STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Preferred Provider Network (PPN)
License Instructions and Application (Initial)

Connecticut General Statutes § 38a-479aa requires all Preferred Provider Networks (PPNs) offering services in the State of Connecticut to be licensed by the Connecticut Insurance Department ("Department"). If you have any questions about your responsibility to be licensed, please refer to Conn. Gen. Stat. §38a-479aa and any applicable amendments. The Connecticut General Statutes can be accessed at http://www.cga.ct.gov/asp/menu/Statutes.asp

Instructions:

- **To assure that a PPN license be issued prior to offering services in Connecticut, the Department recommends that applications be submitted two months in advance. Connecticut law requires that license renewal applications be submitted by March 1st of each year. If your network meets the guidelines for licensure, an invoice for the license fee of $2750 will be forwarded to you. This invoice must be paid prior to the license effective date.**

- **The application must be filled out, completed, and signed by the CEO of the PPN entity certifying that all information provided is true and accurate.**

- **Submit your application and attachments to:**

State of Connecticut Insurance Department
Fraud, Licensee Investigations and Compliance Unit
P O Box 816
Hartford, CT 06142-0816

Hand delivery or Overnight delivery address ONLY:

153 Market Street, 7th floor
Hartford, CT 06103

DO NOT SUBMIT THE LICENSE FEE WITH THIS APPLICATION. You will be billed.

Once licensed, the law requires the PPN to submit quarterly and annual financial reports. To comply, please refer to Conn. Gen. Stat. §38a-479aa and forward those reports to the Department at the address above.

Preferred Provider Network (PPN)
License Application (Initial)

Name of PPN: _____

PPN Tax Identification Number (TIN/FEIN) _____

PPN Business Address: _____

_____

_____

PPN Mailing Address (if different): _____

_____

_____

PPN Phone Number: _____

Contact Information (used by the Department for all future correspondence):

Name: _____ **Title:** _____

Mailing Address: _____

_____

_____

Phone number: _____ **FAX number:** _____

E-mail address:

_____

Does your PPN provide services for workers' compensation only? [ ] NO [ ] YES

If YES, you are *not required* to complete this application. Please return this page and the signed CEO Certification (page 7) to the Insurance Department at the address on the Instructions page.

Is your organization registered with the Department as a Pharmacy Benefit Manager ("PBM") pursuant to Conn. Gen. Stat. Secs. 38a-479aaa et seq.? [ ] NO [ ] YES

If YES, you are *not required* to complete this application. Please return this page and the signed CEO Certification (page 7) to the Insurance Department at the address on the Instructions page.

Name and description of controlling company or organization: _____

_____

_____

Controlling company's or organization's contact name: _____

_____

Business Address: _____

_____

Mailing Address (if different): _____

_____

Name of related or predecessor controlling company or organization:

_____

Address: _____

_____

_____

Explain current relationship with related or predecessor controlling company:

_____

_____

_____

_____

Has any suspension, sanction or disciplinary action been taken against the PPN in Connecticut or any other state?

[ ] No

[ ] Yes If yes, explain: _____

_____

_____

Has any suspension, sanction or disciplinary action been taken against the controlling company or organization in Connecticut or any other state?

[ ] No

[ ] Yes If yes, explain: _____

_____

_____

Describe the PPN's service area: _____

_____

_____

How many total enrollees are served by the PPN: Nationwide: _____ in CT: _____

List participating hospitals in Connecticut:

_____

_____

_____

_____

Name and address of the person to whom applications may be made for participation:

_____

_____

_____

List all entities on whose behalf the PPN has contracts or agreements to provide health care services to Connecticut enrollees (e.g. Managed Care Organizations):

_____

_____

_____

_____

Indicate the type(s) of reimbursement arrangements that the PPN enters into <u>with entities on whose behalf the PPN has contracts or agreements to provide health care services</u> to Connecticut enrollees (e.g. Managed Care Organizations/MCO):

[ ] Capitation
[ ] Fee for Service
[ ] Other -- Please explain: _____

_____

Indicate types of services that the PPN provides for <u>entities on whose behalf the PPN has contracts or agreements to provide health care services</u> to Connecticut enrollees (e.g. Managed Care Organizations):

[ ] Medical services
[ ] Utilization Review – if checked, your CT License Number: _____
[ ] Claims administration
[ ] Dental Services
[ ] Other – List types of services

_____

_____

Indicate type(s) of reimbursement arrangements that the PPN enters into <u>with participating providers:</u>

[ ] Capitation
[ ] Fee for Service
[ ] Other -- Please explain: _____

_____

_____

_____

<u>PLEASE SUBMIT THE FOLLOWING AS ATTACHMENTS:</u>

[ ] Certificates from the Secretary of State affirming that the PPN and its controlling company or organization (if applicable) is in good standing in Connecticut. In addition, for out of state PPNs, controlling companies or organizations, certificates that such PPN, controlling company or organization are in good standing in their states of organization.

[ ] A list of the names, official positions, and occupations of members of the PPN's board of directors or other policy-making body and those executive officers who are responsible for the PPN's activities with respect to the health care services network.

[ ] A list of the names, official positions and occupations of members of the controlling company's or organization's board of directors and those executive officers who are responsible for the controlling company's or organization's activities with regard to the health care services network.

[ ] A list of the PPN's principal owners.

[ ] A list of the controlling company's or organization's principal owners.

[ ] A list of participating primary care physicians, the specialty physicians and other providers, including the number and percentage of each group's capacity to accept new patients.

[ ] A description of the general criteria for selection and/or termination of providers.

[ ] A list of subcontractors of the PPN that provide health care services to Connecticut enrollees and assume financial risk from the PPN; and to what extent each assumes risk. This does not include individual participating providers.

[ ] A table of all major categories of health care services provided by the PPN.

[ ] contingency plan describing how contracted health care services will be provided in the event of insolvency.

[ ] * **Proof that the PPN meets minimum security standards as defined in Conn. Gen. Stat. Sec. 38a-479aa(i) as amended by Public Act 07-191.**
Proof can be in the form of a letter of credit, bond, surety, reinsurance, or reserve exclusively held for "…use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment…". [Sample bond language is attached.]
Please note that the beneficiary of the financial security instrument are the members/providers. *Under no circumstance should the State of Connecticut or the State of Connecticut Insurance Department be named as the beneficiary*.

[ ] The most recently concluded fiscal year-end financial statements for the PPN
AND

[ ] The most recently concluded fiscal year-end financial statements for the controlling company or organization.

- **If the last fiscal year-end financial statements (for the PPN and the controlling company or organization) ended more than 90 days prior to your license application date, you must also include an internally prepared financial statement (using GAAP) for the quarter ending within the 90 days prior to that date. The next fiscal year-end financials must be sent to the Department within 120 days of your fiscal year-end.**

- **Financial statements must be "Reviewed" or "Audited" by an independent certified public accountant (CPA) under U.S. generally accepted accounting principles (GAAP).**

[ ] Provide the names and addresses of the public accounting firm and internal accountant(s) which prepared or assisted in preparation of such financial statements.

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* Financial Security Requirement:

Pursuant to the relevant part of Conn. Gen. Stat. Sec.38a-479aa as amended by Public Act 07-191, the financial security amount shall be at least an amount equal to the greater of (1) an amount sufficient to make payments to participating providers for two months determined on the basis of the two months within the past year with the greatest amounts owed by the preferred provider network to participating providers, (2) the actual outstanding amount owed by the preferred provider network to participating providers, or (3) another amount determined by the commissioner.

Enter below the months, the year, and the amounts in which the network's total payments to provider/members were the highest within the past year. In addition, please provide the amount currently owed to provider/members. As stated above, the instrument used to meet the financial security requirement will be based on the greater of two highest months or the current outstanding amount due.

Highest months of payments to providers within the past year:

Sum of two highest months:
(Connecticut business Only)

$_____

$_____ Year _____ Month _____
$_____ Year _____ Month _____

Actual outstanding amount due providers $ _____ Date ____/____/_____

Each contract between this preferred provider network and its participating providers contains a provision that if the preferred provider network fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the participating provider for any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred provider network.

[ ] YES [ ] NO

CEO CERTIFICATION OF ACCURACY

I, _____, _____of
(Printed Name) (Title)

_____, hereby certify that
(Preferred Provider Network)

I have reviewed the information submitted in accordance with Connecticut General Statutes Section §38a-479aa as revised by Public Act 03-169, and that the information is true and accurate. I understand that any material modification of any matter or document furnished pursuant to this application must be filed with the Insurance Commissioner within thirty (30) days of such modification, including supporting documents to explain the modification.

_____ _____
(Signature of CEO) **(Date)**

SAMPLE BOND FORM

STATE OF CONNECTICUT
PREFERRED PROVIDER NETWORK (PPN) BOND

KNOW ALL MEN BY THESE PRESENTS

That we, _____ of the
(Name of PPN)

County of _____ State of _____

as Principal, and _____, a surety

company having its principal place of business in _____

County of _____State of _____duly authorized to

do business in the State of Connecticut, as Surety, are held and firmly bound unto the

member/providers of the Preferred Provider Network (PPN) named, as Obligees, in the sum of

_____ dollars ($_____) for the payment of which sum the said Principal and Surety do jointly and severally bind themselves, their heirs, executors, administrators, successors, and assigns, and each and every one of them firmly by these presents.

THE CONDITION OF THIS OBLIGATION IS SUCH THAT WHEREAS, the Principal has made application to the Insurance Commissioner of the State of Connecticut for a license to engage in the business of a Preferred Provider Network (PPN) in accordance with the provisions of Section 38a-479aa of the Connecticut General Statutes and any applicable amendments and any regulation promulgated thereunder. This surety is intended for the sole purpose of meeting the obligation as described in Section 38a-479aa(i) "…for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment except that any remaining security may be used for the purpose of reimbursing managed care organizations in accordance with subsection (b) of section 2 of this act."

PROVIDED HOWEVER, that all obligations upon this bond shall cease upon the voluntary or involuntary termination of such license except as to such liability as shall have been accrued thereto.

IN WITNESS WHEREOF, the said Principal and Surety have signed and sealed this instrument this _____ day of _____ 20_____.

WITNESS

_____ By _____L.S.

(As to Principal) _____L.S.

_____ _____L.S. Corporate Seal

(As to Surety) By _____L.S.

_____L.S.