2742.0400 RULES FOR COORDINATION OF BENEFITS.

Subpart 1. **General.** The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.

A secondary plan may take the benefits of another plan into account only when, under this part, it is secondary to that other plan.

Subp. 2. **Dependent child/parents not separated or divorced.** The word "birthday" in the wording shown in subsection (4)(d)(III)(B)(ii) of part 2742.0300, subpart 4 refers only to month and day in a calendar year, not the year in which the person was born.

A group contract which includes coordination of benefits and which is issued or renewed, or which has an anniversary date of July 5, 1986, shall include the substance of the provision in subsection (4)(d)(III)(B)(ii) of part 2742.0300, subpart 4. That provision shall become effective July 5, 1987. Until that provision becomes effective, the group contract shall, instead, use wording like this:

"(ii) ... Except as stated in (iii) ....., the benefits of a plan which covers a person as a dependent of a male are determined before those of a plan which covers the person as a dependent of a female."

Subp. 3. **Longer/shorter length of coverage.** To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the claimant was eligible under the second within 24 hours after the first ended. Thus, the start of a new plan does not include a change in the amount or scope of a plan's benefits; a change in the entity which pays, provides, or administers the plan's benefits; or a change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

The claimant's length of time covered under a plan is measured from the claimant's first date of coverage under that plan. If that date is not readily available, the date the claimant first became a member of the group shall 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.

Subp. 4. **Reduction in plan's benefits when it is secondary.** A secondary plan may reduce its benefits by using the alternatives in items A to C, or any version thereof which is more favorable to a covered person. This is subject to the conditions and limits described in this subpart.

A. Alternative 1, total allowable expenses. When this alternative is used, a secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than total allowable expenses. The amount by which the secondary plan's benefits have been reduced shall be used by the secondary plan to pay allowable expenses, not otherwise paid, which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the secondary plan determines its obligation to pay for allowable

expenses based on all claims which were submitted up to that point in time during the claim determination period.

When this alternative is used, the suggested contract provision is as shown in part 2742.0300, subpart 4, (IV)(B).

The last paragraph quoted in part 2742.0300, subpart 4, (IV)(B) may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.

B. Alternative 2, total allowable expenses with coinsurance. When this alternative is used, a secondary plan may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than a stated percentage, but not less than 80 percent, of total allowable expenses. The amount by which the secondary plan's benefits have been reduced shall be used by the secondary plan to pay the stated percentage of allowable expenses, not otherwise paid, which were incurred during the claim determination period by the person for whom the claim is made. As each claim is submitted, the secondary plan determines its obligation to pay for the stated percentage of allowable expenses based on all claims which were submitted up to that point in time during the claim determination period.

When this alternative is used, the suggested contract provision for use in part 2742.0300, subpart 4, (IV)(B) is as follows:

The benefits of this plan will be reduced when the sum of: (a) the benefits that would be payable for the allowable expenses under this plan in the absence of this coordination of benefits provision; and (b) the benefits that would be payable for the allowable expenses under the other plans in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not claim is made; exceeds the greater of (i) 80 percent of those allowable expenses or (ii) the amount of the benefits in (a). In that case, the benefits of this plan will be reduced so that they and the benefits in (b) do not total more than the greater of (i) and (ii).

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

The paragraph immediately above may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.

C. Alternative 3, maintenance of benefits. When this alternative is used, a secondary plan may reduce its benefits by the amount of the benefits payable under the other plans for the same expenses.

When this alternative is used, the suggested contract provision for use in part 2742.0300, subpart 4, (IV)(B) is shown below.

The benefits that would be payable under this plan in the absence of this coordination of benefits provision will be reduced by the benefits payable under the other plans for the expenses covered in whole or in part under this plan. This applies whether or not claim is made under a plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

The paragraph immediately above may be omitted if the plan provides only one benefit, or may be altered to suit the coverage provided.

This alternative may be used in a plan only when, in the absence of coordination of benefits, the benefits of the plan (excluding benefits for dental care, vision care, prescription drugs, or hearing aid programs) will, after any deductible, be not less than 50 percent of covered expenses for the treatment of mental or nervous disorders or alcoholism or drug abuse, or under cost containment provisions with alternative benefits, such as those applicable to second surgical opinions, precertification of hospital stays, etc.; and not less than 75 percent of other covered expenses.

A plan using this alternative may exclude definitions of and references to allowable expenses, claim determination period, or both.

Subp. 5. **Conditions for use of alternatives 2 and 3.** Alternatives 2 and 3 in subpart 4 permit a secondary plan to reduce its benefits so that total benefits may be less than 100 percent of allowable expenses.

A plan using alternatives 2 and 3 in subpart 4 must comply with the following conditions:

A. The plan must provide prior notice to employees or members that when it is secondary (that is, it determines benefits after another plan) its benefits plus those of the primary plan will be less than 100 percent of allowable expenses; unless the primary plan, by itself, provides benefits at 100 percent of allowable expenses.

B. When the plan is secondary, it must provide a limit on the amount the employee, member, or subscriber is required to pay toward the expenses or services covered under the plan and for which the plan is secondary. The limit shall not exceed $2,000 for any covered person, or $3,000 for any family in any claim determination period.

C. The plan must permit a person to be enrolled for its health care coverage when that person's eligibility for health care coverage under another plan ends for any reason; if the person is eligible for coverage under the plan, and the enrollment is made before the end

of the 31-day period immediately following either the date when health care coverage under the other plan ends; or the end of any continuation period elected by or for that person.

This unrestricted enrollment is not required if a person remains eligible for coverage under that other plan, or a plan which replaces it, without interruption of that person's coverage.

D. If the person is enrolled before the end of the 31-day period, there shall be no interruption of coverage. Thus, the requirements concerning active work of employees, members, or subscribers, or nonconfinement of dependents on the effective date of coverage, shall not be applied. However, coverage for the person under the plan may be subject to the same requirements including underwriting requirements, benefit restrictions, waiting periods, and preexisting condition limitations that would have applied had the person been enrolled under the plan on the later of (a) the date the person first became eligible for the plan's coverage; or (b) the date the employee, member, or subscriber last became covered under the plan.

Credit shall be given under any preexisting condition limitation or waiting period from the later of the dates described in (a) or (b) to the date the person actually enrolled pursuant to the unrestricted enrollment provisions above.

E. A secondary plan which 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. Nothing in this provision shall 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.

Subp. 6. **Excess and other nonconforming provisions.** Some plans have order of benefit determination rules not consistent with parts 2742.0100 to 2742.0400 which declare that the plan's coverage is "excess" to all others, or "always secondary." This occurs because certain plans may not be subject to insurance regulation; or some group contracts have not yet been conformed with parts 2742.0100 to 2742.0400 pursuant to the effective date provisions of these rules.

A plan with order of benefit determination rules which comply with parts 2742.0100 to 2742.0400 (herein called a 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 those contained in parts 2742.0100 to 2742.0400 (herein called a noncomplying plan) on the following basis:

A. If the complying plan is the primary plan, it shall pay or provide its benefits on a primary basis.

B. If the complying plan is the secondary plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, payment shall be the limit of the complying plan's liability.

C. If the noncomplying 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 shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. However, the complying plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the noncomplying plan.

D. If the noncomplying plan reduces its benefits so that the employee, subscriber, or member receives less in benefits than he or she 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 governing state law allows the right of subrogation in subpart 8; then the complying plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to the difference. However, in no event shall the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid. In consideration of such advance, the complying plan shall be subrogated to all rights of the employee, subscriber, or member against the noncomplying plan. An advance by the complying plan shall also be without prejudice to any claim it may have against the noncomplying plan in the absence of subrogation.

Subp. 7. **Allowable expense.** A term such as "usual and customary," "usual and prevailing," or "reasonable and customary" may be substituted for the term "necessary, reasonable, and customary." Terms such as "medical care" or "dental care" may be substituted for "health care" to describe the coverages to which the coordination of benefits provisions apply.

Subp. 8. **Subrogation.** The coordination of benefits concept clearly differs from that of subrogation. Provisions for one may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

Statutory Authority: *MS s 45.023; 72A.19*

History: *10 SR 2234*

Published Electronically: *September 14, 2007*