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18.01.74 - Coordination of Benefits

IDAPA 18
TITLE 01
CHAPTER 74

18.01.74 - COORDINATION OF BENEFITS

000. LEGAL AUTHORITY.

This rule is promulgated and adopted pursuant to the authority vested in the Director under Chapters 2, 21, 22 and 34, Title 41, Idaho Code. (7-1-98)

001. TITLE AND SCOPE.

01. Title. This rule shall be cited in full as Idaho Department of Insurance Rules, IDAPA 18.01.74, "Coordination of Benefits". (7-1-98)

02. Scope. The purpose of this rule is to permit, but not require, plans to include a coordination of benefits (COB) provision unless prohibited by federal law; establish a uniform order of benefit determination under which plans pay claims; provide authority for the orderly transfer of necessary information and funds between plans; reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that, pursuant to these rules, do not pay their benefits first; reduce claims payment delays; and require that COB provisions be consistent with this rule. (7-1-98)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(19)(b)(iv), Idaho Code, this agency may have written statements which pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost at this agency. (7-1-98)

003. ADMINISTRATIVE APPEALS.

All contested cases shall be governed by the provisions of IDAPA 04.01.01, "Idaho Rules of Administrative Procedure of the Attorney General". (7-1-98)

004. DEFINITIONS.

As used in this rule, these words and terms have the following meanings, unless the context clearly indicates otherwise: (7-1-98)

01. Allowable Expense. "Allowable expense" means 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. (7-1-98)

a. The following are examples of expenses of services that are not an allowable expense: (7-1-98)

i. 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. (7-1-98)

ii. If a person is covered by two (2) 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. (7-1-98)

iii. 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. (7-1-98)

iv. 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. (7-1-98)

b. The definition of the "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. (7-1-98)

c. When a plan provides benefits in the form of service, the reasonable cash value of each service will be considered as an allowable expense and a benefit paid. (7-1-98)

d. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan: (7-1-98)

i. Because the covered person does not comply with the plan provisions covering second surgical opinions or precertification of admissions or services. (7-1-98)

ii. Because the covered person has a lower benefit because he or she did not use a preferred provider. (7-1-98)

e. 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 nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan. (7-1-98)

02. Claim. "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of: (7-1-98)

a. Services (including supplies); (7-1-98)

b. Payment for all or a portion of the expenses incurred; (7-1-98)

c. A combination of Subsection 004.02.a. and 004.02.b.; or (7-1-98)

d. An indemnification. (7-1-98)

03. Claim Determination Period. "Claim determination period" means a period of not less than twelve (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. (7-1-98)

a. 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 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. (7-1-98)

b. 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. (7-1-98)

04. Closed Panel Plan. "Closed panel plan" means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), managed care plan, 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. (7-1-98)

05. Coordination of Benefits. "Coordination of benefits" 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. (7-1-98)

06. Custodial Parent. "Custodial parent" means the parent awarded custody 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. (7-1-98)

07. Hospital Indemnity Benefits. "Hospital indemnity benefits" means the 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. (7-1-98)

08. Plan. "Plan" means a form of coverage with which coordination is allowed. The definition of plan in the 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. (7-1-98)

a. This rule uses the term "plan". However, a contract may use "program" or some other term. (7-1-98)

b. Plan may include: (7-1-98)

i. Group insurance contracts and group subscriber contracts; (7-1-98)

ii. Uninsured group or group-type coverage arrangements: (7-1-98)

iii. Group or group-type coverage through closed panel plans; (7-1-98)

iv. 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. (7-1-98)

v. The amount by which group or group-type hospital indemnity benefits exceed two hundred dollars ($200) per day. (7-1-98)

vi. The medical care components of long-term care contracts, such as skilled nursing care. (7-1-98)

vii. Medicare or other governmental benefits, except as provided in Subsection 004.08.c.vii. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program. (7-1-98)

viii. Individual or family insurance contracts. (7-1-98)

ix. Individual or family subscriber contracts. (7-1-98)

x. Individual or family coverage through closed panel plans. (7-1-98)

xi. Individual or family coverage under other prepayment, group practice and individual practice plans. (7-1-98)

c. Plan shall not include: (7-1-98)

i. Group or group-type hospital indemnity benefits of two hundred dollars ($200) per day or less. (7-1-98)

ii. 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. (7-1-98)

iii. Benefits provided in long-term care insurance policies for non-medical service; for example, personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay as fixed daily benefit without regard to expenses incurred or the receipt of services. (7-1-98)

iv. Medical benefits coverage in individual automobile "no fault" and traditional automobile "fault" type contracts. (7-1-98)

v. Limited benefit health coverages, such as, but not limited to, accident only, specified disease, disability income, hospital indemnity, credit insurance benefits, dental insurance, vision insurance; coverages issued to supplement liability insurance; and worker's compensation or similar insurance. (7-1-98)

vi. Medicare supplement policies. (7-1-98)

vii. A state plan under Medicaid. (7-1-98)

viii. A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan. (7-1-98)

ix. Nonrenewable short-term coverages issued for a period of twelve (12) months or less. (7-1-98)

09. Primary Plan. "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 either of the following is true: (7-1-98)

a. The plan either has no order of benefit determination rules, or its rules differ from those permitted by this rule; (7-1-98)

b. All plans that cover the person use the order of benefit determination required by this rule, and under those rules the plan determines its benefits first; (7-1-98)

10. Secondary Plan. "Secondary plan" means a plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination of this rule decides 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 this rule, has its benefits determined before those of the secondary plan. (7-1-98)

11. This Plan. "This plan" means, in a COB provision, the part of the 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 contract providing health care benefits is separate from this plan. A 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. (7-1-98)

005. -- 010. (RESERVED).

011. COB CONTRACT PROVISION.

01. Limits on COB Provisions. A COB provision may not be used that permits a plan to reduce benefits on the basis that: (7-1-98)

a. Another plan exists and the covered person did not enroll in that plan; (7-1-98)

b. A person is or could have been covered under another plan, except with respect to Part B of Medicare; or (7-1-98)

c. A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected. (7-1-98)

02. "Always Excess" or "Always Secondary". No plan may contain a provision that its benefits are "always excess" or "always secondary" except in accord with the order of benefit determination permitted by this rule. (7-1-98)

03. Closed Panel Provider. 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. (7-1-98)

012. -- 015. (RESERVED).

016. RULES FOR COORDINATION OF BENEFITS.

01. Order of Benefit Payments. When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows: (7-1-98)

a. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist. (7-1-98)

b. A plan that does not contain a coordination of benefits provision that is consistent with this rule is always primary. There are two (2) exceptions: (7-1-98)

i. 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. (7-1-98)

ii. Individual plans as they shall always be secondary to group plans. (7-1-98)

c. A plan may consider the benefits paid or provided by another plan only when it is secondary to that other plan. (7-1-98)

02. Order of Benefit Determination. The first of the following rules that describes which plan pays its benefits before another plan is the rule that shall be applied. (7-1-98)

a. A group plan shall always be primary to an individual plan. (7-1-98)

b. 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 rules, Medicare is: (7-1-98)

i. Secondary to the plan covering the person as a dependent; and (7-1-98)

ii. 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. (7-1-98)

c. Child covered under more than one plan. (7-1-98)

i. The primary plan is the plan of the parent whose birthday is earlier in the year if: (7-1-98)

(1) The parents are married; (7-1-98)

(2) The parents are not separated (whether or not they ever have been married); or (7-1-98)

(3) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage. (7-1-98)

ii. If both parents have the same birthday, the plan that covered either of the parents longer is primary. (7-1-98)

iii. 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. (7-1-98)

iv. If the parents are not married or are separated (whether or not they ever have been 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 parent and the parent's spouse (if any) is: (7-1-98)

(1) The plan of the custodial parent; (7-1-98)

(2) The plan of the spouse of the custodial parent; (7-1-98)

(3) The plan of the noncustodial parent; and then (7-1-98)

(4) The plan of the spouse of the noncustodial parent. (7-1-98)

d. Active/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 016.01.b. (7-1-98)

e. Continuation coverage: 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. 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. (7-1-98)

f. Longer/shorter length of coverage: If none of the above rules determines the order of benefits, the plan that covered the person as an employee, member, subscriber or retiree for a longer period of time is primary. (7-1-98)

i. To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) if the person was eligible under the second within twenty-four (24) hours after the first ended. (7-1-98)

ii. The start of a new plan does not include: (7-1-98)

(1) A change in the amount of scope of a plan's benefits; (7-1-98)

(2) A change in the entity that pays, provides or administers the plan's benefits; or (7-1-98)

(3) A change from one type of plan to another (such as from a single employer plan to that of a multiple employer plan). (7-1-98)

iii. 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. (7-1-98)

g. If none of these rules determines the primary plan, the allowable expenses shall be shared equally between the plans. (7-1-98)

017. -- 020. (RESERVED).

021. PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN.

01. Individual Plan Reduction. Individual plans may reduce benefits in accordance with Section 022. (7-1-98)

02. Secondary Plan Reduction. When a 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 one hundred percent (100%) of total allowable expenses. As each claim is submitted, the secondary plan must: (7-1-98)

a. Determine its obligation pursuant to its contract. (7-1-98)

b. Determine whether there are any unpaid allowable expenses during that claims determination period. (7-1-98)

c. Pay up to one hundred percent (100%) of total allowable expenses incurred during the claim determination period. (7-1-98)

03. Reduction of Secondary Plan Benefits. 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 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. (7-1-98)

a. When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of the plan. (7-1-98)

b. The requirements of Subsection 021.02.a. do not apply if the plan provides only one (1) benefit, or may be altered to suit the coverage provided. (7-1-98)

022. INDIVIDUAL PLANS.
Individual plans may provide for a reduction in covered benefits due to the existence of another plan by including language in the contract, policy or certificate that is consistent with this rule. (7-1-98)

023. -- 025. (RESERVED).

026. MISCELLANEOUS PROVISIONS.

01. Benefits in the Form of Services. 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 which provides benefits in the form of services. (7-1-98)

02. Complying Plan Versus Noncomplying Plan. A plan with order of benefit determination rules that comply with this rule (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 rule

(noncomplying plan) on the following basis: (7-1-98)

a. If the complying plan is the primary plan, it shall pay or provide its benefits first; (7-1-98)

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 (7-1-98)

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 the actual benefits of the noncomplying plan, it shall adjust payments accordingly. (7-1-98)

i. 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. (7-1-98)

ii. 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 services. 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 the noncomplying plan in the absence of such subrogation. (7-1-98)

03. COB Versus Subrogation. The COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other. (7-1-98)

04. Timely Payment of Benefits. 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 primary. (7-1-98)

027. -- 030. (RESERVED).

031. EFFECTIVE DATE; EXISTING CONTRACTS.

01. Effective Date of Rule. This rule is applicable to every plan that provides health care benefits and that is issued on or after the effective date of this rule, which is July 1, 1998. (7-1-98)

02. Contract Compliance. A contract that provides health care benefits and that was issued before the effective date of this rule shall be brought into compliance with this rule by the later of: (7-1-98)

a. The next anniversary date or renewal date of the plan; or (7-1-98)

b. The expiration of any applicable collectively bargained contract pursuant to which it was written. (7-1-98)

031. -- 999. (RESERVED).

Subject Index