REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 18 .0103

DEADLINE FOR RECEIPT: Thursday, November 9, 2017

***NOTE WELL:* This request when viewed on computer extends several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Please show that the insertion of (b) on line 8 is new. And then show the changing of (b) on line 26 to (c) and so forth with the rest of the Paragraphs. This was published correctly in the NC Register, so you do not need to highlight this change – simply reflect what was published here.

In (b)(1), (2), and (3), you refer to forms. The contents of rules must in rule or law. Are the contents of these forms in rule or law? Is the intent to rely upon the requirements of the laws cited?

Also, why are you saying the forms are "Commissioner prescribed" What do you mean by this? Why do you need it?

In (b), who is submitting the information? The applying entity?

In (b), lines 8-9, this is not a complete sentence. "To apply for licensure, the information required by G.S. 58-49-50 shall be submitted:" Do you mean "... shall be submitted by:" or "submitting the following:"?

On line 8, this not the correct way to remove the comma after "G.S. 58-49-50" You published it correctly, so please use that here.

In (b)(1), line 12, the citation should be separated by hyphens not periods. This was published correctly, so please use what was published here.

In (b)(2), line 13, please put the comma inside the quotation marks following "Financial Statement"

Aren't the statutory requirements in (b)(2) already captured by the information required in (b)(1)?

In (b)(3), line 15, assuming you need to retain "Commissioner prescribed" then do you mean to state "The Commissioner..."

Amanda J. Reeder
Commission Counsel
Date submitted to agency: October 26, 2017

On line 16, there is an error. You currently have "Biographical The Questionnaire" and I doubt that is the name of the form.

Also in (b)(3), what is this information that shall satisfy the criteria? If you are requiring they state they do not have any of the disqualifications in the statute, why not state that?

> (e) The Commissioner shall not grant or continue a license to any MEWA if the Commissioner deems that any trustee, manager, or administrator is incompetent, untrustworthy, or so lacking in insurance expertise as to make the operations of the MEWA hazardous to the potential and existing insureds; that any trustee, manager, or administrator has been found guilty of or has pled guilty or no contest to a felony, a crime involving moral turpitude, or a crime punishable by imprisonment of one year or more under the law of any state or country, whether or not a judgment or conviction has been entered; that any trustee, manager, or administrator has had any type of insurance license revoked in this or any other state; or that the business operations of the MEWA are or have been characterized, to the detriment of the employers participating in the MEWA, of persons receiving benefits from the MEWA, or of creditors or the public, by the improper manipulation of assets, accounts, or excess insurance or by bad faith.

Why is (b)(5) combined? This seems that the information would be clearer to read if set forth as (b)(5), (b)(6), (b)(7), etc.

In (c), line 26, is the term "forms" the same as "applications" used on line 27? If so, why isn't the same term used for both?

On line 28, who will report these changes to the Commissioner? And what is the deadline? The one set forth in Paragraph (g)? Doesn't this language repeat at least part of Paragraph (g)?

In (d), line 30, define "current"

In (e), how does the MEWA satisfy the Commissioner that the conditions are met?

In (f), line 35, I take it the reference to "statutory accounting principles" is a reference to G.S. 58-49-60? If not, what does the phrase mean?

In the History Note, please change the Readopted Eff. date to December 1, 2017.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

11 NCAC 18 .0103 is readopted as published in 32:02 NCR 61 as follows:

11 NCAC 18 .0103 FILING REQUIREMENTS

(a) All communications and filings ~~must~~shall be made ~~with the Compliance Officer, Technical Services Group, North Carolina Department of Insurance, P.O. Box 26387, Raleigh, N.C. 27611.~~to the Deputy Commissioner, Life and Health Division, North Carolina Department of Insurance, 1201 Mail Service Center, Raleigh, North Carolina 27699-1201.

(b) To apply for licensure, ~~in addition to~~ the information required by G.S. 58-49-50~~, the following items pertaining to the MEWA must~~shall be submitted:

(1) ~~Form MEWA-1 entitled "Application for License for Multiple Employer Welfare Arrangement (MEWA);"~~ The Commissioner prescribed Form MEWA-1 entitled "Application for License for Multiple Employer Welfare Arrangement (MEWA)" required by G.S. 58.49.50;

(2) The Commissioner prescribed Form MEWA-2 entitled "Financial Statement", which shall contain the information required by G.S. 58-49-50(8);

(3) ~~Signed and notarized biographical affidavits by all trustees of the MEWA on~~Commissioner prescribed Form MEWA-3 entitled "Biographical ~~Questionnaire",~~ The Questionnaire," signed and notarized biographical affidavits by all trustees of the MEWA that shall contain information to enable the Commissioner to determine if such persons satisfy the criteria specified in G.S. 58-49-40(e);

(4) A ~~complete~~ list of all names, ~~addresses~~addresses, and telephone numbers of participating employers and the number of employees covered by the MEWA; and

(5) A statement of the reasons for applying for a North Carolina MEWA license; a description of ~~exactly~~ how the MEWA proposes to develop and supervise its operations in North Carolina; the name, title, and qualifications of the person who will be responsible for the MEWA's operation in North Carolina (the managing general agent if the MEWA is domiciled outside of North Carolina); and the location of and a description of the office facilities that will be provided by the MEWA in North Carolina.

(c) All forms may be obtained from the ~~Compliance Officer~~Department's website at http://www.ncdoi.com/lh/LH_MEWA.aspx. Every application ~~must~~shall contain a certification that any changes to the information required by G.S. 58-49-50 and this Rule shall be reported to the Commissioner.

(d) During the pendency of an application, the MEWA shall keep all required information, statements, documents, and materials ~~current and factual.~~current.

(e) An application for a license is not complete until the MEWA has satisfied the Commissioner that the MEWA is in compliance with all of the requirements of Article 49 of General Statute Chapter 58 and this Section. The Commissioner ~~is not required~~ shall not process ~~to process~~ an incomplete application.

(f) All financial information required by G.S. 58-49-50 and ~~this~~ the rules of this Section shall be prepared in accordance with statutory accounting principles.

(g) Any change in the information required by Article 49 of General Statute Chapter 58 or by this Section shall, unless otherwise specified in that Article or in this Section, be reported to the Commissioner within two business days after such change.

History Note: *Authority G.S. 58-2-40(1); 58-49-40; 58-49-50; 58-49-60;*
Eff. ~~July 1, 1992.~~ July 1, 1992;
Readopted Eff. November 1, 2017.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0203

DEADLINE FOR RECEIPT: Thursday, November 9, 2017

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In Item (1), line 8, please consider either inserting a period or a semicolon after "provider."

In the History Note, please change the Readopted Eff. date to December 1, 2017.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: October 26, 2017

11 NCAC 20 .0203 is readopted as published in 32:02 NCR 63 as follows:

11 NCAC 20 .0203 CHANGES REQUIRING APPROVAL

All material changes to an approved contract form shall be filed with the Division for approval before use. For the purpose of this ~~Section~~Rule, a "material change" includes a change ~~in the means of calculating payment to the provider (for example, change from fee for service to capitation), a change in the distribution of risk between parties, or a change in the delegation of clinical or administrative responsibilities.~~in:

(1) the means of calculating payment to the provider for example, change from fee for service to capitation;

(2) the distribution of risk between parties; or

(3) the delegation of clinical and administrative responsibilities.

History Note: *Authority G.S. 58-2-40(1);* ~~*58-50-50; 58-50-55;*~~ *58-65-25;* ~~*58-65-140;*~~ *58-67-10; 58-67-20; 58-67-35; 58-67-115; 58-67-120; 58-67-150;*
Eff. ~~*October 1, 1996.*~~ *October 1, 1996;*
Readopted Eff. November 1, 2017.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0301

DEADLINE FOR RECEIPT: Thursday, November 9, 2017

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In the Submission for Permanent Rule Form, Box 2, you inserted the name of the Section, not the Rule. Please fix this.

In the History Note of the Rule, please change the Readopted Eff. date to December 1, 2017.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: October 26, 2017

11 NCAC 20 .0301 is readopted as published in 32:02 NCR 64 as follows:

11 NCAC 20 .0301 PROVIDER AVAILABILITY STANDARDS

Each network plan carrier shall develop a methodology to determine the size and adequacy of the provider network necessary to serve the members. The methodology shall provide for the development of performance targets that shall address the following:

(1) The number and type of primary care physicians, specialty care providers, hospitals, and other provider facilities, as defined by the carrier.

(2) A method to determine when the addition of providers to the network will be necessary based on increases in the membership of the network plan carrier.

(3) A method for arranging or providing health care services outside of the service area when providers are not available in the area.

History Note: *Authority G.S. 58-2-40(1); ~~58-50-55(b);~~ 58-65-1; 58-65-25; ~~58-65-140;~~ 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;*
Eff. ~~October 1, 1996.~~ October 1, 1996;
Readopted Eff. November 1, 2017.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0302

DEADLINE FOR RECEIPT: Thursday, November 9, 2017

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

On line 4, "carrier" is defined in Rule .0101 of the Chapter as a network plan carrier. Is this the intended use of the term here?

On line 6, what written policies are you referring to? Do they set the performance targets? If so, state that.

In the History Note, please change the Readopted Eff. date to December 1, 2017.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: October 26, 2017

11 NCAC 20 .0302 is readopted as published in 32:02 NCR 64 as follows:

11 NCAC 20 .0302 PROVIDER ACCESSIBILITY STANDARDS

Each carrier shall establish performance targets for member accessibility to primary and specialty care physician services and ~~hospital based~~ hospital-based services. Carriers shall also establish similar performance targets for health care services provided by providers who are not physicians. Written policies and performance targets shall address the following:

(1) The ~~Proximity~~proximity of network ~~providers~~providers, as measured by such means as driving distance or time a member must travel to obtain primary care, ~~specialty care~~ specialty care, and hospital services, taking into account local variations in the supply of ~~providers~~providers, and geographic considerations.

(2) The availability to provide emergency services on a 24-hour, ~~seven~~7 day per week basis.

(3) Emergency provisions within and outside of the service area.

(4) The average or expected waiting time for urgent, routine, and specialist appointments.

History Note: *Authority G.S. 58-2-40(1); ~~58-50-55(b);~~ 58-65-1; 58-65-25; ~~58-65-140;~~ 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;*
Eff. ~~October 1, 1996.~~ October 1, 1996;
Readopted Eff. November 1, 2017.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0404

DEADLINE FOR RECEIPT: Thursday, November 9, 2017

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In Item (1), line 7, so that I am clear – the form contents are what is set forth in the rest of the Rule?

What authority are you relying upon for the sentence on lines 7 – 9? G.S. 58-3-230 gives clear authority for the first sentence on lines 5-7, but not the this one.

> (b) The Commissioner shall by rule adopt a uniform provider credentialing application form that will provide health benefit plans with the information necessary to adequately assess and verify the qualifications of an applicant. The Commissioner may update the uniform provider credentialing application form, as necessary. No insurer that provides a health benefit plan may require an applicant to submit information that is not required by the uniform provider credentialing application form.

On line 9, what is the carrier approving? The provider or the form?

On line 10, I take it "when applicable" is clear to the individuals using the form?

In Sub-Item (1)(l), what is "a statement of completeness and veracity"? Do you mean of the information required by the application?

On line 24, what is a "release of information"? A release?

What are the documents in Sub-Item (1)(m)? Does your regulated public know?

What is the purpose of Item (3)?

In the History Note, what is the purpose of the citation for G.S. 58-67-5?

Also in the History Note, please change the Readopted Eff. date to December 1, 2017.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: October 26, 2017

11 NCAC 20 .0404 is readopted as published in 32:02 NCR 64 as follows:

11 NCAC 20 .0404 APPLICATION

For all providers who submit applications to be added to a carrier's ~~network on or after October 1, 2001:~~network:

(1) The definitions in G.S. 58-3-167 are incorporated into this Rule by reference. Each carrier that is an insurer ~~and~~ that issues a health benefit plan shall obtain and retain on file each provider's signed and dated application on the form approved by the Commissioner under G.S. 58-3-230. All other carriers shall obtain and retain on file the provider's signed and dated application on a form provided by the carrier. All required information shall be current upon final approval by the carrier. The application shall include, when applicable:

(a) The provider's name, address, and telephone number.

(b) Practice information, including call coverage.

(c) Education, ~~training~~training, and work history.

(d) The current provider license, registration, or certification, and the names of other states where the applicant is or has been licensed, registered, or certified.

(e) Drug Enforcement Agency (DEA) registration number and prescribing restrictions.

(f) Specialty board or other certification.

(g) Professional and hospital affiliation.

(h) The amount of professional liability coverage and any malpractice history.

(i) Any disciplinary actions by medical organizations and regulatory agencies.

(j) Any felony or misdemeanor convictions.

(k) The type of affiliation ~~requested (for~~requested, for example, primary care, consulting specialists, ambulatory ~~care, etc.).~~care.

(l) A statement of completeness, veracity, and release of information, signed and dated by the applicant.

(m) Letters of reference or recommendation or letters of oversight from supervisors, or both.

(2) The carrier shall obtain and retain on file the following information regarding facility provider credentials, when applicable:

(a) The ~~Joint Commission on Accreditation of Healthcare Organization's~~ The Joint Commission's certification or certification from other accrediting agencies.

(b) State licensure.

(c) Medicare and Medicaid certification.

(d) Evidence of ~~current~~ active malpractice insurance.

(3) No credential item listed in Items (1) or (2) of this Rule shall be construed as a substantive threshold or criterion or as a standard for credentials that must be held by any provider in order to be a network provider.

History Note: *Authority G.S. 58-2-40(1); 58-2-131; 58-3-167; 58-3-230; 58-65-1; 58-65-25; 58-65-105; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150;*
Eff. October 1, 1996;
Temporary Amendment Eff. October 1, 2001;
Amended Eff. May 1, 2008; ~~August 1, 2002.~~ August 1, 2002;
Readopted Eff. November 1, 2017.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0410

DEADLINE FOR RECEIPT: Thursday, November 9, 2017

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

On line 4, how does the approval occur? And is the approval entirely within the discretion of the carrier?

On lines 6 and 7, how will the monitoring occur? Is there a requirement for frequency?

In Item (2), line 10, is "no less frequently" needed? Generally, terms like "at a minimum" and "at least" are not favored in rules, as rules set the minimum standard. Do you need to retain it here?

For Item (3), line 11, do you need to retain "at least"?

In the History Note, 58-50-55 was repealed by SL 1997-519. Please remove it.

In the History Note, what is the purpose of the citation for G.S. 58-67-5?

Also in the History Note, please change the Readopted Eff. date to December 1, 2017.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: October 26, 2017

11 NCAC 20 .0410 is readopted as published in 32:02 NCR 65 as follows:

11 NCAC 20 .0410 DELEGATION OF CREDENTIAL VERIFICATION ACTIVITIES

Whenever any carrier delegates credential verification activities to a contracting entity, whether an intermediary or subcontractor, the carrier shall review and approve the contracting entity's credential verification program before contracting and shall require that the entity comply with all applicable requirements in this Section. The carrier shall monitor the contracting entity's credential verification activities. The carrier shall implement oversight mechanisms, including:

(1) Reviewing the contracting entity's credential verification plans, policies, procedures, forms, and adherence to verification procedures.

(2) Requiring the contract entity to submit an updated list of providers no less frequently than quarterly.

(3) Conducting an evaluation of the contracting entity's credential verification program at least every three years.

History Note: *Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;*
Eff. October 1, 1996;
Readopted Eff. November 1, 2017.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 20 .0601

DEADLINE FOR RECEIPT: Thursday, November 9, 2017

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

In (a), line 5, and (b), line 14, keep "shall be submitted" and insert an "as" after "electronic format". Thus, state: "shall be submitted in electronic format as an application..." As currently written, these sentences are demanding that the requests themselves submit the application, and I doubt that is the intent here.

In current Paragraph (b), line 15, what is your authority to require review and approval, rather than just review? G.S. 58-67-10(d)(1) appears to govern this, and the statute states:

> (d)(1) A health maintenance organization shall file a notice describing any significant modification of the operation set out in the information required by subsection (c) of this section. Such notice shall be filed with the Commissioner prior to the modification. If the Commissioner does not disapprove within 90 days after the filing, such modification shall be deemed to be approved. Changes subject to the terms of this section include expansion of service area, changes in provider contract forms and group contract forms where the distribution of risk is significantly changed, and any other changes that the Commissioner describes in properly promulgated rules. Every HMO shall report to the Commissioner for his information material changes in the provider network, the addition or deletion of Medicare risk or Medicaid risk arrangements and the addition or deletion of employer groups that exceed ten percent (10%) of the health maintenance organization's book of business or such other information as the Commissioner may require. Such information shall be filed with the Commissioner within 15 days after implementation of the reported changes. Every HMO shall file with the Commissioner all subsequent changes in the information or forms that are required by this Article to be filed with the Commissioner.

It appears that the product line not a part of the provider network. So, are you relying upon the "properly promulgated rules" portion of the statute here to include these changes?

In (b)(2), line 21, is the cross-reference to Rule 11 NCAC 11C .0311 appropriate here? That rule governs HMO service area expansion and doesn't seem to require financial and actuarial information – the statute G.S. 58-67-10 requires documents. If you want the feasibility and market study, why not cite to Rule 11 NCAC 11C .0307, as the Rule does?

On line 17, what is an "IPA model"? Does your regulated public know?

In (c), line 26, what is an "intermediary"? Does your regulated public know?

Amanda J. Reeder
Commission Counsel
Date submitted to agency: October 26, 2017

In (f), lines 33-34, replace "which that HMO owns or control or manages" with "that the HMO owns, controls, or manages…"

In the History Note, please change the Readopted Eff. date to December 1, 2017.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: October 26, 2017

11 NCAC 20 .0601 is readopted as published in 32.02 NCR 65 as follows:

11 NCAC 20 .0601 APPLICATIONS FOR MODIFICATIONS TO SERVICE AREAS OR PRODUCT LINES

(a) All requests to expand an HMO's service area shall ~~be submitted~~ submit in ~~writing as~~ electronic format an application to the Division for review and approval. ~~An HMO shall submit an original and eight copies of the~~ The application, ~~which~~ shall include the following information:

(1) A description of operational changes that will result from the expansion.

(2) Financial and actuarial information as required by 11 NCAC 11C .0311 and 11 NCAC 16 .0605.

(3) A description of provider interest and network development in the service area requested and information as to the HMO's existing provider network.

(4) Copies of any form contracts to be made as a result of the expansion, including providers and subcontractors.

(b) Material changes in the product lines offered by an HMO shall ~~be submitted~~ submit in ~~writing as~~ electronic format an application to the Division for review and approval. For the purposes of this Section, ~~material changes~~"material changes" include the addition of a point of service ~~product;~~product, or the addition of or changes to the HMO's existing health care delivery model, such as the addition of an IPA product or group model product or the addition of a gatekeeper product. ~~HMOs shall submit an original and eight copies of the~~ The ~~application,~~ application ~~which~~ shall include the following information:

(1) A description of operational changes that will result from the expansion.

(2) Financial and actuarial information as required by 11 NCAC 11C .0311 and 11 NCAC 16 .0605.

(3) A description of provider interest and network development in the service area requested and information as to the HMO's existing provider network.

(4) Copies of form contracts to be made as a result of the expansion, including providers and subcontractors.

(c) Notice of the addition of an intermediary shall be submitted by an HMO in writing to the Division within 30 days after the execution of the contract for the intermediary's services.

(d) Notice of the deletion of an intermediary shall be submitted by the HMO in writing within 30 days after termination of the contract, unless termination is immediate, along with a plan to select another intermediary or for the HMO to perform the ~~once~~formerly delegated functions in-house.

(e) All changes to provider and intermediary contract forms shall be submitted to the Division for review and approval in accordance with ~~11 NCAC 20~~ Rule .0203 of this Chapter prior to the use of the amended form.

(f) Each HMO shall submit written notice to the Division of its intent to engage in any arrangement through which that HMO owns or controls or manages any operations of another HMO in any other state, before entering into the arrangement.

History Note: *Authority G.S. 58-2-40; 58-67-10; 58-67-150;*

Eff. ~~October 1, 1996.~~ October 1, 1996;

Readopted Eff. November 1, 2017.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Department of Insurance

RULE CITATION: 11 NCAC 21 .0106

DEADLINE FOR RECEIPT: Thursday, November 9, 2017

The Rules Review Commission staff has completed its review of this Rule prior to the Commission's next meeting. The Commission has not yet reviewed this Rule and therefore there has not been a determination as to whether the Rule will be approved. You may call our office to inquire concerning the staff recommendation.

In reviewing this Rule, the staff recommends the following technical changes be made:

Since "TPA" is defined by G.S. 58-56-4 as a Third Party Administrator, I take it your regulated public understands what this means in this Rule?

What is your authority to require the TPA to send this report to claimants? G.S. 58-3-100(c) requires this from an insurer, but not TPAs. I don't read G.S. 58-56-31 to require this of TPAs. Is there another statute, or is the nature of TPAs such that they should be included as insurers?

In the History Note, please change the Readopted Eff. date to December 1, 2017.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: October 26, 2017

11 NCAC 21 .0106 is readopted as published in 32:02 NCR 65 as follows:

11 NCAC 21 .0106 PAYMENT OF CLAIMS

If claims filed with a TPA or insurer are not paid within 30 days after receipt of the initial claim by the TPA or the insurer, the TPA or the insurer shall at that time mail a claim status report to the claimant.

History Note: *Authority G.S. 58-2-40; 58-3-100; 58-56-31;*
Eff. ~~June 1, 1996.~~ June 1, 1996;
Readopted Eff. November 1, 2017.