



**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.

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 \$2,750 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: Peter.Nakano@ct.gov

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.



**STATE OF CONNECTICUT
INSURANCE DEPARTMENT**

**Preferred Provider Network (PPN)
License Instructions and 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 (pages 8) 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 (pages 8) 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 entity in Connecticut or any other state over the past ten years? *If so, please provide us with a complete list of all actions taken, on an annual basis. This includes actions taken against the entity not just related to PPN activity but also related to any other activity provided by the licensed entity, including but not limited to, TPA or UR activity.*

No

Yes

If answered yes, explain:

Has any suspension, sanction or disciplinary action been taken against the controlling company or organization in Connecticut or any other state over the past ten years? *If so, please provide us with a complete list of all actions taken, on an annual basis. This includes actions taken against the entity not just related to PPN activity but also related to any other activity provided by the licensed entity, including but not limited to, TPA or UR activity.*

No

Yes

If answered yes, explain:

Describe the PPN's service area:

How many total enrollees are served by the PPN?

Nationwide:

Connecticut:

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 pharmacy benefit services to Connecticut enrollees (e.g. Managed Care Organizations):

Indicate the type(s) of reimbursement arrangements that the PPN enters into with entities on whose behalf the PPN has contracts or agreements to provide health care services 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 entities on whose behalf the PPN has contracts or agreements to provide health care services 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

If the PPN includes providers of vision services, the PPN certifies compliance with §20-138b of the Connecticut General Statutes.

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

Capitation

Fee for Service

Other -- Please explain:

PLEASE SUBMIT THE FOLLOWING AS ATTACHMENTS:

A Certificate 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, a certificate that such PPN, controlling company or organization is in good standing in its state 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 beneficiaries 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) preparing or assisting in the preparation of such financial statements.

The PPN hereby certifies, from January 1, 2012 on, it shall maintain a network of participating providers in Connecticut that is consistent with the National Committee for Quality Assurance's network adequacy requirements or URAC's provider network access and availability standards.

*** 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:

\$ _____ Year _____ Month _____

\$ _____ Year _____ Month _____

Sum of two highest months (Connecticut business only):

\$ _____

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, 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 38a-479bb."

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

(As to Principal)

By _____ L.S.

_____ L.S.

(As to Surety)

_____ L.S. Corporate Seal

By _____ L.S.

_____ L.S.