211 CMR 43.00: HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Section

43.01: Applicability

(1) No organization may provide or arrange for health services to enrolled members who are Massachusetts residents in exchange primarily for a prepaid per capita or aggregate fixed sum without being licensed in accordance with the provisions of 211 CMR 43.00.

(2) A university or college health service or plan shall not be required to obtain a license under M.G.L. c. 176G or 211 CMR 43.00 where membership in such service or plan is limited solely to enrolled students, faculty, employees, and affiliates, and their dependents.

43.02: Definitions

As used in 211 CMR 43.00, the following words mean:

Administrative Supervision, action by the Commissioner to apply and carry out the provisions of M.G.L. c. 175J.

Affiliate, an affiliate of, or person affiliated with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

Agent, any person not employed by an HMO who is appointed as an agent of the HMO pursuant to M.G.L. c. 175, § 162S and who markets or sells HMO benefits.

Bureau of Managed Care or Bureau, the bureau in the Division of Insurance established by M.G.L. c. 176O, § 2.

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

Control, including controlling, controlled by and under common control with, the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10% or more of the voting securities of any other person. In the case of a person that is a charitable or nonprofit organization subject to M.G.L. c. 180, control shall be presumed to exist if any other person shall, directly or indirectly, own, control or hold, more than 10% of the aggregate rights in any membership class or shall, directly or indirectly, have the right to appoint or elect more than 10% of the directors serving on the person's board of directors. Any of these aforementioned presumptions may be rebutted by a showing made in the manner provided with respect to HMOs under M.G.L. c. 176G, § 28(j) that

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control does not exist in fact. The Commissioner may determine, after furnishing all persons in interest notice an opportunity to be heard and making specific findings of fact to support such determination, that such control exists in fact, notwithstanding the absence of a presumption to that effect.

Division, the Division of Insurance established pursuant to M.G.L. c. 26, § 1.

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 insured or another 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 and 42 U.S.C. section 1395dd(e)(1)(B).

Evidence of Coverage, any certificate, contract, or agreement including riders, amendments and supplementary inserts, issued to a member in accordance with M.G.L. c. 176G, § 7 and 211 CMR 52.00: *Managed Care Consumer Protections and Accreditation of Carriers*, specifying the benefits to which the member is entitled.

Finding of Neglect, a written determination by the Commissioner that the HMO has failed to make and file the materials required by M.G.L. c. 176G, M.G.L. c. 176O, 211 CMR 43.00 or 52.00: *Managed Care Consumer Protections and Accreditation of Carriers* in the form and within the time required.

Foreign HMO, an alien HMO, except where clearly noted otherwise, or an HMO formed by authority of any state or government other than the commonwealth and qualified to conduct business in the commonwealth.

Health Maintenance Organization or HMO, a company organized under the laws of the commonwealth, or organized under the laws of another state and qualified to do business in the commonwealth, which:

(a) provides or arranges for the provision of health services to voluntarily enrolled members in exchange primarily for a prepaid per capita or aggregate fixed sum.

(b) demonstrates to the satisfaction of the commissioner proof of its capability to provide its members protection against loss of prepaid fees or unavailability of covered health services resulting from its insolvency or bankruptcy or from other financial impairment of its obligations to its members.

Health Maintenance Organization Holding Company System, a health maintenance organization holding company system consists of two or more affiliates, one or more of which is an HMO.

Health Services, at least reasonably comprehensive inpatient, outpatient, and emergency care services including: preventive services, such as immunizations; periodic health exams for adults; prenatal maternity care; well child care including vision and auditory screening; voluntary family planning; nutrition counseling, and health education; and also including pediatric care; and a minimum of 100 days in a 12-month period or 365 lifetime days of noncustodial care in a skilled nursing facility; and which may include, but not be limited to chiropractic services; optometric services; and podiatric services.

Managed Hospital Payment Basis, an agreement or collection of agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of the services.

Member, any individual who has entered into a health maintenance contract, or on whose behalf such an arrangement has been made, with an HMO or carrier or both for health services and any dependent of such individual who is covered by the same contract; provided that in M.G.L. c. 176G, §§ 25 through 29, Enrolled Member shall mean any such individual, and Member shall have the same meaning as set forth in M.G.L. c. 180.

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NAIC, the National Association of Insurance Commissioners.

Net Worth, the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt pursuant to M.G.L. c. 176G, §25(d). References herein to the term "surplus" shall include "net worth."

Organization, an individual, corporation, partnership, business trust, association, organized group of persons whether incorporated or not, or any line of business division, department, subsidiary or affiliate of any thereof and any receiver, trustee or other liquidating agent of any of the foregoing while acting in such capacity.

Person, any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society, operators of any medical service plan and hospital service plan as defined in M.G.L. c. 176A, c. 176B, c. 176C, c. 176E and c. 176F, carriers and HMOs as defined in M.G.L. c. 176G, insurers and sponsors of a legal services plan as defined in M.G.L. c. 176H, any other legal entity or self insurer which is engaged in the business of insurance, including producers, and adjusters, the Massachusetts Insurers Insolvency Fund and any joint underwriting association established pursuant to law. For purposes of 211 CMR 43.00, operators of any such medical and hospital service plans and carriers and such HMOs shall be engaged in the business of insurance. For purposes of M.G.L. c. 176G, §§ 27 through 29, Person, shall have the meaning set forth in M.G.L. c. 175, § 206.

Principal Executive Officer, any chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

Provider, any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

Service Area, the geographical area as approved by the Commissioner within which the HMO has developed a network of providers to afford adequate access to members for covered health services.

Subsidiary, an affiliate controlled by a person directly or indirectly through one or more intermediaries.

Uncovered Expenditures, the cost to an HMO for health care services that are the obligation of such an HMO, for which an enrollee may also be liable in the event of the HMOs' insolvency and for which no alternative arrangements have been made to cover such costs that are acceptable to the Commissioner.

43.03: Licensing

(1) Application for Initial License. Any organization seeking licensure as an HMO under M.G.L. c. 176G must submit an application that contains at least the following information in a format specified by the Commissioner.

(a) Internal Operations Plan.

1. A copy of the basic organizational documents, such as articles of incorporation, articles of association, partnership agreement, trust agreement or any other applicable document establishing the HMO and all amendments thereto;
2. A list of the Board of Directors or similar policy-making body, including the name, principal occupation and employer of each person;
3. A copy of the by-laws, rules and regulations, or other similar document regulating the conduct of the applicant's internal affairs;
4. A copy of the organizational chart with titles in the areas of marketing, administration, enrollment, grievance procedures, quality assurance, contract negotiation and financial matters;

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5. A narrative of the health care plan, facilities and personnel including, but not limited to, the organizational structure, a description of the service area and provider network, the roles, functions, responsibilities of, and interrelationships among providers and the methods of provider reimbursement and risk-sharing arrangements;

6. An inventory of owned, operated, contracted and participating provider facilities including, but not limited to, hospitals, skilled nursing facilities, home health care and medical care services;

7. For HMOs who manage their own health care facilities only, a legal opinion from the General Counsel of the Department of Public Health indicating whether the applicant has complied with the requirements of M.G.L. c. 111;

8. A power of attorney authorizing the Commissioner to accept service of process for any legal actions commenced against an HMO not domiciled in the Commonwealth of Massachusetts; and

9. For staff model HMOs only, an inventory of full-time equivalents of providers by specialty with physician to population ratios.

(b) Utilization Plan.

1. A statement of inpatient and outpatient utilization review measures; and

2. statement of actuarial review and certification of actuarial assumptions made regarding utilization as applied to projected financial statements.

(c) Quality Assurance. A detailed description of the quality assurance system or a certification that the description of the quality assurance system is included in an accompanying accreditation filing submitted under 211 CMR 52.00: *Managed Care Consumer Protections and Accreditation of Carriers*.

(d) Marketing Plan.

1. A marketing plan describing the service area population and existing medical care utilization rates for inpatient and outpatient services in existing facilities in the service area;

2. The anticipated enrollment for the HMO, and the service area population and utilization rates projected for health services delivered in the HMO's service area; and

3. A statement of the size, organization, accountability and marketing methods of the marketing staff.

(e) Member Services.

1. A copy of the evidence of coverage for each different product to be offered or a certification that the evidences of coverage are included in an accompanying accreditation filing submitted under 211 CMR 52.00: *Managed Care Consumer Protections and Accreditation of Carriers*, and a description of the HMO's process for distributing such evidences of coverage to members;

2. A plan for the yearly publication and distribution to members of rates, medical care service hours, location and telephone number(s) for normal service, and for emergency service;

3. A map of the service area and a list of towns included;

4. A copy of the provider directory or a certification that the provider directories are included in an accompanying accreditation filing submitted under 211 CMR 52.00: *Managed Care Consumer Protections and Accreditation of Carriers*, and a description of the process for distributing provider directories to members;

5. A statement of the confidentiality procedures used to maintain member confidentiality involving medical records, grievances, quality assurance studies and contractual provisions in provider agreements;

6. A detailed description of the formal internal grievance systems including procedures for the registration of grievances and procedures for resolution of grievances, with a descriptive summary of written grievances made in the areas of medical care and administrative services; and

7. For renewal applications only, the total number and disposition of malpractice claims and other claims relating to the service or care rendered by the HMO made by, or on behalf of, members of the HMO that were settled or resulted in a judgment during the year by the HMO.

(f) Contractual Arrangements.

1. A copy of the forms of group contracts or a certification that the group contracts are included in an accompanying accreditation filing submitted under 211 CMR 52.00: *Managed Care Consumer Protections and Accreditation of Carriers*;

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2. A copy of every contract form made or to be made between the applicant and any providers of health services or a certification that the contract forms are included in an accompanying accreditation filing submitted under 211 CMR 52.00: *Managed Care Consumer Protections and Accreditation of Carriers*;

3. Administrative contracts including management and marketing contracts, and rental and leasing agreements;

4. Written procedures for the prior review and approval by the HMO of provider subcontracts, including, but not limited to, the language requirements and other standards by which the HMO reviews the subcontracts;

5. Written procedures by which the HMO maintains on file original signed provider contracts and copies of signed provider subcontracts; and

6. For the purposes of 211 CMR 43.03(1)(f), "contract form" means a single copy of each generic contract used for each type of provider and not a copy of every contract signed between the HMO and provider.

(g) Premium Rates.

1. Rates for all insured products offered, as applied to projected financial statements;

2. A statement of the reasons for proposed rates and benefits, their effective dates and their marketing impact;

3. A comparison of current rates, if applicable, and proposed rates, listing premium cost components as percentage of premium; and

4. An explanation by the HMO's actuary supporting the actuarial assumptions and calculations utilized in the submission. The derivation of the rates must be clear and complete. All assumptions used must be stated and supported, and any mathematical factors used must be both defined and derived.

(h) Financial Plan.

1. Audited financial reports, maintained and prepared in accordance with statutory accounting practices and procedures prescribed or permitted by the Commissioner, for at least the prior three fiscal years, if applicable, of the HMO's existence. Reports must be separate for HMOs operated as a line of business, division, department, subsidiary or affiliate as provided in M.G.L. c. 176G, § 3;

2. Financial statements as listed in 211 CMR 43.03(1)(h)2.a. through f. which project the results of operations for the next three calendar years:

a. balance sheet;

b. statement of revenues and expenses;

c. statement of changes in capital and surplus;

d. cash flow;

e. capital expenditure; and

f. repayment schedule for existing or anticipated loans or alternative financing arrangements.

The projection for year one shall consist of actual results for quarters one and two, if available, as well as a projection for quarters three and four. The projections for years two and three shall be on an annual basis. The format shall be consistent with that specified for the quarterly reporting filings and unaudited annual reports required to be filed with the Commissioner pursuant to 211 CMR 43.04(2) and (3).

3. A statement indicating when the HMO estimates that enrollment income and other income from operations will equal expenses;

4. Projections must be accompanied by detailed statements of underlying assumptions used and the bases thereof, including, but not limited to, projected premium rates and documentation as required for premium rates. If available, independent evaluations and assessment of these statements should also be included;

5. A copy of the vote, or portion thereof, of the Board of Directors or governing body of the HMO designating the permissible forms of investments of HMO funds and any limitations thereon;

6. Letters of financial support, credit, bond, or loan guarantee or other financial guarantee to the applicant;

7. A detailed statement of the HMO's plan to establish and maintain reserves or other funds as determined necessary to cover any risks projected and not otherwise assumed by another entity, carrier or reinsurer; a detailed statement of current and projected reserve establishment calculations, amounts, purpose and use of reserve, and assumptions and bases thereof, including, but not limited to, identification of reserves set aside to meet uncovered reinsurance items;

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8. Plans for a surety bond or a deposit of cash or sureties in at least the same amount as a guarantee that the obligation to the members will be performed, unless waived as provided in M.G.L. c. 176G, § 15;

9. Copies of all reinsurance, conversion or other agreements with other insurers, health providers, medical service corporations, hospital service corporations, governmental agencies or organizations or other HMOs to provide payment for the cost of, or to provide the contracted for health care services in the event the HMO is unable or ceases to provide contracted for health services for any reason;

10. A copy of the HMO's official notification of status as a federally qualified HMO if it is so designated;

11. A statement of insurance or funded self-insurance coverage for:

a. protection against loss of property and liability of the HMO;

b. worker's compensation to protect against claims arising from work-related injuries; and

c. medical malpractice liability insurance of the HMO and providers;

12. A listing of shareholders or members or other equity holders or members with holdings of 5% or more of capital shares, partnership interest or other evidence of equity holdings, by name, address, number and percentage of shares or other interest held and any other affiliations with the HMO;

13. A listing of the applicant's legal, accounting and actuarial representatives by name and address;

14. A statement of the plan's accounting system and organization, management and internal controls, method of estimating and handling incurred but not reported liabilities;

15. A statement of fidelity bond coverage of all officers and employees entrusted with the handling of funds; and

16. A detailed description of mechanisms to monitor the financial solvency of any independent practice association, group practice, or other organization contracting with the HMO that assumes substantial financial risk through capitation or other prepaid risk-sharing or risk-transferring arrangements, where substantial financial risk shall mean prepayments totaling more than 5% of an HMO's annual health care expense.

[The following documents may be requested by the Commissioner, but need not be submitted unless such request is made:]

17. Current financial statements for guarantors of the HMO's contractual obligations;

18. Current financial statements for persons or providers or corporate entities which have contracted with the HMO for the provision of medical, administrative, or marketing services, audited if available;

19. A current financial statement of any person who holds a financial interest in the HMO; and

20. Any additional information as deemed necessary by the Commissioner.

(i) Evidence of Compliance with M.G.L. c. 176O and 211 CMR 52.00: *Managed Care Consumer Protections and Accreditation of Carriers*. Any HMO accredited by the Bureau of Managed Care shall be deemed to meet the utilization review requirements of M.G.L. c. 176O and 211 CMR 52.00.

(j) Filing Fee. For initial applications, a filing fee in the amount of $1000 shall be required.

(2) License Renewal. Any organization seeking relicensure as an HMO under M.G.L. c. 176G must submit an application for license renewal that contains at least the following information in a format specified by the Commissioner.

(a) Filing Fee. For renewal applications, a filing fee in the amount of $1,000 shall be required.

(b) Financial Plan. An annual report of financial information maintained and prepared in accordance with statutory accounting practices and procedures prescribed or permitted by the Commissioner, required by M.G.L. c. 176G, § 10 and 211 CMR 43.03(1)(h).

(c) Evidence of Compliance with M.G.L. c. 176O and 211 CMR 52.00: *Managed Care Consumer Protections and Accreditation of Carriers*. Any HMO accredited by the Managed Care Bureau shall be deemed to meet the utilization review requirements of M.G.L. c. 176O and 211 CMR 52.00.

(d) Material Changes to Initial License Application.

1. An HMO shall annually provide written notification to the Commissioner of any material change to the information that was submitted as part of the application for initial licensure according to 211 CMR 43.03(1).

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2. This information shall be in addition to the notification of any material changes that are subject to prior approval of the Commissioner as required by M.G.L. c. 176G, § 16 and 211 CMR 43.08.

(e) Any additional information as deemed necessary by the Commissioner.

(3) Review of Application. Upon receipt of a complete application, the Commissioner shall review the submitted material to determine whether a license shall be granted or renewed. The organization must demonstrate evidence of meeting all requirements set forth in M.G.L. c. 176G, M.G.L. c. 176O, 211 CMR 43.00, and 52.00: *Managed Care Consumer Protections and Accreditation of Carriers* including the following:

(a) Corporate and organizational structure capable of supporting the benefits offered;

(b) Compliance with requirements for determination of need and facilities licenses;

(c) Power of authority authorizing Commissioner to accept service of process for any legal actions commenced against an HMO not domiciled in Massachusetts;

(d) Contractual agreements that adequately protect the interests of members;

(e) Utilization systems ensuring the appropriate and efficient use of health services;

(f) Quality assurance systems monitoring the quality of care provided to members;

(g) Operations financially capable of meeting the risk of providing health services;

(h) Clear and logical plan for marketing of the HMO products;

(i) Adequate provider networks to guarantee that all services contracted for will be accessible to members without delays detrimental to the health of members; and

(j) Sufficient financial reserves or other resources to meet its financial obligations.

(4) Approval of License. Each license issued under M.G.L. c. 176G and 211 CMR 43.00 shall remain in effect for 24 months unless revoked or suspended by the Commissioner. Renewal applications must be submitted by July 1st for a renewal date of January 1st of the subsequent year. The Division will notify all HMOs regarding the status of their HMO license renewals by November 1st of the year in which a timely application has been submitted.

(5) Denial of License. If an application for a license is denied, the Commissioner shall notify the organization in writing, stating the reason(s) for the denial. The organization shall have the right to a hearing on its application within 45 days of its receipt of such notice by filing a written request for a hearing within 15 days of its receipt of such notice. Within 15 days after the conclusion of the hearing, the Commissioner shall either grant a license or shall notify the organization in writing of the denial of a license stating the reason(s) for the denial. The organization shall have the right to judicial review of the Commissioner's decision in accordance with the provisions of M.G.L. c. 30A, § 14.

(6) Nonrenewal of License. If an application for a license renewal is denied, the Commissioner shall notify the organization in writing, stating the reason(s) for the nonrenewal. The organization shall have the right to a hearing on its application within 45 days of its receipt of such notice by filing a written request for a hearing within 15 days of its receipt of such notice. Within 15 days after the conclusion of the hearing, the Commissioner shall either renew the license or shall notify the organization in writing of the nonrenewal of a license stating the reason(s) for the nonrenewal. The organization shall have the right to judicial review of the Commissioner's decision in accordance with the provisions of M.G.L. c. 30A, § 14. During the period following the initial notice of nonrenewal, the HMO may be required to cease offering new business or may be placed under administrative supervision.

(7) Administrative Supervision, Rehabilitation, Liquidation, or Revocation or Suspension of License.

(a) The Commissioner may seek administrative supervision, rehabilitation or liquidation pursuant to M.G.L. c. 176G, §§ 20 or 20A or M.G.L. c. 175J, or revoke or suspend the license issued to the HMO under M.G.L. c. 176G, § 14 for a period not exceeding the unexpired terms thereof, if he or she finds, upon examination or other evidence submitted to him or her any of the following conditions:

1. The HMO is insolvent or is in an unsound condition;

2. The HMO’s business policies or methods are unsound or improper;

3. The HMO’s condition or management is such as to render its further transaction of business hazardous to the public or its members or creditors;

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4. The HMO is transacting business fraudulently;
5. The HMO or its officers, representatives, affiliates or agents have refused to submit to an examination under M.G.L. c. 176G, § 10 or to perform any legal obligation relative thereto;
6. The amount of the HMO's funds, net cash or contingent assets is deficient;
7. The HMO has attempted or is attempting to compromise with its creditors on the ground that it is financially unable to pay its claims in full;
8. The HMO has inadequately reserved for unearned premiums; or
9. The HMO substantively fails to comply with the requirements of M.G.L. c. 176G, M.G.L. c. 175J, 211 CMR 43.00, or any other provision of law or regulation.

(b) Before any 211 CMR 43.03(7) action is taken, the Commissioner shall notify the HMO in writing of his or her intention to take action and the date and place for a hearing on the matter.

(c) Following the hearing, the Commissioner shall notify the HMO in writing of any decision regarding administrative supervision or the revocation or suspension of its license. The HMO has the right to judicial review of the Commissioner's decision in accordance with the provisions of M.G.L. c. 30A, § 14.

(d) Notwithstanding 211 CMR 43.03(7)(b) and (c), if the Commissioner finds upon an examination or at any other time that:

1. an emergency exists requiring immediate action;
2. if the HMO has given consent;
3. the business of the HMO is being conducted fraudulently; or
4. the HMO's condition renders the continuance of its business hazardous, as defined in M.G.L. c. 175J, § 3(C), to its policyholders or the general public, he or she may, without a hearing, order the suspension of the HMO's license pending further proceedings or place the HMO under administrative supervision as set forth in M.G.L. c. 175J.

(e) Any revocation or suspension shall be conducted pursuant to M.G.L. c. 176G, § 20A.

43.04: Reporting

(1) Financial Concerns. Each HMO shall inform the Commissioner of any extraordinary loss or claim which has the potential to render it unable to meet its obligations as they become due, within five business days of its occurrence.

(2) Quarterly Filings. Within 45 days of the close of each fiscal quarter, the Division will collect information according to the format specified by the NAIC or otherwise as specified by the Commissioner.

(3) Unaudited Annual Reports. Each year, every HMO shall file with the Commissioner, on or before March 1st, a report about the HMO's preceding fiscal year that is verified by at least two principal executive officers, in the format specified by the NAIC or otherwise specified by the Commissioner in accordance with the provisions of M.G.L. c. 176G, § 10; provided, that if the Commissioner determines that a threat of insolvency exists to the HMO, he or she may require that such report be made available prior to March 1st; in the alternative, as authorized by the Commissioner, the Commissioner may obtain certain annual reporting information from an alternate source.

(a) Such annual report shall be made on the latest applicable form of annual statement approved by the NAIC, with any additional information the Commissioner may require for filing with the NAIC for the purpose of eliciting a complete and accurate exhibit of the condition and transactions of the HMO. All financial information reflected in the annual statement shall be maintained and prepared in accordance with accounting practices and procedures prescribed or permitted by the Commissioner. The Commissioner shall require that the annual statement be maintained and prepared in accordance with the Annual Statement Instructions and Accounting Practices and Procedures Manual adopted by the NAIC unless further modified by the Commissioner as he or she considers appropriate. The annual statement shall be subscribed and sworn to by its president and secretary or, in their absence, by two of its principal executive officers. The Commissioner may at other times require any such statements as he or she may deem necessary.

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(b) A copy of such annual report shall be sent to the NAIC in an electronic filing form as provided by the NAIC.

(c) Each domestic and foreign HMO authorized to transact insurance in Massachusetts shall annually on or before March 1st, file with the NAIC a copy of its annual statement blank, along with such additional filings as prescribed by the Commissioner for the preceding year. The information filed with the NAIC shall be in the same format and scope as that required by the Commissioner and shall include the signed jurat page and the actuarial certification. Any amendment or addendum to the annual statement filing subsequently filed with the Commissioner shall also be filed with the NAIC. Foreign HMOs that are domiciled in a state that has a law substantially similar to 211 CMR 43.04 shall be deemed to be in compliance with 211 CMR 43.04.

(d) The reporting provisions of 211 CMR 43.04(3) shall apply to all domestic, foreign and alien HMOs that are authorized to transact business in Massachusetts.

(4) Audited Annual Reports. Consistent with M.G.L. c. 176G, § 10 and c. 175, § 4, all HMOs shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the Commissioner, prepared in accordance with statutory accounting practices and procedures prescribed or permitted by the Commissioner, on or before June 1st for the preceding fiscal year. Extensions of the filing date may be granted by the Commissioner for 30-day periods upon showing by the HMO or its independent certified public accountant valid justification for such extension. The request for any extension must be received prior to the due date of the audited financial report in sufficient detail to permit the Commissioner to make an informed decision with respect to the requested extension.

(a) Designation of Independent Certified Public Accountant. All HMOs shall notify the Commissioner of the engagement of a certified public accountant within 30 days of such appointment if such accountant was not the accountant for purposes of 211 CMR 43.00 for the immediately preceding year. Such notification shall include a statement by the president, treasurer and chairman of the audit committee (if any) as to whether in the 24 months preceding the most recent year end, there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosures, or auditing procedures which disagreements if not resolved to the satisfaction of the former accountant would have caused him or her to make reference to the subject matter of the disagreement in connection with his or her opinion. The HMO shall also in writing request such former accountant to furnish it with a letter addressed to the Commissioner stating whether he or she agrees with the statements contained in its letter and, if not, stating the reasons why he or she does not agree. The HMO shall furnish the responsive letters from the former accountant to the Commissioner together with its own.

(b) Qualification of Independent Certified Public Accountant. The Commissioner shall not recognize any person or firm as an independent certified public accountant who is not duly licensed to practice and in good standing under the laws of Massachusetts (or in a state with licensing requirements similar to Massachusetts) and a member in good standing of the American Institute of Certified Public Accountants. Except as otherwise provided in 211 CMR 43.04(4)(b), a certified public accountant shall be recognized as independent as long as he or she conforms to the standards of the profession, as contained in the *Code of Professional Ethics of the American Institute of Certified Public Accountants*, and Rules and Regulations and *Code of Ethics and Rules of Professional Conduct of the Massachusetts Board of Public Accountancy* (or similar code). The Commissioner may hold a hearing to determine whether a certified public accountant is qualified under 211 CMR 43.00, whether he or she is independent, whether an audit performed by him or her conforms to generally accepted auditing standards, or whether the annual audited financial report on which he or she has given his or her opinion presents fairly the financial position and results of operations of the HMO. After a negative ruling on any of the above issues, the Commissioner may require the HMO to replace the accountant.

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(c) Availability and Maintenance of Working Papers of the Independent Certified Public Accountant. The HMOs shall require the independent certified public accountant to make available for review by the Commissioner or his or her appointed agent, the work papers prepared in the conduct of the audit which shall include its parent and affiliates as they relate to the examination of the HMO. The HMO shall require that the accountant retain the audit work papers for a period of not less than five years after the period reported upon. The records of any such audit, examination, or other inspection and the information contained in the records, reports, or books of an HMO shall be confidential and open only to the inspection of the Commissioner and his or her examiners and assistants, except to the extent that production of such records is required by law in a civil or criminal proceeding affecting the HMO. The final report of any such audit, criminal proceeding, or other inspection by or on behalf of the Commissioner shall be a public record.

1. The aforementioned reviews by the Commissioner shall be considered investigations and all working papers obtained during the course of such investigations shall be confidential. If the Commissioner considers them to be relevant, the HMO must require that the independent certified public accountant provide photocopies of any of his or her working papers and these papers may be retained by the Commissioner.

2. "Working Papers", as referred to in 211 CMR 43.04(4)(c), include, but are not necessarily limited to, schedules, analyses, reconciliations, abstracts, memoranda, narratives, flow charts, copies of company records or other documents prepared or obtained by the accountant and his employees in the conduct of their examinations of the HMO.

(d) Annual Audited Financial Report. The report shall include:

1. Opinion of the Independent Certified Public Accountant.
2. Audited Financial Statements, including:
   a. balance sheet;
   b. statement of revenues and expenses;
   c. statement of cash flows;
   d. statement of changes in capital and surplus; and
   e. notes to financial statements.

   f. In general, and except as otherwise provided herein, the financial statements filed pursuant to 211 CMR 43.04(4) should be prepared as follows:

      i. The financial statements shall be comparative, presenting the amounts as of the last date of the current year and the amounts as of the year end immediately preceding.

      ii. If the HMO is included in consolidated or combined financial statements prepared on the basis of statutory accounting practices and procedures prescribed or permitted by the Commissioner, such financial statements must also be included in the filing of the audited financial report. An HMO may make written application to the Commissioner for approval, at his or her discretion, to file an annual audited consolidated or combined financial report in lieu of a separate annual audited financial report for the HMO. In such cases, and in cases of HMOs that have subsidiaries that are required to be consolidated under statutory accounting practices and procedures prescribed or permitted by the Commissioner, the annual audited financial report shall include a columnar consolidating or combining worksheet, as follows:

         - amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet;
         - amounts for the HMO shall be stated separately;
         - non-HMO operations may be shown on the worksheet on a combined or individual basis; and
         - explanations of consolidating and eliminating entries shall be included.

      iii. A reconciliation shall compare the amounts shown in the HMO columns of the worksheet with comparable amounts in the HMO's annual statement of financial condition.

43.04: continued

3. Report of Significant Deficiencies in Internal Controls. In addition to the annual audited financial statements, each HMO shall furnish the Commissioner with a written report prepared by the accountant describing significant deficiencies in the HMO's internal control structure noted by the accountant during the audit. SAS No. 60, Communication of Internal Control Structure Matters Noted in an Audit (AU Section 325 of the Professional Standards of the American Institute of Certified Public Accountants) requires an accountant to communicate significant deficiencies (known as "reportable conditions") noted during a financial statement audit to the appropriate parties within an entity. No report need be issued if the accountant does not identify significant deficiencies. If significant deficiencies are noted, the written report shall be filed annually by the HMO with the Division. The HMO is required to provide a description of remedial actions taken or proposed to correct significant deficiencies, if such actions are not described in the accountant's report.

(e) Notification of Adverse Financial Condition. An HMO subject to 211 CMR 43.00 shall require the independent certified public accountant to immediately notify in writing an officer and all members of its Board of Directors of any determination by the independent certified public accountant that the HMO has materially misstated its financial condition as reported to the Commissioner for the fiscal year ended immediately preceding. The HMO shall furnish such notification to the Commissioner within five days of receipt thereof. If the accountant, subsequent to the date of the audited financial report pursuant to 211 CMR 43.04(4)(d)2., becomes aware of facts which would have affected his or her report, the Commissioner notes the obligation of the accountant to take such action as prescribed by Section 561 of the Statement of Auditing Standards Number One of the American Institute of Certified Public Accountants.

(5) Examination by the Commissioner. The Commissioner shall determine the nature, scope and frequency of examinations conducted pursuant to M.G.L. c. 176G, § 10. Such examinations may cover all aspects of the HMO's assets, condition, affairs and operations and may include and be supplemented by audit procedures performed by independent certified public accountants as herein provided.

(a) The type of examinations performed by the Commissioner's examiners may include, but shall not be limited to, the following:

1. Financial surveillance will consist of a review of the audited financial report and annual statement and may include a review of the independent certified public accountant's working papers if expressly required and a general review of the HMO's corporate affairs and operations to determine compliance with Massachusetts General Laws and the Rules and Regulations of the Commissioner. The examiners may perform alternative or additional examination procedures to supplement those performed by the independent certified public accountants when the examiners determine that such procedures are necessary to verify the financial condition of the HMO;

2. Targeted examinations will cover specific areas of an HMO's operations as the Commissioner may deem appropriate; and

3. Comprehensive examinations will be performed when the report of the accountant as provided for in 211 CMR 43.04(4)(d) or the notification required by 211 CMR 43.04(4)(e) or the results of financial surveillance or targeted examinations or other circumstances indicate in the judgment of the Commissioner that a complete examination of the condition and affairs of the HMO is necessary. Such examinations may be conducted by the Commissioner or his or her appointed agent.

(b) At the completion of each examination described above, the examiner appointed by the Commissioner shall make a full and true report on the results of the examination. Each report shall include a general description of the scope of the examination performed and the extent to which the examiners utilized the work of the HMO's accountants or other certified public accountants to supplement their examination. The cost of all work performed by independent certified public accountants shall be borne by the HMO.

43.04: continued

(6) Exemptions. Upon written application of any HMO, the Commissioner may grant an exemption from compliance with 211 CMR 43.04 or portions thereof if the Commissioner finds, upon review of the application, that compliance with 211 CMR 43.00 would constitute a financial or organizational hardship upon it or its independent certified public accountant. An exemption may be granted at any time for any specified period. Within ten days of receipt of a denial of a written request for an exemption from 211 CMR 43.00, the HMO may request in writing a hearing on its application for exemption. Such hearing shall be held in accordance with M.G.L. c. 30A and the practices of the Commissioner pertaining to administrative hearings.

(7) Material Changes. All material changes to reporting information contained in the HMO's application, including but not limited, to the HMO's articles of incorporation and by-laws, Board of Directors, management structure or key management personnel, investment guidelines, letters of financial support, service area, amendments to the evidence of coverage, significant changes to provider networks, the name under which the HMO does business, and all changes in controlling interest of the HMO, shall be submitted to the Commissioner on or before their effective dates.

(8) Independent Certified Accountant. Pursuant to M.G.L. c. 176G, § 10 and c. 175, § 4, the Commissioner may require HMOs to comply with the provisions of 211 CMR 43.00.

(9) Additional Reports. The Commissioner, if he or she so determines the need exists, may require the HMO to submit additional reports other than those specifically required by 211 CMR 43.00.

43.05: Deposit Requirements

(1) Except as provided in 211 CMR 43.05(2) and (3), each HMO shall maintain a deposit with a trustee acceptable to the Commissioner through which a custodial or controlled account is utilized of cash, securities or any combination of these or other measures that are acceptable to him or her, which is to be used exclusively to protect the interests of policyholders, enrolled members, and the general public and which at all times shall have a value of not less than $1,000,000.

(2) All income from the deposit shall be an asset of the HMO. A HMO that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination of these or other measures of equal amount and value. The Commissioner shall approve any securities before they are deposited or substituted.

(3) The Commissioner may reduce or eliminate the deposit requirement if the HMO deposits with the state treasurer, insurance Commissioner or other official body of the state or jurisdiction of domicile, for the protection of policyholders, enrolled members and subscribers of such HMO and the general public, cash, acceptable securities or surety, and delivers to the Commissioner a certificate to such effect, duly authenticated by the appropriate entity holding the deposit.

(4) If in the opinion of the Commissioner the deposit requirement as established above would be inadequate to protect the interests of enrolled members, the deposit shall be appropriately adjusted in order to protect the interests of policyholders, enrolled members and subscribers of the HMO and the general public.

(5) The deposit shall be an admitted asset of the HMO in the determination of net worth pursuant to M.G.L. c. 176G, § 25. The Commissioner may use the deposit for administrative costs directly attributable to any receivership, administrative supervision, rehabilitation or liquidation pursuant to M.G.L. c. 176G, § 20. If the HMO is ordered into receivership, administrative supervision, rehabilitation or liquidation, the deposit shall be an asset subject to the provisions of M.G.L. c. 176G, § 20.

43.06: Net Worth Requirements

(1) Initial Net Worth. The Commissioner shall require upon issuance of an initial license under this chapter that a HMO shall have an initial adjusted net worth of $1,500,000.

(2) Ongoing Net Worth. Except as provided by 211 CMR 43.06(3), the adjusted net worth of a HMO shall be maintained subsequent to initial licensure in an amount equal to the greater of the following amounts:

(a) $1,000,000;

(b) 2% of annual premium revenues as reported on the most recent annual financial statement filed with the Commissioner on the first $150,000,000 of premium and 1% of annual premium on the premium in excess of $150,000,000;

(c) An amount equal to the sum of three months uncovered expenditures as reported on the most recent financial statement filed with the Commissioner;

(d) An amount equal to the sum of:

1. 8% of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the Commissioner; and

2. 4% of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the Commissioner.

(3) In determining adjusted net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the Commissioner, which shall at a minimum meet the following requirements:

(a) The effective date, amount, interest and parties involved in such debt are clearly set forth;

(b) The principal sum and any interest accrued thereon are subject to and subordinate to all other liabilities of the HMO, and upon dissolution or liquidation, no payment of any kind shall be made until all other liabilities of the HMO have been paid;

(c) The instrument states that the parties agree that the HMO must obtain written approval from the Commissioner prior to any payment of interest or repayment of principal; and

(d) The debt is deemed fully subordinated by the Commissioner in his or her discretion.

(4) Any debt incurred by a note meeting the requirements of 211 CMR 43.06(4) shall not be considered a liability and shall be recorded as equity.

43.07: Premium Rates

(1) All base rates are subject to the Commissioner's disapproval if they do not meet the requirements of M.G.L. c. 176G, § 16.

(2) Small Group Base Rates. Small group and individual base rates shall be submitted in accordance with M.G.L. c. 176J and 211 CMR 66.00: *Small Group Health Insurance*.

(3) Large Group Base Rates. Each HMO shall submit proposed large group base rates for each product at least 90 days prior to their effective date(s).

(4) The Commissioner shall notify the HMO if he or she determines that the HMO's submission is not complete and he or she shall identify the manner in which the submission is not complete. A submission shall not be deemed complete unless it contains: an actuarial opinion stating that the rates are neither excessive, inadequate, nor unfairly discriminatory, and that they are reasonable in comparison to the benefits offered; and any other information required by the Commissioner. As used in 211 CMR 43.07, "actuarial opinion" means a signed written statement by a member of the American Academy of Actuaries based upon the person's review of the appropriate records and of the actuarial assumptions and methods utilized by the HMO in establishing premium rates for applicable health benefit plans. The actuarial opinion also shall explain the method in which the submitted base rates were derived.

43.07: continued

(5) An HMO's submission shall contain the following documentation:

(a) Three years of historic claims payment experience, including member months, shown separately for each year and differentiating among:

1. Inpatient hospital care;
2. Outpatient hospital care, with separate experience for:
   a. Radiological/laboratory/pathology costs; and
   b. All other outpatient costs;
3. Health care provider charges for:
   a. Medical and osteopathic physicians;
   b. Mental health providers; and
   c. All other health care practitioners.
4. Supplies; and
5. Outpatient prescription drugs.

(b) Three years of historic utilization experience, including member months, shown separately for each year and differentiating among:

1. Inpatient hospital care;
2. Outpatient hospital care, with separate experience for:
   a. Radiological/laboratory/pathology costs; and
   b. All other outpatient costs;
3. Health care provider charges for:
   a. Medical and osteopathic physicians;
   b. Mental health providers; and
   c. All other health care practitioners.
4. Supplies; and
5. Outpatient prescription drugs.

(c) Trend factors differentiating among:

1. Inpatient hospital care;
2. Outpatient hospital care, with separate experience for:
   a. Radiological/laboratory/pathology costs; and
   b. All other outpatient costs;
3. Health care provider charges for:
   a. Medical and osteopathic physicians;
   b. Mental health providers; and
   c. All other health care practitioners.
4. Supplies; and
5. Outpatient prescription drugs.

(d) The actuarial basis for all trend factors, including all relevant studies used to derive the factors;

(e) All non-fee-for-service payments to providers, differentiating among:

1. Inpatient hospital care;
2. Outpatient hospital care, with separate experience for:
   a. Radiological/laboratory/pathology costs; and
   b. All other outpatient costs;
3. Health care provider charges for:
   a. Medical and osteopathic physicians;
   b. Mental health providers; and
   c. All other health care practitioners.
4. Supplies; and
5. Outpatient prescription drugs.

(f) Administrative expense load factors, including an explanation of all changes to any administrative expense loads that were used in the prior period's base rates and where changes in administrative expenses may be caused by regulatory requirements or efforts to contain health care delivery costs;

(g) Contribution-to-surplus load factors, including an explanation of all changes to the contribution-to-surplus load factor that are caused by regulatory requirements or other external events;

(h) The anticipated loss ratios for the one year period during which the proposed base rates will be in effect;

43.07: continued

(i) A detailed description of all cost containment programs of the HMO to address health care delivery costs and the realized past savings and projected savings from all such programs;

(j) If the HMO intends to pay similarly situated providers different rates of reimbursement, a detailed description of the bases for the different rates including, but not limited to:

1. Quality of care delivered;
2. Mix of patients;
3. Geographic location at which care is provided;
4. Intensity of services provided; and

(k) Three years of historic base rates for each product.

(6) If the Commissioner disapproves an HMO's proposed base rate(s), he or she shall notify the HMO in writing on the effective date of the proposed base rate(s) and he or she shall state the reason(s) for the disapproval.

(7) Within 30 days of receipt of the disapproval, the HMO may request a hearing on the disapproval. The hearing shall be adjudicatory and *de novo*. The hearing shall commence within 45 days of the Commissioner's receipt of the HMO's request. The Commissioner shall issue a written decision within a reasonable period of time after the conclusion of the hearing.

(8) In the event an HMO's proposed base rate(s) are disapproved, the HMO shall comply with the following:

(a) The HMO shall not quote, issue, make effective, deliver or renew health benefit plans in the Commonwealth using disapproved base rates. The HMO shall instead, if applicable, quote, issue, make effective, deliver or renew all health benefit plans using base rates as in effect 12 months prior to the proposed effective date of the disapproved base rates. 211 CMR 43.07(6)(a) also applies to new health benefit plans whose base rates are disapproved. In calculating premiums, the HMO may apply any applicable, but not previously disapproved, base rate adjustment factors.

(b) The HMO shall recalculate applicable rates for all affected health benefit plans and shall issue rate quotes and make all health benefit plans available through all applicable distribution channels, including intermediaries, the Commonwealth Health Insurance Connector Authority, licensed insurance producers and the HMO's website, in accordance with M.G.L. c. 176J and 211 CMR 66.00 as soon as practicable, but in no event more than ten calendar days after the HMO's receipt of the disapproval.

(c) The HMO shall notify all affected policyholders of the disapproval within ten calendar days of the HMO's receipt of the disapproval.

(d) The HMO shall promptly provide notice of all material changes to the evidence(s) of coverage to all affected individuals and groups in accordance with M.G.L. c. 176O, § 6(a) and 211 CMR 52.00: *Managed Care Consumer Protections and Accreditation of Carriers*.

43.08: Evidence of Coverage

The evidence of coverage for each product offered by the HMO must be submitted to the Commissioner, and is subject to the disapproval of the Commissioner if it does not meet the requirements of M.G.L. c. 176G, M.G.L. c. 176O, 211 CMR 43.00 and 52.13: *Evidences of Coverage*.

43.09: Agents

(1) All agents of licensed HMOs must be duly licensed to sell accident and health insurance products pursuant to M.G.L. c. 175, § 162I.

(2) Nothing in 211 CMR 43.07(1) shall require an HMO to appoint agents.

43.10: Books and Records

Every HMO shall keep and maintain its books of account and other records on a current basis and within Massachusetts. In addition, every HMO shall make, or cause to be made, and retain books and records which accurately reflect:

43.10: continued

(1) The names and last known addresses of all current subscribers to the HMO;

(2) All contracts required to be submitted to the Commissioner and all other contracts entered into by the HMO;

(3) All requests made to the HMO for payment of monies for health care services, the date of such requests, and the dispositions thereof;

(4) The names and last known addresses of persons who solicit or obtain members for an HMO, including but not limited to employees, insurance producers and agents;

(5) The amount of any commissions paid to persons who obtained members for the HMO and the manner in which said commissions are determined; and

(6) the total number and disposition of malpractice claims and other claims relating to the service or care rendered by the HMO made by, or on behalf of, members of the HMO that were settled or resulted in a judgment during the year by the HMO.

Every HMO shall preserve for a period of not less than five years, the last two years of which shall be in an easily accessible place at the main offices of the HMO, the books of account and other records required under the provisions of, and for the purposes of 211 CMR 43.00. After such books and records have been preserved for two years, they may be stored subject to their availability to the Commissioner not more than five days after he or she may request them

43.11: Penalties

(1) If the Commissioner issues a finding of neglect on the part of an HMO, the Commissioner shall notify the HMO in writing that the HMO has failed to make and file the materials required by M.G.L. c. 176G, M.G.L. c. 176O, 211 CMR 43.00 or 52.00: *Managed Care Consumer Protections and Accreditation of Carriers* in the form and within the time required. The notice shall identify all deficiencies and the manner in which the neglect must be remedied. Following the written notice, the Commissioner shall fine the HMO $5000 for each day during which the neglect continues.

(2) Following notice and hearing, the Commissioner shall suspend the HMO's authority to do new business until all required reports or materials are received in a form satisfactory to the Commissioner and the Commissioner has determined that the finding of neglect can be removed.

43.12: Health Maintenance Organization Holding Company System Requirements

(1) All HMOs shall meet the requirements of M.G.L. c. 176G, §§ 27 through 29.

(2) HMOs shall comply with the provisions of 211 CMR 7.00: *Massachusetts Insurance Holding Company System* where consistent with M.G.L. c. 176G. References to terms such as Foreign Insurer, Insurer, Policyholders, Shareholders, and M.G.L. c. 175, §§ 206 through 206D in 211 CMR 7.00 shall correspond to terms Foreign HMO, HMO, Members and Enrolled Members, and M.G.L. c. 176G, §§ 25 through 29.

43.13: Severability

If any provision of 211 CMR 43.00 or application thereof to any regulatee is held invalid, such invalidity shall not affect other provisions of 211 CMR 43.00 and, to that end, the provisions of 211 CMR 43.00 are severable.

REGULATORY AUTHORITY

211 CMR 43.00: M.G.L. c. 175J, § 9; c. 176D, § 11; c. 176G, § 17 and c. 176O, § 17.