PROJECT HISTORY - 2013

COORDINATION OF BENEFITS MODEL REGULATION (#120)

1. Description of the Project, Issues Addressed, etc.

The revisions to the *Coordination of Benefits Model Regulation* (#120) were made to address issues related to medical benefits (med pay) coverage in automobile "no fault" and traditional automobile "fault" type contracts and, as provided in Section 2714 of the federal Public Health Services Act (PHSA), as amended by the federal Affordable Care Act (ACA), the extension of dependent coverage to age 26. The revisions also make it clear that dental coverage is considered a "plan" under the model for purposes of ensuring that a coordination of benefits provision can be included in such coverage and therefore, subject to coordination, which is particularly important given that pediatric dental is an essential benefit under the ACA and might be subject to new cost-sharing limitations. Adoption of these changes will help ensure that a state's coordination of benefits requirements is consistent with the ACA.

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force was responsible for drafting the revisions. The members of the Task Force are: South Dakota, Chair; Idaho, Vice Chair; Arizona; California; Colorado; Connecticut; District of Columbia; Florida; Illinois; Indiana; Kansas; Kentucky; Maine; Massachusetts; Minnesota; Montana; Nebraska; New Jersey; Ohio; Oklahoma; Oregon; Pennsylvania; Tennessee; Utah; Virginia; Washington; West Virginia; and Wisconsin.

3. Project Authorized by What Charge and Date First Given to the Group

The Regulatory Framework (B) Task Force was given a charge in 2012 to: review and revise, as necessary, the *Coordination of Benefits Model Regulation* (#120) to address issues related to medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts and, as provided in section 2714 of the Public Health Service Act (PHSA), the extension of dependent coverage to age 26. *Important*

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc.). Include any parties outside the members that participated.

The revisions were drafted by the Regulatory Framework (B) Task Force, which developed three drafts of proposed revisions to Model #120 prior to its adoption. The Task Force discussed the drafts and the comments received on the drafts at the 2012 Spring National Meeting, 2012 Summer National Meeting, 2012 Fall National Meeting and 2013 Spring National Meeting. All drafts and comments were posted on the Task Force's Web page. Numerous interested parties participated in the drafting process, including consumer representatives and industry representatives.

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited).

The Regulatory Framework (B) Task Force discussed the drafts and comments received on them during person-to-person meetings at the 2012 Spring National Meeting, 2012 Summer National Meeting, 2012 Fall National Meeting and 2013 Spring National Meeting. All drafts and comments were posted on the Task Force's Web page.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group's response).

None

7. Any Other Important Information (e.g., amending an accreditation standard).

None

PROJECT HISTORY - 2004

COORDINATION OF BENEFITS MODEL REGULATION (#120)

1. Description of the project, issues addressed, etc.

The amendments to the NAIC Group Coordination of Benefits Model Regulation revise the model to reflect changes in the health care delivery system since the model was last revised in 1995. The revisions also make the model easier to implement and understand by eliminating unused provisions and rewording esoteric language.

2. Name of group responsible for draft the model:

Regulatory Framework (B) Task Force

States Participating:

Wisconsin, Chair
Arkansas
California
Colorado
Delaware
Florida
Idaho
Iowa
Kansas
Louisiana
Maine
Nebraska
Nevada
New Hampshire
New Mexico
North Carolina
Rhode Island
South Dakota
Vermont
Virginia
West Virginia

3. Project authorized by what charge and date first given to the group:

The following charge given in January 2002: Review and revise the Group Coordination of Benefits Model Regulation to reflect the changes in health care delivery systems since the model was adopted.

4. A general description of the drafting process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.

The revisions, and comments received on them, were reviewed and discussed by the task force and former members of the Coordination of Benefits Working Group.

5. A general description of the due process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited.

Each draft of proposed revisions to the COB model was circulated by email to interested parties and posted on the NAIC website. Interested parties were given the opportunity to submit comments on each draft. The task force and former members of the Coordination of Benefits Working Group reviewed and considered all comments received.

6. A discussion of the significant issues (items of some controversy) raised during the process and the group's response.

There were two controversial issues: (1) whether to revise the model to permit individual-to-group plan coordination; and

(2) whether to delete the benefit reserve provision. On the first issue, after extensive discussion of the pros and cons of permitting such coordination, the task force decided to revise the model regulation to permit individual-to-group plan coordination. Those in favor of permitting such coordination based their reasoning on the idea that an individual should not be able to profit from filing claims under both the individual and group policy. This can happen when individual-to-group plan coordination is not permitted. Those opposed to this revision stated that because consumers paid the premium on both policies, they should be able to reap the benefit even if it permitted double-dipping.

With respect to the second issue, those in favor of eliminating the benefit reserve provision argued that only a handful of states have the provision in their COB laws. One reason for this is that the benefit reserve is too difficult and too costly to administer. In those states that require the benefit reserve, few health carriers have been able to consistently apply it correctly. Those arguing in favor of retaining the provision reminded everyone that the reason for requiring the benefit reserve. Requiring the benefit reserve helped to ensure that the covered person is covered 100% for all allowable expenses, including deductibles and copayments. After considering these arguments, the task force voted to delete the provision. Given the cost of administering the provision and the possible benefit to the consumer, the task force decided that the administrative cost of administering the benefit reserve outweighed any possible benefit.