11 NCAC 12 .0321 was published as a readoption in NCR 34:10 839 but is now being repealed as follows:

11 NCAC 12 .0321 RATE FILING: HMO

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

~~(b) All filings shall be accompanied by:~~

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

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

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

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

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

History Note: *Authority G.S. 58-67-50; 58-67-150;*
Eff. January 22, 1980;
Amended Eff. ~~*February 1, 1992.*~~ *February 1, 1992;*
Repealed Eff. July 1, 2020.

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

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

Purpose. In order to promote consistency in liability for claims and claims determination for [~~Group Accident~~] group accident and [~~Health~~] health coverage, when a person has more than one type of group insurance and there is a basis for a claim under two or more group insurance plans, [~~the department shall require a uniform order of benefits determination as follows:~~] each group accident and health policy and any accident and health certificates issued under a group accident and health policy shall contain uniform order of benefit determination provisions as outlined in this Rule.

(1) Applicability:

(a) [~~This~~]These Coordination of Benefits ("COB") [~~provision applies to this plan~~] provisions apply when [~~a~~] an employee or the employee's covered dependent has health care coverage under This Plan and one or more [~~than one plan.~~] ~~"Plan" and "This Plan" are~~ other Health Plans as defined in Paragraph [~~(2)(a) and (b) of this Rule~~] 2(a) of these provisions and when there is a basis for a claim under This Plan and the other Health Plan(s).

(b) If [~~this COB provision applies, 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. The benefits of this plan:~~] these COB provisions apply, whether This Plan is the Primary Plan or the Secondary Plan is determined pursuant Paragraph (3) of these provisions.

(c) When This Plan is a Primary Plan, its benefits shall be determined before those of the other Secondary Plan(s) and without considering the Secondary Plan's benefits. When there are more than two other Health Plans covering the person, This Plan may be a Primary Plan as to one or more other Health Plans and may be a Secondary Plan as to a different Health Plan or Health Plans.

(d) When This Plan is a Secondary Plan, its benefits shall be determined without considering the benefits of the Primary Plan or any other Secondary Plan and it shall credit to the deductible any amount that would otherwise be credited to it in the absence of coverage by another Health Plan. When This Plan is a Secondary Plan, any amount of those benefits paid for any Allowable Expense may be reduced to the amount of the Allowable Expense that is unpaid by the Primary Plan to prevent the payment of benefits under more than one Health Plan that would total more than one-hundred percent (100%) of the total expense for that claim.

(e) The benefits of This Plan:

(i) Shall not be reduced when,[~~under the order of benefit determination rules, this plan determines its benefits before another plan;~~]pursuant to Paragraph (3) of these provisions, it is determined to be the Primary Plan; but

(ii) May be reduced when, [~~under the order of benefit determination rules, another plan determines its Section (IV) Effect on the Benefits of this plan.~~] pursuant to Paragraph (3) of these provisions, it is determined to be the Secondary Plan.

~~(2) Definitions:~~

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

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

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

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

[~~(b) "This Plan" is the part of the group contact that provides benefits for health care expenses.~~]

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

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

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

(2) Definitions:

(a) “Allowable Expense” means any health care expense, including coinsurance or copayments, without reduction for an applicable deductible, that is covered in full or in part by any of the Health Plans covering the person. When a Health Plan provides benefits in the form of medical services, the reasonable cash value of each service rendered shall be considered both an allowable expense and a benefit paid.

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

(c) "Health Plan" means a plan which provides benefits or services for, or because of, medical or dental care or treatment:

(i) True group insurance. This includes prepayment, group practice or individual practice coverage. It does not include accident and health coverage for students, blanket, franchise individual, automobile and homeowner coverage.

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

Each coverage under Subparagraphs (2)(a)(i) or (ii) of these provisions is a separate Health Plan. Also, if there is more than one schedule of benefits, and COB provisions apply only to one, each of the schedule of benefits is a separate Health Plan.

(d) "Primary Plan" means a Health Plan whose benefits for a person's health care coverage has been determined to be the first claim payor taking the existence of any other Health Plan into consideration, pursuant to Paragraph (3) of these provisions.

(e) "Secondary Plan" means a Health Plan that is not a Primary Plan.

(f) "This Plan" means this group accident and health policy.

(3) Order of Benefit [~~Determination Rules:~~] Determination:

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

(i) the other [~~plan~~] Health Plan has [~~rules~~] provisions coordinating its benefits with those of [~~this plan;~~] This Plan; and

(ii) both ~~those~~ [~~rules~~] the other Health Plan's provisions and [~~this plan's rules,~~] This Plan's provisions in [~~(3)(b)(ii)(B) of this Rule,~~] Subparagraph (3)(b) of these provisions, require that [~~this plan's~~] This Plan's benefits be determined before those of the other Health Plan.

(b) [~~Rules.~~] This [~~plan~~] Plan determines its order of benefits using the first of the following rules which applies:

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

(ii) Dependent Child/Parents Not Separated or Divorced. Except as stated in [~~(3)(b)(iii)(B) of this Rule,~~] Subparagraph (3)(b)(iii) of these provisions, when [~~this plan~~] This Plan and another [~~plan~~] Health Plan cover the same child as a dependent of different persons, called "parents":

(A) the benefits of the [~~plan~~] Health Plan of the parent whose birthday falls earlier in a year are determined before those of the [~~plan~~] Health Plan of the parent whose birthday falls later in that year; but

(B) if both parents have the same birthday, the benefits of the [~~plan~~] Health Plan that has covered a parent for a longer period of time are determined before those of the [~~plan~~] Health Plan that covered the other parent for a shorter period of time.

However, if the other [~~plan~~] Health Plan does not have the [~~rule~~] provision described in [~~Paragraph (3)(a) in this Rule,~~] Subparagraph (3)(b)(ii)(A) of these provisions, but instead has a [~~rule~~] provision based upon the gender of the parent, and if, as a result, the [~~plans~~] Health Plans do not agree on the order of benefits, the [~~rule~~] provision in the other [~~plan~~] Health Plan will determine the order of benefits.

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

(A) first, the [~~plan~~] Health Plan of the parent with custody of the child;

(B) then, the [~~plan~~] Health Plan of the spouse of the parent with custody of the child; and

(C) finally, the [~~plan~~] Health Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the [~~health pay or provide the benefits of the plan of that parent has actual knowledge of those terms,~~] healthcare expenses or healthcare coverage and the Health Plan of the parent has actual knowledge of those terms, the benefits of that [~~plan~~] Health Plan are determined first. [~~In this Rule,~~] Subparagraph (3)(b)(iii)(C) of these provisions does not apply with respect to any [~~claim determination period~~] Claim Determination Period or [~~plan year~~] plan-year during which any benefits are actually paid or provided before the [~~entity~~]Health Plan has that actual knowledge.

(iv) Active Inactive Employee. The benefits of a [~~plan~~] Health Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a [~~plan~~] Health Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other [~~plan~~] Health Plan does not have a provision like Subparagraph (3)(b)(iv), and if, as a result, the [~~plans~~] Health Plans do not agree on the order of benefits, Subparagraph (3)(b)(iv) is ignored.

(v) Longer/Shorter Length of Coverage. If [~~more~~] none of the other provisions of Paragraph (3) [~~of this Rule determines~~] determine the order of benefits, the benefits of the [~~plan~~] Health Plan which covered an employee, member or subscriber longer are determined before those of the [~~plan~~] Health Plan which covered that person for the shorter time.

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History Note: *Authority G.S. 58-2-40; 58-51-1; 58-51-80; 58-51-81; 58-65-1; 58-65-40;*
Eff. February 1, 1976;
Readopted Eff. September 26, 1978;
Amended Eff. February 1, 1992; April 1, 1989; ~~July 1, 1986.~~ July 1, 1986;
Readopted Eff. July 1, 2020.

April 20, 2020

Loretta Peace-Bunch
Department of Insurance
Sent via email only: loretta.peace-bunch@ncdoi.gov

Re: Objection to Rules 11 NCAC 12 .0321 and .0514

Dear Ms. Peace-Bunch:

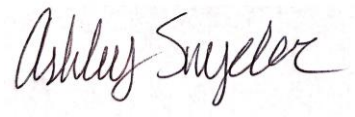
At its April meeting, the Rules Review Commission objected to the above-captioned rules in accordance with G.S. 150B-21.10.

The Commission objected to Rule 11 NCAC 12 .0321 for lack of clarity. Line 5 cross-references a repealed rule. The Rule also uses the undefined terms "excessive," "inadequate" and "unfairly discriminatory" as well as the phrase "data deemed necessary by the commissioner."

The Commission also objected to Rule 11 NCAC 12 .0514 for lack of clarity. The Rule is unclear for reasons detailed in the staff opinion, including multiple versions and meanings of the word "plan." It is also unclear whether "the order of benefit determination rules" refer to Item (3) of the Rule or Sub-item (3)(b) of the Rule. The Rule also uses the following undefined terms: "school accident-type coverage" at line 21; "parts" at line 29; "necessary, reasonable, and customary" at page 2, line 1; "services" at page 2, line 3; and "necessary medical expenses" at page 2, line 5.

Please respond to this letter in accordance with the provisions of G.S. 150B-21.12. If you have any questions regarding the Commission's actions, please let me know.

Sincerely,



Ashley Snyder
Commission Counsel

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.

Ashley Snyder
Commission Counsel

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

11 NCAC 12 .0321 RATE FILING: HMO

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

(b) All filings shall be accompanied by:

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

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

(3) Actuarial data supporting the schedule of premiums;

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

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

History Note: *Authority G.S. 58-67-50; 58-67-150;*
Eff. January 22, 1980;
Amended Eff. ~~February 1, 1992.~~ February 1, 1992;
Readopted Eff. March 1, 2020.

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 .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

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

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

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

(1) Applicability:

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

(b) If this COB provision applies, 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. The benefits of this plan:

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

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

(2) Definitions:

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

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

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

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

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

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

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

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

(3) Order of Benefit Determination Rules:

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

(i) the other plan has rules coordinating its benefits with those of this plan; and

(ii) both those rules and this plan's rules, in (3)(b)(ii)(B) of this Rule, require that this plan's benefits be determined before those of the other Plan.

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

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

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

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

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

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 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 determine the order of benefits.

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

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

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

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

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

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

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

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