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

1. INTRODUCTION. The Texas Department of Insurance adopts new Subchapter V, 28 TAC §§3.3501 – 3.3510, concerning coordination of benefits (COB). The new subchapter is adopted with changes to the proposed text published in the November 8, 2013, issue of the *Texas Register* (38 TexReg 7834).

2. REASONED JUSTIFICATION. This new subchapter is adopted to replace one that is repealed in this issue of the *Texas Register.* This adopted new subchapter is necessary to permit carriers to include COB provisions that are consistent with modern market conditions and to maintain, by regulation, a consistent order in which plans with COB provisions must pay their claims. The department adopted the current COB subchapter in 1994. Because the adoption of the existing COB subchapter occurred nearly 20 years ago, this adoption is necessary to address current industry matters and procedures involving a person covered under more than one plan.

Adopting a new subchapter to replace the outdated current subchapter will provide greater efficiency in the processing of claims when a person is covered under more than one plan. The department does not adopt the National Association of Insurance Commissioner's (NAIC) Coordination of Benefits Model Regulation, but the adopted rule is consistent with it, including modifications to the NAIC model adopted in 2013. A majority of the states have adopted versions of the model regulation, and rules

that are consistent with the NAIC model will promote market efficiency, especially in the context of multistate plans and carriers operating in multiple states.

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

In response to a comment, the department revises §3.3502(a)(6), as proposed, to clarify that the new subchapter applies to the medical care components of individual and group long-term care contracts. The department deletes "such as skilled nursing care subject to Insurance Code Chapter 1651." For consistency with this amendment, the department also amends Form COB TX under Figure: 28 TAC §3.3510(d), as proposed, in the definition section, to delete "such as skilled nursing care."

In response to a comment, the department revises the proposed language of §3.3502 to provide additional clarity on the transition to the new rule, including an explicit allowance for immediate implementation of the rule by carriers. Clarifying amendments to §3.3502 relating to transition are also necessary because, under both the proposed and adopted rule, consumers with multiple coverages could temporarily have some coverage with older COB language and other coverage with different COB language that complies with the new rule. The department has amended subsections (c) and (d) of §3.3502 and added new subsections (e) – (g). Because the adopted rule explicitly permits a carrier to comply with this adopted subchapter immediately, the department has modified proposed §3.3502(c) and (d) to address conflicts that may occur due to different implementation dates by different carriers. Specifically, the department revises §3.3502(c) to make the word "subsection" plural and to expand the referenced subsections from "(d)" to "(d) – (f)." Additionally, the department has replaced the bracketed text in the proposed rule with an actual date by which carriers must implement the new rule. The department also revises §3.3502(d) to provide additional transition clarification by deleting the reference to "the effective date of this subchapter" and replacing it with the required implementation date provided in subsection (c). The department adds §3.3502(e) to provide that a carrier in compliance with applicable form requirements may comply with this subchapter prior to its required implementation date. Additionally, the department adds §3.3502(f) to state that if there is a conflict in COB provisions in different coverages during implementation of the new subchapter for purposes of determining which carrier is primary and which is secondary,

the prior COB rule will govern. Finally, the department moved part of the language previously included in proposed §3.3502(d) to §3.3502(g), to state, "[t]his subchapter does not apply to individual policies issued before March 25, 2014 that are noncancellable or guaranteed renewable." Government Code §2001.036(a) provides that a rule takes effect 20 days after the date on which it is filed in the office of the secretary of state. This new subsection clarifies that new §3.3502(g) refers to the statutory effective date of this new subchapter as opposed to the implementation dates provided in subsections (c) – (f) of this section.

The department, in response to a comment, revises §3.3503(15)(A)(ii), as proposed, to clarify that a plan does not include disability income protection coverage. The department adds, "excluding Disability Income Protection Coverage under §3.3075," because disability income protection is not considered health insurance subject to coordination of benefits. Because of the change to §3.3503(15)(A)(ii), as proposed, the department revises the applicability provision under §3.3502(a)(1) to exclude Disability Income Protection Coverage under §3.3075 and revises Form COB TX under Figure: 28 TAC §3.3510(d) in the definition section, to add "excluding Disability Income Protection Coverage."

Because of the change to §3.3503(15)(A)(ii), as proposed, the department revises Form COB TX under Figure: 28 TAC §3.3510(d), as proposed, in the definition section, to add that a plan does not include "disability income protection coverage."

The adopted amendments to §3.3507(d)(1) as proposed, include nonsubstantive changes in the text to correct punctuation and grammar and to add clarity. Specifically,

the department adds "this subparagraph and" to §3.3507(d)(1)(A); adds "subparagraph (C) applies if" to §3.3507(d)(1)(B); and adds "under," and "as applicable" to §3.3507(d)(1)(C). The department deletes "if subparagraph (B) of this paragraph applies, then" in §3.3507(d)(1)(C).

These changes do not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice of this rule.

3. HOW THE SECTIONS WILL FUNCTION. New §3.3501 provides the purpose of the subchapter. New §3.3502 provides the policies, evidences of coverage, and contracts to which this subchapter applies. In addition to the subchapter applying to group, blanket, or franchise accident and health insurance policies under Insurance Code Chapter 1251, excluding Disability Income Protection Coverage under §3.3075; and group health maintenance organization evidences of coverage under Insurance Code §843.002, this new subchapter for COB includes individual health maintenance organization evidences of coverage under Insurance Code §843.002; individual accident and health insurance policies under Insurance Code §1201.001; individual and group preferred provider benefit plans and exclusive provider benefit plans under Insurance Code Chapter 1301; group insurance contracts, individual insurance contracts, and subscriber contracts that pay or reimburse for the cost of dental care; and the medical care components of individual and group long-term care contracts. Generally, new §3.3502 makes the subchapter applicable to major medical plans regulated by the department and exempts plans that are not regulated by the

department or which are generally purchased with the intent that they not coordinate with other coverage. Additionally, this new subchapter applies to individual plans, and permits coordination with individual coverages.

Some individuals have more than one health plan for their health care needs. For this reason, this subchapter includes individual health plans so that each plan pays its share of the expenses for the care received by the person with more than one health plan. While in the past, individuals have not generally maintained more than one major medical insurance policy, changes in the market will likely result in this occurring more often in the future. For instance, 42 USC §300gg – 14 extends the age of dependent coverage until the child turns 26 years of age. As a result, individuals up to age 26 are permitted to maintain coverage under their parents' health plans. Also, beginning in 2014, under 42 USC §300gg – 1, and subject to certain requirements, each health insurance issuer that offers health insurance coverage in the individual or group market in a state must accept every employer and individual in the state that applies for coverage on a guaranteed issue basis. Without COB provisions applicable to individual coverage, individuals might have an incentive to purchase multiple individual medical policies to have the same claims paid multiple times. For this reason, the new COB subchapter establishes reduction standards that also apply to individual accident and health insurance policies under Insurance Code §1201.101(c)(10).

Insurance Code §1301.134 concerns coordinating payments for preferred provider benefit plans and determining the appropriate payment each health maintenance organization or insurer should make to the physician or health care

provider. Insurance Code §1301.134(h) provides that the provisions of §1301.134 may not be waived, voided, or nullified by contract. For this reason, the new COB subchapter applies equally to preferred provider benefit plans and exclusive provider benefit plans.

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

The new COB subchapter also applies to the medical care components of individual and group long-term care contracts. Insurance Code §1651.051(c)(10) provides that the standards for the provisions of long-term care benefit plans must address reductions. Title 28 TAC §3.3826(a)(6) implements Insurance Code §1651.051(c)(10) to provide that:

(a) No policy or certificate may be delivered or issued for delivery in this state as a long-term care insurance policy or certificate if such policy or certificate limits or

excludes coverage by type of illness, treatment, medical condition, or accident, except as follows:

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

However, 28 TAC §3.3826(a)(6) does not provide for the order of payment when a long-term care insurance plan coordinates its payment when there are expenses for services or items paid under another long-term care insurance or health insurance policy. As previously discussed, Insurance Code §1701.055(b) provides that a form filed under Chapter 1701 with a COB provision may not be approved for use in this state unless the form provides for the order of benefits determination for insured dependent children. Insurance Code §1701.055(b) further provides that an order of benefits determination provision may not be approved if the provision violates the Insurance Code, a rule of the commissioner, or any other law. For these reasons, this new COB subchapter applies to the medical care components of individual and group long-term care contracts. New §3.3502 also clarifies the dates for applying this new subchapter and resolves conflicts.

New §3.3503 provides the definitions of the following words and terms used in the subchapter: "allowable expense," "allowed amount," "birthday," "carrier," "certificate holder," "claim," "closed panel plan," "Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)," "contract," "coordination of benefits," "custodial parent," "group-type contract," "high-deductible health plan," "hospital indemnity benefits," "plan," "policyholder," "primary plan," and "secondary plan." These definitions are necessary

for the proper application of the requirements of the subchapter. The term “plan” is defined to identify those products with which coordination is permitted and not permitted. The term is generally defined to include major medical products whether or not they are regulated by the department, and exclude products that are subject to other coordination requirements or which are generally not intended to be subject to coordination. For example, Insurance Code Chapter 1203 provides the instances in which certain COB provisions are prohibited.

New §3.3504 establishes a general prohibition for when a carrier may not coordinate benefits to reduce the benefits paid under a plan regulated by the proposed new subchapter. This new section clarifies that a carrier is not required to coordinate benefits to reduce the amount it pays, but if it does coordinate benefits, it must comply with the requirements of the subchapter. This section is also consistent with Insurance Code §1701.055(b) which provides that a form filed under Chapter 1701 with a COB provision may not be approved for use in this state unless the form provides for the order of benefits determination for insured dependent children. An order of benefits determination provision may not be approved if the provision violates the Insurance Code, a rule of the commissioner, or any other law; or contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive.

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

New §3.3506 describes the use of the term "plan" in contracts. This section clarifies the parts of a plan that may be coordinated, requires that carriers explain to consumers what plans may be coordinated, and permits limited COB provisions.

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

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

New §3.3509 provides miscellaneous provisions concerning the COB that are necessary to clarify and resolve particular issues.

New §3.3510 explains the model COB provision form for use in contracts. New §3.3510 also explains the model form written in plain language to describe the COB process to the covered person. While this form is not required to be used, this section is necessary to explain the form and its permissible use.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Comment: A commenter suggests that the department revise the proposed rule to encourage or require the use of electronic data matching between commercial insurers to identify overlapping coverage. The commenter explains that, without sharing proprietary information with marketplace competitors, electronic data matching involves

payers collaborating to identify other coverage through mutual data sharing by using an independent third party. Upon identifying a beneficiary with more than one coverage, the commenter states that the other coverage information for that beneficiary is validated and only returned to each of the involved payers.

Response: The department declines to make a change. Because carriers benefit from the coordination of benefits and would presumably benefit from better data matching, the department believes that it is best to allow carriers to pursue those market solutions and business decisions they believe best suit them, rather than imposing requirements by regulation. The department declines to opine on the particular merits of the commenter's proposal for use by carriers.

Comment: A commenter supports the proposed rules establishing new Subchapter V, 28 TAC §§3.3501 – 3.3510, concerning COB. The commenter explains that the proposal is necessary to permit carriers to include COB provisions that are consistent with modern market conditions and to maintain a consistent order in which plans with COB provisions must pay their claims. While the commenter supports the rule, the commenter requests as much flexibility as possible with the effective date. The commenter requests that the department strike §3.3502(d) and amend §3.3502(c) to provide that, "This subchapter applies to individual and group plans that are delivered, issued for delivery, or renewed on or after the rule effective date."

Response: The department agrees in part. The department disagrees with the proposed language, because it would require immediate implementation of the new rule by all carriers. Instead, the adopted section is modified so that a carrier in compliance

with applicable filing requirements may comply with the new subchapter requirements prior to the implementation date of the new rule. Under both permitted transition periods in the proposed and the adopted rule, there is a possibility of consumers having policies with different COB language. In light of the comment, the department has modified the adopted section to provide that if there is a conflict between the order of benefit provisions of different plans for purposes of determining which carriers are primary and secondary, then the order of benefit payments will be determined under the prior version of the COB subchapter.

Comment: A commenter cites to the following proposal preamble language, "The proposed new COB subchapter would also apply to the medical care components of individual and group long-term care contracts, such as skilled nursing care subject to Insurance Code Chapter 1651." The commenter further states that the applicability section in proposed §3.3502 includes subsection six which provides for, "the medical care components of individual and group-long term care contracts, such as skilled nursing care subject to Insurance Code Chapter 1651." The commenter further states that subsection seven provides an exemption for "benefits provided in long-term care insurance policies for nonmedical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, custodial care, or for contracts that pay affixed daily benefit without regard to expenses incurred or the receipt of services."

With respect to "nonmedical services," the commenter requests proposed §3.3502(a)(6) to provide clarification to the interpretation of proposed §3.3502(a)(6) and

(b)(7) as follows, "the medical care components of individual and group long term care contracts, such as medical care components of expenses incurred in a skilled nursing facility, subject to Insurance Code Chapter 1651."

Response: In part, the department agrees that the section can be amended to better provide consistent interpretation of §3.3502(a)(6) and (b)(7). To clarify that this new subchapter applies to the medical care components of any type of service or treatment provided under individual and group long-term care contracts, the department has changed §3.3502(6) to delete the example provided in the proposal.

Comment: A commenter requests removing disability income policies from the definition of "plan" under proposed §3.3503(15)(A)(ii). The commenter explains that the limited benefit policies in 28 TAC §3.3079, referenced by proposed §3.3503(15)(A)(ii), include Basic Hospital Expense Coverage, Basic-Medical-Surgical Expense Coverage, and Disability Income Protection Coverage. The commenter states that because the purpose of disability income coverage is not to provide for medical expenses, it does not seem appropriate to include disability income protection coverage as a plan that can be coordinated against under this proposed new subchapter. The commenter further states that while the NAIC does not include or exclude disability income policies under the definition of "plan" in the COB model, in the legislative history discussion, there is an indication that disability income coverage was not included in the exclusion list because the list was "compiled based on what was typically considered health insurance."

Response: The department agrees that disability income protection coverage does not provide medical expenses and is not typically considered health insurance. The

department agrees that the definition of "plan" should exclude disability income protection coverage. The department has changed the section accordingly. Because of the change to §3.3503(15)(A)(ii), the department also revises the applicability provision under §3.3502(a)(1) to exclude Disability Income Protection Coverage.

Comment: A commenter supports transparent COB policy provisions and plain language disclosures to ensure that consumers are well-informed about the health insurance products they purchase. The commenter states that proposed §3.3510(d) permits a secondary carrier to treat a primary carrier as a noncompliant plan if the primary carrier fails to provide reasonably requested information. The commenter suggests revising §3.3510(d) to include a time line for the primary carrier to comply and a noninclusive list of information that may trigger the noncompliant designation by the secondary carrier. The commenter explains that the suggested revision will ensure that carriers understand their responsibilities and reduce the risk of unnecessary payment delays for consumers.

Response: The department clarifies that the commenter's reference to §3.3510(d) applies to the informal rule proposal for the coordination of benefits. The department agrees that a carrier to which this chapter applies should provide reasonably requested information to a secondary carrier within a certain time frame after it is requested. However, a change is unnecessary because proposed §3.3509(d) includes a time frame to provide the requested information. It provides, "a carrier to which this subchapter is applicable is required to provide reasonable information to a secondary carrier that is needed to determine the benefits to be paid under this subchapter seven days after it is

requested." The department also disagrees that it is necessary to make a change to provide a noninclusive list of information that may trigger the noncompliant designation by the secondary carrier. The department cannot predetermine a list of information that may trigger noncompliance when it is not provided to the secondary carrier. "Reasonable information" will vary with each claim, depending on the information available to the secondary carrier. For these reasons, the department refuses to make a change.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For with changes: American Council of Life Insurers, Health Management Systems, Office of Public Insurance Counsel, Texas Association of Health Plans, and Texas Association of Life and Health Insurers.

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

requirements of federal law and regulations. Section 1201.006 provides that the commissioner may adopt reasonable rules as necessary to implement the purposes and provisions of Chapter 1201. Section 1201.101(a) provides that the commissioner must adopt reasonable rules establishing specific standards for the content of an individual accident and health insurance policy and the manner of sale of an individual accident and health insurance policy, including required disclosures in connection with the sale. Section 1201.101(b) provides that rules adopted under §1201 must establish standards for policy readability and full and fair policy disclosures. Section 1201.101(c)(10) provides that standards established under §1201 may include standards that address reductions. Section 1251.008 provides that the commissioner may adopt rules necessary to administer Chapter 1251. Section 1301.007 requires the commissioner to adopt rules as necessary to implement Chapter 1301 and ensure reasonable accessibility and availability of preferred provider services to residents of this state. Section 1651.004(a) provides that in addition to other rules required or authorized by Chapter 1651, the department may adopt reasonable rules that are necessary and proper to carry out Chapter 1651. Section 1651.004(b) provides that rules adopted under this section must include requirements no less favorable than the minimum standards for long-term care benefit plans adopted in any model laws or regulations relating to minimum standards for benefits for long-term care benefit plans and under federal law. Section 1651.051(a) requires the commissioner to establish by rule: (1) specific standards for provisions of long-term care benefit plans; and (2) standards for full and fair disclosure setting forth the manner, content, and required disclosures for the

marketing and sale of those benefit plans. Section 1651.051(b)(1) – (3) provides that the standards are in addition to and must be in accord with applicable laws of this state, including Chapter 1201; applicable federal law; and any rules, regulations, and standards required by federal law. Section 1651.051(c)(10) provides that the standards must address benefit limitations, exceptions, and reductions. Section 1701.055(b) provides that a form filed under Chapter 1701 that contains a COB provision may not be approved for use in this state unless the form provides for the order of benefits determination for insured dependent children, and it further provides that an order of benefits determination provision may not be approved if the provision violates this code, a rule of the commissioner, or any other law; or contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive. Section 1701.060(a) provides that the commissioner may adopt reasonable rules necessary to implement the purposes of Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria under which each type of form submitted to the department under this chapter will be reviewed and approved by the commissioner or exempted under §1701.005(b); and particular types of forms designated by the commissioner may be given a summary review and approval if considered appropriate by the commissioner to expedite review and approval of those forms. Section 36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

§3.3501. Purpose.

(a) The purpose of this subchapter is to:

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

(2) identify plans with which COB is allowed;

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

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

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

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

§3.3502. Applicability.

(a) This subchapter applies to:

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

Coverage under §3.3075 of this title (relating to Minimum Standards for Disability Income Protection Coverage);

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

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

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

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

(6) the medical care components of individual and group long-term care contracts.

(b) This subchapter does not apply to:

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

(2) workers' compensation insurance coverage;

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

(4) accident only coverage;

(5) specified disease or specified accident coverage;

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

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

(8) Medicare supplement policies;

(9) a state plan under Medicaid;

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

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

(c) Except as provided in subsections (d) – (f) of this section, this subchapter applies to individual and group plans that are delivered, issued for delivery, or renewed on or after September 2, 2014.

(d) A contract delivered, issued for delivery, or renewed before September 2, 2014, must be brought into compliance with this subchapter on the next anniversary date or renewal date of the contract, or the expiration of any applicable collective bargaining contract under which it was written.

(e) A carrier in compliance with applicable filing requirements may comply with this subchapter prior to September 2, 2014.

(f) If there is a conflict, due to the implementation transition permitted by subsections (c) – (e) of this section, between the order of benefit provisions of different plans for purposes of determining which carriers are primary and secondary, then the

order of benefit payments will be determined under the version of this subchapter that was in effect prior to September 2, 2014.

(g) This subchapter does not apply to individual policies issued before March 25, 2014 that are noncancellable or guaranteed renewable.

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

(1) Allowable expense--Except as otherwise provided in §3.3505 of this title (relating to Allowable Expenses), or where a statute requires a different definition, any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

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

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

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

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

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

(A) services, including supplies;

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

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

(D) an indemnification.

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

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

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

(10) Coordination of benefits (COB)--A provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

(11) Custodial parent--

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

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

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

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

(14) Hospital indemnity benefits--Benefits not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

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

(A) plan includes:

(i) any contract to which this subchapter applies;

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

Protection Coverage under §3.3075 of this title (relating to Minimum Standards for Disability Income Protection Coverage);

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

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

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

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

(B) plan does not include:

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

(ii) workers' compensation insurance coverage;

(iii) hospital confinement indemnity coverage or other fixed indemnity;

(iv) specified disease coverage;

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

(vi) accident-only coverage;

(vii) specified accident coverage;

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

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

(x) Medicare supplement policies;

(xi) a state plan under Medicaid;

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

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

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

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

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

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

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

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

§3.3505. Allowable Expenses.

(a) If a covered person advises a plan that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accord with §223 of the Internal Revenue Code of 1986, the primary high-deductible plan’s deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in §223(c)(2)(C) of the Internal Revenue Code of 1986.

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

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

(d) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

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

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

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

payment amount that is different than the primary plan's payment arrangement and if the health care provider's or physician's contract permits, that negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

(h) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drugs, or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of "allowable expenses" in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of "allowable expense" must include similar expenses to which COB applies.

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

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

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

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

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

(a) Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan, and there is no COB among the separate parts of the plan.

(b) If a plan coordinates benefits, its contract must state the types of coverage that will be considered in applying the COB provision of that contract. Whether the contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan" in this subchapter. The model COB contract provisions provide an example of how to define "plan" in §3.3510(d) of this title (relating to Model COB Contract Provisions).

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

§3.3507. Rules for COB and Order of Benefits.

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

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

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

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

(4) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

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

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

(c) Coverage by membership in a group. Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance-type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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

(1) Nondependent or dependent.

(A) Subject to this subparagraph and subparagraph (B) of this paragraph, the plan that covers the person other than as a dependent, for example, as an employee, member, subscriber, policyholder, certificate holder, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan.

(B) If the person is a Medicare beneficiary, subparagraph (C) of this paragraph applies if, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

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

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

(C) Under subparagraph (B) of this paragraph, as applicable, the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder, certificate holder, or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

(2) Dependent child covered under more than one plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

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

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

(ii) if both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

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

(i) if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, and that parent's spouse does, then the spouse's plan is the primary plan. This clause must not apply with respect to any plan year during which

benefits are paid or provided before the entity has actual knowledge of the court order provision.

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

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (A) of this paragraph must determine the order of benefits.

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

(I) the plan covering the custodial parent;

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

(III) the plan covering the noncustodial parent; then

(IV) the plan covering the noncustodial parent's spouse.

(C) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits must be determined, as applicable, under subparagraph (A) or (B) of this paragraph as if the individuals were parents of the child.

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

(E) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in subparagraph (A) of this paragraph to the dependent child's parent(s) and the dependent's spouse.

(3) Active employee, retired, or laid-off employee.

(A) The plan that covers a person as an active employee who is neither laid off nor retired, or as a dependent of an active employee, is the primary plan. The plan that covers that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.

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

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

(4) COBRA or state continuation coverage.

(A) If a person whose coverage is provided under COBRA or under a right of continuation under state or other federal law is covered under another plan,

the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the plan covering that same person under COBRA or under a right of continuation under state or other federal law is the secondary plan.

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

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

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

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

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

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

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

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

(3) The person’s length of time covered under a plan is measured from the person’s first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the claimant's coverage under the present plan has been in force.

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

§3.3508. Procedure to be Followed by Secondary Plan. In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan must calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount that, when combined with the amount paid by the primary plan, results in the total benefits paid or provided by all plans for the claim equaling 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

§3.3509. Miscellaneous Provisions.

(a) A secondary plan that provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan. This subsection does not require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

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

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

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

(3) if the noncompliant plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan must assume that the benefits of the noncompliant plan are identical to its own, and must pay its benefits accordingly. If,

within two years of payment, the complying plan receives information as to the actual benefits of the noncompliant plan, it must adjust payments accordingly.

(c) If a noncomplying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and applicable state law allows the right of subrogation, as provided in this section, then the complying plan must advance to the covered person, or to an assignee on behalf of the covered person, an amount equal to the difference. However, the complying plan may not advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of such advance, the complying plan must be subrogated to all rights of the covered person against the noncomplying plan, in accord with applicable subrogation provisions. The advance by the complying plan must also be without prejudice to any claim it may have against the noncomplying plan in the absence of subrogation.

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

(e) A plan must, in its explanation of benefits provided to covered persons, include the following language, "If you are covered by more than one health benefit plan, you should file all your claims with each plan."

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

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

(h) A contract may not reduce benefits on the basis that:

(1) another plan exists and the covered person did not enroll in that plan;

(2) a person is or could have been covered under another plan, except with respect to Part B of Medicare; or

(3) a person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

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

(j) Under the terms of a closed panel plan, benefits are not payable if the covered person does not use the services of a closed panel plan health care provider or

physician. COB does not occur if a covered person is enrolled in two or more closed panel plans and obtains services from a health care provider or physician in one of the closed panel plans because the other closed panel plan for which health care providers or physicians were not used has no liability. However, COB may occur during the plan year when the covered person receives emergency services that would have been covered by both plans, and the secondary plan must comply with §3.3508 of this title (relating to Procedure to be Followed by Secondary Plan) to determine the amount it should pay for the benefit.

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

§3.3510. Model COB Contract Provisions.

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

(b) Subsection (e) of this section contains an optional model plain language description of the COB process that explains to the covered person how health plans will implement COB. It is not intended to replace or change the provisions that are set forth in the contract. Its purpose is to explain the process by which two or more plans will pay for or provide benefits.

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

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

FIGURE: 28 TAC §3.3510(d):

FORM COB TX

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

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

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

DEFINITIONS

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

(1) Plan includes: group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in-

force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

(2) Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

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

(b) "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

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

(c) "Allowable expense" is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan

covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a health care provider or physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

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

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

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

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

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

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care provider and physician arrangements.

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

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

(f) "Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

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

(a) The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(b) Except as provided in (c), a plan that does not contain a COB provision that is consistent with this policy is always primary unless the provisions of both plans state that the complying plan is primary.

(c) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage must be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

(d) A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

(e) If the primary plan is a closed panel plan and the secondary plan is not, the secondary plan must pay or provide benefits as if it were the primary plan when a covered person uses a noncontracted health care provider or physician, except

for emergency services or authorized referrals that are paid or provided by the primary plan.

(f) When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.

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

(h) Each plan determines its order of benefits using the first of the following rules that apply.

(1) Nondependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan. An example includes a retired employee.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court order stating otherwise, plans covering a dependent child must determine the order of benefits using the following rules that apply.

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

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

(ii) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

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

(i) if a court order states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

(ii) if a court order states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of (h)(2)(A) must determine the order of benefits.

(iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of (h)(2)(A) must determine the order of benefits.

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

(I) the plan covering the custodial parent;

(II) the plan covering the spouse of the custodial parent;

(III) the plan covering the noncustodial parent; then

(IV) the plan covering the spouse of the noncustodial parent.

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

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

(E) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits must be determined by applying the birthday rule in (h)(2)(A) to the dependent child's parent(s) and the dependent's spouse.

(3) Active, Retired, or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan that covers that same person as a retired or

laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the plan that covers the same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if (h)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the plan that has covered the person the shorter period is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

(a) When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim. In addition, the secondary plan must credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel plan, COB must not apply between that plan and other closed panel plans.

COMPLIANCE WITH FEDERAL AND STATE LAWS CONCERNING CONFIDENTIAL INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

FIGURE: 28 TAC §3.3510(e):

FORM COB NOTICE TX

CONSUMER EXPLANATORY BOOKLET

COORDINATION OF BENEFITS (COB)

IMPORTANT NOTICE

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

Double Coverage

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

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

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

Primary or Secondary?

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

When This Plan is Primary

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

Your Own Expenses

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

Your Spouse’s Expenses

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

Your Child's Expenses

- the claim is for the health care expenses of your child who is covered by this plan and

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

Other Situations

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

How We Pay Claims When We Are Primary

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

When This Plan is Secondary

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

How We Pay Claims When We Are Secondary

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits. We will then pay part or all of the allowable expenses left unpaid, as explained below. An "allowable expense" is a health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

If there is a difference between the amount the plans allow, we will usually base our payment on the higher amount. However, if one plan has a contract with the health care provider or physician and the other does not, our combined payments will not be more than the contracted amount. Health maintenance organizations and preferred provider organizations usually have contracts with their providers.

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

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

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

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

Issued at Austin, Texas, on March 3, 2014.

Sara Waitt
General Counsel
Texas Department of Insurance

The commissioner adopts new Subchapter V, 28 TAC §§3.3501 – 3.3510.

Julia Rathgeber
Commissioner of Insurance

COMMISSIONER'S ORDER NO. **3046**