

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

WORKERS' COMPENSATION MANAGED CARE PREMIUM CREDIT PROGRAMS FILING COMPLIANCE QUESTIONNAIRE

COMPANY	Co. File No.
Company Contact:	Phone Number:
E-Mail Address:	

Instructions: All applicable items must be answered. Responses in the shaded area indicate non-compliance with applicable requirements and statutes. Form or rule, page and paragraph references that bring the submission into compliance must be included. Enter "NA" in this column for any item not applicable to the filing being submitted. Failure to complete all items, or responses in the shaded area, will result in this filing being returned without further review.

Name of the Managed Care Organization to be utilized _____

Amount of Credit (can be no more than 10%) _____

_____ %

A. Submission includes:

- | | | | |
|--|------------------------------|-----------------------------|--|
| 1. A copy of the Business Contract or Management Service Agreement | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 2. Documentation of the approval of the agreement/contract by the N.Y.S. Department of Health. | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 3. The Office of Managed Care Workers' Compensation Preferred Provider Organization Certificate of Authority | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 4. The New York Preferred Provider Premium Organization Endorsement (WC 3104 03A) and/or the New York Preferred Provider Organization Endorsement (WC 31 06 16A) (Filed with the New York Compensation Insurance Rating Board) | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 5. Cancellation and nonrenewal guidelines in the New York Workers' Compensation and Employer Liability Manual | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 6. A discount that will remain in effect for no more than 4 years | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |

B. MANAGED CARE ORGANIZATION/PPOs

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|---|------------------------------|------------------------------|-----------------------------|
| 1. The rate modification is applied on a multiplicative basis, after the experience modification and before premium discounts and expense fees. | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 2. The filing includes the requirements that a policyholder has to maintain in order to remain eligible for the credit. | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 3. The filing contains an acknowledgment that any qualified employer who agrees to participate in the program will receive the credit. | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 4. The filing includes a list of all counties in which the credit will be utilized. | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 5. The filing includes procedures to follow when an insured no longer qualifies for the discount, or has misrepresented its compliance with the managed care agreement. | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 6. The credit applies only to insureds located in those counties certified by the Department of Health as approved PPO service areas. | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 7. For employers with operations in counties where the Managed Care Credit is not applicable the premium credit is based on standard premium. | YES <input type="checkbox"/> | NO <input type="checkbox"/> | |
| 8. The program is retrospectively rated. | | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

NOTE: For additional information refer to Circular Letter No. 18(1997) and its supplements.