

**§2332-A. Coordination of benefits**

**1. Authorization.** Provisions contained in group and nongroup nonprofit hospital, medical service or health care subscriber contracts relating to coordination of benefits payable under the contract and under other plans of insurance or of health care coverage under which the subscriber or the subscriber's dependents may be covered must conform to rules adopted by the superintendent. The rules may establish uniformity in the permissive use of coordination of benefits provisions to ensure that the subscriber receives full benefits for covered medical services, to enhance cost containment through avoidance of windfall payments and to avoid claim delays and misunderstandings that otherwise result from the use of inconsistent or incompatible provisions among the several insurers and nonprofit hospital, medical service and health care plans.

[PL 1993, c. 666, Pt. B, §1 (NEW).]

**1-A. Coordination with Medicare.** Coordination of benefits is governed by the following provisions.

A. The contract may not coordinate benefits with Medicare Part A unless:

- (1) The insured is enrolled in Medicare Part A;
- (2) The insured was previously enrolled in Medicare Part A and voluntarily disenrolled;
- (3) The insured stated on an application or other document that the insured was enrolled in Medicare Part A; or
- (4) The insured is eligible for Medicare Part A without paying a premium and the contract states that it will not pay benefits that would be payable under Medicare even if the insured fails to exercise the insured's right to premium-free Medicare Part A coverage. [PL 1997, c. 604, Pt. G, §1 (NEW).]

B. The contract may not coordinate benefits with Medicare Part B unless:

- (1) The insured is enrolled in Medicare Part B;
- (2) The insured was previously enrolled in Medicare Part B and voluntarily disenrolled;
- (3) The insured stated on an application or other document that the insured was enrolled in Medicare Part B; or
- (4) The insured is eligible for Medicare Part A without paying a premium and the insurer provided prominent notification to the insured both when the contract was issued and, if applicable, when the insured becomes eligible for Medicare due to age. The content of the notification must be approved by the bureau. The notification must state that the contract will not pay benefits that would be payable under Medicare even if the insured fails to enroll in Medicare Part B and state that the insured may contact the bureau, the Health Insurance Consumer Assistance Program established in Title 24-A, section 4326 or another relevant organization or agency for assistance in understanding coordination of benefits with Medicare Part B under the insured's contract. [PL 2023, c. 104, §1 (AMD).]

C. Coordination is not permitted with Medicare coverage for which the insured is eligible but not enrolled except as provided in paragraphs A and B. [PL 1997, c. 604, Pt. G, §1 (NEW).]

[PL 2023, c. 104, §1 (AMD).]

**2. Medicaid and Cub Care programs.** Nonprofit service organizations may not consider the availability or eligibility for medical assistance under 42 United States Code, Section 13969, referred to as "Medicaid," or Title 22, section 3174-T, referred to as the "Cub Care program," when considering coverage eligibility or benefit calculations for subscribers and covered family members.

A. To the extent that payment for coverage expenses has been made under the Medicaid program or the Cub Care program for health care items or services furnished to an individual, the State is considered to have acquired the rights of the covered subscriber or family member to payment by the nonprofit service organization for those health care items or services. Upon presentation of proof that the Medicaid program or the Cub Care program has paid for covered items or services, the nonprofit service organization shall make payment to the Medicaid program or the Cub Care program according to the coverage provided in the contract or certificate. [PL 1997, c. 777, Pt. B, §1 (AMD).]

B. A nonprofit service organization may not impose requirements on a state agency that has been assigned the rights of an individual eligible for Medicaid or Cub Care coverage and covered by a subscriber contract that are different from requirements applicable to an agent or assignee of any other covered individual. [PL 1997, c. 777, Pt. B, §1 (AMD).]  
[PL 2005, c. 683, Pt. A, §38 (AMD).]

**3. Credit toward deductible.** When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.  
[PL 2005, c. 121, Pt. D, §1 (NEW).]

#### SECTION HISTORY

PL 1987, c. 402, §A149 (NEW). PL 1991, c. 200, §B2 (AMD). PL 1993, c. 666, §B1 (RPR). PL 1997, c. 604, §G1 (AMD). PL 1997, c. 777, §B1 (AMD). PL 2005, c. 121, §D1 (AMD). PL 2005, c. 683, §A38 (AMD). PL 2023, c. 104, §1 (AMD).

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