AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: IOA Re, Inc.; Stop Loss Disclosure for PHI

Action Requested: County Manager Signature

Parties to the Agreement: IOA RE, Inc & Gunnison County, Colorada

Term Begins: 1/01/2019 **Term Ends:** **Grant Contract #:**

Summary:

HIPAA Privacy release of PHI for the sole purpose of evaluating & accepting risk associated with the Plan Sponsor

Fiscal Impact:

Submitted by: Cheryl Seling **Submitter's Email Address:** cseling@gunnisoncounty.org

Finance Review: ○ Required ◉ Not Required

Comments:

Reviewed by: Discharge Date:

County Attorney Review: ◉ Required ○ Not Required

Comments:
ok db 12/12/18

Reveiwed by: GUNCOUNTY1\dBaumgarten Discharge Date: 12/12/2018 Certificate of Insurance Required

Yes ○ No ◉

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 12/12/2018

◉ Consent Agenda ○ Regular Agenda ○ Worksession Time Allotted: 0

Agenda Date: 12/18/2018

Revised April 2015

IOA Re, Inc.
Instructions for Completing this Disclosure Form

HIPAA Privacy permits the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Plan Sponsor as part of "health care operations". IOA and the Company shall use the information provided solely for the purpose of evaluating the acceptability of this risk and shall not disclose any PHI collected except in performing this risk evaluation.

IOA and the Company will rely upon the information provided in this Disclosure Form, which will become part of the application for stop loss coverage. The purpose of this Form is to allow IOA, on behalf of the Company, to take underwriting action on all known individuals in the categories listed below. It is the Plan Sponsor's responsibility, either directly or through their designated representative, to accurately report all claims known as of the date of this Disclosure by making a thorough review of all applicable records. Such records shall include historical claim reports, disability records, payroll records, current information from administrators, insurers, utilization management companies, managed care companies and any Agent/Broker of the Plan Sponsor. In exchange, the Company will accept the liability for any truly unknown claimants. This Disclosure Form must be completed and signed by the appropriate parties no earlier than thirty (30) days prior for new business (or earlier than thirty (30) days if prior approval is authorized by the IOA underwriter) and no later than ten (10) days after, the proposed Effective Date of stop loss coverage and received by IOA within five (5) days (non-business) of completion.

Upon receipt of this completed Disclosure, IOA will assess all data, new and previously reported, and will inform the producer in writing within seven (7) days (non-business) of any changes to the rates, factors or terms of coverage. IOA, on behalf of the Company, reserves the right to rescind the proposal in its entirety based upon a review of all information submitted during the proposal process.

When completing this Form, remember that Plan Participants may include those on short or long-term disability, COBRA, FMLA, leave of absence, extension of benefits, sick time, vacation time or retirees covered under the plan and for whom coverage is requested in the quote. All of the Plan Participants for which the above situations apply, should be identified accordingly, e.g., John Smith, COBRA, effective xx/xx/xx. List on this Disclosure Form all Plan Participants who are known to meet any of the following criteria:

1. Currently confined to a Medical Facility, or who have been pre-certified for same within the last 90 days.
2. Have received medical services during the past twelve (12) months, the cost of which exceeds 50% of the lowest Specific Deductible/Retention applied for, and for which the bills have been received by the Claims Administrator and entered into their claims system.
3. Have been identified as a candidate for Case Management and/or as having the potential to exceed 50% of the lowest Specific Deductible/Retention applied for during the policy period.
4. Have been diagnosed within the past 12 months with a condition represented by any of the ICD-9 or ICD-10 codes listed on page 3 of this Form.
5. Have had claims denied during the past twelve (12) months that either 1) were for expenses that exceeded 50% of the lowest Specific Deductible/Retention applied for, 2) have been, or have the potential to be, submitted to an Independent Review Organization as required under PPACA's external review process, or 3) were for experimental or investigational services.
6. Have reached their lifetime maximum under the Plan, but could now be reinstated due to an increase in Plan limits.

11.4.15

If the Plan Sponsor fails to disclose any Plan Participant known to fall into one of the above six categories, either intentionally or because a thorough review of all records was not conducted, the Company will have no liability for claims on the Plan Participant who was not disclosed.

Claimant Identifier	DOB	Sex	Diagnosis	Prognosis	Most Recent DOS	$ Expenses Incurred Last 12 Months
See attached reports						

The Plan Sponsor named below represents that the above list accurately discloses all potentially-catastrophic claimants in accordance with the instructions contained in this three-page Disclosure Form and that it is the result of a diligent search in accordance with those instructions. ATTACHED: 50%, Open Items, Trigger thru 10/31/18, Pre Cert 1/1/18-11/5/18 and Large Claim Overview thru 11/5/18

Plan Sponsor:	Claims Administrator: CORESOURCE	Agent/Broker: Frank Stichter
Signature:	Signature: Carrie Taravella	Signature: FMStichter
Name:	Name: Carrie Taravella	Name: Frank Stichter
Title:	Title: Group Underwriter	Title: President
Date:	Date: 11/5/18	Date: 12/10/18

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ICD-9 Codes	ICD-10 Codes	Diagnosis
038-080	A40-A49.9; A70-A75; A80-B34	Infectious Diseases
140-239.9	C00-D48	Malignancies, Neoplasms, Leukemia, Lymphoma
250-250.9	E10-E14	Diabetes
270-279.9	D84; D89; E65-E68; E70-E89	Other Metabolic & Immunity Disorders
280-288.9	D50-D89	Diseases of Blood & Blood Forming Organs
330-337.9	E75; G11-G12; G20-G32; G90-G91; G95	Hereditary & Degenerative Disease of Central Nervous System
340-349.9	G35-G43; G47.4; G60; G80-G99	Other Disorders of Central Nervous System
402-438.9	I10-I69	Heart and Vascular Diseases
440-442.9/444-444.9	I70-I72; I74	Atherosclerosis, Aortic & Other Aneurysms
501-516.9	J61-70; J85-89	Pulmonary Disease
555-579.9	K50-K93	Liver & Intestinal Disorders
584-588.9	N17-N19; N25-N27	Renal Disorders

ICD-9 Codes	ICD-10 Codes	Diagnosis
628-628.9	N97	Infertility
710-710.9	M33-M35	Autoimmune Disorders
715-739	M15-M25; M35.7; M40-M54; M60-M63; M65-M68; M70-M72; M75-M76; M79-M99	Diseases of Musculoskeletal System & Connective Tissue
740-779.9	Q00-Q99; P00-P96	Prematurity & Congenital Disorders
800-806.9/851-854.1	S02; S06; S12-S14; S22; S24; S32; S34;	Intracranial & Spinal Cord Injuries
860-869.1	S20-S39	Other Traumatic & Internal Injuries
885-887.7/895-897.7	S08; S48; S58; S68; S78; S88; S98; T05; T09.6	Traumatic Amputations
941-949.5	T20-T32	Burns
952-957.9	S14; S24; S34; S44; S54; S64; S74; S84; S94	Spinal Cord & Nerve Injuries
996-997.9	I97; N99; T81-T87	Complications of Procedures
V23-V23.9	O09	Supervision of High Risk Pregnancies
V42-V59.9	R68; Z41-Z44; Z46; Z48; Z49; Z51-Z52; Z87; Z93-Z99	Transplant Status & Other Conditions Influencing Health Status

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