
Step 5: Identify adjusters with required skill set
Step 6: Sort adjusters based on internal adjuster rankings
Step 7: Sort adjusters based on current workload or availability
Step 8: Assign claim

Obviously, there can be a lot of decision points along the way to assigning a claim that can potentially impact how successful and effective your claims

process is going to be. Below, we'll dig into a little more detail about some of the individual processes that compliment and determine your assignment decisions.

Process 2: Adjuster organization

Every IA firm has a roster of adjusters, and these adjusters can come from a variety of backgrounds and possess a multitude of skill sets. Making sense of exactly what resources you have and which you should be using when assigning claims can be a challenge however, as there aren't predefined industry standard classifications or rankings. Ensuring that you collect good historical performance, qualification and skills data on your adjusters is paramount to your success.

In addition to assigning claims from their claims management system, most firms also store adjuster data in the CMS. At a bare minimum, this data should consist of adjuster name, location, state license information, and the other basic data required to operate as an adjuster.

For the ability to do more advanced assigning of claims however, additional adjuster detail should be gathered in order to make the best assignment decisions. Examples of this next level of detail may include:

- Claim type experience / specialization
- Additional training certifications (HAAG, Xact level, etc.)
- Years of experience
- Client specific training
- Internal adjuster ratings

With these more specific details, an IA firm at this level is able to more efficiently push their claim assignments out to the proper field resources, and should be able to boost their overall claim efficiencies, generating better results for their carrier partners. So far however, all the data we've talked about is quantitative.

Let's explore what can happen when qualitative data is added in the mix.

Using qualitative data, a much more thorough picture of your actual adjuster pool can be determined, and when used properly, this type of triage can result much higher level of success in your claims process. Many firms employ some type of adjuster ranking process within their triage plans. These rankings are often based on different facets of historical performance, and may be internally reported based on personnel reviews, generated based on Q/A scores, dependent on response and T.I.P. times, etc.

With ranking data such as this being integrated you are not only able to evaluate the list of qualified adjusters available, with the right skills and in the right area for a particular claim, you are also able to select the actual adjuster that is most likely to produce the best possible outcome for that claim based on factual knowledge of their previous performance.

Process 3: Claim processing models / team segmentation

So far, we've discussed triage practices designed to help effectively push property claims out to the traditional Independent Adjuster model and get them assigned to the best field resources available. But what happens when a claim falls outside that model, as in the case of policyholder-serviced, or fully desk-adjusted claims? What if your business includes TPA services or additional FNOL requirements? Where else can claim triage impact and potentially improve your business?

Many IA firms will build out internal teams or claim paths, designed to respond effectively to one type or classification of claims, thus ensuring more consistent claim response and oftentimes even saving carriers money vs. a one-size-fits-all approach.

Most of the same thought processes related to the standard field appraisal procedure can also be applied when it comes to segmenting claims based on teams and/or claim types. With the right data in place, claims can be categorized at any step in the process, and responded to accordingly. For some insight, let's take a look at some of the following examples that illustrate how an incoming claim might be segmented by claim type or team makeup:

Claim 1

A minimal value, low impact claim comes in. This claim may be sent to a phone specialist who is authorized to immediately submit a check approval for the expense.

Claim 2

A claim is received that is classified as a small value, low impact claim. The claim is then sent to a desk adjuster for policyholder contact and estimating.

Claim 3

A claim is received from a client for which the IA provides TPA services. The claim immediately goes to the IA Firm's FNOL team to begin processing.

Claim 4

A flood claim is received and is designated to be handled by a specific set of adjusters who are part of the IA's dedicated flood team and have the additional experience required to deal with this type of claim.

Claim 5

A "traditional" claim comes in. The claim is assigned to a field adjuster and internal IA operations manager for overview. Notifications are sent to an assigned Q/A representative for pre-scheduling.

As you can see, there are a myriad of claim types, and just as many potential paths for a claim to follow through an IA Firms operational structure. Segmenting claims on both claim type, and team capability will help the operations team deliver excellent results to the carrier client, and can even

potentially help reduce internal expenses by utilizing only those resources needed to service that particular claim.

Process 4: Implementation and reporting

So now that you've got your claim types, teams, adjusters and processes mapped out and organized, what's next? Next you put the rubber to the road, and start utilizing the people, processes and technology available to you to truly make a substantial difference in your claims management process.

Implementation:

All the data in the world doesn't do you any good if there's no place to use it. This step is where you get all the details & organizational data into your CMS system. If your current CMS can't support the additional data or new processes, upgrade it or switch to one that can. (Yes – we recognize that the challenges involved in this last sentence should be a whole article by itself.) Typically, this process will start with the following:

- Adding fields for adjuster organization
- Adding fields for claim segmentation
- Importing all gathered data
- Adjusting setup/signup processes to capture required data moving forward
- Defining teams and adjuster groups
- Defining claim flow processes
- Implementing carrier specific variations or requirements
- Notifying all involved parties for what to expect from the workflow changes

After the above steps are taken, test your processes extensively. Then test again, and finally, test some more. Fix any data issues found, and debug any process flows that aren't giving expected results. Once you're satisfied with the overall flow and assignment process, and confident that they are working as expected you can move on to the next phase, reporting.

Reporting:

So you've done all this work, organizing data, defining and implementing processes, and testing to make sure the workflows follow the proper paths. Now you're ready to truly take all of these changes, and make a difference in your organization, by actually deciding what you want to track and reacting to the insights you now have into your company's new work structure.

Defining and building a solid set of reporting practices will give you the ability to dramatically affect your claims workflow. At this stage, you should be familiar with the outcomes you expect, so it's time to start looking at how to react to the gaps and challenges in your process. For example, you could:

- Outline expected turn times for key aspects of the process, such as contact or estimate completion, and implement notifications when these aren't met, to automatically allow teams to get ahead of potential issues.
- Track and record adjuster processing times, and update adjuster ratings in the system accordingly.
- Segment claims by type and/or, and correlate demand with your active adjuster roster, automatically notifying recruiting staff where additional coverage is needed.
- Track which claim types are consistently reopened, and send this data to management in order to give a better understanding these types of claims and to allow for re-evaluation of processes.
- Compare claim billing amounts to claim expenses by claim type, in order to better understand which types of claims best suit your business model.
- Provide T.I.P., policyholder response time, or other information back to your carrier partners, allowing them to evaluate data that may have previously been unavailable to them.

There are a variety of ways which an organization is able to utilize reporting to

improve their outcomes, just a few of which are outlined above.

You know your business best, so it's crucial that you take the data available, and utilize your newfound reporting capabilities to improve the areas where you feel you're weakest, and to reinforce your performance and your carrier relationships across the board.

In summary...

Above we've shown how carriers and IA firms may broadly think about claim triage, and have gone into additional detail covering potential use cases and best practices for its application in processing daily claims.

Collecting the data required, and mapping the process for an effective triage plan can be challenging, but the results gained from a properly implemented process are worth it. Effective claim triage can make substantial improvements in may key areas of your business including: speed, efficiency, accuracy, and reporting. When your triage plan is executed properly, it can also bring with it many additional benefits such as reducing cycle times, improving claim quality, and increasing policyholder satisfaction, which as we all know translates to increased customer retention, both for your carrier partners, and for you as an IA firm.