INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Group Coordination of Benefits (COB)
Model COB Provisions; Procedure to Be Followed by Other Than Primary Plans to Calculate Benefits

Adopted Repeal and New Rule: N.J.A.C. 11:4-28, Appendix A

Adopted Amendment: N.J.A.C. 11:4-28.7

Proposed: November 3, 2003 at 35 N.J.R. 5007(a).

Adopted: February 17, 2004 by Holly C. Bakke, Commissioner, Department of Banking and Insurance

Filed: February 17, 2004 as R. 2004 d. 102, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17:9A-1 et seq., 17:9A-20H, 17:9A-382, 17:12B-1 et seq. and 17:12B-24

Effective Date: March 15, 2004

Expiration Date: November 30, 2005

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance (Department) received one written comment on behalf of Horizon Blue Cross/Blue Shield of New Jersey.

COMMENT: One commenter stated that the "claim determination period" is a term defined in the proposal, but is not used in the description of how benefits are coordinated. The commenter believes that this is an important concept in the description of coordination of benefits, since the liability of the secondary carrier is based not just on the unpaid allowable expenses for a specific claim, but on any unpaid allowable expenses

during that claim determination period. The commenter suggested revising the third paragraph of the "Primary and Secondary Plan" section of the Appendix to read (additions in boldface):

> "The secondary plan(s) will pay up to the remaining unpaid allowable expenses during that claim determination period, but no secondary plan will pay more in a claim determination period, than it would have paid if it had been the primary plan."

RESPONSE: The Department agrees with the suggestion to clarify this provision. The Department has amended this provision by adding "During each claim determination period" at the beginning of the third sentence in the paragraph in question, instead of repeating that term twice.

COMMENT: The commenter stated that the terms "Reasonable and Customary," "as determined by Carrier," and "Carrier," are used by the Department throughout the proposal as a proxy for the insurer issuing the policy. The commenter suggested that, since different rules apply depending upon whether the primary or secondary plan is paying based upon a reasonable and customary determination, the phrase "as determined by [carrier]" should be removed.

RESPONSE: The Department disagrees with the commenter. Each carrier will determine "Reasonable and Customary," based on whatever criteria the carrier uses. The Department recognizes that this determination may not be the same for each carrier. Nevertheless, it will be those "Reasonable and Customary" amounts, as determined by each carrier, that will be used in the COB calculation.

COMMENT: The commenter stated that the fourth paragraph under the provison entitled “Procedures to be followed by the Secondary Plan to calculate benefits” assumes that only HMOs may pay providers based on capitation. The commenter stated that N.J.A.C. 8:38A-4.15(a)5i and 5iv permit capitation for non-HMO plans, except as the sole method of compensation for providers that primarily provide supplies. The commenter suggested changing the reference to “Plan.”

RESPONSE: The Department agrees that capitation is permitted for non-HMO plans. Therefore, the Department is amending this provision by adding “or other plan.”

Federal Standards Statement

The adopted repeal, new rule and amendment regarding the coordination of benefits do not attempt to regulate an area that is regulated by the Federal government through statutes, rules or otherwise. Thus, no Federal standards analysis is necessary.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks *__**thus***__; deletions from proposal indicated with brackets with asterisks ***[**thus**]***):

APPENDIX A

MODEL COB PROVISIONS

. . .

PRIMARY AND SECONDARY PLAN

[Carrier] considers each plan separately when coordinating payments.

The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no coordination of benefits provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. ***[**The**]*** ***<u>During each claim determination period the</u>*** Secondary Plan(s) will pay up to the remaining unpaid allowable expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the [Covered Person] as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the [Covered Person] as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the [Covered Person] as an employee who is neither laid off nor retired, or as a dependent of such person, shall be determined before those for the Plan that covers the [Covered Person] as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the [Covered Person] as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the [Covered Person] under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

a) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
b) If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the plan which covered the other parent for a shorter period of time.
c) "Birthday", as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
d) If the other plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

a) The benefits of the Plan of the parent with custody of the child shall be determined first.
b) The benefits of the Plan of the spouse of the parent with custody shall be determined second.
c) The benefits of the Plan of the parent without custody shall be determined last.
d) If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that plan shall be determined first. The benefits of the plan of the other parent shall be considered as secondary. Until the entity providing coverage under the plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits

In order to determine which procedure to follow it is necessary to consider:
a) The basis on which the Primary Plan and the Secondary Plan pay benefits; and
b) Whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the Reasonable and Customary Charge (R&C), or some similar term. This means that the provider bills a charge and the [Covered Person] may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a reasonable and customary charge is called an "R&C Plan."

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the [Covered Person] may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan." If the [Covered Person] uses the services of a non-network provider, the plan will be treated as an R&C Plan even though the plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation". This means that the HMO ***or other plan*** pays the provider a fixed amount per [Covered Person]. The [Covered Person] is liable only for the applicable deductible, coinsurance or copayment. If the [Covered Person] uses the services of a non-network provider, the HMO ***or other plan*** will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan."

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO" refers to a health maintenance organization plan.

Primary Plan is R&C Plan and Secondary Plan is R&C Plan

The Secondary Plan shall pay the lesser of:
a) The difference between the amount of the billed charges and the amount paid by the Primary Plan; or
b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:
a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or

b) The amount the Secondary Plan would have paid if it had been the Primary Plan. The total amount the provider receives from the Primary Plan, the Secondary Plan and the [Covered Person] shall not exceed the fee schedule of the Primary Plan. In no event shall the [Covered Person] be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is R&C Plan and Secondary Plan is Fee Schedule Plan

If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

a) The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or

b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

The [Covered Person] shall only be liable for the copayment, deductible or coinsurance under the Secondary Plan if the [Covered Person] has no liability for copayment, deductible or coinsurance under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the [Covered Person] be responsible for any payment in excess of the copayment, coinsurance or deductible of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan

If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or

b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is R&C Plan or Fee Schedule Plan

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the [Covered Person] receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or R&C Plan

If the [Covered Person] receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

a) The amount of any deductible, coinsurance or copayment required by the Primary Plan; or

b) The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or R&C Plan and Secondary Plan is Capitation Plan

If the [Covered Person] receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the deductible, coinsurance or copayment imposed by the Primary Plan. The [Covered Person] shall not be liable to pay any deductible, coinsurance or copayments of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO and Secondary Plan is an HMO

If the Primary Plan is an HMO plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the [Covered Person] receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan, except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

NOTE: The term "Carriers" found in brackets should be replaced with the name of the carrier or we/us/our if the carrier uses pronouns when referring to itself. The term "Covered Person" may be replaced with member or subscriber or whatever term the Plan uses to identify the persons covered under the plan. The term "Policy" may be replaced with Contract, Agreement, or some similar term.