RESET FORM

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:
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. Any section of this checklist that is not complete will be returned for completion.***

NOTE: A FILING THAT DOES NOT INCLUDE ALL APPLICABLE MATERIALS AND SUPPORTING DOCUMENTATION WILL BE RETURNED AND NOT REVIEWED.

Date: _____

Carrier Name & NAIC #: _____

Contact Name & Title: _____

Address: _____

Telephone & Fax: _____

Email Address: _____

Product Name & Form #: (Attach a separate sheet if necessary.) _____

NEW APPLICATION SUBMISSIONS

(Pursuant to M.G.L. c. 176I & 211 CMR 51.00)

CARRIERS SEEKING APPROVAL OF AN INTIAL APPLICATION MUST COMPLETE ALL PAGES OF THIS DOCUMENT.

MATRIAL CHANGE SUBMISSIONS

(Pursuant to M.G.L. c. 176I & c. 176O and regulations 211 CMR 51.00 & 211 CMR 52.00)

CARRIERS SUBMITTING A MATERIAL CHANGE SHOULD REVIEW ALL PAGES AND COMPLETE OLNY THOSE PAGES THAT ARE APPLICABLE TO ANY ADDITION(S) OR CHANGE(S) TO MATERIAL(S) PREVIOUSLY SUBMITTED.

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.

PLEASE REVIEW THE FOLLOWING ADDITIONAL CHECKLISTS, COMPLETE AND FORWARD AS APPLICAPLE TO YOUR SUBMISSION:

- CHECKLIST FOR INDIVIDUAL STAND-ALONE VISION AND DENTAL PRODUCTS Pursuant to the Requirements of M.G.L. c. 175, M.G.L. c. 175I, M.G.L. c. 176O, 211 CMR 42.00, and 211 CMR 52.00
- CHECKLIST FOR GROUP STAND-ALONE VISION AND DENTAL PRODUCTS Pursuant to the Requirements of M.G.L. c. 176O and 211 CMR 52.00 & Chapter 162 of the Acts of 2005

CARRIER ACKNOWLEGMENTS:

According to 211 CMR 51.05, "[t]he Evidence of Coverage, including all amendments and material changes, must be submitted to the Commissioner for approval. The Evidence of Coverage must meet the requirements of M.G.L. c. 176I, M.G.L. c. 176O, 211 CMR 51.00 and 52.00: *Managed Care Consumer Protections and Accreditation of Carriers*."

***Initials*_____**

According to 211 CMR 51.06(1), "[e]ach Organization with a Preferred Provider Health Plan…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."

***Initials*_____**

According to 211 CMR 52.02 the term "material change" is defined as "[a] modification to any of a Carrier's, including a Dental or Vision Carrier's, procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of:

- an Insured;
- a Carrier, including a Dental or Vision Carrier; and/or
- a health, Dental, or Vision Care Provider."

***Initials*_____**

According to 211 CMR 52.13(6) "[a] Carrier, including a Dental and Vision Carrier, shall provide to at least one adult Insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, notice of all Material Changes to the Evidence of Coverage. ."

***Initials*_____**

When submitting a material change to a previously filed application for approval of an insured preferred provider plan –

- complete only those sections of the checklist(s) specific to the submission and
- include red-line version(s) of the previously filed document(s).

***Initials*_____**

According to M.G.L. c. 176O §2(d), "[a] carrier that contracts with another entity to perform some or all of the functions governed by this chapter shall be responsible for ensuring compliance by said entity with the provisions of this chapter. Any failure by said entity to meet the requirements of this chapter shall be the responsibility of the carrier to remedy and shall subject the carrier to any and all enforcement actions, including financial penalties, authorized under this chapter."

***Initials*_____**

MATERIALS NECESSARY FOR AN APPROVAL OF AN INITIAL INSURED PREFERRED PROVIDER PLAN

(Pursuant to M.G.L. c. 176I and 211 CMR 51.00)

Once an application has been placed on file the following organizations may operate an insured vision and or dental preferred provider plan 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; and
- Optometric Service Corporations organized under M.G.L. c. 176F.

PLEASE NOTE – CARRIER SUBMISSIONS FILING SCHEDULE PAGES THAT DO NOT CLEARLY ILLUSTRATE COMPLIANCE WITH 211 CMR 51.05(2)(c)1&2 WILL BE RETURNED AND NOT REVIEWED.

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. ____ **Benefit Level -** health benefits provided through a Preferred Provider Health Plan to Covered Persons, as opposed to the payments made to the provider, by the Health Benefit Plan.

Pg. ____ **Commissioner -** the Commissioner of Insurance, appointed pursuant to M.G.L. c. 26, § 6, or his or her designee.

Pg. ____ **Covered Person** - any policyholder, subscriber, member or dependent on whose behalf the insurer is obligated to pay for and/or provide Health Care Services, including those provided under a workers' compensation Preferred Provider Arrangement under the provisions of M.G.L. c. 152.

Pg. ____ **Covered Services -** Health Care Services that an insurer is obligated to pay for or provide under either a Health Benefit Plan or a workers' compensation insurance policy.

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. ____ **Evidence of Coverage -** any certificate, contract, or agreement issued to a Covered Person, including any amendments, riders, or supplementary inserts, stating the health services and benefits to which the Covered Person is entitled under a Preferred Provider Health Plan.

Pg. ____ **Finding of Neglect -** a determination by the Commissioner that an Organization offering a Preferred Provider Health Plan has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00: Managed Care Consumer Protections and Accreditation of Carriers in

the form and within the time required.

Pg. ____ **Health Benefit Plan -** the health insurance policy, subscriber agreement, plan, certificate, agreement, or contract between the Covered Person or Health Care Purchaser and an Organization, which defines the Covered Services, and Benefit Levels available.

Pg. ____ **Health Care Provider -** a provider of Health Care Services licensed or registered pursuant to M.G.L. c. 111 or c. 112.

Pg. ____ **Health Care Purchaser -** a person, partnership, association, or corporation that provides health care coverage to its employees or members and their dependents by reimbursing the Covered Persons directly for covered Health Care Services or by contracting with an Organization to provide, arrange for the provision of, reimburse and/or pay for covered Health Care Services.

Pg. ____ **Health Care Services -** services rendered or products sold by a Health Care Provider within the scope of the provider's license. The term includes, but is not limited to, hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

Pg. ____ **Insured Health Benefit Plan -** a Health Benefit Plan in which the Organization assumes financial risk arising out of the contractual liability to pay for or reimburse Covered Persons for Covered Services. The term does not include a Health Benefit Plan in which an Organization functions solely as a third-party administrator.

Pg. ____ **Organization -** an entity authorized by the Commissioner to bear risk, including, but not limited to companies licensed or otherwise authorized to write accident and health insurance pursuant to M.G.L. c. 175, fraternal benefit societies licensed or otherwise authorized to write accident and 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, or health maintenance organizations licensed pursuant to M.G.L. c. 176G. For the purpose of Workers' Compensation Preferred Provider Arrangements only, "Organization" shall also include an authorized insurer, self-insurer, or self-insurance group as defined in M.G.L. c. 152 §§ 1, 25A and 25E, and any other corporate entity engaged in the delivery or administration of the delivery of health services that has requested approval of a Workers' Compensation Preferred Provider Arrangement on behalf of such insurer, self-insurer or self-insurance group which is acting on behalf of such entity.

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, § 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 - 211 CMR 51.04(1):

According to M.G.L. c. 176I §2, "[a]n organization shall submit information concerning any proposed preferred provider arrangements to the commissioner for approval in accordance with regulations promulgated by the commissioner. Further, according to 211 CMR 51.04(1), "[n]o No 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."

IDENTIFY THE SECTION OF THE SUBMISSION THAT INCLUDES THE FOLLOWING:

_____ a) A description of the geographical area in which the Preferred Providers are located, including **a map** of the distribution of the Preferred Providers;

[Separate geo-access maps and carrier access standards (i.e. 1 provider in 15 miles) for General Dentists and each type of Dental Specialist]

_____ 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:

_____ 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;

_____ 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);

_____ 3. A copy of every standard form contract for all Preferred Provider Arrangements including administrative service agreements [*i.e.* including but not limited to executed

_____ carrier/leased provider network service agreement; other entities performing tasks on behalf of carrier and or leased network including those downstream agreements];

_____ 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

_____ 5. A description of the criteria and method used to select Preferred Providers.

_____ d) A detailed description of the utilization review program;

_____ e) detailed description of the quality assurance program;

f) Preferred Provider directory, which shall include:

_____ 1. A copy of the Preferred Provider directory distributed to Covered Persons; and

_____ 2. A description of the process for distributing the directory to Covered Persons.

_____ g) Filing fee for initial applications as determined by the Executive Office for Administration and Finance as set forth in 801 CMR 4.02: *Fees for Licenses, Permits, and Services to be Charged by State Agencies.*

_____ h) Evidence of compliance with M.G.L. c. 176O: *Managed Care Consumer Protections and Accreditation of Carriers.*

APPLICATION MATERIALS TO BE SUBMITTED – 211 CMR 51.04(2):
INSERT PAGE#&SECTION

_____ (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.

EVIDENCE OF COVERAGE [211 CMR 51.05]:

The Evidence of Coverage must meet the requirements of M.G.L. c. 176I, M.G.L. c. 176O, 211 CMR 51.00 and 52.00: *Managed Care Consumer Protections and Accreditation of Carriers*. As noted in 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 Providers 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 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.

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 The Division of Insurance will collect annual report information for each Organization with a Preferred Provider Health Plan or a Workers' Compensation Preferred Provider Arrangement on April 30th of each year covering the 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 list of preferred providers."

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 Each 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."
Please confirm that the filer understands this requirement.
