The Journal
of
Workers Compensation

Vol. 14 No. 2
Winter 2005

Closing the Recovery Gap

Fred Uehlein and David Jollin

Does any company know for sure if it is maximizing opportunities to reduce total workers compensation costs through third-party recoveries? How many claims managers, risk managers, or CFOs are confident that they are maximizing recovery dollars for their company? Frequently, the recovery mantra is, "How am I going to fix this? Will it take months?"

As we travel around the country talking with insurance professionals, we have rarely heard positive responses to our questions about maximizing recovery. We more often hear one of two refrains, "We've got it covered" or, "We will try to get to this issue later." Judging by what we have heard in interviews with employers and insurers alike, the answer to the question of how long it will take to fix could be "Years."

Such questions may be uncomfortable for those that think they've "got it covered" but have no real metrics to support that belief, as well as for those

that have not had satisfactory results. A greater understanding of recovery systems and opportunities, obtained only through process evaluation and analysis, can result in real solutions and positive change. The good news is that with the cooperation of risk managers, claims managers, primary insurers, TPAs, and reinsurers, maximizing recovery dollars is an achievable goal. What's more, solutions are possible without over-committing valuable management time or cash flow.

This article will review the major stumbling blocks in the recovery process and will suggest ways that managers can implement effective change to maximize results.

What Is Recovery?

Most in the industry would define recovery as recouping cash, yet recovery comes in many forms. We define recovery broadly as *the right to apply a statute to recover money or to reduce committed reserves*.

Recovery might result from statutorily created liens, as in subrogation; it might arise out of common law rights; it might involve offsets, as with the Social Security disability rules; it might come in the form of reimbursement, permissible in nine of the second-injury-fund states; or it might involve rights to full or partial apportionment to another party, as in many other second-injury-fund laws, successive insurer laws, and the new California apportionment law. The common characteristic in this expanded definition of recovery is the reduction of reserves by the assertion of rights against another party, rather than merely through the recovery of actual cash.

Why is this expanded definition of recovery important? We believe it should help to drive the use of new and more effective processes to recover more than standard claims processes that miss so many opportunities.

Recovery Process Status Quo

With this definition in mind, there are a variety of considerations regarding the industry status quo relative to the recovery process. The following are some observations about the existing recovery process.

What Is Not Measured Cannot Be Found

When we discuss recovery programs with insurers and employers, we are struck by the lack of metrics to measure success and to create recovery goals. This dearth of metrics exists both within individual companies and in the industry as a whole. There is no cost-effective "quick fix" here. Collection and analysis of historical data to develop metrics is expensive, yet without metrics, effectiveness is severely hampered.

What Is Found May Not Be Measured

To incorporate a recovery program into a total claims system, management needs to know not only what has been recovered, but also what is in the pipeline — by case, by line of business, by state, and by accident year. This information must include a timeline and a risk assessment for recovery as well as an accounting of what was "waived" or voluntarily passed over for some other claims consideration. This information should be used not only by finance and underwriting departments but also by claims administrators themselves to drive earlier claims resolution and best practices.

Is Recovery a Commodity or a Specialty?

All too often, recovery is treated as a commodity. This is a poor approach when driven by the potential beneficiaries and even worse when used by those who are supposed to be expert in the process. In workers compensation, the rule should be that recovery is anything but a commodity. The recovery process involves the application of complex analytical skills that focus on medical, legal, and investigative disciplines and often encompass multiple approaches. We concede that some portion of recovery work, that which involves low dollar amounts of easily identifiable and repetitive opportunities, is indeed a commodity or needs to be treated like one. However, even these situations require a level of specialized knowledge to effect maximum recovery. Therefore, rather than utilizing a one-size-fits-all response, structuring a program to most effectively match cost with benefit requires that a balance must be found between approaches.

Measuring Cost Without Measuring Net Return Is Meaningless

Those that believe that recovery is a commodity often compound the problem by measuring the cost of the recovery process without measuring the net benefit of recovery. When recovery is treated only as a commodity, significant opportunities are missed. Conversely, when recovery is treated exclusively as a complex and expert process, excessive amounts of money may be expended to capture the recovery. A balance must be struck between cost and benefit, and the net benefit must be measured.

Who Processes the Work Makes a Difference

Generally, those who favor a commodity approach leave all or part of the recovery process in the hands of claims handlers. The effectiveness of this approach may be limited by:

- large caseloads;

- emphasis on closing cases and high annual case turnover;
- measurements that do not factor in recovered money and do not reward extra recovery;
- lack of training in the disciplines involved in recovery;
- lack of experience in the legal system through which the process runs;
- ineffective technology for driving improved recovery performance and assimilating information;
- stability of personnel in a long recovery process, which is often measured in years, not months; and
- inconsistency in process application from office to office, client to client, or state to state.

How the Work Is Processed Matters

Favoring a highly specialized recovery approach is not a panacea in and of itself. The process — from identification to gathering proof to recovery — is often fragmented. Work is split between claims personnel, investigators, and lawyers and often fails to include any built-in process-management accountability. Because the recovery process lacks overall coordination, what is changed once is not subject to continuous measurement and analysis. When change occurs, it is too often a singular approach lacking the flexibility to meet needs differentiated by price, by state, or by matter.

Observations on the Recovery Shortfall

Auditing recovery systems for insurers, third party administrators (TPAs), and employers has given us insight into the scope of the recovery shortfall. We have had a unique perch from which to view some of the opportunities and obstacles that exist.

Characteristics That Impede Progress

There are four common characteristics that frequently impede process change, and without change, revenue continues to be lost.

1. Recovery benefits usually do not accrue, in whole or in part, to the party charged with the recovery function. This is a significant systemic issue that creates a lack of ownership and a misalignment of goals.

2. An assessment of the risks and rewards of process change is often lacking.

3. Managers are reluctant to adopt change without empirical proof of

success but are equally slow to adopt trial programs or to match trial programs against existing ones, which would provide the needed data to make a judgment.

4. When change occurs, it is usually reactive to a "fire," such as a specific customer complaint. The short-term solution of putting out the flames may leave the forest smoldering.

There are numerous additional roadblocks to change that also hinder recovery. These include such obstacles as regulatory scrutiny, human resource challenges, increasing competition, and the inability of the insurance industry to effectively implement rapidly changing technology.

An Eye-Opening Opportunity

In forensically auditing the recovery experience of hundreds of organizations nationwide, in three quarters of all the programs we've examined for either second-injury-fund recovery or for subrogation, we've observed that between 15 percent and 25 percent of the opportunities that exist are either not collected, under-collected, or not collected in a timely fashion. It is disturbing that the only way this can be determined is by forensic audit and analysis rather than by a comparison of benchmarking data. Because of the lack of data, we can translate the scope of the missed opportunity only into anecdotal and conceptual dollars. Nevertheless, the missed opportunities are eye-opening.

For instance, second-injury-fund reimbursement states currently disburse approximately $750 million a year, of which an estimated $100 million is in payment of claims that are eligible for initial reimbursement each year. A single claim for reimbursement in New York alone could be worth more than $250,000 over the life of the claim. States that take over payments to employees (rather than reimbursing insurers after they have made the payments) account for another estimated $250 million a year in disbursements, of which $30 million may be from claims initially submitted for takeover each year. If 15 percent to 25 percent of the opportunities is missed, this leads to the conclusion that the industry is leaving $19.5 million to $32.5 million in "initial" recoveries on the table each year. When the long tail of these recoveries is factored in, the total number exceeds $150 million of recovery and reserve reduction that employers and the industry leave on the table each year.

Further recovery opportunities exist through subrogation. A conservative estimate of the total workers compensation market is $60 billion in

premium, and if a very conservative loss ratio of 50 percent is applied, that would translate to $30 billion in losses. Using a potential recovery rate of 4 percent, a high but achievable goal, this would represent a recovery opportunity of $1.2 billion.[1] Based on our audit experience, we would estimate that, on a collective basis, the industry is most likely recovering only about 1.5 percent of all workers compensation losses, or $450 million. This differential of approximately $750 million of annual recovery is available each year to the industry, but only with more effective recovery processes being implemented. But keep in mind that the potential recovery is probably significantly greater because real-world loss ratios are typically higher than 50 percent, and, for many insurers, may approach 100 percent.

Despite the opportunities, it is difficult for a risk manager or CFO to authorize a recovery-system change if proof cannot be given that more benefit than cost will accrue from such a change. In the absence of metrics that would drive change, a viable alternative is to test different process methods against each other until the empirical evidence reveals the answer.

Tallying the Costs for Recovery

Most claims organizations and employers don't know the actual cost to recover the 75 percent to 85 percent of available dollars that they are currently collecting, let alone the cost to recover the additional 15 percent to 25 percent that is now being missed. Such an analysis would need to take into consideration all the costs for recovery, including process costs, management costs, overhead costs, and third-party costs, including legal services. Most organizations that we've audited can figure out basic process costs, but have not developed a methodology to capture and add third-party and overhead costs related to recovery. Without these analytic tools, it is not only difficult to measure cost-benefit ratio for the purpose of determining whether an internal program is more cost-effective than an outsourced program, but it is also hard to measure the cost-benefit ratio of any internal process change.

The Government Accountability Office recently announced that Medicare recovers only 38 cents for every dollar it seeks to recover, which means its cost is 62 cents on the dollar![2] Clearly, that cost is way out of line, yet private industry can hardly scoff at the poor job the government sector is doing until it addresses its own shop. When we have had the opportunity to gain insights into insurers' costs of recovery, we have found that "all in" costs (most can't measure all costs) have approached 40 cents on the dollar, leaving only 60 cents in net recovery. Outsourced contingent costs, including legal costs, should range well below that number, from 15 percent to 33 percent. Assuming that the outsourcing group will identify at least as many recoveries as an internal operation, there

is clearly room for improvement, if only by outsourcing rather than taking the more time-consuming route of building an internal recovery program.

Flawed Assumptions

Given an understanding of the traditional ways in which claims services have been packaged, it is not surprising that recovery-process change has been slow to take hold. Many beneficiaries of recovery dollars — self-insureds, large-risk-retention employers, insurers, excess insurers, or re-insurers — have existing fixed-price "bundled" contracts encompassing all claims services. All of these companies rightfully assume that a maximum recovery effort is part of their contractual right from their TPA or claims handlers and that all claims specialists are recovery specialists or they should be. It is also assumed that the existing bundled price structure will not change if new claims-handling services or demands arise — such as the demands on adjusters from the new California law. One further assumption is that claims organizations, because they are systematized to handle the core claims functions, are also systematized to handle all recovery processes.

Such buyer's assumptions are flawed. Most contracts for claims adjustment are implemented with recovery as part of the "bundled tasks." While adjusters are specialists in general claims knowledge — as opposed to laymen, underwriters, or safety specialists — they are usually not specialists in recovery, which is a highly skilled specialty within the claims business. It may be very costly to assume that, simply because someone handles claims, they are expert in all aspects of a claim. Today's adjuster is a generalist, and the most effective role for this new breed of adjuster should be playing the role of project manager in handling the various aspects of the claims process that require greater technical skills or a higher level of expertise than the adjuster actually has. This is the reality in this era of business specialization. A good analogy is to a quarterback who doesn't catch touchdown passes or kick field goals, but who puts the team in position to score, with the specialists doing the actual scoring. All parts of this specialized team must be working together for maximum wins.

Our observations lead us to believe that the standard claims-industry practice is for recovery to be offered as a bundled service without appropriate pricing and cost consideration. This strategy historically has been driven by intense competition. In reality, the cost is hidden in missed recovery opportunities, and buyers ultimately pay that price. Appropriate pricing requires careful process-management mapping and complete cost-allocation. In general, this has not happened either because the benefit of a best-practice program has not been understood or because the claims operation offering the bundled service has never been held accountable for best-practice

recovery performance; or subtler still, but arguably worse, no one qualified has allocated the time to restructure the program. A dangerous tail-wagging-the-dog situation has evolved where many claims organizations would rather hide inefficiencies than own up to the need to adopt, or to start fresh by developing, the discipline of best-practices implementation.

Similarly, when an insurer is dealing with its own claims operation, its tendency towards a model of traditional claims-service packaging has left the responsibility for recovery services — in whole or in part — in the hands of individual adjusters who manage this responsibility along with other core functions. Using another football analogy, no head coach would allow a wide receiver to block in the offensive line; a generalist claims adjuster should not be asked to tackle a complex recovery process.

It appears that claims operations have been reluctant to "let go" of any function that they can hold on to, even in the face of evidence that retention is not the most effective path. Some insurers or TPAs have created centralized recovery units but lack consistent company-wide processes and implementation, which would include the discipline of best practice and a cradle-to-grave approach applied to each opportunity, to all recovery matters, and to all states.

Moving Forward to Best Practice

We've identified obstacles, but the central question for risk managers, claims managers, and CFOs remains, "How can I get it done when I have so many time pressures?"

We believe that the consistent application of best practices and the discipline that they require would yield beneficial results. We see the following as universal attributes of a best-practice recovery program:

- consistency in process and results;
- a proactive audit plan;
- trained specialists and legal staff investigating and acting on all opportunities for recovery;
- centralized management;
- production and use of cost, revenue, and expected-revenue reports;
- litigation management to improve and expand results and maintain lower legal costs;
- a centralized reimbursement system;
- connectivity between expected recoveries and claims resolution; and
- a recovery system for all states where opportunity exists.

Methodology Follows Value

With these attributes in mind, TPAs, insurers, and employers must decide the value of change and whether it makes sense to do the work internally within existing operations or to outsource to a specialty recovery firm. Even if metrics are not perfectly in place, an educated opinion on value is essential, not only to reach the decision to change but also to consider how to change. That decision can be reached through internal analysis or through consultancy, using test auditing and process analysis. The cost of an analysis can be miniscule against the increased value of even a 5 percent uptick in recoveries. Since we would counsel that a 15 percent to 25 percent increase in recoveries would generally be a realistic expectation, the costs to increase recovery should be given serious consideration. If dollars are not available to pay for an up-front analysis, it may still be possible to obtain an analysis from an outside source by trading a defined percentage of recovery work in the form of contingent fees.

If an analysis determines that the benefit of process change is marginal, the pursuit of more recoveries need not be totally abandoned. Change might be structured in such a way that the marginal increase is entirely based on outsourced contingent work. A consultant might earn its fee through an "overlap" program working in tandem with internal programs to identify and recover missed opportunities or through work on cases that are too expensive or too difficult for internal operations. While a higher contingency is paid with such an approach, extra marginal dollars are recovered with "no risk."

If an analysis determines that the potential benefit is significant, careful consideration must be given to the best method for your organization to capture the money. Each organization's unique circumstances and current programs must be part of the assessment. Whatever path is taken, it is important that a climate for change is created and shared among all participants. This may involve removing fear of criticism or inserting reward for achievement of new goals or both.

Different Approaches for Different Organizations

The recovery process may vary depending on the specific organization in question. While there may be core similarities for all organizations, the recovery process for an insurer, an excess insurer or reinsurer, a TPA, and a risk-retention employer may have unique characteristics in structure or approach. The following are some considerations for each.

Risk Managers of Self-Insured or Large-Risk-Retention Portfolios

Whether using a TPA or an internal department to manage claims, an organization should start by asking the claims administrators the following questions:

- What have you recovered in subrogation and second-injury-fund dollars in each of the last three years? Can recoveries be broken down by date of injury, by state, by gross amount of recovery, and by net amount of recovery? Can internal and external costs incurred in collection be detailed?
- What is the value of the recovery work in progress? When can this organization expect to receive the benefit?
- What is the projected cost-to-recover of the work in progress from internal and external sources?
- What value can be expected from recoveries going forward, and what is the basis for your opinion?

If the answers to these questions are less than satisfactory, then the organization must ask what plan for change exists. The caveat is to be realistic. There must be an incentive for change. Change also generally costs money. If the organization wants to drive change, your claims administrators should be asked to deliver a program that incorporates some or all of the best-practice attributes that we have outlined. Administrators need to know it is permissible to unbundle the program, using internal or external assets or a mix, if they can produce results and document their cost-benefit.

Large Insurers/TPAs

Large insurers with a significant book of traditional workers compensation business should conduct an analysis of what has been recovered and what is still in the pipeline, segmented by type of recovery and by state. The analysis should encompass the full internal and external process for recovery and its cost.

Management should analyze whether the process includes all or part of the best practices outlined above. Consideration should be given to combining a centralized internal recovery program with outsourced "gap" support in states that require particular specialization or where staffing coverage is lacking, in any difficult cases where specialized expertise is needed, or in cases where the risk and extra costs of recovery can be passed through to outsourced vendors.

Small or Midsized Insurers/TPAs

Does the claims recovery process include all or part of the best practices? Consideration should be given to the advantage of utilizing the superior focus and talent available from an outsourced program to manage recovery costs without sacrificing recovery benefit. If an in-house program is preferable, a gap program as noted above should be considered. Accountability must be built into the program.

Excess Insurers and Reinsurers

Excess insurers and reinsurers face a slightly more difficult issue in that they do not control primary claims practice, yet losses that occur from the failure of recovery have a very high risk of piercing the coverage. Each missed opportunity will have a more severe impact on reserves because the missed opportunities are generally the claims with the largest recovery potential. Merely monitoring recovery opportunities identified by the primary claims-handling organization does little to increase protection or reduce exposure. At the very least, you should be asking the same kinds of questions that a primary risk manager would ask.

Those that are not satisfied with the answers should consider ways to offer an incentive to the claims organization to institute recovery best practices. This could be in the form of cost sharing, premium reduction, or technical assistance. Regular spot-auditing where the resulting information is shared and a partnering approach is used can also be effective for driving change. At a minimum, a proactive information system that holds the primary claims organization accountable for best practice performance should be instituted.

Real Results, Real Money

For most organizations, a small amount of management effort could result in millions of extra dollars hitting the bottom line. The following tasks, once implemented, will deliver more money:

- determine the best practice;
- assess the opportunity cost or value;
- analyze the cost of delivery;
- establish a pricing mechanism that reflects each participant's risk and reward tolerance;
- establish and implement a measurement system;
- build a flexible process that combines the attributes of a factory-like approach for claims that have a low value or clear path to resolution with a more sophisticated, legalistic approach for those claims that

demand complex skill sets;
- ensure that all opportunities to reduce reserves by offsetting costs on third parties are consistently pursued in all states; and
- ensure that each participant in the process "wins" from the change.

Endnotes

1. Lee, R. Gary, "Subrogation: Thar's Gold in Them Thar Claims Files!" *The Journal of Workers Compensation* (Spring 2003): 19.
2. Government Accountability Office, "Medicare Secondary Payer: Improvements Needed to Enhance Debt Recover Process." Available at *http://www.gao.gov/cgi-bin/getrpt?GAO-04-783*.

Fred Uehlein is the founder and chairman of Insurance Recovery Group, a firm that specializes in second-injury-fund, subrogation, and Social Security offset recoveries. He has also been managing partner and founder of a Massachusetts insurance defense law firm. Uehlein has more than 30 years of experience in workers compensation. He is a lecturer and writer on insurance claims issues, second-injury-fund recovery, and litigation management. He is a member of the American Bar Association and is on the advisory committee of John Burton's *Workers Compensation Resources*. Uehlein is a graduate of Boston College Law School and Trinity College. He can be contacted at *wfuehlein@irgfocus.com*.

David Jollin is the president and CEO of Insurance Recovery Group. He has 30 years of experience in the property-casualty industry and has held management positions with Johnson & Higgins, Corroon & Black, and Willis. His experience encompasses sales and service of large risk management accounts, focusing on risk transfer, risk avoidance, claims handling, and settlement services. Prior to joining Insurance Recovery Group, Jollin was Chairman and CEO of Willis of New England. He is a graduate of Brown University. He can be contacted at *djollin@irgfocus.com*.

Insurance Recovery Group, Inc.
959 Concord Street, Suite 200
Framingham, MA 01701
(800) 798-5474
(508) 656-1901 (fax)
www.irgfocus.com