Secretary of the State File Number
6423

Regulation of the

Connecticut Insurance Department

Concerning

Coordination of Benefits Under Health Insurance Plans

Regulations adopted after July 1, 2013, become effective upon posting to the Connecticut eRegulations System, or at a later date if specified within the regulation.

Posted to the Connecticut eRegulations System on **December 12, 2024**

EFFECTIVE DATE
December 12, 2024

Approved by the Attorney General on
September 3, 2024

Approved by the Legislation Regulation Review Committee on
November 26, 2024

Electronic copy with agency head certification statement electronically submitted to and received by the Office of the Secretary of the State on
December 5, 2024

Form ICM-ECOPY (NEW 6/2015)
State of Connecticut
Secretary of the State

IMPORTANT NOTICE FOR CONNECTICUT STATE AGENCIES
This form should be used only for regulations first noticed *on and after March 23, 2015.*

Electronic Copy Certification Statement

(Submitted in accordance with the provisions of section 4-172 of the Connecticut General Statutes)

Regulation of the
Insurance Department
Concerning
Coordination of Benefits Under Health Insurance Plans

Approved by the Legislative Regulation Review Committee: **November 26, 2024**
eRegulations System Tracking Number: **PR-2024-012**

I hereby certify that the electronic copy of the above-referenced regulation submitted herewith to the Secretary of the State is a true and accurate copy of the regulation approved in accordance with sections 4-169 and 4-170 of the *Connecticut General Statutes*.

And I further certify that in accordance with the approval of Legislative Regulation Review Committee, all required technical corrections, page substitutions and deletions, if any, have been incorporated into said regulation.

In testimony whereof, I have hereunto set my hand on **December 4, 2024**.

Andrew N. Mais
Commissioner
Insurance Department

State of Connecticut Regulation of **Insurance Department Concerning**

Coordination of Benefits Under Health Insurance Plans

Section 1. Section 38a-480-3 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-480-3. Definitions

(a) **Plan.**

(1) A “Plan” is a form of coverage with which coordination is allowed. The definition of Plan in the group contract [must] shall state the types of coverage which 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 subsection [38a-480-3 (a)].

(2) The definition shown in the COB Provision in Section 38a-480-4 of the Regulations of Connecticut State Agencies is an example of what may be used. Any definition that satisfies this subsection [38a-480-3 (a)] may be used.

(3) [This regulation] Section 38a-480-3 uses the term “Plan.” However, a group contract may, instead, use “Program” or some other term.

(4) “Plan” shall not include individual or family:

(A) insurance contracts;

(B) subscriber contracts;

(C) coverage through Health Maintenance Organizations (HMOs); or

(D) coverage under other prepayment, group practice and individual practice plan; except as provided in subdivisions (5) and (6) [below] of this subsection.

(5) “Plan” may include:

(A) group insurance and group subscriber contracts;

(B) uninsured arrangements of group or group-type coverage;

(C) group or group-type coverage through HMOs and other prepayment, group practice and individual practice plans; and

(D) 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. Group-type contracts answering this description may be included in the definition of Plan, at the option of the insurer or the service provider

and its contract-client, whether or not uninsured arrangements or individual contract forms are used and regardless of how the group-type coverage is designated (for example, “franchise” or “blanket”). The use of payroll deductions by the employee, subscriber or member to pay for the coverage is not sufficient, of itself, to make an individual contract part of a group-type plan.

(6) “Plan” may include the medical benefits coverage in group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts.

(7) “Plan” may include Medicare or other governmental benefits. That part of the definition of “Plan” may be limited to the hospital, medical and surgical benefits of the governmental program. However, “Plan” shall not include a state plan under Medicaid, and shall not include a law or plan when, by law, its benefits are excess to those of any private insurance plan or other non-governmental plan.

(8) “Plan”:

(A) shall not be construed to include group or group-type hospital indemnity benefits of $30 per day or less; but

(B) may be construed to include the amount by which group or group-type hospital indemnity benefits exceed $30 per day.

“Hospital indemnity benefits” are those not related to expenses incurred. The term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

(9) “Plan” shall not include student accident or student accident and health coverages for which the student or parent pays the entire premium.

(10) “Plan” shall not include:

(A) group contracts issued by or reinsured through the Health Reinsurance Association; or

(B) subscriber contracts issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive health care coverage as provided in Chapter 700a of Connecticut General Statutes.

(b) **This Plan**. In a COB provision, this term refers to the part of the group contract providing the health care benefits to which the COB provision applies and which may be reduced on account 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 like benefits, and may apply other separate COB provisions to coordinate other benefits.

(c) **Primary Plan.** A Primary Plan is one whose benefits for a person's health care coverage [must] is to be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either subdivision (1) or (2) [below] of this subsection is true:

(1) The Plan either has no order of benefit determination rules, or it has rules which differ from those permitted by [this regulation] Section 38a-480-3.

(2) All plans which cover the person use the order of benefit determination rules required by [this regulation] Section 38a-480-3 and under those rules the Plan determines its benefits first. There may be more than one Primary Plan (for example, two Plans which have no order of benefit determination rules).

(d) **Secondary Plan**. A Secondary Plan is one which is not a Primary Plan. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of [this regulation] Section 38a-480-3 decide the order in which their benefits are determined in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of [this regulation] Section 38a-480-3, has its benefits determined before those of that Secondary Plan.

(e) **Allowable Expense**.

(1) "Allowable Expense" [is the necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part under any of the Plans involved] means any health care expense for a covered person that is covered in full or in part by any of the plans covering the person, except where a statute requires a different definition, and that is not subject to reduction due to any person's responsibility for coinsurance, copayment or deductible. However, [items of] any expense under coverages such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of Allowable Expense. A plan which provides benefits only for any such [items of] expense may limit its definition of Allowable Expenses to [like items of] such expense.

(2) When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an Allowable Expense and a benefit paid.

(3) The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense, [under the above definition] as defined in subdivision (1) of this subsection, unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan.

(4) When COB is restricted in its use to a specific coverage in a contract (for example, major medical or dental), the definition of "Allowable Expense" [must] shall include the corresponding expenses or services to which COB applies.

(f) **Claim.** 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) [above] of this subsection; or

(4) an indemnification.

(g) **Claim Determination Period.**

(1) This is the period of time, which [must] shall be not less than twelve consecutive months, over which Allowable Expenses are compared with total benefits payable in the absence of COB, to determine:

(A) whether overinsurance exists; and

(B) how much each Plan will pay or provide.

[It] The claim determination period usually is a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a Plan during a portion of a Claim Determination Period if that person’s coverage starts or ends during that Claim Determination Period.

(2) As each claim is submitted, each Plan is to determine its liability and pay or provide benefits based upon Allowable Expenses incurred to that point in the Claim Determination Period; but that determination is subject to adjustment as later Allowable Expenses are incurred in the same Claim Determination Period.

Section 2. Section 38a-480-4 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-480-4. COB contract provision

(a) **General.** Subsection [38a-480-4] (d) of this section contains a COB Provision for use in group contracts. That use is subject to the [provision] provisions of subsections [38a-480-4] (b) and [38a-480-4] (c) of this section and to the provisions of Section 38a-480-3, Definitions, and Section 38a-480-5, Rules for Coordination of Benefits, of the

Regulations of Connecticut State Agencies. The bracketed references in the COB Provision to those rules are not to be included in a group contract.

(b) **Flexibility.** A group contract's COB provision does not have to use the words and format shown in [this regulation] Section 38a-480-4. Changes may be made to fit the language and style of the rest of the group contract or to reflect the difference among Plans: (1) which provides services; (2) which pay benefits for expenses incurred; and (3) which indemnify. Substantive changes are allowed only as set forth in [this regulation] Section 38a-480-4.

(c) **Prohibited Coordination and Benefit Design.** A group contract may not reduce benefits on the basis that:

(1) another plan exists and the covered person did not enroll in that plan;

(2) [except with respect to Part B of Medicare, a person is or could have been covered under another Plan] a person is eligible for but not enrolled in Medicare; or

(3) a person has elected an option under another Plan providing a lower level of benefits than another option which could have been elected.

No contract may contain a provision that its benefits are "excess" or "always secondary" to any Plan defined in subsection 38a-480-3 (a) of the Regulations of Connecticut State Agencies, except in accord with the rules permitted by [this regulation] Section 38a-480-4.

(Reference: Rules in subsection 38a-480-5 (a) (1) [below] of the Regulations of Connecticut State Agencies.)

(d) Text of the COB Provision.

COORDINATION OF THE GROUP CONTRACT'S BENEFITS WITH OTHER BENEFITS

(1) Applicability.

(A) This Coordination of Benefits ("COB") provision applies to This Plan when an employee or the employee's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

(B) If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

(i) shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but

(ii) may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The above reduction is described in subdivision (4) Effect on the Benefits of This Plan.

(2) Definitions.

(A) A “Plan” is any of these which provides benefits or services for, or because of, medical or dental care or treatment.

(i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage, but not student accident or student accident & health coverage, for which the student or parent pays the entire premium.

(ii) Coverage under a governmental plan or required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program. It also does not include group contracts issued by or reinsured through the Health Reinsurance Association, or subscriber contracts issued by a residual market mechanism established by hospital and medical service corporations and providing comprehensive health care coverage as provided in the Connecticut Health Care Act as now constituted or later amended. Each contract or other arrangement for coverage under (i) or (ii) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

(B) “This Plan” is the part of the group contract that provides benefits for health care expenses.

(C) “Primary Plan”/“Secondary Plan.” The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits. When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be Secondary Plan as to a different Plan or Plans.

(Reference: Rules in subsection 38a-480-5 (a) (1) [below] <u>of the Regulations of Connecticut State Agencies</u>.)

(D) “Allowable Expense” means [a necessary, reasonable, and customary item of] <u>any</u> expense for health care, when the [item of] expense is covered at least in part by one or

more Plans covering the person for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the Plan. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. (Reference: Rule in subsection 38a-480-5 (d) [below] of the Regulations of Connecticut State Agencies.)

(E) "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

(3) Order of benefit determination rules.

(A) General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

(i) the other Plan has rules coordinating its benefits with those of This Plan; and

(ii) both those rules and This Plan's rules, in subparagraph (B) below, require that This Plan's benefits be determined before those of the other Plan.

(B) Rules. This Plan determines its order of benefits using the first of the following rules which applies:

(i) Non-dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.

(ii) Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (B) (iii) below, when This Plan and another Plan cover the same child as a dependent of different persons called "parents":

(a) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but

(b) if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans

do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

(Reference: Rules in subsection 38a-480-5 (a) (2) [below] of the Regulations of Connecticut State Agencies.)

(iii) Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

(a) first, the Plan of the parent with custody of the child;

(b) then, the Plan of the spouse of the parent with the custody of the child; and

(c) finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

(iv) Active/Inactive Employee: The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). 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 (iv) is ignored.

(v) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

(Reference: Rules in subsection 38a-480-5 (a) (3) [below] of the Regulations of Connecticut State Agencies.)

(4) Effect on the benefits of this plan.

(A) When this Section applies. This subdivision (4) applies when, in accordance with subdivision (3) Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plan" in (B) immediately below.

(B) Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

(i) the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(ii) 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 COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. 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.

(5) Right to Receive and Release Needed Information.

Certain facts are needed to apply these COB rules. (The XYZ Company) has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. (The XYZ Company) need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give (The XYZ Company) any facts it needs to pay the claim.

(Reference: Rules in subsections 38a-480-5 (e) [below] of the Regulations of Connecticut State Agencies.)

(6) Facility of Payment.

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, (The XYZ Company) may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. (The XYZ Company) will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

(Reference: Rules in subsections 38a-480-5 (e) [below] of the Regulations of Connecticut State Agencies.)

(7) Right of Recovery

If the amount of the payments made by (The XYZ Company) is more than it should have paid under this COB provision, it may recover the excess from one or more of:

(A) the persons it has paid or for whom it has paid;

(B) insurance companies; or

(C) other organizations. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

(Reference: Rules in subsection 38a-480-5 (e) [below] of the Regulations of Connecticut State Agencies.)

Section 3. Section 38a-480-5 of the Regulations of Connecticut State Agencies is amended to read as follows:

Sec. 38a-480-5. Rules for coordination of benefits

(a) **Order of Benefits.**

(1) General.

(A) The Primary Plan [must] shall pay or provide its benefits as if the Secondary Plan or Plans did not exist.

(B) A Secondary Plan may take the benefits of another Plan into account only when, under these rules, it is Secondary to that other Plan.

(Reference: subsections 38a-480-4 (c) and 38a-480-4 (d) (2) (C) [above] of the Regulations of Connecticut State Agencies.)

(2) Dependent Child/Parents Not Separated or Divorced.

[(A)] The word “birthday” in the wording shown in subsection 38a-480-4 (d) (3) (B) (ii) of [this regulation] Section 38a-480-5 refers only to month and day in a calendar year, not the year in which the person was born.

(Reference: subsections 38a-480-4 (d) (3) (B) (ii) [above] of the Regulations of Connecticut

State Agencies.)

(3) Longer/Shorter Length of Coverage.

(A) 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:

(i) a change in the amount or scope of a Plan’s benefits;

(ii) a change in the entity which pays, provides or administers the Plan’s benefits; or

(iii) a change from one type of Plan to another (such as, from a single employer plan to that of a multiple employer plan).

(B) 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.

(Reference: subsection 38a-480-4 (d) (3) (B) (v) [above] of the Regulations of Connecticut State Agencies.)

(b) **Reasonable Cash Value of Services.** 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.

(c) **Excess and Other Nonconforming Provisions.**

(1) Some Plans have order of benefit determination rules not consistent with [this regulation] Section 38a-480-5 which declare that the Plan's coverage is "excess" to all others, or "always secondary." This occurs because: (A) certain Plans may not be subject to insurance regulation; or (B) some group contracts have not yet been conformed with [this regulation] Section 38a-480-5 pursuant to Section 38a-480-7, Effective Date Existing Contract, of the Regulations of Connecticut State Agencies.

(2) A Plan with order of benefit determination rules which comply with [this regulation] Section 38a-480-5 (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 [this regulation] Section 38a-480-5 (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 [in] 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, such 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 [Noncomlying] Noncomplying Plan

are identical to its own, and shall pay its benefits accordingly. However, the Complying Plan [must] shall adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncomplying Plan.

(D) If:

(i) the Noncomplying Plan reduces its benefits so that the employee, subscriber, or member receives less in benefits [that] 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 (ii) governing state law allows the right of subrogation set forth below; then the Complying Plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to such 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. Such advance by the Complying Plan shall also be without prejudice to any claim it may have against the Noncomplying Plan in the absence of such subrogation.

(Reference: subsections 38a-480-4 (d) (4), (5), (6) and (7) [above] of the Regulations of Connecticut State Agencies.)

(d) **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 COB provisions apply.

(Reference: subsection 38a-480-4 (d) (2) (D) [above] of the Regulations of Connecticut State Agencies.)

(e) **Subrogation**. The COB 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.

(Reference: subsections 38a-480-4 (d) (4), (5), (6) and (7) [above] of the Regulations of Connecticut State Agencies.)

Statement of Purpose:

The purpose of the amendment to [this regulation] Sections 38a-480-3 through 38a-480-5 of the Regulations of Connecticut State Agencies is to clarify the Medicare carve-out per C.G.S.§ 38a-543. It serves to eliminate confusion on whether this applies to

Medicare Part A or B, as both are applicable. It clarifies that a person must not be penalized for not enrolling into Medicare or any other plan that is available. The intent is to remove the terms "usual and customary," "usual and prevailing," "reasonable and customary" and "necessary, reasonable and customary" from the regulation. The goal is to prevent secondary carriers using these terms and relying on the wording within the regulation. We are trying to avoid any attempt for a secondary carrier to reduce liability on the basis that the billed charge exceeds the reasonable and customary (allowable) expense. It is the secondary carrier that is expected to pay the lesser of: (1) what it would have paid if primary, or (2) the balance of billed charges. The primary goal is to make the insured as whole as possible and make it clear how much the secondary carrier is responsible to pay.

Form Agency-Cert-PR-TA-ICM (Rev 11/2017)
State of Connecticut
Secretary of the State

IMPORTANT NOTICE FOR CONNECTICUT STATE AGENCIES
This form is to be used for proposed permanent and technical amendment regulations only and must be completed in full.

AGENCY CERTIFICATION

Connecticut Insurance Department

Proposed Regulation Concerning

Coordination of Benefits Under Health Insurance Plans

eRegulations System Tracking Number **PR2024-012**

I hereby certify the following:

(1) The above-referenced **regulation** is proposed pursuant to the following statutory authority or authorities: **Conn. Gen. Stat. § 38a-8(c).**

For technical amendment regulations proposed without a comment period, complete #2 below, then skip to #8.

(2) As permitted by Section 4-168(h) of the *Connecticut General Statutes*, the agency elected to proceed without prior notice or hearing and posted the text of the proposed technical amendment regulation on eRegulations System website on **N/A**.

For all other non-emergency proposed regulations, complete #3 - #7 below, then complete #8)

(3) The agency posted notice of intent with a specified comment period of not less than 30 days to the eRegulations System website on **July 17, 2024**.

(4) *(Complete one)* ☒ No public hearing held or was required to be held. **OR** ☐ One or more public hearings were held on: **N/A**.

(5) The agency posted notice of decision to move forward with the proposed regulation to the eRegulations System website on **August 29, 2024**.

(6) *(Complete one)* ☒ No comments were received. **OR** ☐ Comments were received and the agency posted the statements specified in subdivisions (1) and (2) of CGS Section 4-168(e) to the eRegulations System website on **N/A**.

(7) The final wording of the proposed regulation was posted to the eRegulations System website on **July 17, 2024**.

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(8) Subsequent to approval for legal sufficiency by the Attorney General and approval by the Legislative Regulation Review Committee, **the final regulation shall be effective**

(Check one and complete as applicable)

☒ When posted to the eRegulations System website by the Secretary of the State.

OR ☐ On _____
(Date must be a specific calendar date not less than 11 days after submission to the Secretary of the State)

	Insurance Commissioner	**8/29/2024**
SIGNED	OFFICIAL TITLE	DATE
(Head of Board, Agency or Commission, or duly authorized deputy)		

OFFICE OF THE ATTORNEY GENERAL
REGULATION CERTIFICATION

Agency: Insurance Department

REGULATION NUMBER: **PR2024-012**

This Regulation is hereby APPROVED by the Attorney General as to legal sufficiency in accordance with Connecticut General Statutes § 4-169.

DATE: 9/3/2024

Signed: _____

Sean Kehoe
Associate Attorney General
Chief of the Division of Government Affairs
Duly Authorized

The Connecticut General Assembly

Legislative Regulation Review Committee

Senator John Kissel
Senate Chair

Representative Lucy Dathan
House Chair

Official Record of Committee Action

November 26, 2024

Agency:	Insurance Department
Description:	Coordination of Benefits Under Health Insurance Plans
LRRC Regulation Number:	2024-024
eRegulation Tracking Number:	PR2024-012

The above-referenced regulation has been

Approved with Technical Corrections

by the Legislative Regulation Review Committee in accordance with CGS Section 4-170.

Catherine M. Thomas
Committee Administrator

State of Connecticut
Office of the Secretary of the State

Confirmation of Electronic Submission

Re: Regulation of the Connecticut Insurance Department concerning
Coordination of Benefits Under Health Insurance Plans
eRegulations System Tracking Number PR2024-012
Legislative Regulation Review Committee Docket Number 2024-024

The above-referenced regulation was electronically submitted to the Office of the Secretary of the State in accordance with Connecticut General Statutes Section 4-172 on December 5, 2024.

Said regulation is assigned Secretary of the State File Number 6423.

The effective date of this regulation is December 12, 2024.

Stephanie Thomas
Secretary of the State
December 12, 2024

By:

/s/ Christopher R. Drake
Christopher R. Drake
Director, Business Services
Division