Legislative Analysis

COORDINATION OF HEALTH BENEFITS

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House Bill 4934 as enacted
Public Act 275 of 2016
Sponsor: Rep. Robert L. Kosowski
House Committee: Insurance
Senate Committee: Insurance
Complete to 1-30-17

BRIEF SUMMARY:

The bill revised the Coordination of Benefits Act. The aim of this act, generally speaking, is to establish a uniform order of benefits determination under which insurance or other health-benefit plans pay claims. The act determines, for example, which policy is primary and which secondary when an individual has coverage under two group health plans. The bill appears to be largely consistent with the Coordination of Benefits Model Regulation developed by the National Association of Insurance Commissioners. The bill took effect July 1, 2016.

For that model and commentary on its provisions, see:
http://www.naic.org/store/free/MDL-120.pdf

FISCAL IMPACT:

The act would have a neutral fiscal impact on the Department of Insurance and Financial Services (DIFS). The act would stimulate higher expenditures, within the short-term, to the extent that DIFS would prepare and publish departmental bulletins and declaratory rulings to provide guidance pertaining to the applicability and interpretation of statutory revisions to the Insurance Code, in addition to training relevant regulatory and enforcement staff on the aspects and effects of the revisions under the act. However, these expenditures would be sufficiently offset with revenue generated by the annual regulatory fee determined by DIFS, subject to a statutory formula, and levied on insurers (totaling approximately $18.2 million during FY 15).

THE APPARENT PROBLEM:

According to the Michigan Association of Health Plans, the bill, along with House Bills 4933 and 4935, represents the first major update of state health insurance laws in more than 20 years. The bill package seeks to clarify the order under which insurance companies will cover claims.

THE CONTENT OF THE BILL:

The act amends the Coordination of Benefits Act. **Coordination of benefits** (COB) is defined in the act as a provision that establishes an order in which insurers pay claims, and

that permits benefits paid under secondary plans to be reduced so that the combined benefits paid under all plans do not exceed 100% of the total allowable expenses of the claim.

Responsibilities of primary and secondary insurers

Under the bill, if an individual is covered under multiple plans, the various insurers must coordinate with one another as follows in order to ensure that the obligation to provide insurance is met, but also that amount required by insurance is not exceeded:

- The primary insurer is responsible to provide benefits as if no secondary insurer exists.
- Secondary insurers should take the amounts to be paid by the primary plan and any other plan that has a higher priority to pay into account when determining how much they must pay.
- When a plan does not list an order of benefits determination, that plan is the primary plan unless it and the other plan both identify the other plan as primary (subject to the closed panel rule, below).
- If the primary plan is a closed panel plan (provides coverage primarily through contracted providers) and the secondary plan is not, the secondary plan covers nonpanel services, except for emergency or referral nonpanel services that are covered by the primary plan.

Determining order of priority

Non-dependent/dependent rule: A person is first covered by a plan in which he or she is an employee, member, subscriber, policyholder or retiree, and then covered under a plan in which he or she is a dependent, unless the person is also a Medicare beneficiary and Medicare dictates that the order is reversed (1. Plan in which a dependent, 2. Medicare, 3. Plan in which an employee, etc.).

Dependent covered under more than one plan rule: Unless a court order states otherwise, the following order of priority determines which insurer covers the dependent:

- If the child's parents are married or living together, the plan of the parent with the earlier birthday is primary, and if they have the same birthday, the plan which has covered the parent longer is primary (birthday rule).
- If the child's parents are divorced, separated, or not living together, the following determines the order of priority (court order rule):
    - If a court order or judgment states that one parent is responsible for health care, the plan of that parent, or that parent's spouse if the parent does not have health insurance, is the primary plan.
    - If a court order or judgement states that both parents are responsible for health care, or that they have joint custody without specifying which is responsible for health care, the order of priority for those plans is determined by the birthday rule.
    - If there is no court order or judgment charging responsibility for health care, the primary plan is the one covered by the following parties, in this order of

priority: (1) custodial parent, (2) custodial parent's spouse, (3) noncustodial parent, (4) noncustodial parent's spouse.

- If the child is covered under multiple plans by individuals who are not his parents, the order of priority for those plans is determined by the birthday rule or court order rule, as applicable, as if those individuals were his parents.
- If the child is married, and is covered by one or both parents' plans and also by his spouse's plan, the plan which has been effect for his family member longer is the primary plan, and the plan in effect shorter is the secondary plan. If they have been in effect the same amount of time, the birthday rule determines the priority among the family members' plans.

Active, retired, or laid-off employee rule: A plan in which the individual is, or is the dependent of, an active employee (active plan) is the primary plan over a plan in which the individual is, or is the dependent of, a retired or laid-off employee (retired/laid off plan), so long as the retired/laid-off plan asserts that it is secondary to the active plan.

This rule does not apply if the plan that covers the member, subscriber, enrollee, or retiree, or a dependent of one of those parties, is the primary plan.

Continuation coverage rule: A plan that covers the individual as an employee, member, subscriber, enrollee or retiree, or a dependent of one of those parties (dependent plan) is the primary plan over a plan by which the individual has a right of continuation coverage pursuant to federal or state law (continuation coverage plan), so long as the continuation coverage plan asserts that it is secondary to the dependent plan.

This rule does not apply if the order of benefits can be determined by the non-dependent/ dependent rule, above.

Longer or shorter length of coverage rule: If none of the four above named rules determines the order of benefits, the primary plan is the plan which has covered the individual for the longer period of time, and the secondary plan is the plan which has covered the individual for the shorter period of time. Two successive plans are treated as one plan for the purposes of this section if coverage under the second plan took effect within 24 hours after coverage under the first plan ended. Changes in the amount or scope of the plan's benefits, the entity that pays, provides, or administers the plan's benefits, or in the type of plan, such as from single-employer to multiple employer, do not constitute the start of a new plan.

Other considerations

A person's first date of coverage under a plan determines the length of time the person has been covered. If the date is not readily available for a group plan, the date the person joined the group plan will be used.

If the insurers cannot agree on the order of benefits within 30 days of receiving the information to pay the claim, the insurers should pay the claim in equal shares and

determine their relative liabilities following payment. An insurer is not required to pay more than it would have paid had the plan it issued been the primary plan.

If a secondary insurer wishes to coordinate benefits in determining the amount to be paid on a claim, the insurer should calculate the benefits it would have paid on the claim in the absence of other health care coverage and, in effect, use that amount to fill in the gaps left by the primary plan, paying for services that it would have covered but that went uncovered by the primary plan. The secondary plan may also reduce its payment so that, in conjunction with the primary plan, the individual does not receive more than 100% reimbursement. For a dental plan claim, the secondary insurer may use this method or, potentially, a non-duplication of benefits method for up to two years after the bill takes effect.

An insurer which issued a contract with health care benefits before this bill takes effect must bring that contract into compliance with the bill either by (1) the next anniversary date or renewal date of the contract, or (2) twelve months after the bill takes effect, whichever is later. If contracted pursuant to collective bargaining, the insurer must bring the contract into compliance by the collective bargaining contract's expiration date.

Current coordination of benefits rules will apply until the date by which contracts must be in compliance with the new rules.

Finally, the bill would repeal the current Section 5 of the Coordination of Benefits Act, which is an obsolete effective date provision from 1984.

The bill was tie-barred to HB 4935, meaning it could only take effect if HB 4935 was also enacted. HB 4935 was enacted as Public Act 276 of 2016, and the two bills took effect July 1, 2016.

MCL 550.252, 550.253, and 550.254, and proposed 550.253a

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