WHAT CPLIC'S CLAIMS DEPARTMENT SEES

EXCESS INSURANCE
&
SPECIAL DISABILITY (2nd Injury) TRUST FUND REPORTING

A Special Problem for Third Party Administrators

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Handling claims as a Third Party Administrator (TPA) places greater obligations on the adjuster than simply handling field assignments for insurance companies.

Many organizations using Third Party Administrators have risk managers. These risk managers, or people in their offices, are the TPA's main contact. Many of these people have little or no experience in the claims field. Even those that do have claims experience, tend to be tied up in other administrative problems common to risk management departments. This places a greater burden upon the TPA, because there may be no one knowledgeable reviewing their work.

Two of the areas that give rise to errors and omissions claims for TPAs are reporting to excess carriers and reporting and collecting second injury trust fund payments. This paper will deal with these two issues.

Reporting to Excess Carriers

This can be a major source of errors and omissions claims. Not only is it easy to miss a reporting date, but, on serious claims, these claims can become extremely expensive.

Ways to Avoid the Exposure

The first way to avoid the exposure is to refuse to accept it. In some contracts, the TPA refuses to accept the duty of reporting to the excess carriers. That duty is left either to the risk management department or to the broker who sold the excess coverage. It is very difficult to compete in the TPA marketplace if you do not accept the responsibility of reporting to the excess carrier.

A second way to avoid the exposure is to agree with an excess carrier (or carriers) that the TPA will send them certain information each month, and they assume the responsibility to cull out the claims they wish to have the TPA report. The monthly data transfer will be in the requested format emphasizing such things as cause, body part and nature codes; paid-to-date and incurred. One well-known workers' compensation excess carrier will do this, but most of the other carriers will refuse a program like this. This puts you in the position of having to monitor cases yourself to make sure that they are reported properly to excess.

How to Monitor Cases

The first thing you have to do is find out information about the excess coverage. You will need to know the following information:

- The carrier's name
- Effective dates
- Self-insured retention or deductible
- Details on their reporting requirements

You must have this information for each and every policy year for which you are handling claims for the client.

If you pick up an account and assume the "tail" (older open claims from the prior TPA) with the account, you will need to know all the excess carrier information listed above for all the back years. The way to handle this is to send your client a letter, with a copy to their broker, asking them for the information for all years. Point out in the letter that you will not be responsible for reporting to any excess carrier when they have not told you who the carrier is, and what the details of coverage are. In addition, they need to supply you with a copy of the contract so that you can understand the reporting requirements within the contract. This can be a big job, particularly if you have a large TPA book of business, but it is absolutely necessary. A sample of such a letter is included in the second section, "Suggested Forms, Letters and Wordings", of the risk management website.

Computer Support

You must have support in your information system to help you track the excess cases. Once you have the information outlined above, by policy year, by client, your IT department should build a program to house the information. This will allow the department to write a report that matches the coverage information with the claims information and produce a list of files that need to be reported to excess carriers. This is harder than it sounds.

First, the report should compare the retention for a given policy year against claims within that policy year. Typically, the reporting requirement is 50% of the SIR, but there are policies with reporting requirements anywhere from 40% to 75% of the SIR. Any claim whose incurred hits the required reporting percentage should show up on the report. This will give supervisors and adjusters a heads up to make sure that losses are reported timely.

You can also key the report to such coding as severity and body part. However, this kind of information is very difficult to keep 100% accurately in an IT system. You will need considerable diligence to make sure these items are up-to-date.

Reporting to Excess Carriers

If you have a questions in your mind about whether or not a claim should be reported to an excess carrier . . . REPORT IT. The carrier may come back and tell you that the case is not yet ripe for reporting, or they will not open a file at that time. They may ask you not to report again until something happens, such as a major reserve change due to a change in medical or indemnity status.

Many adjusters have difficulty realizing that they need to report again to the excess carrier when those qualifiers have been met. This is because of the time that has passed between the initial report, the carrier's response, and when the new reporting trigger they had asked you to follow occurs. Once you have reported the case to the excess carrier, continue to report regularly. It is the best protection you will have.

Carriers Involved in Claims

Most excess policies say that the carrier may get involved in the handling of the claim, at the carriers choice. Most of them would rather not, and then come after you if they don't like some of the results.

Most excess policies require you to let the carrier know when you are going to settle a case in excess of the retention, which will require them to make a payment. They want to be notified, and they may wish to be involved in some fashion or other.
Do not make the mistake of settling a case before you clear it with the excess carrier, if the case may pierce the retention.

Most excess policies require you to let them know if indemnity benefits are paid in excess of six or nine months. Many excess policies require you obtain approval before accepting a claimant as permanently and totally disabled. Many adjusters miss these reporting requirements.

Lines of Insurance

Much of the above applies to workers' compensation, because that is the most frequently self-funded. However, the same kinds of requirements exist in excess policies, and deductible policies, for casualty programs as well.

Carrier Tendencies

Certain carriers will deny coverage or apply a late reporting penalty at the drop of a hat, even though they may owe the case. There are a few that do not.

SDTF Reporting

This is another area where an E&O claim can arise. Second Injury or Special Disability Trust Fund procedures in most states require that there be a report to the trust fund on on a timely basis. This report must include proof of employer knowledge, as well as information to back up the amounts paid, and claimed.

If you miss the reporting date, you may have a second injury trust fund that denies the claims. This leaves you exposed to an E&O claim alleging that financial recoveries available to your client were spoiled.

It is much harder to identify second injury files. Remember, that this applies only to workers' compensation.

The theory behind the second injury fund is to get an employer to hire somebody who comes to them with a disability. The fund will pay any increase in disability that occurs because of an accident at the new job. Otherwise, employers might not hire people who have disabilities.

This means that the first thing you have to do is determine if there was a prior injury, with a disability. Additionally, the second injury generally has to have caused a greater disability and merged in some fashion with the original injury or disability. This must be determined early in the investigation of the claim.

Once you have determined that, your next step is to find a supervisor of the employee who had knowledge of the injury and felt it could be a hindrance to their employment, and get a knowledge affidavit to support that.

The next step is to notify the fund of your claim, and then to prosecute it. There is no way for information systems to help in this situation. There must be a good medical history taken. With this, we can ferret out prior injuries, and possibly disabilities.

This is a subject for training of adjusters, and for supervision in states with Second Injury or Special Disability Trust Funds.

If you have a claim that you think may qualify, it should be fully developed and filed. Do the necessary field investigation to support the knowledge requirement.

Don't forget that second injury claims may be subject to negotiation, so you may not get back as much as you initially requested. However, if you forget to make a claim, your client will ask you for the full amount they thought they could have recovered, and an excess carrier will not reimburse for the portion that could have been recovered.

The initial review of loss notices is extremely important here. It is at this point that you can identify potential second injury claims.

Secondly, make sure the adjuster handling the file gets a good medical history. If you have nurse case managers, make sure they understand second injury issues and the importance of previous injury or disability information.

In the end, identifying second injury cases is an adjusting function. Only larger more serious cases are affected. Anytime you have a prior disability, with a rating, you should be looking for second injury potential, if your state has such a fund.