**Massachusetts Division of Insurance**
**211 CMR 38.00: Coordination of Benefits FAQ**
**10/09/2017**

## Applicability of 211 CMR 38.00

- The provisions of 211 CMR 38.00, including the Order of Benefit Determination section, apply to coverage that: (1) falls under the definition of Plan under 211 CMR 38.02 and (2) is not exempt from state insurance laws.

- Self-funded employee benefit plans are exempt from state insurance laws under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1144, including M.G.L. c. 90, §34A.

- The Group Insurance Commission provides fully-insured and self-funded health insurance to state employees and retirees. Self-funded employee benefit plans are exempt from state insurance laws, including self-funded health benefits plans provided by the GIC.

- Federal law governs the coordination of benefits when an insured is covered by Medicare *and* another health coverage.

    - The Centers for Medicare & Medicaid Services (CMS) sets forth the COB rules when an individual is covered by Medicare and other health coverage. Information about federal COB rules, including the Medicare Secondary Payer (MSP) rules, can be found on the CMS website. In particular, information about the MSP rules can be found at: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html

**Question 1**: ***38.02 Definition of Plan and 38.04(2)(b) Rules for COB : Please confirm that Medicare Supplement policies are explicitly excluded from the definition of Plan, and that the reference to "coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits" in 38.04(2)(b) does not refer to Medicare Supplement policies.***

Response: The Rules for Coordination of Benefits found under 211 CMR 38.02 address the order of benefit payments when a person is covered by two or more *Plans*. Since Medicare Supplement policies are specifically *excluded* from the definition of Plan under 211 CMR 38.02, the rules for coordination of benefits under 211 CMR 34.04 would not apply to Medicare Supplement policies.

**Question 2:** Is travel insurance considered a plan under the definition?

Response: Accident only coverage (including plans marketed as "travel insurance") is not included in the definition of Plan under 211 CMR 38.00 and would not be subject to the coordination provisions.

**Question 3:** ***When PIP is excluded for either DUI, operating a motorcycle, Evading police, etc… Is Med pay still secondary to Health insurance?***

Response: Yes. The unavailability of PIP does not impact the provisions of 211 CMR 38.05(1)(b) that provide that Medical Payments coverage under a motor vehicle policy shall always be secondary to and in excess of any Health Benefit Plan or Personal Injury Protection. Where a claimant has health coverage and MedPay, medical claims must be submitted to the health insurance carrier. The insured is entitled to be paid under the Medical Payments coverage for reasonable medical expenses that are not payable under either the Health Benefit Plan *or* under PIP.

**Question 4:** ***38.04(1)(B) Rules for COB - If a health plan member receives out-of-network care following an accident, does 38.04(1)(b) apply? Would MedPay cover the health plan member's out-of-network services?***

Response: An insured is entitled to receive benefits under his health benefit plan if treatment is sought in accordance with the terms of the health benefit plan. If an insured's medical expenses are not payable under PIP because the insured elected to go outside his health benefit plan to obtain a medical service that could have been obtained through his health benefit plan, then the insured is entitled to be paid for that out-of-network service by the Medical Payments coverage. See *Dominguez v. Liberty Mut. Ins. Co.,* 429 Mass. 112, 706 N.E.2d 647 (1999).

**Question 5:** ***Please clarify the order of priority specific to Med Pay coverage, when health insurers have an "other insurance" clause in their policies? In the past, health insurers would fail to pay claims until the MedPay was exhausted. However, the new regulation seems to indicate that MedPay is now secondary to Health insurance. It appears that these "other insurance" clauses conflict with the new regulations.***

Response: Under 211 CMR 38.05(1)(b), Medical Payments coverage under a motor vehicle insurance policy shall always be secondary to and in excess of any Health Benefit plan or PIP. Accordingly, a fully-insured health benefit plan may not contain language deferring coverage to MedPay.

In some instances, a health benefit plan may be exempt from state insurance laws or may follow federal coordination of benefits rules. Since self-funded employee benefit plans are exempt from state insurance laws, they may or may not follow a state's COB rules. In some instances, the plan documents of a self-funded health benefit plan may contain language deferring primary coverage to the motor vehicle insurer. If a self-funded health benefit plan *does not* contain such deferral language, then the auto insurer may pay reasonable medical expenses that were not payable under an insured's Health Benefit Plan.

**Question 6:**

**Are MassHealth, Affordable Care Act plans (Obamacare), Massachusetts safety/health net plans, ERISA plans and Medicare all considered health benefit plans under the regulation? We want to make sure that MedPay is excess to all these types of plans.**

Response: The provisions of 211 CMR 38.00, including the Order of Benefit Determination section, apply to coverage that: (1) falls under the definition of Plan under 211 CMR 38.02 and (2) is not exempt from state insurance laws. Certain plans are specifically excluded from the definition of Plan, including MassHealth (Medicaid) and Medicare Supplement plans. On the other hand, certain health benefit plans may be exempt from state insurance laws (e.g., self-funded plans) or may follow federal coordination of benefit rules (e.g., Medicare).

"Obamacare" is not a health plan; it is a colloquial term for the provisions of the Affordable Care Act (ACA). Health Benefit Plans that are purchased through an ACA Exchange, even those with subsidies, are private health insurance and are considered "Plans" for the purposes of 211 CMR 38.00.

If a plan follows federal coordination of benefit rules (e.g., Medicare or Tricare), then the auto insurer should pay any benefits in accordance with the applicable federal COB rules.

**Question 7: May a provider that has entered into a contractual arrangement with a Health Benefit Plan balance bill an auto carrier (or an insured) for the difference between the negotiated payments and the provider's charge?**

Response: Where the Personal Injury Protection coverage and Medical Payments Coverage of a motor vehicle policy are secondary to a Health Benefit Plan, the coordination of benefits rules may not be used by a provider to increase the amount of payment to the provider. Thus, the provider may not bill the motor vehicle policy or the insured the difference between the provider's negotiated payment with the health benefit plan and the provider's charge. Unless otherwise permitted under 211 CMR 38.00, the coordination of benefits rules may not be used to circumvent contractual agreements

between providers and plans by increasing the provider payment or decreasing the amount the provider has negotiated to accept in payment for services, less any required deductibles, coinsurance or copayments.