

**R590. Insurance, Administration.**

**R590-131. Accident and Health Coordination of Benefits Rule.**

**R590-131-1. Authority.**

This rule is adopted and promulgated pursuant to Subsection 31A-2-201(3)(a) and Section 31A-22-619.

**R590-131-2. Purpose and Applicability.**

- (1) The purpose of this rule is to:
  - (a) establish a uniform order of benefit determination under which a plan pays a coordination of benefit claim;
  - (b) reduce duplication of benefits by permitting a reduction of the benefits to be paid by a plan when the plan, pursuant to this rule, does not have to pay its benefits first; and
  - (c) provide greater efficiency in the processing of a claim when a person is covered under more than one plan.
- (2) This rule applies to any accident and health insurance plan issued on or after the effective date of this rule.

**R590-131-3. Definitions.**

For the purposes of this rule, the commissioner adopts the definitions in Section 31A-1-301, and the following:

- (1) "Allowable Expense" means 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.
  - (a) If an insurer is advised by a covered person that each plan covering the person is a high-deductible health plan 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.
  - (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 provider, by law or in accordance with a contractual agreement, is prohibited from charging a covered person is not an allowable expense.
  - (d) The following are examples of expenses that are not allowable expenses:
    - (i) 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.
    - (ii) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.
    - (iii) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
    - (iv) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement, or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for each of the plans. However, if the provider 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 provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
  - (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.
    - (i) A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expense in its contract to expenses that are similar to the expenses that it provides.
    - (ii) When COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense shall include 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 because the covered person does not comply with the plan provisions concerning a second surgical opinion or pre-certification of admissions or services.
- (2) "Birthday" refers only to month and day in a calendar year and does not include the year in which the person was born.
- (3) "Child" means a:
  - (a) child as defined in Section 78B-12-102; or
  - (b) dependent child that is provided coverage pursuant to Sections 31A-22-610, 31A-22-610.5, and 31A-22-611.
- (4) "Claim" means a request that benefits of a plan 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 Subsections R590-131-3(4)(a) and R590-131-3(4)(b); or
  - (d) an indemnification.
- (5) "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 a plan, and that excludes benefits for services provided by other providers, except in the cases of emergency or referral by a panel member.
- (6) "Conforming Plan" means a plan that is subject to this rule.
- (7) "Continuation Coverage" means coverage provided under right of continuation pursuant to the federal (COBRA) law, Utah mini-COBRA, or a state extension law. For the purposes of this rule, a person's eligibility status will maintain the same classification under continuation coverage.
- (8) "Coordination of Benefits" or "COB" means a provision establishing an order in which plans pay their coordination of benefit claims, and permitting secondary plans to reduce their benefits so that the combined benefits of each plan does not exceed total allowable expenses.
- (9) "Custodial Parent" means:
  - (a) the legal custodial parent or physical custodial parent as awarded 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.

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

(b) Group-type contract does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

(11) "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.

(12) "Hospital Indemnity Benefits" means benefits not related to 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.

(13) "Non-conforming Plan" means a plan that is not subject to this rule.

(14) "Plan" means a form of coverage with which coordination is allowed.

(a) Separate parts of a plan 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 shall state the types of coverage that will be considered in applying the COB provision of that contract.

(c) Whether a plan's contract uses the term "plan" or some other term such as "program," the contractual definition may be no broader than the definition of "plan."

(d) Plan shall include:

(i) individual and group accident and health insurance contracts and subscriber contracts except as provided by Subsection R590-131-3(14)(e);

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

(iii) coverage through closed panel plans;

(iv) group-type contracts;

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

(vi) Medicare or other governmental benefits, as permitted by law.

(e) Plan may not include:

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

(ii) accident only coverage;

(iii) specified disease or specified accident coverage;

(iv) limited benefit health coverage, as defined in Rule R590-126;

(v) 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;

(vi) 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;

(vii) Medicare supplement policies;

(viii) a state plan under Medicaid; or

(ix) a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

(15) "Policyholder" means the primary insured named in a non-group insurance policy.

(16) "Primary Plan" means 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 has no order of benefit determination;

(b) its rules differ from those permitted by this rule; or

(c) each plan that covers the person use the order of benefit determination provisions in Section R590-131-6 and under those requirements the plan determines its benefits first.

(17) "Retiree employee benefit plan" means an employee benefit plan as defined in 29 U.S.C. 1002(3).

(18) "Secondary Plan" means any plan that is not a primary plan.

(19) "Separated" means married persons who are legally separated.

#### **R590-131-4. COB Contract Provisions.**

(1) A COB provision may not be used that permits a plan to reduce its 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 a retiree employee benefit plan; or

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

(2) 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 provider for either plan.

(a)(i) 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.

(ii) The closed panel plan whose providers were not used has no liability.

(b)(i) COB may occur during the plan year when the covered person receives services from a provider who is on each closed panel, or emergency services that would have been covered by both plans.

(ii) The secondary plan shall use the provisions of Section R590-131-7 to determine the amount it should pay for the benefit.

(3) 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 a plan under Section R590-131-3.

#### **R590-131-5. Rules for Coordination of Benefits.**

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

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

(2) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide 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.

(3) When multiple contracts providing coordinated coverage are treated as a single plan under this rule, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts.

(4) If more than one insurer pays or provides benefits under the plan, the insurer designated as primary within the plan shall be responsible for the plan's compliance with this rule.

(5) If a person is covered by more than one secondary plan, benefits are determined using the rules in Section R590-131-6, and each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan, which, under the rules of this rule, has its benefits determined before those of the secondary plan.

(6)(a) Except as provided in Subsection R590-131-5(6)(b), a plan that does not contain order of benefit determination provisions that are consistent with this regulation is always the primary plan unless the provisions of both plans, regardless of the provisions of this subsection, state that the complying plan is primary.

(b) 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 shall 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.

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

#### **R590-131-6. Determining Order of Benefits.**

Each plan shall determine its order of benefits using the first of the following rules that apply:

(1) Non-dependent or Dependent.

The plan that covers the person other than as a dependent, such as an employee, member, policyholder retiree or subscriber, is the primary plan and the plan that covers the person as a dependent is the secondary plan.

(2) Child Covered Under More Than One Plan.

Unless there is a court decree stating otherwise, a plan covering a child shall determine the order of benefits as follows:

(a) For a child whose parents are married or living together if they have never 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 child whose parents are divorced or separated or are not living together if they have never been married:

(i)(A) If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage, the responsible parent's plan is primary.

(B) If the parent with responsibility has no health care coverage for the child's health care expenses, but the spouse of the responsible parent does have health care coverage for the child's health care expenses, the responsible parent's spouse's plan is the primary plan.

(ii) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of Subsection R590-131-6(2)(a) shall determine the order of benefits.

(iii) If a court decree states that the parents have joint custody without stating that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of Subsection R590-131-6(2)(a) shall determine the order of benefits.

(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.

(v) For a child covered under more than one plan, and one or more of the plans provides coverage for individuals who are not the parents of the child, such as a guardian, the order of benefits shall be determined under Subsection R590-131-6(2)(a) or R590-131-6(2)(b) as if those individuals were parents of the child.

(3) Active, Retired, or Laid-Off Employee.

(a) The plan that covers a person as an active employee who is neither laid off, nor retired, nor a dependent of an active employee, is the primary plan, and the plan covering 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 other plan does not have this rule, and the plans do not agree on the order of benefits, this rule is ignored.

(c) Subsection R590-131-6(3) does not apply if Subsection R590-131-6(1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage.

(a) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to 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 pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

(b) If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule is ignored.

(c) Subsection R590-131-6(3) does not apply if Subsection R590-131-6(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage.

(a) If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

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

(ii) 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.

(iii) 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, the date the person first became a member of the group shall be used as the date to determine the length of time the person's coverage under the present plan has been in force.

(6) If Section R590-131-6 cannot determine the primary plan, the allowable expenses shall be shared equally between the plans.

(7) If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received 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 shall be required to pay more than it would have paid had it been the primary plan.

**R590-131-7. Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim.**

(1) If a secondary plan wishes to coordinate benefits, the secondary plan shall 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.

(2) The secondary plan may reduce its payment 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 100% of the total allowable expense for that claim.

(3) The secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

**R590-131-8. Miscellaneous Provisions.**

(1) Reasonable Cash Value of Services.

(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.

(b) Nothing in this provision may be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan, which provides benefits in the form of services.

(2) Excess and Other Provisions.

(a) Except as provided in Subsection R590-131-8(2)(b), no policy or plan subject to this rule may contain a provision that its benefits are "excess" or "always secondary" to any other plan or policy.

(b) An accident-only blanket policy may contain a provision that its benefits are "excess" or "always secondary" to any other plan or policy.

(c) A plan with COB rules that comply with these rules, which is called a conforming plan, may coordinate benefits with a plan that is "excess" or "always secondary" or that uses COB rules inconsistent with this rule, which is called a non-conforming plan, on the following basis:

(i) if the conforming plan is the primary plan, it shall pay or provide its benefits on a primary basis;

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

(iii) if the non-conforming plan does not provide the information needed by the conforming plan to determine its benefits within a reasonable time after it is requested to do so, the conforming plan shall assume that the benefits of the non-conforming plan are identical to its own and shall pay its benefits accordingly;

(iv) if the conforming plan receives information as to the actual benefits of the non-conforming plan, it may adjust any payments in compliance with Subsection 31A-26-301.6(14)(a)(ii); and

(v)(A) if the non-conforming plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the conforming plan paid or provided its benefits as the secondary plan, and the non-conforming plan paid or provided its benefits as the primary plan, then the conforming plan shall advance to the covered person, or on behalf of the covered person, an amount equal to such difference.

(B) In no event shall the conforming plan advance more than the conforming plan would have paid had it been the primary plan, less any amount it had previously paid.

(C) In consideration of such advance, the conforming plan shall be subrogated to all rights of the covered person against the non-conforming plan in the absence of subrogation.

(3) If the plans cannot agree on the order of benefits within 30 calendar days after the plans have received 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 shall be required to pay more than it would have paid had it been the primary plan.

(4) Subrogation.

COB clearly differs from subrogation. Provisions for one may be included in health care benefit contracts without compelling the inclusion or exclusion of the other.

(5) Right To Receive and Release Needed Information.

(a) Certain facts are needed to apply these COB rules and an insurer has the right to decide the facts it needs.

(b) An insurer may obtain needed facts from or give them to any other organization or person and it need not tell or obtain consent from any person to do this.

(c) To facilitate cooperation with insurers, guidelines for medical privacy issues are provided under Rule R590-206, and Title V of Gramm-Leach-Bliley Act of 1999.

(d) Each person claiming benefits under a plan shall give the insurer any facts it needs to pay the claim.

(6) Right of Recovery.

(a) If the amount of the payments made by an insurer is more than it should have paid under the provisions of this rule, subject to Section 31A-26-301.6, it may recover the excess paid from one or more of the following, if they were paid by the insurer:

(i) an insured;

(ii) a non-contracted provider;

(iii) a contracted provider;

(iv) other insurance companies; or

(v) other organizations.

(b) Reversals of payments made due to issues related to this rule are limited to the time period stated in Section 31A-26-301.6, except as provided in Section 31A-21-313.

(c) It is the insurer's responsibility to see that the proper adjustments between insurers and providers are made.

(7) Notice to Covered Persons. A plan shall, 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."

(8) If otherwise covered benefits are due to a loss subject to Section 31A-22-306, then an accident and health insurer may exclude benefits covered by personal injury protection described in Subsection 31A-22-307(1)(a), up to the:

(a) personal injury protection benefit provided by motor vehicle insurance; or

(b) minimum amount required by Section 31A-22-307, if motor vehicle insurance is not in effect.

(9) Facility of Payment.

(a) A payment made under another plan may include an amount that should have been paid under the plan, and if it does, the insurer may pay that amount to the organization that made that payment.

(b) The amount paid will then be treated as though it were a benefit paid under the plan and the insurer will not have to pay that amount again.

(c) The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

**R590-131-9. COB Scenarios.**

The following scenarios are provided to assist in demonstrating the use of the COB rule:

(1) Parents Not Married, Living Together, No Court Decree. The order of benefits pursuant to Subsection R590-131-6(2)(a) shall be:

(a) the parent whose birthday falls earlier in the calendar year; then

(b) the parent whose birthday falls later in the calendar year; or

(c) if the parents have the same birthday, the plan that has covered the parent longest; then

(d) the plan that has covered the parent the shortest.

(2) Parents Divorced, Separated, Or Not Living Together.

(a) The court decree gives joint custody with the father responsible for the child's health care expenses or health care coverage, and the father has health care coverage. The order of benefits pursuant to Subsection R590-131-6(2)(b)(i) shall be the:

(i) natural father;

(ii) step-mother;

(iii) natural mother; then

(iv) step-father.

(b) The court decree gives joint custody with father responsible for the child's health care expenses or health care coverage, the father does not have health care coverage, but his wife does. The order of benefits pursuant to Subsection R590-131-6(2)(b)(i) shall be the:

(i) step-mother;

(ii) natural mother; then

(iii) step-father.

(c) The court decree gives custody to the father and requires both parents to be responsible for health care expenses or coverage. The father's date of birth (DOB) 12/01, the step-mother's DOB 02/17, the mother's DOB 08/23, and the step-father's DOB 01/10. The order of benefits pursuant to Subsection R590-131-6(2)(b)(ii) shall be the:

(i) step-father;

(ii) step-mother;

(iii) natural mother; then

(iv) natural father.

(d) A court decree awards joint custody and the father physical custody. The court decree does not address health care expenses or coverage. The father's DOB is 12/01, the step-mother's DOB is 02/17, the mother's DOB is 08/23, and the step-father's DOB is 01/10. The order of benefits pursuant to Subsection R590-131-6(2)(b)(iii) shall be the:

(i) step-father;

(ii) step-mother;

(iii) natural mother; then

(iv) natural-father.

(e) A court decree awards joint custody and requires both parents to be responsible for health care expenses or coverage. The child lives with the mother 51% of the year. The father's DOB is 12/01, the step-mother's DOB is 02/17, the mother's DOB is 08/23, and the step-father's DOB is 01/10. The order of benefits pursuant to Subsection R590-131-6(2)(b)(ii) shall be the:

(i) step-father;

(ii) step-mother;

(iii) natural mother; then

(iv) natural father.

(3) Parents Never Married.

(a) The parents are not living together and no court decree exists. The order of benefits pursuant to Subsection R590-131-6(2)(b)(iv) shall be the;

(i) custodial parent;

(ii) custodial parent's spouse;

(iii) non-custodial parent; and then

(iv) non-custodial parent's spouse.

(b) The parents are not living together and the court decree awards custody to mother, but the decree does not address health care expenses or coverage. The order of benefits pursuant to Subsection R590-131-6(2)(b)(iv) shall be the:

(i) natural mother;

(ii) step-father;

(iii) natural father; then

(iv) step-mother.

(4) Children No Longer Minors.

(a) A court decree orders that the natural father is to provide insurance for the minor children and custody is awarded to the natural mother. The dependents are age 18 and older. The order of benefits pursuant to Subsection R590-131-6(2)(b)(iv) shall be the:

(a) natural mother;

(b) step-father;

(c) natural father; then

(d) step-mother.

(b) A court decree orders that the natural father is to provide insurance for the minor child and custody is awarded to the natural mother. The dependent is age 20 and does not reside at either parent's home. The order of benefits shall be based on Subsection R590-131-6(5), Longer or Shorter Length of Coverage.

**R590-131-10. Effective Date for Existing Contracts.**

A contract that provides health care benefits issued before the effective date of this rule shall be brought into compliance with this rule no later than the first renewal date on or after January 1, 2021.

**R590-131-11. Penalties.**

Any insurer that fails to comply with the provisions of this rule shall be subject to the forfeiture and penalty provisions of Section 31A-2-308.

**R590-131-12. Severability.**

If any provision of this rule, R590-131, or its application to any person or situation is held invalid, such invalidity does not affect any other provision or application of this rule which can be given effect without the invalid provision or application. The remainder of this rule shall be given effect without the invalid provision or application.

**KEY: insurance law**

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