

**CHECKLIST FOR THE INITIAL APPROVAL OF AN  
INSURED PREFERRED PROVIDER PLAN**

**Pursuant to the Requirements of M.G.L. c. 176I and 211 CMR 51.00**

**NOTE TO CARRIERS COMPLETING THIS CHECKLIST:**

*Pursuant to Bulletin No. 2001-05, please include a completed checklist when submitting an application for an insured preferred provider plan.*

*When completing this checklist, please indicate for each requirement the page number(s), and/or section(s), where the required information may be found in the submitted materials.*

- *For items requiring company confirmation, please place a checkmark next to the requirement acknowledging confirmation.*
- *If a requirement is not applicable (N/A), please place "N/A" next to the requirement and explain, either within the checklist or on a separate sheet, the legal basis under which the requirement does not apply to the filed materials.*
- *For carriers filing stand-alone dental or vision insured preferred provider plans, please review Chapter 162 of the Acts of 2005 and be sure to complete the appropriate initial checklist(s).*

**Carrier Name & NAIC #:** \_\_\_\_\_

**Contact Name & Title:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone & Fax:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Product Name & Form #:** \_\_\_\_\_  
(Attach separate sheet as necessary)

**\$100 filing fee 801 CMR 4.02(27):** \_\_\_\_\_

**FILINGS THAT DO NOT INCLUDE APPLICABLE COMPLETED CHECKLISTS WILL BE RETURNED. PLEASE REVIEW THE FOLLOWING ADDITIONAL CHECKLISTS TO ASSURE THAT YOUR SUBMISSION IS COMPLETE:**

- GROUP STAND-ALONE VISION AND DENTAL PRODUCTS;
- INDIVIDUAL STAND-ALONE VISION AND DENTAL PRODUCTS MANAGED CARE ;
- REVIEW OF HEALTH MAINTENANCE ORGANIZATIONS LICENSED UNDER M.G.L. c. 176G ;
- REVIEW OF INSURANCE CARRIERS LICENSED UNDER M.G.L. c. 175, c. 176A, and c. 176B; and
- REQUIREMENTS FOR PROVIDER CONTRACTS

**Carrier Certification:**

I \_\_\_\_\_ a duly authorized representative of \_\_\_\_\_  
certify that it is my good faith belief based on the review of this checklist and submitted materials that the submitted materials comply with applicable Massachusetts law.

The following organizations may currently operate insured preferred provider plans according to the provisions of M.G.L. c. 176I and 211 CMR 51.00:

- Companies licensed to write health insurance pursuant to M.G.L. c. 175;
- Fraternal Benefit Societies licensed to write health insurance pursuant to M.G.L. c. 176;
- Non-Profit Hospital Service Corporations organized under M.G.L. c. 176A;
- Medical Service Corporations organized under M.G.L. c. 176B;
- Dental Service Corporations organized under M.G.L. c. 176E;
- Optometric Service Corporations organized under M.G.L. c. 176F; and
- Health Maintenance Organizations licensed to write health insurance pursuant to M.G.L. 176G.

### **211 CMR 51.03: APPLICABILITY**

No Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement may be offered without meeting the filing and other requirements set forth in M.G.L. c. 152 and 176I, and until it is approved by the Commissioner in accordance with the provisions of 211 CMR 51.00.

### **DEFINITIONS FROM M.G.L. C. 176I §1 AND 211 CMR 51.02:**

Pg# \_\_\_\_\_ **Emergency Care**, "services provided in or by a hospital emergency facility to a Covered Person after the development of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the Covered Person's or another person's health in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B)."

Pg# \_\_\_\_\_ **Emergency Medical Condition**, "a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the covered person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B)."

Pg# \_\_\_\_\_ **Preferred Provider**, "a health care provider, group of health care providers or a network of providers who have contracted with an organization to provide specified covered services in the context of a preferred provider arrangement."

Pg# \_\_\_\_\_ **Preferred Provider Arrangement**, "a contract between or on behalf of an Organization and a Preferred Provider that complies with all the applicable requirements of M.G.L. c. 152 c. § 30, c. 176I, and 211 CMR 51.00."

Pg# \_\_\_\_\_ **Preferred Provider Health Plan**, "an insured Health Benefit Plan offered by an Organization that provides incentives for Covered Persons to receive Health Care Services from Preferred Providers in the context of a Preferred Provider Arrangement. A Workers' Compensation Preferred Provider Arrangement shall not be considered a Preferred Provider Health Plan under this regulation."

Pg# \_\_\_\_\_ **Usual and Customary Charge**, "the fees identified by a carrier as the usual fees charged by similar Health Care Providers in the same geographic area."

Pg# \_\_\_\_\_ **Workers' Compensation Preferred Provider Arrangement**, "a Preferred Provider Arrangement between an insurer, self-insurer, or self-insurance group, as defined in M.G.L. c. 152, §§ 1, 25A, or 25E, respectively, and a Preferred Provider to provide all or a specified portion of Health Care Services resulting from workers' compensation claims by Covered Persons against such insurer, self-insurer or self-insurance group under the provisions of M.G.L. c. 152, §30."

**APPROVAL OF PREFERRED PROVIDER HEALTH PLANS AND WORKERS' COMPENSATION PREFERRED PROVIDER ARRANGEMENTS - 211 CMR 51.04(1):**

According to 211 CMR 51.04(1), "[n]o Preferred Provider Health Plan or Workers' Compensation Preferred Provider Arrangement may be approved without first submitting an application in a format specified by the Commissioner that includes at least the following: **[Identify the section(s) of the filing that address each specific requirement]**

Pg# \_\_\_\_\_ (a) A description of the geographical area in which the Preferred Providers are located, including a map of the distribution of the Preferred Providers;

Pg# \_\_\_\_\_ (b) A description of the manner in which covered Health Care Services and other benefits may be obtained by persons using the Preferred Providers, including a description of the grievance system available to Covered Persons, including procedures for the registration and resolution of grievance and any requirement within a Preferred Provider Health Plan that Covered Persons select a gatekeeper provider;

(c) Provider contracts and contracting criteria, including:

Pg# \_\_\_\_\_ 1. A narrative description of the financial arrangements between the Organization and contracting Health Care Providers, identifying any assumption by the providers of financial risk through arrangements such as per diems, diagnosis-related groups, capitation or percentage withholding of fees;

Pg# \_\_\_\_\_ 2. A copy of every standard form contract with preferred physicians and other Health Care Providers, including providers joining the Preferred Provider Arrangement via leasing, subcontracting, or other arrangements whereby the Organization does not contract directly with the providers (do not include rates of payment to providers);

Pg# \_\_\_\_\_ 3. A copy of every standard form contract for all Preferred Provider Arrangements including administrative service agreements;

Pg# \_\_\_\_\_ 4. A copy of the terms and conditions that must be met or agreed to by health care providers desiring to enter into the Preferred Provider Arrangement(s) (do not include rates of payments to health care providers); and

Pg# \_\_\_\_\_ 5. A description of the criteria and method used to select Preferred Providers.

Pg# \_\_\_\_\_ (d) A detailed description of the utilization review program;

(e) A detailed description of the quality assurance program;

(f) Preferred provider directory, which shall include:

Pg# \_\_\_\_\_ 1. A copy of the Preferred Provider directory distributed to Covered Persons; and

Pg# \_\_\_\_\_ 2. A description of the process for distributing the directory to Covered Persons.

Pg# \_\_\_\_\_ (g) Filing fee for initial applications as determined by the Executive Office for Administration and Finance as set forth in 801 CMR 4.02.

\_\_\_\_\_ (h) Evidence of compliance with M.G.L. c. 176O and 211 CMR 52.00.  
**(Refer to appropriate Managed Care Checklists if applicable)**

**APPLICATION MATERIALS TO BE SUBMITTED BY PREFERRED PROVIDER HEALTH PLANS ONLY – 211 CMR 51.04(2):**

\_\_\_\_\_ (a) A narrative description of the Preferred Provider Health Plan to be offered, including a description of whether the plan will be available to small employers eligible under M.G.L. c. 176J;

\_\_\_\_\_ (b) Benefits and Services.

- \_\_\_\_\_ 1. A copy of every standard form contract between the Organization and Health Care Purchasers for the Preferred Provider Health Plan;
- \_\_\_\_\_ 2. A copy of every standard form Evidence of Coverage for every Preferred Provider Health Plan;
- \_\_\_\_\_ 3. A description of any provision for Covered Services to be payable at the preferred level until an adequate network has been established for a particular service or provider type;
- \_\_\_\_\_ 4. A description of all mandated benefits and provider types available at the preferred and non-preferred level;
- \_\_\_\_\_ 5. A description of the incentives for Covered Persons to use the services of Preferred Providers;
- \_\_\_\_\_ 6. A description of any provisions that allow Covered Persons to obtain covered Health Care Services from a non-preferred provider at the Benefit Level for the same covered health care service rendered by a Preferred Provider; and
- \_\_\_\_\_ 7. A description of any provisions within the Preferred Provider Health Plan for holding Covered Persons financially harmless for payment denials by, or on behalf of, the Organization for improper utilization of covered Health Care Services caused by Preferred Providers.

\_\_\_\_\_ (c) Financial Resources.

- \_\_\_\_\_ 1. A description of the arrangements to be used by the Organization to protect covered members from financial liability in the event of financial impairment or insolvency of any Preferred Provider that assumes financial risk; and
- \_\_\_\_\_ 2. Evidence of a surety bond, reinsurance, or other financial resources adequate to guarantee that the Organization's obligations to Covered Persons will be performed.

\_\_\_\_\_ (d) Rates.

- \_\_\_\_\_ 1. A description of the Organization's methodology for establishing premium rates;
- \_\_\_\_\_ 2. A copy of the average rates for community-rated accounts, non-credible accounts, or their equivalent in the rating structure used by the Organization.

**APPLICATION MATERIALS TO BE SUBMITTED BY WORKERS' COMPENSATION  
PREFERRED PROVIDER ARRANGEMENTS ONLY - 211 CMR 51.04(3):**

- \_\_\_\_\_ (a) a list of each type of Health Care Provider and medical specialty involved in the proposed Preferred Provider Arrangement and the number of individuals representing each such type of practice and specialty;
- \_\_\_\_\_ (b) a list of each Organization with which the Health Care Provider has previously entered into a Preferred Provider Arrangement, and of each Organization with which the applicant has a pending application for a Preferred Provider Arrangement;
- \_\_\_\_\_ (c) copy of the letter from the Department of Industrial Accidents approving the applicant's arrangement's utilization review and quality assessment program;
- \_\_\_\_\_ (d) a written agreement to abide by, and a description of the procedure to incorporate, any treatment guidelines or protocols promulgated by the Department of Industrial Accidents pursuant to M.G.L. c. 152, §§ 13 and 30;
- \_\_\_\_\_ (e) a procedure to guarantee cooperation by Preferred Providers with the utilization review and quality assurance program which allow for the removal of noncomplying providers from the arrangement;
- \_\_\_\_\_ (f) a procedure for referring Covered Persons to Health Care Services outside the Preferred Provider Plan when indicated by diagnosis, excessive travel time, and presence of any pre-existing medical condition which would make treatment substantially more difficult;
- \_\_\_\_\_ (g) a position statement indicating how the applicant intends to facilitate the return to work of injured employees in a rapid, cost-effective and safe manner;
- \_\_\_\_\_ (h) a copy from the Organization, if a self-insurer or self-insurance group, of the Organization's current authorization to act as a self-insurer or self-insurance group;
- \_\_\_\_\_ (i) a copy of the information distributed annually to employees which shall include clear reference to the following:
  - \_\_\_\_\_ 1. that an employee is required to obtain treatment within the Preferred Provider Health Plan for the first scheduled appointment or incur the responsibility to pay for such appointment, provided that such person may seek Health Care Services for a compensable injury outside the Preferred Provider Arrangement for the initial scheduled appointment without incurring any financial obligation when such appointment is with a licensed or registered Health Care Provider of a type or specialty not represented within the Preferred Provider Arrangement;
  - \_\_\_\_\_ 2. that an employee may seek Health Care Services for a compensable injury outside the Preferred Provider Arrangement after the initial scheduled appointment without incurring any obligation to pay for such subsequent visit(s) according to the provisions of M.G.L. c. 152, § 30;
  - \_\_\_\_\_ 3. that no copayments or deductibles may be charged employees with compensable injuries who utilize the Preferred Provider Arrangement or any other Health Care Provider under the provisions of M.G.L. c. 152 §§ 13 and 30;
  - \_\_\_\_\_ 4. that each Covered Person has the right to file complaints regarding the provision of Health Care Services with the Health Care Services Board within the Division

of Industrial Accidents;

- \_\_\_\_\_ 5. the names of all current Preferred Providers within the geographic region of such Covered Person or of all current Preferred Providers arranged geographically, to be distributed to Covered Persons upon initial approval of the Preferred Provider Arrangement; which shall also be posted in a convenient and prominent place in workplaces where covered workers are employed, and be re-distributed to Covered Persons after any alleged workplace injury or upon request; and
- \_\_\_\_\_ 6. a clear description of all other rights of Covered Persons and the obligations of applicants as well as information regarding any restrictions or requirements imposed upon Covered Persons by the Preferred Provider Arrangement's utilization review or quality assurance programs.

**EVIDENCE OF COVERAGE FOR INSURED PREFERRED PROVIDER HEALTH PLAN COVERAGE [211 CMR 51.05]:**

\_\_\_\_\_ According to 211 CMR 51.05(1), "[t]he evidence of coverage must meet the requirements of M.G.L. c. 176I, M.G.L. c. 176O, 211 CMR 51.00, 211 CMR 52.00."

**(Refer to appropriate Managed Care Checklist)**

According to 211 CMR 51.05(2) "[t]he Evidence of Coverage must also include the following in clear and understandable language:

- \_\_\_\_\_ (a) a complete description of the benefit differential between services offered by preferred and non-preferred providers;
- \_\_\_\_\_ (b) Provisions that if a Covered Person receives Emergency Care and cannot reasonably reach a Preferred Provider, payment for such care will be made at the same level and in the same manner as if the Covered Person had been treated by a Preferred Provider;
- \_\_\_\_\_ (c) Benefit levels for covered Health Care Services rendered by non-preferred providers must be at least 80% of the Benefit Levels for the same covered Health Care Services rendered by Preferred Providers.
  - \_\_\_\_\_ 1. Payments made to non-preferred providers shall be a percentage of the provider's fee, up to a Usual and Customary Charge, and not a percentage of the amount paid to Preferred Providers.
  - \_\_\_\_\_ 2. The 80% requirement shall be met if the coinsurance percentage for Health Care Services rendered by a non-preferred provider is no more than 20 percentage points greater than the highest coinsurance percentage for the same covered Health Care Services rendered by a Preferred Provider, excluding reasonable deductibles and copayments.
- \_\_\_\_\_ (d) A description of all benefits required to be provided by law in accordance with all of the provisions of the Organization's enabling or licensing statutes."

**Please indicate for each evidence of coverage the page number(s), and/or section(s), where the required information may be found.**

**SMALL GROUP PRODUCTS** [Plans available to both eligible individuals and eligible groups in Massachusetts effective July 1, 2007 – see M.G.L. c. 176J and regulation 211 CMR 66.00]

According to M.G.L. c. 176J, § 1, the term "Health benefit plan" is defined as “[a]ny individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; an individual or group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; an individual or group medical service plan issued by a nonprofit medical service corporation under chapter 176B; and an individual or group health maintenance contract issued by a health maintenance organization under chapter 176G.

The term "health benefit plan" shall not include accident only, credit only, limited scope vision or dental benefits if offered separately; hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed \$500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent; disability income insurance; coverage issued as a supplement to liability insurance; specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set; insurance arising out of a workers' compensation law or similar law; automobile medical payment insurance; insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance; long-term care if offered separately; coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy; or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans. A health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A shall not be considered a health plan for the purposes of this chapter and shall be governed by said chapter 15A. The commissioner may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.”

Please confirm whether the filed plan is intended to be offered to eligible individuals and eligible small groups with between one and fifty eligible employees.

YES \_\_\_ NO \_\_\_

**If NO, please provide the legal basis why the filed plan is not subject to the above-noted statute and regulation.**

**If YES, please review Massachusetts small group law M.G.L. c. 176J and regulation 211 CMR 66.00 including guaranteed issue and guaranteed renewal requirements. Please review that law and included those provisions as required.**

**REPORTING REQUIREMENTS [211 CMR 51.06]:**

According to 211 CMR 51.06(1), “[e]ach Organization with a Preferred Provider Health Plan or Workers’ Compensation Preferred Provider Arrangement shall file with the Commissioner any material changes or additions to the material previously submitted on or before their effective date, including amendments to an Evidence of Coverage and significant changes to the lists of Preferred Providers.”

**Please confirm that the carrier will comply with this requirement.**

According to 211 CMR 51.06(2), “[e]ach Organization with a Preferred Provider Health Plan or a Workers’ Compensation Preferred Provider Arrangement shall on April 30th of each year file with the Commissioner a report covering its prior fiscal year. The annual report shall include at least the following information in a format specified by the Commissioner:

- (a) A summary of the number of Covered Persons;
- (b) A summary of the utilization experience of Covered Persons; and
- (c) A current provider directory that lists Preferred Providers by specialty and geographic area.”

**Please confirm that the carrier will comply with this requirement.**

**Additional Reports**

According to 211 CMR 51.06(3), “[t]he Commissioner may require an Organization to submit additional reports other than those specifically required by M.G.L. c. 176I.”

**Please confirm that the carrier will comply with this requirement.**

Carrier is subject to an assessment by the Department of Revenue as outlined in M.G.L. 176I §11. Please identify the name, title, mailing address and telephone number of the company representative responsible for filing the annual report specified in 211 CMR 51.06(2).

Name & Title:

E-mail address:

Office Address:

Telephone:

Facsimile:

**Approval of Application**

According to 211 CMR 51.04(5), “[e]ach Preferred Provider Health Plan or Workers’ Compensation Preferred Provider Arrangement, approved under M.G.L. c. 176I and 211 CMR 51.00, may continue to be marketed unless such approval is subsequently revoked by the Commissioner. Following approval of any Workers’ Compensation Preferred Provider Arrangement, a copy of the approved application must then be forwarded to the Office of Health Policy at the Department of Industrial Accidents, 600 Washington Street, Boston, MA 02111.”

**Please confirm that the filer understands this requirement.**