

**§ 417.122 Protection of enrollees.**

(a) *Liability protection.* (1) Each HMO must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the HMO. These arrangements may include any of the following:

- (i) Contractual arrangements that prohibit health care providers used by the enrollees from holding any enrollee liable for payment of any fees that are the legal obligation of the HMO.
- (ii) Insurance, acceptable to CMS.
- (iii) Financial reserves, acceptable to CMS, that are held for the HMO and restricted for use only in the event of insolvency.
- (iv) Any other arrangements acceptable to CMS.

(2) The requirements of this paragraph do not apply to an HMO if CMS determines that State law protects the HMO enrollees from liability for payment of any fees that are the legal obligation of the HMO.

(b) *Protection against loss of benefits if the HMO becomes insolvent.* The insolvency protection plan required under § 417.120(a) must provide for continuation of benefits as follows:

- (1) For all enrollees, for the duration of the contract period for which payment has been made.
- (2) For enrollees who are in an inpatient facility on the date of insolvency, until they are discharged from the facility.

**§ 417.124 Administration and management.**

(a) *General requirements.* Each HMO must have administrative and managerial arrangements satisfactory to CMS, as demonstrated by at least the following:

- (1) A policymaking body that exercises oversight and control over the HMO's policies and personnel to ensure that management actions are in the best interest of the HMO and its enrollees.
- (2) Personnel and systems sufficient for the HMO to organize, plan, control and evaluate the financial, marketing, health services, quality assurance program, administrative and management aspects of the HMO.

(3) At a minimum, management by an executive whose appointment and removal are under the control of the HMO's policymaking body.

(b) *Full and fair disclosure*—(1) *Basic rule.* Each HMO must prepare a written description of the following:

- (i) Benefits (including limitations and exclusions).
- (ii) Coverage (including a statement of conditions on eligibility for benefits).
- (iii) Procedures to be followed in obtaining benefits and a description of circumstances under which benefits may be denied.
- (iv) Rates.
- (v) Grievance procedures.
- (vi) Service area.
- (vii) Participating providers.
- (viii) Financial condition including at least the following most recently audited information: Current assets, other assets, total assets; current liabilities, long term liabilities; and net worth.

(2) *Requirements for the description.* (i) The description must be written in a way that can be easily understood by the average person who might enroll in the HMO.

(ii) The description of benefits and coverage may be in general terms if reference is made to a detailed statement of benefits and coverage that is available without cost to any person who enrolls in the HMO or to whom the opportunity for enrollment is offered.

(iii) The HMO must provide the description to any enrollee or person who is eligible to elect the HMO option and who requests the material from the HMO or the administrator of a health benefits plan. For purposes of this requirement, “administrator” (of a health benefits plan) has the meaning it is given in the Employment Retirement Income Security Act of 1974 (ERISA) at 29 U.S.C. 1002(16)(A).

(iv) If the HMO provides health services through individual practice associations (IPAs), the HMO must specify the number of member physicians by specialty, and a listing of the hospitals where HMO enrollees will receive basic and supplemental health services.

(v) If the HMO provides health services other than through IPAs, the HMO must specify, for each ambulatory care