THE COORDINATION OF BENEFITS ACT
Act 64 of 1984

AN ACT to provide for a uniform order of benefits determination under which plans pay claims; to prescribe the powers and duties of certain state governmental officers and entities; and to require the promulgation of rules.

History: 1984, Act 64, Imd. Eff. Apr. 18, 1984;—Am. 2016, Act 275, Imd. Eff. July 1, 2016.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

The People of the State of Michigan enact:

550.251 Short title.

Sec. 1. This act shall be known and may be cited as “the coordination of benefits act”.

History: 1984, Act 64, Imd. Eff. Apr. 18, 1984.

Compiler's note: For transfer of the Department of Insurance and Office of the Commissioner on Insurance from the Department of Licensing and Regulation to the Department of Commerce, see E.R.O. No. 1991-9, compiled at MCL 338.3501 of the Michigan Compiled Laws.

For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.252 Definitions.

Sec. 2. (1) As used in this act:

(a) "Allowable expense" means 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 individual. The amount of a reduction may be excluded from allowable expense if a covered person's benefits are reduced under a primary plan for either of the following reasons:

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

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

(b) "Claim" means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of any of the following:

(*i*) Services including supplies.

(*ii*) Payment for all or a portion of the expenses incurred.

(*iii*) A combination of subparagraphs (*i*) and (*ii*).

(*iv*) An indemnification.

(c) "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 insurer that issues the plan and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

(d) "Coordination of benefits" or "COB" means 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 claims.

(e) "Custodial parent" means any of the following:

(*i*) The parent awarded custody of a child by a court order or judgment.

(*ii*) In the absence of a court order or judgment, the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(f) "Dental care corporation" means a nonprofit dental care corporation incorporated under 1963 PA 125, MCL 550.351 to 550.373.

(g) "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. 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, because the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

(h) "Health maintenance organization" means that term as defined in section 3501 of the insurance code of

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1956, 1956 PA 218, MCL 500.3501.

(i) "Insurer" means that term as defined in section 106 of the insurance code of 1956, 1956 PA 218, MCL 500.106.

(j) Subject to subsections (2) and (3), "plan" means a form of health care coverage with which coordination is allowed. Separate parts of a plan for members of a group that are provided through alternative contracts and that are intended to be part of a coordinated package of benefits are considered 1 plan and there is not COB among the separate parts of the plan. If benefits are coordinated under a plan, the contract must state the types of coverage that will be considered in applying the COB provision of the contract. Whether the contract uses the term "plan" or some other term such as "program", the contractual definition must not be broader than the definition of "plan" in this subdivision. Plan includes any of the following:

(*i*) Group and nongroup insurance contracts and subscriber contracts.

(*ii*) Uninsured arrangements of group or group-type coverage.

(*iii*) Group and nongroup coverage through closed panel plans.

(*iv*) Group-type contracts.

(*v*) The medical care components of long-term care contracts, including skilled nursing care.

(*vi*) Medicare or other governmental benefits, as permitted by law, except as provided in subsection (2)(g). Plan under this subdivision may be limited to the hospital, medical, and surgical benefits of the governmental program.

(*vii*) Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

(*viii*) Group and nongroup dental insurance contracts and subscriber contracts issued by a dental care corporation.

(k) "Primary plan" means a plan under which benefits for an individual's health care coverage are determined without taking into consideration the existence of any other plan. A plan is a primary plan under either of the following circumstances:

(*i*) The plan either has no order of benefit determination rules or its rules differ from those authorized under this act.

(*ii*) All plans that cover the individual use the order of benefit determination rules required under this act and, under those rules, the benefits payable under the plan are determined to be payable first.

(*l*) "Secondary plan" means a plan that is not a primary plan.

(2) For purposes of this act, plan does not include any of the following:

(a) Hospital indemnity coverage benefits or other fixed indemnity coverage.

(b) Accident-only coverage or disability income insurance.

(c) Specified disease or specified accident coverage.

(d) 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.

(e) Benefits provided in long-term care insurance policies for nonmedical services, including 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.

(f) Medicare supplement plans.

(g) A state plan under Medicaid.

(h) A governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

(3) For purposes of this act, plans are issued by any of the following:

(a) A health maintenance organization under which health services are provided, either directly or through contracts with affiliated providers, to individual or group enrollees.

(b) A dental care corporation under which dental benefits are provided to individual or group enrollees.

(c) An insurer that provides for hospital, medical, surgical, dental, or sick care benefits.

History: 1984, Act 64, Imd. Eff. Apr. 18, 1984;—Am. 2016, Act 275, Imd. Eff. July 1, 2016.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.253 Coverage by 2 or more plans; order of benefit payments; length of time covered under plan; inability to agree on order of benefits; amount to be paid by insurer issuing secondary plan; amount to be paid by insurer issuing secondary dental plan; payment of claims or coordination of benefits not provided or authorized by health maintenance organization.

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Sec. 3. (1) If an individual is covered by 2 or more plans, the rules for determining the order of benefit payments are as follows:

(a) The insurer that issues the primary plan shall pay or provide benefits as if a secondary plan does not exist.

(b) If the individual is covered by more than 1 secondary plan, the order of benefit determination rules under this act determine the order under which secondary plan benefits are determined in relation to each other. An insurer that issues a secondary plan shall take into consideration the benefits of the primary plan and the benefits of any other plan that are, under this act, determined to be payable before those of the secondary plan.

(c) Subject to subdivision (d), a plan that does not contain order of benefit determination provisions that are consistent with this act is always the primary plan unless the provisions of both plans, regardless of this subdivision, state that the complying plan is primary.

(d) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the insurer that issues the secondary plan shall pay or provide benefits as if it were the primary plan if a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the insurer that issued the primary plan.

(2) The order in which benefits are payable by insurers that issue plans are determined by using the first of the following rules that applies:

(a) The nondependent/dependent rule. If the individual is not a dependent but is an employee, member, subscriber, policyholder, or retiree under 1 plan and is a dependent under another plan, the order of payment of benefits under the plans is determined as follows:

(*i*) Except as otherwise provided in subparagraph (*ii*), the plan that covers the individual other than as a dependent is the primary plan and the plan that covers the individual as a dependent is the secondary plan.

(*ii*) If the individual is a Medicare beneficiary and, as a result of the provisions of title XVIII of the social security act, 42 USC 1395 to 1395*lll*, Medicare is secondary to the plan covering the individual as a dependent and primary to the plan covering the individual as other than a dependent, then the order of benefits is reversed and the plan covering the individual as other than a dependent is the secondary plan and the plan covering the individual as a dependent is the primary plan.

(b) The dependent covered under more than 1 plan rule. If the individual is a dependent child, unless there is a court order or judgment stating otherwise, the order of payment of benefits under the plans covering the dependent child is determined as follows:

(*i*) If the child's parents are married or are living together, whether or not they have ever been married, as follows:

(A) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.

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

(*ii*) If the child's parents are divorced, separated, or not living together, whether or not they have ever been married, as follows:

(A) If a court order or judgment states that 1 of the parents is responsible for the dependent child's health care expenses or health care coverage and the insurer that issued the plan of the parent with responsibility has actual knowledge of the terms of the order or judgment, that plan is the primary plan. 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 sub-subparagraph does not apply with respect to a plan year during which benefits are paid or provided before the insurer has actual knowledge of the terms of the court order or judgment.

(B) If a court order or judgment states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits is determined in the manner prescribed in subparagraph (*i*).

(C) If a court order or judgment 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 order of benefits is determined in the manner prescribed in subparagraph (*i*).

(D) If there is no court order or judgment allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows, in the following order of priority:

(I) The plan covering the custodial parent.

(II) The plan covering the custodial parent's spouse.

(III) The plan covering the noncustodial parent.

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

(*iii*) If the child is covered under more than 1 plan of individuals who are not the parents of the child, the order of benefits is determined in the manner prescribed in subparagraph (*i*) or (*ii*), as applicable, as if those

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individuals were parents of the child.

(*iv*) If the child is covered under either or both parents' plans and is also covered as a dependent under his or her spouse's plan, the order of benefits is determined in the manner prescribed in subdivision (e). If the dependent child's coverage under his or her spouse's plan began on the same date as his or her coverage under either or both parents' plans, the order of benefits is determined by applying the birthday rule prescribed in subparagraph (*i*) to the dependent child's parents, as applicable, and his or her spouse.

(c) The active, retired, or laid-off employee rule. If the individual is an active employee, laid-off employee, or retired employee, or is a dependent of an active employee, laid-off employee, or retired employee, the order of payment of benefits under the plans covering the individual is determined as follows:

(*i*) The plan that covers the individual as an active employee or as a dependent of an active employee is the primary plan. The plan that covers the individual as a laid-off employee or retired employee or as a dependent of a laid-off employee or retired employee is the secondary plan.

(*ii*) Subparagraph (*i*) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (*i*) and, as a result, the plans do not agree on the order of benefits.

(*iii*) This rule does not apply if the plan that covers the member, subscriber, enrollee, or retiree or the individual as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan.

(d) The continuation coverage rule. If the individual has coverage under a right of continuation pursuant to federal or state law, the order of payment of benefits under the plans covering the individual is determined as follows:

(*i*) The plan that covers the individual as an employee, member, subscriber, enrollee, or retiree or as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan. The plan that covers the individual under the continuation coverage is the secondary plan.

(*ii*) Subparagraph (*i*) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (*i*) and, as a result, the plans do not agree on the order of benefits.

(*iii*) This rule does not apply if the order of benefits can be determined by the rule in subdivision (a).

(e) The longer or shorter length of coverage rule. If the rules in subdivisions (a) to (d) do not determine the order of benefits, the plan that has covered the individual for the longer period of time is the primary plan and the plan that has covered the individual for the shorter period of time is the secondary plan. To determine the length of time an individual has been covered under a plan, 2 successive plans are treated as 1 if the covered individual was eligible under the second plan within 24 hours after coverage under the first plan ended. Any of the following changes do not constitute the start of a new plan:

(*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.

(*iii*) A change from 1 type of plan to another, such as from a single-employer plan to a multiple-employer plan.

(3) A person's length of time covered under a plan is measured from the person's first date of coverage under the 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 person's coverage under the present plan has been in force.

(4) If the insurers that issued plans cannot agree on the order of benefits within 30 calendar days after the insurers have received all of the information needed to pay the claim, the insurers shall immediately 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.

(5) Except as provided in subsection (6), in determining the amount to be paid on a claim by the insurer that issued a secondary plan, if the insurer wishes to coordinate benefits, the insurer shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply the calculated amount to any allowable expense under its plan that is unpaid under the primary plan. The insurer that issued a secondary plan may reduce its payment by the calculated amount so that, when combined with the amount paid under the primary plan, the total benefits paid or provided under all plans for the claim do not exceed 100% of the total allowable expense for the claim.

(6) In determining the amount to be paid on a dental plan claim by the insurer that issued a secondary plan, if the insurer wishes to coordinate benefits, it may do so in accordance with subsection (5) or, for not more than 2 years after the effective date of the amendatory act that added this subsection, it may do so under a nonduplication of benefits method. Under a nonduplication of benefits method, the primary plan payment is subtracted from the secondary plan's allowable benefit amount. If there is a positive balance, the insurer that issued the secondary plan shall make a payment equal to the difference. If there is a negative or zero balance, the insurer that issued the secondary plan shall make no payment. If an insurer that issues a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to

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contribute to a health savings account established in accordance with section 223 of the internal revenue code of 1986, 26 USC 223, 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, 26 USC 223.

(7) A health maintenance organization is not required to pay claims or coordinate benefits for services that are not provided or authorized by the health maintenance organization and that are not benefits under the health maintenance contract.

History: 1984, Act 64, Imd. Eff. Apr. 18, 1984;—Am. 1996, Act 325, Imd. Eff. June 26, 1996;—Am. 2016, Act 275, Imd. Eff. July 1, 2016.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.253a Contract issued before effective date of amendatory act; compliance with changes; transition period.

Sec. 3a. (1) An insurer that, before the effective date of the amendatory act that added this section, issued a contract that provides health care benefits shall bring the contract into compliance with the changes made to this act by the amendatory act that added this section by either of the following dates:

(a) Whichever of the following dates is later:

(*i*) The next anniversary date or renewal date of the contract.

(*ii*) Twelve months after the effective date of the amendatory act that added this section.

(b) If the contract was written pursuant to a collectively bargained contract, the expiration date of the collectively bargained contract.

(2) For the transition period between the effective date of the amendatory act that added this section and the time within which contracts are to be in compliance under subsection (1), a plan that is subject to the prior coordination of benefits requirements shall not be considered a noncomplying plan by a plan subject to the new coordination of benefits requirements and if there is a conflict between the prior coordination of benefits requirements under the prior regulation and the new coordination of benefits requirements under the amended regulation, the prior coordination of benefits requirements apply.

History: Add. 2016, Act 275, Imd. Eff. July 1, 2016.

550.254 Rules.

Sec. 4. The director of the department of insurance and financial services may promulgate rules to implement and supervise this act pursuant to the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

History: 1984, Act 64, Imd. Eff. Apr. 18, 1984;—Am. 2016, Act 275, Imd. Eff. July 1, 2016.

Compiler's note: For transfer of authority, powers, duties, functions, and responsibilities of the insurance bureau and the commissioner of insurance to the commissioner of the office of financial and insurance services and the office of financial and insurance services, see E.R.O. No. 2000-2, compiled at MCL 445.2003 of the Michigan compiled laws.

550.255 Repealed. 2016, Act 275, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to conditional effective date.

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