CR 85-165

STATE OF WISCONSIN)
)
OFFICE OF THE COMMISSIONER OF INSURANCE)

STATE OF WISCONSIN
RECEIVED AND FILED

OCT 13 1986

DOUGLAS LA FOLLETTE
SECRETARY OF STATE

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Thomas P. Fox, Commissioner of Insurance and custodian of the official records of said office, do hereby certify that the annexed order repealing and recreating a rule relating to coordination of benefits provisions in group and blanket disability insurance policies was issued by this office on October 13, 1986.

I further certify that said copy has been compared by me with the original on file in this office and that the same is a true copy thereof, and of the whole of such original.

IN TESTIMONY WHEREOF, I have hereunto subscribed my name in the City of Madison, State of Wisconsin, this 13th day of October, 1986.

Thomas P. Fox
Commissioner of Insurance

2597J

RECEIVED
OCT 14 1986
11:40 am
Revisor of Statutes
Bureau

1-1-87

ORDER OF THE COMMISSIONER OF INSURANCE

To repeal and recreate Ins 3.40 relating to coordination of benefits provisions in group and blanket disability insurance policies.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

The purpose of repealing and recreating Ins 3.40 is to adopt a rule that is written in easier to understand language and format than the present rule and that incorporates various measures, most of which are optional, that will assist in containing health care costs. The rule incorporates the revised model coordination of benefits guidelines adopted by the National Association of Insurance Commissioners in June 1985.

100R1
10/13/86

Coordination of benefits (COB) is a mechanism designed to coordinate benefits between two or more group health plans so that no more than 100% of covered expenses is paid. It also prevents a person from profiting from an illness or injury. This would occur if a person were covered by more than one group health insurance policy and collected from both for the loss. COB consists of a set of rules that define which plan is primary and pays first and which plan is secondary and pays after the primary plan has paid. The primary plan never pays more than it would have paid were there no other coverage. The secondary plan pays the balance of all or a portion of the allowable expenses that were not covered in full by the primary plan, but it never pays more than it would have paid had it been primary.

The rule permits a plan to consider various options. For example, a plan can continue to coordinate at 100% of allowable expenses as it has in the past; or it can coordinate so that less than 100% of allowable expenses are paid. An allowable expense is any item which is covered in whole or in part by either plan. This means that the secondary plan may pay for some expenses that are not covered items under its policy. However, it pays for those expenses because they were covered at least in part by the primary plan.

For example, under the original COB rule assume that an individual is covered by two group policies both of which require a 10% co-payment by the insured. The person is hospitalized, and the total bill is $1,000. The primary policy pays $900 ($1,000 minus the 10% co-pay of $100). The secondary insurer must look at the total bill and pay the balance in full as the remaining charges are "allowable expenses" which were paid at least in part by the primary carrier.

The changes to Ins 3.40 will allow a plan to coordinate allowable expenses at less than 100% and thereby retain its deductible and copayment provisions. The revised rule allows insurers to offer three options which are:

(1) Alternative 1 continues with the current provision which results in plans coordinating at 100% of allowable expenses.

(2) Alternative 2 allows a plan when secondary to reduce its benefits so that total benefits paid during a given period by all plans covering the person are not more than a given amount but never less than 80% of the total allowable expenses.

(3) Alternative 3 allows the secondary plan to pay what it would have paid had it been primary less whatever the primary plan paid. This alternative may be used only if the plan pays at least

(a) 50% of covered treatment of mental or nervous disorders, alcoholism or drug abuse that is in excess of the mandated coverage required by s. 632.89, Stats;

(b) 50% of cost containment provisions such as requirements for a second surgical opinions or pre-certification of hospital stays; and

(c) 75% of other covered expenses.

Any plan that coordinates according to either Alternative 2 or Alternative 3 must contain certain protections for the insured that are not normally part of a group policy. Insureds must be given prior notice advising them that the deductibles and coinsurance features of the policy will be preserved when the plan is secondary. However, the out-of-pocket expenses may not exceed $2,000 for each insured person or $3,000 for the family during the claim determination period (i.e. usually a calendar year) if the plan is

secondary. In addition, a plan must allow a person to enroll for health coverage when the person's coverage under another plan terminates. The insurance company may not impose more rigid underwriting standards than it would have imposed had the person enrolled under the plan when originally eligible.

With these protections, insureds are provided with information that will allow them to decide if it is in their best interests to carry only one group family plan rather than two. Most group plans today require a contribution from the employee, especially if family members are also covered. Those who opt to carry only one family plan will thus realize a savings in the amount paid for coverage. This savings will offset the amount of out-of-pocket expenses paid by the insured because of COB reimbursing at less than 100%.

Because both husband and wife are employed, many families have two group health plans because of fear that one or the other may become unemployed and the family will have no health insurance. Allowing individuals easy access to coverage under either plan negates the need for carrying two group health plans.

In addition to containing health care costs by retaining deductible and copay provisions, allowing plans to coordinate at less than 100% of allowable expenses will also make insured plans more competitive with employer self-funded plans. This is because most self-funded plans are not subject to insurance law. Consequently, they are already able to design their plans so that they coordinate at less than 100% of allowable expenses.

The recreated rule contains several other features that were not included in the original rule. For example, it prohibits a plan from declaring that it is always excess or always secondary to other plans. This provision is essential to prevent situations where two plans covering the same person

both state they are secondary according to the terms of their policies, and neither plan pays the claim. Fall-back provisions are established to assure payment of claims when a complying plan is coordinating with a non-complying plan that is not subject to Wisconsin insurance law.

In addition, plans are not permitted to coordinate against phantom plans. Consequently, plans may not reduce benefits on the basis that a person is eligible for coverage under another plan but actually is not covered by the other plan.

To contain hospital costs, an "allowable expense" does not include the difference between the cost of a private hospital room and the cost of a semi-private hospital room unless the patient's stay in the private room is medically necessary.

To add clarity and certainty of meaning, definitions are included for "claim", "coordination of benefits (COB) provision", "group-type contracts", "hospital indemnity benefits", "primary plan" and "secondary plan".

The maximum allowable exemption for group hospital indemnity plans is increased from $30 per day to $100 per day.

A provision is included to ensure that prepaid plans that provide services to an insured when the prepaid plan is the secondary plan will be reimbursed in cash by the primary plan.

Originally, COB was permitted with both individual and group no-fault automobile contracts but only with group at fault automobile contracts. To avoid duplication of benefits, the recreated rule allow the application of COB to the medical expense benefits coverage of all automobile policies.

The original rule prohibited COB with plans where the premium was paid by parents and that covered grammar and high school students against accidental injury. However, COB was permitted with similar plans which covered college students. The change eliminates the inconsistency and prohibits COB with all school plans.

Provisions of the original rule dealing with small claim waivers, coordinating benefit payments, and public education were deleted from the proposal. These sections did not establish standards of action but only provided guidance as to conduct. As such, they are inappropriate for a rule.

The rule contains a model COB provision that an insurer can incorporate in a group policy.

Although the language is simplified and meanings are clarified, the principle of COB remains the same. The method of determining which plan is primary and which plan is secondary remains the same. Also, there are no substantive changes in the order of benefit determination.

Section 1. Pursuant to the authority invested in the state of Wisconsin commissioner of insurance by ss. 601.41 (3) and 631.23, Stats., Ins 3.40 is repealed and recreated to read as follows:

Ins 3.40 COORDINATION OF BENEFITS PROVISIONS IN GROUP AND BLANKET DISABILITY INSURANCE POLICIES.

(1) PURPOSE. (a) This section establishes authorized coordination of benefits provisions for group and blanket disability insurance policies pursuant to s. 631.23, Stats. It has been found that these clauses are necessary to provide certainty of meaning. Regulation of contract forms will be more effective, and litigation will be substantially reduced if there is uniformity regarding coordination of benefits provisions in health insurance policies.

(b) A Coordination of Benefits (COB) provision as defined in paragraph (3) (e) avoids claim payment delays by establishing an order in which Plans pay their claims and by providing the authority for the orderly

transfer of information needed to pay claims promptly. It avoids duplication of benefits by permitting a reduction of the benefits of a Plan when, by the rules established by this section, a Plan does not have to pay its benefits first.

(c) Coordinating health benefits has been found to be an effective tool in containing health care costs. However, minimum standards of protection and uniformity are needed to protect the insured's and the public's interest.

(2) SCOPE. This section applies to the medical benefits provisions of all automobile insurance policies and to all group and blanket disability insurance policies subject to s. 631.01 (1), Stats., that provide coverage for medical or dental care, treatment or expenses due to either injury or sickness that contain a coordination of benefits provision, an "excess," "anti-duplication," "non-profit" or "other insurance" exclusion by whatever name designated under which benefits are reduced because of other insurance, other than an exclusion for expenses covered by workers compensation, employer's liability insurance or Medicare.

(3) DEFINITIONS. In this section:

(a) "Allowable Expense" means the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made, except as provided in par. (4).

(b) "Claim" means a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of services (including supplies), payment for all or a portion of the expenses incurred, a combination of the previous two, or indemnification.

(c) "Claim Determination Period" means the period of time, not less than twelve consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB to determine whether overinsurance exists and how much each Plan will pay or provide. However, it does not include any part of a year during which a person has no coverage under this Plan or any part of a year before the date this COB provision or a similar provision takes effect.

(d) "Complying Plan" means a Plan with order of benefit determination rules which comply with this section.

(e) A "Coordination of Benefits (COB) provision" means an insurance contract provision intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment.

(f) "Group-type contracts" mean contracts which are not available to the general public and may be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition of Plan at the option of the insurer issuing group-type plans or the service provider and its contract-client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, "franchise" or "blanket"). The use of payroll deductions by the employee, subscriber or member to pay for the coverage is not sufficient, of itself, to make an individual contract part of a group-type plan. Group-type contracts do not include individually underwritten and issued, guaranteed renewable policies that may be purchased through payroll deduction at a premium savings to the insured.

(g) "Hospital indemnity benefits" mean benefits for hospital confinement which are not related to expenses incurred but does not include plans that reimburse a person for actual hospital expenses incurred even if the plans are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

(h) "Noncomplying Plan" means a Plan that declares its benefits to be "excess" or "always secondary" or that uses order of benefit determination rules inconsistent with those contained in this section.

(i) "Plan" means a form of coverage providing benefits for medical or dental care, except as limited under sub. (6), with which coordination is allowed.

(j) "Primary Plan" means a health care plan, determined by the order of benefit determination rules, whose benefits shall be determined before those of the other Plan and without taking the existence of any other Plan into consideration.

(k) "Secondary Plan" means a plan which is not a Primary Plan according to the order of benefit determination rules and whose benefits are determined after those of another Plan and may be reduced because of the other Plan's benefits.

(l) "This Plan" means the part of the group contract that provides 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 group contract providing health care benefits is separate from This Plan.

(4) ALLOWABLE EXPENSE USES AND LIMITATIONS. (a) Items of expense under dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of Allowable Expense. A Plan which provides benefits only for these items may limit its definition of Allowable Expense to these items of expense.

(b) When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered as both an Allowable Expense and a benefit paid.

(c) The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice or as specifically defined in the Plan.

(d) When COB is restricted in its use to a specific coverage in a contract, for example, major medical or dental, the definition of Allowable Expense shall include the corresponding expenses or services to which COB applies.

(5) CLAIM DETERMINATION PERIOD USES AND LIMITATIONS. (a) A Claim Determination Period may not be less than 12 months and usually is a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a Plan during a portion of a Claim Determination Period if that person's coverage starts or ends during that Claim Determination Period.

(b) As each claim is submitted, each Plan shall determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period. However, that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

(6) PLAN USES, LIMITATIONS AND VARIATIONS. (a) The definition of Plan in the group contract shall state the types of coverage which shall be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this subsection.

(b) The definition of Plan shown in the Model COB Provision in APPENDIX A is an example of what may be used. Any definition that satisfies sub. (3) (i) and this sub. may be used.

(c) This section uses the term "Plan". However, a group contract may instead use "Program" or some other term.

(d) "Plan" shall not include individual or family insurance or subscriber contracts or individual or family coverage through health maintenance organizations (HMOs), limited service health organizations (LSHOs), or any other prepayment, group practice or individual practice plan except as provided in sub. (e) and (f).

(e) "Plan" may include: group insurance and group subscriber contracts; uninsured arrangements of group or group-type coverage; group or group-type coverage through HMOs, LSHOs and other prepayment, group practice and individual practice plans; and group-type contracts.

(f) "Plan" may include the medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts.

(g) If "Plan" includes Medicare or other governmental benefits, that part of the definition of "Plan" may be limited to the hospital, medical and surgical benefits of the governmental program. However, "Plan" shall not include a state plan under Medicaid (Title XIX, Grants to State for Medical Assistance Programs, of the United States Social Security Act as amended from time to time) and shall not include a law or plan whose benefits, by law, are excess to those of any private insurance plan or other non-government plan.

(h) "Plan" shall not include group or group-type hospital indemnity benefits of $100 per day or less but may include the amount by which group or group-type hospital indemnity benefits exceed $100 per day.

(i) "Plan" shall not include school accident-type coverages that cover grammar, high school, and college students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

(j) Each contract or other arrangement for coverage is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

(7) PRIMARY PLAN AND SECONDARY PLAN USES AND LIMITATIONS. (a) The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

(b) There may be more than one Primary Plan. For example, two Plans which have no order of benefit determination rules would both be primary. A Plan is a Primary Plan if either subd. 1 or 2 is true:

1. The Plan either has no order of benefit determination rules, or it has rules which differ from those permitted by this regulation.

2. All plans which cover the person use the order of benefit determination rules required by this section, and under these rules the Plan determines its benefits first.

(c) When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

(d) If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this section decide the order in which the benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this section, has its benefits determined before those of that Secondary Plan.

(8) APPLICABILITY. (a) This Coordination of Benefits (COB) provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan.

(b) If this COB provision applies, the order of benefit determination rules shall be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan.

(c) The benefits of This Plan shall not be reduced when, under the order of benefit determination rules, This Plan is primary and determines its benefits before another Plan.

(d) The benefits of This Plan may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first.

(9) FLEXIBILITY AND CONSISTENCY WITH THIS SECTION. (a) APPENDIX A shall be considered authorized clauses pursuant to s. 631.23, Stats., for use in policy forms subject to this section and shall only be changed as provided in this section.

(b) This section permits but does not require the use of COB or "other insurance" provisions. However, if such provisions are used, they must conform with this section and substantially conform to the clauses contained in APPENDIX A. Liberalization of the prescribed language in APPENDIX A, including rearrangement of the order of the clauses, is permitted provided that the modified language is not less favorable to the insured person.

(c) Policy language which reduces benefits because of other insurance and which is inconsistent with this section violates the criteria of s. 631.20, Stats., and shall not be used.

(d) A Plan that includes a COB provision inconsistent with this section shall not take the benefits of another Plan into account when it determines its benefits. There is one exception: a contract holder's

coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder.

(e) A group contract's COB provision does not have to use the words and format contained in APPENDIX A. Changes may be made to fit the language and style of the rest of the group contract or to reflect the differences among Plans which provide services, which pay benefits for expenses incurred, and which indemnify. Substantive changes are allowed only as set forth in this section.

(f) A term such as "usual and customary," "usual and prevailing," or "reasonable and customary" may be substituted for the term "necessary, reasonable and customary". Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the COB provisions apply.

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

(10) PROHIBITED COORDINATION AND BENEFIT DESIGN. (a) A group contract shall not reduce benefits on the basis that:

1. Another Plan exists;

2. Except with respect to Part B of Medicare, that a person is or could have been covered under another Plan; or

3. A person has elected an option under another Plan providing a lower level of benefits than another option which could have been elected.

(b) No contract shall contain a provision that its benefits are "excess or "always secondary" to any Plan defined in sub. (3) (i), except as permitted under this section.

(11) ORDER OF BENEFIT DETERMINATION RULES. (a) 1. The Primary Plan shall pay or provide its benefits as if the Secondary Plan or Plans did not exist.

2. A Secondary Plan may take the benefits of another Plan into account only when, under the rules in sub. (b), it is secondary to that other Plan.

(b) Rules. When there is a basis for a claim under This Plan and another Plan, This Plan determines its order of benefits using the first of the following rules which applies:

1. If the other Plan does not have rules coordinating its benefits with those of This Plan, the benefits of the other Plan are determined first.

2. 'Non-dependent or Dependent'. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

3. 'Dependent Child-Parents Not Separated or Divorced'. Except as stated in subpar. c., when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

a. The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

b. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

c. However, if the other Plan does not have the rule described in subpar. a., but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

d. In this subdivision, the word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.

4. 'Dependent Child-Separated or Divorced Parents'. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. First, the Plan of the parent with custody of the child;

b. Then, the Plan of the spouse of the parent with custody of the child; and

c. Finally, the Plan of the parent not having custody of the child.

d. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of the Plan of the responsible parent are determined first. This subparagraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

5. 'Active or Inactive Employee'. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before those of a Plan which covers that person as a laid off or retired employee, or as that employee's dependent. 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.

6. 'Longer or Shorter Length of Coverage'. a. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

b. To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new Plan does not include:

i. A change in the amount or scope of a Plan's benefits;

ii. A change in the entity which pays, provides or administers the Plan's benefits; or

iii. A change from one type of Plan to another, such as, from a single employer plan to that of a multiple employer plan.

c. The claimant's length of time covered under a Plan is measured from the claimant's first date of coverage under that Plan. If that date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time the claimant's coverage under the present Plan has been in force.

(12) PAYMENT AS A SECONDARY PLAN. (a) In accordance with sub. (11) Order of Benefit Determination Rules, when this Plan is a Secondary Plan as to one or more other Plans, the benefits of This Plan may be reduced according to the alternatives described in par. (b), (c) or (d). Such other Plan or Plans are referred to as "the other Plans" in par. (b), (c) and (d).

(b) Alternative 1. Total Allowable Expenses "Reduction in This Plan's benefits.

1. The benefits of This Plan shall be reduced when the sum of:

a. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision and

b. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made,

exceeds those Allowable Expenses in a Claim Determination Period.

2. If that occurs, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as described, each benefit is reduced in proportion and is then charged against any applicable benefit limit of This Plan."

(c) Alternative 2. Total Allowable Expenses with Coinsurance.

"Reduction in This Plan's Benefits. The benefits of This Plan shall be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made,

exceeds the greater of (i) 80% of those Allowable Expenses or (ii) the amount of the benefits in 1. above. In that case, the benefits of This Plan shall be reduced so that they and the benefits in 2. above do not total more than the greater of (i) and (ii). When the benefits of this Plan are reduced as described, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan."

(d) Alternative 3. Maintenance of benefits "Reduction in This Plan's Benefits. 1. The benefits that would be payable under This Plan in the absence of this COB provision shall be reduced by the benefits payable under the other Plans for the expenses covered in whole or in part under This Plan. This applies whether or not a claim is made under a Plan.

2. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an expense incurred and a benefit payable.

3. When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion . It is then charged against any applicable benefit limit of This Plan."

(13) CONDITIONS FOR USE OF ALTERNATIVES 1, 2 or 3. (a) When Alternative 1 is used, a Secondary Plan may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than total Allowable Expenses. The amount by which the Secondary Plan's benefits are reduced shall be used by the Secondary Plan to pay Allowable Expenses, not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

(b) When Alternative 2 is used, a Secondary Plan may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than a stated percentage, but not less than 80%, of total Allowable Expenses. The amount by which the Secondary Plan's benefits are reduced shall be used by the Secondary Plan to pay the stated percentage of Allowable Expenses not otherwise paid which were incurred

during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the Secondary Plan determines its obligation to pay for the stated percentage of Allowable Expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

(c) When Alternative 3 is used, a Secondary Plan may reduce its benefits by the amount of the benefits payable under the other Plans for the same expenses.

(d) Alternative 3 may be used in a Plan only when, in the absence of COB, the benefits of the Plan, excluding benefits for dental care, vision care, prescription drug or hearing aid programs, shall, after any deductible, be:

1. Not less than 50% of covered expenses for the treatment of mental or nervous disorders, alcoholism or drug abuse in excess of mandated coverage required by s. 632.89, Stats., or for cost containment provisions with alternative benefits, such as those applicable to second surgical opinions, precertification of hospital stays, etc.; and

2. Not less than 75% of other covered expenses.

(e) A Plan using Alternative 3 may exclude definitions of and references to Allowable Expenses, Claim Determination Period, or both.

(f) Alternatives 2 and 3 permit a Secondary Plan to reduce its benefits so that total benefits may be less than 100% of Allowable Expenses. A Plan using Alternative 2 or 3 shall comply with the following conditions:

1. Notice. The Plan must provide prior notice to employees or members that, when it is Secondary, its benefits plus those of the Primary Plan will be less than 100% of Allowable Expense unless the Primary Plan, by itself, provides benefits at 100% of Allowable Expenses.

2. Copayment and Deductible Limit. When the Plan is Secondary, it must provide a limit on the amount the employee, member or subscriber is required to pay toward the expenses or services covered under the Plan and for which the Plan is Secondary. Such limit shall not exceed $2,000 for any covered person or $3,000 for any family in any Claim Determination Period.

3. Unrestricted Enrollment. Under certain circumstances, the Plan shall permit a person to be enrolled for its health care coverage when that person's eligibility for health care coverage under another Plan ends for any reason. This will occur if the person is eligible for coverage under The Plan and the enrollment is made before the end of the 31-day period immediately following either the date when health care coverage under the other Plan ends or the end of any continuation period elected by or for that person. This unrestricted enrollment is not required if a person remains eligible for coverage under that other Plan or a Plan which replaces it, without interruption of that person's coverage.

4. Enrollment Requirements. If the person is enrolled before the end of the period described in subd. 3., there shall be no interruption of coverage. Thus, the requirements concerning active work of employees, members or subscribers or nonconfinement of dependents on the effective date of coverage shall not be applied. However, coverage for the person under the Plan may be subject to the same requirements including underwriting requirements, benefit restrictions, waiting periods, and pre-existing condition limitations that would have applied had the person been enrolled under the Plan on the later of either the date the person first became eligible for the Plan's coverage or the date the employee, member or subscriber last became covered under the Plan. Credit shall be given under any pre-existing condition limitation or waiting period from the later of the dates described in the preceding sentence to the date the person actually enrolled.

(14) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION. Certain facts are needed to apply the COB rules. An insurer has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The insurer need not tell or get the consent of any person to do this. Each person claiming benefits under This Plan shall give the insurer any facts it needs to pay the claim.

(15) FACILITY OF PAYMENT. A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, the insurer responsible for payment may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The insurer 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 reasonable cash value of the benefits provided in the form of services.

(16) RIGHT OF RECOVERY. If the amount of the payments made by the insurer responsible for payment, including the reasonable cash value of any benefits provided in the form of services, is more than it should have paid under a COB provision, it may recover the excess from one or more of:

(a) The persons it has paid or for whom it has paid;

(b) Insurance companies; or

(c) Other organizations.

(17) REASONABLE CASH VALUE OF SERVICES. A Secondary Plan which 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. Nothing in this provision shall be interpreted to require a Plan to reimburse a covered person in cash for the value of services provided by a Plan which provides benefits in the form of services.

(18) EXCESS AND OTHER NONCONFORMING PROVISIONS. (a) Some Plans have order of benefit determination rules not consistent with this section which declare that the Plan's coverage is "excess" to all others or "always secondary." This may occur because:

1. Certain Plans may not be subject to insurance regulation; or

2. Some group contracts are not required to conform with this section until after the effective date of this section.

(b) A Complying Plan may coordinate its benefits with a Noncomplying Plan on the following basis:

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

2. If the Complying Plan is the Secondary Plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary Plan. In such a situation, the payment shall be the limit of the Complying Plan's liability.

3. If the Noncomplying Plan does not provide the information needed by the Complying Plan to determine its benefits within a reasonable time after it is requested to do so, the Complying Plan shall assume that the benefits of the Noncomplying Plan are identical to its own and shall pay its benefits accordingly. However, the Complying Plan shall adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

4. The Complying Plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to the difference if the Noncomplying Plan reduces its benefits so that the employee, subscriber, or member receives less in benefits than he or she would have received had the Complying Plan paid or provided its benefits as the Secondary Plan and the Noncomplying Plan paid or provided its benefits as the Primary Plan.

5. In no event shall the Complying Plan advance more than the Complying Plan would have paid had it been the Primary Plan less any amount it previously paid. In consideration of such advance, the Complying Plan shall be subrogated to all rights of the employee, subscriber, or member against the Noncomplying Plan. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of such subrogation.

(19) SUBROGATION. The COB concept differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

(20) EFFECT ON EXISTING POLICIES. This section applies to every group contract which provides health care benefits and is issued on or after the effective date of this rule. A group contract which provides health care benefits and was issued before the effective date of this section shall be brought into compliance with this rule by the later of:

(a) the next anniversary date or renewal date of the group contract; or

(b) the expiration of any applicable collectively bargained contract pursuant to which it was written.

DRAFTING NOTE: In sub. (18) if the Noncomplying Plan is unwilling to provide the Complying Plan with the necessary information, the Complying Plan should assume the primary position in order to avoid undue claim delays and hardship to the insured. The Complying Plan may, through its subrogation rights, seek reimbursement for such payments. Undue delay in paying the claim may subject the Complying Plan to a violation of Wisconsin Administrative Code section Ins 6.11.

The rule created by this order shall take effect on the first day of January, 1987, as provided in s. 227.22 (2).

Dated at Madison, Wisconsin this 13th day of October, 1986.

Thomas P. Fox
Commissioner of Insurance

100R25
10/13/86

APPENDIX A

Model COB Provision

This appendix provides model COB provision language. The terms and conditions of all insurance contracts containing a COB provision must comply with INS 3.40.

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

(I) APPLICABILITY.

(A) This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

(B) If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(i) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

(ii) may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in Section (IV) Effect on the Benefits of This Plan.

(II) DEFINITIONS.

(A) "Allowable Expense" means a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit paid.

(B) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

(C) "Plan" means any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

(i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(ii) Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

Each contract or other arrangement for coverage under (i) or (ii) is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

(D) "Primary Plan"/"Secondary Plan". The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

(E) "This Plan" means the part of the group contract that provides benefits for health care expenses.

(III) ORDER OF BENEFIT DETERMINATION RULES.

(A) General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

(i) the other Plan has rules coordinating its benefits with those of This Plan; and

(ii) both those rules and This Plan's rules described in subparagraph (B) require that This Plan's benefits be determined before those of the other Plan.

(B) Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(i) Non-dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

(ii) Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (B)(iii), when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

a. the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in that calendar year; but

b. if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in a. but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

(iii) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a. first, the Plan of the parent with custody of the child;

b. then, the Plan of the spouse of the parent with the custody of the child; and

c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(iv) Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's dependent. 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 (iv) is ignored.

(v) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

(IV) EFFECT ON THE BENEFITS OF THIS PLAN.

(A) When This Section Applies. This Section (IV) applies when, in accordance with Section (III) Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in (B).

ALTERNATIVE 1.

(B) Reduction in this Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(i) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(ii) the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Note: The last paragraph may be omitted if the Plan provides only one benefit or may be altered to suit the coverage provided.

ALTERNATIVE 2.

(B) Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(i) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(ii) the benefits that would be payable for the Allowable Expenses under the other Plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made,

exceeds the greater of (a) 80% of those Allowable Expenses or (b) the amount of the benefits in (i) above. In that case, the benefits of This Plan will be reduced so that they and the benefits in (ii) above do not total more than the greater of that (a) and (b).

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan."

ALTERNATIVE 3

(B) Reduction in This Plan's Benefits. The benefits that would be payable under This Plan in the absence of this COB provision will be reduced by the benefits payable under the other Plans for the expenses covered in whole or in part under This Plan. This applies whether or not claim is made under a Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan."

(V) RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these COB rules. The [name of insurance company] has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The [name of insurance company] need not tell or get the consent of any person to do this. Each person claiming benefits under This Plan must give the [name of insurance company] any facts it needs to pay the claim.

(VI) FACILITY OF PAYMENT.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, The [name of insurance company] may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The [name of insurance company] will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

(VII) RIGHT OF RECOVERY.

If the amount of the payments made by the [name of insurance company] is more than it should have paid under this COB provision, it may recover the excess from one or more of:

(A) the persons it has paid or for whom it has paid;

(B) insurance companies; or

(C) other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

The State of Wisconsin
Office of the Commissioner of Insurance

Thomas P. Fox
Commissioner
(608) 266-3585

DATE: October 13, 1986

TO: Gary Poulson

FROM: M. E. Van Cleave
Assistant Deputy Commissioner of Insurance

SUBJECT: Ins 3.40, Clearinghouse 85-165

Enclosed are two copies of an Order of the Commissioner of Insurance repealing and recreating Ins 3.40, Clearinghouse 85-165, relating to the coordination of benefits provisions in group and blanket disability insurance policies.

MEV:LH:jmf
Enclosure
2597J2

P.O. Box 7873, Madison, WI 53707-7873