

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

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

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

Authorized By: Holly C. Bakke, Commissioner, Department of Banking and Insurance

Authority: N.J.S.A. 17:1-8.1, 17:1-15e, 17B:30-13.1, 26:2J-15 and 26:2J-42.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2003-440

Submit written comments by January 2, 2004 to:

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The agency proposal follows:

Summary

The Department of Banking and Insurance (Department) is repealing the current Appendix A to its coordination of benefit (COB) rules found in N.J.A.C. 11:4-28, and replacing it with a new Appendix A. The Department adopted new rules and amendments to N.J.A.C. 11:4-28 on March 5, 2002, but they were not operative until January 1, 2003. It has come to the Department's attention that the current Appendix A does not accurately reflect the requirements

of N.J.A.C. 11:4-28 as amended. The language in the proposed new Appendix A incorporates the requirements of N.J.A.C. 11:4-28 and its text is a template that may be used by carriers in complying with the coordination of benefits notice requirements.

The new Appendix A clarifies the purpose of the provision. Additionally the new Appendix A includes or revises definitions for the following terms: Allowable Expense; Claim Determination Period; Plan; Primary Plan; Secondary Plan; and Reasonable and Customary.

The Appendix also provides the text that carriers may use in order to comply with the requirements of N.J.A.C. 11:4-28.6 for the coordination of benefits with respect to the determination of whether a plan is primary or secondary.

The Department's new Appendix A also includes text that carriers may use to satisfy the requirements of N.J.A.C. 11:4-28.7, which sets forth the procedures to be followed by other than primary plans to calculate benefits. This section has been substantially revised to reflect the detailed rules describing how benefits are coordinated based upon the payment methodologies of the two plans.

The Department is also amending N.J.A.C.11:4-28.7(e)7. The Department is deleting the term "referral" because it is improperly used in regards to actions taken by the primary plan. A primary-care physician would issue a referral to a member so that a member may access care within the provider's network. In a situation where the primary plan, an HMO, would find it necessary and appropriate for a member to use out-of-network services or supplies the primary plan would authorize those services and supplies. The Department has clarified this provision to address services and supplies authorized by the primary plan.

The Department's rule proposal provides for a comment period of 60 days, and, therefore, pursuant to N.J.S.A. 52:14B-3(4)(c) and N.J.A.C. 1:30-3.3(a)5, is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The proposed new Appendix A will have a favorable social impact on payors, providers and consumers in that the language clarification will lead to a better understanding of COB by all affected parties. The Department is deleting the term "referrals" in N.J.A.C. 11:4-28.7(e)7 because it is improperly used in regards to actions taken by the primary plan. A primary-care physician would issue a referral to a member so that a member may access care within the provider's network. In a situation where the primary plan, an HMO, would find it necessary and appropriate for a member to use out-of-network services or supplies the primary plan would authorize those services and supplies. The Department has clarified this provision to address services and supplies authorized by the primary plan and to avoid possible confusion.

Economic Impact

The Department does not anticipate any economic impact on carriers, payors, providers or consumers as the result of the new Appendix A or the deletion of the term "referral". The proposed new Appendix A permits carriers to just copy the proposed text and use it in complying with the coordination of benefits notice requirements found in N.J.A.C. 11:4-28 et seq. The Department is deleting the term "referral" because it is improperly used in regards to actions taken by the primary plan. A primary-care physician would issue a referral to a member so that

a member may access care within the provider's network. In a situation where the primary plan, an HMO, would find it necessary and appropriate for a member to use out-of-network services or supplies the primary plan would authorize those services and supplies. The Department has clarified this provision to address services and supplies authorized by the primary plan. This clarification will not impose any additional cost.

Federal Standards Statement

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

Jobs Impact

The Department anticipates that there will be no loss or generation of, or other impact on, jobs in this State as a result of the proposed repeal and new rule and amendment.

Agriculture Industry Impact

Pursuant to the Right to Farm Act at N.J.S.A. 4:1C-10.3, and the Administrative Procedure Act at N.J.S.A. 52:14B-4(a)(2), the Department does not expect any agriculture industry impact from the proposed repeal new rule and amendment.

Regulatory Flexibility Statement

The proposed repeal and new rule and amendment are unlikely to directly affect any small businesses as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., because those carriers located in New Jersey have a work force in excess of 100 people. Therefore, a regulatory flexibility analysis is not necessary.

Smart Growth Impact

The proposed amendments will not have an impact on the achievement of smart growth or the implementation of the State Development and Redevelopment Plan.

Full text of the proposed repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:4-28, Appendix A.

Full text of the proposed amendment and new rule follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

11:4-28.7 Procedure to be followed by other than primary plans to calculate benefits

(a)-(d) (No change.)

(e) For the purpose of this subsection, plans that pay network providers on the basis of contractual fee schedules shall include HMO plans, HMO POS plans as permitted by N.J.A.C. 8:38-14, indemnity plans using an SCA as permitted by N.J.A.C. 11:4-37 and those indemnity plans that have contracted with providers who have agreed to accept a negotiated payment.

1.-6. (No change.)

7. Where both the primary and secondary plans are HMO plans, and the covered person obtains services or supplies from a provider who is in the secondary HMO plan's network but is not in the primary HMO's plan's network, the primary HMO plan shall have no liability and the secondary HMO plan shall pay or provide benefits as if it were primary except for emergency services or [referrals] **services and supplies** authorized by the primary plan.

(Agency Note: The brackets appearing in the text of the proposed Appendix below are permanent features of its text, and do not signify proposed deletion.)

APPENDIX A**MODEL COB PROVISIONS****COORDINATION OF BENEFITS AND SERVICES****Purpose Of This Provision**

A [Covered Person] may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this [Policy] as an Employee and by another plan as a Dependent of his or her spouse. If he or she is covered by more than one Plan, this provision allows [Carrier] to coordinate what [Carrier] pays or provides with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary plan and which is the secondary plan. Coordination of benefits is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the [Covered Person] is covered.

DEFINITIONS

The words shown below have special meanings when used in this provision. Please read these definitions carefully. [Throughout this provision, these defined terms appear with their initial letter capitalized.]

Allowable Expense: The charge for any health care service, supply or other item of expense for which the [Covered Person] is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below.

When this [Policy] is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense.

[Carrier] will not consider the difference between the cost of a private hospital room and that of a semi-private hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

When this [Policy] is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, [Carrier] will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A Calendar Year, or any portion of a Calendar Year, during which a [Covered Person] is covered by this [Policy] and at least one other Plan and incurs one or more Allowable Expense(s) under such plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

- a) Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
- b) Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
- c) Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice plans, including insurance continued pursuant to a Federal or State continuation law;
- d) Group hospital indemnity benefit amounts that exceed \$150 per day;
- e) Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance plan or non-governmental plan.

Plan does not include:

- a) Individual or family insurance contracts or subscriber contracts;
- b) Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice plans;
- c) Group or group-type coverage where the cost of coverage is paid solely by the [Covered Person] except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
- d) Group hospital indemnity benefit amounts of \$150 per day or less;
- e) School accident –type coverage;
- f) A State plan under Medicaid.

Primary Plan: A Plan whose benefits for a [Covered Person's] health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either either "a" or "b" below exist:

- a) The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
- b) All Plans which cover the [Covered Person] use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the plan determines its benefits first.

Reasonable and Customary: An amount that is not more than the usual or customary charge for the service or supply as determined by [Carrier], based on a standard which is most often charged for a given service by a Provider within the same geographic area .

Secondary Plan: A Plan which is not a Primary Plan. If a [Covered Person] is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid 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 this Coordination of

Benefits and Services provision, has its benefits determined before those of that Secondary Plan.

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 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 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 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

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