



SELF-INSURANCE INSTITUTE OF AMERICA, INC.

EMPLOYEE BENEFITS

THIRD PARTY ADMINISTRATOR

(TPA)

APPOINTMENT QUESTIONNAIRE

Endorsed as an Industry Standard Form for Assistance in the Evaluation of Third Party Administration Companies (TPAs) by Stop-loss (Excess) Insurers and Managing General Underwriters (MGUs).



*Protecting and Promoting Self-Insurance and
Alternative Risk Transfer since 1981*

To the user of the application/questionnaire:

As the self-insurance industry continues to expand, a degree of standardization is important to the level of professionalism of our industry. Over the years, a variety of forms and applications have been developed by various interest groups to assist in the evaluation of third party administrators by insurers and underwriting managers. As a result, there has been little conformity of information supplied, resulting in the use of a multiplicity of forms which has added unnecessary cost to doing business. This form, SIIA-06-01-TPA/AQ has been approved by the Self-Insurance Institute of America, Inc. (SIIA) as an acceptable industry standard form.

Please note – This questionnaire has been developed solely for the purpose of aiding the user and receiver of data to help establish a certain level of standardization for evaluation purposes. SIIA assumes no responsibility to any party regarding the completeness of questions asked, or any use of the information provided. Evaluation of who to do business with is left to the sole direction of the parties involved.

Comments and suggestions may be sent to:

SIIA
P.O. Box 1237
Simpsonville, SC 29681

EMPLOYEE BENEFITS THIRD PARTY ADMINISTRATOR APPOINTMENT QUESTIONNAIRE

Information provided on this form is to be held in confidence by the recipient.
Due to spacing constrictions, you will likely need to attach additional sheets.

PART I - Entity, Location, Ownership, Affiliation

1. Name of Entity: _____

2. Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Web Site: _____

E-mail: _____

3. T.I.N. #: _____

Type of Business: Corporation Partnership Sole Proprietor LLC

4. List of Officers: *Attach additional list if necessary. Submit resumes of Officers, Directors and Owners*

President: _____ Secretary: _____

Vice Pres: _____ Treasurer: _____

Other Officers: _____

5. Please list other companies with whom you have financial interest greater than 10% (i.e. Insurance companies, PPOs, HMOs, MGUs, Brokerage operations, etc.)

6. In the last five years, has your business entity ever been involved in a merger greater than 10%?

Yes No

If yes, please describe: _____

7. In the last five years, has your business entity ever had a change in ownership of greater than 51%?

Yes No

If yes, please describe: _____

8. Has your business entity had a change of name, and/or used a dba or is it operating under an assumed name? Yes No

If yes, previous names were: _____

9. Branch Offices:

Name of Contact: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

E-mail: _____

Name of Contact: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

E-mail: _____

10. How do you produce business (clients)? *Check all those that apply*

- TPA Staff Direct
- Independent Brokers/Agents
- Other, define: _____

11. If you use independent brokers/agents to produce business, is their compensation for service paid by:

- Client?
- TPA?
- Other? Describe: _____

12. If you compensate brokers/agents or other service providers for business development, how do you disclose to client the amount of compensation paid?

13. When do you disclose fees, compensation, etc., to client? *Check all that apply.*
- In the initial proposal
 - In the service agreement
 - At time of 5500 filing
 - Other, explain: _____
14. How many years have you been in business? _____
15. How many clients do you have? _____
16. How many total employee lives are covered by your collective client base? _____

PART II - Systems - Administration and Claims (Hardware and Software)

| | Administration | Claims |
|--|----------------|--------|
| 1. Is your system on-line or manual? | _____ | _____ |
| 2. Version of the software system | _____ | _____ |
| 3. Who developed the system? | _____ | _____ |
| 4. Year it was developed? | _____ | _____ |
| 5. Is your software leased, timeshared or owned? | _____ | _____ |
| 6. If owned, year it was purchased. | _____ | _____ |
| 7. Name of the hardware | _____ | _____ |
| 8. Is the hardware leased, timeshared or owned? | _____ | _____ |
| 9. Have you changed/upgraded systems within 12 months? | _____ | _____ |

If yes, please describe:

A. Administration: _____

B. Claims: _____

C. Is conversion complete? Yes No

10. Is your system EDI compliant to HIPAA standards? Yes No

11. Is your system compliant to HIPAA security standards? Yes No

12. Have you modified the standard system in any way? Yes No

If yes, please describe _____

PART III - Administrative Services (Financial, Eligibility, and Premium Accounting)

1. Staff: Total number of employees in department: _____

2. Name/Job Title of Key Personnel and Managers Years Experience Years w/Current Employer

| Name/Job Title of Key Personnel and Managers | Years Experience | Years w/Current Employer |
|--|------------------|--------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

If necessary, list additional names on a separate page and attach. Please attach resumes.

3. May clients have system access in their offices? Yes No

If yes, which administrative functions can clients perform? _____

4. Can you provide census and premium funding data electronically? Yes No

5. Can you accept and send ACH financial transactions? Yes No

6. System(s) Security and Audit Procedures:

A. Describe security of master file (i.e., who can enter new groups, make changes, etc.):

B. Describe security of client funds: _____

C. Describe record retention program for enrollment cards, billing files, etc.: _____

D. Describe your back-up system(s) in the event that the computer master file is destroyed: _____

7. Does your system calculate individual or group premium for fully insured plans, or calculate levels of funding for self-funded plans? Yes No

8. How is eligibility determined for claims adjudication? _____

9. Describe procedures for adding, deleting and changing plan participants and their benefits:

10. What is your philosophy in serving a client's interest if the client asks you to accelerate claim payments in the last quarter or month of the plan year-end? _____

11. Do you perform bank account reconciliation's on client accounts? Yes No

If no, why not? _____

12. How often do you generate premium billings for insurance coverage? _____

On what days? _____

13. When are premium reminder notices sent? _____

14. For non-payment of excess/stop loss premiums, how are lapse notices sent? _____

15. On what date(s) are premium payments run for insurers and excess insurers? _____

16. Do you remit premiums to carriers on behalf of clients? _____

17. If yes, do you remit gross or net of commissions? _____

18. Do you audit your administration area?

Yes No

If yes, please describe _____

19. Do you have a disaster recovery plan?

Yes No

If yes, please describe _____

20. Provide a list of outside vendors contracted with your TPA and the services they perform?
(Attach a separate sheet)

PART IV - Claims Administration

1. Staff: Total number of employees in:

Adjudication: _____

Support: _____

Managers: _____

| Name/Job Title of Key Personnel and Managers | Years Experience | Years w/Current Employer |
|--|------------------|--------------------------|
|--|------------------|--------------------------|

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

If necessary, list additional names on a separate page and attach. Please attach resumes.

2. How long is claim history maintained on-line? _____

3. Has the department been audited by a third party for accuracy/security? Yes No
If yes, how recently? Please give name of audit firm: _____

Name the type of audit performed: *Check all that apply, and note date.*

- CPA/5500 _____
- Carrier/MGU _____
- SAS 70 – Type 2 _____
- CPA/Performance _____
- Independent Claims Audit _____

4. What is the percent of auto adjudication? _____

A. What percent of claims are received electronically? _____

5. Based on the above definition, what is your average number of claims received daily: _____

6. What is your payment accuracy objective?

A. Procedural: Number of claims paid: _____

B. Financial: Dollar amount paid without error: _____

7. What procedures do you have in place for identifying and reporting potentially large claims (exceeding 50% of the specific deductible trigger diagnosis)?

8. What procedures do you have in place to detect and enforce reimbursement for subrogation, COB or workers' compensation? _____

9. What was your payment accuracy performance during the last twelve months? _____

10. Describe the payment authority limitation for the claims staff and describe the criteria for internal audits: _____

11. What is your average turnaround time from date of receipt to date of payment on a clean claim submission? _____
12. What is your source for determining R&C?
 Surgical
 Medical
 Dental
13. If other, please describe:
 Surgical: _____
 Medical: _____
 Dental: _____
14. Is your R&C database on-line? Yes No
15. How often is R&C data updated? _____
16. Are the ICD-9 codes captured? Yes No
17. Are the CPT codes captured? Yes No
18. For what period of time are hard copy claims files retained? _____

19. Are separate bank accounts maintained for each client? Yes No

A. What is included in each account? _____

B. Who has disbursement authority? _____

C. Is there a trust established for funded plans? Yes No

Describe a "Typical" client fund transaction through your office: _____

20. Do you subcontract any data processing activities? Yes No

If yes, please specify _____

21. Do you utilize off-site or home claim processors? Yes No

If yes, please explain _____

22. What services do you provide for COBRA administration? _____

23. What compliance services do you provide? _____

24. What other services do you provide? Please list. _____

25. What percentage of claims are audited? _____

A. How often? _____

B. Client specific or aggregated? _____

PART V - Managed Care

1. Please list the PPOs you use for the majority of your cases: _____

2. When there isn't a PPO in place, do you reprice hospital bills? If yes, what vendors do you use and at what claim level? _____

3. Describe any other claim cost management providers and processes you may use (i.e., demand management, hospital bill audits, subrogation, fee negotiation, service, etc.): _____

4. What level of utilization review services are performed? _____

5. Are utilization review services performed in-house or through an outside vendor? _____

6. Describe your procedures for professional medical and dental claims review: _____

7. Describe your procedures for auditing and/or negotiating provider bills: _____

8. Describe your procedures for using large case management (LCM): _____

9. Describe the managed care procedures you are using: _____

10. How are cases identified for possible case management? _____

11. Please list the companies you use for Large Case Management services or describe your internal programs: _____

11 a. Disease Management and Predictive Modeling Service: _____

12. Is there a direct linkage between the UR/pre-cert process and case management? If yes, please explain: _____

PART VI – Carriers (Insurers)

1. Please list the excess/stop loss insurers (carriers) with which you have business:
Carrier Name # of Cases # of Lives Estimated Annual Premium \$\$

2. Has any carrier terminated their relationship with you in the last 5 years? Yes No

If yes, who and why? _____

PART VII - Compliance/Legal/Licensing

1. Describe any previous or pending material lawsuits in the last seven (7) years: _____

2. Have any of the principals in your firm or any of your employees (former or current), ever been indicted or convicted of mishandling/misappropriating any insurance company or client funds? Yes No

If yes, please give details: _____

3. Describe your current procedures for handling client or insured complaints and State Insurance Department complaints: _____

4. Has the company (TPA) or its principals ever been adjudged bankrupt? Yes No

If yes, please explain: _____

5. Have you ever been involved in an audit by the Department of Labor (DOL)? Yes No

If yes, please give details: _____

6. If your operating jurisdiction(s) requires licensing, are you licensed as a(n):

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> Third Party Administrator | <u>List States/License Number</u> |
| <input type="checkbox"/> Managing General Agent | _____ |
| <input type="checkbox"/> Agent | _____ |
| <input type="checkbox"/> Other, define: | _____ |
| | _____ |

Please provide a copy of current license(s) listed above.

7. How are you kept informed of changing legal requirements within your market area? _____

How do you inform your clients of these changes? _____

8. What membership(s) do you hold in professional and trade associations? *Check all that apply.*
- SIIA SPBA RIMS IFEBP HCAA
 NALU NAHU LIMRA Other (please list): _____

PART VIII - Insurance/Bonding

1. Do you carry a TPA errors & omissions policy? Yes No

If yes, who is the carrier? _____

What is the expiration date of the policy? _____

What are the limits of coverage for the policy? _____

What is the deductible? _____

- Is contract a claims made policy? Yes No

2. Do you carry a comprehensive general liability policy? Yes No

If yes, who is the carrier? _____

What is the expiration date of the policy? _____

What are the limits of coverage for the policy? _____

What is the deductible? _____

3. Do you carry a professional liability policy for UR (Utilization Review) and/or other services? Yes No

If yes, who is the carrier? _____

What is the expiration date of the policy? _____

What are the limits of coverage for the policy? _____

What is the deductible? _____

4. Do you carry a fidelity bond? Yes No

If yes, who is the carrier? _____

What is the expiration date of the policy? _____

What are the limits of coverage for the policy? _____

What is the deductible? _____

What are the total annual aggregate funds handled for all clients? _____

5. Do you purchase criminal liability insurance? Yes No

If yes, on which employees? _____

6. Have claims been made against any of the above policies in the past two (2) years? Yes No

If yes, please provide details. _____

PART IX – Financial

1. Principal banking relationship (to be used as a reference):

Name of Bank: _____

Address: _____

Phone: _____

Contact: _____ Contact Title: _____

PART X - Attachments

1. Please use this checklist and provide the following attachments. If any of these items cannot be provided, please explain: _____

- Bios of officers, directors, owners and key claims personnel
- Certificate of Insurance for Errors and Omissions Policy, Professional Liability Policy, and/or Bond now in effect (declaration pages are sufficient)
- Copy of TPA, MGU, agency, broker and agent license for each applicable state
- Marketing proposal
- Marketing brochure
- Service agreement (sample of standard agreement used)
- Claim account flowchart/description
- Samples of administrative service reports for Stop Loss reporting
- Samples of aggregate claims reports available to insurers and/or reinsurers
- Sample plan document

I certify that the information on this application is accurate to the best of my knowledge and belief. I also understand that routine inquiries, including credit inquiries, may be made of any or all of the individuals and firms noted herein as references.

Signature: _____

Date: _____

Print Name: _____

Title: _____