Ohio Administrative Code

Rule 3901-8-01 Coordination of benefits.

Effective: November 16, 2023

(A) Purpose

The purpose of this rule is to:

(1) Permit plans to include a coordination of benefits "(COB)" provision;

(2) Provide the authority for the orderly transfer of information needed to pay claims promptly;

(3) Eliminate duplication of benefits by permitting a plan to reduce benefits paid when, pursuant to this rule, it is not required to pay its benefits first;

(4) Reduce claim payment delays; and

(5) Further define the "COB" statute.

(B) Authority

This rule is promulgated pursuant to the authority vested in the superintendent under section 3901.041 of the Revised Code, and section 3902.14 of the Revised Code, providing that the superintendent may adopt rules to carry out the purposes of sections 3902.11 to 3902.14 of the Revised Code.

(C) Definitions

As used in this rule:

(1)

(a) "Allowable expense" means, except as set forth below or otherwise defined by statute, any health care expense, including coinsurance or co-payments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

(b) If a plan is advised by the covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health 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 Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

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

(d) Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

(e) The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug 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 includes similar expenses to which "COB" applies.

(f) 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.

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

(i) Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions for services; or

(ii) Because the covered person has a lower benefit because the covered person did not use a preferred provider.

(2) "Birthday" means the month and day in a calendar year and does not include the year in which an individual is born.

(3) "Claim" means a request that plan benefits be provided or paid. This term includes a request for:

(a) Services, including supplies;

(b) Payment for all or a portion of expenses incurred;

(c) A combination of paragraphs (C)(3)(a) and (C)(3)(b) of this rule; or

(d) Indemnification.

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

(5) "Consolidated Omnibus Budget Reconciliation Act of 1985" or "COBRA" means coverage provided under a right of continuation pursuant to federal law.

(6) "Coordination of benefits" or "COB" means a procedure establishing the order in which plans shall 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.

(7) "Custodial parent" means:

(a) The parent awarded custody of a child by a court decree; or

(b) In the absence of a court decree, the parent with whom the child resides more than one half of the

calendar year without regard to any temporary visitation.

(8) "Group-type contract" means a contract not available to the general public which is obtained and maintained only because of membership in, or in connection with, a particular organization or group, including blanket coverage. This term does not include an individually underwritten and issued, guaranteed renewable policy even if purchased through payroll deduction at a premium savings to the insured since the insured would have a right to maintain or renew the policy independently of continued employment with the employer.

(9) "High-deductible health plan" has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

(10) "Hospital indemnity benefits" means benefits which are not related to actual expenses incurred. The 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.

(11)

(a) "Plan" means a form of coverage with which coordination is allowed. 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) The definition of plan in a contract shall state the types of coverage which 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 paragraph (C)(11) of this rule.

(c) Plan includes:

(i) Group and non-group insurance and subscriber contracts;

(ii) An uninsured arrangement of group or group-type coverage;

(iii) Group or group-type and non-group coverage through a health insuring corporation, closed panel plan or other prepayment, group practice or individual practice plan;

(iv) Group-type contracts;

(v) The medical care components of long term care contracts, such as skilled nursing care;

(vi) Medical benefits coverage under automobile "no fault" and traditional "fault" type contract; and

(vii) Medicare or other governmental benefits, as permitted by law, except as provided in paragraph (C)(11)(d)(vii) of this rule. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

(d) The term "plan" does not include:

(i) Hospital indemnity benefits or other fixed indemnity coverage;

(ii) Accident only coverage or specified accident coverage;

(iii) A supplemental sickness and accident policy excluded from coordination of benefits pursuant to sections 3923.37 and/or 1751.56 of the Revised Code;

(iv) School accident-type coverage;

(v) Benefits provided in long term care insurance policies 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;

(vi) Medicare supplement policies; or

(vii) A state plan under medicaid, or other governmental plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

(12) "Primary plan" means a plan whose benefits for a person's health care coverage are determined without taking the existence of any other plan into consideration. A plan is a primary plan if either of the following conditions is true:

(a) A plan either does not contain order of benefit rules, or it has rules which differ from those permitted by this rule; or

(b) All plans which cover the person use the order of benefits determination required by this rule, and under this rule that plan determines its benefits first.

(13) "School accident-type coverage" means a contract covering elementary, junior high, high school and or college students for accidents only, including athletic injuries, on a twenty-four hour basis or on a "to and from school" basis.

(14) "Secondary plan" means any plan which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this rule determine the order in which their benefits are determined in relationship to each other.

(15) "This plan" means, in a "COB" provision, the part of a contract providing health care benefits to which the "COB" provision applies and which may be reduced because of the benefits of other plans.

(D) Solicitation, certificate and contract provisions

(1) The following language, printed in twelve point type, shall be included as a separate and distinct paragraph on the first page in at least one solicitation, marketing, advertising or enrollment document which shall be provided to potential subscribers of a plan subject to this rule:

"WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC

DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY."

(2) The following language, printed in twelve point type, shall be included as a separate and distinct paragraph on the first page in every contract, policy, certificate/evidence of coverage and summary plan description issued to a beneficiary under a plan subject to this rule:

"NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY."

(3) A contract which utilizes "COB" shall contain the "COB" provisions set forth in appendix A to this rule. Changes in words and format may be made to fit the language and style of the rest of the contract or to reflect the difference among plans which provide services, which pay benefits for expenses incurred, and which indemnify. No substantive changes are permitted.

(4) Each certificate issued under a group contract which utilizes "COB" shall contain the "COB" provisions set forth in appendix A to this rule. Changes in words and format may be made to fit the language and style of the rest of the group certificate or to reflect the difference among plans which provide services, which pay benefits for expenses incurred and which indemnify. No substantive changes are permitted.

If a group policyholder or contractholder distributes its own solicitation, marketing, advertising or enrollment documents to its members who are potential subscribers of a plan subject to these rules, then the plan shall make the foregoing language available for use by the group.

(E) Prohibited coordination and benefit design

(1) A contract shall not reduce benefits on the basis that:

(a) Another plan exists and the covered person did not enroll in that plan;

(b) A person is or could have been covered under another plan, except with respect to part B of medicare; or

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

(2) No contract, certificate or policy shall contain a provision that its benefits are "always excess" or "always secondary" to any other plan, except as otherwise provided in this rule.

(3) 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 provider. In most instances, "COB" does not occur if a covered person is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers 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. Then the secondary plan shall use the provisions of paragraph (H) of this rule to determine the amount it should pay for the benefit.

(4) No plan may use a "COB" provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have that does not meet the definition of plan under paragraph (C)(11) of this rule.

(F) Requirements

(1) Allowable expense

(a) When plans have differing allowable expenses, the larger allowable expense is used for the purpose of division (C) of section 3902.13 of the Revised Code. When benefits paid by a primary

plan are less than the allowable expenses, the secondary plan pays or provides its benefits toward any remaining balance otherwise payable by the insured or the certificate holder. A secondary plan is not required to make a payment of an amount which exceeds the amount it would have paid if it were the primary plan, but in no event, when combined with the amount paid by the primary plan, shall payments by the secondary plan exceed one hundred per cent of the larger of the expenses allowable under the provisions of the applicable policies and contracts.

(b) When a plan provides benefits in the form of services, the reasonable cash value of each service is both an allowable expense and a benefit paid.

(c) When a contract restricts "COB" to specific coverage, allowable expense includes the expenses or services to which "COB" applies under the contract.

(2) A secondary plan is not required to pay for services unless such services are received in accordance with the rules and provisions outlined in its policy, contract or certificate.

(3) A primary plan pays or provides its benefits as if the secondary plan does not exist. A plan that does not contain a coordination of benefits provision shall not take into account benefits of other plans. However, a contract holder's coverage which is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage is excess to any other parts of the plan provided by that 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. A plan that does not contain order of benefit determination provisions that are consistent with this rule is always the primary plan unless the provisions of both plans, regardless of the provisions of paragraph (F)(3) of this rule, state that the complying plan is primary.

(4) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan pays or provides benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

(5) When multiple contracts providing coordinated coverage are treated as a single plan under this

rule, this paragraph 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 is responsible for the plan's compliance with this rule.

(6) A secondary plan may take the benefits of another plan into account when, under this rule, it is secondary to the other plan.

(7) Nothing in these rules prevents a third party payer and a provider from entering into an agreement under which the provider agrees to accept, as payment in full from any or all plans providing benefits to a beneficiary, an amount which is less than the provider's regular charges.

(G) Order of benefit determination

Order of benefits are determined by the first applicable provision set forth in this paragraph:

(1) Non-dependent or dependent. The benefits of a plan covering the person as an employee, member, insured, subscriber or retiree, other than as a dependent, are determined before those of a plan which covers the person as a dependent. However, the benefits of a plan covering the person as a dependent are determined before the benefits of a plan covering the person as other than a dependent if the person is a medicare beneficiary, and as a result of Title XVIII of the Social Security Act and its implementing regulations:

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

(b) Medicare is primary to the plan covering the person as other than a dependent (e.g. a retired employee).

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, plans covering a dependent child determine the order of benefits as follows:

(a) For a dependent child whose parents are married (not separated or divorced) 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;

(ii) If both parents have the same birthday, the plan which has covered the parent for a longer period of time is the primary plan;

(iii) If one plan does not have the rule described in paragraphs (G)(2)(a)(i) and (G)(2)(a)(ii) of this rule because that plan is not subject to the "COB" statutes, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the plan containing the rule based upon the gender of the parent determines the order of benefits.

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

(i) If the specific terms of the court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child, 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, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph (G)(2)(a) of this rule determine the order of benefits.

(iii) If the specific terms of the court decree state that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses or health care coverage of the child, the plans covering the child are subject to the order of benefit determination contained in paragraph (G)(2)(a) of this rule.

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

(A) The plan covering the custodial parent;

(B) The plan covering the custodial parent's spouse;

(C) The plan covering the non-custodial parent; and then

(D) The plan covering the non-custodial 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 is determined, as applicable, under paragraph (G)(2)(a) or (G)(2)(b) of this rule as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The benefits of a plan which covers a person as an active employee who is neither laid off nor retired, or as that active employee's dependent, is the primary plan. If the other plan does not have this provision, and if, as a result, the plans do not agree on the order of benefits, this provision does not apply.

This paragraph does not supersede paragraph (G)(1) of this rule. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under paragraph (G)(1) of this rule. Paragraph (G)(3) of this rule covers the situation where one individual is covered under one policy as an active worker and under another policy as a retired worker. It would also apply to an individual covered as a dependent under both of those policies.

(4) "COBRA" or state continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

(a) The plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is the primary plan;

(b) The continuation coverage provided pursuant to federal or state law is the secondary plan.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This provision does not apply if the order of benefits can be determined under paragraph (G)(1) of this rule.

(5) Longer or shorter length of coverage. If none of the preceding provisions determines the order of benefits, the plan which has covered the person for the longer period of time is the primary plan and the plan which covered that person for the shorter period of time is the secondary plan. For the purposes of this provision:

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

(b) Two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended;

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

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

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

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

(6) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.

(H) Procedure to be followed by secondary plan to calculate benefits and pay a claim.

In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan calculates 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 so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed one hundred per cent of the total allowable expense for that claim. In addition, the secondary plan credits to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(I) Miscellaneous provisions

(1) A secondary plan which provides benefits in the form of services may recover the reasonable cash value of the services from a primary plan, to the extent that benefits for the services are covered by, and have not already been paid or provided by the primary plan. Nothing in this paragraph obligates a plan to reimburse a covered person in cash for value of services provided by a plan that provides benefits in the form of services.

(2) A plan with order of benefit determination rules which comply with this rule (complying plan) may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with this rule (non-complying plan) as follows:

(a) If the complying plan is the primary plan, it pays or provides its benefits first;

(b) If the complying plan is the secondary plan, it pays or provides its benefits first, but the amount of the benefits payable are determined as if the complying plan were the secondary plan. Such payment is the limit of the complying plan's liability;

(c) If a non-complying plan does not provide the information needed by a complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and pays its benefits accordingly. However, if the complying plan receives information within two years of payment as to the actual benefits of the non-complying plan, it shall adjust payments accordingly.

(d) If a non-complying plan which paid or provided benefits as a primary plan reduces its benefits so that a claimant receives less in benefits than he would have received had the complying plan paid or

provided its benefits as the secondary plan, the complying plan shall advance to, or on behalf of, the claimant an amount equal to such difference. The amount advanced, combined with other amounts previously paid by the complying plan, shall not exceed the liability of the complying plan as calculated as if the complying plan were the primary plan.

In consideration of the advance, the complying plan shall be subrogated to all rights of the claimant against the non-complying plan. The advance by the complying plan is without prejudice to any claim it may have against the non-complying plan in the absence of subrogation.

(3) A term such as "medical care" or "dental care" may be substituted for the term "health care" in describing the coverages to which the "COB" provisions of a contract apply.

(4) Provisions regarding either "COB" or subrogation may be included in a health care benefits contract without compelling the inclusion or exclusion of the other in that contract.

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

(J) This rule is applicable to every contract which provides health care benefits and which was issued on or after the effective date of this rule.

(K) Penalties

Whoever violates this rule or any paragraph thereof is deemed to have engaged in an unfair and deceptive insurance act or practice under sections 3901.19 to 3901.26 of the Revised Code, and is subject to proceedings pursuant to those sections.

(L) Severability

If any portion of this rule or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the rule or related rules which can be

given effect without the invalid portion or application, and to this end the provisions of this rule are severable.