Stop-Loss/Reinsurance: Disclosure & Reporting

Industry Study Group Project

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Objectives

The purpose of this effort is to create and promote industry-accepted guidelines to improve the accuracy and timeliness of disclosure and reporting of claims for self-funded employer health benefit programs. It is the intention that the implementation and use of these guidelines will support uniform standards of practice across the industry, for insurers/MGU's/reinsurers (stop-loss carriers) and TPA's.

The purpose of this paper is to articulate the need, rationale and proposed solution. It is also offer suggestions for stop-loss carriers and TPA's on how to operationalize this new standard effectively.

Back to Top

Proposal

Adopt industry standard guidelines for Disclosure Form, Disclosure Instructions (including ICD-9 code set), and related key definitions to create an accepted industry standard.

Back to Top

Background

Self-funded employer stop loss pricing has been through several market cycles, beginning as a fully *pooled* product and evolving to a product where premiums, for the most part, reflect only the exposure base or claims that are *not known* at the time of binding or renewal. Market forces, including managed care plans, have shifted pricing strategies—whereas stop-loss underwriters were in the usual practice of employing

manual rating-methodologies, they are now discounting rates off manual to compete with the external market forces. Known claims are either specifically priced into the premium, or fully/partially priced out of the premium using claim-specific deductibles *(lasers)*, aggregating specific (additional deductible in the covered layer) or other risk transfer mechanisms. The implementation of these risk transfer mechanisms create pressure to get a firm grip on each group's actual experience. As a result, the claims disclosure process, and the accuracy and timeliness thereof, have become increasingly more significant.

For the most part, each stop-loss carrier and/or reinsurer has developed their own unique disclosure process and respective administrative requirements. Consequently, TPA's are faced with multiple disclosure requirements that can be inconsistent, vague or both. While most disclosure requests serve the purpose of obtaining underwriting information for the pricing of risks at the point of sale, there have been isolated instances when disclosures have sometimes been used to retrospectively underwrite at claim time creating E&O exposure for TPA's. Suffice it to say, the increased focus on disclosure has created several levels of unintended consequences for employers, TPA's and stop-loss carriers.

From an *industry standards* perspective, some might say that expectations for loss experience and claim reporting are just now getting to an acceptable level and discipline. Even for the most well run TPA's, the new requirements are creating process change and substantial additional costs.

The purpose of this document, template forms, and instructions are to set forth a set of objective standards that TPA's and stop-loss carriers alike can use to minimize the opportunity for disputes over disclosure issues. The disclosure information must be meaningful to stop-loss carriers for underwriting. At the same time, the duty imposed upon the TPA must be clear and concrete to enable TPA's to feel confident that they have provided the required information and have been able to do so in an efficient way. The disclosure process is not a substitute for honorable dealings between the parties, nor is it a substitute for carriers and TPA's verifying the capabilities of the business partners they choose before entering into agreements.

Back to Top

Issues

It can be debated whether these suggested disclosure and reporting requirements will impact the quantification of the stop-loss carriers' exposure and ultimate pricing of the risk. Nevertheless, there is little doubt that over time, with appropriate reporting and disclosure, stop-loss premiums will accurately reflect the exposure based upon the quality of the claims information in the disclosure. In the meantime, as stop-loss carriers contemplate their way in this evolving environment, the industry is supporting many various reporting and disclosure guidelines. Some are well thought out while others are minimal, and some are quite stringent and voluminous. This wide variation causes inefficiencies and higher costs, which are eventually passed along to the TPA and self-funded employer. With inconsistent disclosure methodologies, there is potential for error and resulting E&O exposure, as well as additional administrative costs for the TPA's.

Since it is inevitable that the trend for a consistent and concrete disclosure will continue, and if handled well, will be good for the industry, some standardization of both requirements and process are in order. To this end, the following highlights the issues at hand:

Incomplete Reporting

Due to incomplete and inconsistent claims disclosure reporting to stop-loss carriers, premiums, at times, fall short of covering the accurate exposure base. Establishing standards for procuring complete and accurate claim information is one positive stop in ensuring the exposure base is adequately priced. Stop-loss carriers do not want to *buy* known losses.

No Consistent or Documented Standards Across the Industry

Regardless of the final requirements, an industry standard for disclosure would create necessary efficiencies and remove substantial opportunity for error. Usually, TPA's have relationships with many carriers. For the most part, each carrier has its own set of disclosure requirements (criterion, data elements and disease codes), as well as its own different set of requirements for ongoing reporting, for disclosure for quotes (typically a subset of the former) and for referral for case management (this typically overlapping with but not identical to either of the former two). This creates reporting efforts in TPA's fraught with a huge potential for errors.

A standard form for disclosure, and the corresponding data elements and disease codes, would mean less chance for error and less time needed for submissions. A standard criterion would also mean consistency in data across all submissions—the TPA could use a single system report (or set of reports) for the effort. The same applies for ongoing reporting.

There should also be a set timetable for each type of reporting, particularly for disclosure statements. TPA's will have the incentive to make sure they keep the timetable so that they can get firm quotes on time to meet client needs. Carriers will get data that is more consistent across submissions within a known and accepted timetable.

E&O Exposure for TPA's

TPA's are hired and compensated for administration of an employer's Plan. They are not a risk taker or insurer. Due to the vagaries in reporting standards and how they are applied, a TPA's E&O liability may be at risk (TPA's are being asked to pay for claims that are denied by the carrier).

Some TPA's have shifted the issue back to carrier by *dumping* the raw data on the carrier for analysis—they have basically disclosed *everything*, leaving it up to the carrier to analyze overwhelming amounts of data. Other TPA's have made genuine efforts to meet the new standards only to be caught with unintentional errors—it will take a while to get claims systems up to the task of the new reporting.

To that end, if the reporting and disclosure standards can be quantified and operationalized with specific steps, then a TPA can have a known process that it can follow, allowing the TPA to then attest to whether it disclosed/reported properly with each underwriting submission. In this process, the carriers would give the TPA

a concrete set of tasks/steps to perform, on which the TPA can then sign-off at the completion of those tasks/steps. If a claim arises that was not reported, and it was an error in the tasks/steps, the TPA is responsible. But if the claim fell outside of the prescribed process, it is treated as part of the carrier's *insurance risk*, the risk of doing Stop-Loss business. TPA adoption and support of the standard will certainly be accelerated if this *operationalizing* aspect is included in the requirements.

Codes vs. Verbiage in Criteria

The current formats for reporting criteria run the gamut. Many of the current carrier disclosure requirements include verbiage only, while others combine codes and verbiage, and the corresponding layouts and data elements are also inconsistent. The criteria can include inconsistent descriptions between carriers for the exact same disease. More importantly, the use of verbiage only creates too many judgment calls on behalf of the TPA and/or the Utilization Management (UM) team. Use of *best judgment* on what constitutes when a claim should be reported sometimes ends up in a disputed claim

When ICD-9 codes are included in requirements, some employ ranges, where as others use specific codes. Use of ranges can create over reporting (ranges typically also include non-critical codes). Where possible, the standard should eliminate open-ended questions altogether, and articulate critical diseases with specific ICD-9 codes. Where it is necessary to include verbiage to describe claims to report, they should be clearly articulated and in a standard form (*e.g., "Have received medical services during the past twelve months the cost of which exceeds the lesser of, 50% of the lowest Specific Retention Amount applied for or $50,000, and for which bills have been received by the Claims Administrator and entered into their Claims System."*).

Operationalization of Requirements

Once a standard for the disclosure/reporting requirements is determined, the next step before adoption is to translate the requirements/criteria into something a TPA can operationalize. To reduce the opportunity for error, where possible, the verbiage in the criteria should be translated into codes and processes. With the advances in TPA automation systems, it is more reliable to have the system flag claims than to rely on human beings to catch the exceptions that need to be reported.

Nearly all of the criteria for disclosure and ongoing reporting can be captured with codes (primarily disease codes) or simple algorithms (*e.g.*, 50% of retention). Some TPA's have already attempted this with their systems. Unfortunately, since TPA's have varying requirements by carrier, it is a time consuming, expensive and error prone task to deal with as many as a dozen code tables. The TPA also runs the risk that it has not *interpreted* the verbiage in the criteria appropriately when it translates it to ICD-9 codes. This situation creates further support for an industry standard.

Note: There may be one area that still needs work from the TPA reporting standpoint, even where automation exists. Years ago few plans had pharmacy card benefits and few if any Stop-Loss contracts included Rx in the specific, much less the aggregate, now many include both. It is not the norm for TPA automation systems to have the detailed PBM/Rx data in the database for Stop-Loss reporting—*e.g.* in

the situation where the combination of medical and Rx costs exceed the reporting trigger, the 50% of retention report for Stop-Loss will not automatically trigger since the system does not have the Rx data available. This requires manual intervention until the TPA can download the Rx data for consolidated and complete reporting.

Consistency of Requirements per Function—Disclosure for Quoting, Ongoing Reporting, & Case Management Referral

Typically carriers have three separate criteria for the above functions. For simplicity and efficiency of automation sake, the criterion for disclosure might best be structured so that it meets the same criterion used for ongoing reporting. Again for automation efficiency, some consideration may be given for consistency with Case Management referral criterion—though it may be a subset or even a superset of the reporting criterion. Consistency in the use of codes, descriptions, etc. is important.

Back to Top

Operational Considerations for Disclosure Reporting

Utilizing the Form

Some carriers can adopt the form by simply notifying the TPA's with which they work and sending out a copy of the final form. Others can adopt it as quickly by amending their TPA administrative manual. And still others may have to file the form as part of their policy filings to make it formally effective, which could take up to a year if a filing is done once annually. Several carriers have already indicated they will accept the form immediately even though they have not completed the administrative changes and/or filings and notifications.

Much like filed policy forms, the disclosure form includes several bracketed sections where carriers can adjust the provisions to match their circumstances. One bracket applies to the minimum dollar amount for claims that have an ICD—9 code on the list. A carrier with a $250,000 retention may see a $5,000 minimum per claim reporting level as below what is germane to their review. Many carriers want to see all claims, regardless of their size (no minimum dollar limit in the brackets)—a $15.00 blood test with an ICD-9 code for End-stage Renal Failure is worth a look.

The timeframes for when the disclosure can be submitted (30, 45, or 60 days prior to renewal date) is bracketed. The less a TPA has to rush to pull together the data and get it signed, the more likely the data will be all inclusive and accurate. Also, more time available for underwriting review and analysis is a good thing. The key is to allow time for good due diligence and still get the quote to the client well ahead of renewal date.

One additional comment: It is important for TPA's to include a detailed list of reports and attachments (include the report name, number of pages, date periods covered, etc.) to confirm what is included in the disclosure. A missing page or even an entire report will often be critical.

Current TPA Client vs. Prospect

Where data is coming from a third party (*i.e.*, the TPA is submitting data for a prospective client), the issue of complete disclosure is more complicated. Carriers may initially only be able to rely on standardized reporting for submissions on current TPA clients (current TPA may use the form required by the incumbent carrier, which may not conform to the disclosure standard). Later, as TPA's build in the necessary processes, carriers will be able to get the same disclosures across the board—TPA's will typically apply the same process (reports) regardless of who is requesting the data, even when the client or agent/consultant requests the data for other quotes; it is typically too much work to do otherwise.

Basic Operations

If the TPA implements routine, ongoing processes that are prompted by the automation system (exception routines and reports) and that keep up the required documentation (online UM notes), then the reporting can be accurate and timely. The current manual processes are time consuming and error prone; most TPA's will choose the automated route if they have an appropriate map. They will also be motivated to avoid potential liability.

Criteria or "The List"

The criteria must be standardized and easily automated to remove human error as much as possible. The list of diseases/conditions would be represented by ICD-9 codes. These can be updated in future years as new code sets are adopted (ICD-10) and as new diseases codes are added.

There are some aspects of existing criteria that will need an algorithm to flag matching claims. A couple of examples of unique requirements where claims must be reported: "Be currently confined to a Medical Facility, or have been precertified within the last three months"; and "Have been identified as a candidate for Case Management and as having the potential to exceed during the policy period, the lesser of, 50% of the lowest Specific Retention Amount applied for, or $50,000." For the interim, the disclosure effort will translate into reporting all precertified cases and all claims in Case Management. *There may be ways to automate these requirements in the future to get the same result, but accomplished using existing data in TPA systems.*

If the list and supplemental algorithms are designed properly, less than 1% of the claims that need reporting will rely on human judgment, and most of these claims will be unique or large and thus identified for reporting.

Signatures on Form—Who Should Sign the Form

There are three signature lines on the form: Plan Sponsor (Employer), Claims Administrator (TPA), and Agent/Broker. Each carrier will need to delineate who should sign the form to be an acceptable disclosure. Required signatures will typically vary based on the individual circumstances of the submission.

For illustrative purposes, several scenarios are outlined below; again, each carrier will need to make the call on who should sign in each situation.

New Case for TPA + New Case to Carrier

When the data is coming from a source other than the prospective TPA submitting to the carrier (e.g. the incumbent TPA, or an Agent/Broker/Consultant), at minimum the employer will be expected to sign the form. If an Agent/Broker/Consultant is the source, they would also be expected to sign.

Often the disclosure statement and accompanying reports are generated by the incumbent TPA and distributed to prospective bidders once complete and signed. In that case, both the employer and the incumbent TPA (and Agent/Broke if involved) will be expected to sign the form. Obviously, the prospective TPA is not involved in the disclosure.

Existing Case for TPA + New Case to Carrier

When the data is coming from the incumbent TPA, both the employer and the incumbent TPA will be expected to sign the form. If an Agent/Broker/Consultant is involved, they too would be expected to sign.

Note: If the Agent/Broker/Consultant is *in control* of the submission, and the TPA does not control what information actually gets to the market/carrier, then it is often the case that an incumbent TPA will not sign the disclosure. In this situation, an alternative is that the TPA will sign the disclosure form, but will also have in place a hold-harmless and indemnity provision with the employer since it is not doing the actual submission to carriers.

Existing Case for TPA + Renewal Case to Carrier

With a current client, carriers may be comfortable to have only the TPA and/or Agent/Broker/Consultant sign the disclosure form. There is typically pushback from the client to sign a disclosure form…"you (the TPA) know better than I what needs to be disclosed." TPA's are typically willing to do so *if the disclosure form process is manageable.*

Tracking New "Claims" to Report—Definition of ***Known Claim***

Known Claim in the context of disclosure includes *all* claims regardless of the status. This translates to reporting:

- Registered Claims—bills that are in the claim system, but have not been processed for payment
- Pended/Suspended Claims—claims that have been reviewed or partially processed, but are awaiting additional information (*e.g.*, subrogation potential from possible WC claim or automobile accident, coordination of benefit potential
- Processed Claims—claims that have been processed, but where checks have not yet been issued/mailed
- Paid Claims—claims that have been processed and checks have been mailed

- Denied Claims—claims that have been processed and denied, or where there was insufficient information to process and were denied according to the DOL regulations.

Note: Claims in this last category have grown substantially given the DOL requirements to pay or deny in the tight timeframes. Claims denied for insufficient information may ultimately resurface as a clean claim, so it may just be a matter of timing. For some risk management related to potential E&O claims, TPA reports should be set up to include all five categories of claims listed above.

When is a Claim "Known"?

A potential gap in the current reporting process is the determination of when is the earliest time the TPA is aware of a claim. A lack of understanding and agreement between carriers and TPA's have ended up in claim denials. If a simple, reasonable definition is adopted that can be clearly substantiated with documentation at the time a claim is in question, then the issue will be fact based versus the current potential ambiguity. Again, this enables the TPA to build operational processes that eliminate the exposure.

The definition of *known claim* starts with the question of, "When does a bill become a claim?" Certainly, the bill is still a bill when the doctor's office drops it in the mailbox. It is still a bill when it arrives in the TPA mailroom and is still unopened in the envelope. It is not reasonable to expect mail clerks to be responsible for recognizing and reporting claims, so realistically the bill is still a bill until it gets entered into the TPA system (some call this *registering a claim*). This should be the point at which the TPA has first knowledge.

There are some more difficult first knowledge issues where the TPA receives a phone call or pre-certification of a potential inpatient stay or pre-authorization of an outpatient procedure, all prior to written notification or receipt of a bill. What if the procedure precertified or preauthorized never actually occurs, or is later deemed not medically necessary? In any event, the separate reporting requirement of precertified cases and those in Case Management are addressed in the instructions of the Disclosure Statement.

For clarity purposes, *Known Claim* is defined as "a bill that has been entered/registered in the TPA claim system."

Registering a Paper Claim

If registering a paper claim (entering a bill into the claims system) is the point of *knowledge* for the TPA, then to be fair, there must be some limitations.

The first requirement would be that all mail is routinely date-stamped by the TPA with the received date. Then the *knowledge date* would be the *entry date* captured by the claim system when input. This would apply as long as bills are entered on a timely basis. It would seem reasonable to expect that, allowing for sickness and absences, etc., six working days would be reasonable. So the definition for the *date of knowledge of a claim* would be the date entered into the claims system, or six working dates from date of receipt (as date-stamped).

Registering EDI Claims

EDI claims are typically received in electronic batch files (received, but unprocessed and unloaded) and must be processed before being entered into the live claims system. Claims must go through several edits before being loaded into the system. Any claim that fails the EDI edits (a claim might be rejected for no provider match) gets suspended in the EDI process (outside of the live claims system) and are not added to the live claims system until the edit failure is rectified. So for the purposes of definition, much like a paper claim, the TPA would not have *knowledge* of an EDI claim until it is finally entered/registered into the live claims system. Some reasonable timeframe should also be applied here, reasonably six working days to enter the claim once the data is clean.

Exception Routines and Reports

For the TPA to be consistent in reporting, it will necessarily create exception routines (based on the standard disclosure criteria) that flag claims to be researched, reviewed and documented for Stop-Loss purposes, and in some cases referred to case management. The same criterion can then be used to pull those claims and the online notes to produce the report(s) that go on to the carrier (ongoing reporting or disclosure reporting). The key is to have a succinct list for the criteria that can be automated.

For new claims, many systems can run an exception routine that flags any newly registered claim for UM review and Stop-Loss reporting. The system can then route the claim (electronic flag) to the appropriate person(s) for review and documentation, even before the claim is processed for payment.

UM Review of New Claims

Though some carriers do not impose the requirement, it has become a *best practice by some TPA's,* even if not overtly required, to review claims that fall under the reportable ICD-9 code list to determine whether the claim will develop into a large claim (needs to go to case management) or whether it is a non-issue. (Basic example: blood tests are submitted by the provider with a diagnosis code of V71.9—Observation for unspecified suspected condition [which is a "rule out" diagnosis, and can include all sorts of high cost diseases], when actually there is no serious diagnosis—it is simply a blood test for anemia). It is constantly debated whether this is beyond what a TPA should be required to do, that this should actually fall under the purview of the carrier.

Typically, a TPA today has to run an exception report against all *known claims* by client and then hand this extensive listing to the UM department for review of each claim prior to reporting to the carrier. The typical manual process includes typing the notes into Word documents and updating every individual case report each month.

To streamline and load-balance the work, once bills are input into the claims system, the system should be set up to flag the claim and electronically route them to the UM team for review. The UM nurse reviews the claims for that day, researches as necessary, and then documents the claim online. These online notes are tagged and used as the source for automated Stop-Loss reporting.

Having the system prompt electronically for UM review, both for potential case management and for Stop Loss reporting, and having online UM notes for automated, consolidated reporting are solid E&O risk management tools.

Ongoing Reporting

The TPA can run a report as appropriate (monthly or as required) that captures the claims that meet the reporting criterion, including the online notes from UM that are pertinent to the carrier's review. Later, with improved secure Internet capabilities, provide online access to the carrier for any claim meeting the reporting requirements (system could actually flag the claims and electronically route the claim to the carrier as it is incurred). Some TPA's have already implemented systems to send an e-mail to the carrier at month-end to prompt them to click a secured URL that connects them to the monthly Stop-Loss reporting page. This lists the reportable claims and allows the carrier to drill down to the details, notes, prognosis, etc. online. This simplifies and speeds the review process, and eliminates the often voluminous requests from carriers for the details of the claims they are interested in reviewing further.

Miscoding

Inevitably, a claim will be miscoded when entered into the system. There are several scenarios: a keying error by TPA's input person (transposed numbers), keying error by Provider, only primary diagnosis (one ICD-9 code) is included on bill or at data entry by TPA when there is co-morbidity (secondary diagnosis is missing), etc. The claim ultimately surfaces in UM, Case Management, or on reports because of rising costs. The TPA then updates the claim information and the claim shows up on the next set of reports.

Certainly, these situations should be considered on a case-by-case basis. If the TPA standard quality measures are in place (accuracy of input), and go through a standard sound disclosure process, an inadvertent miscoding error should be grouped with errors created by Providers on the bill, *i.e.*, in the course of doing business. Frequent or questionable errors can be handled by exception. Carriers choosing quality TPA's will see few, if any, miscoding issues arise.

Back to Top

Sample Process for Ongoing Monitoring and Monthly Reporting

The following is a Sample Process. Each TPA can develop its own process based on its claim system, functions that are outsourced, etc.

Summary of Internal Processes/Tasks

Process 1-New Claims

- Receive a paper claim and register it in the system; receive an EDI claim, pass edits and load it into the system
- Review claims daily that fail EDI edits
- Once claims are in system, run daily system routines to determine if claim meets Stop-Loss/UM/Case Management review criteria
- Route claim to UM for review, research & documentation online
- Route flagged claim to Stop-Loss Reporting

Process 2 – Case Management Referral and Reporting

- Newly input claims/cases routed by system that meet criteria for review and determination by UM nurses
- Other cases referred by claims examiners routed for review and determination by UM nurses
- Print list of Cases in Case Management and send to carrier
- Send copy of Case Management Notes/Reports to carrier
  * Consider process to note "No Change or Activity"

Process 3 – Monthly Reporting

- Run 50% of retention report (suspects) which includes claims already in excess of retention (actual claims)
- Run Stop-Loss Flag (exception) reports (suspects) for Paid, Pending/Suspended, Processed and awaiting payment, Denied, or Registered and not yet processed.
- Monthly updates on any notice or claim previously reported (add a "no change" option)
- Precertification & Case Management Reporting

Back to Top

Sample Process for Disclosure Reporting

The following are *Sample Processes*—each carrier can have a different reporting timeframe included with their disclosure form (*e.g.*, 30, 45 or 60 days) and each TPA can have a different approach to developing reports as well.

Though there are three samples included, the 30-day timeframe is rather time-limited and it is unlikely that most TPA's can consistently generate the reports, get the disclosure form signed by the client, and then forward them on to the carrier within the timeframe. Any delays up front will put in jeopardy the carrier's ability to perform an underwriting review and respond to the TPA in a timely fashion prior to renewal date. Particularly in high volume months, carriers may need additional days to get through the reviews. As a result, a minimum of 45 days and preferably 60 days is recommended.

Note:
There are a couple of items that are reported and documented by UM that are unique to Disclosure. Further definition of requirements (data fields) will be necessary to standardize the reporting (example: Patients currently hospital confined or disabled),

Processes 1, 2, and 3 above must be in place for data to be available.

SAMPLE PROCESS—60-Day Timeframe

90 days out from renewal:

- Run the exception report, the same as for ongoing reporting, which includes UM notes, etc.
- Run large claim report w/ online notes—prognosis and evaluation
- Print list of Precertified Cases and Claims in Case Management
- Print copy of Case Management Notes/Reports
- Refer claims to UM for review as necessary
- Send initial underwriting submission to carrier(s) for pricing contingent on disclosure

60 days out from renewal:

- Run the same reports as above (as soon as the data is available after month-end) and submit with Disclosure Statement
- Disclosure package should be signed and sent to carrier within 5 working days (for data to be *current*)—package should be at the carrier by 40 days prior to renewal

40 days out from renewal:

- Carrier reviews disclosure data and confirms final pricing (ten days to process)

30 days out from renewal:

- TPA confirms timely final pricing with client

30 day after renewal:

- Run the same reports for verification (as part of monthly reporting)

SAMPLE PROCESS—45-Day Timeframe

90 days out from renewal:

- Run the exception report, the same as for ongoing reporting, which includes UM notes, etc.
- Run large claim report w/ online notes—prognosis and evaluation
- Print list of Precertified Cases and Claims in Case Management
- Print copy of Case Management Notes/Reports
- Refer claims to UM for review as necessary
- Send initial underwriting submission to carrier(s) for pricing contingent on disclosure

45 days out from renewal:

- Run the same reports as above on the 16th of the month and submit with Disclosure Statement
- Disclosure package should be signed and sent to carrier within 5 working days (for data to be *current*) —package should be at the carrier by 28 days prior to renewal

28 days out from renewal:

- Carrier reviews disclosure data and confirms final pricing (one week to process)

21 days out from renewal:

- TPA confirms final pricing with client

30 day after renewal:

- Run the same reports for verification (as part of monthly reporting)

SAMPLE PROCESS—30 Day Timeframe

60 days out from renewal:

- Run the exception reports, the same as for ongoing reporting, which includes UM notes, etc.
- Run large claim report w/ online notes—prognosis and evaluation
- Print list of Precertified Cases and Claims in Case Management
- Print copy of Case Management Notes/Reports
- Refer claims to UM for review as necessary
- Send initial underwriting submission to carrier(s) for pricing contingent on disclosure

30 days out from renewal:

- Run the same reports as above (as soon as the data is available after month-end) and submit with Disclosure Statement
- Disclosure package should be signed and sent to carrier within 5 working days (for data to be *current*) —package should be at the carrier by 20 days prior to renewal

20 days out from renewal:

- Carrier reviews disclosure data and confirms final pricing (one week to process)

10 days out from renewal:

- TPA confirms final pricing with client (TPA should confirm this meets client's timeframe)

30 day after renewal:

- Run the same reports for verification (as part of monthly reporting)

Back to Top