

# Industry Trends Report

## FEATURED IN THIS ISSUE:

### The Usual, Customary, and Reasonable Progression

By **Michele Hibbert-Iacobacci**

CMCO, CCSP VP, Information Management & Support





# Industry Trends Report

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## A Message from the CEO

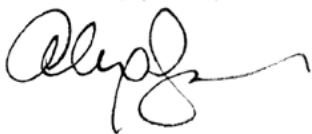
### Usual, Customary, and Reasonable (UCR) Uncovered

Welcome to the Q2 Edition of the 2015 Casualty Mitchell *Industry Trends Report*. In this issue we explore the subject of Usual, Customary and Reasonable (UCR) and its evolution in the P&C medical claims payment landscape. Additionally, I'm delighted to share news from our pharmacy solutions offering and provide a deeper look into the challenges around auto accident claims.

In our feature article on page 4, *The Usual, Customary, and Reasonable Progression*, author Michele Hibbert-Iacobacci clarifies the inconsistent definitions of UCR by shedding light on its history and the varying payment methodologies that have emerged, in part, due to the Patient Protection and Affordable Care Act's (PPACA) individual mandate for coverage. Outside of PPACA, increasing complexity and regulations pose an added challenge leading to a need for reliable explanations as we continue to find better ways to manage cost containment. Michele explores fee-for-service and UCR to uncover what this means for your business.

In our bonus article on page 12, *The Challenges with Auto Accident Pharmacy Claims*, we look into the factors that impact the efficient administration of a claim and what you can do to balance high customer satisfaction while managing pharmacy costs in your organization.

As with every issue, we aim to connect you with knowledge from a range of our subject matter experts to arm you with information to continually improve your business. I believe you will find some useful insights within these pages and thank you for your continued readership of the *Industry Trends Report*.



Alex Sun  
President and CEO  
Mitchell



**Alex Sun**  
President and CEO, Mitchell

[Click here to view the Auto Physical Damage Edition](#)



# The Usual, Customary, and Reasonable Progression

By Michele Hibbert-Iacobacci, CMCO, CCSP  
VP, Information Management & Support



*Toward the end of the 1980's the majority of provider payments were made by public and private payers prevalently in the manner as fee-for-service.*

Usual, Customary and Reasonable (UCR) is medical payment industry terminology used to describe the amount third party payers and/or consumers pay for medical expenses in fee for service (FFS) situations. This type of payment is used when paying for professional provider services such as performance of an office visit, medical procedure or supply. UCR has been defined in insurance policies, regulatory bulletins, statutes and case law. UCR has also been used by database providers

as a marketing term for the data they provide, which may or may not have any relevance with the definition UCR in a particular jurisdiction.

In property and casualty (P&C) medical claims payments, provider network contracts are customarily utilized. Common contracted rates utilize the UCR databases as a benchmark for negotiation of the contracts. When providers are without contracts (out of network) or no regulatory fee schedule is

available, UCR is commonly used as the benchmark for payment.

## **Historical Migration**

Medicare and Medicaid were created in 1965 and were originally administered by Blue Shield. This payment system was one of the original physician FFS reimbursement systems used in the United States. The term used for payment by the Medicare program was "customary, prevailing and reasonable charges" based upon provider historical billing

information. Due to the opposition by the American Medical Association (AMA), the FFS method was chosen to assure the provider groups a fair method would be utilized for payment (Social Security Administration). Recently, Medicare, Medicaid and private payers have seen substantial growth in the number of covered lives, especially in the last two years as a result of baby boomers aging and the Patient Protection and Affordable Care Act's (PPACA) (2010) individual mandate for coverage ([Benefitspro.com](http://Benefitspro.com), 2015). The introduction of the PPACA exposed consumers to the varying payment methodologies within the Medicare and Medicaid programs, which are significantly different in structure than the original FFS schedules from 1965. The current payments used by Medicare and Medicaid do not resemble the original UCR definition as other factors like malpractice and sustainable growth rate expenses influence what providers are paid out of this program.

The experience of the Medicare and Medicaid program influenced private payers to adopt FFS payments as an industry standard. Toward the end of the 1980s the majority of provider payments were made by public and private

payers FFS. FFS payment methods contained no incentive to limit the cost of healthcare services due to the pass-through of cost directly to the payer. Consumers had no real reason or basis for making determinations of cost of healthcare, as they were not educated in the value or how it was derived.

### Provider Networks

Provider networks have provided a medical payment system where the consumer had little effort or effect in the referral process and payments. The providers that are "in network" were generally provided a guarantee of payment at a percentage of customary charges (provider charges) by contract. Provider networks left the guess work out of receivables for practices by providing the benefit to the provider of knowing exactly what was going to be paid. Provider network contracts have been used in P&C as an industry standard for over a decade. Use of provider networks distanced the consumer from the payment activity creating an environment of consumer unfamiliarity with the economics of healthcare spend (Ginsburg, 2005).

Since 2005, "out of network" payments and definitions for UCR have become common knowledge

## About the Quarterly Feature Author...



**By Michele Hibbert-Iacobacci, CMCO, CCSP**  
Vice President, Information Management & Support, Mitchell

As Vice President, Information Management and Support. for Mitchell's Casualty Solutions, her responsibilities include Health Information Management, Regulatory Compliance, Professional Services, Litigation Support, and Consultant to Advanced Analytics & Consulting. For the past 25 years, Ms. Iacobacci's focus has been on working with major casualty insurers implementing rules committees, quality assurance, risk management, compliance programs and review processes necessary in delivering objective bill review systems. Ms. Iacobacci is a Certified Clinical Coding Specialist (CCS-P), and a member of the American Health Information Management Association (AHIMA).

to the consumer seeking care “out of network.” Today’s patients who are out of network are exposed to the industry standard for healthcare payments, which can be 80% of the UCR rate as chosen by the payer (Bernstein, 2012). With rising prices by providers in the P&C market, the portion the patient became responsible for was much larger, leading to capping out on the deductibles at a faster rate and the carrier picking up a substantial increase in payments to providers.

Over time providers wanted to know what the UCR payments were based upon and wanted to charge more than the maximum allowable amount, which incentivized providers to maximize charges. Maximization of charges would not emulate market customary rates by the provider or a desire to “value” the service based upon how effective the procedure was for the patient.

Examples of instructions in primary care to maximize charges or “always charge more than they [provider] expect to get paid” are common place (Chuscavage, 2014).

This behavior was again driven by the FFS regime that manages claims most predominantly in the casualty arena. The positive side of FFS and the use of customary rate databases for payment is that providers could always gauge the receivables, albeit more expensive, and would add consistency in payment expectations.

**Value Based Healthcare**

Value based healthcare are measurable metrics based upon improvement in the value of care to a patient, not in the volume of care administered. Measurable metrics include outcome of care protocols. A recent Forbes article stated “Unchecked, fee-for-service functions as an elaborate incentive program for terrible care.”



## Sample Definitions of UCR by Consumers, Providers and Payers

Source	Definition
<b>BusinessDictionary.com</b>	"Denotes the base amount that is treated as the most typical charge for a medical service when provided in a specific geographic region. Third-party payers such as insurance carriers and employers implement these fees to conclude the amount to be paid on behalf of the enrollee, for services that are recompensed by a health insurance policy or plan" (Business Dictionary).
<b>Wikipedia</b>	"Usual, customary and reasonable (UCR) was and is an American method of generating health care prices,[1] described as "more or less whatever doctors decided to charge." According to Steven Schroeder, Wilbur Cohen inserted UCR into the Social Security Act of 1965 "in an unsuccessful attempt to placate the American Medical Association" (Wikipedia).
<b>Healthcare.gov</b>	"The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount" (Healthcare.gov).
<b>eHealthInsurance.com</b>	"Usual, Customary and Reasonable (UCR) Charge:  This refers to the standard or most common charge for a particular medical service when rendered in a particular geographic area. It is often employed in determining Medicare payment amounts" (eHealthInsurance Insurance Services, Inc., 2015).
<b>Investopedia, LLC</b>	"DEFINITION of 'Usual, Customary and Reasonable Fees'  Out-of-pocket fees that an insurance policy holder must pay for services. Usual, customary and reasonable fees, often abbreviated to UCR fees, are based on the services provided to the policy holders, as well as the area of the country where the services are being provided" (Investopedia, LLC, 2015).
<b>BLS National Compensation Survey</b>	"Usual, customary, and reasonable (UCR) charges - Conventional indemnity plans operate based on usual, customary, and reasonable (UCR) charges. UCR charges mean that the charge is the provider's usual fee for a service that does not exceed the customary fee in that geographic area, and is reasonable based on the circumstances" (Healthterms.pdf)
<b>Patient Advocate Foundation</b>	"Usual, Customary and Reasonable Charges (UCR) are a calculation by a managed care plan of what it believes is the appropriate fee to pay for a specific health care product or service in the geographic area in which the plan operates" (Patient Advocate Foundation, 2002).
<b>Illinois Department of Insurance</b>	"The Usual and Customary fee is defined as the charge for health care that is consistent with the average rate or charge for identical or similar services in a certain geographical area. To determine the Usual and Customary fee for a specific medical procedure or service in a given geographic area, insurers often analyze statistics from a national study of fees charged by medical providers, such as the data base profile set up by the Health Insurance Association of America (HIAA). Some insurers compile their own data using their own claim information" (Illinois Department of Insurance, 2010).
<b>Alaska Insurance Code: 21.55.500</b>	"(23) "usual , customary , reasonable , or prevailing charge " means the charge for a medical care procedure, service, or supply item that is the lowest of the following amounts:  (A) the billed amount for the medical service provider's actual charge;  (B) the charge usually made by that provider for performing that procedure or service or for providing the supply item; or  (C) The customary charge, based on a profile of charges made for the same medical procedure, service, or supply item in the same geographical area by other providers that have performed the same procedure or service or can provide the same supply item."
<b>Pennsylvania: 31 s 69.3</b>	Usual and Customary Charge: The charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided.

## References:

- Business Dictionary. (n.d.). *www.businessdictionary.com*. Retrieved February 2015, from Usual, Customary and Reasonable fees: <http://www.businessdictionary.com/definition/usual-customary-and-reasonable-fees-UCR-fees.html>
- eHealthInsurance Insurance Services, Inc. (2015). *Health Insurance Glossary*. Retrieved February 2015, from <http://www.ehealthinsurance.com/health-insurance-glossary/terms-u/>
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- Social Security Administration. (n.d.). *Social Security History*. Retrieved February 2015, from [www.ssa.gov/history/ssa/lbjmedicare1.html](http://www.ssa.gov/history/ssa/lbjmedicare1.html)
- Wikipedia. (n.d.). *Usual, customary and reasonable*. Retrieved February 2015, from [en.wikipedia.org/wiki/Usual,\\_customary\\_and\\_reasonable](http://en.wikipedia.org/wiki/Usual,_customary_and_reasonable)

It actually rewards providers financially when patients suffer complications or infections, and pays them [providers] more if they order unnecessary tests or procedures" (Binder, 2014).

### **Definitions**

Depending upon the source, the definitions vary for the composite term UCR. Consumers, providers and payers all provide varying degrees of definition for UCR based upon the many available definitions and sources. There are so many definitions considered valid and invalid it has been difficult to ascertain the intent by the various sources. The lack of consistency in definition causes confusion, especially when describing the data used to

calculate UCR. The previous table shows examples that have been submitted by consumers, providers and payers for the same situations in addressing the definition of UCR.

UCR definitions from different sources provide substantial variance with each other and some add-in the terminologies of "prevailing charge" and "necessary charge." Some of these definitions reference paying the lowest of a list of criteria and others reference the highest. References are made to the average of data while other definitions refer to the majority of providers. Several definitions refer to regional criteria while others do not make any mention of geography. As stated, these are not an all-inclusive list of definitions but

are not dissimilar when reviewing regulatory language. Even within states, the health payer definition of UCR is not the same as auto or workers' compensation regulations.

Health payers have utilized outside sources, their own data, non-profit organizations, data consortiums and regulatory requirements to make appropriate payment on claims for out of network. In addition these sources are also used to negotiate contract agreements (i.e., Preferred Provider Network agreements) with providers that apply to specific or all coverage lines. Provider networks and signed individual negotiations using historical provider charges and payments that are accepted by the provider have eliminated



confusion in the industry for the patient who wants to continue to see their primary care provider regardless of coverage.

**FFS and UCR in the Future**

There are varying opinions regarding the usefulness of FFS payments in the future. Calculating data to support the market rates of a service (cost) will still need to be performed even if bundling of services becomes the norm. How will we know if all the efforts of PPACA and value based healthcare systems like Accountable Care Organizations (ACO) are providing benefit? The only way to understand the dynamics between value based and FFS is to maintain the cost for the “widget” while monitoring the incentives to providers that own the outcome of care.

By understanding the cost of an item we will be able to develop financial models that demonstrate improvements for the future.

In P&C—particularly in auto claims—the monitoring of medical care ends when the patient reaches the policy limits. Limits by policy have essentially been set aside for the patient in the form of policy limits in first party claims. Unless care is monitored and the price is reviewed, the limit expires faster and the consumer may be exposed to more expense by either not receiving the appropriate care or care that was charged and paid at a higher rate.

This structure of FFS will use the allotted policy dollars at a faster pace with the consumer losing out in the end. This is essentially what value based health care is trying to mitigate. The goal is to spend less to do more and create higher consumer satisfaction.



# Medical Price Index (MPI)

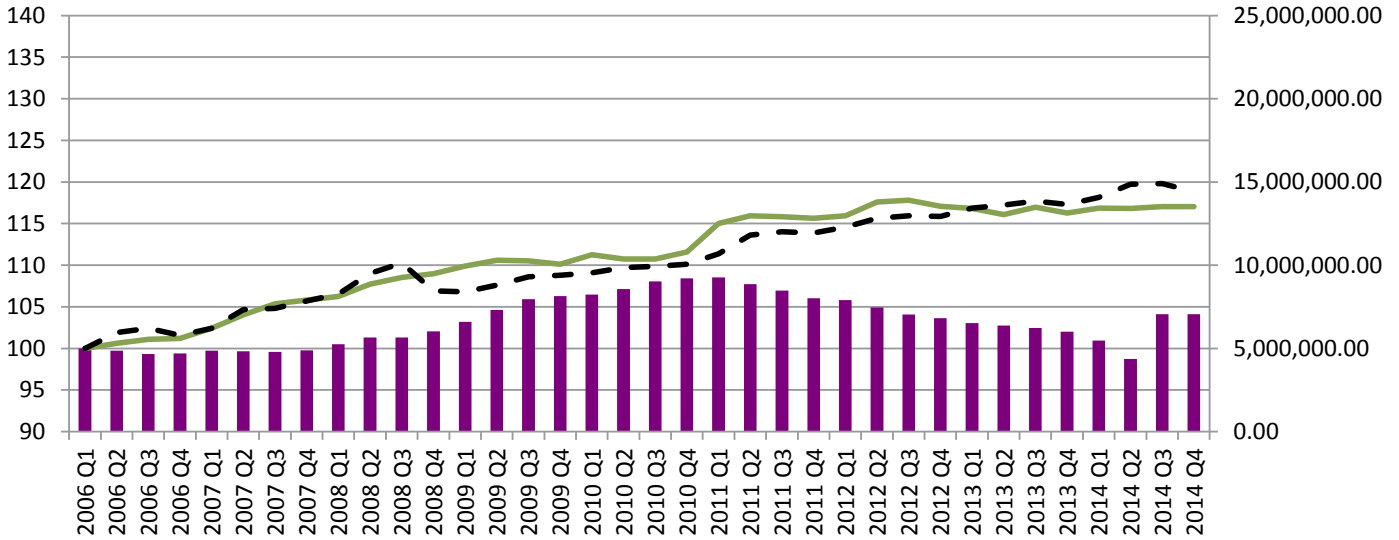


*Since Q1 2006 the MPI has increased 17%. For the same period of time, the National CPI for All Services, as reported by the Bureau of Labor Statistics, increased 19%*

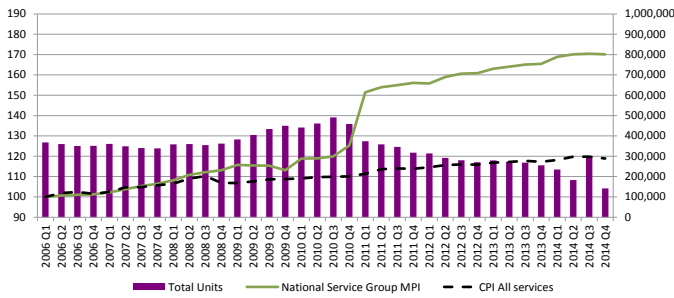
The National MPI was unchanged Q4 2014. Since Q1 2006 the MPI has increased 17%. For the same period of time, the National CPI for All Services, as reported by the Bureau of Labor Statistics, increased 19%. (Source: U.S. Bureau of Labor Statistics, adjusted. Consumer Price Index- All Services- All Urban Consumers, Series CUUR0000SA0. Available at <http://data.bls.gov/cgi-bin/surveymost?cu>)

- Charges associated with physical medicine services have remained relatively constant having only increased 2.8% since Q1 2006. In Q3 2014 the unit cost associated with physical medicine services increased 0.17%.
- Once again, the unit cost for major radiology services remained virtually unchanged in Q4 2014.
- The unit cost for evaluation & management services decreased 0.29% in Q4 2014, eliminating the increase in Q3 2014. Since Q1 2011, evaluation & management services have experienced a 19% increase in unit charge.
- The unit charge for professional services in the emergency room increased another 1.22% in Q4 2014 bringing the total increase since Q1 2006 to 168%.

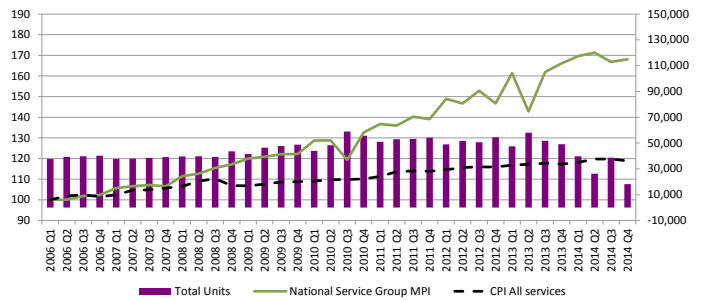
### National MPI



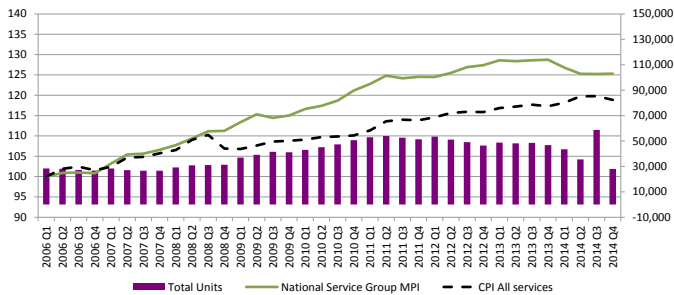
### Evaluation & Management MPI



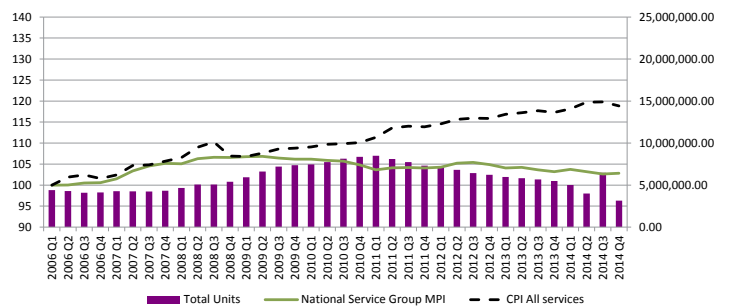
### Emergency Room MPI



### Major Radiology MPI



### Physical Medicine MPI



# The Challenges with Auto Accident Pharmacy Claims

By **Brian Anderson**

General Manager, Mitchell Pharmacy Solutions



*Reimbursement for out-of-network prescriptions often results in paying full retail price.*

Auto insurers face many challenges when processing pharmacy claims. Today we'll review a few of the challenges in the marketplace. These range from ensuring high levels of customer satisfaction to containing costs while efficiently administering a claim.

## Challenges

### Customer Satisfaction

After an auto accident, claimants may find themselves in a frustrating situation when filling

their needed prescriptions at a pharmacy. Claimants often pay out of pocket for their dispensed prescriptions, submit the bill, and then wait for reimbursement. These factors, along with paper processing delays, can result in a poor claim experience and low level of customer satisfaction for policyholders.

According to a 2014 J.D. Power and Associates survey, there is a 56 point increase, or 7%, improvement in auto claims

satisfaction when policyholders do not have to submit for out-of-pocket reimbursement. Out-of-pocket expenses and wait time for reimbursements can result in negative feedback and low levels of claims satisfaction. These factors are easily addressed when customer satisfaction is an important pillar of your business. Insurers that don't require claimants to incur out-of-pocket expenses or submit for claim reimbursements rank in the highest tiers for claims satisfaction.

### Out-of-Network Costs

Prescription claim costs continue to rise, in part, due to out-of-network billing. Without in-network drug formularies, the cost of first-fill prescriptions dispensed out of network by a retail pharmacy, physician or compounding pharmacy are often two to four times the cost of those processed through a network. As refills continue to be processed out of network, prescription costs continue to escalate.

### Efficiency of a Claim

Between paperwork, multiple verification calls and time spent documenting an auto claim, valuable time is often unnecessarily spent on high-frequency, low-severity claims.

Claim adjusters may spend up to 40% of their time on administrative tasks, such as receiving phone calls and handling paper bills. This can result in a considerable drain on your valuable resources and time not directed toward an adjustor's core competencies.

### Conclusion

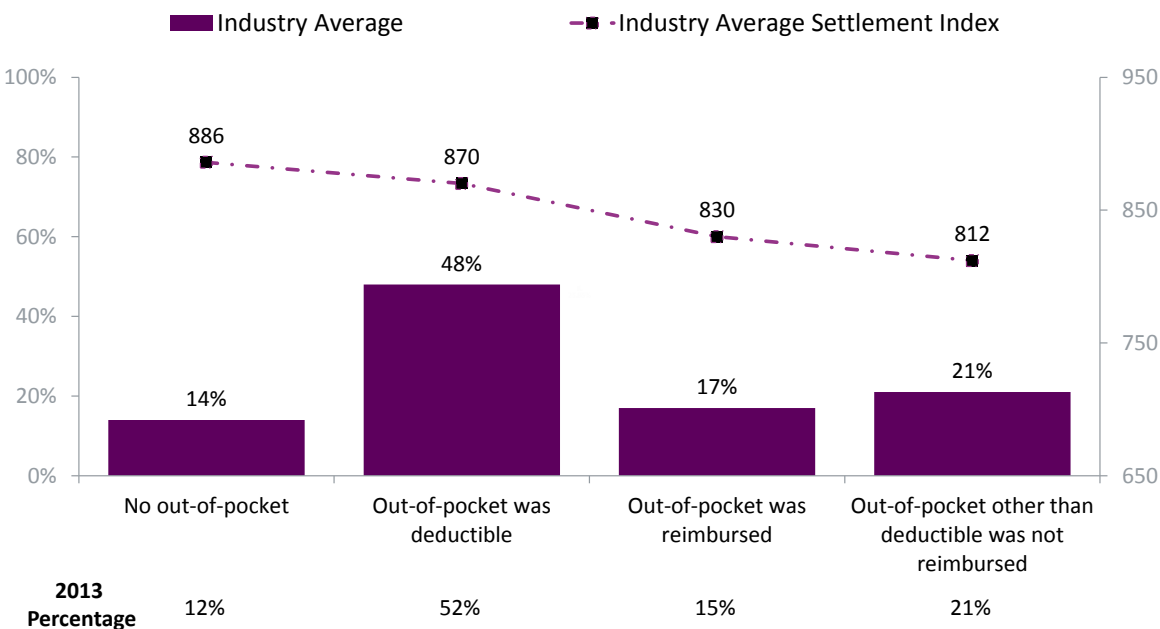
Based on our research, claimants with no out-of-pocket expense who do not wait for reimbursement experience a higher level of satisfaction. Moving prescription claims to in-network pharmacies results in significant cost containment on first-fill and refill prescriptions while also increasing the efficiency of the claims process.

### Impact of Out-of-Pocket Expenses on Auto Claims Satisfaction

According to a 2014 J.D. Power and Associates survey, there is a 56 point increase or 7% improvement in auto claims satisfaction when policyholders do not have to submit for out-of-pocket reimbursement.

An AutoRx client-specific case study revealed that claimants, on average, received six prescriptions. Out-of-network costs totaled \$160 while in-network costs were \$140. The total avoidable expense was 12.5%.

### Impact of Out-of-Pocket Expenses on Auto Claims Satisfaction



# Data Insights



*Oregon experiences far more units of massage therapy than the national average with 37% of all units billed coming from massage.*

We looked at the top 10 procedure codes based on total charge at the national level for first party claims to determine whether individual states encountered differences in concentration, mix or cost.

### **Concentration:**

By comparing the total charges encountered in each state of jurisdiction for the top 10 procedure codes with the total charges for the same state, we discovered that states experienced these codes in varying degrees of

concentration. The map on the next page depicts the percent of total charges that the top 10 procedure codes contributed to total charge. It is easy to see that the top 10 procedure codes in Oregon make up a large portion (47.6%) of the total charges encountered while New York has a greater diversity of service with the top 10 procedure codes only accounting for 10% of total charges.

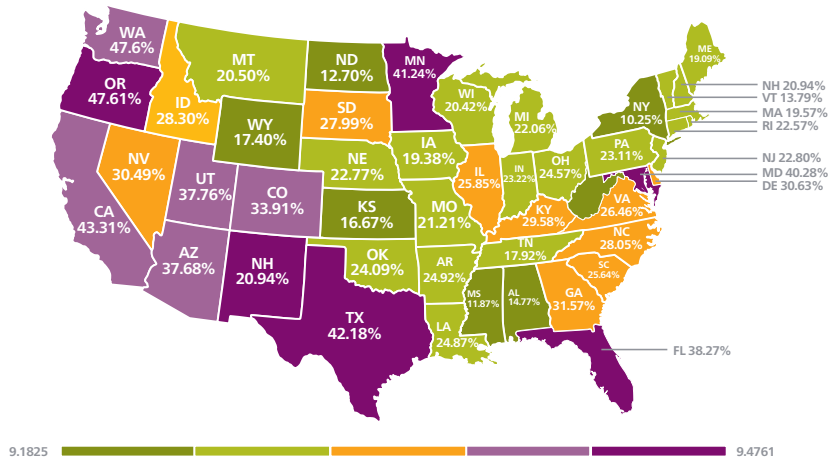
Upon looking at state specific results for Oregon an interesting picture

emerges. The graph on the next page compares the percent of total allowed or weight (grey bar) of each of the top 10 procedure codes with its national weight. Massage therapy (97124) stands out amongst these procedure codes as contributing far more to total allowed than the national average, accounting for 26% of its total allowed amount while the national average (purple dot) is only 5%.

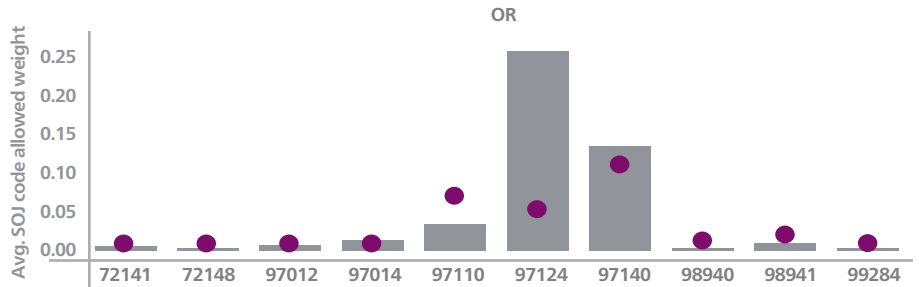
A similar story is seen when utilization is investigated.

The graph compares the unit weight (grey bar) or the total individual units of service billed to the national unit weight. Oregon experiences far more units of massage therapy than the national average with 37% of all units billed coming from massage. The national average of massage therapy units billed is 9%.

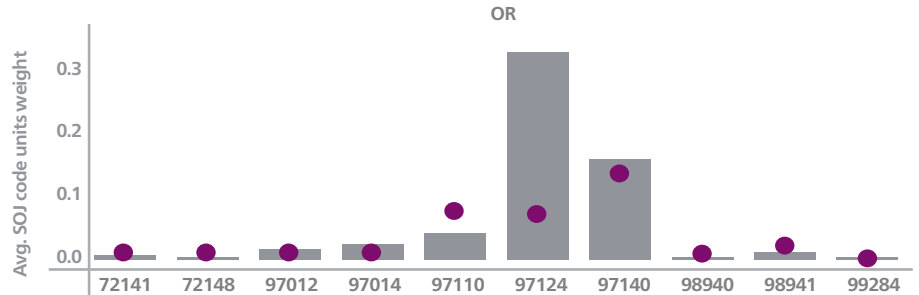
Compounding the entire situation is the unit cost of massage therapy. The national average unit cost for massage therapy is \$30.70 while Oregon's is nearly 25% higher at \$37.92. The graph below ranks each state by unit cost from highest to lowest; at \$37.92 Oregon has the sixth most expensive unit cost.



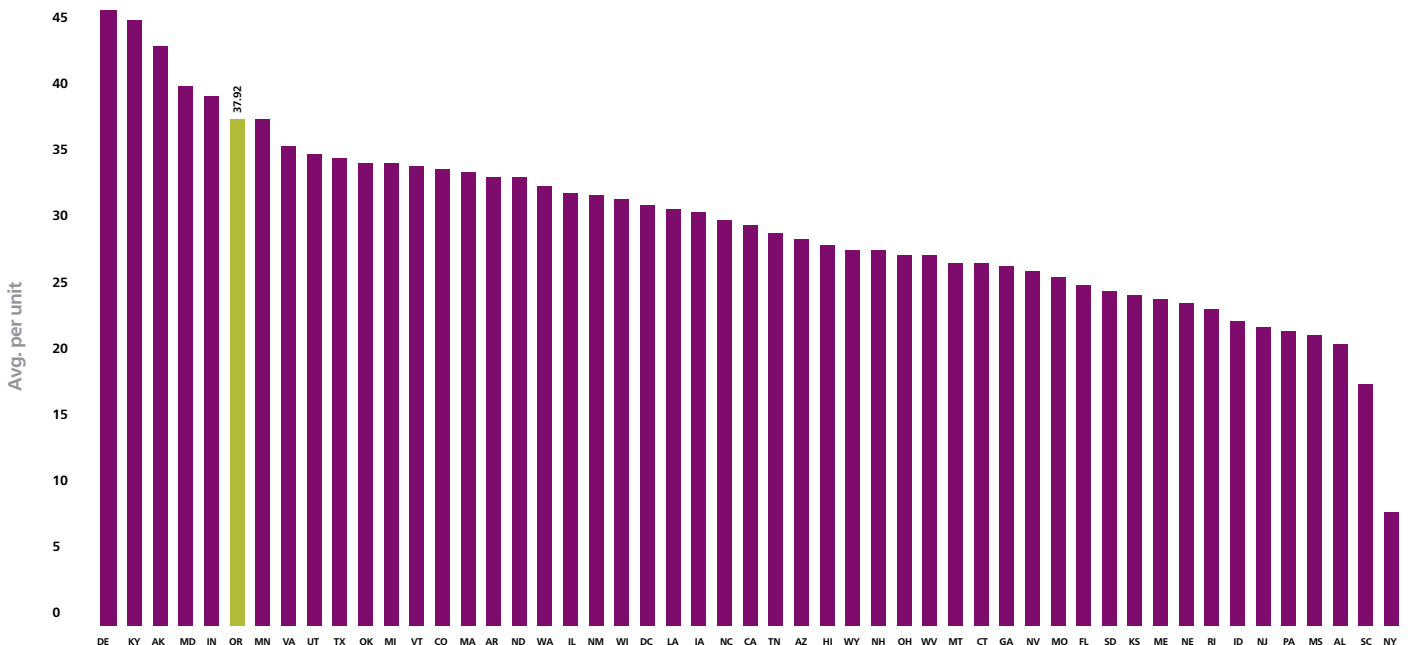
### Total Allowed Weight of Top 10 Services



### Unit Weight of Top 10 Services Billed



### Unit Cost of Massage Therapy



# The Compliance Corner



*Compliance in the Property & Casualty Insurance world can be a challenging endeavor, due to the ever-changing regulatory environment.*

Compliance in the Property & Casualty Insurance world can be a challenging endeavor, due to the ever-changing regulatory environment. At Mitchell, we recognize these challenges and provide updates and insight throughout the year. Here's a quick recap of some recent changes in the regulatory compliance arena:

## **Florida**

On January 5, 2015, HB 165 (PIP automobile insurance) was filed in the Florida Senate. If adopted, this bill will provide an update to how

the specific Medicare fee schedules effective dates would be applicable in the following section of the PIP automobile insurance rules: "(5) CHARGES FOR TREATMENT OF INJURED PERSONS.-2. For purposes of subparagraph 1., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect on March 1 of the year in which the services, supplies, or care is rendered and for the area in which such services, supplies, or care is rendered, and the applicable fee

schedule or payment limitation applies from March 1 until the last day of February of the following year, notwithstanding any subsequent change made to the fee schedule or payment limitation, except that it may not be less than the allowable amount under the applicable schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B."

[House Bill 0165](#)



**Colorado**

Revisions to the Colorado Division of Workers' Compensation Thoracic Outlet Syndrome and Shoulder Injury medical treatment guidelines (MTGs) are effective February, 2015. The Colorado Register, Volume 38, No. 1, dated January 10, 2015, includes a "DOC" format of the revised MTGs:

- [MTG—Thoracic Outlet Syndrome \(doc\)](#)
- [MTG— Shoulder Injury \(doc\)](#)
- The guidelines can also be found on the state's web site in pdf format.
- [Workers' Compensation Proposed and Adopted Rules](#)

**California**

WC to Adopt Version 2.0 Medical EDI Rules and Implementation Guide (cont) During the DWC Educational Conference held February 9–10, 2015, in a session titled DIR Research Issues, a panel discussed the upcoming adoption of the Workers' Compensation Information System (WCIS) Medical Bill Reporting. The changes that were discussed included the following:

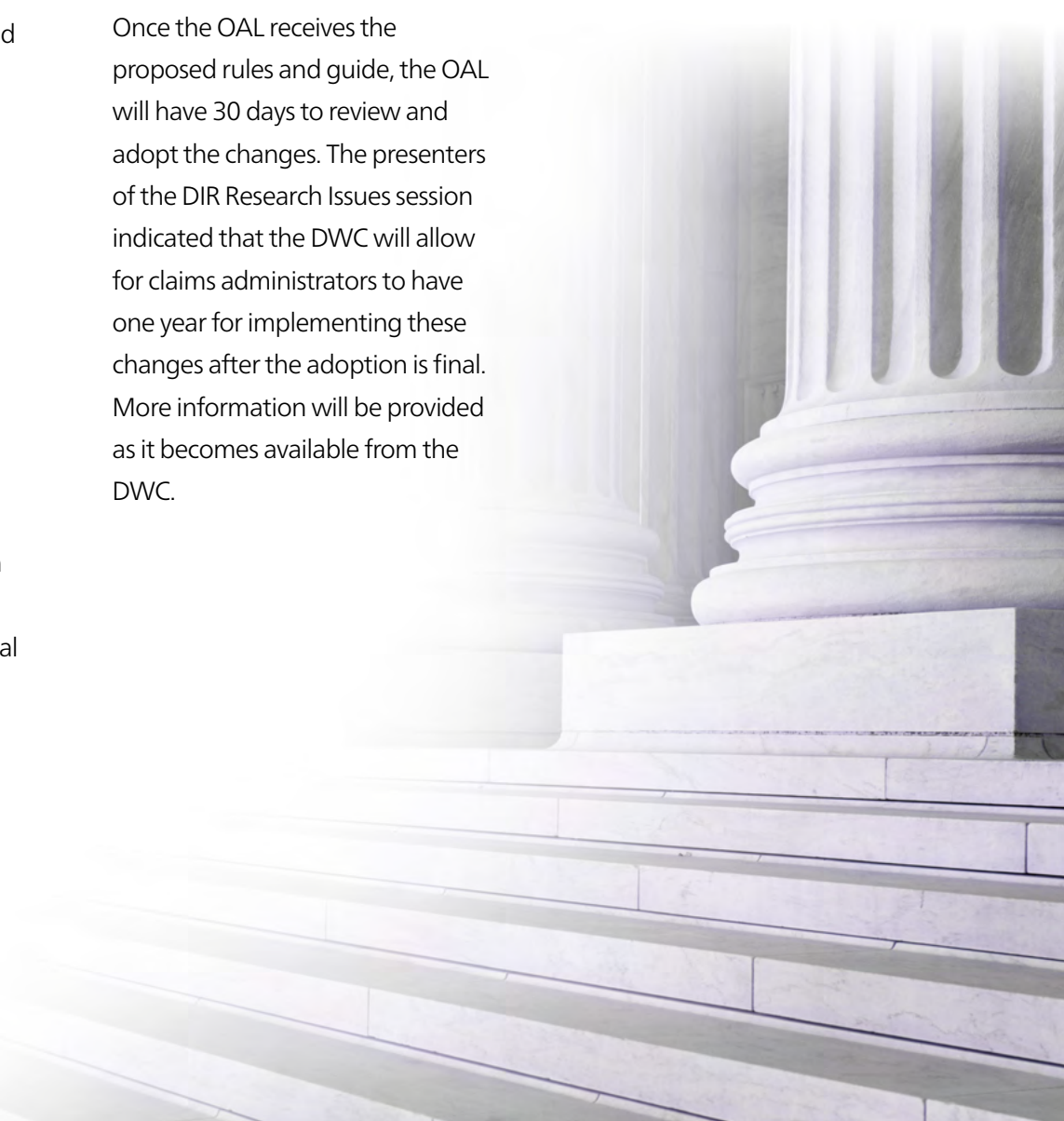
- Use of the IAIABC Release 2.0 standard based on the ASC X12 005010 reporting.
- Addition of 15 new data fields.
- Changes to lien reporting.
- Medical/FROI JCN match.

The state held its last public hearing on January 13, 2015. It is expected that the final draft of the proposed EDI Medical Implementation Guide, Version 2.0 will be sent to the Office of Administrative Law (OAL) for review and adoption. Once the OAL receives the proposed rules and guide, the OAL will have 30 days to review and adopt the changes. The presenters of the DIR Research Issues session indicated that the DWC will allow for claims administrators to have one year for implementing these changes after the adoption is final. More information will be provided as it becomes available from the DWC.

**Texas**

The state issued a data call to collect information on bodily injury and property damage liability claims, due March 2, 2015. Insurance companies can obtain more information and the survey form on the state's web site.

[Commissioner's Bulletin # B-0004-15](#)



# Uh Oh...Uber Has Some Coverage Issues

By Christopher Tidball

Senior Director, Casualty Solutions Consultant, Mitchell

From *PropertyCasualty360.com*

Publish Date: February 9, 2015



*As an insurance claims consultant, I can also understand some potential liability issues that could arise if an Uber driver does not have the proper insurance.*

Uber has transformed the public transportation industry. Riders love it due to costs that are a fraction of a traditional taxi. Cabbies and taxi companies aren't big fans, using a variety of regulatory maneuvers to try and stop Uber's phenomenal growth.

After spending \$100 dollars on a cab, I can certainly understand the allure of Uber. As an insurance claims consultant, I can also understand some potential liability issues that could arise if an Uber driver does not have the proper insurance.

[Read More](#)

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# The Five Pillars of a Provider Network Program

By **Lee Haripko**

Senior Manager, Strategic Partners, Mitchell Auto Casualty Solutions

*From Claims Magazine*

*Publish Date: January 2015*



*Both in the workers' compensation and auto casualty markets, one tremendous opportunity to retain customers and maintain a competitive edge comes from the lower claims costs*

A strong provider network program is critical to a property and casualty (P&C) insurers' cost containment, benefit extension and customer retention strategies. Both in the workers' compensation and auto casualty markets, one tremendous opportunity to retain customers and maintain a competitive edge comes from the lower claims costs associated with provider bills that fall into provider networks..

[Read More](#)

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# Swoop & Squat: Beware of These Insurance Fraudsters

By Christopher Tidball

Interview with Christopher Tidball

Senior Director, Casualty Solutions Consultant, Mitchell

From [PropertyCasualty360.com](http://PropertyCasualty360.com)

Publish Date: March 9, 2015



*A black Firebird had been rear-ended by a semi that subsequently jack-knifed and dumped its load of cars across the freeway.*

It was on June 17, 1992, that the phrase swoop & squat became a household name. This form of staged accidents was commonplace on the highways and byways of Los Angeles where I was a claims investigator. But this was the day the phrase went viral.

The catalyst was an accident that occurred on the 5 freeway in the San Fernando Valley just north of Los Angeles. A black Firebird had been rear-ended by a semi that subsequently jack-knifed and dumped its load of cars across the freeway.

[Read More](#)

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# Smartglasses Help Adjusters See the Future of Claims

By **Beau Sullivan**

Senior Director, User Experience, Mitchell

By **Christopher Tidball**

Senior Director, Casualty Solutions Consultant, Mitchell

From *PropertyCasualty360.com*

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*In the days before personal computers and email, when there were no mobile phones, if you wanted to make a call you dropped a dime into a pay phone...*

Remember when the tools of the trade for adjusting insurance claims involved an instant camera, a voice recorder, a calculator and estimating sheets? In the days before personal computers and email, when there were no mobile phones, if you wanted to make a call you dropped a dime into a pay phone, then hoped someone on the other end would pick up.

“Adjuster notes” were hand-written. Changing reserves meant filling out a form in triplicate and waiting days for processing. There were no smartphones, Internet connections or wearables. The most futuristic things in our collective consciousness were a time-traveling DeLorean and reruns of The Jetsons.

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# About Mitchell



## Mitchell San Diego Headquarters

6220 Greenwich Dr.  
San Diego, CA 92122



Mitchell empowers clients to achieve measurably better outcomes. Providing unparalleled breadth of technology, connectivity and information solutions to the Property & Casualty claims and Collision Repair industries, Mitchell is uniquely able to simplify and accelerate the claims management and collision repair processes.

As a leading provider of Property & Casualty claims technology

solutions, Mitchell processes over 50 million transactions annually for over 300 insurance companies/claims payers and over 30,000 collision repair facilities throughout North America. Founded in 1946, Mitchell is headquartered in San Diego, California, and has approximately 2,000 employees. The company is privately owned primarily by KKR, a leading global investment firm.

For more information on Mitchell, visit [www.mitchell.com](http://www.mitchell.com).

# Mitchell in the News



## Bodily injury claims increasing faster than other lines of coverage: Mitchell

Mitchell's Chris Williamson addresses the evolution of BI payment and claims.

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## Mitchell's 2015 Property & Casualty Conference Unites Leaders

Mitchell announces conclusion of annual Property & Casualty Conference which showcased the latest market trends and technologies aimed at improving business processes and outcomes.

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## Mitchell Launches RepairCenter Hub

Mitchell announces release of RepairCenter Hub, a real-time communication and collaboration platform for the property and casualty industry.

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## Mitchell Announces Winners of Annual AutocheX Premier Achiever Awards

Mitchell selects recipients of the 2014 AutocheX Premier Achiever Awards, honoring collision repair shops throughout the U.S. for exemplary customer service.

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## Smartglasses help adjusters see the future of claims

Mitchell's Beau Sullivan and Chris Tidball explain how smartglasses help adjusters see the future of claims.

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# Industry Trends Report

The **Industry Trends Report** is a quarterly snapshot of the auto physical damage collision and casualty industries. Just inside—the economy, industry highlights, plus illuminating statistics and measures, and more. Stay informed on ongoing and emerging trends impacting the industry, and you, with the Industry Trends Report!

Questions or comments about the Industry Trends Report may be directed to:

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