Auto Casualty, General Liability

What Causes Bodily Injury Claim Overpayments and How to Prevent Them

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Bodily injury claim severity continues to rise, but inflation is only part of the story. Overpayments often occur during demand evaluation, when adjusters must make high-pressure decisions with limited time and incomplete information. In the webinar *Why Bodily Injury Claims Are Being Overpaid and How to Stop It,* Dan Zemel and Mike Fricke explore why claims are overpaid, where demand evaluation breaks down and what high-performing claims organizations do differently to improve claim outcomes. Read the excerpt below, or watch the full webinar for the complete discussion.

Watch the Full Webinar

Dan Zemel (DZ): Managing bodily injury (BI) claim severity remains one of the biggest challenges facing claims organizations. In this discussion, Mike Fricke and I explore where demand evaluation breaks down and why it often leads to overpayments.

Mike Fricke (MF): We'll also share practical examples from our claims experience and discuss the strategies high-performing teams use to strengthen consistency, improve negotiation outcomes and reduce claim leakage.

The Breakdown

DZ: We can all agree that BI severity is rising, and it's not a traditional inflation story that consumer price index is changing. The data indicates that third-party is rising at a higher rate than work comp and medpay.

MF: We expect that this trend is going to continue. Trying to stay on top of the various issues that are driving severity is something of a known nightmare for claims leaders. And that's because there are a ton of areas to consider. It can be part of underwriting. It can be people that you have; it can be the process, the claims themselves and the attorneys or providers or claimants on those claims.

DZ: Where do we see overpayments or inaccuracies actually happening? It's not necessarily in the investigation. It's not when the claim is in litigation. It's when the demand package hits that adjuster's desk. When that clock starts ticking, the pressure cooker is turned on, adjusters are being forced to make high-pressure decisions with imperfect information in a process that's traditionally, from a claims leadership perspective, the least governed in the entire claims ecosystem.

MF: That's right, Dan, we don't see it as a single issue either. There are factors that are in the demands themselves. We see provider buildup driven by plaintiff attorneys. We see escalation of diagnosis even within a single claim, but also over time we see a lot of overutilization of treatment as well as malingering.

Then there are also factors inside claims departments, like adjusters' inexperience with medical terminology. There can be some lack of rigor in negotiations, and what that means is it could be giving up the entire negotiation range immediately because that's easy. The other easy path is arguing to dump limits.

We also see quite a bit of a lack of leadership oversight or lack of ability to have oversight into the negotiation behaviors and the performance of individual adjusters. You used to be able to go sit side-by-side with an adjuster and listen in on negotiations. Now, you can do some of that by listening to recordings with our technology that we have, but being able to have an organizational view is just a blind spot.

DZ: Times have definitely changed. When we think of adjusters in general, they're highly skilled, motivated, and they serve the most important role in a claims organization. Demand packages are complex and chaotic, and the adjusters' days are just as chaotic.

Their phones are ringing; they have meetings, one-on-ones, regulatory compliance, and training. When it comes to completing an evaluation and responding to a demand, they're trying to solve consistency and information problems at the same time. The evaluation that someone does at 9:00 AM on a Tuesday is not going to be the same as one at 2:00 PM on a Wednesday. It could be the same left turn, same soft tissue, 45-year-old male, but there are nuanced differences in each of them.

It's so important for the adjuster to be able to look at each of them from a true case-by-case basis, differentiating the key factors. All the while, they're being asked to react to demands that are engineered to be as difficult as possible.

MF: These personal injury attorneys know what they're doing. The structure of the demand, the narrative upfront, that was playing up the sympathy angle and playing up the injuries and how they're permanent and forever changed from a $600 damaged bumper cover.

The presentation of the specials, it's all intentional. The way it's organized is intentional and strategic in what they're sending to your adjusters. The question we're looking to answer today is how are you equipping your adjusters to handle all of this?

The Cost of Getting it Wrong

DZ: When we think about this, what is the true ultimate cost? Overpayment, leakage and accuracy, however you want to word it, it shows up in a variety of different ways. It could be allowing treatment that is not causally related. It could allow injuries that are not causally related. We spoke earlier about how we're seeing trends rising from a third-party perspective relative to work comp and PIP/medpay.

We're seeing the same thing from a billing practice perspective. Once providers know there's a third-party carrier involved, they get a little bit lax with how they submit their coding for their bills. Without proper oversight and guidance there, these things slide through without even realizing it. Then, you get inconsistent general damage values.

If you think about it from an organizational perspective, you talk to five different people; everyone has a different general damage value. There's a recency bias; there's whoever you're round-tabling it with. That leads to inconsistent approaches from a general damage value perspective. As adjusters are working through their evaluations, they're spending too much time hunting for information within the demand and they're taking financial positions without guidance.

Oftentimes adjusters, they can see when bills just seem to be overpriced for the value, and the charges just seem to be out of alignment without the proper tools and the proper guidance. They don't have anything to anchor themselves to other than they know this is too high; they don't know what they should be changing it to. So, they end up anchoring themselves to these financial positions that are potentially inaccurate.

MF: That leads right into missed negotiation leverage, which is tough to quantify at times, but it might be the larger impact here looking at evaluation and negotiation phases of a bodily injury claim. What you're trying to do is build a knowledge advantage for your adjusters. Some examples, being able to cite a MMI date that is listed on a single page in the demand and is before, the end of actual treatment.

Being able to cite mention of prior injuries that are in the demand or prior treatment or the same type of injury where it's also mentioned and being able to take a look at where gaps, delays and treatment are or not following a treatment plan. All of that is part of negotiation leverage. Like Dan said, being able to anchor your position to objective facts gives adjusters a significant negotiation advantage.

DZ: When we think about litigation, specifically litigation escalation, it is driven at times by low-confidence negotiations. The adjuster has a position, but they don't feel confident in what they're saying. Something isn't related, they're cutting treatment or they're just taking a strong adversarial position on an injury.

When baked into the demand and baked into the medical records, there's objective information that justifies the experience of the claimant. Without being able to find that information easily and allowing themselves to think critically, that information is lost and they put themselves in a position that ultimately is not positive for the claims organization in the future.

These factors in general are present, but they can be the most difficult to assess within a claims organization, especially from a quantitative monetary value perspective. Once in litigation, we know that the economics change; the timeline extends, especially if you're in New York, the costs mount, the original settlement opportunity that you had to truly resolve a case. That window is now closed.

But the ones that are out of pattern from a litigation pressure perspective, we find that they have a demand evaluation problem upstream. It's easy to quantify the downstream litigation costs. It's more difficult to quantify those upstream costs at the same time.

MF: All of these costs impact what matters most to you as claims leaders. That is having reserve accuracy, watching your severity trends in one way or the other, and your loss ratio and combined ratio as an organization. These things don't show up as a single bad outcome. This is not a single claim that went wrong or relying on bad information and having something to go into litigation that you thought should have been handled outside. They accumulate undercover.

What High Performing Teams Do Differently

DZ: We've identified five key characteristics that we've observed these strong organizations are doing. As you look at them, you'll notice that none of them are talent improvement or replacing technology. They're focused on creating strategic systemic adjustments.

MF: I'll start with chaos to clarity. What that means to me is building a structure around the evaluation process. Before an offer goes out, you have to have some structure around what is expected of the user in getting to that offer. You got to have a definition of all the steps that need to be followed on each file prior to making that offer. That all comes from senior leadership buy-in. So having that strong senior leadership top-down presence and expectation, it is not only set but is followed up on. If you don't have that structure, what you will have is a huge amount of variance in your evaluations and then your offers.

Next up, governance. This is talking about governance in the review of medicals. Medical expenses typically represent about two-thirds of the overall settlement. Adjusters need to be able to speak that language. They need to be able to evaluate medical specials at the line-item level with a standardized, consistent approach. That means every demand gets evaluated the same way, not just the most significant ones. Consistently applying that process builds adjusters' skills and strengthens their ability to discuss and negotiate medical specials.

DZ: I feel strongly about the efficacy of time and particularly because I feel like when someone talks about efficacy, they misframe it as efficiency and therefore make it an FTE play. I want our adjusters to do more in the same amount of time or have the same amount of work done with less people.

But time efficacy is about using time wisely and most effectively. Let's say in reality, to do a strong evaluation, maybe the adjuster should spend 90 minutes on it. Then in reality though, they only have the time to spend 60 minutes. In those 60 minutes, as we talked about earlier, their phones are ringing, they have meetings, the voicemail light is indicating on their phone and they're seeing that ticker continue to increase on their computer screen.

And the answer is to ensure that if they spend the 60 instead of 90 or maybe they spend 45 instead of 60, their time is spent looking at and being informed on information within that demand package itself and thinking critically and executing on those decisions that allow for the governance and confidence to be in place. Efficacy is all about ensuring the time you do spend to be as focused as possible.

MF: Part of that time efficacy too is building expertise into the workflow. Instead of expecting an adjuster to just grow that skill over time or throwing a CPT book on their desk and saying memorize this and get better at this, you build it into the workflow. Whether that's Medicare pricing that is built into a review of the meds or CPT coding rules that they can talk about like unbundling or global surgical rules as examples.

You see our benchmark values being able to explain what that is and why it matters in your evaluation and in your offer. Adjusters who are able to cite expert decision support are fundamentally different negotiators from everybody else on the floor. Consistent, repeated use of these tools has a lot of impact beyond just metrics on a single claim. You're building confident adjusters who are going to negotiate better and be more confident going

into that next negotiation on a similar claim. They're going to hold their negotiation positions longer and escalate less.

Case Study: Payer Cut Settlements 45% by Reclaiming Control

DZ: We want to talk about a real engagement with a large carrier that struggled with all five of these categories. They showed severity pressure was driven by those upstream evaluation practices, and I would say lack of consistency with that as well.

They partnered with Enlyte through a six-month pilot focusing on improving the ability of adjusters to be informed, guided in appropriate treatment and pricing guidelines and ultimately creating these defensible negotiation perspectives and positions.

MF: And beyond that, they got some great results. It's interesting to note we don't often get to see the results of a pilot compared to prior results before working with us.

65% reduction in review or evaluation time. This was measured in a pilot across 250 settled claims. That is a meaningful result not only to you as a leader, but to your people that are on the front lines making these decisions. They also had a 45% reduction in their average bodily injury settlement across actual settled claims compared to their control group.

DZ: What the outcome showed was that there was an actual severity reduction, time efficacy improved and critical thinking was front and center. I think it just proves as well that when you solve the information and the consistency problems together, the outcomes truly do improve.

MF: That's absolutely it. There's a ton of upside to uncover in a process like this. This is a scalable plug-and-play solution. No IT lift is required. We have the opportunity to do some high-tech integrations, but it's not required. Turnaround times dropped from our perspective as we have scaled this business over time, and we're doing over 1.5 million demand packages annually at this point. Those defensible benchmarks that we talked about, like Medicare, UCR and billing rules, give adjusters a position they can hold instead of just a number to start from.

DZ: Better information at the right moment in time improves both the quality as well as the speed in decision making.

Key Takeaway

DZ: What we ask you to take away from this discussion is that it's not more process; it's not headcount changes or technology just for the sake of technology. It's about bringing structure, consistency and governance to the single moment where financial risk is the most concentrated. The opportunity lies in the evaluation and demand response. The gap between where organizations are today and where they could be is measurable, and I'd argue it's also closeable.

Watch the full webinar to learn how Demand Package Review can reduce exposure and improve settlement outcomes, or try out the savings calculator to estimate your total savings opportunity.

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