PUBLIC PROTECTION CABINET
Department of Insurance
Division of Health and Life Insurance and Managed Care
(Amended at ARRS Committee)

806 KAR 18:030. Group health insurance coordination of benefits.

RELATES TO: KRS 304.17-042, 304.17A-250(7), 304.18-032, 304.18-085, 304.32-145, 304.38-185, 42 U.S.C. 1395

STATUTORY AUTHORITY: KRS 304.2-110(1), 304.17A-250, 304.18-085, 304.32-145, 304.32-185, 304.32-250, 304.38-150

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110 authorizes the commissioner of the Department of Insurance to promulgate reasonable administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code as defined in KRS 304.1-010. KRS 304.32-250 authorizes the commissioner to promulgate reasonable administrative regulations necessary for the proper administration of KRS 304.32. KRS 304.38-150 authorizes the commissioner to promulgate reasonable administrative regulations necessary for the proper administration of KRS 304.38. This administrative regulation establishes guidelines for coordination of benefits by group health insurance contracts.

Section 1. Definitions.

(1) "Allowable expense" means a health care service or expense, including deductibles, coinsurance, and copayments, that is covered in full or in part by any of the plans covering the person.

(2) "Claim" means a request that benefits of a plan be provided or paid, and the benefits claimed are in the form of:

(a) Services, including supplies;

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

(c) A combination of paragraphs (a) and (b) of this subsection; or

(d) An indemnification.

(3) "Complying plan" means a plan with benefit determination requirements that comply with the requirements of this administrative regulation.

(4) "Coordination of benefits" means a provision establishing an order in which plans 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.

(5) "Custodial parent" means the parent awarded custody of a child by a court decree or with whom the child resides more than one-half (1/2) of the calendar year.

(6) "Insurer" is defined by KRS 304.17A-005(29).

(7) "Noncomplying plan" means a plan without benefit determination requirements or whose benefit determination requirements do not comply with the requirements of this administrative regulation.

(8) "Plan":

(a) Means:

1. A form of coverage with which coordination of benefits is allowed and "health benefit plans" as defined by KRS 304.17A-005(22); and

2. Sometimes includes Medicare benefits pursuant to 42 U.S.C. 1395, or other governmental benefits; and

(b) Does not mean:

1. The medical benefits coverage in a group, group-type, and individual motor vehicle "no-fault" or traditional automobile "fault" type contract; or

2. School accident-type coverages that cover elementary, high school, or college students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a "to-and-from school" basis.

(9) "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 if:

(a) The plan either has no order of benefit determination requirements, or its requirements differ from those permitted by this administrative regulation; or

(b) All plans that cover the person use the order of benefit determination requirements required by this administrative regulation, and under those requirements the plan determines its benefits first.

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

Section 2. Requirements for Coordination of Benefits.

(1) If a person is covered by two (2) or more plans, the requirements for determining the order of benefit payments shall be as established in paragraphs (a) through (c) of this subsection.

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

(b) A plan that does not contain a coordination of benefits provision consistent with this administrative regulation shall always be primary, except that coverage obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may state the supplementary coverage shall be secondary to the basic package of benefits provided by the contract holder.

(c) A plan may take the benefits of another plan into account only if it is secondary to that other plan.

(2) Order of Benefit Determination. The following requirements shall be applied in the following priority, alphabetically to determine the order of plan payment:

(a) Nondependent or dependent.

1. The plan that covers a person other than as a dependent shall be primary.

2. The plan that covers a person as a dependent shall be secondary, unless the person is a Medicare beneficiary, in which case the order of benefits is determined in accordance with 42 U.S.C. 1395.

(b) Dependent child covered under more than one (1) plan. Unless a court decree determines otherwise, or a parent has made an election within the first thirty-one (31) days of birth to add a newborn as a dependent to one parent's plan, plans covering a dependent child, including a newborn subject to KRS 304.17-042 and 304.18-032, shall determine the order of benefits as established in subparagraphs 1. through 4. of this paragraph.

1. The primary plan shall be the plan of the parent whose birthday is earlier in the year if:

a. The parents are married;

b. The parents are not separated, whether or not they have ever been married; or

c. A court decree awards joint custody without establishing that one (1) parent has the responsibility to provide health care coverage.

2. If both parents have the same birthday, the plan that has covered either of the parents longer shall be primary.

3. If a court decree states that one (1) parent is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan shall be primary. If the parent with responsibility has no coverage for the child's health care services or expenses, but the responsible parent's spouse does, the spouse's plan shall be primary.

4. If the parents are divorced, separated, or not married, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses, if any, shall be the plan of the:

a. Custodial parent;

b. Spouse of the custodial parent;

c. Noncustodial parent; and

d. Spouse of the noncustodial parent.

(c) Active or inactive employee. The plan that covers a person as an active employee, neither laid off nor retired, or as an active employee's dependent, shall be primary. The plan covering the same person as a retired or laid-off employee, or as a dependent of a retired or laid-off employee, shall be the secondary plan.

(d) Continuation coverage. If a person has coverage provided pursuant to a right of continuation pursuant to federal or state law and is also covered under another plan, the continuation coverage shall be secondary.

(e) Longer or shorter length of coverage. If the preceding requirements established in paragraphs (a) through (d) of this subsection, respectively, do not determine the order of benefits, the plan that covered the person for the longer period of time shall be primary:

1. To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) if the covered person was eligible under the second within twenty-four (24) hours after the first ended;

2. Changes during a coverage period that do not constitute the start of a new plan include:

a. A change in 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 (1) type of plan to another; and

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

(f) If none of the preceding requirements established in paragraphs (a) through (e) of this subsection, respectively, determines the primary plan, the allowable expenses shall be shared equally between the plans.

Section 3. Procedure to be followed by Secondary Plan to Calculate Benefits and Pay Claim.

(1) A secondary plan shall reduce its benefits so that the total benefits paid or provided by all plans shall not be more than 100 percent of total allowable expenses.

(2) If a person is covered by more than one (1) secondary plan, the order of benefit determination requirements of this administrative regulation shall decide the order in which secondary plans benefits shall be determined in relation to each other.

(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.

Section 4. 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 (1) health benefit plan, you should file all your claims with each plan."

Section 5. Miscellaneous Provisions.

(1) Provision of Services. A secondary plan that provides benefits in the form of services shall only recover the reasonable cash value of 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.

(2) Non-Complying Plan Coordination.

(a) A plan with order of benefit determination requirements that comply with this administrative regulation may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination requirements that do not comply with those contained in this administrative regulation if the:

1. Complying plan is the primary plan, it shall pay or provide its benefits first;

2. Complying 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 complying plan were the secondary plan. In that situation, the payment shall be the limit of the complying plan's liability; and

3. 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. If, within two (2) years of payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it shall adjust payments accordingly.

(b) If the noncomplying plan reduces its benefits so that the covered person 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 as established in paragraph (c) of this subsection, then the complying plan shall advance to or on behalf of the covered person an amount equal to the difference.

(c) The complying plan shall not advance more than the complying plan would have paid had it been the primary plan, less any amount it previously paid for the same expense or service, and:

1. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan; and

2. The advance by the complying plan shall also be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation.

(3) Coordination of benefits differs from subrogation. Provisions for one (1) may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

(4) If the plans cannot agree on the order of benefits within thirty (30) 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 a plan shall not be required to pay more than it would have paid had it been the primary plan.

(13 Ky.R. 104; Am. 509; eff. 9-4-1986; 27 Ky.R. 1896; 2782; eff. 4-9-2001; TAm eff. 8-9-2007; 44 Ky.R. 1407, 1855; 3-9-2018; 48 Ky.R. 1926, 2414; eff. 5-31-2022.)

FILED WITH LRC: February 7, 2022

CONTACT PERSON: Abigail Gall, Regulations Coordinator, 500 Mero Street, Frankfort, Kentucky 40601, phone +1 (502) 564-6026, fax +1 (502) 564-1453, email abigail.gall@ky.gov.