

SUBCHAPTER V. COORDINATION OF BENEFITS
28 TAC §§3.3501 – 3.3510

1. INTRODUCTION. The Texas Department of Insurance proposes new Subchapter V, 28 TAC §§3.3501 – 3.3510, concerning coordination of benefits (COB). This new subchapter is proposed to replace one that is being proposed for repeal in this issue of the *Texas Register*. This proposed new subchapter and the separate repeal of the current subchapter are necessary to permit carriers to include COB provisions that are consistent with modern market conditions and to maintain, by regulation, a consistent order in which plans with COB provisions must pay their claims. The department adopted the current COB subchapter in 1994. Because the adoption of the existing COB subchapter occurred nearly 20 years ago, this proposal is necessary to address current industry matters and procedures involving a person covered under more than one plan.

Proposing a new subchapter to replace the outdated current subchapter will provide greater efficiency in the processing of claims when a person is covered under more than one plan. This proposal does not propose to adopt the National Association of Insurance Commissioner's (NAIC) Coordination of Benefits Model Regulation, but it is consistent with it, including modifications to the NAIC model adopted in 2013. A majority of the states have adopted versions of the model regulation, and rules that are consistent with the NAIC model will promote market efficiency, especially in the context of multistate plans and carriers operating in multiple states.

COB regulations are also necessary to implement the requirements for a form filed with the department that contains a COB provision. Insurance Code §1701.055(b) provides that a form filed under Chapter 1701 with a coordination of benefits provision may not be approved for use in this state unless the form provides for the order of benefits determination for insured dependent children. Section 1701.055(b) further provides that an order of benefits determination provision may not be approved if the provision violates the Insurance Code, a rule of the commissioner, or any other law; or contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive. Insurance Code §1701.060(a) further provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria under which each type of form submitted to the department under Chapter 1701 will be reviewed and approved by the commissioner.

Proposed new §3.3501 provides the purpose of the subchapter. Proposed new §3.3502 provides the policies, evidences of coverage, and contracts to which this subchapter applies. In addition to the subchapter applying to group, blanket, or franchise accident and health insurance policies under Insurance Code Chapter 1251; and group health maintenance organization evidences of coverage under Insurance Code §843.002, this proposed new subchapter for COB includes individual health maintenance organization evidences of coverage under Insurance Code §843.002; individual accident and health insurance policies under Insurance Code §1201.001; individual and group preferred provider benefit plans and exclusive provider benefit

plans under Insurance Code Chapter 1301; group insurance contracts, individual insurance contracts, and subscriber contracts that pay or reimburse for the cost of dental care; and the medical care components of individual and group long-term care contracts, such as skilled nursing care subject to Insurance Code Chapter 1651.

Generally, proposed new §3.3502 makes the subchapter applicable to major medical plans regulated by the department and exempts plans that are not regulated by the department or which are generally purchased with the intent that they not coordinate with other coverage. Unlike the current COB rule, this proposal applies to individual plans and permits coordination with individual coverages.

Some individuals have more than one health plan for their health care needs. For this reason, it is necessary to include individual health plans in the proposed new COB subchapter so that each plan pays its share of the expenses for the care received by the person with more than one health plan. While in the past, individuals have not generally maintained more than one major medical insurance policy, changes in the market will likely result in this occurring more often in the future. For instance, under federal law, 42 USC §300gg-14 extended the age of dependent coverage until the child turns 26 years of age. As a result, individuals up to age 26 are permitted to maintain coverage under their parents' health plans. Also, beginning in 2014, under 42 USC §300gg-1, and subject to certain requirements, each health insurance issuer that offers health insurance coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage on a guaranteed issue basis. Without COB provisions applicable to individual coverage, individuals might have

an incentive to purchase multiple individual medical policies to have the same claims paid multiple times. For this reason, the proposed new COB subchapter establishes reduction standards that also apply to individual accident and health insurance policies under Insurance Code §1201.101(c)(10).

Insurance Code §1301.134 concerns coordinating payments for preferred provider benefit plans and determining the appropriate payment each health maintenance organization or insurer should make to the physician or health care provider. Insurance Code §1301.134(h) provides that the provisions of §1301.134 may not be waived, voided, or nullified by contract. For this reason, it is necessary for the proposed new COB subchapter to apply to preferred provider benefit plans, and equally to exclusive provider benefit plans.

The proposed new subchapter for COB would also apply to group insurance contracts, individual insurance contracts, and subscriber contracts that pay or reimburse for the cost of dental care. Title 42 USC §300gg-6(a) requires, effective January 1, 2014, that a health insurance issuer that offers health insurance coverage in the individual or small group market ensure that such coverage includes the essential health benefits package required under 42 USC §18022. Pediatric services, including oral and vision, are included as part of the essential health benefit package under 42 USC §18022(b)(1)(J). For this reason, it is necessary for the proposed new COB subchapter to include provisions to clarify that dental benefits that are either embedded in a health benefit plan or attached to a health benefit plan must follow the COB rules.

The proposed new COB subchapter would also apply to the medical care components of individual and group long-term care contracts, such as skilled nursing care subject to Insurance Code Chapter 1651. Insurance Code §1651.051(c)(10) provides that the standards for the provisions of long-term care benefit plans must address reductions. Title 28 TAC §3.3826(a)(6) implements Insurance Code §1651.051(c)(10) to provide that:

(a) No policy or certificate may be delivered or issued for delivery in this state as a long-term care insurance policy or certificate if such policy or certificate limits or excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

(6) expenses for services or items available or paid under another long-term care insurance or health insurance policy.

However, 28 TAC §3.3826(a)(6) does not provide for the order of payment when a long-term care insurance plan coordinates its payment when there are expenses for services or items paid under another long-term care insurance or health insurance policy. As previously discussed, Insurance Code §1701.055(b) provides that a form filed under Chapter 1701 with a COB provision may not be approved for use in this state unless the form provides for the order of benefits determination for insured dependent children. Insurance Code §1701.055(b) further provides that an order of benefits determination provision may not be approved if the provision violates the Insurance Code, a rule of the commissioner, or any other law. Thus, it is necessary for this

proposed new COB subchapter to apply to the medical care components of individual and group long-term care contracts, such as skilled nursing care.

Proposed new §3.3503 provides the definitions of the following words and terms used in the subchapter: “allowable expense,” “allowed amount,” “birthday,” “carrier,” “certificate holder,” “claim,” “closed panel plan,” “Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA),” “contract,” “coordination of benefits,” “custodial parent,” “group-type contract,” “high-deductible health plan,” “hospital indemnity benefits,” “plan,” “policyholder,” “primary plan,” and “secondary plan.” These definitions are necessary for the proper application of the requirements of the subchapter. The term “plan” is defined to identify those products with which coordination is permitted and not permitted. The term is generally defined to include major medical products whether or not they are regulated by the department, and exclude products that are subject to other coordination requirements or which are generally not intended to be subject to coordination. For example, Insurance Code Chapter 1203 provides the instances in which certain COB provisions are prohibited.

Proposed new §3.3504 establishes a general prohibition for when a carrier may not coordinate benefits to reduce the benefits paid under a plan regulated by the proposed new subchapter. This section is necessary to clarify that a carrier is not required to coordinate benefits to reduce the amount it pays, but if it does coordinate benefits, it must comply with the requirements of the subchapter. This section is also consistent with Insurance Code §1701.055(b) which provides that a form filed under Chapter 1701 with a COB provision may not be approved for use in this state unless the

form provides for the order of benefits determination for insured dependent children. An order of benefits determination provision may not be approved if the provision violates the Insurance Code, a rule of the commissioner, or any other law; or contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive.

Proposed new §3.3505 provides examples of expenses that are allowable expenses and expenses that are not allowable expenses. This section is essential to the proposed subchapter as it identifies those expenses that will be considered in the calculation of how much a secondary carrier may reduce what it otherwise would have paid.

Proposed new §3.3506 describes the use of the term “plan” in contracts. This section is necessary to clarify the parts of a plan that may be coordinated, to require that carriers explain to consumers what plans may be coordinated, and to permit limited COB provisions.

Proposed new §3.3507 provides the rules for determining the order of benefit payments when a person is covered by two or more plans. This section is essential to the rule as it determines which plan must pay full benefits and which is permitted to reduce its benefits in various situations.

Proposed new §3.3508 provides the procedure to be followed by a secondary plan in determining the amount to be paid by the secondary plan on a claim when coordinating benefits. This section is essential to the rule as it determines how much the secondary plan may reduce the benefits it would ordinarily have paid.

Proposed new §3.3509 provides miscellaneous provisions concerning the COB that are necessary to clarify and resolve particular issues. Proposed new §3.3510 explains the model COB provision form for use in contracts. Proposed new §3.3510 also explains the model form written in plain language to describe the COB process to the covered person. While these forms are not required to be used, this section is necessary to explain the forms and their permissible use.

2. FISCAL NOTE. Jan Graeber, director and chief actuary, Rate and Form Review Office, has determined that for each year of the first five years the proposed new sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

3. PUBLIC BENEFIT/COST NOTE. Ms. Graeber has also determined that for each year of the first five years the proposed subchapter is in effect, there are public benefits anticipated as a result of the enforcement and administration of this proposal, as well as potential costs of compliance for carriers that coordinate benefits. The department has drafted this proposal to maximize public benefits consistent with the authorizing statutes while mitigating costs.

The anticipated public benefits are the establishment of regulatory standards for the consistent COB, including standards for the determination of allowable expenses, and the order of benefit payments. This proposal further provides the public with the

benefit of establishing procedures to coordinate benefits for primary and secondary plans to follow.

On January 24, 2013, the department posted a call for comments on its website that included a request for comments regarding the costs of implementing the proposed new subchapter. As a result, the department received general input on the cost of compliance, but did not receive specific cost estimates.

The department has identified three categories of labor reasonably necessary to implement the proposed changes to the subchapter. Carriers may calculate the total cost of labor for each category by multiplying the number of estimated hours for each cost component by the median hourly wage for each category of labor. The median hourly wage for each category of labor is published online by the Texas Workforce Commission as follows:

(i) a general operations manager or functional director: \$43.55

(<http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=1&indcode=000000&occcode=11-1021&compare=2>)

(ii) a computer programmer: \$40.33

(<http://www.texasindustryprofiles.com/apps/win/eds.php?occgrou=15&occcode=15-1131>)

(iii) an administrative assistant: \$22.98

(<http://www.texasindustryprofiles.com/apps/win/eds.php?occgrou=43&occcode=43-0000>)

The department estimates that a carrier's overall printing, copying, mailing, and transmitting costs will likely be impacted as a result of implementation of the proposed new subchapter. According to the United States Postal Service business price calculator, available at dbcalc.usps.gov, the current cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP code in the United States is \$1.06 cents. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for \$1.06 cents. This estimate is based on an anticipated use of six pages of standard printing paper, with a total weight of one ounce. Additionally, this estimate does not take into consideration future rate increases for the price of a stamp. The department has determined that the cost of a standard business envelope is 1.6 cents. The department further estimates that the cost of printing or copying is between 6 and 8 cents per page.

It is not feasible for the department to estimate the total increased printing, copying, mailing, and transmitting costs attributable to compliance with the proposed new subchapter because there are numerous factors involved that are not suited to reliable quantification by the department. The department estimates that each carrier has the information necessary to determine its individual printing, copying, mailing, and transmitting costs necessary to meet the requirements of the new proposed subchapter.

Sections 3.3501 - 3.3510: Requirements for Coordination of Benefits. This rule proposal contains new requirements for carriers that use COB that will likely necessitate revisions to the COB language contained in most insurance policies and certificates. This could result in administrative costs to update policy documents and

any current enrollee materials. Administrative expenditures could also include mailing costs to distribute the materials. However, the department expects that insurers will avoid most mailing costs as a result of compliance by providing the new policy language and materials with the policy or certificate at issuance or renewal or with updated enrollee materials that are prepared for distribution.

The department estimates that preparation of the required changes to policies and enrollee materials will likely require a one-time cost of approximately two to 10 hours of administrative staff time. The cost to the insurer will vary depending on whether the insurer decides to have an administrative assistant, a general operations manager, or a combination of both positions, perform this function. Proposed §3.3510(d) contains a model COB provision for use in contracts which could reduce the amount of time necessary to make changes. Proposed §3.3510(a) provides that the use of this model form is subject to proposed new §3.3509 and §3.3507.

Proposed new §3.3510(e) contains a model plain language description of the COB process that explains to the covered person how health plans will implement COB in certificates which could also reduce the amount of time necessary to prepare changes to existing enrollee materials.

The department expects that carriers could also incur a cost for developing a new consumer explanatory booklet. A carrier has the option to provide consumers with an explanatory booklet since it is not required by this rule proposal. The department estimates that preparation of the booklet will likely require a one-time cost of approximately two to 10 hours of administrative staff time. The cost to the carrier will

vary depending on whether the carrier elects to have an administrative assistant, a general operations manager, or a combination of both positions, perform this function.

The department expects that a carrier will incur a cost for printing the consumer explanatory booklet. The department estimates that this cost will be approximately six to eight cents per page for printing and paper and that each booklet will consist of three printed pages. It is likely that the carrier has the information necessary to determine its individual printing costs, including the number of pages that will need to be printed and in-house or out-of-house printing costs. A carrier's potential printing costs may vary if the carrier does not use in-house printing. The total cost could also vary depending on the carrier's administrative processes.

The department estimates that some carriers might find it necessary to employ a computer programmer to assist with the computer system modifications regarding the order of payment of benefits when a person is covered by two or more plans. The department estimates that the number of hours necessary to determine the order of benefits will vary from carrier to carrier with a range from five to 40 hours of computer programmer labor. Some additional training for claims payment staff may also be necessary. The cost to the carrier will vary depending on whether the carrier uses the services of a general operations manager, another employee, or some other training method, to train the claims staff on the new payment requirements.

The department notes that the use of COB provisions is voluntary on the part of carriers. Those carriers that do not currently coordinate benefits will incur no costs as a result of this rule proposal. Many of the requirements of the proposed rule may also be

substantially less costly than the estimates in this proposal where carriers already coordinate benefits in ways that comply with the proposed requirements. Because the proposed subchapter permits carriers to consider provider discounts when coordinating benefits, carriers offering preferred provider benefit plans may have substantially reduced claims costs due to the proposed requirements.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. Government Code §2006.002(c) requires that if a proposed rule may have an adverse economic impact on small businesses, state agencies must prepare an economic impact statement that assesses the potential impact of the proposed rule on small businesses. The state agencies must also prepare a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. Government Code §2006.001(2) defines a “small business” as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit, is independently owned and operated, and has fewer than 100 employees or less than \$6 million in annual gross receipts. Government Code §2006.001(1) defines a “micro business” similarly to a “a small business” but specifies that a micro business may not have more than 20 employees. Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those provisions outlined under Government Code §2006.002(b) – (d).

The department believes that the economic impact of the proposal will benefit small and micro business carriers because it permits carriers to reduce claims costs in ways that were not permitted previously. However, as required by Government Code §2006.002(c), the department has determined that the proposal may have an adverse economic effect on approximately 21 to 31 small or micro businesses that are required to comply with the proposed rules. The department does not have precise information regarding the number of small or micro life, accident, and health insurers doing business in Texas. However, for the purpose of this estimate, the department assumes that between 10 to 15 percent of the estimated 208 life, accident, and health insurers and health maintenance organizations (174 life, accident, and health insurers and 34 health maintenance organizations) currently active in the Texas market as of August 12, 2013, are small or micro businesses that coordinate benefits.

The cost of compliance with the proposal will not vary between large businesses and small or micro businesses. The department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note portion of this proposal is equally applicable to small or micro businesses. It is the department's position that to waive or modify the requirements of the proposed subchapter for small and micro businesses would result in a disparate effect on policyholders and other persons affected by this proposal.

The purpose of the proposed rule is to establish current industry procedures to permit carriers with a COB provision to pay their claims. The other regulatory methods considered by the department to accomplish the objectives of the proposal and to

minimize any adverse impact on small and micro businesses include: (i) not proposing the amendments; (ii) proposing different requirements for small and micro businesses; and (iii) excluding small and micro businesses from applicability under the new subchapter included in this proposal.

Not proposing the new subchapter. As previously noted, the purpose of this rule proposal is to establish current industry procedures to permit carriers with a COB provision to pay their claims. The department adopted the current COB subchapter in 1994, nearly 20 years ago. If the department did not propose this rule, no rules could be adopted to address current industry standards for when a person is covered under more than one plan. For this reason, the department has rejected this option.

Proposing different requirements for small and micro businesses. Many changes have been made to earlier drafts of the proposed new subchapter based on input from stakeholders and stakeholder groups, including groups that have small business members. The department believes that proposing different standards than those included in this proposal would not provide a better option for small or micro businesses. Also, the department believes that the potential harm of lessened regulatory requirements to consumers and lessened confusion within the industry about which COB requirements would apply in particular cases would outweigh the potential benefit to small or micro businesses. Although the proposed requirements include model contract provisions and a consumer explanatory booklet, carriers are not required to use these documents under the proposal. Also, the policy documents might not reflect all of the regulatory requirements. Consumers would not know the different

regulations that a small or micro business would follow. For these reasons, the department has rejected this option.

Excluding small and micro businesses from applicability under the proposed new subchapter. If small and micro businesses were excluded from the applicability section under this proposed new subchapter, they would not be subject to the requirements for the COB if their plans include a COB provision. The department believes that the lack of these consumer protections and the lack of consistency within the industry would create potential harm for consumers that would outweigh the potential benefit to small or micro businesses. In addition, excluding small and micro businesses from the applicability section under this proposed new subchapter would not comply with Insurance Code §1701.055(b), which provides that a form filed under Chapter 1701 with a COB provision may not be approved for use in this state unless the form provides for the order of benefits determination for insured dependent children. Insurance Code §1701.055(b) further provides that an order of benefits determination provision may not be approved if the provision violates the Insurance Code, a rule of the commissioner, or any other law. It is necessary for this proposed new COB subchapter to apply to small and micro businesses. For these reasons, the department has rejected this option.

In accord with Government Code §2006.002(c-1), the department has determined that, although the proposal might have an adverse economic effect on small or micro businesses required to comply with the proposal, the proposal does not require a regulatory flexibility analysis under Government Code §2006.002(c)(2). Section 2006.002(c)(2) requires that a state agency, before adopting a rule that may have an

adverse economic effect on small businesses, prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Government Code Section 2006.002(c-1) requires that the regulatory flexibility analysis consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses. An agency is not required to consider alternatives that, while possibly minimizing adverse impacts on small and micro businesses would not be protective of the health, safety, and environmental and economic welfare of the state. Under this proposal, the department has determined that inconsistent COB requirements for small or micro business carriers would not be protective of the economic welfare of the state.

5. TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and so does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on December 9, 2013, to Sara Waitt, General Counsel, by email at: chiefclerk@tdi.texas.gov, or by mail at: Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

An additional copy of the comment must be simultaneously submitted to Jan Graeber, director and chief actuary, Rate and Form Review Office, by email at:

LHLcomments@tdi.texas.gov, or by mail at: Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The commissioner will consider the adoption of the proposed new subchapter in a public hearing under Docket No. 2755 scheduled for November 21, 2013, at 9:00 a.m. in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. Written and oral comments presented at the hearing will be considered.

7. STATUTORY AUTHORITY. The sections are proposed under Insurance Code §§843.151, 1201.006, 1201.101, 1251.008, 1301.007, 1651.004, 1651.051, 1701.055(b), 1701.060, and §36.001. Section 843.151(1) provides that the commissioner may adopt reasonable rules as necessary and proper to implement Chapter 843 and Section 1367.053, Subchapter A, Chapter 1452, Subchapter B, Chapter 1507, Chapters 222, 251, and 258, as applicable to a health maintenance organization, and Chapters 1271 and 1272, including rules to ensure that enrollees have adequate access to health care services. Section 843.151(2) provides that the commissioner may adopt reasonable rules as necessary and proper to meet the requirements of federal law and regulations. Section 1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Chapter 1201. Section 1201.101(a) provides that the commissioner must

adopt reasonable rules establishing specific standards for the content of an individual accident and health insurance policy and the manner of sale of an individual accident and health insurance policy, including required disclosures in connection with the sale. Section 1201.101(b) provides that rules adopted under Section 1201 must establish standards for policy readability and full and fair policy disclosures. Section 1201.101(c)(10) provides that standards established under Section 1201 may include standards that address reductions. Section 1251.008 provides that the commissioner may adopt rules necessary to administer Chapter 1251. Section 1301.007 requires the commissioner to adopt rules as necessary to implement Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to residents of this state. Section 1651.004(a) provides that in addition to other rules required or authorized by Chapter 1651, the department may adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Section 1651.004(b) provides that rules adopted under this section must include requirements no less favorable than the minimum standards for long-term care benefit plans adopted in any model laws or regulations relating to minimum standards for benefits for long-term care benefit plans and under federal law. Section 1651.051(a) requires the commissioner to establish by rule: (1) specific standards for provisions of long-term care benefit plans; and (2) standards for full and fair disclosure setting forth the manner, content, and required disclosures for the marketing and sale of those benefit plans. Section 1651.051(b)(1) – (3) provides that the standards are in addition to and must be in accord with applicable laws of this state, including Chapter 1201; applicable federal law; and any rules,

regulations, and standards required by federal law. Section 1651.051(c)(10) provides that the standards must address benefit limitations, exceptions, and reductions. Section 1701.055(b) provides that a form filed under Chapter 1701 that contains a COB provision may not be approved for use in this state unless the form provides for the order of benefits determination for insured dependent children, and it further provides that an order of benefits determination provision may not be approved if the provision violates this code, a rule of the commissioner, or any other law; or contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive. Section 1701.060(a) provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria under which each type of form submitted to the department under this chapter will be reviewed and approved by the commissioner or exempted under §1701.005(b); and particular types of forms designated by the commissioner may be given a summary review and approval if considered appropriate by the commissioner to expedite review and approval of those forms. Section 36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

8. CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal:

Rule

Statute

28 TAC §§3.3501 – 3.3510 Insurance Code §§843.151, 1201.006,
1201.101, 1251.008, 1301.007, 1651.004,
1651.051, 1701.005, and 1701.060

9. TEXT.

§3.3501. Purpose.

(a) The purpose of this subchapter is to:

(1) permit carriers to include a coordination of benefits (COB) provision in their plans;

(2) identify plans with which COB is allowed;

(3) establish an order in which plans with a COB provision must pay their claims;

(4) reduce duplication of benefits by permitting a reduction of the benefits to be paid by plans that do not have to pay their benefits first; and

(5) provide greater efficiency in the processing of claims when a person is covered under more than one plan.

(b) Severability. If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

§3.3502. Applicability.

(a) This subchapter applies to:

(1) group, blanket, or franchise accident and health insurance policies as described by Insurance Code Chapter 1251;

(2) individual and group health maintenance organization evidences of coverage as defined by Insurance Code §843.002;

(3) individual accident and health insurance policies as defined by Insurance Code §1201.001;

(4) individual and group preferred provider benefit plans and exclusive provider benefit plans as described by Insurance Code Chapter 1301;

(5) group insurance contracts, individual insurance contracts, and subscriber contracts that pay or reimburse for the cost of dental care; and

(6) the medical care components of individual and group long-term care contracts, such as skilled nursing care subject to Insurance Code Chapter 1651.

(b) This subchapter does not apply to:

(1) the Texas Health Insurance Pool as described in Insurance Code Chapter 1506;

(2) workers compensation insurance coverage;

(3) hospital indemnity coverage benefits or other fixed indemnity coverage;

(4) accident only coverage;

(5) specified disease or specified accident coverage;

(6) school accident-type coverages that cover students for accidents only, including athletic injuries, either on a “24-hour” or a “to and from school” basis;

(7) benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(8) Medicare supplement policies;

(9) a state plan under Medicaid;

(10) a governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or

(11) an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

(c) Except as provided in subsection (d) of this section, this subchapter applies to individual and group plans that are delivered, issued for delivery, or renewed on or after (date to be determined, approximately 180 days from the date of adoption).

(d) A contract delivered, issued for delivery, or renewed before the effective date of this subchapter must be brought into compliance with this subchapter on the next anniversary date or renewal date of the contract, or the expiration of any applicable collective bargaining contract pursuant to which it was written. This subchapter does not apply to individual policies issued before the effective date of the rule that are noncancellable or guaranteed renewable.

§3.3503. Definitions. The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Allowable expense--Except as otherwise provided in §3.3505 of this title (relating to Allowable Expenses), or where a statute requires a different definition, 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.

(2) Allowed amount--The amount of a billed charge that a carrier determines to be covered for services provided by a noncontracted health care provider or physician. The allowed amount includes the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(3) Birthday--Refers only to the month and day in a calendar year and does not include the year in which the individual is born.

(4) Carrier--An entity authorized under the Insurance Code to provide coverage subject to this subchapter, including an insurer, health maintenance organization, group hospital service corporation, or stipulated premium company.

(5) Certificate holder--An insured or enrollee who is covered other than as a dependent under a group plan or a group-type plan.

(6) Claim--A request that benefits be provided or paid. The benefits claimed may be in the form of:

(A) services, including supplies;

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

(C) a combination of subparagraphs (A) and (B) of this paragraph;

or

(D) an indemnification.

(7) Closed panel plan--A plan that provides health benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes benefits for services provided by other health care providers or physicians, except in cases of emergency or referral by a panel member.

(8) Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)--Coverage provided under a right of continuation under federal law.

(9) Contract--Refers to an insurance policy, insurance certificate, or health maintenance organization evidence of coverage.

(10) 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.

(11) Custodial parent--

(A) the parent with the right to designate the primary residence of a child by a court order under the Family Code or other applicable law; or

(B) in the absence of a court order, the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

(12) Group-type contract--A contract that is not available to the public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage.

(13) High-deductible health plan--A high-deductible health plan under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and Insurance Code Chapter 1653.

(14) Hospital indemnity benefits--Benefits not related to expenses incurred. This 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.

(15) Plan--A form of coverage with which coordination is allowed. For purposes of this subchapter:

(A) plan includes:

(i) any contract to which this subchapter applies;

(ii) limited benefit policies under §3.3079 of this title (relating to Minimum Standards for Limited Benefit Coverage);

(iii) uninsured arrangements of group or group-type coverage;

(iv) the medical benefits coverage in automobile insurance contracts; and

(v) Medicare or other governmental benefits, as permitted
by law; and

(vi) group insurance contracts, individual insurance
contracts, and subscriber contracts that pay or reimburse for the cost of dental care.

(B) plan does not include:

(i) the Texas Health Insurance Pool as described in
Insurance Code Chapter 1506;

(ii) workers' compensation insurance coverage;
(iii) hospital confinement indemnity coverage or other fixed
indemnity;

(iv) specified disease coverage;
(v) supplemental benefit coverage under §3.3080 of this title
(relating to Supplemental Coverage) and as described in Insurance Code Chapter 1203;

(vi) accident-only coverage;
(vii) specified accident coverage;
(viii) school accident-type coverages that cover students for
accidents only, including athletic injuries, either on a "24-hour basis" or on a "to and
from school" basis;

(ix) benefits provided in long-term care insurance contracts
for nonmedical services, for example, personal care, adult day care, homemaker
services, assistance with activities of daily living, respite care, and custodial care or for

contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(x) Medicare supplement policies;

(xi) a state plan under Medicaid;

(xii) a governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan;
or

(xiii) an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

(16) Policyholder--The primary insured named in an individual health insurance policy or evidence of coverage.

(17) Primary plan--A plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

(A) the plan either has no order of benefit determination rules, or its rules differ from those permitted by this subchapter; or

(B) all plans that cover the person use the order of benefit determination rules required by this subchapter, and under those rules, the plan determines its benefits first.

(18) Secondary plan--A plan that is not a primary plan.

§3.3504. General Prohibition. A carrier may not coordinate benefits to reduce the benefits paid under a plan regulated by this subchapter in the absence of a COB provision in the contract that meets the requirements of this subchapter. Despite §11.511(1)(B) of this title (relating to Optional Provisions), and subject to the requirements of Insurance Code Chapter 1203 and this subchapter, an HMO group plan may coordinate benefits with an individual or conversion plan.

§3.3505. Allowable Expenses.

(a) If a covered person advises a plan that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accord with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible 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.

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

(c) Any expense that a health care provider or physician is prohibited from charging a covered person by law or in accord with a contractual agreement is not an allowable expense.

(d) 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.

(e) If a person is covered by two or more plans that do not have negotiated fees and that compute their benefit payments on the basis of usual and customary fees, allowed amounts, relative value schedule reimbursement, or other similar reimbursement methodology, any amount charged by the health care provider or physician in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

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

(g) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement, or other similar reimbursement methodology and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician 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 health care provider's or physician's contract permits, that negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(h) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drugs, 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" must include similar expenses to which COB applies.

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

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

(1) the covered person does not comply with the plan provisions concerning second surgical opinions or prior authorization of admissions or services; or

(2) the covered person has a lower benefit because the covered person did not use a preferred health care provider or preferred physician.

§3.3506. Use of the Term "Plan" in Contracts.

(a) 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.

(b) If a plan coordinates benefits, its contract must 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 subchapter. The model COB contract provisions provide an example of how to define “plan” in §3.3510(d) of this title (relating to Model COB Contract Provisions).

(c) A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

§3.3507. Rules for COB and Order of Benefits.

(a) Coverage by two or more plans. When a person is covered by two or more plans, the rules for determining the order of benefit payments will be determined as provided in paragraphs (1) – (5) of this subsection.

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

(2) A plan may take into consideration the benefits paid or provided by another plan only when, under this subchapter, it is secondary to that other plan.

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

(4) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, 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 must be responsible for the plan's compliance with this subchapter.

(5) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan, that, under the rules of this subchapter, has its benefits determined before those of that secondary plan.

(b) Exception. Except as provided by subsection (c) of this section and §3.3509(b) of this title (relating to Miscellaneous Provisions), a plan that does not contain order of benefit determination provisions that are consistent with this subchapter is always the primary plan unless the provisions of both plans state that the complying plan is primary.

(c) Coverage by membership in a group. 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 must 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.

(d) Order of benefit determination. Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or dependent.

(A) Subject to subparagraph (B) of this paragraph, the plan that covers the person other than as a dependent, for example, as an employee, member, subscriber, policyholder, certificate holder, 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:

(i) secondary to the plan covering the person as a dependent; and

(ii) primary to the plan covering the person as other than a dependent, for example, a retired employee;

(C) If subparagraph (B) of this paragraph applies, then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder, certificate holder, 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 order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

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

(ii) 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 divorced or are not living together, whether or not they have ever been married:

(i) if a court order 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, and that parent's spouse does, then the spouse's plan is the primary plan. This clause must not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court order provision.

(ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (A) of this paragraph must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or

health care coverage of the dependent child, the provisions of subparagraph (A) of this paragraph must determine the order of benefits.

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

(I) the plan covering the custodial parent;

(II) the plan covering the custodial parent's spouse;

(III) the plan covering the non-custodial parent; then

(IV) the plan covering the non-custodial parent's

spouse.

(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 must be determined, as applicable, under subparagraph (A) or (B) of this paragraph as if the individuals were parents of the child.

(D) For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, subsection (e) of this section applies.

(E) 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 must be determined by applying the birthday rule in subparagraph (A) of this paragraph to the dependent child's parent(s) and the dependent's spouse.

(3) Active employee, 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 a dependent of an active employee, is the primary plan. The plan that covers 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 plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not conform to the requirements of subparagraph (A) of this paragraph, and as a result, the plans do not agree on the order of benefits, this paragraph does not apply.

(C) This paragraph does not apply if paragraph (1) of this subsection can determine the order of benefits.

(4) COBRA or state continuation coverage.

(A) If a person whose coverage is provided under COBRA or under a right of continuation under 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 plan that covers the same person under COBRA or under a right of continuation does not conform to the requirements of subparagraph (A) of this paragraph, and as a result, the plans do not agree on the order of benefits, this paragraph does not apply.

(C) This paragraph does not apply if paragraph (1) of this subsection can determine the order of benefits.

(e) Length of time. If subsection (d) of this section does not determine the order of benefits, the plan that has covered the person for the longer period of time is the primary plan. The plan that has covered the person for the shorter period of time is the secondary plan.

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

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

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

(B) a change in the entity that pays, provides, or administers the plan's benefits; or

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

(3) 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 must be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

(f) Sharing equally between the plans. If subsections (a) – (e) of this section do not determine the order of benefits, the allowable expenses must be shared equally between the plans.

§3.3508. 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 must 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 that, when combined with the amount paid by the primary plan, results in the total benefits paid or provided by all plans for the claim equaling 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

§3.3509. Miscellaneous Provisions.

(a) A secondary plan that provides benefits in the form of services may recover the reasonable cash value of providing 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. This subsection does not require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

(b) A plan with order of benefit determination rules that comply with this subchapter may coordinate its benefits with a noncompliant plan that is “excess” or “always secondary” or that uses order of benefit determination rules that are inconsistent with those contained in this subchapter on the following basis:

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

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

(3) if the noncompliant 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 must assume that the benefits of the noncompliant plan are identical to its own, and must pay its benefits accordingly. If, within two years of payment, the complying plan receives information as to the actual benefits of the noncompliant plan, it must adjust payments accordingly.

(c) If a 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 applicable state law allows the right of subrogation, as provided in this section, then the complying plan must advance to the covered person, or to an assignee on behalf of the covered

person, an amount equal to the difference. However, the complying plan may not 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 must be subrogated to all rights of the covered person against the noncomplying plan, in accord with applicable subrogation provisions. The advance by the complying plan must also be without prejudice to any claim it may have against the noncomplying plan in the absence of subrogation.

(d) A carrier to which this subchapter is applicable is required to provide reasonable information to a secondary carrier that is needed to determine the benefits to be paid under this subchapter seven days after it is requested. Provisions for COB or subrogation may each be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

(e) A plan must, 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."

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

(g) Despite the provisions of this subchapter, a carrier must comply with the prompt pay requirements of Chapter 21, Subchapter T of this title (relating to Submission of Clean Claims).

(h) A contract may not reduce 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.

(i) No plan may contain a provision that its benefits are "always excess" or "always secondary" to any plan as defined in this subchapter, except in accord with the rules permitted by this subchapter.

(j) 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 plan health care provider or physician. COB does not occur if a covered person is enrolled in two or more closed panel plans and obtains services from a health care provider or physician in one of the closed panel plans because the other closed panel plan whose health care providers or physicians 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, and the secondary plan must comply with §3.3508 of this title (relating to Procedure to be Followed by Secondary Plan) to determine the amount it should pay for the benefit.

(k) No plan may use a COB provision, or any other provision that allows it to reduce its benefits based on the existence of any other coverage its insured or enrollee may have that does not meet the definition of plan under this subchapter.

§3.3510. Model COB Contract Provisions.

(a) Subsection (d) of this section contains an optional model COB provision form for use in contracts. The use of this model form is subject to the provisions of §3.3509 of this title (relating to Miscellaneous Provisions) and the provisions of §3.3507 of this title (relating to Rules for COB and Order of Benefits).

(b) Subsection (e) of this section contains an optional model plain language description of the COB process that explains to the covered person how health plans will implement COB. 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 or more plans will pay for or provide benefits.

(c) A COB provision or a plain language description does not have to use the words and format shown in the model forms. Changes may be made to fit the language and style of the rest of the contract or to reflect the difference among plans that provide services, pay benefits for expenses incurred, and indemnify. No substantive changes are allowed.

(d) The model COB contract provisions are as follows:

FIGURE: 28 TAC §3.3510(d):

FORM COB TX

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

DEFINITIONS

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

(1) Plan includes: group, blanket, or franchise accident and health insurance policies; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts, such as skilled nursing care; limited benefit coverage that is not issued to supplement individual or group in-force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts 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; Medicare supplement policies; a state plan under Medicaid; a governmental plan

that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

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

(b) "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 benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total allowable expense.

(c) "Allowable expense" is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the person. 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. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

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

(1) The difference between the cost of a semi-private hospital room and a private hospital 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 or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or relative value schedule reimbursement methodology, or other similar reimbursement

methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

- (3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
- (4) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the health care provider or physician 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 health care provider's or physician's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.
- (5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.
- (d) "Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care provider or physician. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.
- (e) "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care providers and physicians that have contracted with or are employed by the plan, and that excludes coverage for services provided by other health care providers and physicians, except in cases of emergency or referral by a panel member.
- (f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

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

- (a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
- (b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both plans state that the complying plan is primary.
- (c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must 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.
- (d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
- (e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except for emergency services or authorized referrals that are paid or provided by the primary plan.
- (f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, 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 must be responsible for the plan's compliance with this subchapter.
- (g) If a person is covered by more than one secondary plan, the order of benefit determination rules of this subchapter decide the order in which secondary plans' benefits are determined in relation to each other. Each secondary plan must take into consideration the benefits of the primary plan or plans and the benefits of any other plan that, under the rules of this contract, has its benefits determined before those of that secondary plan.
- (h) Each plan determines its order of benefits using the first of the following rules that apply.

- (1) Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, 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 federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.
- (2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

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

 - (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - (ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
 - (B) For a dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

 - (i) if a court order 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. This rule applies to plan years commencing after the plan is given notice of the court decree.
 - (ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.
 - (iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.
 - (iv) if there is no court order allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- (I) the plan covering the custodial parent;
 - (II) the plan covering the spouse of the custodial parent;
 - (III) the plan covering the noncustodial parent; and then
 - (IV) the plan covering the spouse of the noncustodial parent.

 - (C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of (h)(2)(A) or (h)(2)(B) must determine the order of benefits as if those individuals were the parents of the child.

 - (D) For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, (h)(5) applies.

 - (E) 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 must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.
- (3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.
- (4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by 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 COBRA, state, or other federal continuation coverage is the secondary plan. 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 does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

- (5) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.
- (6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

- (a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid 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 then 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 equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- (b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

COMPLIANCE WITH FEDERAL AND STATE LAWS CONCERNING CONFIDENTIAL INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. [Organization responsible for COB administration] will comply with federal and state law concerning confidential information for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Each person claiming benefits under this plan must give [Organization responsible for COB administration] any facts it needs to apply those rules and determine benefits.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

(e) The model COB notice publication is as follows:

FIGURE: 28 TAC §3.3510(e):

FORM COB NOTICE TX

CONSUMER EXPLANATORY BOOKLET COORDINATION OF BENEFITS (COB)

IMPORTANT NOTICE

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

Double Coverage

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

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

COB is complicated and covers a wide variety of circumstances. This is only an outline of some of the most common ones. If your situation is not described, read your evidence of coverage or contact the Texas Department of Insurance.

Primary or Secondary?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the “primary” or “secondary” benefit payer. The primary plan always pays first when you have a claim. Any plan that does not contain Texas’ COB rules will always be primary unless the provisions of both plans state that the complying plan is primary.

When This Plan is Primary

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

Your Own Expenses

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

Your Spouse’s Expenses

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

Your Child’s Expenses

- the claim is for the health care expenses of your child who is covered by this plan and
 - you are married and your birthday is earlier in the year than your spouse’s, or you are living with another individual, regardless of whether or not you have ever been married to that individual, and your birthday is earlier than that other individual’s birthday. This is known as the “birthday rule”; or
 - you are separated or divorced and you have informed us of a court order that makes you responsible for the child’s health care expenses; or
 - there is no court order, but you have custody of the child.

Other Situations

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

How We Pay Claims When We Are Primary

When we are the primary plan, we will pay the benefits in accord with the terms of your contract, just as if you had no other health care coverage under any other plan.

When This Plan is Secondary

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

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An “allowable expense” is a 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 there is a difference between the amount the plans allow, we will usually base our payment on the higher amount. However, if one plan has a contract with the health care provider or physician and the other does not, our combined payments will not be more than the contracted amount. Health maintenance organizations and preferred provider organizations usually have contracts with their providers.

We may reduce our payment by any amount so that, when combined with the amount paid by the primary plan, the total benefits paid equal 100 percent of the total allowable expense for your claim. We will credit any amount we would have paid in the absence of your other health care coverage toward our own plan deductible.

We will not pay an amount the primary plan did not cover because you did not follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain prior authorization as required by that plan, we will not pay the amount of the reduction, because it is not an allowable expense.

**Questions About COB?
Contact the Texas Department of Insurance
1-800-252-3439
In Austin Call 512-463-6515**

10. CERTIFICATION. This agency certifies that legal counsel has reviewed the proposal and found it to be within the agency's legal authority to adopt.

Issued at Austin, Texas, on October 25, 2013.



Sara Waitt
General Counsel
Texas Department of Insurance