

COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN
COMMISSIONER



OFFICE OF THE MONTANA
STATE AUDITOR

ADVISORY MEMORANDUM

To: Health insurance issuers offering group or individual health insurance coverage

From: MONICA J. LINDEEN
Commissioner of Securities and Insurance
Montana State Auditor

Date: July 6, 2012

FEDERAL AND STATE CONSUMER DISCLOSURES

INTRODUCTION

The final federal regulations regarding Summary of Benefits and Coverage and Uniform Glossary (SBC) [26 CFR Parts 54 and 602; 29 CFR Part 2590; 45 CFR part 147] are in effect for policies and certificates issued or renewed after September 23, 2012. As you are aware, Montana has its own consumer disclosure laws, which have some provisions that are similar to the federal regulations. [Mont. Code Ann. 33-22-244 and 33-22-521 (2011)] The federal law requires issuers to use the format and templates prescribed in the federal regulations. The purpose of this Advisory Memorandum is to describe how issuers may satisfy, in part, the consumer disclosure requirements of the Montana law by utilizing the prescribed federal template. I encourage issuers doing business in Montana to streamline this process whenever possible in order to avoid confusing consumers with duplicative and possibly conflicting disclosure documents. This can be accomplished by delivering the SBC as required by federal law and delivering (at the same time) a separate Montana outline of coverage form that incorporates by reference the information in the SBC, but adds the Montana specific disclosures.

MONTANA AND FEDERAL CONSUMER DISCLOSURE REQUIREMENTS

The Montana code requirements are as follows:

33-22-521. Disclosure standards -- group policy. (1) In order to provide for full and fair disclosure in the sale of disability insurance, a group disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is filed with and approved by the insurance commissioner in accordance with 33-1-501 and is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant;

(f) a description of any preauthorization or other preapproval requirements for medical care;

(g) a prominently displayed statement of the insured's responsibility for payment of billed charges beyond those charges reimbursed by the insurer when the insured uses health care services from a health care provider who is outside a network of health care providers used by the insurer; and

(h) a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding 5 years, if the trend data is available.

(3) If applicable, the outline of coverage must disclose that the policy does not contain coverage for mental illness or chemical dependency.

(4) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate group disability policy.

(5) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

(6) An outline of coverage must also be sent to an employee when an employee is sent a certificate of insurance.

(7) Prior to issuance of a group disability insurance policy, written informational materials describing the policy's cancer screening coverages must be provided to a prospective applicant. The informational materials are not subject to filing with and approval of the insurance commissioner.

The same disclosure requirements are applied to individual market insurers in Mont. Code Ann. 33-22-244. In addition to these disclosures, the Office of the Commissioner

of Securities and Insurance (CSI) requires that consumers be notified of their right to obtain estimated covered and out-of-pocket costs for certain health care services from insurers and health care providers as outlined in Mont. Code Ann. Title 50, chapter 4, part 5. [See Advisory Memorandum entitled, "Disclosure of Healthcare Costs" dated August 21, 2009 on the CSI website: www.csi.mt.gov . This disclosure of health care cost information should also be in the Montana specific outline of coverage document.

This advisory memorandum does not detail the federal requirements, but rather indicates where the federal requirements will be deemed to satisfy the Montana requirements. The CSI has determined that the following state requirements may be satisfied by referencing the federal template: (a) a general description of the principal benefits and coverages provided by the policy and (b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured. [Mont. Code Ann. 33-22-244 (2) (a) and (b) and 33-22-521 (2) (a) and (b)] The remainder of the provisions in subsections (2) (c) through (h), (3), (4), (5), (6), and (7) in both statutes are Montana specific disclosure requirements that must be included in the Montana outline of coverage, which should also specifically incorporate by reference the federal SBC, rather than repeating the information twice. Pursuant to federal law, these additional Montana-specific provisions cannot be incorporated into the federal templates. The premium and rating information required in (2) (d), (e), and (h) must be complete and incorporated into the main body of the filed form. The CSI has determined that almost all insurers have historical premium trend data available, so that requirement will not be waived without specific permission from the Forms Bureau Chief.

TIME FOR DELIVERY

The Montana outline of coverage must be delivered at the time of application and at the time of renewal if any of the provisions (other than the renewal premium) have changed since the time the original outline of coverage was delivered.

The SBC must be delivered as required by the federal regulations.

FORM FILING REQUIREMENTS

The Montana specific outline of coverage form must be filed and approved prior to use, pursuant to Mont. Code Ann. 33-1-501. The SBC must also be filed with the CSI for review in order to determine compliance with legally required disclosures, even if the insurer decides to use duplicative and separate federal and state documents.

Please submit both the Montana outline of coverage form for review and approval and the federal template for review no later than July 30, 2012, in order to have the forms reviewed and approved for use after September 23, 2012. If you have questions, please contact the Forms Bureau Chief, Rosann Grandy at 406-444-2040 or rgrandy@mt.gov.