## IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

## Market Oversight

## 18.04.14 – Coordination of Benefits

**Who does this rule apply to**?
*This rule applies to insurance contracts that include medical benefits coverage.*

**What is the purpose of this rule**?
*The purpose of this rule allows plans to include a coordination of benefits (COB) provision; establish a uniform order of benefit determination; provides authority for the transfer of information and funds; reduces duplication of benefits and claim payment delays; requires COB provisions be consistent with this rule; and provides efficiency in processing claims.*

**What is the legal authority for the agency to promulgate this rule**?
*This rule implements the following statutes passed by the Idaho Legislature:*

Insurance -
- 41-02, et seq., Idaho Code – The Department of Insurance
- 41-21, et seq., Idaho Code – Disability Insurance Policies
- 41-22, et seq., Idaho Code – Group and Blanket Disability Insurance
- 41-34, et seq., Idaho Code – Hospital And Professional Service Corporations

**Who do I contact for more information on this rule**?

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# *Table of Contents*

# 18.04.14 – COORDINATION OF BENEFITS

**000. LEGAL AUTHORITY.**
Title 41, Chapters 2, 21, 22 and 34, Idaho Code. (7-1-21)T

**001. TITLE AND SCOPE.**

**01. Title**. IDAPA 18.04.14, "Coordination of Benefits." (7-1-21)T

**02. Scope**. This chapter applies to all plans, as defined. It allows plans to include a coordination of benefits (COB) provision unless banned 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; and provide greater efficiency in the processing of claims when a person is covered under more than one (1) plan. (7-1-21)T

**002. INCORPORATION BY REFERENCE.**
This rule incorporates by reference the full text of the National Association of Insurance Commissioners (NAIC) Model Coordination of Benefits Contract Provisions (Appendix A) and the NAIC Consumer Explanatory Booklet (Appendix B), published as part of the NAIC 2013 Coordination of Benefits model regulation and available on the Idaho Department of Insurance website. (7-1-21)T

**003. -- 009. (RESERVED)**

**010. DEFINITIONS.**
As used in this chapter, these words and terms have the following meanings, unless the context clearly indicates otherwise: (7-1-21)T

**01. Allowable Expense**. Any health care expense including coinsurance or copayments, and without reduction for any applicable deductible that is covered in full or in part by any of the plans covering the person. 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 will not be subject to the deductible as described in Section 223 (c) (2) (C) of the Internal Revenue Code of 1986. An expense that a provider by law or in accordance with contractual agreement is banned from charging a covered person is not an allowable expense. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense. (7-1-21)T

**a.** The following are examples of expenses or services that are not an allowable expense: (7-1-21)T

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 provides coverage for private hospital rooms) is not an allowable expense. (7-1-21)T

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, or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense. (7-1-21)T

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. (7-1-21)T

iv. 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 is 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 is the allowable expense used by the secondary plan to determine its benefits. (7-1-21)T

**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 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" includes similar expenses to which COB applies. (7-1-21)T

**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. (7-1-21)T

**d.** The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan: (7-1-21)T

i. Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services: or (7-1-21)T

ii. Because the covered person has a lower benefit because the covered person did not use a preferred provider. (7-1-21)T

**02. Birthday**. Refers only to month and day in a calendar year and does not include the year in which the individual is born. (7-1-21)T

**03. Claim**. A request that benefits of a plan be provided or paid. The benefits claimed may be in the form of: (7-1-21)T

**a.** Services (including supplies); (7-1-21)T

**b.** Payment for all or a portion of the expenses incurred; (7-1-21)T

**c.** A combination of Paragraphs 010.03.a. and 010.03.b. of this chapter; or (7-1-21)T

**d.** An indemnification. (7-1-21)T

**04. Closed Panel Plan**. 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. (7-1-21)T

**05. Consolidated Omnibus Budget Reconciliation Act of 1985 or "COBRA"**. Coverage provided under a right of continuation pursuant to federal law. (7-1-21)T

**06. Coordination of Benefits (COB)**. 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. (7-1-21)T

**07. Custodial Parent**. 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. (7-1-21)T

**08. Group-Type Contract**. 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. (7-1-21)T

**09. 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. (7-1-21)T

**10. Hospital Indemnity Benefits**. 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. (7-1-21)T

**11. Plan**. 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 states 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 this definition. The definition of "plan" in the incorporated Appendix A is an example. (7-1-21)T

**a.** Plan includes: (7-1-21)T

i. Group and nongroup insurance contracts and subscriber contracts; (7-1-21)T

ii. Uninsured group or group-type coverage arrangements; (7-1-21)T

iii. Group and nongroup coverage through closed panel plans; (7-1-21)T

iv. Group-type contracts; (7-1-21)T

v. The medical care components of long-term care contracts, such as skilled nursing care; (7-1-21)T

vi. Medicare or other governmental benefits, except as provided in Subparagraph 010.11.b.ix. of this chapter. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program. (7-1-21)T

vii. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts. No plan is prescribed to coordinate benefits provided that it pays benefits as a primary plan. If a plan coordinates benefits, it will do so in compliance with the provisions of this chapter. (7-1-21)T

viii. Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental or vision care. (7-1-21)T

**b.** Plan does not include: (7-1-21)T

i. Hospital indemnity coverage or other fixed indemnity coverage; (7-1-21)T

ii. School accident-type coverages, such as contracts that cover students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a "to and from school" basis; (7-1-21)T

iii. Specified disease or specified accident coverage; (7-1-21)T

iv. Accident only coverage; (7-1-21)T

v. 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 a fixed daily benefit without regard to expenses incurred or the receipt of services; (7-1-21)T

vi. Limited benefit health coverage as defined in IDAPA 18.04.08, "Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule." (7-1-21)T

vii. Medicare supplement policies; (7-1-21)T

viii. A state plan under Medicaid; or (7-1-21)T

ix. A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan. (7-1-21)T

**12. Policyholder**. The primary insured named in a non-group insurance policy. (7-1-21)T

**13. Primary Plan**. A plan whose benefits for a person's health care coverage needs to be determined without taking the existence of any other plan into consideration. A plan is a primary plan if; (7-1-21)T

**a.** The plan either has no order of benefit determination rules, or its rules differ from those permitted by this rule; or (7-1-21)T

**b.** All plans that cover the person use the order of benefit determination prescribed by this rule, and under those rules the plan determines its benefits first. (7-1-21)T

**14. Secondary Plan**. A plan that is not a primary plan. (7-1-21)T

**011. -- 020. (RESERVED)**

**021. USE OF MODEL COB CONTRACT PROVISION.**

**01. Coordination of Benefits.** The incorporated by reference Appendix A contains a model COB provision for use in contracts. The use of this model COB provision is subject to the provisions of Subsections 021.02 through 021.04 and the provisions of Section 022. (7-1-21)T

**02. Coordination of Benefits Attachment.** The incorporated by reference Appendix B is a plain language description of the COB process that explains to the covered person how health 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 two (2) or more plans will pay for or provide benefits. (7-1-21)T

**03. Application of Requirements**. The COB provision contained in the incorporated by reference Appendix A and the plain language explanation in the incorporated by reference Appendix B do not have to use the specific words and format as shown. Changes may be made to fit the language and style of the rest of the contract or to reflect differences among plans that provide services, that pay benefits for expenses incurred and that indemnify. No substantive changes are permitted. (7-1-21)T

**04. Limits on COB Provisions**. A COB provision will not be used that permits a plan to reduce benefits on the basis that: (7-1-21)T

**a.** Another plan exists and the covered person did not enroll in that plan; (7-1-21)T

**b.** A person is or could have been covered under another plan, except with respect to Part B of Medicare; or (7-1-21)T

**c.** A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected. (7-1-21)T

**05. "Always Excess" or "Always Secondary."** No plan may contain a provision that its benefits are "always excess" or "always secondary" except in accordance with this rule. (7-1-21)T

**06. 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 (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; the secondary plan will use the provisions of Section 023 of this chapter to determine the amount it should pay for the benefit. (7-1-21)T

**07. Plan Requirements**. 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 Subsection 010.11 of this rule. (7-1-21)T

## 022. 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: (7-1-21)T

**a.** The primary plan pays or provides its benefits as if the secondary plan or plans did not exist. (7-1-21)T

**b.** If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan pays or provides 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. (7-1-21)T

**c.** When multiple contracts providing coordinated coverage are treated as a single plan under this rule, Section 022 of this chapter 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 (1) carrier pays or provides benefits under the plan, the carrier designated as primary within the plan is responsible for the plan's compliance with this rule. (7-1-21)T

**d.** If a person is covered by more than one (1) secondary plan, the order of benefit determination requirements of this rule decide the order in which secondary plan benefits are determined in relation to each other. Each secondary plan takes into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the requirements of this rule, has its benefits determined before those of that secondary plan. (7-1-21)T

**02. Consistent Order of Benefit Provisions**. Except as provided in Paragraph 022.02.a. of this chapter, a plan that does not contain order of benefit determination provisions that are consistent with this rule is always the primary plan unless the provisions of both plans, regardless of the provisions of Subsection 022.02 of this chapter, state that the complying plan is primary. (7-1-21)T

**a.** 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 is 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. (7-1-21)T

**b.** A plan may take into consideration the benefits paid or provided by another plan only when, under the requirements of this rule, it is secondary to that other plan. (7-1-21)T

**03. Order of Benefit Determination**. Each plan determines its order of benefits using the first of the following rules that applies. (7-1-21)T

**a.** 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. 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: (7-1-21)T

i. Secondary to the plan covering the person as a dependent; and (7-1-21)T

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, policyholder or retiree, is the secondary plan and the other plan covering the person as a dependent is the primary plan. (7-1-21)T

**b.** Unless there is a court decree stating otherwise, plans covering a dependent child determine the order of benefits as follows: (7-1-21)T

i. For a dependent child whose parents are married or are living together, whether or not they have ever been married: (7-1-21)T

(1) The plan of the parent whose birthday falls earlier in the calendar year is primary plan; or (7-1-21)T

(2) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan. (7-1-21)T

ii. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married: (7-1-21)T

(1) If a court decree states that one of the parents is responsible for the dependent 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 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 does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provisions; (7-1-21)T

(2) 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 Subparagraph 022.03.b.i. of this chapter determine the order of benefits; (7-1-21)T

(3) If a court decree states that the parents have joint custody without specifying that one (1) parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph 022.03.b.i. of this chapter determine the order of benefits; or (7-1-21)T

(4) 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: (7-1-21)T

(a) The plan covering the custodial parent; (7-1-21)T

(b) The plan covering the custodial parent's spouse; (7-1-21)T

(c) The plan covering the noncustodial parent; and then (7-1-21)T

(d) The plan covering the noncustodial parent's spouse. (7-1-21)T

(5) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined, as applicable under Subparagraph 022.03.b.i. or 022.03.b.ii. of this chapter as if those individuals were parents of the child. (7-1-21)T

(6) For a dependent child who has coverage under either or both parents' plans and also has their own coverage as a dependent under a spouse's plan, the provisions of Paragraph 022.02.e. apply. 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 is determined by applying the birthday rule in Subparagraph 022.02.b.i. to the dependent child's parent(s) and the dependent's spouse. (7-1-21)T

**c.** The plan that covers a person as an active employee; that is, an employee who is neither laid-off nor retired or as a dependent of an active employee 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. 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 Paragraph 022.03.a. of this chapter. (7-1-21)T

**d.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to federal or state 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. 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. This provision does not apply if the rule in Paragraph 022.03.a. of this chapter can determine the order of benefits. (7-1-21)T

**e.** If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for a shorter period of time is the secondary plan. (7-1-21)T

i. To determine the length of time a person has been covered under a plan, two (2) successive plans are treated as one (1) if the covered person was eligible under the second plan within twenty-four (24) hours after the coverage under the first plan ended. (7-1-21)T

ii. The start of a new plan does not include: (7-1-21)T

(1) A change in the amount or scope of a plan's benefits; (7-1-21)T

(2) A change in the entity that pays, provides or administers the plan's benefits; or (7-1-21)T

(3) A change from one type of plan to another such as from a single employer plan to a multiple employer plan. (7-1-21)T

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 is used as the date from which to determine the length of time the person's coverage under the present plan has been in force. (7-1-21)T

**f.** If none of the preceding rules determines the order of benefits, the allowable expenses are shared equally between the plans. (7-1-21)T

**023. PROCEDURE TO BE FOLLOWED BY SECONDARY PLAN.**
In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan calculates 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 one hundred percent (100%) of the total allowable expense for that claim. In addition, the secondary plan credits to its plan deductible any amounts it would have credited to its deductible in the absence of other benefit care coverage. (7-1-21)T

**024. NOTICE TO COVERED PERSONS.**
A plan, in its explanation of benefits provided to covered persons, includes the following language: "If you are covered by more than one (1) health benefit plan, you should file all your claims with each plan." (7-1-21)T

**025. 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 requires 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. (7-1-21)T

**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: (7-1-21)T

**a.** If the complying plan is the primary plan, it pays or provides its benefits first; (7-1-21)T

**b.** If the complying plan is the secondary plan, it pays or provides its benefits first, but the amount of the benefits payable is determined as if the complying plan were the secondary plan. In such a situation, the payment is the limit of the complying plan's liability; and (7-1-21)T

**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 assumes that the benefits of the noncomplying plan are identical to its own and pays its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as the actual benefits of the noncomplying plan, it adjusts payments accordingly. (7-1-21)T

i. If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than the covered person 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 advances to the covered person or on behalf of the covered person an amount equal to the difference. (7-1-21)T

ii. In no event does 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 is subrogated to all rights of the covered person against the noncomplying plan. The advance by the complying plan is to be without prejudice to any claim it may have against the noncomplying plan in the absence of such subrogation. (7-1-21)T

**03. COB Versus Subrogation**. COB differs from subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other. (7-1-21)T

**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 immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan is obligated to pay more than it would have paid had it been primary. (7-1-21)T

**026. -- 999. (RESERVED)**

# Subject Index