

I Mina'Trentai Kuåttro Na Liheslaturan
BILL STATUS

BILL NO.	SPONSOR	TITLE	DATE INTRODUCED	DATE REFERRED	CMTE REFERRED	PUBLIC HEARING DATE	DATE COMMITTEE REPORT FILED	FISCAL NOTES	NOTES
132-34 (COR)	Dennis G. Rodriguez, Jr.	AN ACT TO AMEND SECTIONS § 6101, § 6102, § 6103, AND § 6104, AND TO ADD §§ 6102.1, 6106, 6107, 6107.1, 6107.2, 6107.2.1 THROUGH 6107.2.13, 6107.3, 6107.4, 6107.5, 6107.5.1 THROUGH 6107.5.9, 6107.6, 6107.6.1, 6107.6.2, 6107.7, 6107.7.1, 6107.8, 6107.9, 6107.9.1, 6107.9.2, 6107.10, 6107.11, 6107.11.1 THROUGH 6107.11.5, 6107.12, 6107.13, 6107.14, 6107.15, 6107.16, 6107.17, 6107.18, 6107.19, 6107.20, 6107.20.1 THROUGH 6107.20.3, 6107.21, AND 6107.22, ALL TO CHAPTER 6, DIVISION 1, TITLE 10 OF THE GUAM CODE ANNOTATED, RELATIVE TO IMPROVING EFFICIENCY IN PROGRAM OPERATIONS AND EXPANDING HEALTHCARE ACCESS TO THE GUAM MEDICAID PROGRAM BY ESTABLISHING A MANAGED CARE PILOT PROGRAM TO BE KNOWN AS "THE HEALTH CARE PARA TODU PLAN".	6/23/17 4:58 p.m.						

MINA' TRENTAI KUATTRO NA LIHESLATURAN GUAHAN
2017 (FIRST) Regular Session

Bill No. 132 -34 (COR)

Introduced by:

Dennis G. Rodriguez, Jr. 

AN ACT TO AMEND SECTIONS § 6101, § 6102, § 6103, AND § 6104, AND TO ADD §§ 6102.1, 6106, 6107, 6107.1, 6107.2, 6107.2.1 THROUGH 6107.2.13, 6107.3, 6107.4, 6107.5, 6107.5.1 THROUGH 6107.5.9, 6107.6, 6107.6.1, 6107.6.2, 6107.7, 6107.7.1, 6107.8, 6107.9, 6107.9.1, 6107.9.2, 6107.10, 6107.11, 6107.11.1 THROUGH 6107.11.5, 6107.12, 6107.13, 6107.14, 6107.15, 6107.16, 6107.17, 6107.18, 6107.19, 6107.20, 6107.20.1 THROUGH 6107.20.3, 6107.21, AND 6107.22, ALL TO CHAPTER 6, DIVISION 1, TITLE 10 OF THE GUAM CODE ANNOTATED, RELATIVE TO IMPROVING EFFICIENCY IN PROGRAM OPERATIONS AND EXPANDING HEALTHCARE ACCESS TO THE GUAM MEDICAID PROGRAM BY ESTABLISHING A MANAGED CARE PILOT PROGRAM TO BE KNOWN AS "THE HEALTH CARE PARA TODU PLAN".

2017 JUN 23 PM 4:58


BE IT ENACTED BY THE PEOPLE OF GUAM:

Section 1. Legislative Intent. *I Liheslaturan Guåhan* finds that in examining the uninsured in Guam, both the low-income individuals and families and employees of small businesses clearly stand out as having high rates of un-insurance. *I Liheslaturan Guåhan* takes note that although a large segment of the labor force on Guam in this range already enjoys prepaid health coverage either by virtue of collective bargaining agreements, employer-sponsored plans, or individual initiative, there is a need to extend that protection to citizens and workers who at present do not possess any, or possess only inadequate, prepayment coverage. It is therefore the intention of *I Liheslaturan Guåhan* to focus efforts on these two populations in order

1 to significantly decrease the number of uninsured. It is the intent of I
2 Liheslaturan Guåhan to provide for the care of this portion of our population
3 via a commercial managed care program called Health Care Para Todu. I
4 Liheslaturan Guåhan finds in 10 GCA Health and Safety Chapter 6, Guam
5 Medical Assistance Plan, §§ 6101 thru 6105, the desire to give persons
6 under the Medicaid program the opportunity to be enrolled in prepaid health
7 plans. This law gives the Department of Public Health and Social Services
8 the authority to contract with health care providers to establish pilot
9 programs that show value. In the research, it is discovered that significant
10 cost savings and quality improvements may be achieved in the commercial
11 managed care arena and that this initiative is a first step toward evolving into
12 future innovative practices such as Accountable Care Organizations.

13 The assumption is that this group consists of people between 108% and
14 200% of the Guam adjusted, federal poverty level. With increasing health
15 care costs and premiums, health insurance can be out of reach for families
16 earning less than 200% of the federal poverty level. Subsidization options
17 should be considered for this population to make coverage more affordable.
18 Voluntary individual program participation and an employer mandate should
19 require the financial contribution of employees, employers, and government
20 entities.

21 It is therefore resolved to facilitate the application of Section 1115 of
22 the Social Security Act (Medicaid waiver) in order to provide expansion of
23 the Medicaid program to eligible beneficiaries not currently covered, within
24 the range of 108% to 200% of the applicable Guam Federal Poverty Level. It
25 is estimated that an additional 15,000 to 16,000 lives will be eligible for
26 health insurance. It is also the intent to allow flexibility to the Director,
27 Department of Public Health and Social Services, in the Section 1115

1 application process and the ever-changing Federal rules, to coordinate and
2 amend specific idiosyncrasies of the plan in order to align with current
3 Federal policy.

4 Section 2. § 6101, Chapter 6, Division 1, Title 10 of the Guam
5 Code Annotated, is hereby *amended* to read:

6 “§ 6101. Statement of Policy. The Legislature declares that
7 ~~m~~Medicaid recipients receiving medical assistance under Title XIX [federal
8 law] and those persons enrolled under the Medicaid Program of the Social
9 Security Act whose premiums are being paid for by the government of
10 Guam shall be given the opportunity to be enrolled in prepaid health plans as
11 a means of affording them comprehensive health care and related remedial
12 and preventive services.

13 ~~Prepaid Health Plan (PHP) as used herein means a multi-specialty~~
14 ~~group practice or an individual practice association developed to provide~~
15 ~~medical services on a prepaid basis.~~

16 ~~The Department of Public Health and Social Services shall contract~~
17 ~~with a qualified Prepaid Health Plan pursuant to this Chapter and shall~~
18 ~~award such contract on a non-bid basis.~~

19 ~~Each Prepaid Health Plan shall furnish to the Department such~~
20 ~~information and reports as the Department may find necessary in performing~~
21 ~~its functions under this Chapter. Such information and reports shall include,~~
22 ~~but shall not be limited to, statistical information regarding utilization of~~
23 ~~services, age and sex, specific mortality and morbidity rates, services~~
24 ~~supplied, manpower resources and costs of health care and administration,~~
25 ~~compiled from a basic data system as the Department may require. The~~
26 ~~Prepaid Health Plan and the Department shall maintain such records and~~
27 ~~afford access thereto to verify the information and reports which may be~~

1 ~~required under this Chapter. The Department shall annually conduct a survey~~
2 ~~of beneficiaries to determine their satisfaction with the services provided by~~
3 ~~the Prepaid Health Plan.~~

4 All health care services available under this Chapter shall be
5 equivalent to the level and basic scope of services required under public
6 assistance programs. It is the objective of this legislation that health care, as
7 provided in Guam under Title XIX of the Social Security Act, ~~be~~ is available
8 and accessible at all times to all qualified recipients. It is further the intent of
9 this Chapter such care shall be of the highest quality.”

10 **Section 3. § 6102, Chapter 6, Division 1, Title 10 of the Guam**
11 **Code Annotated is hereby *amended* to read:**

12 **“§ 6102. Responsibility.** The Department shall, in carrying out the
13 intent of this Chapter, contract with a ~~multispecialty group practice of an~~
14 ~~individual practice association~~ qualified health care plan contractor (s)
15 through a Prepaid Health Care Plan, to establish pilot programs which
16 demonstrate the value or lack thereof of such a program in delivering or
17 financing health care services in such a manner. Each pilot program ~~be~~ is for
18 a specified duration not to exceed four (4) years and each pilot program shall
19 be evaluated annually for its efficiency, effectiveness and quality. ~~The~~
20 ~~Department shall pursue the feasibility of establishing the following as pilot~~
21 ~~program:~~

22 ~~A per person risk assuming contract with one (1) or more organization~~
23 ~~which provide payment to a specified class or classes of providers.~~

24 ~~Persons eligible for services under the public assistance program shall~~
25 ~~be assigned by the Department to a Prepaid Health Plan which affords any~~
26 ~~qualified medicaid provider within the territory of Guam an opportunity to~~
27 ~~participate in the plan under reasonable restrictions approved by the~~

1 ~~Department; provided, however, such persons shall be entitled to request and~~
2 ~~receive a medicaid card if assignment to a plan does not meet with their~~
3 ~~satisfaction.~~

4 ~~For purposes of this Section "risk assuming" means the pilot program~~
5 ~~contractor agrees to assume the risk of utilization of services or costs of~~
6 ~~services, or both.~~

7 The Department shall establish, through contracts, health service
8 delivery systems as pilot programs to determine whether high-quality
9 comprehensive medicaid Medicaid benefits can be provided at a reasonable
10 cost on a prepayment basis on such a system. ~~The pilot programs shall have~~
11 ~~at least the following characteristics:~~

12 ~~The programs shall be operated either by the Department directly or~~
13 ~~through contracts with Prepaid Health Plans.~~

14 ~~The programs shall enroll medicaid recipients and be funded by the~~
15 ~~Department on a prepayment capitation basis. Such rate of payment shall be~~
16 ~~determined annually and shall be ten percent (10%) less than valid claims~~
17 ~~incurred by the Department for covered medicaid recipients projected on an~~
18 ~~annual basis as reflected by the accrued average monthly claims for the~~
19 ~~previous six (6) months plus all anticipated increases in costs in the contract~~
20 ~~year. The rate shall not include any costs of the Department for claims or~~
21 ~~administrative fees to fiscal intermediaries. The per capita amounts~~
22 ~~determined shall be based on sound actuarial data and be recognized to vary~~
23 ~~between the categories of aid to families with dependent children, aid to the~~
24 ~~totally disabled, aid to the blind, old age security or such other categories as~~
25 ~~may be determined by the Director of the Department.~~

26 The programs shall provide the full range of services offered under
27 the public assistance program and shall meet all statutory requirements and

1 all regulatory and contractual requirements established by the Department
2 for the program.

3 The programs shall emphasize the innovative use of health personnel
4 including mid-level medical, nursing and dental professionals in ambulatory
5 settings.

6 Medicaid recipients enrolling in a pilot program pursuant to this
7 Chapter shall be offered a choice of qualified primary care physicians
8 employed or under contractual arrangements with the Prepaid Health Plan to
9 be the recipients' designated primary care physicians.

10 The Director, Department of Public Health and Social Services shall
11 create and administer the Health Care Para Todu Plan with the authority to
12 submit and apply for any:

13 a) Federal waivers necessary to implement the program in a manner
14 consistent with this Chapter, including without limitation approval
15 for a comprehensive waiver under Section 1115 of the Social
16 Security Act, 42 U.S.C. §1315; and

17 b) Medicaid State Plan Amendments necessary to implement the
18 program in a manner consistent with this Chapter.

19 Implementation of the Health Care Para Todu plan is conditioned
20 upon the receipt of necessary federal approvals and as such, if the DPHSS
21 does not receive the necessary federal approvals, the program shall not be
22 implemented.

23 The Director, DPHSS, through the Director, Department of
24 Administration, is specifically authorized to pay premiums and supplemental
25 cost-sharing subsidies as appropriate directly to the qualified health plan
26 contractor (s) for enrolled individuals.

1 Upon receipt of necessary federal approval, during calendar year
2 2017, the DPHSS shall transition to include the expansion category and shall
3 develop and implement a strategy to inform potential eligible Medicaid
4 recipient populations of the Health Care Para Todu plan.”

5 **Section 4. A new § 6102.1 is *added* to Chapter 6, Division 1, Title**
6 **10, Guam Code Annotated, to read:**

7 **“§ 6102.1 Evaluation of Health Care Para Todu Plan. Under**
8 Section 1115 of the Social Security Act, waivers are experiments, pilots, or
9 demonstration programs; they require evaluation (42 CFR 431.424). The
10 Director, DPHSS shall consider in an evaluation of premium assistance the
11 following:

- 12 a) The extent to which the approach results in covering more
13 individuals than would have been the case without the expansion;
14 b) The effect on access to care;
15 c) Whether enrollees are able to access necessary benefits through a
16 wrap, and the process for administering the wrap;
17 d) The impact of premiums, cost sharing, and incentives for healthy
18 behaviors on enrollment and service utilization;
19 e) The overall costs to the state and federal Medicaid program and
20 federal spending generally.

21 The terms and conditions of the waivers include evaluation
22 requirements, although the specific research questions and design are settled
23 through a subsequent approval process. The Director, DPHSS, shall submit
24 an evaluation design plan that includes a discussion of the hypotheses, the
25 data and methods of collection, how the impact of the waiver will be
26 isolated, and a timeline (42 CFR 431.424). The Director, DPHSS, shall
27 provide updates on enrollment as part of the evaluation process, with

1 implementation updates and outcomes data as required per the Section 1115
2 waiver.

3 One purpose of the evaluation is to determine whether or not the
4 waivers were cost effective in a manner that takes into account both the
5 initial and the longer-term costs and implications, such as health outcomes.
6 There should also be specific research questions that the evaluations shall
7 answer, for example, whether premium assistance beneficiaries have equal
8 or better access to care, fewer gaps in coverage, continuity of provider
9 access, and satisfaction with services. The Director, DPHSS, shall therefore,
10 in alignment with the timetable established in the Section 1115 waiver,
11 report to *I Liheslaturan Guåhan*, through the Speaker and Chairman of the
12 Health Committee, updates from the established evaluation criteria.”

13 **Section 5. § 6103, Chapter 6, Division 1, Title 10 of the Guam**
14 **Code Annotated is hereby *amended* to read:**

15 **“§ 6103. Plan.** The government of Guam shall take an integrated,
16 employer sponsored, market-based approach to covering low-income
17 residents by offering new coverage opportunities, stimulating market
18 competition, and offering alternatives via a pilot project to eligible
19 beneficiaries with income between 108% to 200% of the Guam adjusted
20 federal poverty level. This prepaid health plan shall be known as the Health
21 Care Para Todu Plan. This program is not considered an entitlement program
22 and is subject to cancellation upon appropriate notice. It is employer-
23 sponsored coverage as referred in Section 1906A of the Social Security Act,
24 Health Insurance Premium Payment Programs.

25 Prepaid Health Plans contracting under this Chapter shall guarantee
26 and provide assurances to the Department of Public Health and Social
27 Services that all services contracted for shall be readily available and

1 accessible and that further, all medical services covered under the contract
2 which are required on an emergency basis be available on a 24-hour, seven
3 days a week basis, either in the Prepaid Health Plans own facilities or
4 through arrangements with another provider which has been approved by the
5 Department. The Department is hereby directed to establish standards of
6 care and to conduct testing and review procedures to assure compliance with
7 such standards.

8 It is in the public interest that medical assistance of the proper quality
9 and quantity ~~be~~ is provided in the most effective and economical manner
10 consistent with such high quality medical standards. It is further the
11 objective of this Chapter that there shall be proper utilization of all health
12 care services.

13 All administrative powers and duties with respect to Prepaid Health
14 Plans, including determination of per capita payment rates, approval of
15 prepaid health contracts and pilot programs which provide health care
16 services pursuant to prepaid health contracts is hereby vested with the
17 Director of the Department of Public Health and Social Services herein
18 referred to as Director.

19 The Director is hereby empowered to establish a basic schedule of
20 benefits for prepaid plans conforming to the scope and duration of
21 ~~m~~Medicaid health services as set forth in Federal requirements for ~~the~~
22 ~~territory of~~ Guam to enumerate standards of participation for such Prepaid
23 Health Plans and pilot programs and subject to this Chapter.

24 In the administration of this Chapter and in the negotiating of
25 contracts thereunder, the Department shall give due consideration to the
26 reputation of the prepaid health organization in providing such benefits, to
27 the accessibility and availability of its facilities and resources for health care

1 to enrolled persons under this Chapter, and to new and innovative concepts
2 in the delivery of health care services.

3 No contract between the Director and a Prepaid Health Plan shall be
4 approved unless the plan and its facilities meet quality program standards.
5 These standards shall require the Prepaid Health Plan to demonstrate to the
6 Department that it has adequate financial resources, physical facilities,
7 organizational and administrative capacities, and a sound program design to
8 discharge its contractual obligations.

9 The Prepaid Health Plan will maintain financial records in accordance
10 with applicable Federal guidelines and will also have annual audits
11 performed by an independent certified public accountant. Certified financial
12 statements shall be filed annually as soon as practical after the close of the
13 plan's fiscal year and in any event within a period not to exceed one hundred
14 twenty (120) days thereafter. For good cause, the Department may grant
15 exceptions to the time within which annual financial statements are to be
16 submitted to the Department.

17 The Prepaid Health Plan shall be liable for all valid out-of-area
18 emergency services ~~which~~ that are required by the contract and rendered by
19 another provider. Payment for such services shall cover treatment of
20 emergency conditions provided plan has been notified within seventy- two
21 (72) hours of occurrence until such time as the patient may reasonably be
22 transferred to the Prepaid Health Plan's facilities.

23 The Prepaid Health Plan shall establish procedures for continuously
24 reviewing the quality of care, the utilization of services and facilities and
25 costs. Information derived from such review shall be made available to the
26 Department.

27 If the enrollee has an unresolved grievance, a fair hearing shall be

1 made available under appropriate provisions of the ~~Government Code of~~
2 ~~Guam~~ Administrative Adjudication Law to resolve all grievances regarding
3 care and administration of the plan. Findings and recommendations of the
4 Director based on the results of the fair hearing shall be binding on the plan
5 and the enrollees.

6 The Director shall report annually to ~~the Legislature~~ I Liheslaturan
7 Guåhan on the experience with the prepaid plan with specific reference to
8 consumer satisfaction and dissatisfaction, quality and utilization.”

9 Section 6. Section 6104, Chapter 6, Division 1, Title 10 of the
10 Guam Code Annotated is hereby *amended* to read:

11 “§ 6104. Program Availability. Any provider of medical assistance
12 under the Guam Medical Assistance Plan ~~which~~ that has entered into a
13 contract with the Department of Public Health and Social Services pursuant
14 to this Chapter. may make the benefits known to enrollees by means of
15 relevant methods and materials. The materials may be disseminated to
16 enrollees by the Department at the contractor's expense. The contractor shall
17 be responsible for all presentations by such representatives and for all ethical
18 and professional content of the plans materials. Examples of all printed or
19 illustrated material prepared by the contractor shall be submitted prior to
20 dissemination.

21 Medicaid managed care plans must maintain a sufficient number, mix,
22 and geographic distribution of providers and cover out-of-network services
23 if the network is unable to provide them as provided in 42 CFR 438.206-
24 207 and 42 CFR 438.52. Medicaid managed care plans also must provide
25 access to essential community providers per 45 CFR 156.235. However,
26 patients seeking care “out of network” when there are “in-network”
27 providers available is not an option in Medicaid managed care. Medicaid

1 managed care plans shall contract with at least one federally qualified health
2 center (FQHC) or rural health center (RHC)."

3
4 Section 7. Section 6106, Chapter 6, Division 1, Title 10 of the
5 Guam Code Annotated is hereby *added* to read:

6 "§ 6106. Definitions, Terms and Concepts. Unless the context
7 otherwise requires, the definitions contained in this Section shall govern the
8 provisions of this Chapter:

9 a) **Co-pay.** In health insurance, a co-pay (copayment) is a fixed
10 amount you pay for covered services, typically when you get the
11 service.

12 b) **Coinsurance.** In health insurance, coinsurance is the share of
13 costs of the allowed amount for a covered service after a patient
14 reaches his or her deductible.

15 c) **Deductible.** The health insurance deductible is the amount the
16 patient has to pay out-of-pocket for covered services before the
17 insurance begins to pay.

18 d) **Department.** means the Department of Public Health and Social
19 Services (DPHSS).

20 e) **Director** means the Director of the Department of Public Health
21 and Social Services (DPHSS).

22 f) **Delivery System** means that Medicaid benefits under this
23 expansion plan that are offered via a managed care plan. Fees for
24 the plan will be taken from the Para Todu fund.

25 g) **Employer** means any individual or type of organization, including
26 any partnership, association, trust, estate, joint stock company,
27 insurance company, or corporation, whether domestic or foreign, a

1 debtor in possession or receiver or trustee in bankruptcy, or the
2 legal representative of a deceased person, who has one or more
3 regular employees in the employer's employment. "Employer"
4 does **not** include:

5 1) The Government of Guam, any of its political subdivisions, or
6 any instrumentality of the Government of Guam or its political
7 subdivisions;

8 2) The United States government or any instrumentality of the
9 United States;

10 3) Any other state or political subdivision thereof or
11 instrumentality of such state or political subdivision;

12 4) Any foreign government or instrumentality wholly owned by a
13 foreign government, if [:]

14 5) The service performed in its employ is of a character similar to
15 that performed in foreign countries by employees of the United
16 States government or of an instrumentality thereof.

17 h) **Employer Mandate** means that employers of any employee
18 meeting the beneficiary criteria must provide health insurance
19 coverage under this plan or a similar commercially available plan.

20 i) **Employee Participation.** Individual employees eligible for this
21 program are not required to participate.

22 j) **Employment** means service, including service in interstate
23 commerce, performed for wages under any contract of hire, written
24 or oral, expressed or implied, with an employer.

25 k) **Federal Poverty Guideline** means the poverty guidelines updated
26 annually in the Federal Register by the U.S. Department of Health

1 and Human Services under authority of §673(2) of the Omnibus
2 Budget Reconciliation Act of 1981.

3 1) **Guam Income Guidelines** means the Federal poverty guidelines
4 adjusted for the higher cost of living on Guam relative to the
5 national standard.

6 m) **Health Savings Account (HSA).** An HSA is a tax-exempt trust or
7 custodial account set up with a qualified HSA trustee to pay or
8 reimburse certain medical expenses incurred. There are four
9 federal requirements to be eligible for HSAs:

10 1) A person must be covered simultaneously by a qualified “high-
11 deductible” health insurance policy (HDHP).

12 2) For 2015, and 2016 participants in qualified HDHPs are
13 required to pay the first \$1,300 of their medical expenses
14 (\$2,600 for family coverage) before insurance benefits begin.
15 (Conventional insurance plans, whose participants cannot
16 contribute to HSAs, typically have had deductibles of about
17 one-third to one-half these amounts; however many new health
18 plans sold through ACA health exchanges have deductibles of
19 \$1,000 to \$6,000 for 2014 through 2016.)

20 3) The HSA enrollee cannot be covered by any other health
21 insurance plan, such as a spouse’s plan.

22 4) The HSA enrollee must be under age 65.

23 5) The HSA enrollee cannot be claimed as a dependent on
24 someone else’s federal income tax return.

25 6) A patient is considered to be an eligible individual for the entire
26 year if he or she is an eligible individual on the first day of the
27 last month of the patient’s tax year (December 1 for most

1 taxpayers). If the patient meets these requirements, he or she is
2 an eligible individual even if the patient's spouse has non-
3 HDHP family coverage, provided the spouse's coverage does
4 not cover the patient. There is no income, employment or other
5 age limits in the federal law.

6 **(u) Health Maintenance Organization (HMO)** is a health plan in
7 which the patient must choose a Primary Care Physician (PCP)
8 from a network of local healthcare providers who will refer the
9 patient to in-network specialists or hospitals when necessary. All
10 the care is coordinated through that PCP.

11 **(v) Medical Home** also known as the **patient-centered medical**
12 **home (PCMH)**, is a team-based health care delivery model led by
13 a health care provider that is intended to provide comprehensive
14 and continuous medical care to patients with the goal of obtaining
15 maximized health outcomes

16 **(w) Medical Necessity or Medically Necessary** is a condition that
17 must be determined on an individual basis and must consider
18 available research findings; health care practice guidelines and
19 standards issued by professionals, recognized organizations or
20 government agencies. Medical Necessity or Medically Necessary
21 means the treatment must be certain to save lives or significantly
22 alter an adverse prognosis:

- 23 1) In accordance with generally accepted standards of medical
24 practice; and
- 25 2) Clinically appropriate in terms of type, frequency, extent, site
26 and duration.

1
2 (x) **Member or covered person** means an eligible person who enrolls
3 in the Health Care Para Todu Program.

4 (y) **Non-Provider** means a person who provides hospital, medical,
5 dental or behavioral health care, but does not have a contract or
6 subcontract with the Program.

7 (z) **Practitioner** means a person licensed pursuant to Chapter 12 of
8 Division 1, Part 1 of Title 10 of the Guam Code Annotated.

9 (aa) **Premium** means the amount payable to a prepaid health care plan
10 contractor as consideration for the contractor's obligations under a
11 prepaid health care plan.

12 (bb) **Preferred Provider Organization (PPO)** is a type of health plan
13 in the Individual and Family health insurance market. PPO plans
14 allow you to visit whatever in-network physician or healthcare
15 provider you wish without first requiring a referral from a primary
16 care physician. This Health Care Para Todu plan does not use a PPO
17 model for provision of services.

18 (cc) **Prepaid health care plan** means any agreement by which any
19 prepaid health care plan contractor undertakes in consideration of a
20 stipulated premium:

- 21 1) Either to furnish health care, including hospitalization, surgery,
22 medical or nursing care, drugs or other restorative appliances,
23 subject to, if at all, only a nominal per service charge; or
24 2) To defray or reimburse, in whole or in part, the expenses of
25 health care.

26 (dd) **Prepaid health care plan contractor** means:

- 1) Any medical group or organization that undertakes under a prepaid health care plan to provide health care; or
- 2) Any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care; or
- 3) Any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care.

(ee) **Prepaid health care plan** means any agreement by which any prepaid health care plan contractor undertakes in consideration of a stipulated premium:

- 1) Either to furnish health care, including hospitalization, surgery, medical or nursing care, drugs or other restorative appliances, subject to, if at all, only a nominal per service charge; or
- 2) To defray or reimburse, in whole or in part, the expenses of health care.

(ff) **Prepaid health care plan contractor** means:

- 1) Any medical group or organization which undertakes under a prepaid health care plan to provide health care; or
- 2) Any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care; or
- 3) Any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care.

1 (gg) **Primary Care Practitioner** also means a nurse practitioner
2 licensed pursuant to Article 3 of Chapter 12, Division 1, Part 1 of
3 Title 10 of the Guam Code Annotated, or a physician's assistant
4 licensed pursuant to Article 16 of Chapter 12, Division 1, Part 1 of
5 Title 10 of the Guam Code Annotated. Nothing in this Act shall
6 expand the scope of practice for nurse practitioners or for physician
7 assistants as defined in Chapter 12 of Division 1, Part 1 of Title 10 of
8 the Guam Code Annotated.

9 (hh) **Provider** means any person who contracts with the Program for
10 the provision of hospitalization, medical, dental or behavioral health
11 care to members according to the provisions of this Chapter, or any
12 subcontractor of such Provider delivering services pursuant to this
13 Article.

14 (ii) **Provider Sponsored Health Plan** means a health insurance
15 company owned by a health system, physicians group, or hospital.

16 (jj) **Program** means the Health Care Para Todu Plan established by
17 this Article.

18 (kk) **Required health care benefits** refer to the PPACA List of Ten
19 Essential Health Benefits. Additional benefits mandated under Guam
20 Law may also be applied.

21 (ll) **Regular employee** means a person employed in the employment
22 of any one employer for at least twenty hours per week but does not
23 include a person employed in seasonal employment.

24 (mm) **Wages** means all remuneration for services from whatever
25 source, including commissions, bonuses, and tips and gratuities paid
26 directly to any individual by a customer of the individual's employer,

1 and the cash value of all remuneration in any medium other than
2 cash.”

3 **Section 8. A new § 6107, Chapter 6, Division 1, Title 10 of the**
4 **Guam Code Annotated is hereby *added* to read:**

5 **“§6107 Health Care Para Todu Pilot Project.** The Health Care Para
6 Todu pilot project is an Employer Sponsored Insurance (ESI) Premium
7 Assistance Medicaid expansion program with employee contributions via a
8 health savings account. The primary objective of this pilot project is to
9 provide access to affordable health insurance coverage to the people of
10 Guam by providing assistance with the cost of the premiums. The focus of
11 this plan is on those citizens that work but do not earn enough money to
12 include health insurance in their family budget.

13 The Government of Guam will apply for a Medicaid Section 1115 waiver
14 to complete a 3-year pilot project in support of this program. This approach
15 uses a combination of federal and local Medicaid dollars in addition to
16 employer and employee contributions to pay the employee’s share of
17 premiums to employer-offered private health insurance coverage. The target
18 demographic in this demonstration is 108% - 200% of the Guam adjusted
19 Federal Poverty Level (FPL). Upon successful completion and approval of
20 the 1115 waiver, the Territory will conduct a competitive managed care bid
21 process to implement the plan in the managed care arena.

22 **Section 9. A new § 6107.1, Chapter 6, Division 1, Title 10, Guam C**
23 **ode Annotated, is *added* to read:**

24 **“§6107.1 Health Care Para Todu Pilot project goals.** The goals of
25 the Para Todu pilot project include:

- 1 a) Promote member engagement in health and personal responsibility,
2 including the appropriate use of health care services.
- 3 b) Increase the use of preventive services.
- 4 c) Increase provider engagement in member healthy behaviors and
5 participation in the Medicaid community
- 6 d) Reduce the number of uninsured low-income island residents and
7 increase access to healthcare services.
- 8 e) Reduce the number of uninsured therefore increasing the
9 reimbursement of care provided by Guam Memorial Hospital and
10 local providers.
- 11 f) Reduce the number of uninsured residents, which may serve as a
12 catalyst for local providers to expand their practice by participating in
13 the National Health Service Corps program.
- 14 g) Promote value-based decision making and personal health
15 responsibility.
- 16 h) Promote disease prevention and health promotion to achieve better
17 health outcomes.
- 18 i) Provide Para Todu members with opportunities to seek job training
19 and stable employment to reduce dependence on public assistance.”

20 **Section 10. A new § 6107.2, Chapter 6, Division 1, Title 10 of the**
21 **Guam Code Annotated is hereby *added* to read:**

22 **“§6107.2 Employer Mandate. The cost of medical care in case of**
23 **sudden need may consume all or an excessive part of a person's**

1 resources. Although a large segment of the labor force on Guam already
2 enjoys coverage of this type either by virtue of collective bargaining
3 agreements, employer-sponsored plans, or individual initiative, there is a
4 need to extend that protection to workers who at present do not possess any
5 prepayment coverage. Every employer who pays to a regular employee
6 monthly wages in an amount that places the employee into the Guam
7 adjusted Federal poverty level between 108% to 200% shall provide
8 coverage of such employee as outlined in this Section.

9 This Chapter shall not be construed to diminish any protection already
10 provided pursuant to collective bargaining agreements or employer-
11 sponsored plans that is more favorable to the employees benefited thereby
12 than the protection provided by this chapter or at least equivalent thereto,
13 provided that presently existing collective bargaining agreements shall not
14 be affected by the provisions of this section”.

15 **Section 11. A new § 6107.2.1, Chapter 6, Division 1, Title 10 of the**
16 **Guam Code Annotated is hereby *added* to read:**

17 **“§6107.2.1 Place of performance. Employment includes an**
18 **individual's entire service, performed within or both within and without**
19 **Guam, if:**

20 a) The service is localized in Guam; or

21 b) The service is not localized in any state but some of the service is
22 performed in Guam and[:]

23 1) The individual's base of operation, or, if there is no base of
24 operation, the place from which such service is directed or
25 controlled, is in Guam; or

26 2) The individual's base of operation or place from which the
27 service is directed or controlled is not in any state in which

1 some part of the service is performed but the individual's
2 residence is in Guam.”

3 **Section 12. A new § 6107.2.2, Chapter 6, Division 1, Title 10 of the**
4 **Guam Code Annotated is hereby *added* to read:**

5 **“§6107.2.2 Excluded employment service. Employment as**
6 **defined in §6106 does not include:**

- 7 a) Service performed by an individual in the employ of an employer
8 who, by the laws of the United States, is responsible for care and cost
9 in connection with such service; or
- 10 b) Service performed by an individual in the employ of [the] individual's
11 spouse, son, or daughter, and service performed by an individual
12 under the age of twenty-one in the employ of the individual's father or
13 mother; or
- 14 c) Service performed in the employ of a voluntary employee's
15 beneficiary association providing for the payment of life, sick,
16 accident, or other benefits to the members of the association or their
17 dependents or their designated beneficiaries, if:
- 18 1) Admission to membership in the association is limited to
19 individuals who are officers or employees of the United States
20 government; and
- 21 2) No part of the net earnings of the association inures (other than
22 through such payments) to the benefits of any private
23 shareholder or individual; or
- 24 d) Service performed by an individual for an employer as an insurance
25 agent or as an insurance solicitor if all service performed by the
26 individual for the employer is performed for remuneration by way of
27 commission; or

- 1 e) Service performed by an individual for an employer as a real estate
2 salesperson or as a real estate broker if all service performed by the
3 individual for the employer is performed for remuneration by way of
4 commission; or
- 5 f) Service performed by an individual who, pursuant to the federal
6 Economic Opportunity Act of 1964, is not subject to the provisions of
7 law relating to federal employment, including unemployment
8 compensation; or
- 9 g) Domestic in-home and community-based services for persons with
10 developmental and intellectual disabilities under the Medicaid home
11 and community-based services program pursuant to title 42 Code of
12 Federal Regulations sections 440.180 and 441.300, and title 42 Code
13 of Federal Regulations, part 434, subpart A, as amended, or when
14 provided through state funded medical assistance to individuals
15 ineligible for Medicaid, and identified as chore, personal assistance
16 and habilitation, residential habilitation, supported employment,
17 respite, and skilled nursing services, as the terms are defined and
18 amended from time to time by the department of human services,
19 performed by an individual whose services are contracted by a
20 recipient of social service payments and who voluntarily agrees in
21 writing to be an independent contractor of the recipient of social
22 service payments; or
- 23 h) Domestic services, which include attendant care, and day care
24 services authorized by the department of human services under the
25 Social Security Act, as amended, or when provided through state-
26 funded medical assistance to individuals ineligible for Medicaid,
27 when performed by an individual in the employ of a recipient of social

1 service payments. For the purposes of this Subsection (h) only, a
2 "recipient of social service payments" is a person who is an eligible
3 recipient of social services such as attendant care or day care
4 services."

5 Section 13. A new § 6107.2.3, Chapter 6, Division 1, Title 10 of the
6 Guam Code Annotated is hereby *added* to read:

7 **"§6107.2.3 Principal and secondary employer defined;**
8 **coercion, interference, etc. prohibited.** If an individual is concurrently a
9 regular employee of two or more employers as defined in this Chapter, the
10 principal employer shall be the employer who pays the individual the most
11 wages; provided that if one of the employers, who does not pay the most
12 wages, employs the regular employee for at least thirty-five (35) hours per
13 week, the employee shall determine which of the employers shall be the
14 employee's principal employer. The employee's other employers are
15 secondary employers. An employer so designated as the principal employer
16 shall remain as such principal employer for one year or until change of
17 employment, whichever is earlier. If an individual is concurrently a regular
18 employee of a public entity that is not an employer as defined in §6106 and
19 of an employer as defined in §6106 the latter shall be deemed to be a
20 secondary employer. An employer who, directly or indirectly, interferes with
21 or coerces or attempts to coerce an employee in making a determination
22 under this section shall be subject to the penalty provided under §6107."

23 Section 14. A new § 6107.2.4, Chapter 6, Division 1, Title 10 of the
24 Guam Code Annotated is hereby *added* to read:

25 **"§6107.2.4 Choice of plan type and of contractor. Every**
26 employer required to provide coverage for the employer's employees by a
27 prepaid group health care plan under this Chapter may elect the particular

1 contractor but the employee shall not be obligated to contribute a greater
2 amount to the premium than the employee would have to contribute had the
3 employer elected coverage with the contractor providing the prevailing
4 coverage of the respective type in Guam”

5 Section 15. A new § 6107.2.5, Chapter 6, Division 1, Title 10 of the
6 Guam Code Annotated is hereby *added* to read:

7 “§6107.2.5 Liability for payment of premium; withholding;
8 recovery of premium. Every employer shall contribute the applicable
9 premium slated at 65% with the government contributing the balance as
10 defined in the final Section 1115 Waiver. The employer shall withhold the
11 employee's HSA contribution from the employee's wages with respect to pay
12 periods as specified by the Director. If an employee separates from the
13 employee's employment after the employee's employer has prepaid the
14 employee's share of the cost of providing health care coverage, the employer
15 may deduct an amount not to exceed one-half of the premium cost but
16 without regard to the 1.5 per cent limitation, from the last salary or wages
17 due the employee, or seek other appropriate means to recover the premium.”

18 Section 16. A new § 6107.2.6, Chapter 6, Division 1, Title 10 of the
19 Guam Code Annotated is hereby *added* to read:

20 ‘§6107.2.6 Commencement of coverage. The employer shall
21 provide the coverage required by this Chapter for any regular employee,
22 who has been in the employer's employ for four consecutive weeks, at the
23 earliest time thereafter at which coverage may be provided with the prepaid
24 health care plan contractor selected pursuant to this Chapter.”

25 Section 17. A new § 6107.2.7, Chapter 6, Division 1, Title 10 of the
26 Guam Code Annotated is hereby *added* to read:

1 **“§6107.2.7 Continuation of coverage in case of inability to**
2 **earn wages.** If an employee is hospitalized or otherwise prevented by
3 sickness from working, the employer shall enable the employee to continue
4 the employee's coverage by contributing to the premium the amounts paid
5 by the employer toward such premium prior to the employee's sickness for
6 the period that such employee is hospitalized or prevented by sickness from
7 working. This obligation shall not exceed a period of three months
8 following the month during which the employee became hospitalized or
9 disabled from working, or the period for which the employer has undertaken
10 the payment of the employee's regular wages in such case, whichever is
11 longer.”

12 **Section 18. A new § 6107.2.8, Chapter 6, Division 1, Title 10 of the**
13 **Guam Code Annotated is hereby *added* to read:**

14 **“§6107.2.8 Liability of secondary employer.** An employer
15 who has been notified by an employee, in the form prescribed by the
16 Director, that the employer is not the principal employer as defined in
17 §6107.2.3 shall be relieved of the duty of providing the coverage required by
18 this Chapter. The employer shall notify the director, in the form prescribed
19 by the director, that the employer is relieved from the duty of providing
20 coverage or of any change in that status.”

21 **Section 19. A new § 6107.2.9, Chapter 6, Division1, Title 10 of the**
22 **Guam Code Annotated is hereby *added* to read:**

23 **“§6107.2.9 Exemption of certain employees.**

- 24 a) In addition to the exemption specified in §6107.2.2, an employer shall
25 be relieved of the employer's duty under section §6107.2 with respect
26 to any employee who has notified the employer, in the form specified
27 by the Director, that the employee is:

1 1) Protected by health insurance or any prepaid health care plan
2 established under any law of the United States;

3 2) Covered as a dependent under a prepaid health care plan,
4 entitling the employee to the health benefits required by this
5 Chapter;

6 3) A recipient of public assistance or covered by a prepaid health
7 care plan established under the laws of the State governing
8 medical assistance.

9 b) Employers receiving notice of a claim of exemption under this
10 Subsection shall notify the Director of such claim in the form
11 prescribed by the Director.”

12 Section 20. A new § 6107.2.10, Chapter 6, Division 1, Title 10 of
13 the Guam Code Annotated is hereby *added* to read:

14 “**§6107.2.10 Termination of Exemption.** If an exemption,
15 which has been claimed by an employee pursuant to §6107.2.9 terminates
16 because of any change in the circumstances entitling the employee to claim
17 such exemption, the employee shall promptly notify the principal employer
18 of the termination of the exemption and the employer thereupon shall
19 provide coverage as required by this Chapter. If because of a change in the
20 employment situation of an employee or a redetermination by an employee
21 as provided in §6107.2.3, a principal employer becomes a secondary
22 employer or a secondary employer becomes the principal employer, the
23 employee shall promptly notify the employers affected of such change and
24 the new principal employer shall provide coverage as required by this
25 Chapter.”

26 Section 21. A new § 6107.2.11, Chapter 6, Division 1, Title 10 of
27 the Guam Code Annotated is hereby *added* to read:

1
2 “§ 6107.2.11 Non-complying employer held liable for
3 employee's health care costs. Any employer who fails to provide coverage
4 as required by this chapter shall be liable to pay for the health care costs
5 incurred by an eligible employee during the period in which the employer
6 failed to provide coverage.”

7 Section 22. A new § 6107.2.12, Chapter 6, Division 1, Title 10 of
8 the Guam Code Annotated is hereby *added* to read:

9 “§ 6107.2.12 Penalties. Any person who, after twenty-one
10 (21) days written notice and the opportunity to be heard by the Director, is
11 found to have violated any provision of this Chapter or rule adopted
12 hereunder for which no penalty is otherwise provided, shall be fined not
13 more than \$250 for each offense. All fines collected pursuant to this Chapter
14 shall be deposited into the Para Todu fund.”

15 Section 23. A new § 6107.2.13, Chapter 6, Division1, Title 10 of the
16 Guam Code Annotated is hereby *added* to read:

17 “§ 6107.2.13 Penalties; injunction. If an employer fails to
18 comply, the employer shall pay a penalty of not less than \$25 or \$1 for each
19 employee for every day during which such failure continues, whichever sum
20 is greater. The penalty shall be assessed under rules and regulations
21 promulgated by the Director and shall be collected by the Director and paid
22 into the fund for premium payments established by this plan. The Director
23 may, for good cause shown, remit all or any part of the penalty. Any
24 employer, employee, or prepaid health care plan contractor who willfully
25 fails to comply with any other provision of this Chapter or any rule or
26 regulation hereunder may be fined not more than \$200 for each such
27 violation. Any employer who fails to initiate compliance with the coverage

1 requirements for a period of thirty (30) days, may be enjoined by the circuit
2 court of the circuit in which the employer's principal place of business is
3 located from carrying on the employer's business any place in Guam so long
4 as the default continues, such action for injunction to be prosecuted by the
5 attorney general or any county attorney if so requested by the director.”

6 **Section 24. A new § 6107.3, Chapter 6, Division 1, Title 10 of the**
7 **Guam Code Annotated is hereby *added* to read:**

8 **“§6107.3. Freedom of collective bargaining.** In addition to the
9 policy stated in §6107.2 nothing in this Chapter shall be construed to limit
10 the freedom of employees to bargain collectively for different prepaid health
11 care coverage, if the protection provided by the negotiated plan is more
12 favorable to the employees benefited than the protection provided by this
13 Chapter or at least equivalent thereto, or for a different allocation of the
14 costs thereof. A collective bargaining agreement may provide that the
15 employer oneself undertakes to provide the health care specified in the
16 agreement. If the health care provisions of the applicable collective
17 bargaining agreements to which their employer is a party do not cover the
18 employees rendering particular types of services, the provisions of this
19 Chapter shall be applicable with respect to them. An employer or group of
20 employers shall be deemed to have complied with the provisions of this
21 Chapter if they undertake to provide health care services pursuant to a
22 collective bargaining agreement and the services are available to all other
23 employees not covered by such agreement.”

24 **Section 25. A new § 6107.4, Chapter 6, Division 1, Title 10 of the**
25 **Guam Code Annotated is hereby *added* to read:**

26 **“§6107.4 Exemption of followers of certain teachings or**
27 **beliefs.** This Chapter shall not apply to any individual who pursuant to the

1 teachings, faith, or belief of any group, depends for healing upon prayer or
2 other spiritual means.”

3 **Section 26.** A new § 6107.5, Chapter 6, Division 1, Title 10 of the
4 **Guam Code Annotated** is hereby *added* to read:

5 “§6107.5 Funding. The Para Todu pilot project shall use the current
6 Federal Medical Assistance Percentages (FMAP) of 55% Federal and 45%
7 Local to fund the expansion population. The Government of Guam (local)
8 portion shall be funded by a combination of the Health Insurance Premium
9 fee per §6107.5.5, and an employer contribution of 65% of the Government
10 of Guam premium portion. Funds allocated to Guam during the PPACA
11 process shall be used to support the Para Todu Program. These funds will be
12 transmitted to the Government of Guam and deposited in the Fund.”

13 **Section 27.** A new § 6107.5.1, Chapter 6, Division 1, Title 10 of the
14 **Guam Code Annotated** is hereby *added* to read:

15 “§6107.5.1 Guam Health Insurance Para Todu Fund. The Director,
16 Department of Administration shall establish a Guam Health Insurance Para
17 Todu Fund for the purpose of collecting funds for the payment of premiums.
18 The Fund created, is separate and apart from other funds and accounts of the
19 Government of Guam, a fund known as the Guam Health Insurance Para
20 Todu Fund ('Fund'). The Fund shall not be commingled with the General
21 Fund or any other fund or account of the Government of Guam, and shall be
22 kept in a separate bank account. This fund is established to pay for
23 premiums, which shall be administered exclusively for the purposes of this
24 Chapter. The Fund, to include any monies in the Fund dedicated and
25 dispersed for purposes specified in this Act, shall not be subject to the

1 transfer authority of *I Maga'lahan Guåhan*. All premiums payable under this
2 Act shall be paid from this fund. The fund shall consist of:

- 3 a) All money appropriated by *I Liheslaturan Guåhan*, if any, in support
4 of the Para Todu Program.
5 b) All money collected from the Guam Health Insurance Premium Fee.
6 c) Federal Government contributions for the purposes of premium
7 payments.
8 d) All fines and penalties collected pursuant to this Chapter.”

9 Section 28. A new § 6107.5.2, Chapter 6, Division 1, Title 10 of the
10 Guam Code Annotated is hereby *added* to read:

11 “§6107.5.2 Management of the fund. The Director of the
12 Department of Administration (DOA) shall be the treasurer and custodian of
13 the **Para Todu Fund** and shall administer the fund in accordance with the
14 directions of the Director of Public Health and Social Services
15 (DPHSS). All moneys in the fund shall be held in trust for the purposes of
16 this Chapter only and shall not be expended, released, or appropriated or
17 otherwise disposed of for any other purpose. Moneys in the fund may be
18 deposited in any depository bank in which general funds of Guam may be
19 deposited but such moneys shall not be commingled with other Guam funds
20 and shall be maintained in separate accounts on the books of the depository
21 bank. Such moneys shall be secured by the depository bank to the same
22 extent and in the same manner as required by the general depository law of
23 Guam; and collateral pledged for this purpose shall be kept separate and
24 distinct from any other collateral pledged to secure other funds of Guam.”

25 Section 29. A new § 6107.5.3, Chapter 6, Division 1, Title 10 of the
26 Guam Code Annotated is hereby *added* to read:

1 “§6107.5.3 Disbursements from the Fund. Expenditures of moneys
2 in the Para Todu Fund shall not be subject to any provisions of law
3 requiring specific appropriations or other formal release by the government
4 officers of money in their custody. All payments from the fund shall be
5 made upon warrants drawn upon the Director of DOA supported by
6 vouchers approved by the Director.

7 Section 30. A new § 6107.5.4, Chapter 6, Division 1, Title 10 of the
8 Guam Code Annotated is hereby *added* to read:

9 “§6107.5.4 Investment of moneys. With the approval of the
10 Director, DPHSS, the Director, DOA, may, from time to time, invest such
11 moneys in the Para Todu Fund as are in excess of the amount deemed
12 necessary for the payment of benefits for a reasonable future period. Such
13 moneys may be invested in bonds of any political or municipal corporation
14 or subdivision of Guam, or any of the outstanding bonds of Guam or
15 invested in bonds or interest-bearing notes or obligations of Guam or of the
16 United States, or those for which the faith and credit of the United States are
17 pledged for the payment of principal and interest. The investments shall at
18 all times be so made that all the assets of the fund shall always be readily
19 convertible into cash when needed for the payment of benefits. The
20 Director, DOA, shall dispose of securities or other properties belonging to
21 the fund only under the direction of the Director, DPHSS.”

22 Section 31. A new § 6107.5.5, Chapter 6, Division 1, Title 10 of the
23 Guam Code Annotated is hereby *added* to read:

24 “§6107.5.5 Health Insurance Premium Fee. There is established a
25 4% health insurance premium fee on all healthcare insurance premiums paid
26 in Guam for the coverage of company employees and their dependents', or
27 individuals. Such fees shall be collected from the healthcare insurance

1 companies providing such coverage on Guam. The Director, Department of
2 Revenue and Taxation (DRT), shall collect such fees from insurance
3 providers and transmit them to the Treasurer of Guam for deposit in the
4 Fund. The Director DRT shall:

5 a) Develop the necessary forms and instructions to be sent to all
6 insurance companies issuing healthcare insurance. Such forms and
7 instructions shall direct these insurance companies to pay the four
8 percent (4%) assessment as a condition of continuing to do business
9 of Guam;

10 b) The DOA shall act as the repository for the Fund as set forth in
11 §6107.5 of this Chapter for use as authorized pursuant to this Chapter
12 in carrying out the purpose of the Fund.

13 c) The Director DOA shall be the disbursing and certifying officer for
14 the Fund, and shall comply with the provisions of Chapter 14 of Title
15 46, Guam Code Annotated.

16 d) The Director, DOA shall maintain appropriate records of the Fund and
17 shall provide accounting and auditing services for the Fund.

18 e) Insurance companies shall be allowed to include the “Health
19 Insurance Premium Fee in the administration deduction portion of the
20 medical loss ratio (MLR) calculations.”

21 **Section 32. A new § 6107.5.6, Chapter 6, Division, 1, Title 10 of the**
22 **Guam Code Annotated is hereby *added* to read:**

23 **“§6107.5.6 Health Savings Account. There is established a health**
24 **savings account (HSA) as a method to create an avenue for beneficiaries to**
25 **save money to pay for medical cost. The HSA may be established with local**
26 **banking institutions or the Department of Administration may establish a**
27 **program similar to a health savings account within the Treasury of the**

1 Government of Guam. The option to create a government sponsored HSA
2 shall only be initiated if Federal policy precludes or no banking intuition
3 provides such health savings accounts. The core of the intent is to enable the
4 individual beneficiary to share in the cost of healthcare based on their
5 means. Both the Government and the member contribute to the account and
6 the account is used to pay for the plan's deductible and copayment. A
7 review of Internal Revenue Service, HSA requirements requires the Para
8 Todu program use a High Deductible Health Plan (HDHP) option.
9 Therefore, the deductible for the plan is set at \$1500. The HSA will consist
10 of two portions; a Core and Non-Core portion. Participant contributions will
11 go to the Core portion and government contributions will go into the non-
12 core portion.

13 To meet the deductible, the federal and local government will
14 contribute \$1,000 in the 55/45 FMAP split and placed in non-core portion of
15 the HSA. The employee beneficiary would be responsible for the remaining
16 \$500 of the deductible. However, employee beneficiaries may earn up to
17 \$350 by completing a variety of free preventive health items. For instance-
18 completing a health risk assessment, completing a physical examination, etc.
19 The Director, Department of Public Health and Social Services, will
20 determine the specific events and dollar amounts associated up to the
21 \$350.00 limit set in this Subsection. The remaining \$150 dollars would be a
22 cash contribution via payroll deduction or direct cash contribution into the
23 HSA by the participant. The non-core portion shall go to the payment of the
24 \$1500 deductible and supplemented by funds in the core portion. The core
25 portion, once the deductible is met, then may be used to fund co-payments
26 and other such specific qualifying and medically necessary healthcare goods
27 and services, as established by the Director, DPHSS. The minimum

1 participant required payments into the HSA are equal to the lesser of two
2 percent (2%) of their annual household income or ninety-nine dollars (\$99)
3 per year. Members “own” their contributions in the core portion, and
4 therefore, funds are eligible to be carried forward if the members benefit
5 eligibility changes.

6 **Section 33. A new § 6107.5.7, Chapter 6, Division 1, Title 10 of the**
7 **Guam Code Annotated is hereby *added* to read:**

8 **“§6107.5.7 Employee Contribution via Health Savings Account.**

9 Participation in the Para Todu program **requires** enrollees to contribute a
10 certain amount toward a health savings account (HSA) or something similar
11 depending on the outcome of an approved Section 1115 waiver process, that
12 can later be used to pay for per-service charges. Once a member enrolls in
13 the Para Todu Program, continued eligibility is contingent on payment of
14 monthly contributions. Members who do not pay their required monthly
15 contribution within Sixty (60) days from the due date will be dis-enrolled
16 from Para Todu Program coverage. The member may reenroll in Para Todu
17 Program coverage, but, prior to restarting benefits, the former member is
18 required to pay all debt owed from prior missed payments. Recognizing that
19 member income and family size may change throughout the benefit period,
20 members may request a recalculation of the 2 Percent (2%) of income
21 required contribution amount after any qualifying event such as a change in
22 household size, or a change in employment. All changes to contribution
23 amounts will be effective the first day of the month following the
24 recalculation.”

25 **Section 34. A new § 6107.5.8, Chapter 6, Division 1, Title 10 of the**
26 **Guam Code Annotated is hereby *added* to read:**

1 “§6107.5.8 Employer Contribution. The employer of an eligible
2 employee shall contribute on a monthly basis a percentage (planned 65%) of
3 the premium for that employee to the Para Todu Fund or as determined by
4 the Section 1115 Demonstration Waiver process. Employer contributions
5 may be included in addition to the Santos Act deduction.”

6 Section 35. A new § 6107.5.9, Chapter 6, Division 1, Title 10 of the
7 Guam Code Annotated is hereby *added* to read:

8 “§6107.5.9 Employee Contribution. The notion of personal
9 responsibility in the form of financial contribution resonates deeply with
10 some policymakers and constituents. Employee contributions in the Para
11 Todu project do not include premium payments but do include a portion of
12 the deductible and payment of certain service copays.

13 Current Federal law allows for Medicaid enrollees to pay cost
14 sharing, but is precluded from charging premiums for enrollees with income
15 at or below 150 percent of the federal poverty level (FPL) (42 CFR 447.55).
16 Per-service charges are limited to nominal amounts for individuals with
17 income at or below 100 percent FPL and are prohibited for certain services
18 (42 CFR 447.56(a)(2)). Additionally, all cost sharing (including premiums
19 and per-service charges) incurred by members of a family is subject to an
20 aggregate limit of 5 percent of the family’s income, and the territory must
21 have a process in place to track spending toward the limit that does not rely
22 on documentation from the enrollee (42 CFR 447.56(f)). The approved
23 amendment stipulates that no household shall pay more than 2 percent of
24 income toward the monthly contributions and cost sharing provisions are
25 consistent with Medicaid requirements (CMS 2014a). In both, the 5 percent
26 of income aggregate cap remains in force.”

1 Section 36. A new § 6107.6, Chapter 6, Division 1, Title 10 of the
2 Guam Code Annotated is hereby *added* to read:

3
4 **“§6107.6 Health Care Para Todu Pilot Project Implementation.**

5 Upon approval of the Section 1115 Waiver, the Director, Department of
6 Administration, in coordination with the Director, DPHSS, shall form a
7 Health Care Para Todu Pilot Project Negotiating Team to solicit bids for
8 selection of a contractor. The composition of the Negotiating Team shall
9 include:

- 10 a) Director of Administration- shall serve as Chairperson;
11 b) Director of Bureau of Budget and Management Branch, or designee;
12 c) Director of the Department of Public Health and Social Services, or
13 designee;
14 d) Chairperson of the Committee on Health of I Liheslaturan Guåhan or
15 designee;
16 e) Chairperson of the Committee on Appropriations of I Liheslaturan
17 Guåhan or designee; and
18 f) One member of the general public, appointed by I Maga'lahren
19 Guåhan.

20 Section 37. A new § 6107.6.1, Chapter 6, Division 1, Title 10 of the
21 Guam Code Annotated is hereby *added* to read:

22 **“§6107.6.1 Authority to contract for consultant.** The Negotiating
23 Team may obtain technical support from other financial and health- related

1 agencies. The Negotiating Team shall develop its rules of procedure in
2 accordance with the Administrative Adjudication Law. The Negotiating
3 Team with the approval of *I Maga 'lahi Guåhan* is authorized to contract an
4 actuary competent to develop proposed health insurance rates or other
5 recognized expert to train and/or advise the Negotiating Team." The
6 Negotiating Team and its consultant will review all proposals. The
7 consultant is authorized to communicate with any offeror or registered party
8 and to request and obtain information. The Negotiating Team shall issue a
9 Request for Proposal (RFP) subject to the competitive selection procedures
10 for professional services found in the Guam Procurement Law (Title 5 GCA
11 § 5001, *et seq.*) and its regulations (Title 2 GAR Div. 4 § 1101, *et seq.*)
12 Specifically, the procedure for this RFP is found at Title 2 GAR Div. 4, §
13 3114 and its subsections. The Negotiating Team shall follow a process
14 similar to that of the Government of Guam Employee Health Insurance
15 negotiating process. The Negotiating Team's desired plan designs and
16 alternatives shall follow the provisions of the approved Section 1115
17 Demonstration Waiver. Offeror must specify in their proposal any
18 component to which they cannot comply and any changes they desire to the
19 proposed plan design. The Negotiating Teams decision on any interpretation
20 of the benefit plan design shall be final. The duration of any contract
21 resulting from the RFP shall be for three years or as approved in the Section
22 1115 waiver."

23 **Section 38. A new § 6107.6.2, Chapter 6, Division 1, Title 10 of the**
24 **Guam Code Annotated is hereby *added* to read:**

25 **"§6107.6.2 Authority to contract for managed care system. The**
26 **Department of Public Health and Social Services in coordination with the**
27 **Department of Administration and other Government of Guam agencies as**

required may enter into contracts with managed care organizations, including health insuring corporations, to provide health care services to Medicaid recipients. In connection with such group benefits, the Government of Guam (Government) will accept proposals from interested and qualified health insurance companies (including health maintenance organizations, preferred provider networks, accountable care organizations and provider sponsor health plans), and/or Third Party Administrators coupled with Reinsurance, licensed under applicable Guam laws, to provide health insurance coverage for eligible residents of Guam under the Para Todu Health pilot project. All health insurance companies and/or Third Party Administrators coupled with Reinsurance must be licensed and comply with all regulatory requirements as promulgated by the Guam Insurance Commissioner, pursuant to the Insurance Statute of Guam and other applicable laws. The intent, pursuant to this Article is to present to the Governor of Guam negotiated proposed contracts for consideration for the requested services. The governor will then choose to enter into contracts from the bids provided. All qualified proposals will be reviewed, evaluated and scored separately by the Negotiating Team. It is not the intent of this article to enter into an exclusive contract. As the Health Care Para Todu Pilot Project is an Employer it is the intent to offer choice. Employers have choice of plans currently offered to their employees, as such it is the intent to allow this choice in this plan. The Para Todu Negotiating Team is established pursuant to this Article. The top ranked eligible proposals will be chosen, and those offerors will enter into negotiations with the Negotiating Team. At the time of enrollment the Contractor shall provide enrollees at a minimum the following:

- a) Explanation of the Plan and Benefit Schedule;

- 1 b) Selection, assignment and contact information of a Primary Care
2 Provider;
3 c) Health Risk Appraisal with basic biometrics.
4

5 The Negotiating Team may determine additional enrollment
6 processes. The contractor is encouraged to engage local non-profit
7 organizations and health consortia to participate in the enrollment process.
8 Health Plans are encouraged to seek and attain accreditation from the
9 National Committee for Quality Assurance (NCQA) and to include
10 Accredited Patient Centered Medical Homes (PCMH) within their networks.

11 **Section 39. A new § 6107.7, Chapter 6, Division1, Title 10 of the**
12 **Guam Code Annotated is hereby *added* to read:**

13 **“§6107.7 Participant Qualifications. Beneficiary Qualifications: To**
14 **be eligible for this program a person must meet the following criteria-**

- 15 a) Be employed;
16 b) Age 19 through 64;
17 c) Be a resident of Guam and United States citizen;
18 d) Have an annual total income between 108% and 200% of the current
19 Guam adjusted Federal Poverty Level (see table that follows for
20 general wage eligibility guidelines);
21 e) Employees must have been uninsured for 3 months and/or have had
22 no employer-sponsored insurance for 6 months;
23 f) Must agree to participate in the Health Savings Account;

g) The employee must sign a waiver of coverage form with the employer. A copy form will be submitted to the Department of Revenue and Taxation. Employers are not allowed to coerce employees to sign the waiver under penalty of law.”

The following chart indicates the FY 2016 Guam Adjusted Federal Poverty Level (FPL) used in this program:

FY 2016 Guam Adjusted Federal Poverty Level (FPL)

Federal Poverty Level 100%		FPL @108%	FPL @ 138%	FPL @ 150%	FPL @ 200%
Household size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	\$981	\$1,059	\$1,354	\$1,471	\$1,962
2	\$1,328	\$1,434	\$1,833	\$1,991	\$2,655
3	\$1,675	\$1,809	\$2,312	\$2,513	\$3,350
4	\$2,021	\$2,183	\$2,789	\$3,032	\$4,042
5	\$2,368	\$2,557	\$3,268	\$3,552	\$4,736
6	\$2,715	\$2,932	\$3,747	\$4,073	\$5,430
7	\$3,061	\$3,306	\$4,224	\$4,592	\$6,122
8	\$3,408	\$3,681	\$4,703	\$5,112	\$6,816
9	\$3,755	\$4,055	\$5,182	\$5,633	\$7,510
10	\$4,102	\$4,430	\$5,661	\$6,153	\$8,204
11	\$4,449	\$4,805	\$6,140	\$6,674	\$8,898
12	\$4,796	\$5,180	\$6,618	\$7,194	\$9,592
13	\$5,143	\$5,554	\$7,097	\$7,715	\$10,286

14	\$5,490	\$5,929	\$7,576	\$8,235	\$10,980
15	\$5,837	\$6,304	\$8,055	\$8,756	\$11,674

Federal Poverty Level 100%		FPL@108%	FPL @ 138%	FPL @ 150%	FPL @ 200%
Household size	Yearly Income	Yearly Income	Yearly Income	Yearly Income	Yearly Income
1	\$11,770	\$12,712	\$16,243	\$17,655	\$23,540
2	\$15,930	\$17,204	\$21,983	\$23,895	\$31,860
3	\$20,100	\$21,708	\$27,738	\$30,150	\$40,200
4	\$24,252	\$26,192	\$33,468	\$36,378	\$48,504
5	\$28,416	\$30,689	\$39,214	\$42,624	\$56,832
6	\$32,580	\$35,186	\$44,960	\$48,870	\$65,160
7	\$36,732	\$39,671	\$50,690	\$55,098	\$73,464
8	\$40,896	\$44,168	\$56,436	\$61,344	\$81,792
9	\$45,060	\$48,665	\$62,183	\$67,590	\$90,120
10	\$49,224	\$53,162	\$67,929	\$73,836	\$98,448
11	\$53,388	\$57,659	\$73,675	\$80,082	\$106,776
12	\$57,552	\$62,156	\$79,422	\$86,328	\$115,104
13	\$61,716	\$66,653	\$85,168	\$92,574	\$123,432
14	\$65,880	\$71,150	\$90,914	\$98,820	\$131,760
15	\$70,044	\$75,648	\$96,661	\$105,066	\$140,088

1
2

Federal Poverty Level 100%		FPL@108%	FPL @ 138%	FPL @ 150%	FPL @ 200%
Household size	Hourly Wage	Hourly Wage	Hourly Wage	Hourly Wage	Hourly Wage
1	\$5.66	\$6.11	\$7.81	\$8.49	\$11.32
2	\$7.66	\$8.27	\$10.57	\$11.49	\$15.32

3	\$9.66	\$10.44	\$13.34	\$14.50	\$19.33
4	\$11.66	\$12.59	\$16.09	\$17.49	\$23.32
5	\$13.66	\$14.75	\$18.85	\$20.49	\$27.32
6	\$15.66	\$16.92	\$21.62	\$23.50	\$31.33
7	\$17.66	\$19.07	\$24.37	\$26.49	\$35.32
8	\$19.66	\$21.23	\$27.13	\$29.49	\$39.32
9	\$21.66	\$23.40	\$29.90	\$32.50	\$43.33
10	\$23.67	\$25.56	\$32.66	\$35.50	\$47.33
11	\$25.67	\$27.72	\$35.42	\$38.50	\$51.33
12	\$27.67	\$29.88	\$38.18	\$41.50	\$55.34
13	\$29.67	\$32.04	\$40.95	\$44.51	\$59.34
14	\$31.67	\$34.21	\$43.71	\$47.51	\$63.35
15	\$33.68	\$36.37	\$46.47	\$50.51	\$67.35

Section 40. A new § 6107.7.1, Chapter 6, Division 1, Title 10 of the Guam Code Annotated is hereby *added* to read:

“§6107.7.1 Presumptive Eligibility. The presumptive eligibility process includes two programs: Hospital Presumptive Eligibility (HPE) and Presumptive Eligibility (PE). Presumptive eligibility (PE) and Hospital Presumptive eligibility (HPE) allow an individual to be quickly determined eligible for certain Medicaid programs on a temporary basis. PE is intended to help individuals that may be eligible for coverage who are facing acute health care issues and is not intended to be a primary method of enrollment into the Guam Health Care Para Todu Plan or Medicaid. An individual may become PE eligible when he or she visits a provider who has enrolled to be a Qualified Provider (QP) and answers a short list of eligibility questions including age, income, pregnancy status, and residency status. This

1 information is quickly assessed and a determination regarding their
2 eligibility for coverage is made. Individuals who are found eligible have
3 coverage starting that same day. They are given a PE Acceptance letter that
4 serves as their proof of coverage. PE is intended to help individuals that may
5 be eligible for coverage who are facing acute health care issues and is not
6 intended to be a primary method of enrollment into Medicaid. The Director,
7 DPHSS, shall determine the process for determination of a QP and further
8 refine the PE function.”

9 **Section 41. A new § 6107.8, Chapter 6, Division 1, Title 10 of the**
10 **Guam Code Annotated is hereby *added* to read:**

11 “§6107.8 Eligibility of Participating Health Care Providers.
12 Health Care Providers may participate in this expansion program if their
13 practice maintains at least a 15% patient mix of standard Medicaid,
14 Medicare and/or Medically Indigent Program patients.”

15 **Section 42. A new § 6107.9, Chapter 6, Division 1, Title 10 of the**
16 **Guam Code Annotated is hereby *added* to read:**

17 “§6107.9 Enrollment for Para Todu participants. A Para Todu
18 program participant shall enroll in a comprehensive health plan offered by a
19 managed care organization under contract with the DPHSS. All of the
20 following apply to the health plan:

- 21 a) It shall cover physician, hospital inpatient, hospital outpatient,
22 pregnancy-related, mental health, pharmaceutical, laboratory, and
23 other health care services the Director, DPHSS determines necessary.
- 24 b) It shall not begin to pay for any services it covers until the required
25 deductible is met.
- 26 c) It shall require copayments for certain services covered by the health
27 plan.

1 Section 43. A new § 6107.9.1, Chapter 6, Division 1, Title 10 of the
2 Guam Code Annotated is hereby *added* to read:

3 “§6107.9.1 Program Participation and Eligibility Process
4 Standards. The Director, DPHSS shall establish a process to validate
5 eligibility for participation of individuals in the Para Todu Pilot Project
6 according to this Chapter.”

7 Section 44. A new § 6107.9.2, Chapter 6, Division 1, Title 10 of the
8 Guam Code Annotated is hereby *added* to read:

9 “§6107.9.2 Individual waivers. An employee may waive
10 individually all of the required health care benefits pursuant to this chapter
11 by:

- 12 a) Requesting the waiver in writing submitted to the employer; and
- 13 b) Receiving approval of the waiver from the Director upon the Director
14 determining that the employee has other coverage under a prepaid
15 health care plan, which provides benefits that meet the standards.
- 16 c) The employer who receives from an employee a written request for a
17 waiver under this Subsection shall transmit to the Director a copy of
18 the waiver; on a form prescribed by the Director, and a copy of the
19 prepaid health care plan on the basis of which the waiver is requested.
- 20 d) A waiver under this Subsection is binding for one (1) year and is
21 renewable for subsequent one-year periods.
- 22 e) An employer who, directly or indirectly, coerces or attempts to coerce
23 an employee in making a waiver under this Subsection shall be
24 subject to penalty.”

25 Section 45. A new § 6107.10, Chapter 6, Division 1, Title 10 of the
26 Guam Code Annotated is hereby *added* to read:

1 **“§6107.10 Health Care Para Todu Program Copayments.** The
2 general co-payment schedule for services provided is shown below. See the
3 Schedule of Benefits for specifics.

4	a) <u>Outpatient Services</u>	<u>\$4.00</u>
5	b) <u>Inpatient Services</u>	<u>\$75.00</u>
6		
7	c) <u>Preferred RX</u>	<u>\$4.00</u>
8	d) <u>Non-preferred RX</u>	<u>\$8.00</u>
9	e) <u>Non-emergency use of the ER</u>	<u>\$8.00”</u>

10 **Section 46.** A new § 6107.11 Chapter 6, Division 1, Title 10 of the
11 **Guam Code Annotated** is hereby *added* to read:

12 **“§6107.11 General Health Benefits**

13 Members receive benefits under the Para Todu Program up to a
14 maximum value of three hundred thousand dollars (\$300,000) per year, and
15 up to one million dollars (\$1,000,000) lifetime.”

16 **Section 47.** A new § 6107.11.1, Chapter 6, Division 1, Title 10 of
17 **the Guam Code Annotated** is hereby *added* to read:

18 **“§6107.11.1 Schedule of Benefits.** The following chart depicts a
19 quick reference to the general health benefits the Health Care Para Todu
20 Plan covers. Specific benefits will be contained in the Beneficiary document
21 provided by the contractor upon finalization of the Section 1115 waiver
22 process and contract negotiation processes. Some items may change during
23 this _____ period.

Schedule of Benefits				
Your Benefits: What your plan covers	Standard Medicaid Benefits	Group VIII Medicaid Benefits	Para Todu Expansion Benefits 108 % to 149 %	Para Todu Expansion Benefits 150 % to 200 %
Deductible Per Individual Member	None	None	\$1,500	1,500
Deductible Per Family	Not Applicable	Not Applicable	Applies	Applies
If a member meets their \$1,500 deductible, the plan begins to pay for covered services for that individual				
Coverage Maximums	None	None	\$300,000	\$300,000
Individual member annual maximum				
Out of Pocket Maximums (including accumulated deductible and copays)	None	None	None	None
Per Individual member per policy year				
Per Family per policy year				

Lifetime Maximum Cap				
Any Services in the Philippines, Hawaii & the U.S. Mainland and any foreign participating providers. (Pre-Certification Required)	For services not available on island; Prior Authorization required	For services not available on island; Prior Authorization required	For services not available on island; Prior Authorization required	For services not available on island; Prior Authorization required
Deductible and Co-Pay do not apply to these benefits when you go to a Participating Provider:				
Preventive Services (Out-Patient Only)				
Includes Annual Preventive Exams, Health Risk Appraisal and Preventive Lab Services (Guam and Philippines only)	Plan pays 100%,	Plan pays 100%,	Plan pays 100%,	Plan pays 100%,

In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations				
Immunizations/Vaccinations				
In accordance with the guidelines established by the Advisory Committee on Immunization Practices	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Pre-Natal Care				
Including Routine Labs and 1st Ultrasound	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Well-Child Care				
Infancy (Newborn to nine months) Maximum seven visits	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Early Childhood (One to four years old) Maximum seven visits				

Middle Childhood / Adolescence (Five to 17 years old) Maximum one visit/year				
In accordance with the Bright Futures/American Academy of Pediatrics recommendations for Preventive Pediatric Health Care				
Well-Woman Care				
In accordance with the guidelines supported by the Health Resources and Services Administration (HRSA), and the Women's Health and Cancer Act	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Deductible does not apply to these benefits when you go to a Participating Provider. Co-payments do not accrue towards the deductible :				
Annual Eye Exam				

Once per Member per Plan Year	Plan pays 100 %	Not covered for age 21-64	\$4.00 copay	\$4.00 copay
Outpatient Physician Care & Services				
1. Primary Care Visits	Plan pays 100 %	Plan pays 100 %	\$4.00 copay	\$4.00 copay
2. Specialist Care Visits	Plan pays 100 %	Plan pays 100 %	\$4.00 copay	\$4.00 copay
3. Urgent Care Centers	Plan pays 100 %	Plan pays 100 %	\$4.00 copay	\$4.00 copay
4. Voluntary Second Surgical Opinion	Plan pays 100 %	Plan pays 100 %	Plan pays 100 %	Plan pays 100 %
5. Home Health Care Visit	Plan pays 100 % (PA required)	Plan pays 100 %	Plan pays 100 %	Plan pays 100 %
6. Hospice Care in Guam only, maximum 180 days at a maximum of \$150 per day (Pre-Certification Required)	Limited to two 90-day periods, PA required beyond 180 days.	Hospice Care, not covered off-island; maximum 180 days (PA required)	Hospice Care, not covered off-island; maximum 180 days (PA required)	Hospice Care, not covered off-island; maximum 180 days (PA required)
7. Outpatient Laboratory	Plan pays 100 %	Plan pays 100 % ; \$5 co-pay per visit for services a \geq \$50 (applicable to clients with income beyond 100 % FPL)	Plan pays 100 % ; \$5 co-pay per visit for services a \geq \$50 (applicable to clients with income beyond 100 % FPL)	Plan pays 100 % ; \$5 co-pay per visit for services a \geq \$50 (applicable to clients with income beyond 100 % FPL)

8. X-Ray Services	Plan pays 100 %	Plan pays 100 % ; \$5 co-pay per visit for services a \geq \$50 (applicable to clients with income beyond 100 % FPL)	Plan pays 100 % ; \$5 co-pay per visit for services a \geq \$50 (applicable to clients with income beyond 100 % FPL)	Plan pays 100 % ; \$5 co-pay per visit for services a \geq \$50 (applicable to clients with income beyond 100 % FPL)
9. Injections (Does not include those on the Specialty Drugs List and Orthopedic injections)	Plan pays 100 %	Plan pays 100 %	\$4.00 copay	\$4.00 copay
Prescription Drugs				
1. Formulary generic drugs per prescription unit	Plan pays 100 %	Plan pays 100 % \$2.50 co-payment per drug prescription that agency pays \geq\$25 per drug (applicable to clients with income beyond 100 % FPL)	Plan pays 100 % \$4.00 co-payment per drug prescription that agency pays \geq\$25 per drug (applicable to clients with income beyond 100 % FPL)	Plan pays 100 % \$4.00 co-payment per drug prescription that agency pays \geq\$25 per drug (applicable to clients with income beyond 100 % FPL)

2. Formulary brand name drugs per prescription unit	Plan pays 100% (If no generic available)	Plan pays 100% (If no generic available) COST-SHARING POPULATION: *Prescription Drugs - \$2.50 co-payment per prescription drug that agency pays \$25 & above per prescription drug.	Plan pays 100% (If no generic available) COST-SHARING POPULATION: *Prescription Drugs - \$8.00 co-payment per prescription drug that agency pays \$25 & above per prescription drug.	Plan pays 100% (If no generic available) COST-SHARING POPULATION: *Prescription Drugs - \$8.00 co-payment per prescription drug that agency pays \$25 & above per prescription drug.
3. Mail Order	Not Applicable	Not Applicable	Plan pays 100%, no copay	Plan pays 100%, no copay
4. Non-Formulary (Medically Necessary Only and Pre-Certification Required)	Plan pays 100%	Plan pays 100% COST-SHARING POPULATION: *Prescription Drugs - \$2.50 co-payment per prescription drug that agency pays \$25 & above per prescription drug.	Plan pays 100% COST-SHARING POPULATION: *Prescription Drugs - \$8.00 co-payment per prescription drug that agency pays \$25 & above per prescription drug.	Plan pays 100% COST-SHARING POPULATION: *Prescription Drugs - \$8.00 co-payment per prescription drug that agency pays \$25 & above per prescription drug.
5. Specialty Drugs (Medically Necessary Only and Pre-Certification Required)	Plan pays 100%	Plan pays 100% COST-SHARING POPULATION: *Prescription Drugs - \$2.50 co-payment per prescription drug that agency pays \$25 & above per prescription drug.	Plan pays 100% COST-SHARING POPULATION: *Prescription Drugs - \$8.00 co-payment per prescription drug that agency pays \$25 & above per prescription drug.	Plan pays 100% COST-SHARING POPULATION: *Prescription Drugs - \$8.00 co-payment per prescription drug that agency pays \$25 & above per prescription drug.
Deductible must be met for				

the following services:				
Acupuncture				
30 visits per member per plan year	Not covered	Plan pays 100% 30 visits per fiscal year	30 visits per fiscal year, \$4.00 copay per visit	30 visits per fiscal year, \$4.00 copay per visit
AIDS Treatment				
Exclusive of Experimental drugs	Plan pays 100%	Plan pays 100% Approved FDA treatment and drugs	Plan pays 100% Approved FDA treatment and drugs	Plan pays 100% Approved FDA treatment and drugs
Airfare Benefit to Centers of Excellence only				
For members who meet qualifying conditions, Plan provides round-trip airfare (Plan Approval Required)	Plan pays 100% for medically necessary services that are not available on island. (PA required) Round trip air transportation to an eligible patient, one (1) parent/guardian if patient is a minor.	Covered at a participating provider for services not available on Guam.	(PA required) Round trip air transportation to an eligible patient, one (1) parent/guardian if patient is a minor.	(PA required) Round trip air transportation to an eligible patient, one (1) parent/guardian if patient is a minor.
Allergy Testing				
	For medically necessary service	\$500.00 annually (PA required)	\$500.00 annually (PA required)	\$500.00 annually (PA required)
Ambulatory Surgi-center Care (Pre-Certification Required)				
	Plan pays 100%	Plan pays 100% (PA required)	Plan pays 100% (PA required)	Plan pays 100% (PA required)

Blood & Blood Derivatives	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Breast Reconstructive Surgery (In accordance with 1998 W.H.C.R.A)	Not Covered	Plan pays 100% (PA required)	Plan pays 100% (PA required)	Plan pays 100% (PA required)
Cardiac Surgery	Plan pays 100%	Plan pays 100%. PA required for off- services not available on Guam.	\$75 copay, PA required for off-island services not available on Guam.	\$75 copay, PA required for off-island services not available on Guam.
Cataract Surgery	Plan pays 100%	Plan pays 100%. PA required for off-island services not available on Guam.	Plan pays 100% (PA required)	Plan pays 100% (PA required)
Outpatient Only (including conventional lens)				
Chemical Dependency	Plan pays 100%. Outpatient psychiatric and psychological services to include counseling and medications.	Plan pays 100%. Outpatient psychiatric and psychological services to include counseling and medications.	Plan pays 100%. Outpatient psychiatric and psychological services to include counseling and medications.	Plan pays 100%. Outpatient psychiatric and psychological services to include counseling and medications.
Chemotherapy Benefit	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Chiropractic Care				
30 visits per member per plan year	Not covered	30 visits per fiscal year	\$4.00 copay, 30 visits per fiscal year	\$4.00 copay, 30 visits per fiscal year

Congenital Anomaly Diseases Coverage	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Diagnostic Testing				
MRI, CT scan, and other diagnostic procedures (Pre-Certification Required)	Plan pays 100% (Doctor's referral and PA is required for CT scan, MRA and MRI only)	Includes diagnostic radiology and laboratory services (PA is required for CT, Scan, MRI, MRA, and other type of non-invasive diagnostic imaging) COST-SHARING POPULATION: Diagnostic Laboratory and Radiology Services - \$5.00 co-payment for visit that agency pays \$50 & above.	Includes diagnostic radiology and laboratory services (PA is required for CT, Scan, MRI, MRA, and other type of non-invasive diagnostic imaging) Diagnostic Laboratory and Radiology Services - \$5.00 co-payment for visit that agency pays \$50 & above.	Includes diagnostic radiology and laboratory services (PA is required for CT, Scan, MRI, MRA, and other type of non-invasive diagnostic imaging) Diagnostic Laboratory and Radiology Services - \$5.00 co-payment for visit that agency pays \$50 & above.

Durable Medical Equipment (DME)	<p>Plan pays 100%. Medical equipment/machine is limited to every five years.</p> <p>PA is required for wheelchair, hospital bed, and cpap/bipap machine only and medical supplies. The lesser amount between purchase and rental of each type DME.</p>	<p>Plan pays 100%. One (1) of each type DME Every Five Years: Standard wheelchair, standard hospital bed, walker, crutches, standard CPAP, and oxygen and accessories. Physician Prescription and PA is required. The lesser amount between purchase and rental of each type DME.</p>	<p>Plan pays 100%. One (1) of each type DME Every Five Years: Standard wheelchair, standard hospital bed, walker, crutches, standard CPAP, and oxygen and accessories. Physician Prescription and PA is required. The lesser amount between purchase and rental of each type DME.</p>	<p>Plan pays 100%. One (1) of each type DME Every Five Years: Standard wheelchair, standard hospital bed, walker, crutches, standard CPAP, and oxygen and accessories. Physician Prescription and PA is required. The lesser amount between purchase and rental of each type DME.</p>
Elective Surgery PA Required	<p>Plan pays 100%. PA is required for elective surgery with one or more day admission prior to surgery.</p>	<p>Plan pays 100%. Non-emergency Outpatient Surgeries.</p>	<p>\$75.00 copay, PA required</p>	<p>\$75.00 copay, PA required</p>
Emergency Care	<p>Plan pays 100%. PA is required for medically necessary services that are not available on island.</p>	<p>Plan pays 100%. PA is required for medically necessary services that are not available on island.</p>	<p>\$4.00 copay, PA is required for medically necessary services that are not available on island.</p>	<p>\$4.00 copay, PA is required for medically necessary services that are not available on island.</p>
1. On/Off Island emergency facility, physician services, laboratory, X-rays				
2. Ambulance Services (Ground Transportation Only)				

For off-island emergencies, Plan must be contacted and advised within 48 hours				
End Stage Renal Disease / Hemodialysis	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Audiological examinations, Hearing Aids	Plan pays 100%. Limited every 3yrs (PA required)	\$500 every 3yrs (PA required)	\$500 every 3yrs (PA required)	\$500 every 3yrs (PA required)
Maximum \$500 per member per plan year				
Hospitalization & Inpatient Benefits	Plan pays 100%. Prior Authorization is required after the first 60 days that includes weekends.	Plan pays 100%. Prior Authorization is required after the first 60 days that includes weekends.	\$75.00 copay, per day up to 10 days. No copay after 10 days. Authorization is required after the first 30 days that includes weekends.	\$75.00 copay, per day up to 10 days. No copay after 10 days. Authorization is required after the first 30 days that includes weekends.
1. Room & Board for a semi-private room, intensive care, coronary care and surgery 2. All other inpatient hospital services including laboratory, x-ray, operating room, anesthesia and medication 3. Physician's hospital services				
Implants	Plan pay 100%. Orthopedic	Plan pay 100%. And an	Plan pay 100%. And an	Plan pay 100%. And an

Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopedic internal prosthetic devices	internal and external prosthetic devices not covered	orthopedic external prosthetic device is covered.	orthopedic external prosthetic device is covered.	orthopedic external prosthetic device is covered.
(Limitations apply, please refer to contract)				
Inhalation Therapy	Plan pays 100%	Plan pays 100%	\$4.00 copay	\$4.00 copay
Maternity Care	Plan pays 100%	Plan pays 100%	\$75 copay	\$75 copay
Labor and Delivery				
Mental Health Care	Plan pays 100%. Outpatient basis for up to 20 sessions for age 21 and older. Mental disorders and psychological services for recipients below the age of 21 are covered without limitation.	Plan pays 100%. Outpatient psychiatric and psychological services to include counseling and medications.	\$4.00 copay, Outpatient basis for up to 20 sessions for age 21 and older. Mental disorders and psychological services for recipients below the age of 21 are covered without limitation.	\$4.00 copay, Outpatient basis for up to 20 sessions for age 21 and older. Mental disorders and psychological services for recipients below the age of 21 are covered without limitation.
Nuclear Medicine	Plan pays 100%	COST-SHARING POPULATION: Nuclear Medicine - \$5.00 co-payment for visit that agency pays \$50 & above (Prior Authorization Required)	\$5.00 co-payment for visit that agency pays \$50 & above (Prior Authorization Required)	\$5.00 co-payment for visit that agency pays \$50 & above (Prior Authorization Required)
(Pre-Certification Required)				

Occupational Therapy	Plan pays 100% (PA required) Limited to outpatient hospital only.	20 visits per Fiscal Year. Includes the maintenance, acquisition, and restoration of skills in an inpatient and outpatient services only. (PA and Justification are required for additional visits)	\$4.00 copay, 30 visits per Fiscal Year. Includes the maintenance, acquisition, and restoration of skills in an inpatient and outpatient services only. (PA and Justification are required for additional visits).	\$4.00 copay, 30 visits per Fiscal Year. Includes the maintenance, acquisition, and restoration of skills in an inpatient and outpatient services only. (PA and Justification are required for additional visits)
Organ Transplant	Not covered	Not covered	Not covered	Not covered
Orthopedic Conditions	Plan pay 100%. Orthopedic internal and external prosthetic devices are not covered.	Plan pay 100%.	Plan pay 100%.	Plan pay 100%.
Internal and External Prosthesis				
Physical Therapy/Occupational Therapy	Plan pays 100% (PA required) Limited to outpatient hospital only.	Plan pays 100%. Includes the maintenance, acquisition, and restoration of skills in an inpatient and outpatient services only. (PA required)	30 visits per Fiscal Year. Includes the maintenance, acquisition, and restoration of skills in an inpatient and outpatient services only. (PA and Justification are required for additional visits)	30 visits per Fiscal Year. Includes the maintenance, acquisition, and restoration of skills in an inpatient and outpatient services only. (PA and Justification are required for additional visits)
(Pre-Certification Required)				
Radiation Therapy	Plan pays 100%	Plan pays 100%	\$4.00 copay	\$4.00 copay
(Pre-Certification Required)				

Robotic Surgery/Robotics Suite	not covered	not covered	not covered	not covered
(Pre-Certification Required)				
Skilled Nursing Facility	Plan pays 100%. Limited to 180 days maximum per fiscal year.	Plan pays 100%. 60 days max per fiscal year.	\$75.00 copay, per day up to 10 days. No copay after 10 days. PA required. 180 days maximum per fiscal year	\$75.00 copay, per day up to 10 days. No copay after 10 days. PA required. 180 days maximum per fiscal year
(Pre-Certification Required)				
Sleep Apnea	Plan pays 100 % (PA required)	Plan pays 100 % (PA required)	\$4.00 copay	\$4.00 copay
Diagnostics and Therapeutic Procedure				
(Pre-Certification Required)				
Sterilization Procedures (Tubal Ligation and Vasectomy)				
Vasectomy (Outpatient Only)	Plan pays 100 % (PA required)	Plan pays 100 % (PA required)	\$4.00 copay, no PA required.	\$4.00 copay, no PA required.
Hysterectomy			\$4.00 copay, no PA required.	\$4.00 copay, no PA required.

Vision Care	<p>Eye Exam: Limited to every two (2) years. (PA is required)</p> <p>Corrective Lenses: Maximum \$80 every two (2) years.</p> <p>Bi-focal Lenses: Maximum \$128 every two (2) years. (PA is required)</p>	<p>Eye Exam: Limited to every two (2) years. (PA is required)</p> <p>Corrective Lenses: Maximum \$80 every two (2) years.</p> <p>Bi-focal Lenses: Maximum \$128 every two (2) years. (PA is required)</p> <p>Not covered for ages 21-64</p>	<p>Corrective Lenses: Maximum \$100 every two (2) years.</p> <p>Bi-focal Lenses: Maximum \$135 every two (2) years.</p>	<p>Corrective Lenses: Maximum \$100 every two (2) years.</p> <p>Bi-focal Lenses: Maximum \$135 every two (2) years.</p>

1 Section 48. A new § 6107.11.2, Chapter 6, Division 1, Title 10 of the
2 Guam Code Annotated is hereby *added* to read:

3 **“§6107.11.2 Essential Health Benefits.** The Affordable Care Act’s
4 ten essential health benefits are part of the Health Care Para Todu plan and
5 include:

- 6 a) Ambulatory patient services (Outpatient care). Care you receive
7 without being admitted to a hospital, such as at a doctor’s office,
8 clinic or same-day (“outpatient”) surgery center. Also included in this
9 category are home health services and hospice care.
- 10 b) Emergency Services (Trips to the emergency room). Care you receive
11 for conditions that could lead to serious disability or death if not
12 immediately treated, such as accidents or sudden illness. Typically,
13 this is a trip to the emergency room, and includes transport by
14 ambulance. You cannot be penalized for going out-of-network or for
15 not having prior authorization.
- 16 c) Hospitalization (Treatment in the hospital for inpatient care). Care you
17 receive as a hospital patient, including care from doctors, nurses and
18 other hospital staff, laboratory and other tests, medications you
19 receive during your hospital stay, and room and board. Hospitalization
20 coverage also includes surgeries, transplants and care received in a
21 skilled nursing facility, such as a nursing home that specializes in the
22 care of the elderly.
- 23 d) Maternity and newborn care. Care that women receive during
24 pregnancy (prenatal care), throughout labor, delivery and post-
25 delivery, and care for newborn babies.
- 26 e) Mental health services and addiction treatment. Inpatient and
27 outpatient care provided to evaluate, diagnose and treat a mental

health condition or substance abuse disorder. This includes behavioral health treatment, counseling, and psychotherapy.

f) Prescription drugs. Medications that are prescribed by a doctor to treat an illness or condition. Examples include prescription antibiotics to treat an infection or medication used to treat an ongoing condition, such as high cholesterol. At least one prescription drug must be covered for each category and classification of federally approved drugs, however limitations do apply. Some prescription drugs can be excluded. “Over the counter” drugs are usually not covered even if a doctor writes you a prescription for them. The Para Todu plan limits drugs covered, covering only generic versions of drugs where generics are available. Some medicines are excluded where a cheaper equally effective medicine is available, or the insurer may impose “Step” requirements (expensive drugs can only be prescribed if doctor has tried a cheaper alternative and found that it was not effective). Some expensive drugs will need special approval

g) Rehabilitative services and devices – Rehabilitative services (help recovering skills, like speech therapy after a stroke) and habilitative services (help developing skills, like speech therapy for children) and devices to help you gain or recover mental and physical skills lost to injury, disability or a chronic condition (this also includes devices needed for “habilitative reasons”). Plans have to provide 30 visits each year for either physical or occupational therapy, or visits to the chiropractor. Plans must also cover 30 visits for speech therapy as well as 30 visits for cardiac or pulmonary rehab.

h) Laboratory services. Testing provided to help a doctor diagnose an injury, illness or condition, or to monitor the effectiveness of a

1 particular treatment. Some preventive screenings, such as breast
2 cancer screenings and prostate exams, are provided free of charge.

3 i) Preventive services, wellness services, and chronic disease treatment.

4 This includes counseling, preventive care, such as physicals,
5 immunizations and screenings, like cancer screenings, designed to
6 prevent or detect certain medical conditions. Also, care for chronic
7 conditions, such as asthma and diabetes.

8 j) Pediatric services. Care provided to infants and children, including

9 well child visits and recommended vaccines and immunizations.

10 Dental and vision care must be offered to children younger than 19.

11 This includes two routine dental exams, an eye exam and corrective
12 lenses each year.”

13 **Section 49. A new § 6107.11.3, Chapter 6, Division 1, Title 10 of**
14 **the Guam Code Annotated is hereby *added* to read:**

15 **“§6107.11.3 Adult Preventive Care Benefits. The Fifteen (15)**
16 **preventive services for adults are immunizations, screenings for depression,**
17 **blood pressure, colorectal cancer, and high cholesterol. Diet and alcohol**
18 **abuse counseling, though not screening services are also included as no out-**
19 **of-pocket services.**

20 a) Abdominal Aortic Aneurysm one-time screening for men of specified
21 ages that have ever smoked

22 b) Alcohol Misuse screening and counseling

23 c) Aspirin use to prevent cardiovascular disease for men and women of
24 certain ages

25 d) Blood Pressure screening for all adults
26

- e) Cholesterol screening for adults of certain ages or at higher risk
- f) Colorectal Cancer screening for adults over 50
- g) Depression screening for adults
- h) Diabetes (Type 2) screening for adults with high blood pressure
- i) Diet counseling for adults at higher risk for chronic disease
- j) HIV screening for everyone ages 15 to 65, and other ages at increased risk
- k) Immunization vaccines for adults—doses, recommended ages, and recommended populations vary:
 - 1) Hepatitis A
 - 2) Hepatitis B
 - 3) Herpes Zoster
 - 4) Human Papillomavirus
 - 5) Influenza (Flu Shot)
 - 6) Measles, Mumps, Rubella
 - 7) Meningococcal
 - 8) Pneumococcal
 - 9) Tetanus, Diphtheria, Pertussis
 - 10) Varicella
- l) Obesity screening and counseling for all adults
- m) Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- n) Syphilis screening for all adults at higher risk

- 1 o) Tobacco Use screening for all adults and cessation interventions for
2 tobacco users.”

3 Section 50. A new § 6107.11.4, Chapter 6, Division 1, Title 10 of
4 the Guam Code Annotated is hereby *added* to read:

5 **“§6107.11.4 Women Preventive Care Benefits.** These provisions
6 include well-woman visits, counseling for domestic violence victims,
7 domestic violence screenings, and contraception counseling and dispensing.

- 8 a) Anemia screening on a routine basis for pregnant women.
9 b) Breast Cancer Genetic Test Counseling (BRCA) for women at higher
10 risk for breast cancer.
11 c) Breast Cancer Mammography screenings every 1 to 2 years for
12 women over 40.
13 d) Breast Cancer Chemoprevention counseling for women at higher risk.
14 e) Breastfeeding comprehensive support and counseling from trained
15 providers, and access to breast-feeding supplies, for pregnant and
16 nursing women.
17 f) Cervical Cancer screening for sexually active women.
18 g) Chlamydia Infection screening for younger women and other women
19 at higher risk.
20 h) Contraception: Food and Drug Administration-approved contraceptive
21 methods, sterilization procedures, and patient education and
22 counseling, as prescribed by a health care provider for women with
23 reproductive capacity (not including abortifacient drugs). This does
24 not apply to health plans sponsored by certain exempt “religious
25 employers.”

- 1
- 2 i) Domestic and interpersonal violence screening and counseling for all
- 3 women.
- 4 j) Folic Acid supplements for women who may become pregnant.
- 5 k) Gestational diabetes screening for women 24 to 28 weeks pregnant
- 6 and those at high risk of developing gestational diabetes.
- 7 l) Gonorrhea screening for all women at higher risk.
- 8 m) Hepatitis B screening for pregnant women at their first prenatal visit.
- 9 n) HIV screening and counseling for sexually active women.
- 10 o) Human Papillomavirus (HPV) DNA Test every 3 years for women
- 11 with normal cytology results who are 30 or older.
- 12 p) 16. Osteoporosis screening for women over age 60 depending on risk
- 13 factors.
- 14 q) Rh Incompatibility screening for all pregnant women and follow-up
- 15 testing for women at higher risk.
- 16 r) Sexually Transmitted Infections counseling for sexually active
- 17 women.
- 18 s) Syphilis screening for all pregnant women or other women at
- 19 increased risk.”

20 Section 51. A new § 6107.11.5, Chapter 6, Division 1, Title 10 of

21 the Guam Code Annotated is hereby *added* to read:

22 “§ 6107.11.5 Health Risk Appraisal. The Contractor shall

23 administer a Health Risk Appraisal (HRA) at the time of member enrollment

24 into the Para Todu Pilot Project.

- 1 a) The HRA shall have either National Committee for Quality Assurance
2 (NCQA) Wellness and Health Promotion (WHP) Certification or
3 Health Information Products (HIP) Certification.
- 4 b) The member shall be provided a copy of the HRA and encouraged to
5 take the HRA to their first appointment.
- 6 c) The contractor shall have a process to recall an individual member
7 HRA in event the HRA is misplaced.
- 8 d) The contractor shall establish a process to provide the HRA to the
9 Members PCP/Medical Home.
- 10 e) The contractor shall aggregate the HRA data and provide a report of
11 de-identified aggregated information to the Director, DPHSS,
12 Chairperson, Guam Legislature Health Care Committee.
- 13 f) The contractor shall provide aggregate data reports to network
14 providers.”

15 **Section 52. A new § 6107.12, Chapter 6, Division 1, Title 10 of the**
16 **Guam Code Annotated is hereby *added* to read:**

17 **“§ 6107.12 Medical Exclusions.**

- 18 a) No benefits will be paid for Injury or Illness, (a) when the Covered
19 Person is entitled to receive disability benefits or compensation (or
20 forfeits his or her right thereto) under Worker's Compensation or
21 Employer's Liability Law for such Injury or Illness or (b) when
22 Services for an Injury or Illness are rendered to the Covered Person
23 by any federal, state, territorial, municipal or other governmental
24 instrumentality or agency without charge, or (c) when such Services
25 would have been rendered without charge but for the fact that the
26 person is a Covered Person under the Plan.

1
2 b) No benefits will be paid if any material statement made in an
3 application for coverage, enrollment of any Dependent or in any
4 claim for benefits is false. Upon identifying any such false
5 statement, Company shall give the Covered Person at least 30 day's
6 notice that his or her benefits have been suspended and that his or
7 her coverage is to be terminated. If the false statement is fraudulent
8 or is an intentional misrepresentation of a material fact, such
9 termination shall be retroactive to the date coverage was provided
10 or continued based on such fraudulent statement or intentional
11 misrepresentation of material fact. If the false statement was not a
12 fraudulent statement or intentional misrepresentation of material
13 fact, termination of coverage shall be effective no earlier than the
14 date of the suspension. The Covered Person may dispute any
15 termination of coverage by filing a claim under the grievance
16 procedure provided for in the Agreement. If a grievance is filed, the
17 resolution of the matter shall be in accordance with the outcome of
18 the grievance proceedings. If no grievance is filed for any
19 retroactive termination and the Company paid benefits prior to
20 learning of any such false statement, the Subscriber must reimburse
21 the Company for such payment. Terminations of coverage shall be
22 handled in accordance with the applicable claims procedure
23 requirements of Section 2719 of the PHSA, as added by PPACA.
24 Retroactive terminations of coverage shall not violate the applicable
25 prohibitions on rescissions of Section 2712 of the PHSA, as added
26 by PPACA, and rescissions shall be handled in compliance with
27 PPACA's applicable claim denial requirements.

- 1
- 2 c) No benefits will be paid for confinement in a Hospital or in a
3 Skilled Nursing Facility if such confinement is primarily for
4 custodial or domiciliary care. (Custodial or domiciliary care
5 includes that care which consists of training in personal hygiene,
6 routine nursing services and other forms of self-care. Custodial or
7 domiciliary care also includes supervisory services by a Physician
8 or Nurse for a person who is not under specific medical or surgical
9 treatment to reduce his or her disability and to enable that person to
10 live outside an institution providing such care.) Company and not
11 Covered Person shall be liable if the Company approves the
12 confinement, regardless of who orders the service.
- 13 d) No benefits will be paid for nursing and home health aide services
14 provided outside of the home (such as in conjunction with school,
15 vacation, work or recreational activities).
- 16 e) No benefits will be paid for private Duty Nursing. This provision
17 does not apply to Home Health Care.
- 18 f) No benefits will be paid for special medical reports, including those
19 not directly related to treatment of the Member. (e.g., Employment
20 or insurance physicals, and reports prepared in connection with
21 litigation.)
- 22 g) No benefits will be paid for services required by third parties,
23 including but not limited to, physical examinations, diagnostic
24 services and immunizations in connection with obtaining or
25 continuing employment, obtaining or maintaining any license

1 issued by a municipality, state, or federal government, securing
2 insurance coverage, travel, school admissions or attendance,
3 including examinations required to participate in athletics, except
4 when such examinations are considered to be part of an appropriate
5 schedule of wellness services.

6 h) No benefits will be paid for court ordered services, or those
7 required by court order as a condition of parole or probation.

8 i) No benefits will be paid for Services and supplies provided to a
9 Covered Person for an Injury or Illness resulting from an attempted
10 suicide by that Covered Person unless resulting from a medical
11 condition (including physical or mental health conditions) or from
12 domestic violence.

13 j) No benefits will be paid for Services and supplies provided in
14 connection with intentionally self-induced or intentionally self-
15 inflicted injuries or illnesses unless resulting from a medical
16 condition (including physical or mental conditions) or from
17 domestic violence.

18 k) No benefits will be paid for Services and supplies provided to a
19 Covered Person for Injuries incurred while the person was
20 committing a criminal act.

21 l) Unless otherwise specifically provided in the Agreement, no benefit
22 will be paid for, or in connection with, airfare and the Company
23 will not pay for the transportation from Guam to any off-island
24 facility, nor for any other non-medical expenses such as taxes,
25 taxis, hotel rooms, etc. In no event will the Company pay for air

1 ambulance or for the transportation of the remains of any deceased
2 person.

3
4 m) No benefits will be paid for living expenses for Covered Persons
5 who require, or who of their own accord seek, treatment in
6 locations removed from their home

7 n) No benefits will be paid for Services and supplies provided to a
8 dependent of a non-Spouse Dependent. Dependents of non-Spouse
9 Dependents are not eligible for coverage. For example, when a
10 Dependent, other than a Spouse of the Subscriber, has a child, that
11 child is a dependent of a non-Spouse Dependent and is not eligible
12 to become covered under the Plan, unless such child otherwise
13 becomes eligible for enrollment.

14 o) No benefits will be paid for home uterine activity monitoring.

15 p) No benefits will be paid for services performed by an immediate
16 family member for whom, in the absence of any health benefits
17 coverage, no charge would be made. Immediate family member is
18 defined as parents, spouses, siblings, or children of the insured
19 member.

20 q) No benefits will be paid for treatment of occupational injuries and
21 occupational diseases, including those injuries that arise out of (or
22 in the course of) any work for pay or profit, or in any way results
23 from a disease or injury that does. If a Member is covered under a
24 Workers' Compensation law or similar law, and submits proof that
25 the Member is not covered for a particular disease or injury under

1 such law, that disease or injury will be considered "non-
2 occupational" regardless of cause. The Covered Benefits under the
3 Group Health Insurance Certificate for Members eligible for
4 Workers' Compensation are not designed to duplicate any benefit to
5 which they are entitled under Workers' Compensation Law. All
6 sums payable for Workers' Compensation services provided under
7 the Group Health Insurance Certificate shall be payable to, and
8 retained by Company. Each Member shall complete and submit to
9 Company such consents, releases, assignments and other documents
10 reasonably requested by Company in order to obtain or assure
11 reimbursement under the Workers' Compensation Law.

12 r) No benefits will be paid for:

13 1) Drugs or substances not approved by the Food and Drug
14 Administration (FDA), or

15 2) Drugs or substances not approved by the FDA for
16 treatment of the illness or injury being treated unless
17 empirical clinical studies have proven the benefits of such
18 drug or substance in treating the illness or injury.

19 s) No benefits will be paid for experimental or Investigational treatments
20 and Procedures, or ineffective surgical, medical, psychiatric, or dental
21 treatments or procedures, research studies, or other experimental or
22 investigational treatments and procedures or pharmacological
23 regimes, unless deemed medically necessary by patient's physician
24 and pre-authorized by Company. Experimental and investigational
25 treatments and procedures are those medical treatments and

1 procedures that have not successfully completed a Phase III trial, have
2 not been approved by the FDA and are not generally recognized as the
3 accepted standard treatment for the disease or condition from which
4 the patient suffers. Experimental and investigational treatments
5 include off label therapies. Off-label therapies are those medical
6 therapies that use a FDA approved drug or procedure for a non-
7 indicated use. Also, these Experimental or investigational medical and
8 surgical procedures, equipment, and items or medications, are
9 otherwise not covered by Medicare or covered under qualifying
10 clinical trials.

11 t) No benefits will be paid for services or supplies related to Genetic
12 Testing.

13 u) No benefits will be paid for Services and supplies provided to perform
14 transsexual surgery or to evaluate the need for such surgery.
15 Evaluations and subsequent medications and Services necessary to
16 maintain transsexual status are also excluded from coverage, as are
17 complications or medical sequelae of such surgery or treatment.

18 v) No benefits will be paid for injuries incurred by the operator of a
19 motorized vehicle while such operator is under the influence of
20 intoxicating alcoholic beverage, controlled drugs, or substances. If a
21 blood alcohol level or the DRAEGER ALCO TEST is available and
22 shows levels that are equal to or exceed 0.08 grams percent (gms%) or
23 that exceed the amount allowed by law as constituting legal
24 intoxication, no benefits will be paid.

1 w) No benefits will be paid for any medical Service or supply which is
2 available to the Covered Person on Guam and which is paid by or
3 reimbursable through a governmental agency or institution. However,
4 notwithstanding the aforesaid, in no event will the Company consider
5 the availability of benefits under Medicaid or Para Todu Health Plan
6 when paying benefits under this Agreement.

7
8 x) No benefits will be paid in connection with elective abortions
9 unless Medically Necessary.

10 y) No benefits will be paid for vision care services and supplies,
11 including orthoptics (a technique of eye exercises designed to
12 correct the visual axes of eyes not properly coordinated for
13 binocular vision), Lasik, keratoplasty, and radial keratotomy,
14 including related procedures designed to surgically correct
15 refractive errors except as provided in the Covered Benefits section
16 of the Group Health Insurance Certificate.

17 z) No benefits will be paid in connection with any injuries sustained
18 while the Covered Person is operating any wheeled vehicle during
19 an organized, off-road, competitive sporting event.

20 aa) No benefits will be paid for personal comfort or convenience
21 items, including those services and supplies not directly related to
22 medical care, such as guest meals and accommodations, barber
23 services, telephone charges, radio and television rentals,
24 homemaker services, travel expenses, take-home supplies.

25 bb) No benefits will be paid for hypnotherapy.

- 1 cc) No benefits will be paid for religious, marital and sex counseling,
2 including services and treatment related to religious counseling,
3 marital/relationship counseling, and sex therapy.
- 4 dd) No benefits will be paid for cosmetic Surgery, or other services
5 intended primarily to improve the Member's appearance or
6 treatment relating to the consequences of, or as a result of,
7 Cosmetic Surgery. This exclusion does not apply to:
- 8 1) Medically Necessary reconstructive surgery as described in
9 the Covered Benefits sections Mastectomy and
10 Reconstructive Breast Surgery or Reconstructive Surgery.
- 11 2) Surgery to correct the results of injuries causing an
12 impairment;
- 13 3) Surgery as a continuation of a staged reconstruction
14 procedure, including but not limited to post-mastectomy
15 reconstruction;
- 16 4) Surgery to correct congenital defects necessary to restore
17 normal bodily functions, including but not limited to, cleft lip
18 and cleft palate.
- 19 ee) No benefits will be paid for routine foot/hand care, including
20 routine reduction of nails, calluses and corns
- 21 ff) Except as otherwise provided in this agreement, no benefit will be
22 paid for specific non-standard allergy services and supplies,
23 including but not limited to, skin titration (wrinkle method),
24 cytotoxicity testing (Bryan's Test), treatment of non-specific
25 candida sensitivity, and urine autoinjections.

1 gg) No benefits will be paid for Services and supplies associated with
2 growth hormone treatment unless the Covered Person is proven to
3 have growth hormone deficiency using accepted stimulated growth
4 hormone analyses and also shows an accelerated growth response to
5 growth hormone treatment. Under no circumstances will growth
6 hormone treatment be covered to treat short stature in the absence
7 of proven growth hormone deficiency.

8 hh) No benefits will be paid for Services and supplies provided for
9 liposuction.

10 ii) No benefits will be paid for weight reduction programs, or dietary
11 supplements, except as pre-authorized by Company for the
12 Medically Necessary treatment of morbid obesity.

13 jj) No benefits will be paid for any drug, food substitute or
14 supplement or any other product, which is primarily for weight
15 reduction unless medically necessary.

16 kk) Except as provided in this Agreement, or unless medically
17 necessary for the treatment of Morbid Obesity or other disease, no
18 benefits will be paid in connection with gastric bypass, stapling or
19 reversal if for the purpose of weight reduction or aesthetic
20 purposes.

21 ll) No benefits will be paid for surgical operations, procedures or
22 treatment of obesity, except when pre-authorized by Company.

23 mm) No benefits will be paid for the treatment of male or female
24 Infertility, including but not limited to:

- 1) The purchase of donor sperm and any charges for the storage of sperm;
- 2) The purchase of donor eggs and any charge associated with care of the donor required for donor egg retrievals or transfers or gestational carriers;
- 3) Charges associated with cryopreservation or storage of cryopreserved embryos (e.g. office, hospital, ultrasounds, laboratory tests, etc.);
- 4) Home ovulation prediction kits;
- 5) Injectable Infertility medications, including but not limited to, menotropins, hCG, GnRH agonists, IVIG;
- 6) Artificial Insemination, including in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), and any advanced reproductive technology ("ART") procedures or services related to such procedures;
- 7) Any charges associated with care required for ART (e.g., office, Hospital, ultrasounds, laboratory tests, etc.);
- 8) Donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- 9) Any charge associated with a frozen embryo transfer including but not limited to thawing charges;

1 10) Reversal of sterilization surgery; and

2 11) Any charges associated with obtaining sperm for ART
3 procedures.

4 nn) Except as provided in this Agreement, no benefits will be paid
5 for the purchase or rental of durable or disposable medical equipment
6 and supplies, other than for :

7 1) Equipment and supplies used in a Hospital or Skilled Nursing
8 Facility or in conjunction with an approved Hospital or
9 Skilled Nursing Facility confinement or as otherwise noted in
10 the Agreement or

11 2) Items covered as preventive care under well-women coverage
12 such as breastfeeding supplies in accordance with reasonable
13 medical management techniques.

14 oo) No benefits will be paid for household equipment, including
15 but not limited to, the purchase or rental of exercise cycles, water
16 purifiers, hypo-allergenic pillows, mattresses or waterbed, whirlpool
17 or swimming pools, exercise and massage equipment, central or unit
18 air conditioners, air purifiers, humidifiers, dehumidifiers, escalators,
19 elevators, ramps, stair glides, emergency alert equipment, handrails,
20 heat appliances, improvements made to a Member's house or place of
21 business, and adjustments to vehicles.

22 pp) No benefits will be paid for Services and supplies provided for
23 penile implants of any type.

24 qq) No benefits will be paid for Services and supplies to correct
25 sexual dysfunction.

1 rr) Except as specifically provided, if a benefit is excluded, all Hospital,
2 surgical, medical treatments, prescription drugs, laboratory services,
3 and x-rays in relation to the excluded benefits are also excluded as of
4 the time it is determined that the benefit is excluded.

5 ss) Except as specifically provided in this Agreement, no benefits will be
6 provided for Services and supplies not ordered by a Physician or not
7 Medically Necessary.

8 tt) No benefits will be paid for temporomandibular joint disorder
9 treatment (TMJ) including treatment performed by prosthesis
10 placed directly on the teeth except as covered in the Covered
11 Benefits Section

12 uu) Except as specifically provided in this Agreement, no benefits will
13 be paid for corrective appliances, artificial aids and durable
14 equipment.

15 vv) No benefits will be paid for Services for which the Covered
16 Person or Subscriber is not legally obligated to pay.

17 ww) No benefit will
18 be paid for ambulance services when used for routine and
19 convenience transportation to receive outpatient or inpatient
20 services, unless deemed medically necessary with prior
21 authorization obtained from Company.

22 xx) No benefit will be paid for elective or voluntary enhancement
23 procedures, surgeries, services, supplies and medications including,
24 but not limited to, hair growth, hair removal, hair analysis, sexual

1 performance, athletic performance, anti-aging, and mental
2 performance, even if prescribed by a Physician.

3 yy) No benefits will be paid for hospital take-home drugs.

4
5 zz) No benefits will be paid for fees for any missed appointments or
6 voluntary transfer of records as requested by the Covered Person.

7 aaa) No benefits will be paid for educational services. Special education,
8 including lessons in sign language to instruct a Member, whose ability
9 to speak has been lost or impaired, to function without that ability, are
10 not covered.

11 bbb) No benefits will be paid for Intelligence, IQ, aptitude ability,
12 learning disorders, or interest testing not necessary to determine the
13 appropriate treatment of a psychiatric condition

14 ccc) No benefits will be paid for Psychoanalysis or psychotherapy
15 credited toward earning a degree or furtherance of education or
16 training regardless of diagnosis or symptoms or whether providing
17 or receiving the Service.

18 ddd) No benefits will be paid for non-medically necessary services,
19 including but not limited to, those services and supplies:

20 1) Which are not Medically Necessary for the diagnosis and
21 treatment of illness, injury, restoration of physiological
22 functions, or covered preventive services;

23 2) That do not require the technical skills of a medical, mental
24 health or a dental professional;

- 1 3) Furnished mainly for the personal comfort or convenience of
2 the Member, or any person who cares for the Member, or any
3 person who is part of the Member's family, or any Provider;
- 4 4) Furnished solely because the Member is an inpatient on any
5 day in which the Member's disease or injury could safely and
6 adequately be diagnosed or treated while not confined;
- 7 5) Furnished solely because of the setting if the service or
8 supply could safely and adequately be furnished in a
9 Physician's or a dentist's office or other less costly setting.
- 10 fff) As required by HIPAA, no source-of-injury exclusion, such as
11 exclusion 28 for off-road sporting events, will apply if the accident
12 resulted from an act of domestic violence or a medical condition
13 (including both physical and mental health conditions).
- 14 ggg) Elective cosmetic surgery, except as provided for in the Women's
15 Health Act;
- 16 hhh) Custodial care, domiciliary care, private duty nursing services or
17 rest cures, except as provided for in hospices;
- 18 iii) Personal comfort or convenience items;
- 19 jjj) Any service not medically necessary for the diagnosis or treatment of
20 a disease, injury or condition;
- 21 kkk) Over-the-counter drugs not listed in the Drug Formulary;
- 22 lll) Drugs not listed in the Drug Formulary, unless otherwise provided in
23 this Act.

1 mmm) Experimental drugs, experimental and palliative treatments or
2 procedures, unless approved by the Administrator;

4 nnn) fertility procedures, reversal of sterilization and services related to
5 artificial conception;

6 ooo) treatment, services and supplies related to sexual dysfunction;

7 ppp) trans-sexual surgery and related services;

8 qqq) motorized limbs;

9 rrr) services for any incarcerated person;

10 sss) care or services furnished by immediate relatives or members of the
11 patient's household, unless rendered as a duly licensed medical
12 practitioner employed by a health care Provider;

13 ttt) health cares services, which are provided and reimbursed by other
14 local or Federal programs, the Para Todu pilot project is the payer of
15 last resort;

16 uuu) tissue and organ transplants, and any other related hospital, surgical
17 drug, radiology, laboratory or other medical services before, during
18 and after transplant;

19 vvv) treatment and services for artificial weight reduction, including
20 gastric bypass stapling or reversal, or liposuction;

21 www) treatment by any method for temporomandibular joint disorders,
22 including, but not limited to, crowning, wiring or repositioning of
23 teeth;

xxx) treatment for injuries sustained in the commission of an illegal or criminal act, including driving under the influence;

yyy) any work-related injury, subject to compensation pursuant to the Workers Compensation Law;

zzz) care for military service connected disabilities to which the patient is legally entitled to government benefits or care;

aaaa) orthopedic footwear, unless attached to an artificial foot or unless attached as a permanent part of a leg brace; and

bbbb) benefits and services not specifically listed as covered.”

Section 53. A new § 6107.13, Chapter 6, Division 1, Title 10 of the Guam Code Annotated is hereby *added* to read:

“§ 6107.13 Dental Services.

Dental benefits must include at least the following coverage at participating dentists:

- a) 100% coverage for diagnostic and preventive services
- b) 80% coverage for fillings, simple extractions and surgical extractions
- c) 80% coverage for anesthesia, such as conscious sedation and nitrous oxide/analgesia (laughing gas), for children under age 13
- d) 50% coverage for endodontics, periodontics and prosthodontics, including crowns and bridges
- e) \$1,000 annual plan maximum (no separate maximums on benefits may be imposed).”

Section 54. A new § 6107.14, Chapter 6, Division 1, Title 10 of the Guam Code Annotated is hereby *added* to read:

1 **“§ 6107.14 Dental Exclusions**

2 a) Work in progress on the effective date of coverage. Work in
3 progress is defined as:

4 1) A prosthetic or other appliance, or modification of one, where
5 an impression was made before the patient was covered, or

6 2) A crown, bridge, or cast restoration for which the tooth was
7 prepared before the patient was covered, or

8 3) Root canal therapy, if the pulp chamber was opened before the
9 patient was covered.

10 b) Services not specifically listed in the agreement, services not
11 prescribed, performed or supervised by a dentist; services which are
12 not medically or dentally necessary or customarily performed;
13 services that are not indicated because they have a limited or poor
14 prognosis; or services for which there is a less expensive,
15 professionally acceptable alternative.

16 c) Any service unless required and rendered in accordance with
17 accepted standards or dental practice

18 d) A crown, cast restoration, denture or fixed bridge or addition of
19 teeth to one, if work involves a replacement or modification of a
20 crown, cast restoration, denture or bridge installed less than 5 years
21 ago, or one that replaces a tooth that was missing before the date
22 the enrollee became eligible for services under the plan (including
23 previously extracted or missing teeth).

- 1 e) Replacement of existing dentures, crowns or fixed bridgework if the
2 existing dentures, crowns or fixed bridgework can be made
3 serviceable.
- 4 f) Precision attachments, interlocking device, one component of
5 which is fixed to an abutment or abutments the other is integrated
6 into a fixed or removable prosthesis in order to stabilize and/or
7 retain it; or stress breakers, part of a tooth-borne and/or prosthesis
8 designed to relieve the abutment teeth and their supporting tissues
9 from harmful stress.
- 10 g) Replacement of lost or stolen appliance, or replacement of any
11 appliance damaged while not in the mouth.
- 12 h) Any service for which the enrollee received benefits under any
13 other coverage offered by the company.
- 14 i) Spare or duplicate prosthetic devices.
- 15 j) Services included, related to or required for:
- 16 1) Implants;
- 17 2) Cosmetic purposes;
- 18 3) Services or appliances to change the vertical dimension or to
19 restore or maintain the occlusion, including but not limited
20 to equilibrium, full mouth rehabilitation and restoration for
21 malalignment of teeth;
- 22 4) Temporomandibular joint (TMJ) or craniomandibular
23 disorders, myofunctional therapy or the correction or
24 harmful habits;
- 25 5) Experimental procedures; and

- 1 6) Intentionally self-inflicted injury unless resulting from a
2 medical condition (including physical or mental conditions)
3 or from domestic violence.
- 4 k) Any over the counter drugs or medicine, unless prescribed by a
5 dentist or physician.
- 6 l) Fluoride varnish.
- 7 m) Charges for finance charge, broken appointments, completion of
8 insurance forms or reports, providing records, oral hygiene
9 instruction, pit and fissure sealants and dietary instruction, or lack
10 of cooperation on the part of the patient.
- 11 n) Charges in excess of the amount allowed by the plan for a covered
12 service.
- 13 o) Any treatment, material, or supplies that are for orthodontic
14 treatment, including extractions for orthodontics.
- 15 p) Services for which no charge would have been made had the
16 agreement not been in effect.
- 17 q) Surgical grafting procedures.
- 18 r) General anesthetic, conscious sedation, and other forms of relative
19 analgesia, except as otherwise specifically provided herein, unless
20 deemed medically necessary by patient's dentist or physician and pre-
21 authorized by Company.
- 22 s) Services paid for by Workers' Compensation.

- 1 t) Charges incurred while confined as an inpatient in hospital unless
2 such charges would have been covered had treatment been rendered
3 in dental office.
- 4 u) Treatment and/or removal of oral tumors.
- 5 v) All surgical procedures except for surgical extractions of teeth and
6 periodontal surgeries performed by a dentist.
- 7 w) Panoramic x-ray or full mouth x-ray if provided less than 3 years
8 from the covered person's last full mouth x-ray; and full mouth x-
9 rays if provided less than three years from Covered Person's last
10 panoramic x-ray".

11 Section 55. A new § 6107.15, Chapter 6, Division 1, Title 10 of the
12 Guam Code Annotated is hereby *added* to read:

13 **"§6107.15 Non- Emergency Medical Transportation (NEMT). The**
14 **Contractor shall develop a process that ensures that Health Care Para Todu**
15 **plan enrollees have the necessary transportation to medical examinations and**
16 **treatment (42 CFR 440.170(a))."**

17 Section 56. A new § 6107.16, Chapter 6, Division 1, Title 10 of the
18 Guam Code Annotated is hereby *added* to read:

19 **"§ 6107.16 Patient Centered Medical Home. Network primary care**
20 **providers shall strive to provide the concepts of a patient centered medical**
21 **home as provided below:**

- 22 a) Patient-centered: A partnership among practitioners, patients, and
23 their families ensures that decisions respect patients' wants, needs,
24 and preferences, and that patients have the education and support they
25 need to make decisions and participate in their own care.
- 26 b) Comprehensive: A team of care providers is wholly accountable for a

1 patient's physical and mental health care needs, including prevention
2 and wellness, acute care, and chronic care.

3 c) Coordinated: Care is organized across all elements of the broader
4 health care system, including specialty care, hospitals, home health
5 care, community services and supports.

6 d) Accessible: Patients are able to access services with shorter waiting
7 times, "after hours" care, 24/7 electronic or telephone access, and
8 strong communication through health IT innovations.

9 e) Committed to quality and safety: Clinicians and staff enhance quality
10 improvement to ensure that patients and families make informed
11 decisions about their health."

12 **Section 57. A new § 6107.17, Chapter 6, Division 1, Title 10 of the**
13 **Guam Code Annotated is hereby *added* to read:**

14 **"§ 6107.17 Community Health Centers (CHC). The contractor shall**
15 **utilize the CHC's as a network provider."**

16 **Section 58. A new § 6107.18, Chapter 6, Division 1, Title 10 of the**
17 **Guam Code Annotated is hereby *added* to read:**

18 **"§ 6107.18 Member Use of Primary Care Physicians (PCP). The**
19 **contractor shall provide a list of network primary care physicians from**
20 **which members may select for their "medical home". The list will contain**
21 **the Physicians name, clinic name if available, location, phone number and**
22 **specialty. The contractor shall coordinate with the PCP on the number of**
23 **new members the PCP will accept and manage the enrollment to that PCP."**

24 **Section 59. A new § 6107.19, Chapter 6, Division 1, Title 10 of the**
25 **Guam Code Annotated is hereby *added* to read:**

26 **"§ 6107.19 Change in Primary Care Physician. Contractor shall**
27 **develop processes for members to change their primary care**

1 physician/medical home to include a satisfaction survey that addresses the
2 reason for change. The de-identified information from this survey will be
3 shared with the PCP and the Administrator, DPHSS.”

4 **Section 60. A new § 6107.20, Chapter 6, Division 1, Title 10 of the**
5 **Guam Code Annotated is hereby *added* to read:**

6
7 **“§ 6107.20 Reports and Surveys.** The Contractor shall provide the
8 reports and surveys required and described pursuant to this Article to the
9 Director, Department of Public Health and Social Services, and to the Guam
10 Legislature through the Chairperson of the Health Care Committee. The
11 contractor shall also provide information to the appropriate network
12 providers.”

13 **Section 61. A new § 6107.20.1, Chapter 6, Division 1, Title 10 of**
14 **the Guam Code Annotated is hereby *added* to read:**

15 **“§ 6107.20.1 Healthcare Effectiveness Data and Information Set**
16 **(HEDIS).** The contractor shall participate in the United States Department
17 of Health and Human Services, Agency for Healthcare Research and Quality
18 (AHRQ), HEDIS clinical performance program.”

19 **Section 62. A new § 6107.20.2, Chapter 6, Division 1, Title 10 of**
20 **the Guam Code Annotated is hereby *added* to read:**

21 **“§ 6107.20.2 Consumer Assessment of Healthcare Providers and**
22 **Systems (CAHPS).** The contractor shall participate in the United States
23 Department of Health and Human Services, Agency for Healthcare Research
24 and Quality (AHRQ), CAHPS consumer experience survey program.
25 Participation in the CAHPS Database is entirely free to sponsors. By
26 participating, survey sponsors contribute to a national database that confers

1 many benefits related to benchmarking for quality improvement and ongoing
2 research.

3 a) At a minimum, the contractor shall conduct the CAHPS survey
4 modules, CAHPS Health Plan Survey Measures and the Clinician and
5 Group Survey.

6
7 b) Specific benefits for sponsors of the Health Plan Survey (in the
8 Medicaid and CHIP sectors) include receiving a customized case-mix
9 adjusted sponsor report comparing results to appropriate benchmarks.
10 All sponsors also have access to annual chart books that present
11 summary-level comparisons of survey results by selected
12 characteristics (region, sector, facility size, etc.). The contractor shall
13 maintain information as provided in the CAHPS guidelines and share
14 access information to the public. Specifically, the contractor shall
15 inform the Director, DPHSS and Chairperson, Guam Legislature,
16 Committee on Health on the process to access this database.

17 c) The Contractor and network providers are encouraged to ensure
18 CAHPS surveys are accessible, standardized, health plans, providers,
19 and other sponsoring organizations are able to use the results to
20 compare and assess their performance vis-à-vis similar organizations
21 and pinpoint strengths and weaknesses in patients' experiences.
22 Sponsoring organizations can also use the results to evaluate the
23 effectiveness of interventions to improve specific aspects of patients'
24 experiences."

25 **Section 63. A new § 6107.20.3, Chapter 6, Division 1, Title 10 of**
26 **the Guam Code Annotated is hereby *added* to read:**

1 **“§ 6107.20.3 Claims Reports.** The contractor shall provide the
2 following reports:

3 **Medical Claims Report**

- 4 a) Claim by type of Service
- 5 b) Large claim report
- 6 c) Number of Days Hospitalized
- 7 d) Average Days of Confinement
- 8 e) Average Hospital Charges
- 9 f) Average Hospital Payments
- 10 g) Number of Outpatient Physician Visits
- 11 h) Average Cost of Outpatient Physician Visits
- 12 i) Average Hospital Charges
- 13 j) Average Hospital Payments
- 14 k) Professional Procedures
- 15 l) Average Cost of Professional Procedures

16 **Pharmacy Claims Report**

- 17 a) Prescription utilization report
- 18 b) Number of Brand Prescriptions Filled
- 19 c) Number of Generic Prescriptions Filled
- 20 d) Average Brand Prescriptions Cost
- 21 e) Average Brand Generic Cost
- 22 f) Top 50 prescribed prescriptions
- 23 g) Top 50 high cost prescriptions

24 Subject to 4 GCA § 4302 (g), the contractor shall provide, at a
25 minimum, the monthly data requirements outlined below. Plans must also
26 submit a corresponding data dictionary describing the data provided.

- 27 a) A unique contract identifier that links detailed demographic, claims

1 utilization, and cost information

2 b) Enrollment by Plan, Tier/Class, Employment Status, and other
3 Subgroups as required by the Government

4 c) Patient demographics including date of birth, gender, and relationship
5 to subscriber

6 d) Medical, Dental, Vision and Wellness claims by line detail, including:

7 1) Diagnosis code (ICD9 or ICD10)

8 2) Procedure codes (CPT, HCPC, CDT)

9 3) Revenue codes

10 4) Service dates

11 5) Service provider, including:

12 i. Name

13 ii. Tax ID

14 iii. Provider ID

15 iv. Specialty code

16 v. City

17 vi. State

18 vii. Zip code

19 e) Plan payments

20 f) Member payment responsibility, including:

21 1) Copay

22 2) Coinsurance

23 3) Deductible

24 g) Claim paid date

25 h) Type of bill

26 i) Facility type

27 j) Prescription Drug claims by line detail, including:

- 1) NDC codes
- 2) Formulary tier identifier
- 3) Pharmacy, including:
 - i. Name
 - ii. Provider ID
 - iii. City
 - iv. State
 - v. Zip code

k) Plan payments

l) Member payment responsibilities, including:

- 1) Copay
- 2) Coinsurance
- 3) Deductible

m) Claim paid date

n) Injectable drug indicator

o) GPI number

p) Ingredient cost

q) Dispensing fee

r) Rebate.”

Section 64. A new § 6107.21, Chapter 6, Division 1, Title 10 of the Guam Code Annotated is hereby *added* to read:

“§ 6107.21 Quality of Care, Performance and Outcomes

Measures. The following performance goals are given. Participation in achieving these performance goals is voluntary though encouraged to network providers. They are provided as a measure to improve quality of care. The Health Insurance Contractor shall develop a process for PCP’s to

participate. At a minimum, the following resources shall be used in determining performance incentives.

- a) CAHPS survey results
- b) USPTF measures
- c) Claims data
- d) HRA

<u>Measure</u>	<u>Reference</u>	<u>Measure</u>	<u>Data Source</u>
<u>Completion of Contractor provided Health Risk Appraisal</u>	<u>§6107.11.5</u>	<u>Percent of members completed</u>	<u>HRA count</u>
<u>Number of members completing a physical examination.</u>	<u>Schedule of Benefits</u>	<u>Percent of members completed</u>	<u>Claims database</u>
<u>Getting Timely Care, Appointments, and Information</u>	<u>§ 6107.20.2</u>	<u>Clinician and Group survey</u>	<u>CAHPS</u>
<u>How Well Your Providers Communicate</u>	<u>§ 6107.20.2</u>	<u>Clinician and Group Survey</u>	<u>CAHPS</u>
<u>Patients Rating of Provider</u>	<u>§ 6107.20.2</u>	<u>Clinician and Group Survey</u>	<u>CAHPS</u>
<u>Health Status/Functional Status</u>	<u>§6107.11.5</u>	<u>Health Risk Appraisal</u>	<u>HRA</u>
<u>Tobacco use counseling and interventions: non-pregnant adults</u>	<u>The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco</u>	<u>Claims</u>	<u>USPSTF</u>

<u>Obesity screening and counseling: adults</u>	<u>The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m² or higher to intensive, multicomponent behavioral interventions</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Obesity screening and counseling: children</u>	<u>The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up</u>	<u>The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m² or higher to intensive, multicomponent behavioral interventions.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Diabetes screening</u>	<u>The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Hypertension (HTN): Controlling High Blood Pressure</u>	<u>The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Colorectal Cancer Screening</u>	<u>The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.</u>	<u>Claims</u>	<u>USPSTF</u>

<u>Breast Cancer Screening</u>	<u>The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Cervical cancer screening</u>	<u>The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Lung cancer screening</u>	<u>The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adult's ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Chlamydia screening: women</u>	<u>The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Rh incompatibility screening: first pregnancy visit</u>	<u>The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Hepatitis B screening: pregnant women</u>	<u>The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit</u>	<u>Claims</u>	<u>USPSTF</u>

<u>Breastfeeding interventions</u>	<u>The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Syphilis screening: pregnant women</u>	<u>The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Preeclampsia prevention: aspirin</u>	<u>The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia</u>	<u>Claims</u>	<u>USPSTF</u>
<u>Immunizations</u>	<u>The Advisory Committee on Immunization Practices (ACIP) approves immunization schedules recommended for persons living in the United States. The adult immunization schedule provides a summary of ACIP recommendations on the use of licensed vaccines routinely recommended for adults aged 19 years or older. The adult immunization schedule is also approved by the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Nurse-Midwives (ACNM).</u>	<u>Database</u>	<u>DPHSS Immunization Database</u>

”

Section 65. A new § 6107.22, Chapter 6, Division 1, Title 10 of the Guam Code Annotated is hereby *added* to read:

“§6107.22 Appeal Rights. Health Care Para Todu plan applicants and beneficiaries have a right to adequate notice and the opportunity to challenge an adverse action before an impartial party. Enrollees also continue to receive treatment while an appeal is pending (42 CFR 431.200-250). In addition, Health Care Para Todu plan enrollees have access to plan-level

1 procedures to appeal decisions made by the MCO, for example, denial of a
2 requested service (42 CFR 438.400-424). Standard appeals should be
3 resolved within 45 days, but MCOs must have in place a process for
4 expedited review (42 CFR 438.408-410)."

5 **Section 66. Small Business Incentive Committee.** The Director
6 of the Department of Revenue and Taxation *shall* establish a Small Business
7 Incentive Committee to provide recommendations on the creation of a
8 program to provide small businesses an offset mechanism on the financial
9 impact of the implementation of this program. The membership of the
10 Small Business Incentive Committee shall consist of the Director of the
11 Department of Revenue and Taxation; the Chairman of the Committee on
12 Appropriations and Adjudication of *I Liheslaturan Guahan* who may elect to
13 delegate the Director of the Office of Finance and Budget of *I Liheslaturan*
14 *Guahan* as his or her alternate; the Director of the Department of
15 Administration; the Director of the Bureau of Budget and Management
16 Research; and, a Member of the Guam Chamber of Commerce as delegated
17 by the President of the Guam Chamber of Commerce. The Committee *shall*
18 submit, within 90 days of enactment, their recommendations for the offset
19 business program.

20 **Section 67. Effective Date.** This Act shall be effective October 01,
21 2018, *provided however*, the implementation of this Act *shall further* be
22 contingent upon:

- 23 (a) The prior receipt of appropriate federal approvals relative to the
24 provisions of this Act;

- 1 (b) The identification of available funds and the enactment of a
2 coinciding appropriation for the implementation of this Act;
3 and
4 (c) Subject to the provisions of (a) and (b) of this section, there
5 shall be an enrollment period initiated and conducted from July
6 01, 2018 through September 10, 2018.