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BULLETIN 08-29

Date: October 22, 2008

To: Health Maintenance Organizations ("HMOs"), Insurers, and Nonprofit Health Service Plans

Re: Advertisements and Marketing Documents

The purpose of this Bulletin is to remind all HMOs, Insurers and Nonprofit Health Service Plans (hereinafter "carriers") of the requirements regarding advertisements and marketing documents. It has come to the attention of the Administration that many carriers are failing to include the appropriate information in various advertisements or marketing documents, including benefit outlines.

The standards for marketing documents used by HMOs are enumerated in § 19-714 of the Health-General Article. Each marketing document that sets forth the health care services of a health maintenance organization must fully and clearly describe:

- The health care services under each benefit package and every other benefit the member is entitled to
- Where and how services may be obtained
- Each exclusion or limitation on any service or other benefit that it provides
- Each deductible and copayment feature
- For small employers, a reasonable disclosure of the provisions that relate to the HMO's right to change premium rates, provisions that relate to renewability of policies and contracts and provisions that require an employer to make dependent coverage available to eligible employees but do not require the employer to make a contribution to the premium payment for dependents

The standards for advertisements for insurers and nonprofit health service plans are found in COMAR 31.15.02.03B, which reads:

> B. Exceptions, Reductions, and Limitations. When an advertisement refers to any dollar amount, period of time for which any benefit is payable, cost of policy, or

specific policy benefit or the loss for which the benefit is payable, it shall disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the tendency to mislead or deceive.

Agency Note:

(1) The term "exception" means any provision in a policy whereby coverage for a specified hazard is entirely eliminated. It is a statement of a risk not assumed under the policy.

(2) The term "reduction" means any provision which reduces the amount of the benefit. A risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than would be otherwise payable had the reduction clause not been used.

(3) The term "limitation" means any provision which restricts coverage under the policy other than an exception or a reduction.

(4) Waiting, Elimination, Probationary, or Similar Periods. When a policy contains a time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement covered by §B of this regulation shall disclose the existence of these periods.

(5) Preexisting Conditions.

(a) An advertisement covered by §B of this regulation shall disclose the extent to which any loss is not covered if the cause of the loss is traceable to a condition existing before the effective date of the policy.

(b) When a policy does not cover losses traceable to preexisting conditions, an advertisement of the policy may not state or imply that the applicant's physical condition or medical history will not affect the issuance of the policy or payment of a claim under it. This limits the use of the phrase "no medical examination required" and phrases of similar import.

Do these requirements apply to all advertisements or marketing documents?

Not necessarily. Advertisements that relate to payable benefits, losses covered, or premiums must comply. Marketing documents that provide only general information do not have to provide this information; however, all marketing materials must be truthful and not misleading. For insurers and non-profit health service plans, a complete list of what constitutes an "advertisement" may be found in COMAR 31.15.02.01 B(1). Section 19-704 of Health-General Article does not provide a definition of what constitutes "a marketing document." Thus, the term "marketing document" will be given its most broad definition.

Any summary of benefits, benefit outline or schedule of benefits distributed as a unique document must comply with these requirements.

What type of disclosure is required regarding where and how services may be obtained?

When a service is covered only if the member receives the service in a particular type of facility or with a certain provider or if the member must receive approval from the carrier or a provider, this must be disclosed. For example, the advertisement or marketing document must disclose if:

- A member must select a primary care provider
- A service is covered only if the member has a referral from his or her primary care provider
- A service is covered only if the member receives the service from a participating provider
- A service is covered only if the primary care provider or specialist has obtained authorization from the carrier

What if the policy includes coinsurance?

Advertisements or marketing documents must identify any coinsurance amount due under the policy when the advertisement or marketing document references benefits, covered losses, or premiums.

Is the marketing document required to list all policy exclusions and/or limitations?

No. For each covered service identified in an advertisement or marketing document, any exclusion or limitation applicable to the covered service must be identified. If other exclusions or limitations apply and these are not listed in the marketing document, it must disclose: (1) that other exclusions or limitations apply; and (2) how to obtain a complete list of exclusions and limitations prior to purchasing the policy. All information that is required to be disclosed must comply with COMAR 31.15.02.05.

What is a small employer?

A small employer is defined as an employer with two to 50 eligible employees.

Is each advertisement or marketing document given or directed to small employers required to provide a reasonable disclosure of the provisions that relate to the carrier's right to change premium rates, provisions that relate to renewability of policies and contracts and provisions that require an employer to make dependent coverage available to eligible employees but do not require the employer to make a contribution to the premium payment for dependents?

No. Unless an advertisement or marketing material references benefits, covered losses, or premiums, a carrier may satisfy this requirement by providing this information in solicitation and sales materials as set forth in § 15-1206 of the Insurance Article.

Questions about this bulletin may be directed to the Life/Health Section at 410-468-2170.

Beth Sammis
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Maryland Insurance Administration