STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Preferred Provider Network (PPN)
License Application

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.

Such license shall be issued or renewed annually on July first and applications shall be submitted by May first of each year in order to qualify for the license issue or renewal date.

- **The application must be completed, including all attachments, and signed by the CEO of the PPN entity certifying that all information provided is true and accurate.**
- **After applying for licensing via NIPR.com, submit this application and all required attachments to the Department via the Attachment Warehouse. Alternatively, documents may be submitted via e-mail (tpa.cid@ct.gov) or secure fax (860.297.3872).**
- **QUESTIONS: email CID.TPA@CT.GOV**
- **NOTE: PLEASE DO NOT SEND ANY PAPER DOCUMENTS VIA REGULAR MAIL, UPS, FED EX, ETC.- INCLUDING BONDS. ALL DOCUMENTS MAY BE SUBMITTED IN THE FASHION OUTLINED ABOVE.**

Name of PPN: _____

PPN Tax Identification Number (TIN/FEIN): _____

PPN Business Address: _____

_____

PPN Mailing Address (if different): _____

_____

PPN Phone Number: _____

Contact Information

Name: _____

Title: _____

Mailing Address: _____

_____

Phone Number: _____

Fax Number: _____

E-Mail Address: _____

Business Web Site Address: _____

Business E-Mail Address: _____

Mailing 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 6) 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 6) to the Insurance Department at the address on the Instructions page.

Name & Description of Controlling Company or Organization:

Contact Name: _____

Business Address: _____

_____

Mailing Address (if different): _____

_____

Name of Related/Predecessor Controlling Company of Organization:

_____

Contact Name: _____

Business Address: _____

_____

Mailing Address (if different): _____

_____

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 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 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:

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):

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

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

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

- ☐ Capitation
- ☐ Fee for Service
- ☐ Other -- Please explain:

For PPN license applicants, as per C.G.S. 38a-479aa(b), please upload the following to the NAIC "Attachment Warehouse" once you've submitted an application:

- PPN form APP2024 required in addition to the NIPR e-application.
- Certificate from the CT Secretary of State regarding the PPN's good standing to do business in Connecticut;
- A copy of the PPN's and controlling company's financial statement completed in accordance with sections 38a-53 (annual statement) and 38a-54, (CPA Audited Report), as applicable for the end of its most recently concluded fiscal year, along with the name and address of any public accounting firm or internal accountant which prepared the financial statement;
- A list of names, official positions and occupations of members of the PPN's and the controlling company's board of directors and of those executive officers who are responsible for the PPN's and controlling company's activities with respect to the health care services network;
- A list of the PPN's and the controlling company's principal owners;
- In the case of out-of-state PPN, a certificate that such PPN is in good standing in its state of organization;
- In the case of a Connecticut or out-of-state PPN, a report of the details of any suspension, sanction or other disciplinary action relating to such PPN;
- A general description of the PPN and participation in the PPN, including:
    - The primary care physicians, the specialty physicians, any other contracting providers and the number and percentage of each group's capacity to accept new patients;
    - A table listing all major categories of health care services provided by the PPN;
    - A list of subcontractors of the PPN, not including individual participating providers, that assume financial risk from the PPN and to what extent each subcontractor assumes financial risk;
    - A contingency plan describing how contracted health care services will be provided in the event of insolvency; and

The following are also worth noting, and it is expected that documentation will be uploaded to the NAIC Attachment Warehouse that shows compliance with the provisions below:

- Each PPN shall maintain a minimum net worth of either (1) the greater of (A) $500,000, or (B) an amount equal to 8% of its annual expenditures as reported on its most recent financial statement completed and filed with the CID, or (2) another amount determined by the CID.
- Each PPN shall maintain or arrange a letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the CID 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. Such outstanding amount shall be at least an amount equal to the greater of (1) an amount sufficient to make payments to participating providers for four months determined on the basis of the two months within the past year with the greatest amounts owed by the PPN to participating providers, (2) the actual outstanding amount owed by the PPN to participating providers, or (3) another amount determined by the CID. Such amount may be credited against the PPN's minimum net worth requirements set forth above.

Financial Security Requirement:

Pursuant to the relevant part of Conn. Gen. Stat. Sec.38a-479aa as amended by Public Act 17-198, 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 four months determined on the basis of the four 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 four highest months or the current outstanding amount due.

Highest months of payments to providers within the past year:

Sum of four highest months:
(Connecticut business only)

$_____

$_____ Year _____ Month _____

$_____ Year _____ Month _____

$_____ 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, 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

_____	By _____L.S.	
(As to Principal)	_____L.S.	
_____	_____L.S.	Corporate Seal
(As to Surety)	By _____L.S.	
	_____L.S.	