

TITLE 110: NORTHERN MARIANA ISLANDS RETIREMENT FUND

SUBCHAPTER 110-30.1 GROUP HEALTH INSURANCE PROGRAM RULES AND REGULATIONS

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Subchapter Authority: 1 CMC § 8424.

Subchapter History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 29 Com. Reg. 26692 (Aug. 17, 2007); Amdts Proposed 29 Com. Reg. 26657 (July 18, 2007); Amdts Adopted 28

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Com. Reg. 26304 (Oct. 30, 2006); Amdts Proposed 28 Com. Reg. 26029 (Aug. 24, 2006); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Proposed 28 Com. Reg. 25589 (Apr. 17, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Emergency and Proposed 25 Com. Reg. 20083 (Apr. 30, 2003) (effective for 120 days from Apr. 23, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 21 Com. Reg. 16995 (Nov. 15, 1999); Amdts Proposed 21 Com. Reg. 16883 (Aug. 23, 1999); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997); Adopted 19 Com. Reg. 15387 (May 15, 1997); Proposed 19 Com. Reg. 15106 (Feb. 15, 1997); Emergency 18 Com. Reg. 14326 (Sept. 15, 1996) (effective for 120 days from Sept. 9, 1996).

Commission Comment: PL 1-43 (effective Jan. 19, 1980), formerly codified at 1 CMC §§ 8301, et seq., originally created the Northern Mariana Islands Retirement Fund. PL 6-17 (effective May 7, 1989), the “Northern Mariana Islands Retirement Fund Act of 1988,” codified as amended at 1 CMC §§ 8301-8394, repealed and reenacted PL 1-43, as amended. See PL 6-17, ch. 1 § 8312; see also the commission comment to 1 CMC § 8301. PL 13-60 (effective Dec. 5, 2003), the “Retirement Integrity Assurance Act,” amended numerous provisions of the 1988 NMI Retirement Fund Act.

1 CMC § 8312 creates the Northern Mariana Islands Retirement Fund (NMIRF) as an autonomous agency and public corporation of the government of the Commonwealth of the Northern Mariana Islands. NMIRF, through a Board of Trustees, is empowered to establish, maintain and operate a retirement fund program for the public employees of the Commonwealth. 1 CMC § 8315(a). 1 CMC § 8315(g) (renumbered by PL 13-60) authorizes NMIRF to adopt rules and regulations as necessary for the exercise of the funds powers, performance of its duties and administration of its operations.

The group life and health insurance programs were originally administered by the Personnel Office. Executive Order 94-3 § 307(c) (effective Aug. 23, 1994) transferred the administration of the programs to the Department of Finance. See Executive Order 94-3, reprinted in the commission comment to 1 CMC § 2001; see also PL 10-19 § 1, reprinted in the commission comment to 1 CMC § 8421. PL 10-19 (effective June 21, 1996), codified at 1 CMC §§ 8421-8427, transferred the administration of the government life and health insurance programs to the NMIRF. See 1 CMC § 8421.

In 1995, the Department of Finance adopted Group Health Insurance Program (GHIP) Regulations pursuant to Executive Order 94-3 § 307(c). The history of the 1995 DOF regulations is as follows: Adopted 17 Com. Reg. 12721 (Jan. 15, 1995); Proposed 16 Com. Reg. 12663 (Dec. 15, 1994).

NMIRF first promulgated Group Health and Life Insurance Program Rules and Regulations in May 1997. In October 1997, NMIRF repealed the Group Health Insurance Program provisions of the May 1997 regulations and promulgated new rules and regulations governing the Group Health Insurance Program with extensive revisions. See § 110-30.1-001 of this subchapter and the commission comment thereto.

The 2002 Group Health Insurance Program Rules and Regulations, codified in this subchapter, readopted and republished the GHIP regulations in their entirety with extensive amendments. The 2003 amendments again re-promulgated the Group Health Insurance Program Rules and Regulations in their entirety. The 2012 amendments repealed and re-promulgated the subchapter in its entirety. The history sections in this subchapter date from the October 1997 regulations.

The Commission corrected the spelling of “dependent” throughout this subchapter.

Part 001 - General Provisions

§ 110-30.1-001 Introduction

The government of the Commonwealth of the Northern Mariana Islands provides its eligible

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employees, retirees and their eligible family members with an optional group health insurance program is to provide financial assistance to enrollees to help them pay for necessary health care. Public Law 10-19 [1 CMC §§ 8421-8427] transferred the administrative functions of the program, existing inventory and staff to the NMI Retirement Fund effective June 21, 1996. The GHLIP group health insurance plan group policy of insurance, as negotiated from year to year and these rules and regulations set forth the terms and conditions of this benefit.

Modified, 1 CMC § 3806(d), (f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The original paragraphs were not designated. The Commission designated subsections (a) through (e).

The 2002 amendments amended subsections (c) and (e). In subsection (c), the October 1997 regulations provided:

“These rules and regulations govern the program and repeal parts I, II, III, IV, V, VI, VIII and IX of the rules and regulations published in the Commonwealth Register, volume 19, number 2, on February 15, 1997, and adopted by the notice and certification of adoption appearing in the Commonwealth Register, volume 19, number 5, on May 15, 1997.”

See 19 Com. Reg. at 15576 (Aug. 15, 1997).

The 2002 amendments changed subsection (c) so that it repealed part VII of the May 1997 amendments instead of part VIII. This change was probably in error, because part VII governed the Group Life Insurance Program, which remained in effect after the October 1997 Group Health Insurance Program amendments. Part VIII, entitled Group Health Insurance Program Description,” has been effectively repealed by the promulgation of the 1997 and 2002 Group Health Insurance Program Regulation amendments. See 19 Com. Reg. at 15117 (Feb. 15, 1997). The error is significant, as it repeals the only provision promulgated regarding the Group Life Insurance Program administered by NMIRF.

The 2003 amendments amended subsection (d). The 2003 amendments re-promulgated the Group Health Insurance Program Rules and Regulations in their entirety. The Commission, therefore, cites the 2003 amendments in the history sections throughout this subchapter. The 2012 amendments completely re-wrote this section.

§ 110-30.1-005 Definitions

(a) “Act” means Public Law 10-19 [1 CMC 8241-8427], an Act to Transfer the Administration of the Government Health Insurance Programs to the Northern Mariana Islands Retirement Fund, which was enacted into law effective June 21, 1996, and all subsequent amendment.

(b) “Administrator” means the Administrator of the NMI Retirement fund or his or her designee. Where the fund has contracted with a private insurance company to provide benefits under the plan, the term Administrator may, at times, refer to the private insurance company.

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- (c) “Application/Change Form” means the form prescribed by the Administrator and required to be submitted to the Administrator by any person wishing to enroll himself or herself and/or his or her dependents in the program.
- (d) “Board” means the Board of Trustees of the NMI Retirement Fund.
- (e) “Child” means a subscriber’s:
- (1) Natural child;
 - (2) Legally adopted child or child placed for adoption;
 - (3) Stepchild living with the subscriber in a normal parent/child relationship; and
 - (4) Any individual that a court of competent jurisdiction has ordered that the subscriber provide health insurance coverage for, as their child.
- (f) “Contribution” means the share of the premium required to be paid by the government or the subscriber.
- (g) “Co-payment” means the specified portion or percentage of the cost of covered benefits that an enrollee must pay to the provider of services.
- (h) “Covered benefits” means the health care services covered under the program.
- (i) “Dependent” means a subscriber’s:
- (1) Spouse or domestic partner;
 - (2) Eligible child(ren); and
 - (3) Ward, over whom a subscriber has been made legal guardian by a court of competent jurisdiction.
- (j) “Domestic partner” means a subscriber’s current partner where the subscriber and the partner satisfy all of the following:
- (1) Both are at least eighteen years of age and are mentally competent;
 - (2) They have cohabitated for two years or more years;
 - (3) They share the same regular and permanent residence, with the current intent to continue to do so indefinitely;
 - (4) They share a close personal and intimate relationship and are not related by blood closer than would bar marriage in the place where they legally reside;
 - (5) They assume responsibility for each other’s welfare and financial well-being; and
 - (6) Neither is legally married to another.
- (k) “Effective date” means the date on which a person is accepted as a subscriber, as established and recorded by the Administrator, and is the date on which such subscriber is first eligible for benefits under this program.
- (l) “Eligible child” means a subscriber’s child who:
- (1) Is under 26 years of age; or
 - (2) Is permanently disabled, as defined in these regulations.

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(m)(1) “Employee” means a person who is receiving salary or wages from the government and who is:

(i) Employed by the government and regularly scheduled to work 20 or more hours per week; or

(ii) An elected or appointed government official.

(2) However, as to any period, the term employee will not include any individual who, during such period, is classified or treated by the government as an independent contractor, a consultant, a leased employee, or an employee of an employment agency or any entity other than the government, even if such individual is subsequently determined to have a common law employee of the government during such period. This definition also excludes any individual who serves on a government board or commission, but is not otherwise a government employee, and any individual employed by the government in violation of applicable law. Nothing in this definition will be construed to affect retirees who are authorized by law to draw their retirement benefits while working for the government in a non-employee classification.

(n) “Enrollee” means any eligible employee, retiree, survivor, or dependent whose enrollment in the program has been approved by the Administrator and for whom all premium payments are current, unless failure to make premium payments was no fault of the subscriber.

(o) “Enrollment change form” means the Application/Change Form prescribed by the Administrator and required to be submitted to the Administrator by any person wishing to change his or her benefit or enrollment option or to add or delete coverage of dependents.

(p) “Fiscal year” means any October 1 through the following September 30.

(q) “Fund” means the Northern Mariana Islands Retirement Fund.

(r) “GHLI trust fund” means the CNMI government group health and life insurance trust fund. The GHLI trust fund shall be segregated from other funds and held in trust and administered by the Administrator under the fiduciary supervision of the Board.

(s) “GHLI” means the CNMI government group health and life insurance program.

(t) “Government” means the CNMI government, its departments, agencies, instrumentalities, public corporations, municipal governments, and other CNMI government entities and autonomous agencies.

(u) “Non-participating or non-preferred provider” means a provider of services who, when rendering a service covered by the plan to an enrollee, does not have an agreement with the plan to charge only a specified amount.

(v) “Open season or open enrollment” means that period of time, designated by the Administrator, during which employees may apply for enrollment in the program for themselves and their dependents and during which subscribers may apply to change their benefit and enrollment options in the program.

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- (w) “Participating or preferred provider” means a provider of services who, when rendering a service covered by this plan to an enrollee, agrees with the plan to collect not more than a specified amount.
- (x) “Permanently disabled” with respect to a subscriber’s dependent means the dependent is:
- (1) Incapable of self support because of a mental or physical handicap; and
 - (2) Reliant upon the subscriber for financial support and maintenance.
- (y) “Plan” means the CNMI Government’s Group Health Insurance Program group health insurance policy. This term may be used interchangeably with the term program.
- (z) “Plan document” means the CNMI Group Health Insurance Program group health insurance policy and any supplements or riders providing any changes to coverage.
- (aa) “Plan year” means the fiscal year (October 1 through September 30). For a new enrollee, the plan year begins when such enrollee’s coverage begins and continues through the following September 30.
- (bb) “Premium” means the total amount of contributions required to be paid into the GHLI trust fund for participation of an enrollee in the program.
- (cc) “Program” means the CNMI Government’s Group Health Insurance Program group health insurance policy. This term may be used interchangeably with the term plan.
- (dd) “Retiree” means a former employee who is receiving annuity payments through the Northern Mariana Islands Retirement Fund as a result of service, age or disability. The term “retiree” does not include a spouse or former spouse or domestic partner of a retiree receiving an annuity as a result of a domestic relations court order or any other individual receiving an annuity as a consequence of a relationship with a retiree.
- (ee) “Spouse” means an employee’s or retiree’s current legal husband or wife from whom the employee or retiree is not legally separated.
- (ff) “Subscriber” means any employee or retiree who is enrolled in the program and in whose name the enrollment is registered.
- (gg) “Survivor” means the spouse or domestic partner of a deceased employee or retiree who is receiving a survivor annuity benefit under the laws governing the NMI Retirement Fund (which requires that they have not remarried).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Proposed 28 Com. Reg. 25589 (Apr. 17, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

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Commission Comment: The original regulation contained no subsection (f). The Commission corrected the designation of subsections pursuant to 1 CMC § 3806(a). The original paragraphs of subsection (m) were undesignated. The Commission designated them as subsections (m)(1) and (m)(2). The Commission corrected the capitalization of the words “domestic partner,” “subscriber,” “dependent,” “employee,” “retiree,” and “spouse” throughout the section pursuant to 1 CMC § 3806(f). The Commission struck the figures “18” from subsection (j)(1) and “2” from subsection (j)(2) pursuant to 1 CMC § 3806(e).

Part 100 - Eligibility

§ 110-30.1-101 Employees Generally

All employees are eligible to apply to enroll themselves and their dependents in the program.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

§ 110-30.1-105 Retiring Employees

(a) Upon retiring from government service, employees who are subscribers shall be provided with an option, to be exercised within six months of the date of retirement, to continue their Commonwealth government health insurance coverage under the same group terms and conditions as that government coverage, if any, offered each fiscal year to Commonwealth government employees. Any employee who is a subscriber at the time of retirement who declines to exercise their option to continue health insurance within six months of the date of their retirement, or who exercises the option and subsequently cancels their health insurance coverage more than six months after the date of retirement, shall not be entitled to reapply for coverage thereafter.

(b) Employees who are not subscribers at the time of their retiring from government service shall not be allowed to apply for Commonwealth government health insurance coverage at that time or at any time subsequent to their retirement.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The original paragraphs in this section were undesignated. The Commission designated them as subsections (a) and (b) pursuant to 1 CMC § 3806(a). The Commission corrected the capitalization of the words “employee” and “subscriber” pursuant to 1 CMC § 3806(f). The pre-2012 version of this section was entitled “Dependent Children.”

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§ 110-30.1-110 Dependents of a Subscriber Who Are Otherwise Eligible On Their Own Account

If a subscriber should terminate coverage for a dependent and that dependent would otherwise have been eligible to have been enrolled on their own account (either as an active employee or upon their own retiree) had they not already been an enrollee, the dependent may enroll on their own account, provided they do so within thirty days of their coverage being terminated. This section shall apply in the event of a divorce resulting in the loss of coverage as a dependent, when the dependent otherwise was eligible to enroll on their own account.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was entitled “Notice of Enrollment Rights.” The Commission corrected the capitalization of the words “subscriber,” “dependent,” and “enrollee” pursuant to 1 CMC § 3806(f). The Commission struck the figure “30” pursuant to 1 CMC § 3806(e).

§ 110-30.1-115 Enrollment of Newly Acquired Dependents

Within thirty days of a subscriber acquiring a new dependent as a result of marriage, newly formed domestic partnership, birth, adoption or placement for adoption, newly acquired stepchild, or appointment by a court of the subscriber as legal guardian or order by the court that a subscriber provide health insurance for another as their child, the subscriber may submit an Enrollment Change Form seeking to add the dependent outside of an open season. If such form is submitted more than thirty days after the new dependent is acquired, the enrollment shall be denied and the subscriber may then only add the dependent during an open season.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 29 Com. Reg. 26692 (Aug. 17, 2007); Amdts Proposed 29 Com. Reg. 26657 (July 18, 2007); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Proposed 28 Com. Reg. 25589 (Apr. 17, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The Commission corrected the capitalization of the words “subscriber,” “dependent,” “domestic partnership,” and “open season” pursuant to 1 CMC § 3806(f). The Commission struck the figure “30” pursuant to 1 CMC § 3806(e). The pre-2012 version of this section was entitled “Retiring Employees.”

§ 110-30.1-120 Spouse and Domestic Partner’s Right to Enroll Upon Death of Employee or Retiree

A spouse or domestic partner who was an enrollee on the date of the death of their spouse employee or retiree subscriber, is eligible to enroll in the program for himself or herself and the

deceased subscriber's dependents within 30 days of the death of spouse and to remain enrolled, if, and only for as long as, they continue to qualify for and receive a survivor's benefit from the NMI Retirement Fund. The survivor may not enroll his or her own dependents that are not also the dependents of the deceased spouse.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 29 Com. Reg. 26692 (Aug. 17, 2007); Amdts Proposed 29 Com. Reg. 26657 (July 18, 2007); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The Commission corrected the capitalization of the words "spouse," "domestic partner," "enrollee," "employee," "retiree," "subscriber," "dependents," and "survivor" pursuant to 1 CMC § 3806(f). The pre-2012 version of this section was entitled "Retirees and Their Dependents in Prior Program."

§ 110-30.1-125 Proof of Eligibility

The Administrator may require such documentation as he or she deems necessary to verify the eligibility of any person. If satisfactory documentation is received by the deadline specified by the Administrator, the person will be considered eligible as of the date determined by the Administrator. If satisfactory documentation is not received by the deadline specified by the Administrator, the person will not be considered eligible and will not be able to be enrolled until re-application at the next Open Season.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The Commission corrected the capitalization of the words "open season" pursuant to 1 CMC § 3806(f). The pre-2012 version of this section was entitled "Retirees Not Enrolled in Government Plan."

§ 110-30.1-130 Documentation Required for Permanently Disabled Dependent Enrollment

(a) When a subscriber includes a permanently disabled dependent on their Application/Change Form, the subscriber shall also provide the following documentation:

- (1) A physician's certification that the dependent has a mental or physical handicap that prevents them from being able to self-support; and
- (2) Proof that the dependent is reliant upon the subscriber for financial support and maintenance, including copies of tax returns in which the subscriber claims the dependent and an affidavit of the subscriber attesting to such dependency.

(b) In the case of a permanently disabled child, the above listed documents must be provided

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to the Administrator within 30 days after the permanently disabled child attains age 26 in order for coverage to continue.

(c) The Administrator may request a subscriber re-certify a dependent's permanent disability, but not more frequently than annually. The Administrator may terminate the coverage of a permanently disabled dependent for failure of the Subscriber to provide the required documents within a reasonable time.

(d) The subscriber shall have an affirmative duty to inform the Administrator of any change of status that would disqualify a permanently disabled dependent from continued coverage including: the end of financial dependence on the subscriber, or the end of mental or physical handicap that prevents the dependent from being able to self-support.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The paragraphs in the original regulation were undesignated. The Commission designated them as subsections (a) through (d) pursuant to 1 CMC § 3806(a). The Commission corrected the capitalization of the words "subscriber" and "dependent" pursuant to 1 CMC § 3806(f). The pre-2012 version of this section was entitled "Spouse Enrolled in this Program on Death of Retiree."

§ 110-30.1-135 Documentation Required for Spouse or Domestic Partner Enrollment

When a subscriber includes a spouse or domestic partner on their Application Form or on an Enrollment Change Form, the subscriber shall also provide the following documentation:

(a) For a spouse - a marriage certificate; or

(b) For a domestic partner - an Affidavit of Domestic Partnership executed by both domestic partners before a Fund employee or an official notary. Such Affidavit shall certify satisfaction of all the requirements contained in the definition of domestic partner.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The Commission corrected the capitalization of the words "subscriber," "spouse," and "domestic partner" pursuant to 1 CMC § 3806(f). The pre-2012 version of this section was entitled "Survivors and Dependents in Prior Program." Former sections 110-30.1-140 through 110-30.1-170 were repealed in 2012.

Part 200 - Enrollment

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§ 110-30.1-201 Enrollment Categories

(a) The available enrollment categories are:

- (1) Single, refers to the subscriber only. Only one enrollee may be covered under this category of the plan;
- (2) Couple, refers to a subscriber and one dependent. The dependent may be a spouse, domestic partner or eligible child, but a maximum of two total enrollees (including the subscriber) may be covered under this category of the plan.
- (3) Family, refers to a subscriber with two or more dependents. The dependents may be a spouse, or domestic partner and eligible children or the dependents may all be eligible children. There is no limit to the number of enrollees that may be covered under this category of the plan, provided all enrollees are eligible.

(b) Categories in chart form:

Single	Employee only	1 total enrollee
Couple	Employee + Spouse or Employee + Domestic Partner or Employee + Eligible Child	2 total enrollees
Family, Not Including a Domestic Partner	Employee + Spouse + 1 or more Eligible Children or Employee + 2 or more Eligible Children	No limit to the number of enrollees
Family, Including a Domestic Partner	Employee + Domestic Partner + 1 or more Eligible Children	No limit to the number of enrollees

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Proposed 28 Com. Reg. 25589 (Apr. 17, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was entitled “Enrollment Options and Categories.” The 2012 amendments changed the numbering scheme of Part 200.

§ 110-30.1-205 Enrollment Process

A person wishing to enroll himself or herself and/or his or her dependents in the program must file an application form with the Administrator, specifying the enrollment category they desire

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and listing the dependents for which they seek coverage. A subscriber wishing to change his or her enrollment or that of his or her dependents must file an Enrollment Change Form with the Administrator. Both forms are available at the GHLIP office and any other office designated by the Administrator.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

§ 110-30.1-210 New Employee Enrollment Period and Effective Date of Coverage

A new employee may apply, for himself or herself and his or her dependents, to enroll in the program within 30 days after his or her date of hire. Enrollment will be effective as of the first day of the pay period following approval of the application.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

§ 110-30.1-215 Other Employee Enrollment Period and Effective Date of Coverage

(a) Employees, who are not new employees, may only apply to enroll themselves or their dependents (other than newly acquired dependents) during an open season. If an employee applies to enroll during an open season, such enrollment will be effective as of the date specified by the Administrator.

(b) By submitting an Enrollment Change Form, a subscriber may enroll a newly acquired dependent within thirty days of acquiring the new dependent as a result of marriage, newly formed domestic partnership, birth, adoption or placement for adoption, newly acquired stepchild, or appointment by a court of the subscriber as legal guardian or order by the court that a subscriber provide health insurance for another as their child. If such form is submitted more than thirty days after the new dependent is acquired, the enrollment shall be denied and the subscriber may then only add the dependent during an open season.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

Commission Comment: The paragraphs of this section were undesignated in the original regulation. The Commission designated them as subsections (a) and (b). The Commission struck the figure “30” in subsection (b) pursuant to 1 CMC § 3806(e).

§ 110-30.1-220 Survivors’ Enrollment Period After Death of Employee or Retiree

(a) A spouse or domestic partner who was an enrollee on the date of the death of their spouse employee or retiree subscriber may enroll for himself or herself and the deceased subscriber’s

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dependents, within 30 days of the death of spouse*. The survivor may remain enrolled, only for as long as they continue to qualify for and receive a survivor's benefit from the NMI Retirement Fund. The survivor may not enroll his or her own dependents that are not also the dependents of the deceased spouse.

(b) Survivor enrollment will be effective from the first date covered by the survivor's benefit, or from the date of application, whichever is later. A survivor may apply to enroll any newly acquired dependent only if such dependent is a child of the deceased spouse subscriber.

* So in original.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

Commission Comment: The paragraphs of this section were undesignated in the original regulation. The Commission designated them as subsections (a) and (b). The Commission inserted an apostrophe in the section title pursuant to 1 CMC § 3806(g).

§ 110-30.1-225 Special Enrollment under Qualified Medical Child Support Orders

A child identified in a qualified medical child support order as an eligible dependent will be accepted upon submission of a certified copy of the court order, without regard to any enrollment season restrictions.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

§ 110-30.1-230 Medicare Part A/Mandatory Enrollment

It is a condition of enrollment in the program that if any enrollee is eligible for Medicare Part A at no cost, such enrollee must enroll in Medicare Part A.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

§ 110-30.1-235 Election to Terminate/Form for Retirees and Survivors

Any retiree or survivor wishing to terminate his or her enrollment may do so by signing a form prescribed by the Administrator acknowledging that he or she understands that termination of their enrollment will preclude them from re-enrolling at a later date, unless they become eligible as the dependent of another.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

§ 110-30.1-240 Identification Cards

The Administrator, or private insurance carrier holding the policy may provide each enrollee with an identification card.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

§ 110-30.1-245 Retroactive Enrollments and Termination

Retroactive enrollments and terminations are not allowed unless specifically provided for in the policy.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

§ 110-30.1-250 Approval of Enrollment or Enrollment Change

Nonwithstanding any other provision to the contrary, no enrollment or enrollment change will become effective without the approval of the Administrator. If the Administrator has not acted on an application form or enrollment change within 30 days of its receipt, the application for enrollment or enrollment change shall be deemed denied.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

§ 110-30.1-255 No Guarantee of Enrollment

Employment by or retirement from the government does not guarantee enrollment or continued enrollment.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

§ 110-30.1-260 Enrollment Denied

The Administrator may deny an application for enrollment because the applicant is ineligible, has filed fraudulent documents or for any other reason the Administrator deems in the best interest of the program.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

Part 300 - Benefits

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§ 110-30.1-301 Benefits Coverage

Benefits coverage shall be pursuant to the terms of the GHLIP group health insurance policy as it is negotiated from year to year.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was entitled “Basics.”

§ 110-30.1-305 Summary Chart (Table) on Changing Enrollment/Benefits

The following table summarizes some basic rules for changing enrollment options:

Events which prompt enrollment or change in enrollment	From not enrolled to enrolled	From single to couple	From single to family	From family to single	From family to couple	Time during which an application must be filed with the Administrator
Open season	Yes	Yes	Yes	Yes	Yes	Time of Open Season is specified by the Administrator each year.
Acquisition of spouse, domestic partner, child or other dependent	No	Yes	Yes	No	No	Within 30 days of acquisition of new dependent
Divorce, legal separation, annulment, end of domestic partnership, death of a spouse or child, a child’s loss of dependent status	No	No	No	Yes	Yes	Anytime
Change in status from spouse to survivor of retiree or employee	Yes	Yes	Yes	Yes	Yes	Within 30 days of the date of death of employee or retiree

Modified 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Proposed 28 Com. Reg. 25589 (Apr. 17, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was entitled “Chart.”

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§ 110-30.1-310 Additional Rules for Changing Enrollment Categories (Adding or Deleting Dependents)

In addition to the rules outlined elsewhere, the following rules also apply to changing enrollment categories:

- (a) A subscriber may cancel his or her enrollment and/or that of any of his or her dependents at any time;
- (b) A subscriber may change between high and low coverage levels only during open season;
- (c) Changes to enrollment categories made pursuant to a change in family status must be consistent with such change in status, and the enrollee must provide any documentation required by the Administrator to substantiate such change in status;
- (d) If a subscriber changes enrollment categories, the new benefits will apply only to services received after the change is effective;
- (e) The effective date of any change in enrollment will be the first day of the government's next pay period for an employee subscriber or, for retiree and survivor subscribers, the first day of the next benefit pay period, unless the change is made during an open season, in which case the change will be effective as the date specified by the Administrator.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The Commission inserted an apostrophe in the word "government's" in subsection (d) pursuant to 1 CMC § 3806(g). The pre-2012 version of this section was entitled "Inpatient Hospital Room and Board Benefits."

§ 110-30.1-315 Enrollment Change Form

To change enrollment categories, the subscriber must file an Enrollment Change Form with the Administrator.

Modified 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Proposed 28 Com. Reg. 25589 (Apr. 17, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15,

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1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was entitled “Other Benefits.”

§ 110-30.1-320 Administrator Approval Required

No change in enrollment category will be effective without the approval of the Administrator. If the Administrator has not acted upon an application for change in enrollment category within thirty days of its receipt, the application shall be deemed denied.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011).

Part 400 - Coinsurance and Co-payments

§ 110-30.1-401 Required Coinsurance and Co-payments

The required coinsurance and co-payments shall be pursuant to the terms of the GHLIP group health insurance policy as it is negotiated from year to year.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was titled “Office Visit.” Former sections 110-30.1-405 through 110-30.1-430 were repealed in 2012.

Part 500 - Limitations and Exclusions

§ 110-30.1-501 Limitations and Exclusions of Coverage

The limitations and exclusions of coverage shall be pursuant to the terms of the GHLIP group health insurance policy as it is negotiated from year to year.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Proposed 28 Com. Reg. 25589 (Apr. 17, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was titled “Inpatient Limitations.”

§ 110-30.1-505 Workers’ Compensation; Employer Liability Law

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(a) The plan will not pay benefits for any services when the enrollee is entitled to receive payment of medical expenses, disability benefits or compensation for injury or illness (or forfeits his rights thereto) under any workers' compensation or employers liability law. The enrollee has the affirmative duty to inform the Administrator if they are seeking workers' compensation benefits.

(b) In the event the Enrollee formally appeals the denial of a claim for workers' compensation, the enrollee shall notify the Administrator of such appeal. The plan will then provide benefits under this plan, but such benefits shall be considered an advance or loan to the enrollee. If the claim is declared eligible for benefits under workers' compensation or employers liability law or if the enrollee reaches a compromise settlement of the workers' compensation claim, the enrollee agrees to repay the advance or loan the plan has the right of subrogation*.

* So in original.

Modified 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Proposed 28 Com. Reg. 25589 (Apr. 17, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The paragraphs of this section were undesignated in the original regulation. The Commission designated them as subsections (a) and (b) pursuant to 1 CMC § 3806(a). The Commission inserted an apostrophe after the word "workers" in the section title pursuant to 1 CMC § 3806(g). The pre-2012 version of this section was titled "Physical Exam Limitation."

§ 110-30.1-510 Services Provided Without Charge

The plan will not pay benefits for any services:

(a) When services for an injury or illness are provided without charge to the enrollee by any federal, state, territorial, municipal, or other government instrumentality or agency, or

(b) When services for an injury or illness would have been provided without charge or collection but for the fact that the person is an enrollee under this plan.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

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Commission Comment: The pre-2012 version of this section was titled “Physical and Occupational Therapy and Chiropractic Limitations.”

§ 110-30.1-515 False Statements and Misrepresentations

The plan will not pay any benefits, to the extent that such benefits are payable, by reason of any false statement or other misrepresentation made in an application for membership or in any claims for benefits. If the plan pays such benefits before learning of any false statement, the subscriber agrees to reimburse the plan for such payment.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was titled “Surface Ambulance Limitation.”

§ 110-30.1-520 Provider, Enrollee Negligence

The plan is not an insurer against nor liable for the negligence or other wrongful act or omission of any provider, providers* employee, or other person or for any act or omission of any enrollee.

* So in original.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was titled “Home Health Limitation.”

§ 110-30.1-525 Availability and Quality of Providers Not Guaranteed

The plan does not guarantee the availability or quality of any medical service provider, including preferred providers.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Proposed 28 Com. Reg. 25589 (Apr. 17, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

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Commission Comment: The pre-2012 version of this section was titled “Mental Health/Substance Abuse Limitations.”

§ 110-30.1-530 Acts of War

The plan will not pay benefits for services required in the treatment of an injury or illness that results from an act of war or armed aggression, whether or not a state of war legally exists, or that occurs during a period of active duty of any armed force of any state or nation.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Proposed 28 Com. Reg. 25589 (Apr. 17, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was entitled “Sleep Disorder Limitations.” Former sections 110-30.1-535 through 110-30.1-550 were repealed in 2012.

Part 600 - Premiums

§ 110-30.1-601 Premiums

The premiums charged for each enrollment category shall be pursuant to the terms of the GHLIP group health insurance policy as it is negotiated from year to year.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of Part 600 was titled “Exclusions.” The pre-2012 version of this section was entitled “Introduction.”

§ 110-30.1-605 Subscriber Contributions

The subscriber or survivor shall be responsible for one half of the premium for the subscriber’s or survivor’s enrollment category. All employee, retiree, and survivor contributions shall be made through deductions from the employee’s paycheck or retiree’s or survivor’s benefit check as the case may be. An employee on leave without pay shall pay 100% of the premium to the GHLI trust fund in advance of the due date of such premiums. If a retiree’s or survivor’s benefit is insufficient to cover one half of the premium, the retiree or survivor shall pay the amount by which their benefit is short from covering the premium, to the GHLI trust fund in advance of the due date of such premiums.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com.

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Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was titled “Workers’ Compensation; Employer Liability Law.”

§ 110-30.1-610 Government/Fund Contributions

The government shall be responsible for one half of the premium for their employees’ enrollment categories. The government shall not pay a contribution toward health insurance of its employees other than towards the GHLIP coverage. The NMI Retirement Fund shall be responsible for one half of the premium for the retirees’ and survivors’ enrollment categories.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was entitled “Service Provided without Charge.”

§ 110-30.1-615 Payment; When Made

(a) Within five working days following the close of each pay period, each autonomous agency, public corporation and other government entity that processes its own payroll, shall remit to the GHLI trust fund the total premiums due for its employees, including contributions deducted from employees’ paychecks. Also within five working days following the close of each pay period, the Department of Finance shall remit to the GHLI trust fund the total premiums due for its employees, including contributions deducted from employees’ paychecks.

(b) Within five working days following the close of benefits pay period, the NMI Retirement Fund shall remit to GHLI trust fund the total premiums due for retirees and survivors, including contributions deducted from benefit paychecks.

(c) If such premiums are not received by the GHLI trust fund by the 10th working day following each pay period or benefit pay date, interest will be charged on the amount due at a rate determined by the Administrator.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

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Commission Comment: The paragraphs of this section were undesignated in the original regulation. The Commission designated them as subsections (a) through (c) pursuant to 1 CMC § 3806(a). The pre-2012 version of this section was titled “False Statements and Misrepresentations.”

§ 110-30.1-620 List of Enrolled Employees

With each remittance of premiums, each autonomous agency, each public corporation, any other government agency that processes its own payroll, the Department of Finance, and the NMI Retirement Fund shall submit to the Administrator a list of all enrolled employees, retirees and survivors for whom premium is being paid. This list will be the definitive identification of all enrollees in the program.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was titled “Provider, Enrollee Negligence.”

§ 110-30.1-625 List of Enrolled Dependents

The private insurance carrier shall maintain a current list of all enrolled dependents and shall seek to verify continued eligibilities of these dependents on an annual basis. The subscriber shall have an affirmative duty to inform the private insurance carrier, through the Administrator, of any change to circumstances that causes any of the subscriber’s dependents to lose eligibility.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was titled “Availability and Quality of Providers Not Guaranteed.”

§ 110-30.1-630 Full and Timely Payment

It is the responsibility of each subscriber or survivor and each paying entity to make certain that premiums are fully and timely paid.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

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7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was titled “Acts of War.”

§ 110-30.1-635 Payment Receipt

The Administrator will issue a receipt of payment to each subscriber or survivor submitting premiums directly to the GHLI trust fund.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 28 Com. Reg. 25883 (June 19, 2006); Amdts Proposed 28 Com. Reg. 25715 (May 19, 2006); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was titled “Excluded Charges and Services.”

§ 110-30.1-640 Deposit of Premiums Into GHLI Trust Fund

The Administrator shall cause all premiums received to be deposited into the GHLI trust fund and shall maintain such premiums there until transmission to the private insurance carrier when due.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was titled “Coverage Determination.”

§ 110-30.1-645 Review of Program

The CNMI Government may engage an experienced health insurance actuary or underwriter to review the financial status of the program, to review the plan document and these regulations, and to make recommendations for changes to improve the program.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

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Commission Comment: The pre-2012 version of this section was titled “Custodial or Domiciliary Care.”

Part 700 - Coordination of Benefits and Double Coverage

§ 110-30.1-701 Primary or Secondary Payor Determination

When an enrollee is covered by another health insurance plan, including Medicare, the Coordination of Benefits Guidelines established by the National Association of Insurance Commissioners (NAIC) will be used to determine whether the program will be the primary or secondary payor. These guidelines have included the following provisions:

- (a) The plan covering the enrollee as an active employee will be the primary payor;
- (b) If a child is covered under two plans, the plan of the parent whose birthday occurs first in the calendar year will be the primary payor;
- (c) If other guidelines fail to establish which plan is the primary payor, the plan covering the enrollee for the longer time will be the primary payor.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 title of Part 700 was “Health Care Providers.” The pre-2012 version of this section was titled “Eligible Providers.”

§ 110-30.1-705 Double Coverage Payment Provision

If the program is the primary payor, it will pay for covered benefits in accordance with the plan document. If the program is the secondary payor, it will pay a reduced amount, so that, when added to the amount payable by the other plan, the total amount paid by both plans will not exceed the provider’s charges for covered benefits. In no event will the amount paid by the program exceed the allowable expenses it would have paid had it been the primary payor. Also, in no event will the program pay for non-covered benefits.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

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Commission Comment: The pre-2012 version of this section was titled “No Program/Provider Relationships.”

§ 110-30.1-710 Information on Other Plans of Subscriber

(a) The double coverage provision applies whether or not a claim is filed under the other plan. As a condition of enrollment, a subscriber agrees to provide information as to other health insurance that he or she and his or her dependents may have, and authorizes the Administrator to obtain information as to benefits available from the other plan, and to recover overpayment, should they occur, from the other plan, on behalf of the subscriber and any of his or her enrolled dependents.

(b) For purposes of enforcing or determining the applicability of this part, the subscriber, on his or her own behalf or on behalf of his or her dependents:

- (1) Will disclose all coverage under any other plan;
- (2) Consents to the plan releasing to any part or obtaining from any party any information which the plan deems necessary for purposes of coordination of benefits;
- (3) Authorizes direct reimbursement to or from any other plan when such direct payment is appropriate and necessary to facilitate the coordination and adjustments of the plans and other plans payments under this section; and
- (4) Will, upon request, execute and deliver such instruments or documents as may be required to satisfy the intent of this section.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was titled “Provider Negligence.”

§ 110-30.1-715 Special Provisions Regarding Medicare and No-fault Motor Vehicle Insurance Coverage

(a) The federal Medicare program will be considered the primary plan unless the enrollee is an active employee covered under the plan. Where an employee or dependent is covered by both Medicare and this plan, applicable federal statutes will determine which plan is primary. If the enrollee reaches the eligible age or has a condition which makes him or her eligible for coverage under the Medicare Act, as amended (title XVII of the Social Security Act of 1965), or is receiving Social Security income benefits, the enrollee must enroll in all portions of the Medicare program open to the enrollee at no cost and sign and maintain in effect the necessary releases.

(b) Any no-fault motor vehicle insurance coverage will be considered the primary plan and its benefits will be applied first. Before the plan pays benefits under this plan for any injury

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covered by no-fault insurance, the plan will list the medical expenses that no-fault covers according to the date on which the expenses were incurred. The plan will add up the no-fault expenses for each successive day until the day when the no-fault benefit maximum is exhausted. From that day on, covered services received by the enrollee will be eligible for payment under this plan. The plan will follow this procedure even when the no-fault insurer pays all of its benefits for non-medical expenses or when the actual order of payment differs.

(c) If another person caused the motor vehicle accident and the enrollee may recover damages from that person, any benefits for which the enrollee may be eligible shall be subject to the provisions of this part. The plan is not liable to pay any benefits for injuries caused by another person, but may assist the enrollee by providing coverage he or she would have received as a benefit after the no-fault benefits have been exhausted as described in subsection (b) above, subject to the right of subrogation.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was titled “Preferred or Participating Providers Network.”

§ 110-30.1-720 Double Coverage under This Plan

An enrollee may not seek double coverage by being a subscriber, and also being the dependent of another subscriber under this plan. Only one category of enrollment and coverage will be permitted for an individual.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was titled “Provider Directory.”

Part 800 - Subrogation

§ 110-30.1-801 Recovery of Damages for Injury or Illness Caused by Another

If an injury or illness of an enrollee is or may have been caused by another person or party and the enrollee has or may have a right to recover damages therefore* against that person or party, the plan shall not be liable to pay any benefits provided under the policy. However, upon the execution and delivery to the plan of all papers it requires to secure its rights of reimbursement, the plan may pay benefits in connection with such injury or illness. If an enrollee is injured or

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infected through the act or omission of another person or entity and recovers damages from the other person or entity, the enrollee shall reimburse the plan for the cost of the benefits provided by the program in treating such condition. The amount of such reimbursement must equal the amount of the recovery or the programs* cost for such benefits, whichever is less. If the plan pays any benefits because of such injury or illness, the plan shall have a lien against any recovery to the extent of such payments. Such lien may be filed with such other person or party, his or her agent or insurance company, or the court; and such lien shall be satisfied from any recovery received by the enrollee.

* So in original.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of Part 800 was titled “Premiums.” The pre-2012 version of this section was titled “Premiums.”

§ 110-30.1-805 Damages Not Recovered; Right of Subrogation

If there is no recovery of damages, the plan shall be subrogated to the enrollees* rights against the wrongdoer to the extent of the cost of the benefits provided by the plan, including the right to sue in the enrollee’s name and to compromise the claim in order to indemnify the plan for amounts paid.

* So in original.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was titled “Subscriber Contributions.”

§ 110-30.1-810 Assignment of Claim Payment

It is a condition of enrollment in the plan that each enrollee agrees that he or she, his or her guardian, his or her survivor, and his or her estate will execute and deliver an assignment of claim payment form, and any other necessary forms prescribed by the Administrator, to the

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Administrator upon request, and shall render any necessary assistance, other than pecuniary, to enable the plan to secure the rights provided by this part.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was titled “Government Contributions.” Former sections 110-30.1-815 through 110-30.1-870 were repealed in 2012.

Part 900 - Administration

§ 110-30.1-901 Responsibilities of the Board

The Board has fiduciary responsibility with respect to the collection and remittance of employer and employee/retiree/survivor premiums. The Board serves as a fiscal and administrative agent of the CNMI government with respect to the GHLIP. The Board will administer and manage the program in accordance with the plan document and these regulations.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of Part 900 was titled “Claims and Payment for Services.” The pre-2012 version of this section was titled “Covered Services.

§ 110-30.1-905 Administrators Authority

(a) The Administrator has the authority to make decisions, as necessary for the optimal functioning of the program, within the authority granted him by the Board in these regulations. The Administrator is responsible for the daily functions of the program including, but not limited to, receiving and depositing premiums, remitting premiums as required, and facilitating the enrollment of subscribers and changes to enrollment categories requested by subscribers.

(b) Subject to the review and oversight of the Board, the Administrator shall have all discretionary powers necessary to administer the program and control its operation in accordance with the terms of the plan document, these regulations and applicable law, including but limited to the power to

- (1) Obtain insurance through the RFP process;
- (2) Negotiate the insurance policy for the program;

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- (3) Set the administrative fee which shall be added to the premium charged, to cover administrative expenses of the GHLIP;
- (4) Interpret the provisions of this plan document;
- (5) To* determine any question relating to the administration or operation of the program;
- (6) Make and enforce decision regarding who is eligible for benefits and when they may enroll or change their enrollment.

(c) All decisions of the Administrator, any actions taken or omitted by the Administrator in respect of the program and within the powers granted by the Act or under this plan document, and any interpretation of this plan document by the Administrator shall be conclusive and binding on all persons other than the Board, and shall be given the maximum possible consideration allowed by law.

* So in original.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The initial paragraph of this section was undesignated in the original regulation. The Commission designated it as subsection (a) pursuant to 1 CMC § 3806(a). The Commission corrected the semicolon at the end of subsection (b)(6) to a period pursuant to 1 CMC § 3806(g). The pre-2012 version of this section was titled “Filing of Claims (General Rules).”

§ 110-30.1-910 Maintenance of Program Records

The Administrator will create and maintain, or facilitate the creation and maintenance by another party, the program records necessary to implementation of the program.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was titled “Payment of Claims (General Rules).”

§ 110-30.1-915 Contracts for Insurance and Administration Authorized

The Board, acting through the Administrator, has the authority to contract with private insurance carriers and/or administrators to insure and/or administer the program.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com.

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Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was titled "Filing of Claims by Providers."

§ 110-30.1-920 GHLI Trust Fund

- (a) The GHLI trust fund was established for holding premiums, administrative service charges and any investment earnings thereon.
- (b) Moneys in the GHLI trust fund are to be expended for the payment of insurance premiums, reasonable costs of administration, and other allowable expenses related to the program.
- (c) The Administrator shall maintain the GHLI trust fund at any recognized financial institution whose deposits are insured by an agency of the U.S. federal government. However, the full amount of money held in the GHLI trust fund need not be so insured.
- (d) The Administrator, under the direction of the Board, shall have sole and exclusive expenditure authority over the GHLI trust fund.
- (e) The Administrator shall establish an accounting system for the GHLI trust fund in accordance with generally accepted governmental accounting standards and issue accounting reports to the Board as required but at least semiannually.
- (f) The Administrator shall report to the CNMI Legislature and Governor on the financial status of the GHLI trust fund within sixty days after the end of each fiscal year.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was titled "Payment of Claims to Providers." Former sections 110-30.1-925 through 110-30.1-965 were repealed in 2012.

Part 1000 - Termination

§ 110-30.1-1001 When Termination Occurs

Enrollment in the program will terminate upon the Plan's notification that:

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- (a) For an enrollee if he/she no longer meets the definition of enrollee;
- (b) For an enrollee if such individual files false documents to establish eligibility;
- (c) For an enrollee if the enrollee dies;
- (d) For all enrollees if the government terminates the program;
- (e) For a subscriber if the subscriber terminates his or her enrollment;
- (f) For a dependent if the subscriber's enrollment terminates;
- (g) For a dependent if the subscriber terminates the enrollment of the dependent;
- (h) For a survivor and all dependents of the former subscriber if the survivor remarries;
- (i) For an employee, 30 days after the employee ceases to be employed by the government, provided the entire premium for coverage after the end of employment is paid, otherwise upon termination of employment, unless the former employee qualifies as a retiree or dependent of another;
- (j) For a spouse on the first day of the month following termination of the marriage, other than through death of the subscriber;
- (k) For a domestic partner on the first day of the month following termination of the domestic partnership, other than through death of the subscriber;
- (l) For a child if he/she no longer meets the definition of child;
- (m) For a child if he/she no longer meets the definition of eligible child;
- (n) For a dependent if he/she no longer meets the definition of dependent.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The Commission corrected the period at the end of subsection (i) to a semicolon pursuant to 1 CMC § 3806(g). The pre-2012 version of Part 1000 was titled "Managed Care." The pre-2012 version of this section was titled "Managed Care Program Reviews."

§ 110-30.1-1005 Effective Date of Termination

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Except as specified* provided elsewhere, all terminations of enrollment will be effective as of the first day of the pay period or semi-monthly annuity payment period following the event causing the termination.

* So in original.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was titled “Benefits Reductions.”

§ 110-30.1-1010 Termination of Subscriber Terminates Dependents; Re-enrollment

If a subscriber’s enrollment terminates, coverage for all of such subscriber’s enrolled dependents also terminates as of the subscriber’s date of termination, except as specifically provided for survivors elsewhere in these regulations. A subscriber whose enrollment has terminated will not be eligible to re-enroll until an open season is declared or unless the subscriber otherwise becomes eligible. Notwithstanding the previous sentence, if the subscriber’s enrollment terminates because of non-payment or untimely payment of subscriber contributions while the subscriber is on leave without pay pursuant to the Family and Medical Leave Act of 1993, or if the subscriber qualifies under the Uniformed Services Employment and Reemployment Rights Act of 1993, the provisions of those acts will govern.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was titled “Pre-admission Review.”

§ 110-30.1-1015 Notification to Administrator of Loss of Dependent Status

If an enrolled dependent no longer meets the definition of dependent, the subscriber must ensure that the Administrator is notified within 30 days of the date the change occurred. If the Administrator is not so notified, payment of benefits for such dependent* will be denied retroactively to the date the change occurred, even though premiums were paid, and premiums will not be refunded. Also, any claim filed on behalf of such dependent after the date the dependent no longer met the definition of dependent, may be considered a false claim.

* So in original.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com.

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Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was titled “Surgical Review.”

§ 110-30.1-1020 CNMI Legislature; Power to Abolish or Amend Program Law

The CNMI Legislature has the power to abolish the program or to amend the law creating and governing the program at any time.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001).

Commission Comment: The pre-2012 version of this section was entitled “Inpatient Review.” Former sections 110-30.1-1025 through 110-30.1-1030 and Parts 1100 through 1900 were repealed in 2012.

Part 2000 - Reconsideration and Appeals

§ 110-30.1-2001 Request for Reconsideration of Denial

If an application for enrollment, enrollment change or continued enrollment is denied in whole or in part for reasons other than for failing to meet a stated time deadline, or if adverse action is otherwise taken against a subscriber, the subscriber or the subscriber’s representative may submit a written request for reconsideration to the Administrator within thirty days of the notice of denial is issued or other adverse action is taken. The subscriber or subscriber’s representative must state the reason he or she believes the denial was inappropriate and may submit any supporting data. A subscriber has the right to be represented by an attorney of his or her choosing, but shall bear the cost of the representation, or they may choose to represent themselves.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of Part 2000 was titled “Miscellaneous Provisions.” The pre-2012 version of this section was titled “Amendments.”

§ 110-30.1-2005 Informal Conference

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The Administrator will discuss the request for reconsideration with the subscriber or subscriber's representative at an informal conference either by telephone or in person. Such informal conference will be held within thirty days following the Administrator's receipt of the written request for reconsideration if at all possible. The Administrator shall require the written consent of the subscriber or the subscriber's adult dependents before discussing privileged or confidential medical information with the subscriber's representative or any other non-privileged third party.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011); Amdts Adopted 25 Com. Reg. 20964 (Aug. 22, 2003); Amdts Proposed 25 Com. Reg. 20632 (July 15, 2003); Amdts Adopted 24 Com. Reg. 19633 (Oct. 30, 2002); Amdts Emergency and Proposed 24 Com. Reg. 19256 (June 17, 2002) (effective for 120 days from June 7, 2002); Amdts Proposed 23 Com. Reg. 18648 (Nov. 23, 2001); Amdts Adopted 19 Com. Reg. 15735 (Oct. 15, 1997) (repealing and re-promulgating the Group Health Insurance Program provisions of the May 1997 regulations); Amdts Proposed 19 Com. Reg. 15573 (Aug. 15, 1997).

Commission Comment: The pre-2012 version of this section was titled "Effective Date."

§ 110-30.1-2010 Administrator's Decision on Reconsideration

The Administrator's decision on reconsideration shall be in writing and sent to the subscriber or the subscriber's representative, within thirty days of the informal conference. The Administrator shall state the specific reasons for his or her decision and refer to the provisions in the Act, the plan document or other rules or regulations on which the decision is based.

Modified, 1 CMC § 3806(f).

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

Commission Comment: The Commission inserted an apostrophe in the word "Administrator's" pursuant to 1 CMC § 3806(g).

§ 110-30.1-2015 Appeal of Administrator's Decision to Board

A subscriber may appeal the Administrator's decision on reconsideration to the Board within thirty days of the Administrator's decision on reconsideration, pursuant to the Administrative Procedure Act [1 CMC §§ 9101, et seq.] and other applicable law, rules and regulations. Such appeal must be in writing and sent to the Chairman, Board of Trustees, NMI Retirement Fund, P.O. Box 501247, Saipan, MP 96950-1247. The subscriber shall also serve a copy of the appeal on the Administrator within the same time period.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

Commission Comment: The Commission corrected the capitalization of the word "subscriber" pursuant to 1 CMC § 3806(f).

§ 110-30.1-2020 Appeal Hearing

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Upon receipt of a notice of appeal, the Board may appoint a hearing officer to hold a hearing on the record or, in an appropriate case, the Board may itself conduct a hearing on the record. The hearing shall be conducted according to the procedures set forth in the Administrative Procedure Act [1 CMC §§ 9101, et seq.]

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

§ 110-30.1-2025 Appeal to Commonwealth Superior Court

Any further appeal or review of the Board's decision shall be made to the Commonwealth Superior Court in accordance with 1 CMC §§ 9112(b) and 9113. If the court finds in favor of the plan, the subscriber shall be liable for attorney's fees and other costs incurred by the plan in its defense. If the court finds in favor of the subscriber, the plan shall pay its own attorney's fees and other costs and those of the subscriber.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

Commission Comment: The Commission corrected the capitalization of the word "subscriber" pursuant to 1 CMC § 3806(f).

Part 3000 - Governing Laws

§ 110-30.1-3001 Program Administered in Accordance with CNMI and Certain Federal Laws

Notwithstanding any other provision of the plan document in this subchapter, the program will be administered in accordance with applicable CNMI and U.S. federal government laws, except in cases in which the CNMI has the authority to, and has chosen to, opt-out of such federal laws. Federal laws for which the CNMI may have opted-out include the Public Health Service Act, the Health Insurance Portability and Accountability Act of 1996, the Mental Health Parity Act of 1996, the Family and Medical Leave Act of 1993, the Uniformed Services Employment and Re-employment Rights Act of 1993, the Americans with Disabilities Act of 1990, and the Pregnancy Discrimination Act of 1979.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

§ 110-30.1-3005 Conflict Between Plan and Law

In case of conflict between the plan document or regulations and any CNMI or applicable U.S. federal law, the law will govern.

History: Adopted 34 Com. Reg. 32298 (Feb. 29, 2012) (repealing and replacing the subchapter); Proposed 33 Com. Reg. 32231 (Dec. 29, 2011); Emergency 33 Com. Reg. 32128 (Dec. 29, 2011).

Commission Comment: The former Appendix A, titled "Group Health and Life Insurance Trust Fund Drug Formulary," was repealed by the 2012 amendments.