

NOTICE OF INTENT

Department of Insurance
Commissioner of Insurance

Regulation 32—Group Coordination of Benefits

Under the authority of R.S. 22:3.2014 and the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Insurance gives notice that the following proposed regulation is to be adopted and become effective January 1, 1997. This intended action complies with the statutory law administered by the Department of Insurance.

Existing regulation 32 of the Department of Insurance is to be repealed as of the effective date of this proposed regulation.

Proposed Regulation 32

Group Coordination of Benefits

Section 1. Authority

This regulation is adopted and promulgated by the Department of Insurance pursuant to the authority granted by R.S. 22:3.2014 and the Administrative Procedure Act, R.S. 49:950 et seq. This regulation replaces and repeals the regulation of similar purpose which took effect on January 20, 1994.

Section 2. Purpose and Applicability

The purpose of this regulation is to:

- A. permit, but not require, plans to include a coordination of benefits (COB) provision unless prohibited by federal law;
- B. establish a uniform order of benefit determination under which plans pay claims;
- C. provide authority for the orderly transfer of necessary information and funds between plans;
- D. reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this regulation, do not have to pay their benefits first;
- E. reduce claims payment delays; and
- F. require that COB provisions be consistent with this regulation.

Section 3. Definitions

As used in this regulation, these words and terms have the following meanings, unless the context clearly indicates otherwise:

A. *Allowable Expense*—a health care service or expense including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as set forth below or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

(1) The following are examples of expenses or services that are not an allowable expense:

(a) If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for private hospital rooms) is not an allowable expense.

(b) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fee for a specified benefit is not an allowable expense.

(c) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

(d) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans.

(2) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expenses in its contract to services or

expenses that are similar to the services or expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense shall include similar services or expenses to which COB applies.

(3) When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

(4) The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

(a) Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or

(b) Because the covered person has a lower benefit because he or she did not use a preferred provider.

(5) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were primary when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

B. *Claim*—a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

(1) services (including supplies);

(2) payment for all or a portion of the expenses incurred;

(3) a combination of Paragraphs (1) and (2) above; or

(4) an indemnification.

C. *Claim Determination Period*—a period of not less than 12 consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of COB, to determine whether overinsurance exists and how much each plan will pay or provide.

(1) The claim determination period is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.

(2) As each claim is submitted, each plan determines its liability and pays or provides benefits based upon allowable expenses incurred to that point in the claim determination period. That determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

D. *Closed Panel Plan*—a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

E. *Coordination of Benefits*—a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

F. *Custodial Parent*—the parent awarded custody of a child by a court decree. In the absence of a court decree, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation is the custodial parent.

G. *Hospital Indemnity Benefits*—benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

H. *Plan*—a form of coverage with which coordination is allowed. The definition of plan in the group contract must state the types of coverage that will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition. Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no COB among the separate parts of the plan.

(1) The definition shown in the model COB provision in Appendix A is an example but any definition that satisfies this subsection may be used.

(2) This regulation uses the term "plan." However, a contract may use "program" or some other term.

(3) Plan may include:

- (a) group insurance contracts and group subscriber contracts;
- (b) uninsured arrangements of group or group-type coverage;
- (c) group or group-type coverage through closed panel plans;
- (d) group-type contracts. Group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including franchise or blanket coverage. Individually underwritten and issued guaranteed renewable policies are not "group-type" even if purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer;
- (e) the amount by which group or group-type hospital indemnity benefits exceed \$300 per day;
- (f) the medical care components of group long-term care contracts, such as skilled nursing care;
- (g) the medical benefits coverage in group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts; and
- (h) medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (4)(i) below. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

(4) Plan shall not include:

- (a) individual or family insurance contracts;
- (b) individual or family subscriber contracts;
- (c) individual or family coverage through closed panel plans;
- (d) individual or family coverage under other prepayment, group practice and individual practice plans;
- (e) group or group-type hospital indemnity benefits of \$300 per day or less;
- (f) school accident-type coverages. These contracts cover students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;
- (g) benefits provided in group long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- (h) medicare supplement policies;
- (i) a state plan under Medicaid; or
- (j) a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

I. *Primary Plan*—a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either of the following is true:

- (1) the plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or
- (2) all plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

J. *Secondary Plan*—a plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under the rules of this regulation, has its benefits determined before those of that secondary plan.

K. *This Plan*—in a COB provision, the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from this plan. A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with similar

benefits, and may apply another COB provision to coordinate with other benefits.

Section 4. Use of Model COB Contract Provision

A. Appendix A contains a model COB provision for use in group contracts. That use is subject to the provisions of Subsections B, C and D below and to the provisions of Section 5.

B. Appendix B is a plain language description of the COB process that explains to the covered person how insurers will implement coordination of benefits. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which the two (or more) plans will pay for or provide benefits, how the benefit reserve is accrued and how the covered person may use the benefit reserve.

C. The COB provision (Appendix A) and the plain language explanation (Appendix B) do not have to use the specific words and format shown in Appendix A or Appendix B. Changes may be made to fit the language and style of the rest of the group contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted.

D. A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

- (1) another plan exists and the covered person did not enroll in that plan;
- (2) a person is or could have been covered under another plan, except with respect to Part B of Medicare; or
- (3) a person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

E. No plan may contain a provision that its benefits are "always excess" or "always secondary" except in accord with the rules permitted by this regulation.

F. Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel provider. In most instances, COB does not occur if a covered person is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the claim determination period when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan must use the benefit reserve to pay any unpaid allowable expense.

Section 5. Rules for Coordination of Benefits

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.

B. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan.

D. Order of Benefit Determination. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

(1) Non-dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

- (a) secondary to the plan covering the person as a dependent; and
- (b) primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) Child Covered Under More Than One Plan

- (a) The primary plan is the plan of the parent whose birthday is earlier in the year if:

(i) the parents are married;
(ii) the parents are not separated (whether or not they ever have been married); or

(iii) a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

(b) If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

(c) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.

(d) If the parents are not married or are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

- (i) the plan of the custodial parent;
- (ii) the plan of the spouse of the custodial parent;
- (iii) the plan of the noncustodial parent; and then
- (iv) the plan of the spouse of the noncustodial parent.

(3) Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under Subsection B(1).

(4) Continuation Coverage

(a) If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.

(b) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or Shorter Length of Coverage. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.

(a) To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within 24 hours after the first ended.

(b) The start of a new plan does not include:

- (i) a change in the amount or scope of a plan's benefits;
- (ii) a change in the entity that pays, provides or

administers the plan's benefits; or

(iii) a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

(c) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

(6) If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

Section 6. Procedure to be Followed by Secondary Plan

A. (1) When a plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The secondary plan shall calculate its savings by subtracting the amount that it paid as a secondary plan

from the amount it would have paid had it been primary. These savings shall be recorded as a benefit reserve for the covered person and shall be used by the secondary plan to pay any allowable expenses, not otherwise paid, that are incurred by the covered person during the claim determination period. As each claim is submitted, the secondary plan must:

- (a) determine its obligation, pursuant to its contract;
- (b) determine whether a benefit reserve has been recorded for the covered person;

and

- (c) determine whether there are any unpaid allowable expenses during that claims

determination period.

(2) If there is a benefit reserve, the secondary plan shall use the covered person's recorded benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claim determination period the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

B. The benefits of the secondary plan shall be reduced when the sum of the benefits that would be payable for the allowable expenses under the secondary plan in the absence of this COB provision and the benefits that would be payable for the allowable expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds the allowable expenses in a claim determination period. In that case, the benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses.

(1) When the benefits of a plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the plan.

(2) The requirements of Paragraph B(1) do not apply if the plan provides only one benefit, or may be altered to suit the coverage provided.

Section 7. Notice to Covered Persons

A plan shall, in its explanation of benefits provided to covered persons, include the following language: "If you are covered by more than one health benefit plan, you should file all your claims with each plan."

Section 8. Miscellaneous Provisions

A. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. Nothing in this provision shall be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

B. (1) A plan with order of benefit determination rules that comply with this regulation (complying plan) may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this regulation (noncomplying plan) on the following basis:

(a) if the complying plan is the primary plan, it shall pay or provide its benefits first;

(b) if the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and

(c) If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. If, within two years of payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it shall adjust payments accordingly.

(2) If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than he or she would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to or on behalf of the covered person an amount equal to the difference.

(3) In no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan shall also be without prejudice to any claim it may

have against a noncomplying plan in the absence of subrogation.

C. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

D. If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been primary.

Section 9. Effective Date; Existing Contracts

A. This regulation is applicable to every group contract that provides health care benefits and that is issued on or after the effective date of this regulation, which is January 1, 1997.

B. A group contract that provides health care benefits and that was issued before the effective date of this regulation shall be brought into compliance with this regulation by the later of:

- (1) the next anniversary date or renewal date of the group contract; or
- (2) the expiration of any applicable collectively bargained contract pursuant to which it

was written.

APPENDIX A

Model Cob Contract Provisions Coordination of this Group Contract's Benefits with Other Benefits

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100 percent of the total allowable expense.

Definitions

A. *Plan*—any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) *Plan* includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of \$300 per day; medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.

(2) *Plan* does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); amounts of hospital indemnity insurance of \$300 or less per day; school accident type coverage, benefits for nonmedical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

C. *Allowable Expense*—a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

(1) If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms) is not an allowable expense.

(2) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a

specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the allowable expense for all plans.

(5) The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

D. *Claim Determination Period*—a calendar year. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

E. *Closed Panel Plan*—is a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. *Custodial Parent*—a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

A. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

B. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

D. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

(1) *Non-dependent or Dependent*. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

(2) *Child Covered Under More Than One Plan*. The order of benefits when a child is covered by more than one plan is:

(a) The primary plan is the plan of the parent whose birthday is earlier in the year if:

(i) the parents are married;

(ii) the parents are not separated (whether or not they

ever have been married); or

(iii) a court decree awards joint custody without

specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

(b) If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years

commencing after the plan is given notice of the court decree.

(c) If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- (i) the plan of the custodial parent;
- (ii) the plan of the spouse of the custodial parent;
- (iii) the plan of the noncustodial parent; and then
- (iv) the plan of the spouse of the noncustodial parent.

(3) Active or Inactive Employee. The plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled B(1).

(4) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

(5) Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

(6) If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

Effect on the Benefits of this Plan

A. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each claim is submitted, this plan will:

- (1) determine its obligation to pay or provide benefits under its contract;
- (2) determine whether a benefit reserve has been recorded for the covered person; and
- (3) determine whether there are any unpaid allowable expenses during that claims

determination period.

If there is a benefit reserve, the secondary plan will use the covered person's benefit reserve to pay up to 100 percent of total allowable expenses incurred during the claim determination period. At the end of the claims determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. [Organization responsibility for COB administration] may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. [Organization responsibility for COB administration] need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give [Organization responsibility for COB administration] any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, [Organization responsibility for COB administration] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. [Organization responsibility for COB administration] will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by [Organization responsibility for COB administration] is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

APPENDIX B CONSUMER EXPLANATORY BOOKLET COORDINATION OF BENEFITS

IMPORTANT NOTICE

This is a summary of only a few of the provisions of your health plan to help you understand coordination of benefits, which can be very complicated. This is not a complete description of all the coordination rules and procedures, and does not change or replace the language contained in your insurance contract, which determines your benefits.

Double Coverage

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both choose to have family coverage through both employers.

When you are covered by more than one group health plan, state law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The aim is to make sure that the combined payments of all plans do not add up to more than your covered health care expenses.

Coordination of benefits (COB) is complicated, and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact your state insurance department.

Primary or Secondary?

You will be asked to identify all the plans that cover family members. We need this information to determine whether we are "primary" or "secondary." The primary plan always pays first.

Any plan which does not contain your state's coordination of benefits rules will always be primary. When this Plan Is Primary

If you or a family member are covered under another plan in addition to this one, we will be primary when;

Your Own Expenses

The claim is for your own health care expenses, unless you are covered by Medicare and both you and your spouse are retired.

Your Spouse's Expenses

The claim is for your spouse, who is covered by Medicare, and you are not both retired.

Your Child's Expenses

- A. The claim is for the health care expenses of a child covered by this plan and;
- B. your birthday is earlier in the year than your spouse's. This is known as the "birthday rule," or
- C. you are not married and you have informed us of a court decree that makes you responsible for the child's health care expenses; or
- D. there is no court decree, but you have custody of the child.

Other Situations

We will be primary when any other provisions of state or federal law require us to be.

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

How We Pay Claims When We Are Secondary

We will be secondary whenever the rules do not require us to be primary.

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid. An "allowable expense" is a health care service or expense covered by one of the plans, including copayments and deductibles.

1. If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMO) and preferred provider organizations (PPO) usually have contracts with their providers.

2. We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.

3. If the primary plan covers similar kinds of health care, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.

4. We will not pay an amount the primary plan didn't cover because you didn't follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an allowable expense.

Benefit Reserve

When we are secondary we often will pay less than we would have paid if we had been primary. Each time we "save" by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve.

1. We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the savings.

2. To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans.

3. Savings can build up in your reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

Questions about Coordination of Benefits?

Contact Your State Insurance Department

A public hearing on this proposed regulation will be held on September 24, 1996 in the Plaza Hearing Room of the Insurance Building located at 950 North Fifth Street, Baton Rouge, LA, at 8:30 a.m. All interested persons will be afforded an opportunity to make comments.

Interested persons may submit oral or written comments to Lester Dunlap, Assistant Commissioner, Department of Insurance, Box 94214, Baton Rouge, LA 70804-9214, telephone (504) 342-5415. Comments will be accepted through the close of business at 4:30 p.m. September 24, 1996.

James H. "Jim"

Brown

Commissioner

FISCAL AND ECONOMIC IMPACT STATEMENT FOR ADMINISTRATIVE RULES RULE TITLE: Regulation 32—Coordination of Benefits

I. ESTIMATED IMPLEMENTATION COSTS (SAVINGS) TO STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is not anticipated that the adoption of proposed Regulation 32 would result in any implementation costs (savings) to the Department of Insurance; however, should any costs result from the adoption of Regulation 32, such costs would be absorbed by the Department of Insurance within its existing appropriation.

II. ESTIMATED EFFECT ON REVENUE COLLECTIONS OF STATE OR LOCAL GOVERNMENTAL UNITS (Summary)

It is not anticipated that the adoption of proposed Regulation 32 will result in any impact on revenue collections of state or local governmental units.

III. ESTIMATED COSTS AND/OR ECONOMIC BENEFITS TO DIRECTLY AFFECTED PERSONS OR NONGOVERNMENTAL GROUPS (Summary)

Adoption of proposed Regulation 32 should eliminate the duplication of benefits by permitting a reduction of benefits to be paid by plans that, pursuant to rules established by this regulation, do not have to pay their benefits first and should reduce the claim-payment delays; however, there is insufficient data available at this time to determine the extent of any economic benefits to insurers or to insureds.

IV. ESTIMATED EFFECT ON COMPETITION AND EMPLOYMENT (Summary)

It is not anticipated that adoption of Regulation 32 would have any effect on employment or competition.

Brenda St. Romain
Assistant Commissioner/
Management and Finance
9608#075

RichardW.England
Assistant to the
Legislative Fiscal Officer