

AN ACT

ENTITLED, An Act to revise certain requirements for coordination of benefits of group health plans.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

For the purposes of this chapter, the term, allowable expense, means a health care service or expense including deductibles, coinsurance, or copayments, that is covered in full or in part by any of the plans covering the person, except as provided in this section. If a plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Expenses that are not allowable include the following:

- (1) If a covered 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, (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for private hospital rooms) is not an allowable expense;
- (2) If a person is covered by two or more plans that compute the benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fee for a specified benefit is not an allowable expense;
- (3) 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; or
- (4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees 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 all plans.

Section 2. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

For the purposes of this chapter, the term, claim, means a request that benefits of a plan be provided or paid. The benefits claimed may be in the form of:

- (1) Services (including supplies);
- (2) Payment for all or a portion of the expenses incurred;
- (3) A combination of subdivisions (1) and (2) of this section; or
- (4) An indemnification.

Section 3. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

For the purposes of this chapter, the term, closed panel plan, means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other 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 plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel provider.

Section 4. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

For the purposes of this chapter, the term, coordination of benefits or COB, 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.

Section 5. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

For the purposes of this chapter, the term, custodial parent, means the parent awarded custody

of a child by a court decree. 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 is the custodial parent.

Section 6. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

For the purposes of this chapter, the term, hospital indemnity benefits, means benefits not related to expenses incurred. The term does not include reimbursement-type benefits even if designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Section 7. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

For the purposes of this chapter, the term, plan, means a form of coverage with which coordination is allowed. The definition of plan in the group contract shall state the types of coverage that will be considered in applying the COB provision of that contract. The right to include a type of coverage is limited by the rest of this definition. Separate parts of a plan for members of a group 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.

Section 8. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

A plan may include:

- (1) Group insurance contracts and group subscriber contracts;
- (2) Uninsured arrangements of group or group-type coverage;
- (3) Group or group-type coverage through closed panel plans;
- (4) Group-type contracts. Group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group, including franchise or blanket

coverage. Individually underwritten and issued guaranteed renewable policies are not group-type even if 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;

- (5) The amount by which group or group-type hospital indemnity benefits exceed two hundred dollars per day;
- (6) The medical care components of group long-term care contracts, such as skilled nursing care;
- (7) The medical benefits coverage in group, group-type and individual automobile, no fault, and traditional automobile fault-type contracts; and
- (8) Medicare or other governmental benefits, as permitted by law, except as provided in section 10 of this Act. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

Section 9. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

No plan may include:

- (1) Individual or family insurance contracts;
- (2) Individual or family subscriber contracts;
- (3) Individual or family coverage through closed panel plans;
- (4) Individual or family coverage under other prepayment, group practice and individual practice plans;
- (5) Group or group-type hospital indemnity benefits of two hundred dollars per day or less;
- (6) School accident-type coverages. These contracts cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a to-and-from school basis;

- (7) Benefits provided in group long-term care insurance policies for nonmedical 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;
- (8) Medicare supplement policies;
- (9) A state plan under medicaid; or
- (10) A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

Section 10. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

For the purposes of this chapter, the term, primary plan, means a plan whose benefits for a person's health care coverage shall be determined without taking the existence of any other plan into consideration. A plan is a primary plan if either of the following is true:

- (1) The plan either has no order of benefit determination rules, or its rules differ from those permitted by this chapter; or
- (2) All plans that cover the person use the order of benefit determination rules required by this chapter, and under those rules the plan determines its benefits first.

Section 11. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

For the purposes of this chapter, the term, secondary plan, means a plan that is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules of this chapter decide the order in which secondary plans benefits are determined in relation to each other. 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 chapter, has its benefits determined before those of that secondary plan.

Section 12. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

For the purposes of this chapter, the term, this plan, means, in a COB provision, the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group contract providing health care benefits is separate from this plan. A group contract may apply one COB provision to certain of its benefits (such as dental benefits), coordinating only with similar benefits, and may apply another COB provision to coordinate with other benefits.

Section 13. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

The plan definition of allowable expense may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug, or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expenses in its contract to services or expenses that are similar to the services or expenses that it provides. If COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense shall include similar services or expenses to which COB applies.

Section 14. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

The amount of the reduction may be excluded from allowable expense if a covered person's benefits are reduced under a primary plan:

- (1) Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or
- (2) Because the covered person has a lower benefit because the person did not use a panel provider.

Section 15. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as

follows:

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 primary when a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

Section 16. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

The director shall, by rules promulgated pursuant to chapter 1-26, prescribe the format for the COB provision and a plain language explanation of the COB process for use in group contracts.

Section 17. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

A COB provision may not be used that permits a plan to reduce its benefits on the basis that:

- (1) Another plan exists and the covered person did not enroll in that plan;
- (2) A person could have been covered under another plan, except with respect to Part B of medicare;
- (3) A person is covered under another plan, except as allowed in this Act; or
- (4) A person has elected an option under another plan providing a lower level of benefits than another option that could have been elected.

Nothing in this Act prohibits a plan from coordinating as a secondary payor with medicare to the extent allowed by federal law.

Section 18. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

No plan may contain a provision that its benefits are always excess or always secondary unless that provision is in accord with the rules permitted by this chapter.

Section 19. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as

follows:

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. 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 because the other closed panel plan (the one whose providers were not used) has no liability. However, COB may occur during the claim determination period if the covered person receives emergency services that would have been covered by both plans. Then the secondary plan shall use the benefit reserve to pay any unpaid allowable expense.

Section 20. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

If a person is covered by two or more plans, the rules for determining the order of benefit payments are as contained in sections 23 to 26, inclusive, of this Act.

Section 21. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

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

Section 22. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

A plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary. However, 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.

Section 23. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as

follows:

A plan may consider the benefits paid or provided by another plan only if it is secondary to that other plan.

Section 24. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

The first of the following rules that describes which plan pays its benefits before another plan is the governing rule:

- (1) The plan that covers the person other than as a dependent, for example as an employee, member, subscriber, or retiree, is primary and the plan that covers the person as a dependent is secondary. However, if the person is a medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, medicare is:
 - (a) Secondary to the plan covering the person as a dependent; and
 - (b) Primary to the plan covering the person as other than a dependent (e.g. a retired employee),then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary;
- (2) The primary plan is 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 ever have been married); or
 - (c) A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage;
- (3) If both parents have the same birthday, the plan that has covered either of the parents longer is primary;
- (4) If the specific terms of a court decree state that one of the parents is responsible for the

child's health care expenses or health care coverage, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary;

- (5) If the parents are not married or are separated (whether or not they ever were married) or are divorced, 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 is:
 - (a) The plan of the custodial parent; then
 - (b) The plan of the spouse of the custodial parent; then
 - (c) The plan of the noncustodial parent; and then
 - (d) The plan of the spouse of the noncustodial parent;
- (6) The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule does not apply. Coverage provided an individual as a retired worker and as a dependent of that individual's spouse as an active worker will be determined under section 35 of this Act;
- (7) If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

Section 25. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

If the provisions of sections 23 to 26, inclusive, of this Act do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan.

Section 26. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

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

Section 27. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

The start of a new plan does not include:

- (1) A change in the amount or scope of a plan's benefits;
- (2) A change in the entity that pays, provides or administers the plan's benefits; or
- (3) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

Section 28. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

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 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.

Section 29. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

If none of the provisions of sections 22 to 30, inclusive, of this Act determine the primary plan, the allowable expenses shall be shared equally between the plans.

Section 30. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

If a plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all

plans for any claim or claims are not more than one hundred percent of total allowable expenses. In determining the amount of a claim to be paid by the secondary plan should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid in the absence of other insurance and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by any amount that, when combined with the amount paid by the primary plan, exceeds the total allowable expense for that claim.

Section 31. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

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.

Section 32. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

A secondary plan that provides benefits in the form of services may 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. Nothing in this section may be interpreted to require a plan to reimburse a covered person in cash for the value of services provided by a plan that provides benefits in the form of services.

Section 33. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

A plan with order of benefit determination rules that comply with this chapter (complying plan) may coordinate its benefits with a plan that is excess or always secondary or that uses order of benefit determination rules that are inconsistent with those contained in this chapter (noncomplying plan) on the following basis:

- (1) If the complying plan is the primary plan, it shall pay or provide its benefits first;
- (2) 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, the payment shall be the limit of the complying plan's liability; and
- (3) 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. If, within two years of payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it shall adjust payments accordingly.

Section 34. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than the person 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 set forth below, then the complying plan shall advance to or on behalf of the covered person an amount equal to the difference.

Section 35. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

In no event may the complying plan 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. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan. 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.

Section 36. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

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

Section 37. That chapter 58-18A be amended by adding thereto a NEW SECTION to read as follows:

If the plans cannot agree on the order of benefits within thirty 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 no plan may be required to pay more than it would have paid had it been the primary plan.

Section 38. That § 58-18A-1 be repealed.

Section 39. That § 58-18A-2 be repealed.

Section 40. That § 58-18A-3 be repealed.

Section 41. That § 58-18A-4 be repealed.

Section 42. That § 58-18A-5 be repealed.

Section 43. That § 58-18A-6 be repealed.

Section 44. That § 58-18A-7 be repealed.

Section 45. That § 58-18A-9 be repealed.

Section 46. That § 58-18A-10 be repealed.

Section 47. That § 58-18A-11 be repealed.

Section 48. That § 58-18A-12 be repealed.

Section 49. That § 58-18A-13 be repealed.

Section 50. That § 58-18A-14 be repealed.

Section 51. The provisions of this Act apply to group health plans that are issued or renewed on or after July 1, 2000.

An Act to revise certain requirements for coordination of benefits of group health plans.

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I certify that the attached Act
originated in the

HOUSE as Bill No. 1056

Chief Clerk

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Speaker of the House

Attest:

Chief Clerk

President of the Senate

Attest:

Secretary of the Senate

House Bill No. 1056

File No. _____

Chapter No. _____

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Received at this Executive Office
this ____ day of _____ ,

19__ at ____ M.

By _____
for the Governor

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The attached Act is hereby
approved this _____ day of
_____, A.D., 19__

Governor

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STATE OF SOUTH DAKOTA,
ss.
Office of the Secretary of State

Filed _____, 19__
at _____ o'clock __ M.

Secretary of State

By _____
Asst. Secretary of State