TITLE 365. INSURANCE DEPARTMENT
CHAPTER 10. LIFE, ACCIDENT AND HEALTH
SUBCHAPTER 11. COORDINATION OF BENEFIT GUIDELINES

365:10-11-1. Purpose

The purpose of this subchapter is to adopt the Model Group Coordination of Benefits Regulation, as promulgated by the National Association of Insurance Commissioners. This subchapter is intended to establish uniformity in the permissive use of over insurance provisions and to avoid claim delays and misunderstandings that could otherwise result from the use of inconsistent or incompatible provisions amount Plans. It is contrary to the public policy of this state for a Plan to declare its coverage to be "excess" to all others, or always "secondary", or to reduce its benefits because of the existence of duplicate coverage in a manner other than as permitted by this regulation; or to reduce its benefits because a person covered by the Plan is eligible for any other coverage. It is requested that courts give effect to this public policy when they consider the interrelation of Plans with order of benefit determination rules which comply with this subchapter and Plans with order of benefit determination rules which differ from those set forth in this subchapter.

365:10-11-2. Definitions

The following words or terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Allowable expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made except where a statute requires a different definition. However, items of expense under coverage such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A plan which provides benefits only for any such items of expense may limit its definition of allowable expense to like items of expense. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid. The difference between the cost of a private hospital room and the cost of a semi-private hospital room shall not be deemed to be an "Allowable Expense," except for the period of time during which the patient's confinement to a private hospital room is deemed medically necessary in terms of generally accepted medical practice.

"Plan" includes the following:

(A) Group and nongroup insurance contracts and subscriber contracts;

(B) Uninsured arrangements of group or group-type coverage;

(C) Group and nongroup coverage through closed panel plans;

(D) Group-type contracts;

(E) The medical care components of long-term care contracts, such as skilled nursing care;

(F) The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts;

(G) Medicare or other governmental benefits, as permitted by law, except as provided in a state plan under Medicaid. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; and

(H) Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

"Plan" does not include:

(A) Hospital indemnity coverage benefits or other fixed indemnity coverage;

(B) Accident only coverage;

(C) Specified disease or specified accident coverage;

(D) Limited benefit health coverage;

(E) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

(F) Benefits provided in long-term care insurance policies for non-medical 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;

(G) Medicare supplement policies;

(H) A state plan under Medicaid; or

(I) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan; or

(J) Disability income protection coverage.

"This plan" means that portion of the policy which provides the benefits that are subject to this subchapter.

365:10-11-3. Effect on benefits

(a) **Determining benefits.** This section shall apply in determining the benefits as to a person covered under the Plan for any claim determination period if, for the allowable expense incurred as to such person during such period, the sum of:

(1) the benefits that would be payable under this Plan in the absence of this provision, and

(2) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

(b) **Claim determination period.** As to any claim determination with respect to which this section is applicable, the benefits that would be payable under this Plan in the absence of this provision for the allowable expenses incurred as to such person during such claim determination period shall be reduced to the extent necessary to that the sum of such reduced benefits and all the benefits payable for such allowable expenses under all other Plans, except as provided in (c) of this section, shall not exceed the total of such allowable expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefore.

(c) **Coordination of benefits.** The benefits of another Plan will be ignored for the purpose of determining the benefits under this Plan if:

(1) the other Plan which is involved in (b) of this section and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this plan have been determined, and

(2) the rules set forth in (d) of this section would require this Plan to determine its benefits before such other Plan.

(d) **Order of benefit determination.** For the purpose of (c) of this section, the rules establishing the order of benefit determination are:

(1) The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent.

(2) The following guidelines apply with respect to claims regarding dependent children:

(A) Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a plan which covers the person on which expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this paragraph regarding dependents, which results either in each Plan determining benefits before the other or in each Plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this paragraph shall determine the order of benefits.

(B) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

(C) In the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parents without custody.

(D) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding (B) and (C) of this paragraph, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

(3) When (1) and (2) of this subsection do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period time shall be determined before the benefits of a Plan which has covered such person the shorter period of time, provided that:

(A) the benefits of a plan covering the person on whose expenses claim is based as a laid-off or retired employee, or dependent of such person, shall be determined after the

benefits of any other Plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person; and

(B) if either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining its benefits after the other, then the provisions of (A) above shall not apply.

(4) When a claim under a Plan with a COB provision involves another Plan which also has a COB provision, the carriers involved should use the rules in (1) through (3) of this subsection to decide the order in which the benefits payable under the respective plans will be determined. Note:

(A) In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the amount of scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another, (e.g. single employer to multiple employer Plan, or vice versa, or single employer to a Taft-Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this paragraph.

(B) If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, the absence of specific information to the contrary, the carrier shall assume, for purposes of this paragraph, that the claimant's length of time covered under that plan shall be measured from claimant's effective date of coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group coverage, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his coverage under that Plan has been in force.

(5) Some Plans have order of benefit determination rules not consistent with this section which declare that the Plan's coverage is "excess" to all others, or "always secondary". This occurs because:

(A) certain Plans may not be subject to insurance section; or

(B) some group contracts have not yet been conformed with this section pursuant to the effective date.

(6) A Plan with order of benefit determination rules which complies with this section (herein called a Complying Plan) may coordinate its benefits with a Plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this section (herein called a Noncomplying Plan) on the following basis:

(A) If the Complying Plan is the Primary Plan, it shall pay or provide its benefits on a primary basis.

(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, such payment shall be the limit of the Complying Plan's liability.

(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. However, the Complying Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

365:10-11-4. Right to receive and release necessary information

For the purpose of determining the applicability of and implementing the terms of this section of this Plan or any provision of similar purpose of any other Plan, the insurer or service plan may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the insurer or service plan deems to be necessary for such purposes. Any person claiming benefits under this plan shall furnish to the insurer or service plan such information as may be necessary to implement this section. Occasionally this will necessitate a carrier making payment as the primary carrier with a right of recovery in the event that subsequent investigation proves that payment as a secondary carrier should have been made.

365:10-11-5. Benefit payments

Carriers shall use the following claims administration procedures to expedite claim payments where COB is involved:

(1) **Improving exchange of benefit information.**

(A) There should be continued and improved education of claim personnel stressing accurate and prompt completion of the HIC Duplicate Coverage Inquiry (DUP-1) Form by the inquiring carrier and the responding carrier. This education effort should also be encouraged through local claim associations.

(B) Claim personnel should be encouraged to make every effort, including use of the telephone, to speed up exchange of COB information. All carriers shall respond to inquiries at least thirty (30) days from receipt of such inquiries.

(C) Carriers should encourage building a local date file of other group plans in the area, with at least basic information on group health plans for major employers.

(2) **Time limits for payment.** Each carrier shall establish a time limit after which full or partial payment should be made. When payment of a claim is necessarily delayed for reasons other than the application of a COB provision, investigation of other valid coverage should be conducted concurrently so as to create no further delay in the ultimate payment on benefits.

365:10-11-6. Subrogation

The concept of coordination of benefits is clearly distinguishable from that of subrogation. Provisions for either may be included in a group health insurance policy without compelling the inclusion or exclusion of the other.

365:10-11-7. Small claim waivers

Carriers shall waive the investigation of possible other coverage for COB purposes on claims less than $50, but if additional liability is incurred to raise the small claim above $50, the entire liability may be included in the COB computation.

365:10-11-8. Public education

Each carrier has an affirmative obligation to urge its respective group policyholder-clients to take reasonable steps to assure that those insured by the group policy or subscriber contract have been exposed to reasonably concise explanations, with as little technical terminology as is commensurate with accuracy, as to the purpose and operation of COB. Such educational effort may take the form of articles in the company magazines or newspapers, speeches before the appropriate labor organization in the case of a unionized company, brochures added to pay envelopes, notices on the company bulletin board, material used by personnel department in counseling employees, and the like.

365:10-11-9. Applicability

(a) Group policies or contracts which are in force at the time of promulgation of this subchapter which contain an "excess" clause, "anti-duplication" provision, or any other provision by whatever name designated under which benefits would be reduced because of other existing coverages, other than the COB provisions established in this subchapter, shall be brought into compliance by the later of the next anniversary or renewal date of the group policy or contract or the expiration of the applicable collectively bargained contract, pursuant to which they are written, if any.

(b) The definition of "Plan" in 365:10-11-2 applies to plans that are delivered, issued for delivery, or renewed on or after January 1, 2015. A contract that is in force on January 1, 2015, must be brought into compliance with the definition of "Plan" on the next anniversary date or renewal date of the contract, or the expiration of any applicable collective bargaining contract under which it was written.

365:10-11-10. Facility of payment

Whenever payments which should have been made under this Plan in accordance with this section have been made under any other Plans, the insurer or service plan shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the insurer or service plan shall be fully discharged from liability under this Plan.

365:10-11-11. Right of recovery

Whenever payment has been made by the insurer with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, the insurer or service plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the insurer or service plan shall determine:

(1) any persons to or for or with respect to whom such payments were made;

(2) any other insurers; or
(3) service plans or any other organizations.