211 CMR 38.00: COORDINATION OF BENEFITS (COB)

Section

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38.01: Purpose and Applicability

211 CMR 38.00 establishes an order in which Plans pay their claims when a person is covered by more than one Plan. Any Plan which contains a Coordination of Benefits provision must comply with 211 CMR 38.00. A Plan that does not contain such a provision may not take the benefits of another Plan into account when determining its benefits.

38.02: Definitions

As used in 211 CMR 38.00, these words and terms shall have the following meanings, unless the context clearly indicates otherwise:

Allowable Expense.

(a) Except as set forth in 211 CMR 38.02 or elsewhere in 211 CMR 38.00, or where a statute requires a different definition, Allowable Expense means any 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 person.

(b) If a Plan is advised by a covered person that all Plans covering the person are High-deductible Health Plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, 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.

(c) An expense or a portion of an expense that is not covered by any of the Plans is not an Allowable Expense.

(d) Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

(e) 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.

(f) Expenses that are not Allowable Expenses include, but are not limited to:

1. If a person is confined in a private hospital room, 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, unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, then any amount charged by the provider in excess of the highest reimbursement amount 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, then any amount in excess of the highest of the negotiated fees is not an Allowable Expense.

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4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, then the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

(g) 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 Expense in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of Allowable Expense shall include similar expenses to which COB applies.

(h) The amount of the reduction may be excluded from Allowable Expense when 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 covered person did not use a preferred provider.

(i) Nothing in 211 CMR 38.02: Allowable Expense shall be interpreted to require a Plan that makes its provider payments on the basis of capitation or other similar reimbursement methodology to make any reimbursements beyond the negotiated capitation arrangement between the provider and carrier.

Birthday. Refers only to month and day in a calendar year and does not include the year in which the individual is born.

Claim. A request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of:

(a) services (including supplies);
(b) payment for all or a portion of the expenses incurred;
(c) a combination of 211 CMR 38.02: Claim(a) and (b); or
(d) an indemnification.

Closed Panel Plan. A Health Benefit 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 Health Benefit Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral approved by the Health Benefit Plan.

Consolidated Omnibus Budget Reconciliation Act of 1985 or COBRA. Coverage provided under a right of continuation pursuant to federal law.

Coordination of Benefits or (COB). 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.

Custodial Parent. 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.

Group-type Contract. A contract for coverage which is not available to the general public and can be obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. A 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 since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

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Health Benefit Plan. A policy, contract, certificate or agreement entered into, offered or issued to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. For the purposes of 211 CMR 38.00, Medical Payments Coverage and Personal Injury Protection shall not be considered a Health Benefit Plan.

High-deductible Health Plan. Has the meaning given the term under Section 223 of the Internal Revenue Code of 1986, as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Hospital Indemnity Benefits. Insurance policies offered as independent, non-coordinated benefits which for the purposes of 211 CMR 38.00 shall mean policies issued under M.G.L. c. 175 which provide a benefit to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, that are sold as a supplement and not as a substitute for a health benefit plan.

Medical Payments Coverage. Medical coverage that may be purchased by a person pursuant to M.G.L. c. 175, § 113C in conjunction with the purchase of a Massachusetts motor vehicle insurance policy.

Personal Injury Protection (PIP). The coverage included in a Massachusetts motor vehicle liability policy as set forth and defined by M.G.L. c. 90, §§ 34A and 34M.

Plan. A form of coverage with which coordination is allowed. 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. If a Plan coordinates benefits, its contract must state the types of coverage which will be considered in applying the COB provision of that contract.

(a) Plan shall include:

1. group and nongroup insurance contracts and group and nongroup subscriber contracts;
2. uninsured arrangements of group coverage or group-type coverage;
3. group and nongroup coverage through Closed Panel Plans;
4. Group type Contracts;
5. the medical care components of long term care contracts, such as skilled nursing care;
6. the medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts, to the extent permitted by law;
7. Medicare or other governmental benefits, as permitted by law, except as provided in 211 CMR 38.02: Plan(b)(8). 211 CMR 38.02: Plan(a)(7) may be limited to the hospital, medical and surgical benefits of the governmental program;
8. Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; and
9. Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of vision care.

(b) Plan shall not include:

1. Hospital Indemnity Benefits coverage or other fixed indemnity coverage;
2. Accident only coverage;
3. Specified disease or specified accident coverage;
4. Insured contracts that pay a fixed daily benefit without regard to which expenses are incurred or services received;
5. Medicare Supplement policies;
6. School accident-type coverages that cover students for accidents only, including those contracts covering students for accidents or athletic injuries, either on a 24 hour basis or on a "to and from school" basis;
7. Benefits provided in long-term care insurance policies for non-medical services or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
8. A state plan under Medicaid; or
9. A governmental plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

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Policyholder. The primary insured named in a nongroup insurance policy.

Primary Plan. A Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. Except as otherwise provided in 211 CMR 38.00, a Plan is a Primary Plan if either:

(a) the Plan either has no order of benefit determination rules, or it has rules which differ from those permitted by 211 CMR 38.00; or

(b) all Plans which cover the person use the order of benefit determination rules required by 211 CMR 38.00, and under those rules the Plan determines its benefits first.

Secondary Plan. A Plan which is not a Primary Plan.

38.03: COB Contract Provisions

(1) Any Plan which contains a COB provision must provide information to persons covered under the Plan about its COB provision and the rules used to determine whether it is a Primary Plan or Secondary Plan and to determine and calculate Allowable Expense.

(2) A COB provision may not be used that permits a Plan to reduce its benefits on the basis that:

(a) Another Plan exists and the covered person did not enroll in that Plan;

(b) A person is or could have been covered under another Plan, except with respect to Part B of Medicare; or

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

(d) No Plan may contain a COB provision that its benefits are "always excess" or "always secondary" except in accordance with the rules permitted by 211 CMR 38.00.

(e) No Plan may use a COB provision, or any other provision that allows it to reduce its benefits with respect to any other coverage its insured may have, that does not meet the definition of 211 CMR 38.02: Plan.

38.04: Rules for Coordination of Benefits

(1) When a person is covered by two or more Plans, 211 CMR 38.04 determines the order of benefit payments:

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

(b) 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 the Primary Plan when a covered person uses the services of a health care provider that is not within the Primary Plan's Closed Panel provider network, except for emergency services or authorized referrals that are paid or provided by the Primary Plan.

(c) If the Primary Plan is not a Closed Panel Plan and the Secondary Plan is a Closed Panel Plan, and the covered person uses the services of a health care provider that is not within the Secondary Plan's provider network, then the Secondary Plan is not required to pay or provide benefits, except for emergency services or authorized referrals that are paid or provided by the Primary Plan.

(d) When multiple contracts providing coordinated coverage are treated as a single Plan under 211 CMR 38.00, 211 CMR 38.04 applies only to the Plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the Plan, the carrier designated as primary within the Plan shall be responsible for the Plan's compliance with 211 CMR 38.00.

(e) If a person is covered by more than one Secondary Plan, the order of benefit determination rules of 211 CMR 38.00 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 211 CMR 38.00, has its benefits determined before those of that Secondary Plan.

38.04: continued

(2) (a) Except as otherwise provided in 211 CMR 38.00, a Plan that does not contain order of benefit determination provisions that are consistent with 211 CMR 38.00 is always the Primary Plan unless the provisions of both Plans, regardless of the provisions of 211 CMR 38.04(2)(a), state that the complying Plan is primary.
(b) 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.

(3) A Plan may take the benefits paid or provided by another Plan into account only when, under 211 CMR 38.00, it is secondary to that other Plan.

38.05: Order of Benefit Determination

Each Plan determines its order of benefits using the first of 211 CMR 38.05 that applies:

(1) Medical Payments Coverage and PIP Coverage in Motor Vehicle Insurance Policies
(a) If a person who has a Health Benefit Plan and a motor vehicle insurance policy incurs expenses or requires services as a result of an accident with a motor vehicle:
Personal Injury Protection, as defined by M.G.L. c. 90, § 34A, shall always be primary and pay the first $2,000 of expenses as allowed under said statute. PIP shall thereafter be secondary to any such Health Benefit Plan(s) and shall coordinate with the Health Benefit Plan(s) pursuant to M.G.L. c. 90, §§ 34A and 34M.
(b) Medical Payments Coverage under a motor vehicle insurance policy shall always be secondary to and in excess of any Health Benefit Plan or Personal Injury Protection, as defined under 211 CMR 38.00.

(2) Non-dependent or Dependent.
(a) Subject to the provisions of 211 CMR 38.05(2)(b), the Plan that covers the person other than as a dependent - for example, as an employee, member, subscriber (that is, other than as a dependent), Policyholder or retiree - is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan.
(b) 1. 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 dependent; and
b. Primary to the Plan covering the person as other than a dependent (*e.g.*, retired employee),
2. Then the order of benefits is reversed so that the Plan covering the person as an employee, member, subscriber, policyholder or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.

(3) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, Plans covering a dependent child shall determine the order of benefits as follows:
(a) If two or more Plans cover a dependent child whose parents are married or are living together, whether or not they have ever been married, then,:
1. The Plan of the parent whose Birthday falls earlier in the calendar year is the Primary Plan;
2. If both parents have the same Birthday, the Plan that has covered the parent the longest is the Primary Plan.
(b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
1. If the specific terms of a court decree state that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. 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. 211 CMR 38.05(3)(b)1. does not apply with respect to any plan year during which any benefits are actually paid or provided before the entity has the actual knowledge of the court decree provisions;

38.05: continued

2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of 211 CMR 38.05(3)(a) shall determine the order of benefits;
3. If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses or health care coverage of the dependent child, the provisions of 211 CMR 38.05(3)(a) shall determine the order of benefits; or
4. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
a. The Plan covering the Custodial Parent;
b. The Plan covering the Custodial Parent's spouse;
c. The Plan covering the non-Custodial Parent; and then
d. The Plan covering the non-Custodial Parent's spouse.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under 211 CMR 38.05(3)(a) or (b) as if those individuals were parents of the child.
(d) 1. For a dependent child who has coverage under either or both parents' Plans and also has his or her own coverage as a dependent under a spouse's Plan, 211 CMR 38.05(6) applies.
2. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' Plans, the order of benefits shall be determined by applying the birthday rule in 211 CMR 38.05(3)(a) to the dependent child's parent(s) and the dependent's spouse.

(4) Active Employee or Retired or Laid-off Employee.
(a) The Plan that covers a person as an active employee that is an employee who is neither laid off nor retired or as a dependent of an active employee is the Primary Plan. The Plan covering that same person as a laid off or retired employee or as a dependent of a laid-off or retired employee is the Secondary Plan.
(b) If the other Plan does not have 211 CMR 38.05(4), and if, as a result, the Plans do not agree on the order of benefits, 211 CMR 38.05(4) is ignored.
(c) 211 CMR 38.05(4) does not apply if 211 CMR 38.05(2) can determine the order of benefits.

(5) COBRA or State Continuation Coverage.
(a) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the Plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the Secondary Plan.
(b) If the other Plan does not have 211 CMR 38.05(5), and if, as a result, the Plans do not agree on the order of benefits, 211 CMR 38.05(5) is ignored.
(c) 211 CMR 38.05(5) does not apply if 211 CMR 38.05(2) can determine the order of benefits.

(6) Longer or Shorter Length of Coverage.
(a) If none of 211 CMR 38.05(1) through (5) determines the order of benefits, the Plan that covered the person for a longer period of time is the Primary Plan and the Plan that covered the person for the shorter period of time is the Secondary Plan.
(b) To determine the length of time a person has been covered under a Plan, two successive Plans shall be treated as one if the covered person was eligible under the second Plan within 24 hours after coverage under the first Plan ended.
(c) 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 which pays, provides or administers the Plan's benefits;
3. A change from one type of Plan to another (such as, from a single employer Plan to that of a multiple employer Plan).

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(d) 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.

(7) If none of 211 CMR 38.05(1) through (6) determines the order of benefits, the Allowable Expenses shall be shared equally between the Plans.

38.06: Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim

In determining the amount to be paid by the Secondary Plan on a Claim, should the Plan wish to coordinate benefits, the Secondary Plan shall calculate the benefits it would have paid on the Claim in the absence of other health care coverage 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 payments by an amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the Claim do not exceed 100% of the total Allowable Expenses for the Claim. In addition, the Secondary Plan shall credit toward its Plan deductible the amounts it would have credited to its deductible in the absence of other health care coverage.

38.07: 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 health benefit plan, you should file all your claims with each plan."

38.08: Miscellaneous Provisions

(1) A Secondary Plan that provides benefits in the form of services may recover the reasonable 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 211 CMR 38.08 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.

(2) (a) A Plan with order of benefit determination rules which comply with 211 CMR 38.00 ("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 211 CMR 38.00 ("non-complying 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, such payment shall be the limit of the complying plan's liability; and

3. If the non-complying 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 non-complying 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 non-complying plan, it shall adjust payments accordingly.

(b) If the non-complying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the Secondary Plan and the non-complying plan paid or provided its benefits as the Primary Plan, and governing state law allows the right of subrogation set forth in 211 CMR 38.08(2)(c), then the complying plan shall advance to the covered person or on behalf of the covered person an amount equal to the difference.

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(c) 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 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 non-complying plan. The advance by the complying plan shall also be without prejudice to any Claim it may have against a non-complying plan in the absence of subrogation.

(3) COB Differs from Subrogation. Provisions for one 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 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 no Plan shall be required to pay more than it would have paid had it been the Primary Plan.

38.09: Effective Date

211 CMR 38.00 is applicable to any plan contract covering residents of the Commonwealth which is issued or renewed within or without the Commonwealth on or after the effective date of 211 CMR 38.00. A Plan contract that provides health care benefits and that was issued before the effective date of 211 CMR 38.00 shall be brought into compliance with 211 CMR 38.00 by:

(1) the later of:
(a) The next anniversary date or renewal date of the contract; or
(b) January 1, 2018; or

(2) The expiration of any applicable collectively bargained contract pursuant to which it was written.

38.10: Severability

If any provision of 211 CMR 38.00 or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of 211 CMR 38.00 or the applicability of such provision to other persons, entities or circumstances shall not be affected thereby.

REGULATORY AUTHORITY

211 CMR 38.00: M.G.L. Chs. 175, 176A, 176B, 176C, 176D, 176E, 176F, 176G and 176I.