

RRC STAFF OPINION

PLEASE NOTE: THIS COMMUNICATION IS EITHER 1) ONLY THE RECOMMENDATION OF AN RRC STAFF ATTORNEY AS TO ACTION THAT THE ATTORNEY BELIEVES THE COMMISSION SHOULD TAKE ON THE CITED RULE AT ITS NEXT MEETING, OR 2) AN OPINION OF THAT ATTORNEY AS TO SOME MATTER CONCERNING THAT RULE. THE AGENCY AND MEMBERS OF THE PUBLIC ARE INVITED TO SUBMIT THEIR OWN COMMENTS AND RECOMMENDATIONS (ACCORDING TO RRC RULES) TO THE COMMISSION.

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .0321

RECOMMENDED ACTION:

- Approve, but note staff's comment
- X Object, based on:
 - Lack of statutory authority
 - X Unclear or ambiguous
 - Unnecessary
 - Failure to comply with the APA
 - Extend the period of review

COMMENT:

Staff recommends objection for lack of clarity. Specifically, line 5 provides a cross-reference to Rule 11 NCAC 12 .0307 which has been repealed. As a result, the filing requirements for schedules of premiums are unclear. Additionally, the Rule is ambiguous as written since it uses the undefined terms "excessive," "inadequate" and "unfairly discriminatory" at line 10 as well as the phrase "data deemed necessary by the commissioner" at line 12.

1 11 NCAC 12 .0321 is readopted as published in NCR 34:10 839 as follows:

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3 **11 NCAC 12 .0321 RATE FILING: HMO**

4 (a) All schedules of premiums for enrollee coverage for health care services, or amendment thereto, shall be filed in duplicate
5 in accordance with 11 NCAC 12 .0307(b)(5), indicating whether the schedule is original or amended.

6 (b) All filings shall be accompanied by:

7 (1) A certification by the chief executive officer of the corporation that the premiums applicable to an enrollee
8 are not individually determined based on the status of his health;

9 (2) A certification by an actuarial expert that such premiums are established in accordance with actuarial
10 principles for various categories of enrollees and are not excessive, inadequate, or unfairly discriminatory;

11 (3) Actuarial data supporting the schedule of premiums;

12 (4) Such other data deemed necessary by the commissioner to determine whether to approve or disapprove the
13 filing;

14 (c) Actuarial data and rates required by this Rule shall be filed in triplicate.

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16 *History Note: Authority G.S. 58-67-50; 58-67-150;*

17 *Eff. January 22, 1980;*

18 *Amended Eff. ~~February 1, 1992~~ February 1, 1992;*

19 *Readopted Eff. March 1, 2020.*

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AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 12 .0514

RECOMMENDED ACTION:

- Approve, but note staff's comment
- X Object, based on:
 - Lack of statutory authority
 - X Unclear or ambiguous
 - Unnecessary
 - Failure to comply with the APA
 - Extend the period of review

COMMENT:

Staff recommends objection to this Rule governing selection of benefits for accident and health insurance for lack of clarity. This Rule is unclear as written for many reasons, including use of the defined terms "plan" at line 18 and "this plan" at line 30 in addition to the undefined terms "separate plan" at line 28 and "other plan" on page 2, line 30. Staff notes the term is partially capitalized as "other Plan" on page 2, line 15, so it is additionally unclear if this term has a different meaning. The multiple versions and meanings of the word "plan" used throughout this Rule make the Rule confusing and thus, ambiguous as written.

At line 11, this Rule states, ". . . 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." It is unclear to staff whether "the order of benefit determination rules" refers to Item (3) of this Rule or Sub-item (3)(b) of this Rule. The term "rule" also appears to refer to requirements within specific "plans" at page 2, lines 30-32. The multiple uses of the word "rule," none of which follow the definition of the term in G.S. 150B-2(8a), further confuse the meaning of this Rule.

The Rule also includes the following undefined terms which make the Rule unclear: "school accident-type coverage" at line 21; "parts" at line 29; the phrase "necessary, reasonable, and customary" at page 2, line 1; "services" at page 2, line 3; and "necessary medical expenses" at page 2, line 5. Overall, staff recommends objection for ambiguity.

Ashley Snyder
Commission Counsel

1 11 NCAC 12 .0514 is readopted as published in NCR 34:10 839 as follows:

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3 **11 NCAC 12 .0514 COORDINATION: GROUP A/H CONTRACT BENEFITS: GROUP COVERAGES**

4 Purpose. In order to promote consistency in liability for claims and claims determination for Group Accident and Health
5 coverage, the department shall require a uniform order of benefits determination as follows:

6 (1) Applicability:

7 (a) This Coordination of Benefits ("COB") provision applies to this plan when a employee or the
8 employee's covered dependent has health care coverage under more than one plan. "Plan" and
9 "This Plan" are defined in (2)(a) and (b) of this Rule.

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

13 (i) Shall not be reduced when, under the order of benefit determination rules, this plan
14 determines its benefits before another plan; but

15 (ii) May be reduced when, under the order of benefit determination rules, another plan
16 determines its Section (IV) Effect on the Benefits of this plan.

17 (2) Definitions:

18 (a) A "Plan" is any of these which provides benefits or services for, or because of, medical or dental
19 care or treatment:

20 (i) True group insurance. This includes prepayment, group practice or individual practice
21 coverage. It does not include school accident-type coverage, blanket, franchise
22 individual, automobile and homeowner coverage.

23 (ii) Coverage under a governmental plan or required or provided by law. This does not
24 include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance
25 Programs, of the United States Social Security Act as amended from time to time). It
26 also does not include any plan when, by law, its benefits are excess to those of any
27 private insurance program or other non-governmental program.

28 Each contract or other arrangement for coverage under (2)(a) (i) or (ii) is a separate plan. Also, if an arrangement
29 has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

30 (b) "This Plan" is the part of the group contract that provides benefits for health care expenses.

31 (c) "Primary Plan"/"Secondary Plan". The order of benefit determination rules state whether this
32 plan is a Primary Plan or Secondary Plan as to another plan covering the person. When this plan
33 is a Primary Plan, its benefits are determined before those of the other plan and without
34 considering the other plan's benefits. When there are more than two plans covering the person,
35 this plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to
36 a different plan or plans.

1 (d) "Allowable Expense" means a necessary, reasonable, and customary item of expense for health
2 care, when the item of expense is covered at least in part by one or more plans covering the
3 person for whom the claim is made. When a plan provides benefits in the form of services, the
4 reasonable cash value of each service rendered will be considered both an allowable expense and
5 a benefit paid. Total benefits paid must be equal to 100 percent of necessary medical expenses
6 covered by both plans.

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

10 (3) Order of Benefit Determination Rules:

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

- 13 (i) the other plan has rules coordinating its benefits with those of this plan; and
- 14 (ii) both those rules and this plan's rules, in (3)(b)(ii)(B) of this Rule, require that this plan's
15 benefits be determined before those of the other Plan.

16 (b) Rules. This plan determines its order of benefits using the first of the following rules which
17 applies:

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

21 (ii) Dependent Child/Parents Not Separated or Divorced. Except as stated in (3)(b)(iii)(B)
22 of this Rule, when this plan and another plan cover the same child as a dependent of
23 different persons, called "parents":

24 (A) the benefits of the plan of the parent whose birthday falls earlier in a year are
25 determined before those of the plan of the parent whose birthday falls later in
26 that year; but

27 (B) if both parents have the same birthday, the benefits of the plan that has covered
28 a parent for a longer period of time are determined before those of the plan that
29 covered the other parent for a shorter period of time.

30 However, if the other plan does not have the rule described in Paragraph (3)(a) in this Rule, but instead has a rule based upon
31 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
32 determine the order of benefits.

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

36 (A) first, the plan of the parent with custody of the child;

37 (B) then, the plan of the spouse of the parent with custody of the child; and

1 (C) finally, the plan of the parent not having custody of the child.

2 However, if the specific terms of a court decree state that one of the parents is responsible for the health pay or provide the
3 benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. In this
4 Rule, (3)(b)(iii)(C) does not apply with respect to any claim determination period or plan year during which any benefits are
5 actually paid or provided before the entity has that actual knowledge.

6 (iv) Active Inactive Employee. The benefits of a plan which covers a person as an employee
7 who is neither laid off nor retired (or as that employee's dependent) are determined
8 before those of a plan which covers that person as a laid off or retired employee (or as
9 that employee's dependent). If the other plan does not have (3)(b)(iv), and if, as a result,
10 the plans do not agree on the order of benefits, (3)(b)(iv) is ignored.

11 (v) Longer/Shorter Length of Coverage. If more of Paragraph (3) of this Rule determines
12 the order of benefits, the benefits of the plan which covered an employee, member or
13 subscriber longer are determined before those of the plan which covered that person for
14 the shorter time.

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16 *History Note: Authority G.S. 58-2-40; 58-51-1; 58-65-1; 58-65-40;*
17 *Eff. February 1, 1976;*
18 *Readopted Eff. September 26, 1978;*
19 *Amended Eff. February 1, 1992; April 1, 1989; ~~July 1, 1986.~~ July 1, 1986.*
20 *Readopted Eff. March 1, 2020.*
21