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PART I. GENERAL PROVISIONS

Section 101. Authority
The rules and procedures of the Republic of Palau Healthcare Fund (hereinafter “HCF”) documented in this Operations Manual (hereinafter “HCF OM”) are promulgated pursuant to and in accordance with the Administrative Procedure Act, as codified in 6 PNC §101 ff. and RPPL No. 8-14, as codified in Title 41, Chapter 9 of the PNC. These rules and regulations have been promulgated by the Republic of Palau Healthcare Financing Governing Committee (hereinafter “Committee”) and shall have the force and effect of law. [Source: 41 PNC §908]

Section 102. Purpose and Scope
The purpose of these rules and regulations is to ensure effective and efficient implementation and administration of the National Healthcare Financing Act, RPPL 8-14, by its Committee and by the Social Security Administration, as the administrative agency mandated with the responsibility and duty of administering the provisions of the HCFA. [Source: 41 PNC §908]

Section 103. To Whom Applicable
Unless contrary to the purpose and intent of the HCFA, these regulations are to be enforced by employees of the Social Security Administration and of the Ministry of Health of the Republic of Palau and shall be made available for public inspection upon request at the offices of the Social Security Administration during regular hours of operation. [Source: 6 PNC §123]

Section 104. Definitions
Unless otherwise specified, definitions as set forth in 41 PNC §702 and 41 PNC §901 are incorporated into and made a part of these rules and procedures for all purposes. Other definitions specifically applicable to these regulations are:
(a) Account holder: The individual identified as the owner of a particular medical savings account.
(b) Approved provider: An individual or organization that is licensed or otherwise officially recognized as meeting the required standards to provide and charge for medical care to others by the jurisdiction where the provider is located.
(c) Dependent: A spouse, child under the age of eighteen, or child under the age of twenty-two who is a bona fide student, of the account holder.
(d) Designated beneficiary (or “beneficiary”): A dependent or other individual authorized to access an account holder’s Medical Savings Account. [Source: 41 PNC §901]

Section 105. Amendments

Any provision of these regulations may be amended consistent with the Administrative Procedures Act, as codified in 6 PNC §101 ff. Any person may request the adoption, amendment, or repeal of any of these regulations by submitting a written petition to the Committee specifying in detail the rule to be adopted, amended, or repealed and the basis for such request. Amendments to these regulations shall be consistent with statutes and with regulations adopted by the Ministry of Health and the Social Security Administration as they relate to administration of the HCFA. [Source: 41 PNC §908(c)(5)]

Section 106. Sovereign Immunity
The Committee is a governmental entity, that when acting in its official capacity, is protected by the Doctrine of Sovereign Immunity unless otherwise provided by statute. [Doctrine of Sovereign Immunity]

Section 107. Funds
All funds are collected by the Republic of Palau Social Security Administration (ROPSSA), therefore all applicable policies apply. These funds received by ROPSSA shall be deposited on a daily basis. No funds shall be held overnight. For safety purposes, deposits made after 4:30 PM shall be accompanied by two Administration employees. [Source: SSA By-Laws]

Section 108. Discretion of the Administrator
The Social Security Administration has discretion in administering these regulations and policies as it deems necessary to ensure compliance with the HCFA and efficient operation of the Healthcare Fund. [Source: RPPL No. 8-14]

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Administrators (Administrator) shall have the discretion to deviate from these rules and procedures as they deem necessary to best serve the interests of the Fund. In the event that the Administrator deviates from such rules and procedures, they shall inform the Board in writing during the next regular meeting. This section does not approve any acts committed by the Administrator that are contrary to law.

[Source 41 PNC § 724 & SSA By-Laws]

Section 109. Uniformity
All provisions of these rules and procedures shall be interpreted and applied in a uniform, nondiscriminatory manner.

[Article IV, Section 5. ROP Constitution]

Section 110. Severability
If any provision of these rules and procedures or the application thereof to any employee or circumstance is held invalid, the invalidity does not affect other provisions or applications of these

rules and procedures that can be given effect without the invalid provision or application. To this end, the provisions of these rules and procedures are severable.

[General Provision]

Section 111. Effective Date

These rules and procedures shall take effect upon their approval by a majority vote of the Committee, consistent with the Administrative Procedures Act. All actions prior to the effective date of these rules and procedures shall not be subject to these newly promulgated rules and procedures. [General Provision]

Section 112. Record Keeping

The Administrator shall maintain records of all employees and of all contributors, including self-employed persons, for a minimum of ten (10) years. The Administrator shall maintain all other records in accordance with SSA Record Retention & Destruction Policy. [Source 41 PNC § 908(c)(5)]

Section 113. Availability of Records

All statistical information and reports routinely produced for administrative purposes shall be made available upon written request and upon payment of the costs of reproducing the report. Requests, other than requests for personally identifiable financial and medical information, and any other submissions shall be directed to the Administrator and shall generally be made available upon written request and upon payment of the costs of gathering and reproducing the information.

[Source 6 PNC §121(a)]

Section 114. Information or Records Not Publicly Available

Personally identifiable financial and medical information shall be kept confidential and may only be released with the express written consent of the subject of the information, as indicated by their signature on the form approved for that purpose. No written consent shall be valid for more than one year. (a) If the individual is a minor, only the express written consent of a parent with custody or a court-appointed guardian will be accepted for the purpose of releasing financial or medical information on the individual. (b) If the individual is adjudged incompetent, only the written authorization of a court-appointed guardian will be accepted for the purpose of releasing financial or medical information on them. Personally identifiable financial and medical information may be released for the purposes of the functions and operations under the HCFA. For example, the funds available in a medical savings account may be transmitted to and from the Ministry of Health and the individual’s treatment providers. Personally identifiable financial and medical information including a Medical Number, may also be released to any person as required by court order from a duly recognized jurisdiction and as otherwise authorized by the Committee. [Source 41 PNC §960]

PART II. ORGANIZATION

Section 201. Governance

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The Health Care Financing Act (HCFA) regulations govern the administration of the HCFA.

Section 202. Formation of the Healthcare Financing Committee

The Committee is established to administer the HCFA, excluding investments, which are within the exclusive authority of the Social Security Board.

- Its membership consists of the Minister of Finance or their designee, the Minister of Health or their designee, the Administrator, one representative appointed by the Governor's Association, and one representative appointed by the Chamber of Commerce.

- Committee members shall elect one member to be Chairman and another to be Vice Chairman at the first meeting. Subsequent elections shall take place whenever another individual becomes a member of the Committee or after two years, whichever comes first.

[Source: 41 PNC § 901 and 907]

Section 203. Chairman of the Committee

The Chairman shall preside over all meetings of the Committee and shall sign all contracts, deeds, and other instruments unless otherwise authorized by the HCFA, these regulations, or as designated by the Chairman.

[Source: Unknown]

Section 204. Vice Chairman of the Committee

The Vice Chairman shall perform the duties of the Chairman in the absence of the Chairman. In the case of dismissal, resignation, or death of the Chairman, the Vice Chairman shall serve as Chairman until a new Chairman is elected by a majority of the membership.

[Source: Unknown]

Section 205. General Powers of the Committee

The Committee provides, maintains, operates, and reports on the financial sound healthcare systems established by the HCFA and provides an orderly means to finance and deliver comprehensive healthcare coverage to the people of the Republic of Palau.

[Source: 41 PNC § 908(a)]

Section 206. Fiduciary Duties

Members of the Committee shall be expected to conduct themselves with the highest standard of care and loyalty in performing their duties.

[Source: Unknown]

Section 207. Memorandum of Understanding

A Memorandum of Understanding among the Ministry of Finance, Ministry of Health, and the Social Security Administration shall address coordination of the following functions:

- The duties and responsibilities of each of the agencies when operating under the HCFA;

- Producing an annual report within 90 days after the end of each fiscal year to the President of the Republic of Palau, the President of the Senate, and the Speaker of the House of Delegates of the Olbiil Era Kelulau detailing the financial status of the Fund, its investments, MSA participation, medical care utilization, and other matters as requested;

- Coordinating any other activities among the agencies necessary to meet the objectives of the HCFA.

[Source: 41 PNC § 911 & 912]

Section 208. Duties and Responsibilities of the Committee

The Committee exercises and performs the following powers and duties in the name of the Medical Savings Account (MSA) and National Health Insurance (NHI) of the Republic of Palau:

- Transact any business;

- Enter into any contracts for management, medical or ancillary service providers, third-party administrators, auditing, actuarial, investment, legal, or any other advice or services;

- Issue subpoenas and administer the oaths appropriate for the administration of the two plans;

- Bond any employee of the Administration in such cases and in such amounts as necessary;

- Have the authority to promulgate by-laws, procedures, policies, or rules and regulations, which shall have the force and effect of law, necessary to carry out any duty, operation, or function as required under this Act.

[Source: Unknown]

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Carry out adjudicative proceedings;

- Maintain bank accounts and a bank overdraft for normal operations.

- Delegate any power, function, duty, or responsibility as necessary to ensure the administration and operation of the two plans and funds.

- Ensure that any HCFA functions being performed by external entities are performed in the best financial interest of the Health Care Fund and its MSA/NHI members, whether performed by other government agencies through a Memorandum of Understanding, by a contracted Consultant or Third Party Administrator, or otherwise.

- Approve recommendations, official documents, and other actions that require approval by the Committee.

[Source 41 PNC § 908]

Section 209. Meetings, Official Action of the Committee

- The Minister of Finance, Minister of Health, and Administrator shall call the first meeting of the Committee. Subsequently, the Committee shall meet at the call of the Chairman or a majority of the members of the Committee. The time and place of such a meeting shall be designated by the Chairman.

- Three members of the Committee shall constitute a quorum for the purposes of conducting business and exercising its powers and for other purposes. A majority vote of members present shall

be required for any decision by the Committee. Minutes of all meetings shall be recorded.

- The minutes of each meeting shall be recorded by the Secretary or a person designated by the Chairman. The minutes shall be prepared for distribution at least two days prior to the next Committee meeting. Such minutes and recordings shall be kept by the Board for a minimum of ten years for record-keeping purposes.

[Source ____]

Section 210. The Administrator

- The Administrator shall be responsible for the general day-to-day administration and operation of the healthcare financing system. In addition, the Committee may delegate to the Administrator such powers, duties, and responsibilities as are necessary and proper to carry out the effective and proper operation of the healthcare financing system.

[Source 41 PNC § 909(a)]

Section 211. Duties of the Administrator

- The Administrator shall be delegated duties and responsibilities which shall include, but are not limited to:

- To oversee the general administration of the HCFA and carry into operation the goals, objectives, and policies established by the HCFA and the Committee.

- To oversee and direct the day-to-day activities and operation of the HCFA including the direction and supervision of all administrative and technical activities; this includes the activities performed by other government agencies through a Memorandum of Understanding or activities by a contracted Consultant or Third Party Administrator, and to recommend to the Committee, any amendments, terminations, or replacements of such agreements.

- To select, hire, terminate, and discipline employees at his or her discretion, but subject to such personnel guidelines and procedures as may be promulgated by the Committee.

- To contract for professional (including legal, auditing, and accounting), technical, and advisory services, and to plan, organize, coordinate, and control the services of such employees and independent contractors subject to such guidelines and procedures as may be adopted by the Social Security Board or the Committee.

- To attend, unless excused by the Committee, all meetings of the Committee and submit reports on the affairs of the MSA/NHI as requested.

- To keep the Committee advised on the needs of the MSA/NHI.

- To ensure that any and all HCFA functions being performed by external entities are performed in the best financial interest of the Health Care Fund and its MSA/NHI members, whether performed by other government agencies through a Memorandum of Understanding, by a contracted Consultant or Third Party Administrator, or otherwise.

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Section 210. Duties of the Administrator

(a) To enforce all rules, procedures, policies, and by-laws;

(h) To receive and maintain all files and records, including those of all employers and employees subject to 41 PNC, Chapter 9, these regulations, and all other applicable regulations and laws;

(i) To make available for public inspection all rules and other written statements of policy or interpretations formulated, adopted, or used, and all final orders, decisions, and opinions of general applicability or effect upon the public;

(j) To audit records, issue subpoenas, and administer oaths appropriate to the administration of the MSA/NHI;

(k) To furnish an annual report and audited statement of accounts to the President and the Olbiil Era Kelulau within ninety (90) days of books closing;

(l) To institute whatever legal proceedings he or she shall deem necessary and proper to collect delinquent contributions and interest due and owing to the MSA from any employer or to collect any other sums owed to the MSA/NHI;

(m) To maintain bank accounts as deemed necessary for the purposes of administration of the HCFA, including the establishment of a separate bank account in a bank that is FDIC insured for all monies used to fund operations;

(n) To hold hearings and make decisions in accordance with 41 PNC, Chapter 9 and these regulations for the purpose of determining any question involving any right, benefit, or obligation of any person subject to 41 PNC, Chapter 9;

(o) To make proper adjustments whenever an error has been made; provided, however, that no adjustment shall be made when adjustment or recovery would be contrary to law;

(p) To make recommendations to the Committee for legislation to improve the MSA/NHI and to directly lobby the Olbiil Era Kelulau to enact such legislation;

(q) To annually formulate a list of specific goals and objectives for the MSA/NHI for review by the Committee;

(r) To perform such other and additional duties as may be required or delegated by the Committee;

(s) To contract with medical and ancillary providers, including other medical facilities such as hospitals and surgical centers or third-party administrators as necessary;

(t) To attend and assist in the affairs of the Medical Referral Committee and to certify to such committee that each case, at the time of referral, meets the provisions of the HCFA and its regulations;

(u) To develop and issue Benefit and Policy Interpretation Bulletins when more detail or clarification is needed over time. The Benefit and Policy Interpretation Bulletins are to be used as guides by the Plan and its providers to make coverage and policy determinations under the Plan.

[Source 6 PNC § 122 and 41 PNC § 909, 911, & 959]

Section 212. Delegation by Administrator

The Administrator may delegate any of their powers and functions under 41 PNC, Chapter 9 and these regulations to any employee. A delegation is revocable, in writing, at will. It may apply to the whole of the Republic of Palau or in part and is subject to such limitations and conditions as deemed proper and necessary by the Administrator. No delegation made by the Administrator prevents the exercise of performance of a power or function by the Administrator.

[Source 41 PNC § 909(c) & 725]

Section 213. Budget
The Administrator shall prepare and submit to the Social Security Board, the Committee, and to appropriate authorities, on forms and in the manner and at such times as may be prescribed, or in such form as the Administrator deems proper, a detailed budget estimate and the amount required to be appropriated for the next fiscal year.

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Following Fiscal Period, from October 1st through September 30th of the following year, for proper operations including:

1. The audited accounts for the prior fiscal year;
2. A statement showing the estimates of contributions, other income, and expenditures for the fiscal year in progress, together with any summaries, schedules, and supporting information deemed necessary;
3. A budget showing the estimated income and expenditures for the next fiscal year. [Source 41 PNC § 909(e)]

Section 214. Audits, Accounts & Reports
The Administrator shall maintain accounts and records relating to all funds and transactions under the HCFA. Such accounts and records shall be subject to audit by an independent auditor appointed by the Board. [Source 41 PNC § 958(a)]

Section 215. Actuary
The Board and Committee shall jointly appoint an Actuary, who meets the requirements developed and agreed upon by the Board and the Committee, on terms and conditions as agreed upon in writing between the Administrator and the Actuary. Any report submitted to the Board following an actuarial valuation shall also be submitted to the Committee, the Olbiil Era Kelulau, and the President of the Republic of Palau, with any appropriate recommendations for changes or amendments. [Source RPPL 8-14, Section 4(b)]

Section 216. Auditor
(a) The Board and Committee shall jointly appoint an independent auditor, who meets the requirements developed and agreed upon by the Board and the Committee, on terms and conditions as agreed upon in writing between the Administrator and the Auditor. The auditor shall audit the accounts within ninety (90) days after the end of each fiscal year.
(b) The Administrator shall, as soon as practicable, submit the accounts and the Auditor’s report to the Olbiil Era Kelulau and the President of the Republic of Palau. The accounts and report shall also be made available to the general public upon request.
(c) The Administrator shall receive any annual reports from the Public Auditor on the financial balance of the MSA and provide such reports to the Committee and the Board. [Source 41 PNC § 958]

Section 217. Legal Counsel

The Administrator is encouraged to employ a full or part-time attorney to advise and handle legal affairs. However, if for any reason the Administrator is unable to employ a private, in-house attorney, the Attorney General's Office shall provide legal services upon request. [Source 41 PNC § 909(a)]

Section 218. Professional Services

The Administrator may contract for professional (including legal, auditing, and accounting), technical, and advisory services on behalf of the MSA/NHI. All contracts for professional services shall be in writing and clearly indicate:

(a) the work the professional is contracted for;

(b) the course of action the Committee has agreed to take;

(c) a statement that the professional has no conflicts of interest in pursuing any matter under the contract;

(d) the compensation the professional is to receive. The Administrator shall require such contract professionals to submit written summaries of the status of the work at regular intervals. At the completion of such professional services, the Administrator shall obtain all files, documents, work product, or other instruments that are the Administration's rightful property. [Source 41 PNC § 908 & 909]

PART IV GENERAL BENEFITS

Section 301. General Eligibility

(a) General MSA Eligibility: All employed and self-employed individuals shall contribute to an MSA for the benefit of that account holder and their spouse and dependent children, if any, and in accordance with regulation.

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established by the Administration.

The account holder may designate additional beneficiaries for their MSA, in accordance with regulations established by the Administration or the Committee.

(b) NHI Eligibility for Employed Persons and Their Dependents: All account holders and their dependents shall be eligible for coverage under NHI based on the deduction of the subscription costs from the account holder's MSA in accordance with these regulations.

(c) NHI Eligibility for Individuals age 60 and Over, Disabled or Unemployed: Citizens who are 60 and older and not working; citizens who are disabled and not working; and citizens who are currently unemployed shall be eligible for coverage under NHI based on the payment of subscription costs by the National Government or any other government entity.

(d) NHI Eligibility for All Other Permanent Residents: All other individuals who are permanent residents

of Palau may enroll for coverage under NHI in accordance with these regulations.

[Source 41 PNC § 917(b), 918(b), 951, and 952]

Section 302. Eligibility on More than One MSA: An individual may be a designated beneficiary on more than one MSA. Payments shall first be deducted from the MSA where the individual is the account holder and then shall be deducted from any MSA where the individual is a spouse and mandatory designated beneficiary. Last, payments shall be deducted from any other MSA where the individual is a designated beneficiary.

[Source 41 PNC § 940]

Section 303. Income Guidelines for Co-payments and Use Schedules:
(a) The Committee shall develop a Schedule of Benefits for MSA/NHI based on negotiated fee schedules established with medical providers. The Sliding Fee Schedule adopted by the Minister of Health, in effect on the date RPPL 8-14 was enacted, shall be used to establish the amounts that may be authorized by the covered individual to be deducted from their MSA account.

(b) In addition, the Cost Schedule adopted by the Minister of Health, in effect on the date RPPL 8-14 was enacted, shall be considered when the Committee establishes a Reimbursement Schedule containing the amounts approved for reimbursement for a covered service under NHI.

(c) The amounts established in the Sliding Fee Scale and Reimbursement Schedule may be amended from time to time, with the approval of the Committee.

[Source 41 PNC § 939(b)]

Section 304. Retroactive Payments: No payments shall be made from any MSA or under NHI for expenses incurred or services performed prior to the date an individual’s eligibility begins.

[Source 41 PNC § 939 & 955b]

PART V. MEDICAL SAVINGS ACCOUNTS (MSA)

Section 401. Designated Beneficiaries: Designated Beneficiaries of Medical Savings Accounts under the National Healthcare Act of 2010 shall include, at a minimum, the participating employee, their spouse, and their dependent children. Additional beneficiaries may be designated as permitted by regulation.
[Source 41 PNC § 940]

Section 402. Payments to Exiting Foreign Employees: (a) All non-Palauan citizens who contributed to the Medical Savings Fund and who are permanently exiting the Republic of Palau shall be entitled to withdraw any funds remaining in their individual Medical Savings Account after all payments due have been fully made.

(b) Such an exiting employee shall submit a request for the withdrawal of contributions on an official

form, their immigration exit clearance, and any other information deemed necessary by the Administrator. There shall be a six-month wait period before the funds can be withdrawn.

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Section 402. Timing of Payment from the Fund

The period between the exit date and the issuance of this payment from the Fund shall not exceed the beginning of the first full calendar quarter after the month in which the contributions were paid by the employer. [Source: 41 PNC § 941]

Section 403. Availability of Funds

(a) Funds held within an MSA shall become available for use by the account holder and their designated beneficiaries no later than the beginning of the first full calendar quarter after the month in which the contributions were paid by the employer.

(b) When the account holder changes their designation of beneficiaries, the funds within that MSA account shall become available for use to all beneficiaries a day after a change has been made. However, if the reported change is made within thirty (30) days of the end of a calendar quarter, the change shall not take effect until the beginning of the second calendar quarter after the report is made. [41 PNC § 918(b) & 940]

Section 404. Order of Priority for Payment from an MSA

After the subscription cost for NHI for the account holder and their spouse and dependents are deducted, other payments requested to be made from an MSA by the account holder and designated beneficiaries shall be made in the following order of priority during each calendar quarter:

(a) Subscription cost for NHI for any other designated beneficiary, which is not covered by that designated beneficiary's own MSA.

(b) Private health insurance premiums for the account holder and their spouse and dependents.

(c) Private health insurance premiums for any other designated beneficiary, which is not covered by that designated beneficiary's own MSA.

(d) Payment for covered services as defined in Section 507 provided by BNH to the account holder, in the order service was provided, and then provided by BNH to his or her spouse and dependents, in the order service was provided.

(e) Payment for covered services as defined in Section 507 provided by BNH for any other

designated beneficiary, which is not covered by that designated beneficiary's own MSA.

(f) Payment for covered services as defined in Section 507 provided by any other approved on-island provider for the account holder and his or her spouse and dependents, in the order the service was provided.

(g) Payment for covered services as defined in Section 507 provided by any other approved on-island provider for any other designated beneficiary, which is not covered by that designated beneficiary's own MSA, in the order the service was provided.

(h) Any other payment for covered services as defined in Section 507, in the order service was provided. [41 PNC § 939(b) & 952(b)]

Section 405. Payment of Premiums for Private Health Insurance Coverage

(a) An account holder may authorize payment of premiums for private health insurance coverage for themselves, dependents, and other designated beneficiaries from their MSA by submitting a written request to the HCF on the form approved for that purpose. Upon receiving the written authorization, the Administrator shall request that the private health insurer submit a request for payment for the premium to the HCF. The HCF shall then make payment to any insurer who agrees to accept such payment, for all premiums authorized by account holders.

(b) A withdrawal of this authorization shall be submitted in writing by the account holder on the form approved for that purpose and shall take effect for the next regularly scheduled payment after the written withdrawal is received by the HCF.

(c) If the insurer does not agree to accept payment of premiums from the HCF within thirty days of the request, the HCF shall provide written notification to the account holder. [Source: 41 PNC § 952(b)]

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account holder and shall not make any payment to the insurer.
(d) The HCF shall not submit payment to an insurer unless the insurer agrees in advance, in writing, to accept such payment and submits a request for payment directly to the HCF on a form approved for that purpose.
(e) The HCF shall not reimburse the account holder, an employer, or any other person for premiums already paid to an insurer and shall not pay a premium to anyone other than directly to the insurer.
(f) The HCF may enter into agreements with companies providing health insurance coverage on Palau governing payment of premiums under this section. [Source 41 PNC § 939]

Section 406. Payments to Ministry of Health
The account holder or any designated beneficiary may authorize a payment to BNH in writing on a

form approved for that purpose for any healthcare service not excluded by these regulations. Upon receipt of proof of providing the covered service and the authorization for payment using the form approved for that purpose, including electronic transmission of the proofs, the HCF shall pay BNH the approved amount for that covered healthcare service. Authorized payments from MSAs to BNH may be aggregated and paid as may be determined by agreement of the Ministry of Health and the Administrator. [Source 41 PNC § 939]

Section 407. Payments to Other Providers on Palau and Outside of Palau
The account holder or any designated beneficiary may authorize payment in writing using a form approved for that purpose for any healthcare service not excluded by these regulations to other approved providers on Palau. The approved provider shall submit a request for payment to the HCF for all covered services, which includes proof of providing the covered service and the authorization for payment, on a monthly or quarterly basis using a form approved for that purpose. The HCF shall pay the approved provider on a monthly or quarterly basis, as agreed by the provider and the HCF. However, the amount paid for the covered service shall not exceed the amount that is deemed Usual, Customary, or Reasonable for that service. [Source 41 PNC § 957(a) (b)]

Section 408. Limitations on Withdrawals
(a) If an account holder or any designated beneficiary authorizes payment from an MSA for services not covered or not from an approved provider, the HF shall advise the account holder and the provider that payment is not approved.
(b) The HF shall not withdraw funds from an MSA unless authorized in writing by the account holder or a designated beneficiary.
(c) The HF shall not withdraw funds from an MSA account if the withdrawal results in a negative balance in the MSA. [Source ____]

Section 509. Succession Upon the Death of an Individual who has a Medical Savings Account, the money in that account shall be used to pay off any outstanding healthcare costs incurred to a healthcare provider by that individual or other beneficiary of that individual's account for any costs incurred prior to the individual account holder's death. Additionally, any costs due to a Healthcare Facility incurred after that individual's death directly relating to the cause of the individual's death shall be paid from the individual's account. [Source 41 PNC § 963(a)] Any amount remaining from the employee's share shall be transferred to a Medical Savings Account for:
(a) The surviving spouse; or
(b) If there is no surviving spouse, to the children, in equal shares; or
(c) If there are no surviving spouse or children, then to the parents, in equal shares; or
(d) If there are no surviving spouse or children or parents, then to the estate of the deceased individual.

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PART V. NATIONAL HEALTH INSURANCE

A. Summary of Plan Description

1. Section 501. Summary of Plan Description

a. This summary explains the health services covered and not covered, the portion of health care costs a covered individual will pay, and the portion the Plan will pay. It also explains many of the rights, obligations, and conditions between covered individuals and the Plan. [Source 41 PNC § 963(b)]

b. The Plan Administrator will develop and issue Benefit and Policy Interpretation Bulletins (BPIBs) over time when more detail or benefit clarification is needed. The BPIBs are based on available publications relating to coverage determinations, applicable laws and regulations, research, studies, and evidence from other sources, and the practicalities of providing healthcare services to the citizens of Palau. [Source 41 PNC § 55 (c)]

B. TERMS, CONDITIONS & PROVISIONS

1. Section 502. Terms, Conditions, and Provisions

a. Benefit Period is the period of one year starting on October 1st and ending September 30th of each year. If a Covered Service commenced prior to September 30th and treatment ended after September 30th, the entire Covered Service will be part of the prior Benefit Period.

b. Member Cost Share: For certain Covered Services, a covered individual may be required to pay a portion of the Maximum Allowed Amount as a cost-share amount (for example, Deductible, Copayment, and/or Coinsurance). The Deductibles, Copayments, and Coinsurance for the type of Covered Services are outlined on the Plan's Schedule of Benefits in Section 509. Some Covered Services do not require any deductible, copayment, or coinsurance.

i. Deductible: The dollar amount of Covered Services, listed in the Schedule of Benefits, which the covered individual must pay for before the Plan will pay for those Covered Services in each Benefit Period.

ii. Coinsurance: A specific percentage of the Maximum Allowable Amount for a Covered Service that a covered individual must pay. Coinsurance normally applies after the Deductible.

iii. Copayment: A specific dollar amount of the Maximum Allowable Amount for a Covered Service which a covered individual must pay. The Copayment normally applies after the Deductible. The Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowable Amount.

iv. Out-of-Pocket Limit: A specified dollar amount of expense incurred by a covered individual for Covered Services as listed on the Schedule of Benefits. When the Out-of-Pocket Limit is reached for a covered individual, then no additional Coinsurance or Copayments are required for that person unless otherwise specified in the Schedule of Benefits.

c. Maximum Allowable Amount / Allowed Amount / Usual-Customary-Reasonable Charges (UCR): The Plan's payments for Covered Services will be based on the Maximum Allowable Amount. This is the amount that the Plan determines is the maximum payable for each Covered Service. The Maximum Allowable Amount or UCR is the lesser of the actual charge or first-party payment. [Source 41 PNC §

963(b)]

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Operations Manual Content for Editing

Section A: Payment Determination

(a) The payment amount the Plan makes to a provider under a contract with that provider, or the payment amount the Plan makes to a contracted provider for the same services in a similar location.

(b) Alternatively, the payment amount the U.S. Centers for Medicare and Medicaid Services reimburses its participating providers for the same service or supplies in the same geographical U.S. area.

(c) If neither (a) nor (b) apply, the payment amount the Plan determines as a fair amount. This amount will be based on any available information and will reflect the complexity or severity of treatment, the level of skill and experience required for the treatment, and comparable providers' fees and costs in the geographical area to deliver care.

(d) Notice of Claim & Proof of Loss: The Plan is not liable unless it receives written notice that Covered Services have been rendered within 90 days of receiving the Covered Services, and the notice must have the data needed to determine benefits.

(e) Member's Cooperation: By enrollment under the Plan, each covered individual agrees to complete and submit any authorizations, consents, releases, assignments, and other documents as may be requested by the Plan in order to obtain or assure reimbursement under any other insurance, benefit plan, or governmental program. Any member who fails to cooperate will be responsible for any charge for services.

(f) Physical Examination: When a claim is pending, the Plan reserves the right to request a covered individual to be examined by an appropriate provider as often as reasonably required.

(g) Plan's Sole Discretion: The Plan may, as approved by its Referral Committee, cover services and supplies not specifically covered if it is determined that such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a covered individual.

(h) Recovery of Overpayments: If a benefit payment is made by the Plan that exceeds the benefit amount entitled, the Plan has the right to require the return of the overpayment; deduct from an account holder's MSA, or reduce by the amount of the overpayment any future benefit payment made to or on behalf of that person or another person in their family. This right does not affect any other right of recovery with respect to such overpayment.

Section B: Eligibility & Entitlement

(a) Initially, NHI coverage shall begin April 1, 2011, for those individuals who pay subscription costs for both the October-December 2010 and January-March 2011 quarters.

(b) NHI coverage shall begin on the first day of the first calendar quarter following two full, consecutive quarters of payment of the subscription costs, for individuals who were not eligible under HCF OM 503(a) above, such as those who did not earn remuneration during both the October-December 2010 and January-March 2011 quarters.

(c) Initially, NHI coverage shall begin on April 1, 2011, for individuals eligible based on payment of subscription costs by the National Government, provided the individual was eligible for payment of subscription costs by the National Government for both the October-December 2010 and January-March 2011 quarters.

(d) NHI coverage shall begin on the first day of the first calendar quarter following two full, consecutive quarters of payment of the subscription costs by the National Government, for nonworking elderly, non-working individuals.

Edited Content for Chunk 12

Disabled and currently unemployed individuals who were not initially eligible under HCF OM 503(c) may become eligible for coverage. For example, an eligible individual who did not reach the age of 60 until January 2011 and did not pay subscription costs beginning in the October-December 2010 quarter will not have coverage starting on April 1, 2011. Their coverage shall begin on July 1, 2011, at the earliest, based on payment of subscription costs by the National Government unless coverage under government has been retroactively paid to allow immediate coverage.

(e) NHI coverage shall begin on April 1, 2011 for individuals who pay for two full, consecutive quarters, based partly on subscription costs paid by the National Government and partly based on deductions from an MSA during the October-December 2010 and January-March 2011 quarters.

(f) Self-employed individuals may only enroll at the beginning of a Benefit Period. [Source 41 PNC § 955(b)] Section 504. Amount of Subscription Costs

(a) On a quarterly basis, or more often as agreed between the National Government and SSA, the National Government shall pay 2.25% of the mean annual remuneration, as determined by the Committee, in subscription costs for coverage for each eligible individual citizen.

(b) For employees and the self-employed, the amount shall be 2.25% of remuneration, as defined by the Social Security Act.

(c) An individual who does not have payments withheld through employment or paid by the National Government may report and pay the subscription costs quarterly to the HCF using the form provided for that purpose to obtain coverage for themselves beginning no earlier than October 1, 2010. The subscription cost for an individual under this HCF OM 504(c) shall be 2.25% of the official minimum wage at the time the report is filed and payment is made.

[Source 41 PNC § 952 & Social Security Act] Section 502. Rate Modification
The subscription rate may be modified by regulation if required to ensure sustainability of the Palau Health Insurance system, based on the following factors:

(a) The annual financial balance resulting from the operations of Palau Health Insurance;
(b) The amount of return achieved on the investment of reserves; and
(c) Any approved changes in benefit provisions that will likely affect the financial situation of Palau Health Insurance in the future.
[Source 41 PNC § 952(d)]
Section 505. When Coverage Ends Under NHI
(a) Covered Individuals may be Terminated from the Plan for the following reasons:

(i) Following two quarters of non-payment of subscription fees. The Termination Date will be the last day for which subscription fees had been paid.
(ii) Upon notice from the Administrator to an Account Holder that an individual(s) does not meet the eligibility requirements of the Plan. The Termination Date shall be no less than thirty days from the date of such notice.

(b) If a Covered Individual is Terminated due to (a)(i) above and becomes a Covered Individual again due to employment or self-employment, that Covered Individual will be treated as a newly Covered Individual under the Plan.
[Source 41 PNC § 952(f)]
Section 506. Dependents
(a) To be eligible to enroll as a Dependent, one must be:

(i) The Account holder’s Legal Spouse.
(ii) The Account holder’s Domestic Partner: Domestic Partnership means a person of the opposite sex who has signed the Domestic Partner Affidavit certifying that:

he or she is the sole Domestic Partner and has been for twenty-four (24) months or more;
he or she is at least eighteen (18) years old;
he or she is mentally competent;
is not related by blood.

Edited Content for Chunk 13

Domestic Partner Coverage and Eligibility

(a) Eligibility Criteria

1. The individual must be in a domestic partnership as defined by law, meaning they are not married to anyone else and are financially interdependent with the account holder. For purposes under the Plan, a Domestic Partner shall not be treated the same as a Legal Spouse, and the children of a Domestic Partner who are not the account holder's children are not eligible for coverage. A Legal Spouse may be covered immediately after marriage. A Domestic Partner may only begin coverage at the beginning of a Benefit Period.

2. The Account holder's or the Account holder's Legal Spouse's children under the age of twenty-two (22), including natural children, stepchildren, newborn and legally adopted children.

3. Children under the age of twenty-two (22) for whom the Account holder or the Account holder's Legal Spouse is the legal guardian or as otherwise required by law. Legal Guardianship must be for "Full Guardianship" and must not be limited or Shared.

4. A child of a covered Dependent (i.e., a grandchild of the covered Account holder or the Account holder's covered Legal Spouse) until the Dependent child (not the grandchild) reaches age twenty-two (22).

5. An unmarried Dependent who cannot work to support themselves due to mental or physical disability. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within thirty (30) days after the Dependent would normally become ineligible.

6. To obtain coverage for children, The Plan may require that the Account holder complete a "Dependency Affidavit" and/or provide the Plan with a copy of any documents the Plan may require such as court documents, birth certificates, marriage certificates, or tax filings. [Source 41 PNC § 55(c)]

D. Covered & Non-Covered Services and Applicable Section 507

1. This section, along with Section 550 – "Limitations & Exclusions", outlines health care services for which the Plan will and will not provide Benefits. All Benefits and Covered Services are subject to the Deductibles, Coinsurance, Copayments, Maximums, exclusions, limitations, terms, conditions, and provisions as shown on the Schedule of Benefits of Section 509 and in these regulations. Benefits for Covered Services are based on the Maximum Allowable amount. To receive maximum Benefits for Covered Services, a covered individual must follow the terms set forth in these regulations including obtaining any required pre-approvals.

2. To be covered, the service must be medically necessary. "Medically necessary" means health care services or products provided to a covered individual for the purpose of preventing, diagnosing, or treating an illness, injury, or disease, or the symptoms of an illness, injury, or disease in a manner that is:

- Consistent with generally accepted standards of medical practice.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Demonstrated through scientific evidence to be effective in improving health outcomes.
- Representative of "best practices" in the medical profession.
- Not primarily for the convenience of the covered individual or physician or other health care

practitioner.

(b) Health Services: Not all the benefits outlined are covered under the National Health Insurance Plan or reimbursable under account holders' Medical Savings Accounts. Applicability or coverage of benefits is dependent on:

 Each Service.

 If the service was rendered in Palau or Off-island.

 If it pertains to NHI or MSA. The Schedule of Benefits in Section 509 specifies the details of each service. Health services that are not covered under the National Health Insurance Plan or reimbursable under account holders' Medical Savings Accounts will be clearly indicated in the Schedule of Benefits.

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Services offered include:

1. Office Visits and Doctor Services
2. Inpatient Hospital Services
3. Alternatives to Inpatient Hospital Stays, such as Skilled Nursing Facility (SNF)
4. Home Health Care and Hospice Care
5. Emergency Care
6. Outpatient Diagnostic Services
7. Prescription Drug Benefit
8. Preventive Care Services
9. High-Level Therapy Services
10. Short-Term Outpatient Rehabilitation Therapy Services
11. Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Surgical Supplies

Under the heading of "Surgical Supplies," Transportation Services including Ground Ambulance and Air transportation are included. Additionally, Wellness and Disease Management, Transplant Services are part of the offerings.

Section 508: Covered Services at BNH

(a) The Plan will not reimburse BNH for any capital costs or costs of personnel employed by the Ministry of Health.

(b) The cost of inpatient medical services to be reimbursed to BNH is determined by applying the most recent Reimbursement Schedule.

(c) Covered services at BNH include other professional services, supplies, appliances, equipment, drugs or biologicals provided by a third-party provider and not directly from BNH.

Section 509: Schedule of Benefits (table)

Section 511: Providers Other than Belau National Hospital

The Administration may enter into agreements for reimbursement to providers other than Belau

National Hospital for inpatient care and off-island referrals, including medical evacuation, provided that:

(a) The reimbursement does not exceed the amount that would be paid to Belau National Hospital for the same services;

(b) Any off-island referral, including medical evacuation, is approved by the Medical Referral Committee using the same standards applied to referrals made by Belau National Hospital.

Section 530: Covered Off-island Care and Other Services that Require Approval

NHI reimburses for Off-island Care and Other Services that may require approval if the following conditions are met:

(a) Services must comply with existing laws and regulations, be medically necessary, and be administered in the most practical, cost-effective setting for that particular medical case.

(b) The Administrator, through the Medical Referral Committee, shall only certify or approve medical services for off-island treatment, whether preapproved or post-approved:

- That meet the requirements of (a) above,
- That are covered under the Plan and meet all conditions of coverage under the Plan, and
- That are administered in the most practical, cost-effective facility for that particular case.

Section 531: Covered Medical Evacuation

(a) For approved off-island referrals, NHI reimburses for the cost of one round-trip economy class airline ticket for the covered individual at the lowest published economy fare on the date of travel subject to the Travel Co-payment Schedule in Section 543.

(b) If a stretcher is medically necessary for medical transportation, then NHI reimburses for the costs of round-trip economy class airline tickets at the lowest published economy fare on the date of travel for the number of seats necessary to meet airline requirements.

Edited Content for Chunk 15

Travel Co-payment Schedule (in Section 543)

(c) If a medical attendant is medically necessary, NHI shall also reimburse for the cost of one round-trip economy class airline ticket for one individual at the lowest published economy fare on the date of travel, subject to the Travel Co-payment Schedule in Section 543.

(d) If the covered individual is a minor, NHI shall also cover the cost of one round-trip economy class airline ticket at the lowest published economy fare on the date of travel for the parent or guardian who accompanies the minor at the time of the medical evacuation, subject to the Travel Co-payment Schedule in Section 543.

(e) Inter-island medical evacuation costs within Palau are not reimbursable. [Source 41 PNC § 955]

Section 532. Non-referred, Emergency Off-island Care

The plan will only pay for services provided to treat a bona fide emergency. The plan will only pay up to charges that are usual, customary, or reasonable. The Referral Committee will use any and all available resources and information to determine:

* Whether a bona fide emergency situation existed.
* A fair and reasonable charge for the service. [Source 41 PNC § 955]

Section 533. When Coverage is Secondary
(a) At the time of service, a covered individual shall disclose whether they have a healthcare or medical coverage plan including but not limited to those provided through a foreign government, such as that provided by US Medicare, civil service, military service, or a workers' compensation plan.

(b) If the medical services provided by an approved provider are subject to coverage under a preexisting plan, then the Plan will Coordinate Benefits. The Plan will develop guidelines for the Coordination of Benefits and issue such guidelines as to not duplicate coverage.

(c) The HCF shall work with the Ministry of State to coordinate secondary coverage for healthcare services provided to an insured individual covered by a foreign government. [Source 41 PNC § 955]

[Sections 534 through 539 Reserved for Future Use]

E. Co-Payments
Section 540. Co-payment for Inpatient Care
NHI reimburses BNH for each covered stay after a copayment from the individual of 20% of the total cost up to a ceiling of $200.00 to $400.00, depending on household income, and after excluding the costs of personnel employed by the Ministry of Health as determined by the Co-payment Schedule in Section 542. The Ministry of Health determines the amount of, and collects, this copayment from the individual receiving services. [Source 41 PNC § 955(a)(1)]

Section 541. Co-payment for Off-island Referrals
NHI reimburses for the covered costs of off-island medical care, including medical evacuation services, provided to an insured individual, directly to BNH, subject to the conditions, limitations, and exceptions set forth in these regulations, after a copayment of 20% of total cost of services up to a ceiling of $1,000.00 to $4,000.00, depending on household income for each covered stay as determined by the Co-payment Schedule in Section 542 and "Travel Co-payment Schedule" contained in Section 543. The Plan determines the amount of, and collects, this copayment from the individual. [Source 41 PNC § 955(a)]

Section 542. Co-payment Schedule (table) [Source 41 PNC §955(a)(2)]

Section 543. Travel Co-payment Schedule
The co-payment for "Care Approved Under Section 553" below will include any additional cost for minors. (table) [Source ___] [Sections 544 through 549 Reserved for Future Use]

F. Exclusions & Limitations

Section 550. Limitations & Exclusions Inpatient Services
In this section, items that are not covered include:

* Cosmetic surgery or procedures
* Elective abortions
* Experimental or investigational treatments
* Treatment for injuries sustained while under the influence of alcohol or drugs
* Treatment for injuries sustained during participation in dangerous sports or activities
* Treatment for injuries sustained during commission of a crime
* Treatment for self-inflicted injuries
* Treatment for mental health disorders that are not medically necessary
* Services provided by providers who have been terminated from the NHI network
* Services provided outside of Palau without prior authorization
* Any other services or treatments deemed unnecessary or inappropriate by the Ministry of Health. [Source 41 PNC § 955(b)]

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Excluded Items Not Covered by the Plan

Items not covered by the plan will not be reimbursed, even if they are medically necessary. These exclusions apply to coverage provided under NHI and the cost of reimbursable services under MSA unless the excluded item is indicated as “Payable” under the MSA column. (Source 41 PNC § 955(c) and 956)

Section 552. Special Provisions for Organ Transplants

(a) Organ transplants are excluded from coverage, but the Committee may specify a specific number of kidney transplants that may be approved for reimbursement to BNH during an upcoming calendar period, provided that the sustainability of the HCF can be maintained with the inclusion of that number of kidney transplants.

(b) Prior to specifying the number of kidney transplants which may be approved, the Minister of Health, the Minister of Finance, and the Administrator shall enter into an agreement establishing specific criteria for eligibility of a covered individual for an approved transplant. The criteria shall require a good prognosis, limit approval to one transplant per covered individual, require the individual to demonstrate active compliance with recommended healthy lifestyle choices and active participation in disease prevention measures, and such other criteria as may be determined by the parties.

(c) All other exclusions and limitations found elsewhere in these regulations shall apply. (Source ___)

Section 553. Special Provisions for Diagnostic Referrals

Care for off-island diagnostic purposes is excluded. In addition, follow-up treatment and evaluations following a covered off-island referral treatment may not be covered. However, where BNH lacks access to medically necessary diagnostic equipment or specialist services and no timely, reasonable substitute for the equipment or specialist services are available, either electronically or on Palau or, in the Plan's determination, that the continuity of care be provided by the off-island provider, then the off-island referral may be approved for reimbursement, subject to other exclusions and limitations found elsewhere in these regulations. (Source ___)

Section 555. Amounts Payable by NHI

(a) The Administrator, with approval from the Committee, shall negotiate and enter into agreements or contractual relationships for off-island medical services with one or more providers to protect the sustainability of the HF and to seek the lowest cost for services while maintaining service quality.

(b) Until provider contracts are established, the Committee shall determine the amounts which are payable for medical care provided through off-island referrals, but the Plan shall continue to determine the cost of care by negotiating with providers on a case-by-case basis. (Source 41 PNC § 955 & 957)

Section 556. Maximum Benefits for Off-island Referrals

In addition to other exclusions and limitations, the amount reimbursable for covered costs shall be subject to a maximum benefit of $35,000 for each calendar year. This maximum benefit may be adjusted by the Governing Committee provided the adjustment is part of an overall review and adjustment of coverage limitations and is demonstrated to be fiscally sustainable through an actuarial study. (Source 41 PNC § 955(c))

G. Medical Referral Committee

Section 501. Role of Medical Referral Committee for Approving Off-island Care

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(a) The Medical Referral Committee process serves to provide quality, affordable, and cost-effective tertiary care.

(b) At the same time, the process also serves to prevent resources from being used for off-island care that is not necessary or appropriate.

Edited Content for Chunk 17

Care Quality

Care can be provided for the patient either through outpatient or inpatient care on Palau. To prevent siphoning of resources from primary care in general, the Medical Referral Committee process for individuals covered through PHI follows the same standards as for an individual not covered through PHI, as provided in Title 34, Palau National Code §333.

Section 502: Approval of Medical Referral Committee Required
Approval of the Medical Referral Committee shall be required for any case submitted for coverage to Palau Health Insurance where care is provided off-island.

Section 503: Standards To Be Used
The Medical Referral Committee shall base referral decisions on an analysis of and subject to the following:
- The patient's ability to pay for the costs of a medical referral
- The patient's life expectancy
- A patient with a condition that can be treated adequately in Palau may not be granted medical referral benefits
- The likelihood that the patient's condition will be substantially improved
- A patient with a condition that the Medical Referral Committee determines is terminal shall not be granted medical referral benefits
- Other factors the Medical Referral Committee deems appropriate. [Source 34 PNC 333(d)]

Section 504: Process for Palau Health Insurance Cases
If the Committee approves the referral of a patient eligible for coverage by PHI, the approval shall be in writing on the form adopted and approved for that purpose and shall include:
- Patient's name, DOB, and SSN/clinic number
- Name and ICD-9 code of patient's diagnosis or diagnoses being approved for off-island treatment
- Specific services to be provided by name and by CPT treatment code
- Identity and amount quoted for providing specific services for each off-island provider who offered services
- Recommendation of Provider to be selected
- Projected length of stay

Section 505: Quotation Process for Off-Island Referrals
(a) The following process shall be used to obtain quotes for services for cases approved for off-island referral:
- The primary physician prepares a Medical Summary and presents it to the Medical Referral Program Coordinator
- The Coordinator sends the Medical Summary to three healthcare providers recommended by the

Committee as best suited to provide the expected services
- The Coordinator contacts the three healthcare providers and requests quotes for the costs of care, broken down by service and as a total amount
- The Committee reviews the quotes and may select the provider based on a combination of cost, availability, ability to provide the care, and past experience with the provider in similar cases
- The Coordinator then informs both the patient and HF of the estimated costs of care
- The patient's share of the costs is collected prior to further action on the referral
- The Coordinator advises the HF when the patient's share has been collected and action is taken on the referral.
(b) If the off-island provider requests approval for additional treatment, the Medical Referral Committee shall review the request using the same process as for a new referral, except that additional quotes are not required, if the additional treatment meets the standards and, in the judgment of the Committee, the additional quoted costs are reasonable and necessary. The HF shall be immediately notified of the approval of additional treatment using the same form.

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Section 506. Approved Benefits by Medical Referral Committee

(a) Costs approved by the Medical Referral Committee include:

- Physician services
- Nursing services
- Other professional healthcare services
- Bed and board
- Diagnostic or therapeutic services
- Drugs and biologicals used or consumed while an inpatient, including a limited supply of drugs and biologicals medically necessary to facilitate the individual's departure and required until they can obtain a continuing supply
- Supplies, appliances, and equipment used or consumed while an inpatient, including a limited supply of drugs and biologicals medically necessary to facilitate the individual's departure and required until they can obtain a continuing supply
- Medical evacuation, including whether an escort is required

(b) All costs approved shall be those reasonable and necessary to provide treatment for the patient's diagnoses.

Section 507. Modifications for Processing Off-island Referrals

The Ministry of Health (MOH) may modify the process for Palau Health Insurance cases and obtaining quotations for costs found in subsections 4 and 5, above, provided agreement is reached with the Healthcare Fund Governing Committee and the changes in process and quotations will not reduce access to off-island care or increase the cost to the individual, MOH, or the Healthcare Fund.

Section 554. Medical Referral Committee Standards

Payments for covered off-island medical care shall be made only for covered services approved

by the Plan when applying the medical standards in effect on the date RPPL 8-14 was enacted until such time as the standards are formally updated. [Source 41 PNC § 955(a)(2)]

PART VI. CLAIMS PROCESSING FOR MSAs

Section 601. General Provisions for Claims Approval

(a) The account holder or beneficiary shall authorize payment to be deducted from an MSA account in writing at the time service is provided using the form from the provider and approved by the HF for that purpose. The form shall also authorize, but not require, the provider to verify sufficient funds are available in an MSA account.

(b) The provider shall submit a request for payment to the HCF for all covered services, which includes proof of providing the covered service and the authorization for payment, on a monthly or quarterly basis using a form approved for that purpose. The HCF shall pay the approved provider on a monthly or quarterly basis, as agreed by the provider and the HCF.

(c) If sufficient funds are not available in the individual’s MSA accounts to make full payment, the Administrator may do the following, in his or her discretion:

- Notify the provider that payment is denied due to an insufficient balance in the individual’s MSA accounts

- Delay payment for up to thirty (30) days, provided that sufficient deposits are expected in an MSA account to make full payment.

(d) The Plan may amend the provisions of this section with the issuance of a Benefit and Policy Interpretation Bulletin. [Source 41 PNC § 939]

Section 602. No Payment of Unauthorized Claims

No payment shall be made for services from any MSA unless the account holder or designated beneficiary authorized payment in writing on a form approved for that purpose by the HCF. [Sections 603 through 700 Reserved for Future Use]

PART VII. CLAIMS PROCESSING FOR NHI

Section 701. General Provisions for Claims Approval

BNH shall aggregate and submit all claims for covered services at BNH for payment on a monthly or quarterly basis in an electronic format which provides the following information:

- Name, date of service, provider name, service provided, diagnosis code, and amount billed.

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f. Obtain the following information for individuals receiving inpatient or off-island referral services:

 Individual's birth date, Social Security Number, BNH clinic number, or other unique identifier

 Dates of each covered service

 Listing of each covered service provided using standardized codes and classifications approved by the Committee

- Diagnoses supporting each covered service
- Certification that the co-payment has been collected from the individual receiving services
- Amount and source of any other payments received for each covered service
- Any other information deemed reasonable and necessary for processing payment

NHI will reimburse BNH for covered services to covered individuals on a monthly or quarterly basis, as agreed by the HF and BNH. The Plan may amend the provisions of this section with the issuance of a Benefit and Policy Interpretation Bulletin.

[Source 41 PNC § 955]

Section 702. Reimbursement to Covered Individuals:

(a) The HF may reimburse covered individuals for covered services where payments were made directly to a provider. In addition to a valid Proof of Payment, the covered individual shall be required to submit the same information as the approved provider, prior to reimbursement.

(b) The HF may enter into agreements with insurers licensed to provide coverage in the Republic of Palau to reimburse an insurer for covered services by an approved provider to a covered individual, which have already been paid by the insurer. If the insurer and the HF enter into such an agreement, the insurer shall be required to submit the same information as the approved provider, prior to reimbursement.

[Source 41 PNC § 955]

[Sections 703 through 800 Reserved for Future Use]

PART VIII. Determinations, Notices, Complaints, & Appeals

Section 801. Administrative Procedures Act Applies: Determinations, notices, complaints, and appeals involving any right, benefit, or obligation under 41 PNC, Chapter 9, or these regulations are governed by the adjudicative process found in the Administrative Procedures Act, as codified in 41 PNC, Title 6, Subchapter III.

[Source 41 PNC §908]

PART XII. Offenses and Penalties

Section 1202. False Claim: An individual who knowingly submits a false claim for benefits or obtains money from the Fund under false pretenses for the purpose of misleading, defrauding, or cheating the Fund shall, upon conviction, be guilty of a felony and may be sentenced to imprisonment for a period not exceeding five (5) years, or a fine of not more than five thousand dollars ($5,000) or double the amount of money fraudulently obtained; whichever is greater, or both. This section does not preclude any criminal prosecution by the Office of the Attorney General under 17 PNC.

Section 1203. Knowingly Falsify Statements and Reports: An employer who knowingly makes a false statement or falsifies any report of record for the purpose of misleading, defrauding, or cheating the Fund shall, upon conviction, be guilty of a felony and may be sentenced to imprisonment for a period not exceeding five (5) years, or a fine of not more than five thousand dollars ($5,000), or both. This section does not preclude any criminal prosecution by the Office of the Attorney General under 17 PNC.

Section 1204. Failure to Report or Pay: An employer or self-employed individual who fails to report or pay any amount of contributions due to the Fund shall be liable for interest on the unpaid balance of the contribution at the rate of twelve percent (12%) per annum from its due date until the date it is

paid.
[Source 41 PNC § 961(a), (b), and (c)]

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Contributions or interest due under this Act are referred to any attorney for collection, whether or not suit is brought for the collection thereof. In such cases, the employer shall additionally be liable for the full cost of reasonable attorney's fees and the costs of collection, including court costs. [Source 41 PNC § 961(c)]

Section 1205. Knowingly Fail to Report or Pay
An employer who knowingly fails to report or pay any amount of contributions due to the Fund shall, upon conviction, be guilty of a misdemeanor and may be sentenced to imprisonment for a period not exceeding twelve (12) months or a fine of not more than two thousand dollars ($2,000), or both. This penalty applies for each such offense committed by the employer. This section does not preclude any criminal prosecution by the Office of the Attorney General under 17 PNC. [Source 41 PNC § 961(d)]

In case any contributions, interest, or penalties due under 41 PNC are referred to an attorney for collection, whether or not suit is brought for their collection, the employer shall additionally be liable for reasonable attorney's fees and costs of collection, including court costs.

(i) The amount of any civil penalty, interest, attorney's fee, or cost of collection shall be paid to the Retirement Fund. [Source 41 PNC § 772(c)]

PART XIII. Ethics and Secrecy
PART I. Confidentiality of Personal Health Information

Section 1301. Commitment to Confidentiality of Personal Health Information
The Ministry of Health (MOH) is committed to protecting the confidentiality of the personal health information in its custody and control. Anyone who collects, uses, or discloses personal health information on MOH's behalf is required to follow these 10 information practices:

Section 102. Accountability for Personal Health Information
(a) MOH is responsible for the personal health information in its custody or control, and has designated Privacy Officers (PO). The POs are accountable for MOH's compliance with its Privacy Policy and related legislation.
(b) MOH demonstrates its commitment to privacy and the confidentiality of personal health information by:
(i) Implementing policies and procedures to protect personal health information.
(ii) Educating anyone who collects, uses, or discloses personal health information on MOH's behalf about their responsibilities under MOH's privacy policies.
(iii) Implementing policies and procedures through the Privacy Office to:

- Receive and respond to complaints
- Field inquiries on privacy-related matters, and
- Make material on MOH's privacy policies and procedures publicly available.

(iv) Reviewing this Privacy Policy on an annual basis.

Section 103. Identifying Purposes for Which Personal Health Information is Being Collected

(a) MOH collects personal health information for purposes related to direct patient/client care, administration and management of MOH programs and services, patient billing, administration and management of the health care system, research, teaching, statistical reporting, fundraising, and as permitted or required by law.

(b) When personal health information that has been collected is to be used for a purpose not previously identified, the new purpose will be identified. Unless the new purpose is permitted or required by law, written consent of the subject of the record is required before the information can be used for that purpose.

Section 104. Consent for the Collection, Use, and Disclosure of Personal Health Information

(a) MOH will generally rely on implied consent from our clients or their legally authorized representative for the collection, use, or disclosure of personal health information and MOH will collect only the minimum amount necessary to fulfill the purpose for which it is collected.

(b) Written consent is required before collecting, using, or disclosing personal health information beyond what is necessary to fulfill the purpose for which it was collected unless the new use or disclosure is permitted or required by law.

(c) MOH will obtain express consent when the information is sensitive in nature.

(d) MOH will not use deception to obtain consent and will provide individuals with clear, understandable explanations of how their personal health information will be used and disclosed.

(e) Individuals have the right to refuse or withdraw consent at any time, subject to legal or contractual restrictions and reasonable notice. Refusal or withdrawal of consent may impact MOH's ability to provide services.

(f) MOH will inform individuals of their rights regarding their personal health information, including their right to access, correct, and request the transfer of their personal health information.

(g) MOH will implement procedures for handling requests for access, correction, or transfer of personal health information in a timely manner and in accordance with its Privacy Policy and related legislation.

(h) MOH will maintain records of all consents obtained to demonstrate compliance with its Privacy Policy and related legislation.

Edited Content for Chunk 21

Section 104. Disclosure and Consent for Personal Health Information (PHI)

(a) MOH may use, disclose, or access PHI as permitted or required by law without express consent for the purposes and functions of administration of the Healthcare Fund (HF).

(b) In some circumstances, MOH will obtain express consent to collect, use, or disclose personal health information. For example, an invoice may explicitly authorize disclosure of personal health information to the HF that is necessary for accurate billing and reporting purposes. When consent is required, an individual may withdraw consent at any time, but the withdrawal cannot be retroactive. The withdrawal may also be subject to legal or contractual restrictions and reasonable notice.

(c) When an individual authorizes billing for services to an insurer such as the HF or a private health insurance provider, they are also consenting to release of personal health information to that organization.

Section 105. Limiting Collection of Personal Health Information
MOH limits the amount and type of personal health information it collects to that which is necessary to fulfill the purposes identified. Information is collected directly from the individual, unless the law permits or requires collection from third parties.

Section 106. Limiting Use, Disclosure, and Retention of Personal Health Information
MOH uses and discloses personal health information for purposes related to direct patient/client care, administration and management of MOH programs and services, patient billing, administration and management of the healthcare system, research, teaching, statistical reporting, fundraising, and as permitted or required by law.

Section 107. Accuracy of Personal Health Information
To the extent reasonably possible, personal health information will be as accurate, complete, and up-to-date as is necessary for the purposes for which it is to be used.

Section 108. Safeguards for Personal Health Information
(a) MOH has implemented security safeguards for the personal health information it holds, which include: physical measures (such as locked filing cabinets), organizational measures (such as permitting access on a "need-to-know" basis only), and technological measures (such as the use of passwords, encryption, and audits).

(b) MOH requires anyone who collects, uses, or discloses personal health information on its behalf to be aware of the importance of maintaining the confidentiality of personal health information. This is done through the signing of confidentiality agreements, privacy training, and contractual means.

(c) MOH ensures that the personal health information in its custody and control is protected against theft, loss, and unauthorized use or disclosure.

(d) Care is used in the disposal or destruction of personal health information to prevent unauthorized parties from gaining access to the information.

Section 109. Openness About Personal Health Information Policies and Practices
Information about MOH's policies and practices relating to the management of personal health information are available from the MOH Administrative offices, including:

(a) Contact information for the Privacy Officers (POs), to whom complaints or inquiries can be made;

(b) The process for obtaining access to personal health information held by MOH, and making requests for its correction;

(c) A description of the type of personal health information held by MOH, including a general account of its use and disclosures;

(d) A copy of any brochures or other information that explains MOH's privacy policies, procedures, or regulations.

Section 110. Individual Access to Personal Health Information
(a) Individuals may make written requests to have access to their records of personal health information, in accordance with MOH's policy for accessing personal health information.

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Access and Correction to Records

(b) The Ministry of Health (MOH) will respond to an individual's request in a reasonable time and may charge for the cost of reproducing or accessing records, as established by a separate policy.
(c) MOH will take reasonable steps to ensure that the requested information is made available in a form that is understandable.
(d) Individuals who successfully demonstrate the inaccuracy or incompleteness of their personal health information may request that MOH amend their information.

PART XIV. IMPROVEMENT EFFORTS
Section 1401. Authority For Improvement Efforts. The Board and Committee shall continue to explore other possible options for improving the scope and financial sustainability of the National Medical Savings Fund and National Health Insurance, including, but not limited to, pursuing funding under the Compact of Free Association with the United States. Further, any changes which have financial implications for the Fund, whether by bill or by regulation, shall be accompanied by a report from an actuary prior to approval. [Source RPPL 8-14, Section 4]
Section 1402. Purpose. The Olbiil Era Kelulau established the healthcare financing system to address

the increasing costs of delivering healthcare and the escalating accounts receivable at the Ministry of Health. The mechanisms are a combination of MSAs and insurance for catastrophic care, with the continued safety net of governmental spending. These ensure continued access to healthcare and foster development of public and private providers. In addition, the population is to be encouraged to adopt healthy lifestyles and take personal responsibility for his or her own health. [Source RPPL 8-14, Section 1]

Section 1403. Actions to be Taken. To further those goals and objectives, the Health Fund (HF) shall collaborate with the Minister of Health and other governmental, non-profit, and for-profit entities to monitor usage and collect information relevant to making decisions for improving both the MSA and NHI programs; seek financial and other support to expand covered services; and review and consider modifying subscription rates after two years of operations. Specifically, the HF shall promote, encourage, and use standard coding and classifications, participate in the Pacific National Health Accounts Network, and monitor and report on the following factors after two years of operations:

(a) The annual financial balance resulting for the operations of National Health Insurance;

(b) The amount of return achieved on the investment of reserves;

(c) Proposed changes in benefit provisions that will likely affect the financial situation of the NHI in the future; and,

(d) Proposed reductions in subscription costs for individuals participating in preventive care programs, as certified by the Ministry of Health.

[Source 41 PNC § 955(d)]
