230-RICR-20-30-2

TITLE 230 – DEPARTMENT OF BUSINESS REGULATION

CHAPTER 20 – INSURANCE

SUBCHAPTER 30 – HEALTH INSURANCE

PART 2 - Coordination of Benefits

2.1 Authority

This Part is adopted and promulgated pursuant to R.I. Gen. Laws § 27-20.6-6.

2.2 Purpose

A. This Part applies to all plans that are issued on or after the effective date of this part. The purpose of this Part is to:

1. Establish a uniform order of benefit determination under which plans pay their claims;

2. Reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to rules established by this Part, do not have to pay their benefits first; and

3. Provide greater efficiency in the processing of claims when a person is covered under more than one plan

B. In order to accomplish the goals of this Part the Department or the Office of Health Insurance Commissioner may require licensees to use a standardized process and form, including manual and electronic formats, to increase the accuracy of coverage information when multiple carriers are involved.

2.3 Definitions

A. The following words and terms, when used in this Part, shall have the following meanings unless the context clearly indicates otherwise.

1. “Allowable expense”

a. "Allowable expense" except as set forth below or where a statute requires a different definition, means any health care expense, including coinsurance or co-payments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

b. If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

c. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense

d. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense

e. The following are examples of expenses that are not allowable expenses:

(1) If a 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 is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest of the negotiated fees is not an allowable expense

(3) If a person is covered by two (2) 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.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology 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. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement

and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

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

g. 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.

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

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

(2) Because the covered person has a lower benefit because the covered person did not use a preferred provider.

B. "Birthday" refers only to month and day in a calendar year and does not include the year in which the individual is born.

C. "Claim" means 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 (1) and (2) above; or.

4. An indemnification.

D. "Closed panel plan" means 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 excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

E. “Consolidated Omnibus Budget Reconciliation Act of 1985” or “COBRA” means coverage provided under a right of continuation pursuant to federal law.

F. “Coordination of benefits” or “COB” means 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.

G. “Custodial parent” means:

1. The parent awarded custody of a child by a court decree: or.

2. 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.

H. “Group-type contract” means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. “Group-type contract” does not include an individually underwritten and issued guaranteed renewable policy even if the policy is 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.

I. “High-deductible health plan” has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003

J. “Hospital indemnity benefits” means benefits not related to expenses incurred. “Hospital indemnity benefits” 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.

K. "Plan" means a form of coverage with which coordination is allowed. 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. If a plan coordinates benefits, its contract shall state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term “plan” or some other term such as “program,” the contractual definition may be no broader than the definition of “plan” in this subsection. The definition shown in the Model COB Provision, in Appendix A, provided in a bulletin issued for that purpose, is an example.

1. “Plan” includes:

a. Group insurance and 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

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 § 2.3(K)(4)(h) of this Part. 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

2. “Plan” does not include:

a. Hospital indemnity benefits or other group or group-type fixed indemnity coverage

b. Accident only coverage

c. Specified disease or specified accident coverage

d. Limited benefit health coverage

e. School accident-type coverages. These contracts cover students for accidents only, including athletic injuries, either on a twenty four (24) hour basis or on a "to and from school" basis; and

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, and shall not include a plan (such as the Catastrophic Health Insurance Plan benefits provided pursuant to R.I. Gen. Laws §§ 42-62-5 through 42-62-8) when, by law, its

benefits are in excess of those of any private insurance plan or other non-governmental plan

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

L. "Policyholder" means the primary insured named in a nongroup insurance policy

M. "Primary plan" means 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

1. The Plan either has no order of benefit determination rules, or it's rules differ from those permitted by this Part; or

2. All plans that cover the person use the order of benefit determination rules required by this Part, and under those rules the plan determines its benefits first.

N. "Secondary plan" means a plan which is not a Primary Plan.

2.4 Applicability and Scope

This Part applies to all plans that are issued on or after the effective date of this Part which is October 1, 1990.

2.5 Model COB Contract Provisions

A. Appendix A provided in a bulletin issued for that purpose, contains a model COB provision for use in Secondary Plan contracts. That use is subject to the provisions of §§ 2.5(B), (C) and (D) of this Part and to the provisions of § 2.6 of this Part.

B. Appendix B provided in a bulletin issued for that purpose, is a plain language description of the COB process that explains to the covered person how Secondary Plans 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 (2) or more plans will pay for or provide benefits.

C. The COB provision contained in Appendix A provided in a bulletin issued for that purpose, and the plan language explanation in Appendix B provided in a bulletin issued for that purpose, do not have to use the specific words and format shown in Appendix A provided in a bulletin issued for that purpose. Changes may be made to fit the language and style of the rest of the group contract or to reflect the 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" to any plan as defined in this Part., except in accordance with the rules permitted by this Part.

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 (2) 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 plan year when the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use the provision of § 2.7 of this Part to determine the amount it should pay for the benefit.

G. No plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan under § 2.3(K) of this Part.

2.6 Rules for Coordination of Benefits

A. When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan shall pay or provide its benefits as if the Secondary Plan or Plans did not exist;

2. 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 the primary plan 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

3. When multiple contracts providing coordinated coverage are treated as a single plan under this of this Part, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides

benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this of this Part.

4. If a person is covered by more than one secondary plan, the order of benefit determination rules of this of this Part 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 of this Part, has its benefits determined before those of that secondary plan.

B. Except as provided in § 2.6(B)(1) of this Part below, a plan that does not contain order of benefit determination provisions that are consistent with this of this Part is always the primary plan unless the provisions of both plans, regardless of the provisions of this paragraph, state that the complying plan is primary.

1. 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 take into consideration the benefits paid or provided by another plan only when, under the rules of this of this Part, it is secondary to that other plan.

D. Order of Benefit Determination. Each Plan determines its order of benefits using the first of the following rules that applies:

1. Non-Dependent or Dependent.

a. Subject to § 2.6(D)(1)(b) of this Part, the plan that covers the person other than as a dependent, for example as an employee, member, subscriber, policyholder or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

b. 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:

(1) Secondary to the plan covering the person as a dependent; and

(2) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),

(3) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan

2. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

a. For a dependent child whose parents are married or are living together, whether or not they have ever been married-:

(1) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

(2) If both parents have the same birthday the plan that has covered the parent longest is the primary plan.

b. For a dependent child whose parents are separated or divorced or are not living together, whether or not they have ever been married:

(1) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(AA) The plan covering the custodial parent;

(BB) The plan covering the custodial parent's spouse;

(CC) The plan covering the non-custodial parent; and then

(DD) The plan covering the non-custodial parent's spouse.

(2) If a court decree states that one of the parents is responsible for the health care expenses or health care coverage of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph does not apply with respect to any plan year during which benefits are paid or provided before the entity has knowledge of the court decree provision;

(3) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care

coverage, the provisions of § 2.6(D)(2)(a) of this Part shall determine the order of benefits;

(4) If a court decree states that the parents have joint custody, without stating that one of the parents is responsible for the health care expenses or health care coverage of the dependent child, the provisions of § 2.6(D)(2)(a) of this Part shall determine the order of benefits.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under § 2.6(D)(2)(a) of this Part as if those individuals were parents of the child.

d. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in § 2.6(D)(5) of this Part applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in § 2.6(D)(2)(a) of this Part to the dependent child's parent(s) and the dependent's spouse.

3. Active Employee or Retired or Laid-Off Employee.

a. The plan that covers a person as an active employee who is, neither laid off nor retired (or as that employee's dependent) is the primary plan. The plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

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

c. This rule does not apply if the rule in § 2.6(D)(1) of this Part can determine the order of benefits.

4. COBRA or State Continuation Coverage

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

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.

c. This rule does not apply if the rule in § 2.6(D)(1) of this Part can determine the order of benefits.

5. Longer or Shorter Length of Coverage.

a. If the preceding rules do not determine the order of benefits, the plan that covered the person longer is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

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

c. The start of a new plan does not include:

(1) A change in the amount or scope of a plan's benefits;

(2) A change in the entity which pays, provides or administers the plan's benefits; or

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

d. 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, 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 order of benefits, the allowable expenses shall be shared equally between the plans.

2.7 Procedure to be followed by Secondary Plan to Calculate Benefits and Pay a Claim

In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not

exceed 100 percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

2.8 Notice to Covered Persons

A plan, other than automobile contracts, 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.”.

2.9 Miscellaneous Provisions

A. A Secondary Plan which 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 which provides benefits in the form of services.

B. Compliant and Non-Compliant Plans

1. A plan with order of benefit determination rules that comply with this of this Part. (Complying Plan) may coordinate its benefits with a plan which is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in this of this Part. (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 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 (2) years of payment, the complying plan receives information as to the actual benefits of the non-complying 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 such advance, the Complying Plan shall be subrogated to all rights of covered person against the Noncomplying Plan. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the 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 thirty (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 the primary plan.

2.10 Effective Date for Existing Contracts

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

1. The later of:

a. The next anniversary date or renewal date of the contract; or

b. Twelve months (12) following June 1, 2014; or

2. The expiration of any applicable collectively bargained contract pursuant to which it was written.

B. For the transition period between the adoption of this of this Part and the timeframe for which plans are to be in compliance pursuant to § 2.10(A) of this Part, a plan that is subject to the prior COB requirements shall not be considered a non-complying plan by a plan subject to the new COB requirements and if there is a conflict between the prior COB requirements under the prior regulation and the new COB requirements under the amended of this Part, the prior COB requirements shall apply.

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TITLE 230 - DEPARTMENT OF BUSINESS REGULATION (INCLUDES THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER)

CHAPTER 20 - INSURANCE

SUBCHAPTER 30 - HEALTH INSURANCE

PART 2 - COORDINATION OF BENEFITS (FORMERLY INSURANCE REGULATION 48) (230-RICR-20-30-2)

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