CR 88-91

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

TO ALL TO WHOM THESE PRESENTS SHALL COME, GREETINGS:

I, Robert D. Haase, Commissioner of Insurance and custodian of the official records of said Office, do hereby certify that the annexed order amending and creating a rule relating to coordination of benefits provisions in group and blanket disability insurance policies was issued by this Office on the 28th day of June, 1989.

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 28th day of June, 1989.

Robert D. Haase
Commissioner of Insurance

2729T

9-1-89

ORDER OF THE COMMISSIONER OF INSURANCE

AMENDING AND CREATING A RULE

To amend Ins 3.40 (2), (6) (d) and (f), (18) (b) (intro.), APPENDIX A (II) (C) (i), and APPENDIX A (III) (B) (iii) and to create Ins 3.40 (11) (b) 4 e relating to coordination of benefits provisions in group and blanket disability insurance policies.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41 (3), 631.23, 632.77, Stats.

Statutes interpreted: ss. 631.23, 632.32 (4) (b), and 632.77, Stats.

Ins 3.40 relates to coordinating benefits when a person is covered by two or more group health policies. It determines which plan is primary and pays first and which plan is secondary and pays after the primary plan has paid.

As group health insurance became more prevalent and as more women entered the labor market, more individuals found themselves covered by two group health policies. In the event of sickness or injury, these people collected maximum benefits from both policies and thereby made a profit on the sickness or injury. This in turn resulted in increased health care and insurance costs.

To prevent this from happening, some insurers designed their policies so that they would pay only excess benefits. That is, they would pay any

outstanding payments after payments made by another insurer for the same benefit. If both insurers took this approach, benefit payments could be delayed while the insurers determined which company should provide primary coverage.

This prompted the National Association of Insurance Commissioners (NAIC) to adopt the Coordination of Benefits (COB) Guidelines in the early 1970s. The guidelines establish uniform procedures for insurers to follow when a person is covered by two or more group health policies. They also assure fair treatment for insureds as the guidelines require insurers to pay up to 100% of all allowable expenses.

A majority of the states have adopted the guidelines for use in insured group policies, and many employer self-funded plans exempt from state insurance regulation also follow the guidelines. Wisconsin first adopted the guidelines in 1980 as Wisconsin Administrative Code section Ins 3.40. Since then the Office of the Commissioner of Insurance has amended the rule to incorporate changes and additions made by the NAIC. The last change occurred in 1986 when the rule was repealed and recreated.

The current changes address three issues that arose as a result of the rewrite of the rule and one new issue not previously addressed by the COB guidelines. The issues are:

(1) Coordination with the medical benefits of automobile policies.

(2) Blanket policies that provide coverage for limited periods of time.

(3) Determining which plan is primary for dependent children whose parents are divorced but who have joint custody of the child.

The NAIC COB Guidelines have always applied to group disability policies only. When OCI first promulgated the guidelines, it expanded the scope to include blanket disability policies that provide 24-hour coverage as well as traditional group policies.

A blanket policy is defined under s. 600.03 (4), Stats., as "a group policy covering unscheduled classes of persons, with the persons insured to be determined by definition of the class with or without designation of the persons covered but without any individual underwriting." Examples of blanket policies are ones issued to volunteer fire departments to cover the volunteers only while they are serving or to youth camps to cover the children while they are at camp. The policies usually offer limited benefits and are relatively inexpensive because they are normally excess to all other coverage.

When OCI rewrote Ins 3.40 and removed the "24-hour" provision, insurers could no longer market limited blanket polices as excess to all other coverage. This was not OCI's intent. Wisconsin's COB guidelines are now in conflict with the NAIC guidelines and the laws of other states. The amendment will alleviate this problem by only applying the COB guidelines to blanket policies if they provide continuous, 24-hour coverage.

The NAIC COB guidelines apply to the medical benefits provisions of both fault and no-fault automobile policies. OCI included that provision in Ins 3.40 when the rule was recreated. However, that provision is in conflict with s. 632.32 (4) (b), Stats., which states that the medical benefits provision of an automobile policy may be excess to any other benefits to which a person is entitled.

The amendment removes that conflict by removing from COB the medical benefits paid under an individual "fault" type automobile policy. The rule also allows the medical benefits of an automobile "no-fault" type or group or group-type "fault" policy to be excess to the benefits offered by a group or blanket disability policy.

The rules also makes clear that the rule does not apply to benefits paid under medical assistance.

Finally, the COB guidelines establish procedures for insurers to follow to determine which parent's plan is primary for dependent children. This includes situations where the parents are divorced and one parent has custody of the child. However, the COB guidelines do not establish rules for insurers to follow when the parents have joint custody of the child or when the court has ordered both parents to provide health care benefits for the child. The rule establishes a procedure for insurers to follow in these situations.

SECTION 1. Ins 3.40 (2) and (6) (d) and (f) are amended to read:

Ins 3.40 (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 24-hour continuous 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 worker's compensation, employer's liability insurance ~~or~~, Medicare, medical assistance or individual traditional automobile "fault" contracts. Except as permitted under s. 632.32 (4) (b), Stats., this section applies to the medical benefits provisions in an automobile "no fault" type or group or group-type "fault" policy.

(6) (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 ~~pars.~~ par. (e) ~~and (f)~~.

(6) (f) "Plan" may include the medical benefits coverage in group, group-type, and individual automobile "no fault" ~~and~~ contracts; but, as to the traditional automobile "fault" ~~type~~ contracts, only the medical benefits written on a group or group-type basis may be included.

SECTION 2. Ins 3.40 (11) (b) 4 e is created to read:

Ins 3.40 (11) (b) 4 e If the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to subdiv. 3.

SECTION 3. Ins 3.40 (18) (b) (intro.), APPENDIX A (II) (C) (i), and APPENDIX A (II) (B) (iii) are amended to read:

Ins 3.40 (18) (b) (intro.) ~~A~~ Except for expenses covered by worker's compensation, employer's liability insurance, medicare, or medical assistance, or traditional automobile "fault" contracts, a Complying Plan may coordinate its benefits with a Noncomplying Plan on the following basis:

APPENDIX A (II) (C) (i) Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

APPENDIX A (III) (B) (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.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to (III) (B) (ii).

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.

EFFECTIVE DATE. The rule created by this order shall take effect on the first day of September, 1989, as provided in s. 227.22 (2) (b), Stats.

Dated at Madison, Wisconsin, this 28th day of June, 1989.

Robert D. Haase
Commissioner of Insurance

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06/26/89