

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 RELATIVE TO IMPROVING EFFICIENCY IN PROGRAM OPERATIONS AND EXPANDING HEALTHCARE ACCESS TO THE GUAM MEDICAID PROGRAM BY PURSUING A SECTION 1115 WAIVER UNDER 42 U.S.C. §1315 THEREBY AUTHORIZING THE ESTABLISHMENT OF A MANAGED CARE PILOT PROGRAM TO BE KNOWN AS "THE HEALTH CARE PARA TODU PLAN".	6/23/17 4:58 p.m.	7/5/17	Committee on Appropriations and Adjudication	9/19/17 9:00 a.m.	10/18/17 1:27 p.m. As Substituted by the Committee on Appropriations and Adjudication.	Fiscal Note Request 7/5/17 Fiscal Note 7/27/17	



Office of the Speaker
BENJAMIN J.F. CRUZ
I Mina'trentai Kuåtto na Liheslaturan Guåhan
Committee on Appropriations and Adjudication

October 17, 2017

C-5 2017 OCT 18 PM 1:27

The Honorable Régine Biscoe Lee
Chairwoman
I Mina'trentai Kuåtto na Liheslaturan Guåhan
34th Guam Legislature
Guam Congress Building
163 Chalan Santo Papa
Hagåtña, Guam 96910

RE: Committee Report on Bill No. 132-34 (COR), As Substituted by the Committee

Dear Chairwoman Biscoe Lee:

Transmitted herewith is the Report of the Committee on Appropriations and Adjudication on Bill No. 132-34 (COR), As Substituted by the Committee - D. G. Rodriguez, Jr. - "An act relative to improving efficiency in program operations and expanding healthcare access to the Guam Medicaid Program by pursuing a Section 1115 waiver under 42 U.S.C. § 1315 thereby authorizing the establishment of a managed care pilot program to be known as "the Health Care Para Todu Plan."

Committee votes are as follows:

<u>1</u>	TO DO PASS
<u>0</u>	TO NOT PASS
<u>4</u>	TO REPORT OUT ONLY
<u>0</u>	TO ABSTAIN
<u>0</u>	TO PLACE IN INACTIVE FILE

Sincerely,


BENJAMIN J.F. CRUZ
Chairman

RECEIVED
OCT 18 2017

COMMITTEE ON RULES
10:59 a.m.

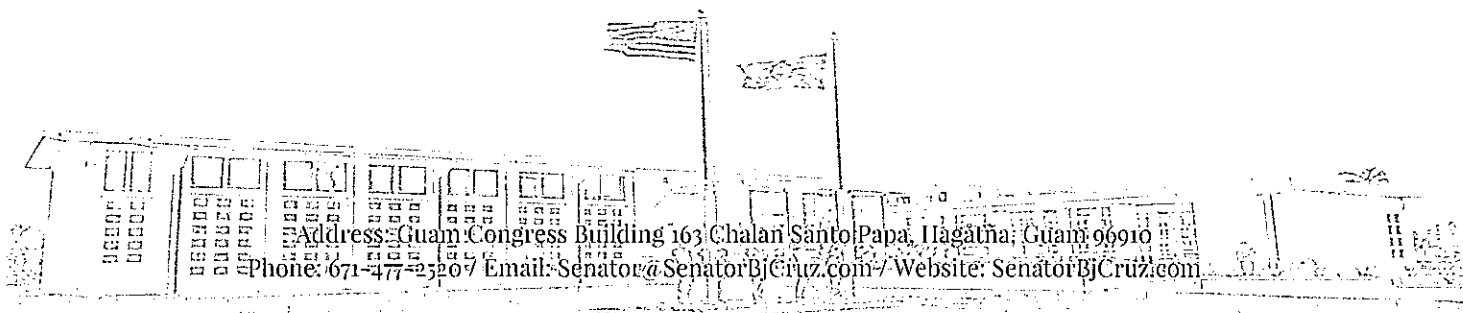


Office of the Speaker
BENJAMIN J.F. CRUZ
I Mina'trentai Kuåtro na Liheslaturan Guåhan
Committee on Appropriations and Adjudication

COMMITTEE REPORT

Bill No. 132-34 (COR), As Substituted by the Committee

“An act relative to improving efficiency in program operations and expanding healthcare access to the Guam Medicaid Program by pursuing a Section 1115 waiver under 42 U.S.C. § 1315 thereby authorizing the establishment of a managed care pilot program to be known as “the Health Care Para Todu Plan.”



Address: Guam Congress Building 163 Chalan Santo Papa, Hagatna, Guam 96910
Phone: 671-477-2520 / Email: Senator@SenatorBJCruz.com / Website: SenatorBJCruz.com



Office of the Speaker
BENJAMIN J.F. CRUZ
I Mina'trentai Kuåtiro na Liheslaturan Guåhan
Committee on Appropriations and Adjudication

MEMORANDUM

TO: All Members

FROM: Speaker Benjamin J.F. Cruz
Chairman, Committee on Appropriations and Adjudication

SUBJECT: Committee Report on Bill No. 132-34 (COR), As Substituted by the Committee

Transmitted herewith for your consideration is the Committee Report on Bill No. 132-34 (COR), As Substituted by the Committee - D. G. Rodriguez, Jr. - "An act relative to improving efficiency in program operations and expanding healthcare access to the Guam Medicaid Program by pursuing a Section 1115 waiver under 42 U.S.C. § 1315 thereby authorizing the establishment of a managed care pilot program to be known as "the Health Care Para Todu Plan."

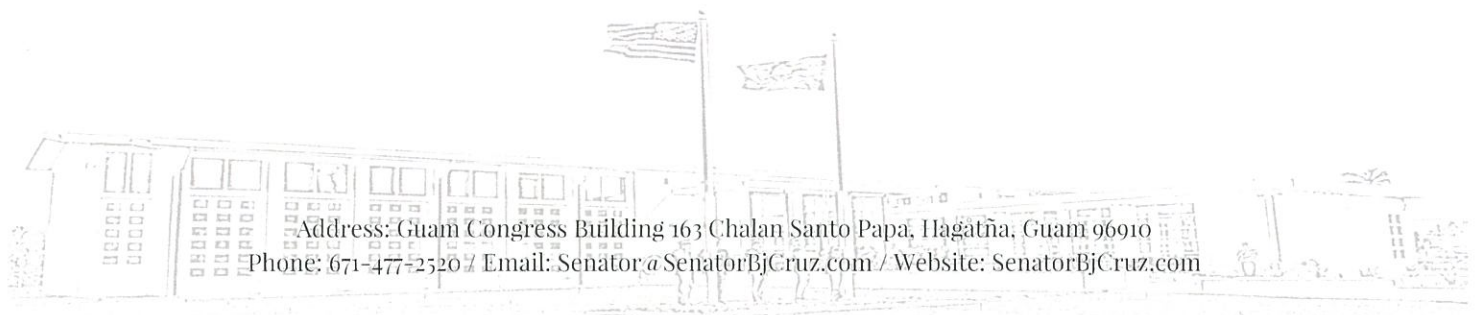
This report includes the following:

- COR Referral of Bill No. 132-34 (COR)
- Notices of Public Hearing
- Public Hearing Agenda
- Public Hearing Sign-in Sheet
- Copies of Submitted Testimony & Supporting Documents
- Committee Vote Sheet
- Committee Report Digest
- Bill No. 132-34 (COR), As Introduced
- Bill No. 132-34 (COR), As Substituted
- COR Pre-referral Checklist
- Fiscal Note Requirement and Funding Availability Note

Please take the appropriate action on the attached voting sheet. Your attention to this matter is greatly appreciated. Should you have any questions or concerns, please do not hesitate to contact me.

Sincerely,


BENJAMIN J.F. CRUZ
Chairman



Address: Guam Congress Building 163 Chalan Santo Papa, Hagatña, Guam 96910
Phone: 671-477-2520 / Email: Senator@SenatorBjCruz.com / Website: SenatorBjCruz.com



COMMITTEE ON RULES

I Mina Trentai Kuåttro na Liheslaturan Guåhan • 34th Guam Legislature

JUL 05 2017
MEMO

To: Rennae Mèno
Clerk of the Legislature

Attorney Julian Aguon
Legislative Legal Counsel

From: Senator Telena Cruz Nelson
Chairman of the Committee on Rules

Re: Referral of Bill No. 132-34 (COR)

Buenas yan Håfa adai.

As per my authority as Chairman of the Committee on Rules and subject to § 6.01(d)(1), Rule VI of our Standing Rules (see B(2) and B(3) of the pre-referral checklist), I am forwarding the referral of **Bill No. 132-34 (COR)**.

Please ensure that the subject bill is referred, in my name, to Speaker Benjamin J.F. Cruz, Chairperson of the Committee on Appropriations and Adjudication. I also request that the same be forwarded to the prime sponsor of the subject bill.

After committee review, the subject bill may be further referred by the Committee on Appropriations to the Principal Committee of subject matter jurisdiction, pursuant to § 6.01(d)(1), Rule VI of our Standing Rules. If the Committee on Appropriations determines that a subsequent referral is in order, the Committee on Rules respectfully advises that the subject bill be referred to Senator Dennis G. Rodriguez, Jr., Chairperson of the Committee on Health, Tourism, Military Affairs, and Senior Citizens.

Attached, please see the COR pre-referral checklist for your information, which shall be attached as a committee report item to the bill.

If you have any questions or concerns, please feel free to contact Christian Valencia, Committee on Rules Director, at 472-2461.

Thank you for your attention to this important matter.

Respectfully,

Senator Telena Cruz Nelson
Acting Chairperson, Committee on Rules



I Mina' Trentai Ku'itro Ne Lhe'staturan
BILL STATUS

BILL NO.	SPONSOR	TITLE	DATE INTRODUCED	DATE REFERRED	CMTE REFERRED	PUBLIC HEARING DATE	DATE COMMITTEE REPORT FILED	FISCAL NOTES	NOTES
132-34 (CON)	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.	7/5/17	Committee on Appropriations and Adjudication				

**FIRST NOTICE of Public Hearing - Tuesday, September 19, 2017**

3 messages

Media Communications <media@senatorbjcruz.com>

Tue, Sep 12, 2017 at 2:00 PM

Cc: Clerks <clerks@guamlegislature.org>, Committee on Rules Guam Legislature <corguamlegislature@gmail.com>, Management Information System <mis@guamlegislature.org>, Joe San Agustin <protocol@guamlegislature.org>, "Sergeant-at-Arms (Legislature)" <sgtarms@guamlegislature.org>
 Bcc: speaker@senatorbjcruz.com, aguon4guam@gmail.com, senatordrodriguez@gmail.com, phnotice@guamlegislature.org, phmaterials@guamlegislature.org, sarah.elmore@senatorbjcruz.com, hermina.certeza@senatorbjcruz.com, orleen@senatorbjcruz.com, epocaigue@senatorbjcruz.com, carlo.branch@senatorbjcruz.com, cipo@guamlegislature.org

September 12, 2017

MEMORANDUM

To: All Members / All Senators

From: Speaker Benjamin J.F. Cruz, Chairman

Re: **FIRST NOTICE OF PUBLIC HEARING**

Håfa Adai! The Committee on Appropriations and Adjudication will conduct a Public Hearing on **TUESDAY, SEPTEMBER 19, 2017** in the **I Liheslatura Public Hearing Room** at the Guam Congress Building with the following schedule:

9:00 AM

BillNo. 157-34 (COR) – F.B. Aguon, Jr. – An act to repeal and reenact Article 2 of Chapter 10, Title 12, Guam Code Annotated, relative to authorizing Jose D. Leon Guerrero Commercial Port to issue revenue bonds and other indebtedness for the purpose of financing or refinancing improvements and/or working capital relating to the Jose D. Leon Guerrero Commercial Port and other related facilities and operations of the Jose D. Leon Guerrero Commercial Port; and approving the terms and conditions of the issuance of one or more series of such bonds pursuant to such article for such purposes.

2:00 PM

BillNo. 131-34 (COR) – D.G. Rodriguez, Jr. – An act *add* new §§ 103121 and 103122 to Chapter 103 of Title 11, Guam Code Annotated, to provide under Guam Law, the equivalent statutory application of Section 2794 [Rate Review] and Section 2718 [Medical Loss Ratio] of the United States Public Health Service Act.

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Bill No. 133-34 (COR) D.G. Rodriguez, Jr. – An act to *repeal* and *reenact* Article 9 of Chapter 2, Division 1, Title 10 of the Guam Code Annotated, relative to transforming the Medically Indigent Program (MIP) into the island community health plan to afford greter access to healthcare services and efficiency in program operations and for other purposes to be known as the "Mañaina yan Mañe'lu Island Community Health Plan of 2017".

Testimonies may be submitted via hand delivery to the Office of Speaker Benjamin J.F. Cruz at the Guam Legislature; via postal mail to Guam Congress Building, 163 Chalan Santo Papa, Hagatna, GU 96910; or via e-mail to senator@senatorbjcruz.com. Please

submit testimonies at least one day prior to the date of the hearing.

All government activities, programs, and services are accessible for people with disabilities in compliance with Title II of the Americans with Disabilities Act (ADA). Should you or interested parties require assistance or special accommodations to fully participate in this public hearing, please contact Mr. Carlo J. Branch at the Office of the Speaker at 477-2520 or via e-mail at carlo.branch@senatorbjcruz.com.

We look forward to your attendance and participation.

cc: Clerks
COR
MIS
Protocol
Sgt at Arms

The Office of Speaker Benjamin J.F. Cruz
Committee on Appropriations and Adjudication
I Mina'trentai Kuáttro Na Liheslaturan Guåhan
T (671) 477-2520 | F (671) 477-2522
<http://www.senatorbjcruz.com>

3 attachments

 **PUBLIC HEARING AGENDA BILL NO. 157-34 - Copy.pdf**
742K

 **FIRST NOTICE - PH MEMO BILL NO. 157-34 .pdf**
863K

 **FIRST NOTICE - PH PR BILL NO. 157-34.pdf**
13478K

Protocol Guam Legislature <protocol@guamlegislature.org>
To: Media Communications <media@senatorbjcruz.com>

Tue, Sep 12, 2017 at 2:09 PM

Confirming that it is posted on the legislature's calendar:

tom

[Quoted text hidden]

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Joe San Agustin

Chief Protocol Officer

I Mina'trentai Kuáttro na Liheslaturan Guåhan

Guam Congress Building, 163 Chalan Santo Papa, *Hagåtña*, Guam 96910

www.guamlegislature.org / protocol@guamlegislature.org

Champaco, Carly <CChampaco@guam.gannett.com>
To: Media Communications <media@senatorbjcruz.com>

Thu, Sep 14, 2017 at 9:20 AM

Hafa A dai,

Thank you for sending this information. It has been added to our Government Meetings listing and will be published as soon as possible.

Please be aware that the listing runs on a space-available basis in print with new listings given priority.

Sincerely,

Carly Champaco

News Assistant

9/18/2017

Senator BJ Cruz Mail - FIRST NOTICE of Public Hearing - Tuesday, September 19, 2017

Pacific Daily News



W: (671) 479-0404

From: Media Communications <media@senatorbjcruz.com>

Date: Tuesday, September 12, 2017 at 2:04 PM

Cc: Clerks <clerks@guamlegislature.org>, Committee on Rules Guam Legislature <orguamlegislature@gmail.com>, Management Information System <mis@guamlegislature.org>, Joe San Agustin <protocol@guamlegislature.org>, "Sergeant-at-Arms (Legislature)" <sgtarms@guamlegislature.org>

Subject: FIRST NOTICE of Public Hearing - Tuesday, September 19, 2017

All



Office of the Speaker
BENJAMIN J.F. CRUZ
I Mina'trentai Kuåtro na Liheslaturan Guåhan
Committee on Appropriations and Adjudication

September 12, 2017

MEMORANDUM

To: All Members / All Senators
From: Speaker Benjamin J.F. Cruz, Chairman

Re: **FIRST NOTICE OF PUBLIC HEARING**

Håfa Adai! The Committee on Appropriations and Adjudication will conduct a Public Hearing on **TUESDAY, SEPTEMBER 19, 2017** in the ***I Liheslatura* Public Hearing Room** at the Guam Congress Building with the following schedule:

9:00 AM

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2:00 PM

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Address: Guam Congress Building 103 Chalan Santo Papa, Hagåtña, Guam 96910
Phone: 671-477-2520 / Email: Senator@SenatorBjCruz.com / Website: SenatorBjCruz.com

the “Mañaina yan Mañe’lu Island Community Health Plan of 2017”.

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We look forward to your attendance and participation.



Office of the Speaker
BENJAMIN J.F. CRUZ
I Mina'trentai Kuåtiro na Liheslaturan Guåhan
Committee on Appropriations and Adjudication

FOR IMMEDIATE RELEASE

September 12, 2017

FIRST NOTICE OF PUBLIC HEARING

In accordance with the Open Government Law, P.L. 24-109, relative to notice for public meetings, let this release serve as five (5) days' notice for a Public Hearing by the Committee on Appropriations and Adjudication scheduled on **TUESDAY, SEPTEMBER 19, 2017** in the **Guam Legislature Public Hearing Room** at the Guam Congress Building, on the following:

9:00 AM

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2:00 PM

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Address: Guam Congress Building 103 Chalan Santo Papa, Hagatna, Guam 96910
Phone: 671-477-2520 / Email: Senator@SenatorBjCruz.com / Website: SenatorBjCruz.com

Testimonies may be submitted in person to the Office of Speaker Benjamin J.F. Cruz at the Guam Legislature; by postal mail to Guam Congress Building, 163 Chalan Santo Papa, Hagåtña Guam 96910 or by email to senator@senatorbjcruz.com. Copies of written testimonies received at least one day before the scheduled date will be available at the hearing.

Individuals requiring assistance or special accommodations should contact Mr. Carlo J. Branch at the Office of the Speaker at 477-2520, or by e-mail at carlo.branch@senatorbjcruz.com.

###



Media Communications <media@senatorbjcruz.com>

SECOND NOTICE of Public Hearing - Tuesday, September 19, 2017

1 message

Speaker Benjamin J.F. Cruz / Media <media@senatorbjcruz.com>

Sat, Sep 16, 2017 at 5:00 PM

Cc: Clerks <clerks@guamlegislature.org>, Committee on Rules Guam Legislature <corguamlegislature@gmail.com>, Management Information System

<mis@guamlegislature.org>, Joe San Agustin <protocol@guamlegislature.org>, "Sergeant-at-Arms (Legislature)" <sgtarms@guamlegislature.org>

Bcc: phnotice@guamlegislature.org, phmaterials@guamlegislature.org, "Dennis G. Rodriguez, Jr." <senatordrodriguez@gmail.com>, "Frank B. Aguon, Jr." <aguon4guam@gmail.com>

September 16, 2017

MEMORANDUM

To: All Members / All Senators

From: Speaker Benjamin J.F. Cruz, Chairman

Re: SECOND NOTICE OF PUBLIC HEARING

Håfa Adai! The Committee on Appropriations and Adjudication will conduct a Public Hearing on **TUESDAY, SEPTEMBER 19, 2017** in the **I Liheslatura Public Hearing Room** at the Guam Congress Building with the following schedule:

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healthcare services and efficiency in program operations and for other purposes to be known as the "Mañaina yan Mañe'lu Island Community Health Plan of 2017".

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We look forward to your attendance and participation.


cc: Clerks
COR
MIS
Protocol
Sgt at Arms

The Office of Speaker Benjamin J.F. Cruz
Committee on Appropriations and Adjudication
I Mina'trentai Kuâtto Na Liheslaturan Guåhan
T (671) 477-2520 | F (671) 477-2522
<http://www.senatorbjcruz.com>

3 attachments

 **PUBLIC HEARING AGENDA BILL NO. 157-34 - Copy.pdf**
742K

 **SECOND NOTICE - PH MEMO BILL NO. 157-34 .pdf**
860K

 **SECOND NOTICE - PH PR BILL NO. 157-34.pdf**
13477K



Office of the Speaker
BENJAMIN J.F. CRUZ
I Mina'trentai Kuåtiro na Liheslaturan Guåhan
Committee on Appropriations and Adjudication

September 15, 2017

MEMORANDUM

To: All Members / All Senators
From: Speaker Benjamin J.F. Cruz, Chairman

Re: **SECOND NOTICE OF PUBLIC HEARING**

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2:00 PM

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Bill No. 133-34 (COR) D.G. Rodriguez, Jr. – An act to *repeal* and *reenact* Article 9 of Chapter 2, Division 1, Title 10 of the Guam Code Annotated, relative to transforming the Medically Indigent Program (MIP) into the island community health plan to afford greter access to healthcare services and efficiency in program operations and for other purposes to be known as

Address: Guam Congress Building 103 Chalan Santo Papa, Hagatna, Guam 96910
Phone: 671-477-2520 / Email: Senator@SenatorBjCruz.com / Website: SenatorBjCruz.com

the “Mañaina yan Mañe’lu Island Community Health Plan of 2017”.

Testimonies may be submitted via hand delivery to the Office of Speaker Benjamin J.F. Cruz at the Guam Legislature; via postal mail to Guam Congress Building, 163 Chalan Santo Papa, Hagatna, GU 96910; or via e-mail to senator@senatorbjcruz.com. Please submit testimonies at least one day prior to the date of the hearing.

All government activities, programs, and services are accessible for people with disabilities in compliance with Title II of the Americans with Disabilities Act (ADA). Should you or interested parties require assistance or special accommodations to fully participate in this public hearing, please contact Mr. Carlo J. Branch at the Office of the Speaker at 477-2520 or via e-mail at carlo.branch@senatorbjcruz.com.

We look forward to your attendance and participation.



Office of the Speaker
BENJAMIN J.F. CRUZ
I Mina'trentai Kuåtiro na Liheslaturan Guåhan
Committee on Appropriations and Adjudication

FOR IMMEDIATE RELEASE

September 15, 2017

SECOND NOTICE OF PUBLIC HEARING

In accordance with the Open Government Law, P.L. 24-109, relative to notice for public meetings, let this release serve as two (2) days' notice for a Public Hearing by the Committee on Appropriations and Adjudication scheduled on **TUESDAY, SEPTEMBER 19, 2017** in the **Guam Legislature Public Hearing Room** at the Guam Congress Building, on the following:

9:00 AM

Bill No. 157-34 (COR) – F.B. Aguon, Jr. – An act to repeal and reenact Article 2 of Chapter 10, Title 12, Guam Code Annotated, relative to authorizing Jose D. Leon Guerrero Commercial Port to issue revenue bonds and other indebtedness for the purpose of financing or refinancing improvements and/or working capital relating to the Jose D. Leon Guerrero Commercial Port and other related facilities and operations of the Jose D. Leon Guerrero Commercial Port; and approving the terms and conditions of the issuance of one or more series of such bonds pursuant to such article for such purposes.

2:00 PM

Bill No. 131-34 (COR) – D.G. Rodriguez, Jr. – An act *add* new §§ 103121 and 103122 to Chapter 103 of Title 11, Guam Code Annotated, to provide under Guam Law, the equivalent statutory application of Section 2794 [Rate Review] and Section 2718 [Medical Loss Ratio] of the United States Public Health Service Act.

Bill No. 132-34 (COR) D.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”.

Bill No. 133-34 (COR) D.G. Rodriguez, Jr. – An act to *repeal* and *reenact* Article 9 of Chapter 2, Division 1, Title 10 of the Guam Code Annotated, relative to transforming the Medically Indigent Program (MIP) into the island community health plan to afford greter access to healthcare services and efficiency in program operations and for other purposes to be known as the “Mañaina yan Mañe’lu Island Community Health Plan of 2017”.

Address: Guam Congress Building 103 Chalan Santo Papa, Hagatna, Guam 96910
Phone: 671-477-2520 / Email: Senator@SenatorBjCruz.com / Website: SenatorBjCruz.com

Testimonies may be submitted in person to the Office of Speaker Benjamin J.F. Cruz at the Guam Legislature; by postal mail to Guam Congress Building, 163 Chalan Santo Papa, Hagåtña Guam 96910 or by email to senator@senatorbjcruz.com. Copies of written testimonies received at least one day before the scheduled date will be available at the hearing.

Individuals requiring assistance or special accommodations should contact Mr. Carlo J. Branch at the Office of the Speaker at 477-2520, or by e-mail at carlo.branch@senatorbjcruz.com.

###



Office of the Speaker
BENJAMIN J.F. CRUZ
I Mina'trentai Kuåtiro na Liheslaturan Guåhan
Committee on Appropriations and Adjudication

PUBLIC HEARING AGENDA

Tuesday, September 19, 2017

Guam Legislature Public Hearing Room • Guam Congress Building

9:00 AM

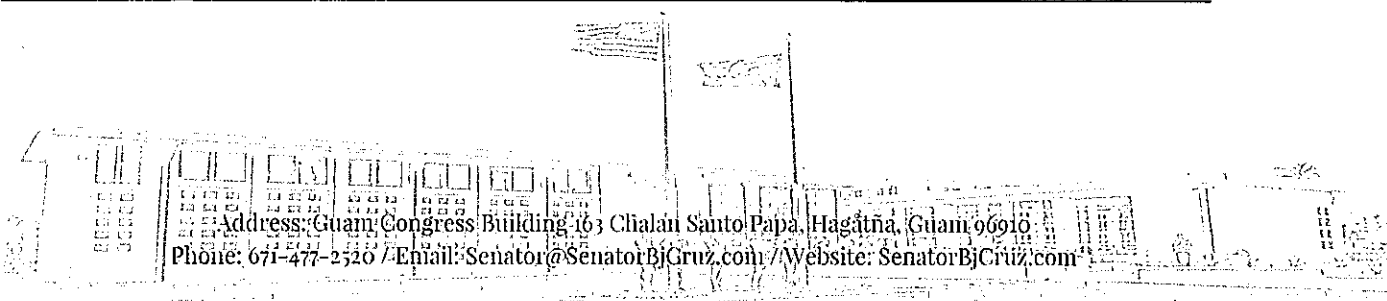
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Phone: 671-477-2520 / Email: Senator@SenatorBjCruz.com / Website: SenatorBjCruz.com



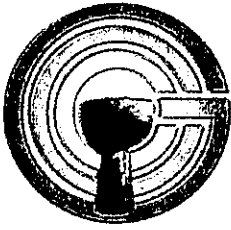
2:00 PM • Tuesday, September 19, 2017

Guam Legislature Public Hearing Room | Guam Congress Building

Bill No. 132-34 (COR) D.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”.

[illegible]

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 Phone: 671-477-2520 / Email: Senator@Cruz.com / Website: Senator@Cruz.com



GUAM CHAMBER OF COMMERCE
PARTNERS IN PROGRESS

July 29, 2017

THE HONORABLE BENJAMIN J.F. CRUZ
Chair, Committee on Appropriations and Adjudication
I Mina' Trentai Kuatttro Liheslaturan Guahan
Suite 301, 155 Hesler St.
Hagåtña, Guam, 96910

RE: BILL 132-34. 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".

Dear Speaker Cruz,

Thank you for the opportunity to submit our comments on Bill 132-34. While we commend the efforts of the bill's author in terms of addressing the issues related to Medicaid, the Guam Chamber of Commerce is indeed very concerned with the creation of the *Health Insurance Premium Fee* that would help fund a portion of the *Health Care Para Todu Plan*. A standard business practice entails the passing of new costs to the consumers, and this legislation, as drafted, would increase the premiums of health insurance on island.

The Guam Chamber of Commerce represents over 400 business members, many of whom either provide medical insurance to their employees, or purchase coverage via the Guam Chamber of Commerce's health insurance program, and they would all be adversely impacted by Bill 132-34. While the objectives of the legislation clearly display the importance of assisting those who are currently uninsured, it shouldn't come at the expense of increasing the premiums of those currently paying for coverage today.

Bill 132-34 does allow the 4% proposed fee to be applied towards the calculations of Medical Loss Ratios (MLR). However, this still won't prevent premiums from increasing, as anticipated operating costs are included in the proposals at the onset, and MLR's are only beneficial for the consumer if loss ratios are below a certain threshold. In other words, while this is a positive gesture, it still does not address the primary concerns of this legislation.

While an overhaul of both the Medicaid and MIP (which is addressed in Bill 133-32) programs are important, the government needs to either seek a funding source that won't impact the everyday pocketbook, or seek ways to reduce government spending. Please note that in the span of a year there have been bills or proposals introduced, which would increase Business Privilege Taxes, Minimum Wage, Liquid Fuel Taxes, Port Tariffs, Utility Rates, and the implementation of TESS Law which would impact the cost of goods entering the port. All of these mandates will affect the everyday cost of living.

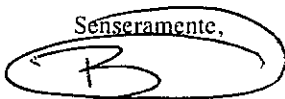
Page 2
Letter to Speaker Cruz
Re: Bill No. 132-34

Another concern in the legislation is the Employer Mandate provision which would require employers who don't provide health insurance to offer it. While we encourage businesses to provide this important benefit for their employees, there are some entities that may not have the financial capabilities to do so. Will the government provide a subsidy for the smaller businesses who will endure these challenges?

If it is the resolve of the government to pursue this *Health Insurance Premium Fee*, then we recommend that this issue be placed as a referendum for the voters to decide in the 2018 General Election. Public Law 31-255 stipulates that the "creation of any new fee for a service already provided by the Government of Guam prior to the establishment of the new fee, and where such service previously funded through other revenues", shall mandate the approval of voters. Because Bill 132-34 creates a new fee for a service the government currently provides, and also (partially) funds, the creation of the *Health Insurance Premium Fee* should be determined by the voters.

In summary, the Guam Chamber of Commerce does not support Bill 132-34 as drafted. We believe that in the process, this legislation will hurt many of those paying for coverage today through increased premiums, and will also impact taxpayers, who will end up paying for the costs associated with increased rates of the government's health insurance program. Likewise, because of the price tag, many employers, specifically the smaller entities, may have to move from more comprehensive programs to the Para Todu plan. Unless the Guam Legislature can find a more reasonable funding source that minimizes the impact towards the community, this legislation needs to be tabled, or the *Health Insurance Premium Fee* should be placed on an election referendum for voters to decide.

Thank you for the opportunity to present our comments. We are certainly open to further discussion on this issue.

Senseramente,


BOBBY SHRINGI
Chairman of the Board



EDDIE BAZA CALVO
GOVERNOR

RAY TENORIO
LIEUTENANT GOVERNOR

GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT



JAMES W. GILLAN
DIRECTOR

LEO G. CASIL
DEPUTY DIRECTOR

SEP 18 2017

Speaker Benjamin J.F. Cruz

SEP 19 2017

Testimony on Bill 132-34(COR)
September 19, 2017

Time: 8:00 AM [] PM File No. 34-910
Received By: [Signature]

Buenas! Mr. Chairman, and members of the Committee on Health, Tourism, Military Affairs, and Senior Citizens. The Department of Public Health and Social Services supports the intent of Bill No. 132-34 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". However, the following concerns need to be taken into consideration.

- Medicaid Program funding is capped.
- Patient Protection Affordable Care Act (ACA) of 2010 funding expiration in Fiscal Year 2019.
- Currently, the Government is unable to fully fund and secure local funding to match the Medicaid grant award for the current Medicaid enrollees. Payment to providers is dependent on Guam's revenue or cash flow.
- Issue on benefit coordination and reimbursement of Medicaid patients' emergency medical services (off-island referral) if Department of Administration failed to timely remit insurance premium for a specific month(s). (Please see attached letter from insurance company due to untimely payment of Foster Care Children's insurance premium.)
- More staff and administrative funding needed for implementation if approved by CMS. Currently, eligibility determination section is behind on processing applications due to slow recruitment process and problems on staff retention due to low salary (Letter was submitted to DOA to upgrade the Eligibility Specialist position since January 2017. No action has been taken up to this day.)
- Any approved Medicaid SPA or WAIVER must be implemented based on the effective date stipulated on the SPA or Waiver. It cannot be contingent on the identification of available funds.

GOVERNMENT OF GUAM
DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
DIPATTAMENTON SALUT PUPBLEKO YAN SETBISION SUSIAT

- Funding should be appropriated to hire a consultant/actuary to do a feasibility study/research based on this bill's requirement.

This is our initial comments on Bill 132-34. Additional comments will be provided as necessary. Thank you for the opportunity to speak on behalf of this bill.



JAMES W. GILLAN

Speaker Benigno F. Cruz

JOHN Q. CARLOS
P o Box 9453
Dededo, Guam 96912

SEP 19 2017
Time: 9:15
Received By: [Signature]

The Honorable Dennis G. Rodriguez, Jr.
Chairman, Committee on Health, Tourism, Military Affairs,
And Senior Citizens
I Mina'trenta Kuattro Na Liheslaturan Guahan
Guam Congress Building
163 Chalan Santo Papa
Hagatna, Guam 96910

Re: Bill No 132-34, "The Health Care Para Todu Plan"

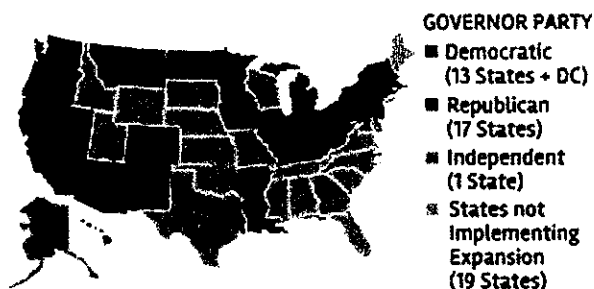
Dear Senator Rodriguez:

My name is John Carlos. I am a retired regulator. I am a consumer advocate. I am in favor of Bill No. 132-34.

This bill provides a framework for Guam to start the process of Medicaid expansion under Section 1115 of the Social Security Act. If approved by the Guam Legislature, the Guam Department of Public Health and Social Services can use the approved bill as a template to apply with the Centers for Medicare and Medicaid Services (CMS) to expand Medicaid in Guam.

As of September 2017, thirty one of the 50 states have applied for, given approval by CMS and have implemented Medicaid expansion in their respective states. The Medicaid map is copied below.

**Medicaid Expansion States by
Governor's Party Affiliation, Sept. 2017**



<http://www.kff.org/medicaid/slide/expansion-states-are-split-between-republican-and-democratic-governors/>

The former Governor of Indiana, now Vice President Pence, applied for Medicaid expansion using a plan designed by health care consultant and currently, the administrator for CMS Seema Verma.

The Healthy Indiana Medicaid expansion program is funded by federal Medicaid funds, a two per cent (2%) contribution from applicants with household income from 130% to 200% of the Federal Poverty Level (FPL) and by the state of Indiana. The Healthy Indiana program includes a power health savings account (HSA) for each Medicaid recipient. This program enabled Indiana to provide a significant revenue to clinics and hospitals in Indiana.

The proposed funding for the Guam Medicaid expansion is as follows:

- (1) Qualified applicants with household income from 108% to 200% of the Guam Adjusted Federal Poverty Level shall be required to:
 - (a) contribute two per cent (2%) of their income to a health insurance fund and
 - (b) contribute at least \$500.00 to a health savings account.
- (2) The Medicaid cost sharing is forty five percent (45%) Guam funds and fifty five percent (55%) Medicaid funds. Each employer is mandated to contribute sixty five percent (65%) of the forty five percent (45%) of the Guam share of the premium for each individual employee.
- (3) There is approximately \$168.0 million balance of the Affordable Care Act allocated Medicaid Funding for Guam. Medicaid shall fund the fifty five percent (55%) for each individual premium cost. This funding is good until 2019.
- (4) A four percent (4%) health insurance tax on health insurance premium for health insurance companies doing business in Guam. It is my understanding that insurers selling health insurance have been exempted from paying the 4% gross receipts tax through the GEDA qualifying certificate program. I think these health insurance companies are in good financial condition now and can give back some benefits to Guam.

On May 1, 2017, the Office of Public Accountability issued a report of the 2016 audit of the Guam Memorial Hospital Authority (GMHA). Some highlights of the report on self-paying patients are:

- For the past five years self-paying patients received an average of \$27.0 million medical care per year. The provision for bad debts averages \$16.0 million or 59% of the billings. For 2016 billings for self-pay patients were \$34.0 million. Collection were 43%. GMHA continues to provide 32% provision for bad debts.
- GMHA has raised hospital fees by 5% effective April 1, 2017 and another 5% every subsequent fiscal year.

The above information from the audit of GMHA suggests that Government of Guam and patients with insurance coverage are paying and in effect giving an indirect subsidy to some of the self-paying patients who have no insurance coverage.

It has been demonstrated that in Medicaid expansion there was a net financial benefit to the Medicaid expansion states. Also, the increase in the costs of insurance in the Medicaid expansion states in the individual, the small and large health insurance market, is more moderate.

The proposed US Senate Better Reconciliation Act of 2017 converts federal Medicaid funding to a per capita allotment and limit growth in federal Medicaid spending beginning in 2020.

Similarly, the proposed HR 1628 American Health Care Act of 2017 also converts federal Medicaid funding to a per capita allotment and limit growth in federal Medicaid spending beginning in 2020 using 2016 as a base year as well as provide state option to receive a block grant for non-expansion adults and children or only non-expansion adults.

It is not certain if either the house or the senate bill for health care will pass. However, the common feature of both health care proposals is that federal

Page 4, Testimony in Bill No. 132-34.

Medicaid funding could remain in reduced allocated amounts or be converted into either a per capita allotment or a block grant beginning 2020.

For all the foregoing reasons, I am in favor of Bill No. 132-34.

Sincerely,


JOHN CARLOS

Darryl A. Borja Taggerty
P.O. Box 3476
Hagåtña, Guam 96932

September 19, 2017

The Honorable Senator Dennis G. Rodriguez, Jr.
Chairman, Committee on Health, Tourism, Military Affairs, & Senior Citizens
34th Guam Legislature
761 S. Marine Corps Drive, Suite B1
Tamuning, Guam 96931

Re: Testimony on Bill No. 132-34

Dear Mr. Chairman:

Thank you for soliciting the viewpoint of the public regarding Bill No. 132-34.

Since this bill was introduced in June, I was offended by the branding of the proposal with your own political campaign slogan. It appears to be an unethical attempt to extend your political campaign into publicly-funded program materials. I urge your colleagues to remove this and all other instances of blatant electioneering from public policy drafts during legislative session.

Following the 1980's repeal of Certificate of Need health industry investment restrictions, massive inflation in health care costs shifted health care as a factor in family and corporate budgets, and the national economy. The medical professional, pharmaceutical and medical equipment lobbies prevented the national adoption of universal coverage patterned after the successful Hawaii and Massachusetts state plans. The federal government then lagged Medicaid and Medicare reimbursements to slow price increases, *per procedure and formulary* item. Key features of the Affordable Care Act were compromised at the beginning, causing its eventual failure. During this entire time the national Public Health Service and federally-funded health programs continued to provide basic care for Americans unable to afford market offerings. Proven federal and state health care delivery systems have been in place for decades, but our leaders lack the political will to adapt them to our needs.

We understand that Guam opted to not expand Medicaid with Obamacare funds, especially since Guam has to cover 50% of billings with its own revenues. But that begs the question, why do Guam leaders now propose to fully fund private insurance administrative overhead and corporate profits instead of direct medical costs of care? The direct cost of administering health

care by DPHSS (not GMH) is lower than through private insurers. Is the subject bill really the best proposal you can think of?

I question whether this bill would expand coverage at all. It appears that employers will be able to shift current sub-living wage employees to the 65% government subsidized program. Also, what company needs a special provision like Section 11 for off-island workers? Would that be United, Black or DZSP, each of which have low-paid employees contracted on but working outside of Guam? Para Todu looks like a federally-funded welfare program for local companies. Please clarify these apparent corporate gifts.

I favor the expansion of health care for those without, and cost control. I also understand that investment in medical education, equipment and places of professional practice must generate profit to be sustainable. Government of Guam and federal employees, and corporate managers, enjoy the best coverage. We see "medical missions" by local professionals and companies deliver care to neglected, remote or impacted communities at no cost. Can your committee put all working models together end-to-end to locally construct a "continuum of care" without placing the health insurance companies' administrators and shareholders first in line to be paid?

Thank you for considering my perspectives on this important proposal.

Sincerely,

DARRYL A. BORJA TAGGERTY
Member, Citizens for Public Accountability

September 19, 2017



The Honorable Benjamin J. F. Cruz
Speaker, 34th Guam Legislature
Committee on Appropriations and Adjudication
155 Hesler Place
Hagatna, GU 96910

Via Email: senator@senatorbjcruz.com

Subject: Testimony for Bill Nos. 132-34 (COR) & 133-34 (COR)

Dear Speaker Cruz:

Thank you for the opportunity to provide testimony for Bill No. 132-34 that would establish a Medicaid Managed Care pilot program known as "The Health Care Para Todu Plan," and Bill No. 133-34 that would transform the Medically Indigent Program (MIP) into a managed care program known as the "Island Community Health Plan."

Due to the short notice of the testimony request, Guam Regional Medical City (GRMC) is unable to provide a thorough review and comment for these bills. However, our preliminary review found that both bills present the same concern that GRMC expressed earlier this year in testimony against Bill No. 3-34 (exclusive health plan for GovGuam health insurance), since neither of these bills require a bidding health plan to include GRMC in their respective provider network. As a result, any health plan selected by GovGuam to participate in either of these managed care programs without GRMC in network would expose Medicaid and MIP beneficiaries to: 1) extreme financial risk, 2) lack of equal hospital access, and 3) a restriction on the right to choose any local hospital.

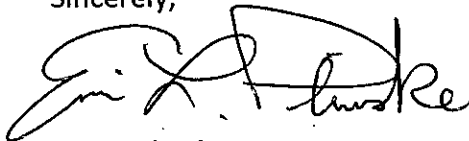
1. **Financial Risk** – Most patients access GRMC through the emergency room, and many are admitted due to the severity of their condition. When a health plan does not place GRMC in its provider network, the hospital bill is sent directly to the patient and it becomes the patient's sole responsibility. For services at out-of-network providers, health plans generally require their members to pay the provider and then seek reimbursement from the health plan. The first primary challenge is that most patients do not have the money to pay for their hospital bills with no health plan negotiated rates. The second primary challenge is that Guam-based health plans only give their members 90 days from the date of discharge to prove that they paid their bill at an out-of-network provider by turning in their receipts and a copy of their medical records to the health plan. If the patient does not accomplish this within 90 days, they are usually not eligible for any reimbursement from their health plan. If the patient does manage to come up with the finances to pay the entire hospital bill within 90 days, they may then be eligible to seek reimbursement from their health plan at 70% of "eligible" charges. However, this presents the third primary challenge since eligible charges are determined by the health plan and rarely have anything to do with the actual billed charges. Eligible charges are commonly defined by the health plan as the lowest in-network negotiated rate, so 70% of that rate will only be a small fraction of the actual billed charges at an out-of-network provider. As a result, any reimbursement the patient would receive from their health plan would likely be a small percentage of the actual billed charges they would have already paid to the out-of-network provider.

2. **Equal Access Provision** – The Guam Medicaid State Plan complies with the federal Equal Access Provision in 42 C.F.R. § 1396(a)(30)(A) so that care and services for Medicaid and MIP beneficiaries will be available at least to the extent that such care and services are available to the general population in the geographic region. If Bill Nos. 132-34 and 133-34 are passed into law, Medicaid and MIP beneficiaries may be exposed to lack of equal hospital access if any health plan is selected that does not have GRMC in its network.

3. **Right to Choose Provision** – The Guam Medicaid State Plan also has a provision for the Right to Choose a provider, and passage of Bill Nos. 132-34 and 133-34 will restrict the right to choose GRMC if any health plan is allowed to participate that does not have GRMC in its provider network. It is important to realize that patients are generally taken to the closest hospital for emergencies due to the risk of death or serious bodily impairment, especially when they are transported in an ambulance. In addition, the majority of hospital admissions result from emergency room visits. Therefore, GRMC feels that it is both unreasonable and unethical for a health plan to limit or restrict coverage at one of only two civilian hospitals on Guam, especially when GRMC is the only one that provides advanced specialty care.

For these reasons, GRMC cannot support Bill Nos. 132-34 and 133-34 as currently written.

Sincerely,



Eric L. Plinske
Director of Corporate Affairs

Cc: Margaret A. Bengzon, GRMC Chairperson & CEO
Michael W. Cruz, MD, GRMC President & COO
Senator Dennis G. Rodriguez, Jr.

Testimony in Opposition to Bill 132 & 133

By Ken Leon-Guerrero, Spokesperson Guam Citizens for Public Accountability

I oppose Bills 132 and 133 on the basis that it does not appear to me to do anything other than transfer badly needed funds from the government healthcare programs to private insurance companies with no guarantee the transfer will result in more coverage and better coverage; just more expensive coverage.

At a time many states and even the US Congress are looking at enabling some form of “Medicaid for All,” this bill transfers the funding that could be used for a Guam version of “Medicaid for All” to private insurance companies, and appears to me to be little more than an attempt to improve the profitability of the local insurance companies at public expense.

I had been hoping to see something along the lines of the Universal Medical Coverage for employees that Hawaii enacted in 1974.. As a result of the foresight of Hawaii’s elected officials back in 1974; 93% of the population has healthcare coverage, and the lowest year over year increases in medical expenses in the nation.

When I talk to business owners about why they don’t offer medical benefits, they cite competition as the main reason. They believe that if they offer medical benefits and their prices go up, they give competitors who don’t offer medical benefits a competitive edge. That is the reason why so many working people on Guam don’t have healthcare coverage, and are forced onto the taxpayer funded Medicaid or MIP programs.

Mandatory healthcare coverage for all employees is not addressed in these bills. Without mandatory healthcare coverage for all employees, any healthcare reform bill for Guam will be doomed to be a very expensive failure for taxpayers.

There are no safe guards in these bills that I can see that will ensure the level of the coverage provided by contractors does not go down below the current benefit levels offered in Medicaid and MIP.

There is nothing in these bills I see that bars the addition deductibles and co-pays common to all commercially available plans, to these taxpayer funded plans.

1 The high co-pays and deductibles on existing commercially offered plans are the reason
2 why so many people with medical insurance wait until medical conditions progress to the
3 point they are forced use the emergency room as their Primary Care Provider.

4 I am concerned about the “pilot program” aspect of these bills that allows the programs to
5 be cancelled at anytime. These “temporary” provisions are what cause it to feel like a
6 pork barrel benefit for commercial healthcare companies.

7 And since the Governor’s family is going to be a direct beneficiary of these bills; these
8 bills are something that public will be watching closely after the past series of pork barrel
9 projects that were designed to benefit members of the Governor’s family.

10 The Leyon Super Award that put an additional \$13 Million taxpayer dollars in the
11 pockets of the Governor’s family

12 The Guam YTK award that will potentially put nearly \$20 Million taxpayer dollars in the
13 pockets of members of the Governor’s family.

14 The Simon Sanchez Pork Barrel debacle where a company owned by members of the
15 Governor’s family got a contract to build a more expensive and smaller high school
16 considering they have never designed built or managed a high school construction
17 project.

18 The most recent pork barrel gift being the multivendor government healthcare plan that
19 cost taxpayers an additional \$21 Million dollars, with most of that money going to a
20 company owned by the Governor’s family.

21 This is a complicated Bill. It could be a good bill with changes starting with mandatory
22 universal coverage for all employees, a guarantee that benefits will not be less than
23 currently offered, and a guarantee there will be no deductible or co-pays. But until
24 universal coverage for all employees becomes the starting point for healthcare reform, all
25 that voters and taxpayers are going to see is another “pork barrel” project to enrich
26 politically well connected special interests, at taxpayer expense.

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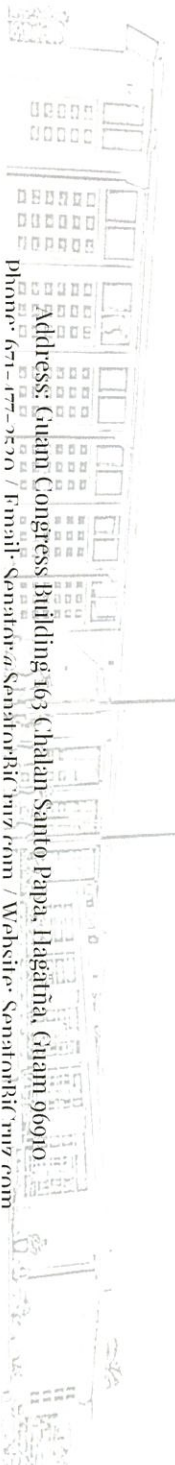


Office of the Speaker
BENJAMIN J.F. CRUZ
I Mind trenlai Kiadto na Liheslaturan Guahan
Committee on Appropriations and Adjudication

COMMITTEE VOTING SHEET

Bill No. 132-34 (COR), As Substituted by the Committee - D. G. Rodriguez, Jr. - "An act relative to improving efficiency in program operations and expanding healthcare access to the Guam Medicaid Program by pursuing a Section 1115 waiver under 42 U.S.C. § 1315 thereby authorizing the establishment of a managed care pilot program to be known as "the Health Care Para Todu Plan."

COMMITTEE MEMBERS	SIGNATURE	TO DO PASS	TO NOT PASS	TO REPORT OUT ONLY	TO ABSTAIN	TO PLACE IN INACTIVE FILE
CRUZ, BENJAMIN J.F. Chairperson				<input checked="" type="checkbox"/>		
AGUON, JR., FRANK B. Vice Chairperson	 17 OCT 2017			<input checked="" type="checkbox"/>		
TERLAJE, THERESE M. Member						
ESPALDON, JAMES V. Member				<input checked="" type="checkbox"/>		
RODRIGUEZ, JR., DENNIS G. Member		<input checked="" type="checkbox"/> 10/17/17				
SAN NICOLAS, MICHAEL, F.Q. Member						
LEE, REGINE BISCOE Member						
MORRISON, THOMAS A. Member				<input checked="" type="checkbox"/>		





Office of the Speaker
BENJAMIN J.F. CRUZ
I Mina'trentai Kuåtiro na Liheslaturan Guåhan
Committee on Appropriations and Adjudication

COMMITTEE REPORT DIGEST

Bill No. 132-34 (COR), As Substituted by the Committee - D. G. Rodriguez, Jr. - "An act relative to improving efficiency in program operations and expanding healthcare access to the Guam Medicaid Program by pursuing a Section 1115 waiver under 42 U.S.C. § 1315 thereby authorizing the establishment of a managed care pilot program to be known as "the Health Care Para Todu Plan."

I. OVERVIEW

Bill No. 132-34 (COR) was introduced by Senator Dennis G. Rodriguez, Jr. on June 23, 2017, and referred to the **Committee on Appropriations and Adjudication** on July 5, 2017.

The Committee on Appropriations and Adjudication convened a public hearing on Tuesday, September 19, 2017, beginning at 2:00 PM in the Guam Legislature Public Hearing Room. The hearing for Bill No. 132-34 (COR) began at 3:30 PM and ended at 4:15 PM.

Public Notice Requirements

All legal requirements for public notices were met, with requests for publication sent to all media and all Senators on September 12, 2017, and September 16, 2017, via email. Copies of the hearing notices are appended to the report.

Senators Present

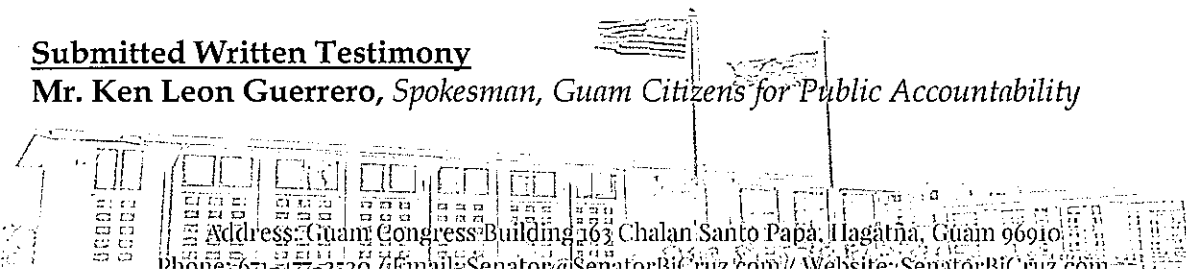
Speaker Benjamin J.F. Cruz, *Chairperson*
Vice Speaker Therese M. Terlaje, *Member*
Senator Dennis G. Rodriguez, Jr., *Member*
Senator Régine Biscoe Lee, *Member*
Senator Telena C. Nelson
Senator Fernando B. Esteves

Appeared Before the Committee

Mr. Ken Leon-Guerrero, *Spokesperson, Guam Citizens for Public Accountability*
Mr. Paul Zerzan, *Citizen*
Mr. Eric L. Plinske, *Director of Corporate Affairs, Guam Regional Medical City*
Mr. John Q. Carlos, *Retired Regulator/Consumer Advocate*

Submitted Written Testimony

Mr. Ken Leon Guerrero, *Spokesman, Guam Citizens for Public Accountability*



Mr. Daryrl A. Taggerty, *Member, Guam Citizens for Public Accountability*
Mr. Eric L. Plinske, *Director of Corporate Affairs, Guam Regional Medical City*
Mr. John Q. Carlos, *Citizen*
Mr. James W. Gillan, *Director, Guam Department of Public Health and Social Services*
Mr. Bobbly Shringi, *Chairman of the Board, Guam Chamber of Commerce*

II. TESTIMONY & DISCUSSION

Speaker Benjamin J.F. Cruz, Chairman of the Committee on Appropriations and Adjudication (Committee), called the hearing to order and announced **Bill No. 132-34 (COR)**. The chairman then called upon the measure's sponsor, Senator Dennis G. Rodriguez, Jr. to provide a statement (*included in this report*).

After reading the measure's short title, **Senator Rodriguez** continued:

"How this works, Mr. Chairman, is that there would be a formula combination of resources that would pay for this because it's a Medicaid expansion. Fifty five (55) percent of the premiums would come from the federal government. The remaining forty five (45) percent is the government share and from that forty five (45) percent share the employer will be required to pay sixty five (65) percent of the premium. The employee would also be required to contribute the health savings account no more than two (2) percent of their annual salary and the Government of Guam share from that the remaining would be coming from a fee, the four (4) percent fee that we talked about earlier is the equivalent to the four (4) percent Gross Receipts Tax (GRT) that the insurance companies don't pay for because of a qualifying certificate and so Mr. Chair, this bill facilitates as part of these programs options, mandatory health savings account, a function for beneficiaries. It also ensures healthy behavior incentives are included in the proposals and it also provides a required employer mandate in order to meet the goals of this pilot project of a need to have employer mandate shall be evaluated and we also have a section in this bill that will provide some sort of incentive to small businesses for them to be able to afford to be part of this program."

Chairman Cruz:

"Thank you. We'll start with Mr. Leon Guerrero and Mr. Taggerty."

Mr. Ken Leon Guerrero:

"Okay, my name is Ken Leon Guerrero with Guam's Citizens for Public Accountability and I'm testifying in opposition to Bill No. 132-34 (COR) and 133-34 (COR) because I think it's the right thing to do but I think it's taking the wrong approach. Back in 1974, the state of Hawaii, an island economy, saw the

problem of health care coverage a long time ago and they passed the law making it mandatory. Health insurance coverage was mandatory for companies that employed five (5) or more people and as a result of that, today Hawaii has the second (2nd) highest coverage in the United States at ninety three percent (93%). One other state and I think it's Connecticut or Massachusetts is at ninety seven percent (97%). Now the reason I say it's the wrong approach because here we're going to be taking Medicaid dollars and even with the doubling of the poverty level we still leave a lot of people uncovered and the reason I bring this up is because during my work I've run into a lot of people who work for businesses. I mean one (1) person came up to me. She's a professional in a doctor's office. They don't provide any medical benefits so she and her husband got divorced so she would qualify for Medicaid you know. It's an unfortunate situation that here on Guam, that businesses who want to provide medical benefits can't because the business environment is so competitive because it's so small. We're talking about a workforce of sixty-eight thousand (68,000) people and we're talking about the fact that one-third (1/3) of those work for government in Guam or the federal government. One-third (1/3) of those work in the hotel industry and many of the hotels, they structure their jobs so that people don't qualify for benefits and that's why you have people to work in the hotel industry that work two (2) or three (3) jobs to make a living that way the hotels even though they have medical benefits, can avoid pain.

"In Hawaii, it was mandatory, you have five (5) employees that didn't matter, full-time, part-time, you had to pay fifty percent (50%) of the employee's coverage. Right now, that is two hundred and sixty-eight dollars (\$68.00). When I was working in Hawaii, it was seventy-five dollars (\$75.00) so from 1974 to 2017, the employer share has gone from seventy-five (75) to two hundred thirty-eight dollars (\$238.00). During that same period of time, a Burger King chicken sandwich meal has gone from a dollar ninety-nine (\$1.99) to eleven dollars and seventy-five cents (\$11.75) so that program obviously is working in Hawaii and because so much of the Hawaiian population has reason to go to primary care providers. The increases in the cost of medical procedures in the state of Hawaii has been single digits for years so in the time right now we're in the United States, depending on the location, medical expenses have gone up between twenty five (25) and thirty three percent (33%) in 2015. The cost of medical procedures in the state of Hawaii went up seven percent (7%).

"So, getting more people covered works. Now the governor proudly proclaimed that the problem with Guam Memorial Hospital is that seven (7) out of ten (10) patients don't have coverage so why don't we fix that problem.

Let's make it possible for seven (7) out of ten patients to have coverage which making it mandatory for the employers as opposed to some hybrid form of tax increase and using government funds because when I talk to business owners, they're willing to provide medical benefits for their employees but they can't afford it because if they provide medical benefits and this guy over here doesn't then I am going to go out of business so that's one of the reasons why we see so many business owners on Guam reluctant to provide medical benefits because it's not a level playing field we have a small economy.

"It's only two hundred and twelve (212) square miles. It's not like we have people driving across the border to get medical benefits here on Guam so we have a fairly stable homogeneous population and if medical cover if we had universal medical coverage as opposed to universal health care. There's a difference because like you said we have four (4) companies here that are very competitive, the problem they have is finding clients that are willing to pay for medical benefits. Now if every single company on Guam that had five (5) or more employees was required to provide a minimum level of medical coverage and every company was required to pay fifty percent of the employer premium, that would be a level playing field and I could offer my employees medical knowing that he was going to be forced to. Only competitive advantage he would get to see if he was able to negotiate a better plan with one (1) of the four (4) companies than I am able to. The way I look at this program right here, we're shifting massive amounts of government revenue to support the insurance companies, when it's not needed because if we had that mandatory health coverage we wouldn't need to transfer money from government programs to commercial providers. We could use the money for the government programs to improve the government programs for those employees who legitimately qualify for Medicaid and MIP and probably reduce it because how many of the MIP and Medicaid people have jobs but they're on the program simply because they have families and they don't have coverage through their work?

"Well I know too personally, right off the bat that if they had medical coverage through work they would be more than willing to pay the fifty percent (50%) their share and that would take two families off Medicaid and I'm sure that when we look at the rolls of Medicaid. There would be a lot more people that would come off which would reduce the cost of the Medicaid so that's the big concern I have because when I look at this program we're going to be transferring government money to commercial programs but there's no guarantee that the commercial programs are going to offer as good a plan as the current Medicaid an MIP offer now. There's nothing that says you cannot go less

than the current benefits offered under Medicaid or MIP because when you take this money move it to a private carrier then they're going to have to add their overhead on top of it including taxes and profits so they're either going to reduce the benefits that they offer through this hybrid plan or they're going to have to raise the premiums or what they will do is dramatically increase deductibles and co-pays.

"Now we consider that the majority of people that went on to Medicaid and MIP, the concept was they were lower income. Right now, MIP and Medicaid do not have deductibles and co-pays to the best of my knowledge so what's going to happen if we start throwing deductibles and co-pays? Well I'll tell you, when I made the transition from my plan the government of Guam plan, I was shocked because I went from a plan that had no deductible to a plan that had twenty-five-hundred-dollar (\$2500) deductible and that hurt so if we're going to take people who have low income, so low that they qualify for Medicaid and MIP. Where are they going to get the medical the money to pay for the deductibles to see a primary care physician? They won't! They'll still go to the emergency room as their primary care physician because if they can't afford to see a primary care, they're going to wait until they can't avoid going to the emergency room so what I see is that it under the plan as written now without and even this plan doesn't have a mandatory coverage aspect."

Senator Dennis G. Rodriguez, Jr:

"You've been saying a lot of things. I was going to wait till you're done because you're saying a lot of inaccurate information. So I don't know if you read the bill or if you read it. I don't know if you understood it because a lot of things you were saying about employer mandate that's not here is here requiring that it addresses the amount of hours an employee makes that is eligible to be covered so a lot of things that you're saying so I'm really asking politely if maybe you can read it and I can sit down with you make you understand it because a lot of things you're saying...come on, Ken."

Mr. Leon Guerrero:

"I've been trying to sit down with you for a while and we haven't been able to find the time but my initial look at it, I didn't see anything. Just answer the question: is there mandatory coverage for all companies?"

Chairman Cruz:

"Finish your testimony and then we'll move on please. Okay."

Mr. Leon Guerrero:

"Okay, I'll go ahead and finish my testimony here because obviously when according to the author of the bill, I have dramatically misunderstood the tenets of the program and maybe now their office will find time to sit down and set me straight on these bills so I'll go ahead and go with Mr. Taggerty's testimony."

Mr. Leong Guerero proceeds to read testimony on behalf of Mr. Darryl Taggerty (*written testimony included in this report*).

Chairman Cruz:

"Thank you. Mr. Zerzan, did you wish to testify on this bill?"

Mr. Zerzan:

"I'm opposed to this bill, because I think it is not sustainable. Okay? I've lived in different countries that have universal health coverage or whatever you want to call it. And the fact is, everywhere on Earth, medical cares cost a lot of money. People get sick. They die. It's expensive. Nobody can afford it.

"We are trying to address a problem that has no solution, and no country on this planet has solved it, but they claim they do. So I've been in Taiwan and Hong Kong and other countries that have universal coverage, and as a working resident there, I'm covered by it so I go to the hospital, and it's a lot quicker—I get quicker service, and I pay less money out of my wallet than I do in Guam. Okay? So it sounds like it's a really good deal, but the way they pay for it...they have no more you know—money doesn't grow on trees—we don't have unlimited money. In Guam, our medical care seems unaffordable, but family housing is affordable. I can afford to have a family in Guam. Okay? Now, your thinking is 20th-century thinking. In the 20th century, the biggest concern was overpopulation in undeveloped countries, and I don't think you're aware of how serious the problem of the 21st century is. The problem of the 21st century is de-population in developed countries.

"Every industrialized country in the world, except America, has universal health coverage, and every industrialized country in the world, except America, is undergoing de-population. They are not having enough children, and one reason is they cannot afford family housing. The other reason is, why have children? The government will take care of you with free medical care. Okay? That's what they think. If you don't have babies, you get more sleep and more money. Okay? This is extremely serious. Taiwan is planning to close down half their universities—half their universities—because they don't have the population. I

worked overseas as a teacher, teaching English, and it's harder and harder to find work, because there are fewer and fewer children. Okay? Hong Kong Express postponed its flights from Nagoya to Guam, because of the North Korean crisis. Delta cancelled their flights not because of North Korean crisis, it's because Japan is a dying country – it's old people.

"When these old people die, there will be no more Japan. Sweden, Germany, Portugal, the U.K., Canada are not having sustainable demographics. They're going the way of the Etruscans and the Spartans and the Assyrians, and you're not aware of this, but I lived in these countries. I travel there; I see what's happening, and government cannot provide sustainable medical care. I wish it could, but it cannot. The way they pay for it is they don't have a future. When you don't have children you got a lot of money, and you can spend it—the accumulated capital of generations because there is no future. And that's why you go to France or Germany or Sweden or Denmark and you see this high quality of life, because they are spending basically what we have in Fort Knox. There is no future there.

"Now, if you want to help the people of Guam, we don't commit national suicide with socialist programs. Socialism is sweet poison. Capitalism is a very bitter medicine, but it works. So you grow the economy on Guam. You reduce taxes. You provide jobs for businesses so people have employment. And then we can afford insurance, we can afford charity. Charity is a far more efficient means of delivering social services than is government. If I work for a charity, and I think you're a deadbeat, I'm a volunteer—I'm not going to mess with you. Or if I work for a charity.

I suffer from compassion exhaustion, there are too many sick people...I quit, and I let another volunteer take my place. But when government provides it. I'm a bureaucrat that only cares about my pension, and I don't provide services of quality. I don't care if you're cheating, and I'm not gonna make trouble... I got a job. You're coming here and tell me some a sob story, I've heard it a million times—I don't care. Private charity works better than government. Okay? So the government of Guam simply cannot afford this. This is an illusion. Universal medical coverage is a scam that causes national suicide. Right now we have affordable housing. We don't have affordable medical care. I don't want to go for the illusion of affordable medical care if it's gonna mean we don't have affordable housing. Okay? Does everybody understand what I'm saying? Anybody have any questions? Okay. Thank you."

Chairman Cruz prompted Mr. Eric L. Plinske to testify.

Mr. Plinske:

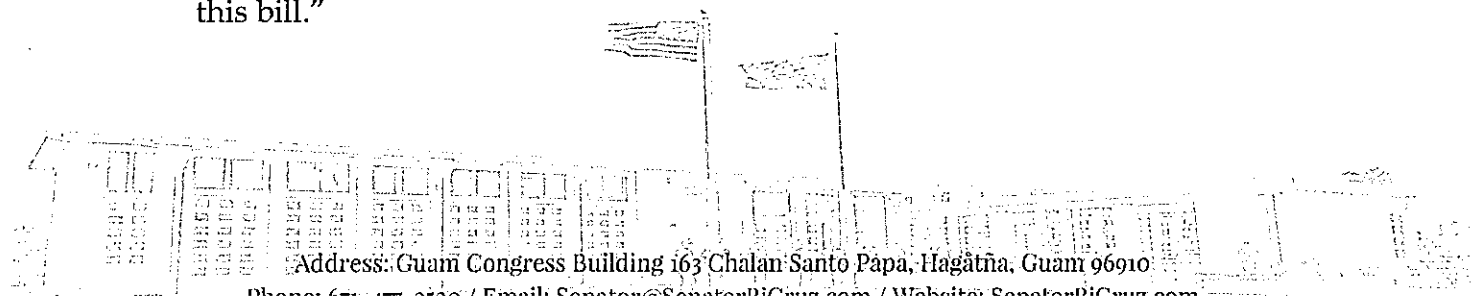
"Thank you, Speaker and fellow senators... Senator Rodriguez. From Guam Regional Medical City, I'm Eric Plinske, Director of Corporate Affairs, and I'm here on behalf of our [Chief Executive Officer], Margaret A. Bengzon, and Chief Operating Officer, Dr. Michael W. Cruz. Senator Rodriguez, we would like to compliment you on a creative, comprehensive, and a complex couple of bills. My comments here are really about both: the 132-34 and 133-34 so I'll kind of combine it, but it's short, because of its complexity and the fact that our in-house legal counsel is off-island, and our director of Government Reimbursement is in a couple of weeks' minimum already of jury duty [so] we haven't been able to tackle all of it and give as comprehensive of a review in comments as we'd like to. But preliminarily, we had to look at how the bills would affect GRMC and our patients, so I'll share with you our thoughts. And Speaker, I think you probably won't see this as much of a surprise from prior public hearings. Thank you for the opportunity."

Mr. Plinske proceeded to read his written testimony (*included in this report*) against Bill No. 132-34 (COR).

Chairman Cruz prompted Mr. John Q. Carlos to read his testimony before the Committee.

Mr. Carlos proceeded to read his written testimony (*included in this report*) in support of Bill No. 132-34 (COR). He added:

"Lastly may I point out that the reimbursement under Medicaid funding for the other states is very high compared to Guam. In some states they get eighty (80) percent funding from Medicaid, the lowest I think is maybe around seventy (70), in contrast Guam only gets fifty five (55) cents to a dollar. For the foregoing reasons, I believe Guam should at least try to provide a mechanism in order to submit something to the CMS that we're trying to make use of the funds that were allocated to us, and secondly the mechanism here where in we require some form of contribution from the qualified recipients, is similar to that which was approved for Indiana. We should take that into concern, if we don't do nothing, there's nothing to be lost. But if we get approval for some reason from CMS, it will be a net gain not only for the inhabitants of Guam, but also for the medical providers as well as the hospitals, GMHA and GRMC. I'm in favor of this bill."



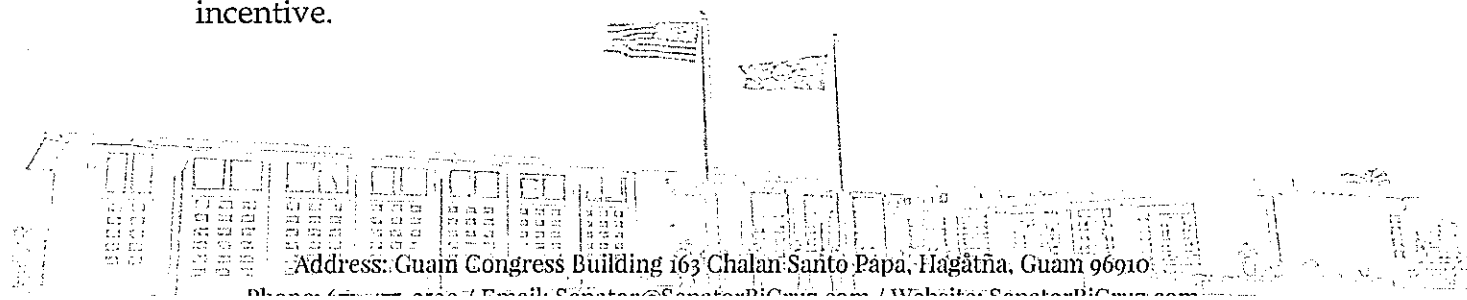
Chairman Cruz:

"Thank you very much Mr. Carlos for your very comprehensive testimony. Senator Rodriguez?"

Senator Rodriguez:

"Thank you very much Mr. Chairman and thank you to all of you for your testimony. We look forward to being able to explain this further to the community, and also to my colleagues. But just to give as my closing here for this bill, and to make it to try to explain it in simple terms. What this is, is that there's a big population of our people who are the working individuals who don't have health insurance. These are people that working companies, the companies do not provide them health insurance, and so what this does is that that one hundred and eight (108) to two hundred (200) percent population we estimate to be about sixteen thousand (16,000) individuals that would be affected by this. We would now help them pay for an employer-sponsored health insurance, health insurance premium. So we have over a hundred seventy million (\$170,000,000) that's still in the account in the bank that the federal government provided Guam from the Affordable Care Act. And so from that that's where we are anticipating to use the fifty five (55) percent of the federal government is providing. So let's say a premium of four thousand dollars (\$4,000) now will be split fifty five forty five (55/45). The fifty five (55), I think that's about twenty-two hundred dollars (\$2,200) That twenty-two hundred dollars (\$2,200) will come from that federal money. The hundred seventy million (\$170,000,000) that we still have, the forty-five (45) percent now, that would come from the government of Guam.

"The formula is that there's three (3) sources of that, one would be the employer, because the bill has an employer mandate. The employer must pay sixty-five (65) percent of the remaining eighteen hundred dollars (\$1,800), and so the second source of funding, that forty-five (45) percent would be the employee. The employee now would have to pay no more than two (2) percent of their annual income, and if you do an individual who makes minimum wage a full-time employee, that comes out to be about three hundred sixty-five dollars (\$365) a year that they would be obligated to pay. However, if they take advantage of incentives that this bill requires, that the insurance that they purchase have incentives such as what we have in the Government of Guam. If you go to the gym or Wellness Center ten (10) times a month for a quarter, you get a certain amount up to four hundred dollars (\$400) a year that you're able to receive as an incentive.



"For this we said you must have that program, the money you receive does not go to you for you to go spend and buy cigarettes, and go you know spend the night out-of-town. It's your money, but must be put into a health savings account, so that helps health savings account grows, stays with you and you can use it now when you have to go to the hospital or when you go to the clinic for your copay, or if you need to pay for your medicine. That's what your health savings account would be used for. The final source of payment on the remaining would be from the government of Guam, and that's where it's not existing government resources that we're going to use. The proposal is to assess the four (4) percent on the two hundred fifty-plus million dollar (\$250,000,000+) a year industry, which is the insurance industry, is to assess that four (4) percent and from that about twelve million dollars (\$12,000,000) a year that we anticipate will be used to find the government share of that eighteen hundred (\$1,800) that we're required to pay for. And so by doing that, more people will be covered, the whole idea is that they don't go to the hospital the whole idea is they go to the primary care clinic, that they get primary care and prevention services. But if they do end up in the hospital, we want to make sure that they have coverage and they're able to pay for that. So that's really, in at least the short period of time that I have here to be able to explain in simple terms, but as we have, we've talked to GRMC, see we've gone around the community and explained this plan, and so we'll do that as much as we could before we ask the Chairman to place it on session agenda. So thank you very much, Mr. Chair."

Chairman Cruz:

"Vice Speaker, do you have any questions?"

Vice Speaker Therese Terlaje:

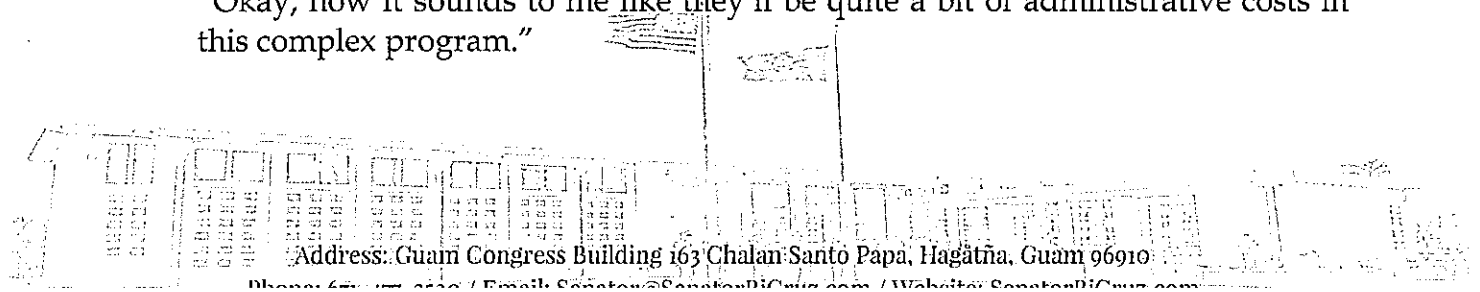
"Only one at the sponsor, could you tell us which part in here talks about that four (4) percent, sorry."

Chairman Cruz:

"Questions of the panel please, if you have none, thank you. Senator Lee, do you have any questions? Senator Nelson, do you have any questions? Senator Esteves, do you have any questions? Thank you, thank you very much. Yes, go ahead."

Mr. Zerzan:

"Okay, now it sounds to me like they'll be quite a bit of administrative costs in this complex program."



Chairman Cruz:

"Okay, you can take that up with him later. We're going to move on."

Seeing that there were no further questions nor individuals present to testify, the Chairman declared **Bill No. 132-34 (COR)** as heard.

Additional Written Testimony

The Committee also received testimony from **Mr. Bobby Shringi, Chairman of the Guam Chamber of Commerce Board**, and **Mr. James W. Gillan, Director of the Guam Department of Public Health and Social Services**.

Mr. Shringi's testimony (*included in this report*) indicated that the Chamber of Commerce did not support the measure as drafted, stating that "the legislation will hurt many of those paying for coverage today through increased premiums, and will also impact taxpayers, who will end up paying for the costs associated with increased rates of the government's health insurance program." The Chamber ultimately recommended either tabling the bill or placing the Health Insurance Premium Fee on an election referendum for voters to decide.

Mr. Gillan's testimony (*included in this report*) expressed support for the intent of Bill No. 132-34 (COR), but noted the following concerns:

- Medicaid Program funding is capped.
- Patient Protection Affordable Care Act (ACA) of 2010 funding expiration in Fiscal Year 2019.
- Currently, the Government is unable to fully fund and secure local funding to match the Medicaid grant award for the current Medicaid enrollees. Payment to providers is dependent on Guam's revenue or cash flow.
- Issue on benefit coordination and reimbursement of Medicaid patients' emergency medical services (off-island referral) if Department of Administration failed to timely remit insurance premium for a specific month(s). (Please see attached letter from insurance company due to untimely payment of Foster Care Children's insurance premium.)
- More staff and administrative funding needed for implementation if approved by CMS. Currently, eligibility determination section is behind on processing applications due to slow recruitment process and problems on staff retention due to low salary (Letter was submitted to DOA to upgrade the Eligibility Specialist position since January 2017. No action has been taken up to this day.)
- Any approved Medicaid SPA or WAIVER must be implemented based on the effective date stipulated on the SPA or Waiver. It cannot be contingent on the identification of available funds.

- Funding should be appropriated to hire a consultant/actuary to do a feasibility study/research based on this bill's requirement.

III. FINDINGS AND RECOMMENDATIONS

Following the measure's Public Hearing, the Committee on Appropriations and Adjudication made the following changes to Bill No. 132-34 (COR):

- Removed all original language from Section 2 and onward, and placed it in an Exhibit "A" to serve as the proposed statutory framework for a waiver application under Section 1115 of the Social Security Act, 42 U.S.C. §1315.
- Added language in Section 2 authorizing the Director of the Department of Public Health and Social Services to submit and apply federal waivers and Medicaid State Plan Amendments necessary to implement the program proposed in Exhibit "A." Section 2 now reads:

"Section 2. Director Authorized. Notwithstanding any other provision of law, rule, or regulation, the Director of the Department of Public Health and Social Services shall submit and apply for the following:

- (a) Federal waivers necessary to implement the Health Care Para Todu proposed in Exhibit "A" attached, including without limitation approval for a comprehensive waiver under Section 1115 of the Social Security Act, 42 U.S.C. §1315; and
- (b) Medicaid State Plan Amendments necessary to implement the program proposed in Exhibit "A" attached, after a waiver under Section 1115 of the Social Security Act, 42 U.S.C. §1315 has been granted."

- Added language in Section 3 noting that the passage of Bill No. 132-34 (COR) does not indicate the adoption of the amendments to existing Guam law proposed by Exhibit "A" as the exhibit merely serves as a proposed framework for a waiver application. Section 3 now reads:

"Section 3. Exhibit "A." Nothing herein shall be construed as to adopt the amendments to existing Guam law proposed by Exhibit "A" attached. Exhibit "A" is provided by way of example and shall serve as the proposed statutory framework for a waiver application under Section 1115 of the Social Security Act, 42 U.S.C. §1315.



- Number of hours indicating the principal employer on page 21 of Exhibit "A," Section 11, was amended from thirty five (35) to twenty (20). Section 11 (in part) now reads:
 "**Section 11.** A new § 6107.2.3, Chapter 6, Division 1, Title 10 of the Guam Code Annotated is hereby added to read:
 "§6107.2.3 Principal and secondary employer defined; coercion, interference, etc. prohibited. If an individual is concurrently a regular employee of two or more employers as defined in this Chapter, the principal employer shall be the employer who pays the individual the most wages; provided that if one of the employers, who does not pay the most wages, employs the regular employee for at least twenty (20) hours per week, the employee shall determine which of the employers shall be the employee's principal employer."

• Poverty levels throughout Exhibit "A" were updated using the 100% Guam Medicaid Poverty Level.

The Committee on Appropriations and Adjudication to which was referred **Bill No. 132-34 (COR) - D. G. Rodriguez, Jr. - "An act relative to improving efficiency in program operations and expanding healthcare access to the Guam Medicaid Program by pursuing a Section 1115 waiver under 42 U.S.C. § 1315 thereby authorizing the establishment of a managed care pilot program to be known as "the Health Care Para Todu Plan"** hereby submits these findings to *I Mina'trentai Kuâtro na Liheslaturan Guåhan* and reports out **Bill No. 132-34 (COR), As Substituted by the Committee** with a recommendation TO *Report at a later date*

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".

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

2017 JUN 23 PM 4:58

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 (FOHC) 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'lahaen
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 Guâhan 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

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

- 27 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					
If a member meets their \$1,500 deductible, the plan begins to pay for covered services for that individual	Not Applicable	Not Applicable	Applies	Applies	
Coverage Maximums					
Individual member annual maximum	None	None	\$300,000	\$300,000	
Out of Pocket Maximums (including accumulated deductible and copays)					
Per Individual member per policy year	None	None	None	None	
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 %
Early Childhood (One to four years old) Maximum seven visits			Plan pays 100 %	Plan pays 100 %

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 ≥ \$50 (applicable to clients with income beyond 100 % FPL)	Plan pays 100 % ; \$5 co-pay per visit for services a ≥ \$50 (applicable to clients with income beyond 100 % FPL)	Plan pays 100 % ; \$5 co-pay per visit for services a ≥ \$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 ≥ \$50 (applicable to clients with income beyond 100% FPL)	Plan pays 100 % ; \$5 co-pay per visit for services a ≥ \$50 (applicable to clients with income beyond 100% FPL)	Plan pays 100 % ; \$5 co-pay per visit for services a ≥ \$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 ≥\$25 per drug (applicable to clients with income beyond 100% FPL)	Plan pays 100 % \$4.00 co-payment per drug prescription that agency pays ≥\$25 per drug (applicable to clients with income beyond 100% FPL)	Plan pays 100 % \$4.00 co-payment per drug prescription that agency pays ≥\$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) 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
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.
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.
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
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
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.
Allergy Testing			
	For medically necessary service	\$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)

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)	Plan pays 100%. Medical equipment/machine is limited to every five years. 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.	Plan pays 100%. One (1) of each type DME Every Five Years: Standard wheelchair, standard 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.	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.	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.
	Plan pays 100%. PA is required for elective surgery with one or more day admission prior to surgery.	Plan pays 100%. Non-emergency Outpatient Surgeries.	\$75.00 copay, PA required	\$75.00 copay, PA required
Emergency Care	Plan pays 100%. PA is required for medically necessary services that are not available on island.	Plan pays 100%. PA is required for medically necessary services that are not available on island.	\$4.00 copay, PA is required for medically necessary services that are not available on island.	\$4.00 copay, PA is required for medically necessary services that are not available on island.
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					
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	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.	Plan pays 100%. Prior 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.	\$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.
Implants	Plan pay 100%. Orthopedic	Plan pay 100%. And an	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)	
	Organ Transplant	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%.	
	Internal and External Prosthesis				
Physical Therapy/Occupational Therapy					
	(Pre-Certification Required)	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)	
Radiation Therapy		Plan pays 100%	Plan pays 100%	\$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

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

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

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

26 h) Laboratory services. Testing provided to help a doctor diagnose an
27 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;

3
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;

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

3
4 yyy) any work-related injury, subject to compensation pursuant to the
5 Workers Compensation Law;

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

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

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

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

13 “§ 6107.13 Dental Services.

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

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

24 Section 54. A new § 6107.14, Chapter 6, Division 1, Title 10 of the
25 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.

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

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

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

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

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

- a) Patient-centered: A partnership among practitioners, patients, and their families ensures that decisions respect patients' wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care.
- 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>

1

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

4 “§6107.22 Appeal Rights. Health Care Para Todu plan applicants and
5 beneficiaries have a right to adequate notice and the opportunity to challenge
6 an adverse action before an impartial party. Enrollees also continue to
7 receive treatment while an appeal is pending (42 CFR 431.200-250). In
8 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.

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

Bill No. 132-34 (COR)

As Substituted by the Committee on
Appropriations and Adjudication

Introduced by:

Dennis G. Rodriguez, Jr.

**AN ACT RELATIVE TO IMPROVING EFFICIENCY IN
PROGRAM OPERATIONS AND EXPANDING HEALTHCARE
ACCESS TO THE GUAM MEDICAID PROGRAM BY
PURSUING A SECTION 1115 WAIVER UNDER 42 U.S.C.
§1315 THEREBY AUTHORIZING THE ESTABLISHMENT OF
A MANAGED CARE PILOT PROGRAM TO BE KNOWN AS
“THE HEALTH CARE PARA TODU PLAN.”**

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 to significantly decrease the number of uninsured. It is the intent of *I Liheslaturan Guåhan* to provide for the care of this portion of our population via a commercial managed care program called Health Care Para Todu. *I Liheslaturan Guåhan* finds in 10 GCA Health and Safety Chapter 6, Guam Medical Assistance Plan, §§ 6101 thru 6105, the desire to give persons under the Medicaid program the opportunity to be enrolled in prepaid

1 health plans. This law gives the Department of Public Health and Social Services
2 the authority to contract with health care providers to establish pilot programs that
3 show value. In the research, it is discovered that significant cost savings and
4 quality improvements may be achieved in the commercial managed care arena and
5 that this initiative is a first step toward evolving into future innovative practices
6 such as Accountable Care Organizations.

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

14 It is therefore resolved to facilitate the application of Section 1115 of the
15 Social Security Act (Medicaid waiver) in order to provide expansion of the
16 Medicaid program to eligible beneficiaries not currently covered, within the range
17 of 108% to 200% of the applicable Guam Federal Poverty Level. It is estimated
18 that an additional 15,000 to 16,000 lives will be eligible for health insurance. It is
19 also the intent to allow flexibility to the Director, Department of Public Health and
20 Social Services, in the Section 1115 application process and the ever-changing
21 Federal rules, to coordinate and amend specific idiosyncrasies of the plan in order
22 to align with current Federal policy.

23 *I Liheslatura* further finds that proposed legislative amendments necessary
24 to implement Health Care *Para Todu* are contingent on Federal Waivers which
25 may or may not be granted. As such, *I Liheslatura* intends to provide the proposed
26 statutory framework upon which such a waiver may be pursued--allowing for any
27 needed statutory changes to occur once the requisite waiver has been granted.

1 **Section 2. Director Authorized.** Notwithstanding any other provision of
2 law, rule, or regulation, the Director of the Department of Public Health and Social
3 Services *shall* submit and apply for the following:

4 (a) Federal waivers necessary to implement the Health Care *Para Todu*
5 proposed in **Exhibit “A”** attached, including without limitation approval
6 for a comprehensive waiver under Section 1115 of the Social Security
7 Act, 42 U.S.C. §1315; and

8 (b) Medicaid State Plan Amendments necessary to implement the program
9 proposed in **Exhibit “A”** attached, after a waiver under Section 1115 of
10 the Social Security Act, 42 U.S.C. §1315 has been granted.

11 **Section 3. Exhibit “A.”** Nothing herein *shall* be construed as to adopt the
12 amendments to existing Guam law proposed by Exhibit “A” attached. Exhibit “A”
13 is provided by way of example and *shall* serve as the proposed statutory
14 framework for a waiver application under Section 1115 of the Social Security Act,
15 42 U.S.C. §1315.

16 **Section 4.** This Act shall be effective immediately upon enactment.

EXHIBIT “A”

EXHIBIT "A"

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".

1 **BE IT ENACTED BY THE PEOPLE OF GUAM:**

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

4 **"§ 6101. Statement of Policy.** The Legislature declares that
5 ~~m~~Medicaid recipients receiving medical assistance under Title XIX [federal
6 law] and those persons enrolled under the Medicaid Program of the Social
7 Security Act whose premiums are being paid for by the government of
8 Guam shall be given the opportunity to be enrolled in prepaid health plans as
9 a means of affording them comprehensive health care and related remedial
10 and preventive services.

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

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

EXHIBIT "A"

1 ~~Each Prepaid Health Plan shall furnish to the Department such~~
2 ~~information and reports as the Department may find necessary in performing~~
3 ~~its functions under this Chapter. Such information and reports shall include,~~
4 ~~but shall not be limited to, statistical information regarding utilization of~~
5 ~~services, age and sex, specific mortality and morbidity rates, services~~
6 ~~supplied, manpower resources and costs of health care and administration,~~
7 ~~compiled from a basic data system as the Department may require. The~~
8 ~~Prepaid Health Plan and the Department shall maintain such records and~~
9 ~~afford access thereto to verify the information and reports which may be~~
10 ~~required under this Chapter. The Department shall annually conduct a survey~~
11 ~~of beneficiaries to determine their satisfaction with the services provided by~~
12 ~~the Prepaid Health Plan.~~

13 All health care services available under this Chapter shall be
14 equivalent to the level and basic scope of services required under public
15 assistance programs. It is the objective of this legislation that health care, as
16 provided in Guam under Title XIX of the Social Security Act, be is available
17 and accessible at all times to all qualified pilot program participants . It is
18 further the intent of this Chapter that such care shall be of the highest
19 quality.”

20 **Section 2.** § 6102, Chapter 6, Division 1, Title 10 of the Guam Code
21 Annotated is hereby *amended* to read:

22 **“§ 6102. Responsibility.** The Department shall, in carrying out the
23 intent of this Chapter, contract with a ~~multispecialty group practice of an~~
24 ~~individual practice association~~ qualified health care plan contractor (s)
25 through a Prepaid Health Care Plan, to establish pilot programs which
26 demonstrate the value or lack thereof of such a program in delivering or
27 financing health care services in such a manner. Each pilot program ~~be is~~ for

EXHIBIT "A"

1 a specified duration not to exceed four (4) years and each pilot program shall
2 be evaluated annually for its efficiency, effectiveness and quality. The
3 Department shall pursue the feasibility of establishing the following as pilot
4 program:

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

7 Persons eligible for services under the public assistance program shall
8 be assigned by the Department to a Prepaid Health Plan which affords any
9 qualified medicaid provider within the territory of Guam an opportunity to
10 participate in the plan under reasonable restrictions approved by the
11 Department; provided, however, such persons shall be entitled to request and
12 receive a medicaid card if assignment to a plan does not meet with their
13 satisfaction.

14 For purposes of this Section "risk assuming" means the pilot program
15 contractor agrees to assume the risk of utilization of services or costs of
16 services, or both.

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

22 The programs shall be operated either by the Department directly or
23 through contracts with Prepaid Health Plans.

24 The programs shall enroll medicaid recipients and be funded by the
25 Department on a prepayment capitation basis. Such rate of payment shall be
26 determined annually and shall be ten percent (10%) less than valid claims
27 incurred by the Department for covered medicaid recipients projected on an

EXHIBIT "A"

1 ~~annual basis as reflected by the accrued average monthly claims for the~~
2 ~~previous six (6) months plus all anticipated increases in costs in the contract~~
3 ~~year. The rate shall not include any costs of the Department for claims or~~
4 ~~administrative fees to fiscal intermediaries. The per capita amounts~~
5 ~~determined shall be based on sound actuarial data and be recognized to vary~~
6 ~~between the categories of aid to families with dependent children, aid to the~~
7 ~~totally disabled, aid to the blind, old age security or such other categories as~~
8 ~~may be determined by the Director of the Department.~~

9 The programs shall provide the full range of services offered under
10 the public assistance program and shall meet all statutory requirements and
11 all regulatory and contractual requirements established by the Department
12 for the program.

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

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

20 **Section 3.** § 6103, Chapter 6, Division 1, Title 10 of the Guam Code
21 Annotated is hereby *amended* to read:

22 “§ 6103. Plan. The government of Guam shall take an integrated,
23 employer sponsored, market-based approach to covering low-income
24 residents by offering new coverage opportunities, stimulating market
25 competition, and offering alternatives via a pilot project to eligible
26 beneficiaries with income between 108% to 200% of the Guam adjusted
27 federal poverty level. This prepaid health plan shall be known as the Health

EXHIBIT "A"

1 Care Para Todu Plan. This program is not considered an entitlement program
2 and is subject to cancellation upon appropriate notice. It is employer-
3 sponsored coverage as referred in Section 1906A of the Social Security Act,
4 Health Insurance Premium Payment Programs.

5 Prepaid Health Plans contracting under this Chapter shall guarantee
6 and provide assurances to the Department of Public Health and Social
7 Services that all services contracted for shall be readily available and
8 accessible and that further, all medical services covered under the contract
9 which are required on an emergency basis be available on a 24-hour, seven
10 days a week basis, either in the Prepaid Health Plans own facilities or
11 through arrangements with another provider which has been approved by the
12 Department. The Department is hereby directed to establish standards of
13 care and to conduct testing and review procedures to assure compliance with
14 such standards.

15 It is in the public interest that medical assistance of the proper quality
16 and quantity ~~be~~ is provided in the most effective and economical manner
17 consistent with such high quality medical standards. It is further the
18 objective of this Chapter that there shall be proper utilization of all health
19 care services.

20 All administrative powers and duties with respect to Prepaid Health
21 Plans, including determination of per capita payment rates, approval of
22 prepaid health contracts and pilot programs which provide health care
23 services pursuant to prepaid health contracts is hereby vested with the
24 Director of the Department of Public Health and Social Services herein
25 referred to as Director.

26 The Director is hereby empowered to establish a basic schedule of
27 benefits for prepaid plans conforming to the scope and duration of

EXHIBIT "A"

1 ~~m~~Medicaid health services as set forth in Federal requirements for the
2 ~~territory of~~ Guam to enumerate standards of participation for such Prepaid
3 Health Plans and pilot programs and subject to this Chapter.

4 In the administration of this Chapter and in the negotiating of
5 contracts thereunder, the Department shall give due consideration to the
6 reputation of the prepaid health organization in providing such benefits, to
7 the accessibility and availability of its facilities and resources for health care
8 to enrolled persons under this Chapter, and to new and innovative concepts
9 in the delivery of health care services.

10 No contract between the Director and a Prepaid Health Plan shall be
11 approved unless the plan and its facilities meet quality program standards.
12 These standards shall require the Prepaid Health Plan to demonstrate to the
13 Department that it has adequate financial resources, physical facilities,
14 organizational and administrative capacities, and a sound program design to
15 discharge its contractual obligations.

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

24 The Prepaid Health Plan shall be liable for all valid out-of-area
25 emergency services ~~which~~ that are required by the contract and rendered by
26 another provider. Payment for such services shall cover treatment of
27 emergency conditions provided plan has been notified within seventy- two

EXHIBIT "A"

1 (72) hours of occurrence until such time as the patient may reasonably be
2 transferred to the Prepaid Health Plan's facilities.

3 The Prepaid Health Plan shall establish procedures for continuously
4 reviewing the quality of care, the utilization of services and facilities and
5 costs. Information derived from such review shall be made available to the
6 Department.

7 If the enrollee has an unresolved grievance, a fair hearing shall be
8 made available under appropriate provisions of the ~~Government Code of~~
9 Guam Administrative Adjudication Law to resolve all grievances regarding
10 care and administration of the plan. Findings and recommendations of the
11 Director based on the results of the fair hearing shall be binding on the plan
12 and the enrollees.

13 The Director shall report annually to the ~~Legislature~~ I Liheslaturan
14 Guåhan on the experience with the prepaid plan with specific reference to
15 consumer satisfaction and dissatisfaction, quality and utilization."

16 **Section 4.** § 6104, Chapter 6, Division 1, Title 10 of the Guam Code
17 Annotated is hereby *amended* to read:

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

EXHIBIT “A”

1 Medicaid managed care plans must maintain a sufficient number, mix,
2 and geographic distribution of providers and cover out-of-network services
3 if the network is unable to provide them as provided in 42 CFR 438.206-
4 207 and 42 CFR 438.52. Medicaid managed care plans also must provide
5 access to essential community providers per 45 CFR 156.235. However,
6 patients seeking care “out of network” when there are “in-network”
7 providers available is not an option in Medicaid managed care. Medicaid
8 managed care plans shall contract with at least one federally qualified health
9 center (FQHC) or rural health center (RHC).”

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

12 **“§ 6106. Definitions, Terms and Concepts.** Unless the context
13 otherwise requires, the definitions contained in this Section shall govern the
14 provisions of this Chapter:

- 15 a) **Co-pay.** In health insurance, a co-pay (copayment) is a fixed
16 amount you pay for covered services, typically when you get the
17 service.
- 18 b) **Coinsurance.** In health insurance, coinsurance is the share of
19 costs of the allowed amount for a covered service after a patient
20 reaches his or her deductible.
- 21 c) **Deductible.** The health insurance deductible is the amount the
22 patient has to pay out-of-pocket for covered services before the
23 insurance begins to pay.
- 24 d) **Department.** means the Department of Public Health and Social
25 Services (DPHSS).
- 26 e) **Director** means the Director of the Department of Public Health
27 and Social Services (DPHSS).

EXHIBIT "A"

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

4 g) **Employer** means any individual or type of organization, including
5 any partnership, association, trust, estate, joint stock company,
6 insurance company, or corporation, whether domestic or foreign, a
7 debtor in possession or receiver or trustee in bankruptcy, or the
8 legal representative of a deceased person, who has one or more
9 regular employees in the employer's employment. "Employer"
10 does not include:

11 1) The Government of Guam, any of its political subdivisions, or
12 any instrumentality of the Government of Guam or its political
13 subdivisions;

14 2) The United States government or any instrumentality of the
15 United States;

16 3) Any other state or political subdivision thereof or
17 instrumentality of such state or political subdivision;

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

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

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

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

EXHIBIT “A”

- 1 j) **Employment** means service, including service in interstate
2 commerce, performed for wages under any contract of hire, written
3 or oral, expressed or implied, with an employer.
- 4 k) **Federal Poverty Guideline** means the poverty guidelines updated
5 annually in the Federal Register by the U.S. Department of Health
6 and Human Services under authority of §673(2) of the Omnibus
7 Budget Reconciliation Act of 1981.
- 8 l) **Guam Income Guidelines** means the Federal poverty guidelines
9 adjusted for the higher cost of living on Guam relative to the
10 national standard.
- 11 m) **Health Savings Account (HSA)**. An HSA is a tax-exempt trust or
12 custodial account set up with a qualified HSA trustee to pay or
13 reimburse certain medical expenses incurred. There are four
14 federal requirements to be eligible for HSAs:
- 15 1) A person must be covered simultaneously by a qualified “high-
16 deductible” health insurance policy (HDHP).
- 17 2) For 2015, and 2016 participants in qualified HDHPs are
18 required to pay the first \$1,300 of their medical expenses
19 (\$2,600 for family coverage) before insurance benefits begin.
20 (Conventional insurance plans, whose participants cannot
21 contribute to HSAs, typically have had deductibles of about
22 one-third to one-half these amounts; however many new health
23 plans sold through ACA health exchanges have deductibles of
24 \$1,000 to \$6,000 for 2014 through 2016.)
- 25 3) The HSA enrollee cannot be covered by any other health
26 insurance plan, such as a spouse’s plan.
- 27 4) The HSA enrollee must be under age 65.

EXHIBIT “A”

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

3 6) A patient is considered to be an eligible individual for the entire
4 year if he or she is an eligible individual on the first day of the
5 last month of the patient’s tax year (December 1 for most
6 taxpayers). If the patient meets these requirements, he or she is
7 an eligible individual even if the patient’s spouse has non-
8 HDHP family coverage, provided the spouse’s coverage does
9 not cover the patient. There is no income, employment or other
10 age limits in the federal law.

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

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

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

EXHIBIT "A"

1) In accordance with generally accepted standards of medical practice; and

2) Clinically appropriate in terms of type, frequency, extent, site and duration.

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

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

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

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

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

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

EXHIBIT "A"

- 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.

(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

EXHIBIT "A"

1 2) Any nonprofit organization which undertakes under a prepaid
2 health care plan to defray or reimburse in whole or in part the
3 expenses of health care; or

4 3) Any insurer who undertakes under a prepaid health care plan to
5 defray or reimburse in whole or in part the expenses of health
6 care.

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

15 (hh) **Provider** means any person who contracts with the Program for
16 the provision of hospitalization, medical, dental or behavioral health
17 care to members according to the provisions of this Chapter, or any
18 subcontractor of such Provider delivering services pursuant to this
19 Article.

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

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

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

EXHIBIT “A”

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

4 (mm) **Wages** means all remuneration for services from whatever
5 source, including commissions, bonuses, and tips and gratuities paid
6 directly to any individual by a customer of the individual's employer,
7 and the cash value of all remuneration in any medium other than
8 cash.”

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

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

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

EXHIBIT “A”

1 **Section 7.** A new § 6107.1, Chapter 6, Division 1, Title 10, Guam C
2 ode Annotated, is *added* to read:

3 “§6107.1 Health Care Para Todu Pilot project goals. The goals of
4 the Para Todu pilot project include:

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

EXHIBIT "A"

1 **Section 8.** A new § 6107.2, Chapter 6, Division 1, Title 10 of the
2 Guam Code Annotated is hereby *added* to read:

3 “§6107.2 Employer Mandate. The cost of medical care in case of
4 sudden need may consume all or an excessive part of a person's
5 resources. Although a large segment of the labor force on Guam already
6 enjoys coverage of this type either by virtue of collective bargaining
7 agreements, employer-sponsored plans, or individual initiative, there is a
8 need to extend that protection to workers who at present do not possess any
9 prepayment coverage. Every employer who pays to a regular employee
10 monthly wages in an amount that places the employee into the Guam
11 adjusted Federal poverty level between 108% to 200% shall provide
12 coverage of such employee as outlined in this Section.

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

19 **Section 9.** A new § 6107.2.1, Chapter 6, Division 1, Title 10 of the
20 Guam Code Annotated is hereby *added* to read:

21 “§6107.2.1 Place of performance. Employment includes an
22 individual's entire service, performed within or both within and without
23 Guam, if:

24 a) The service is localized in Guam; or

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

EXHIBIT "A"

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

4 2) The individual's base of operation or place from which the
5 service is directed or controlled is not in any state in which
6 some part of the service is performed but the individual's
7 residence is in Guam."

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

10 "§6107.2.2 Excluded employment service. Employment as
11 defined in §6106 does not include:

12 a) Service performed by an individual in the employ of an employer
13 who, by the laws of the United States, is responsible for care and cost
14 in connection with such service; or

15 b) Service performed by an individual in the employ of [the] individual's
16 spouse, son, or daughter, and service performed by an individual
17 under the age of twenty-one in the employ of the individual's father or
18 mother; or

19 c) Service performed in the employ of a voluntary employee's
20 beneficiary association providing for the payment of life, sick,
21 accident, or other benefits to the members of the association or their
22 dependents or their designated beneficiaries, if:

23 1) Admission to membership in the association is limited to
24 individuals who are officers or employees of the United States
25 government; and

EXHIBIT "A"

- 1 2) No part of the net earnings of the association inures (other than
2 through such payments) to the benefits of any private
3 shareholder or individual; or
- 4 d) Service performed by an individual for an employer as an insurance
5 agent or as an insurance solicitor if all service performed by the
6 individual for the employer is performed for remuneration by way of
7 commission; or
- 8 e) Service performed by an individual for an employer as a real estate
9 salesperson or as a real estate broker if all service performed by the
10 individual for the employer is performed for remuneration by way of
11 commission; or
- 12 f) Service performed by an individual who, pursuant to the federal
13 Economic Opportunity Act of 1964, is not subject to the provisions of
14 law relating to federal employment, including unemployment
15 compensation; or
- 16 g) Domestic in-home and community-based services for persons with
17 developmental and intellectual disabilities under the Medicaid home
18 and community-based services program pursuant to title 42 Code of
19 Federal Regulations sections 440.180 and 441.300, and title 42 Code
20 of Federal Regulations, part 434, subpart A, as amended, or when
21 provided through state funded medical assistance to individuals
22 ineligible for Medicaid, and identified as chore, personal assistance
23 and habilitation, residential habilitation, supported employment,
24 respite, and skilled nursing services, as the terms are defined and
25 amended from time to time by the department of human services,
26 performed by an individual whose services are contracted by a
27 recipient of social service payments and who voluntarily agrees in

EXHIBIT "A"

1 writing to be an independent contractor of the recipient of social
2 service payments; or

3 h) Domestic services, which include attendant care, and day care
4 services authorized by the department of human services under the
5 Social Security Act, as amended, or when provided through state-
6 funded medical assistance to individuals ineligible for Medicaid,
7 when performed by an individual in the employ of a recipient of social
8 service payments. For the purposes of this Subsection (h) only, a
9 "recipient of social service payments" is a person who is an eligible
10 recipient of social services such as attendant care or day care
11 services."

12 **Section 11.** A new § 6107.2.3, Chapter 6, Division 1, Title 10 of the
13 Guam Code Annotated is hereby *added* to read:

14 **"§6107.2.3 Principal and secondary employer defined;**
15 **coercion, interference, etc. prohibited.** If an individual is concurrently a
16 regular employee of two or more employers as defined in this Chapter, the
17 principal employer shall be the employer who pays the individual the most
18 wages; provided that if one of the employers, who does not pay the most
19 wages, employs the regular employee for at least twenty (20) hours per
20 week, the employee shall determine which of the employers shall be the
21 employee's principal employer. The employee's other employers are
22 secondary employers. An employer so designated as the principal employer
23 shall remain as such principal employer for one year or until change of
24 employment, whichever is earlier. If an individual is concurrently a regular
25 employee of a public entity that is not an employer as defined in §6106 and
26 of an employer as defined in §6106 the latter shall be deemed to be a
27 secondary employer. An employer who, directly or indirectly, interferes with

EXHIBIT "A"

1 or coerces or attempts to coerce an employee in making a determination
2 under this section shall be subject to the penalty provided under §6107."

3 **Section 12.** A new § 6107.2.4, Chapter 6, Division 1, Title 10 of the
4 Guam Code Annotated is hereby *added* to read:

5 **"§6107.2.4 Choice of plan type and of contractor. Every**
6 employer required to provide coverage for the employer's employees by a
7 prepaid group health care plan under this Chapter may elect the particular
8 contractor but the employee shall not be obligated to contribute a greater
9 amount to the premium than the employee would have to contribute had the
10 employer elected coverage with the contractor providing the prevailing
11 coverage of the respective type in Guam"

12 **Section 13.** A new § 6107.2.5, Chapter 6, Division 1, Title 10 of the
13 Guam Code Annotated is hereby *added* to read:

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

25 **Section 14.** A new § 6107.2.6, Chapter 6, Division 1, Title 10 of the
26 Guam Code Annotated is hereby *added* to read:

EXHIBIT "A"

1 ‘§6107.2.6 Commencement of coverage. The employer shall
2 provide the coverage required by this Chapter for any regular employee,
3 who has been in the employer's employ for four consecutive weeks, at the
4 earliest time thereafter at which coverage may be provided with the prepaid
5 health care plan contractor selected pursuant to this Chapter.’”

6 **Section 15.** A new § 6107.2.7, Chapter 6, Division 1, Title 10 of the
7 Guam Code Annotated is hereby *added* to read:

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

19 **Section 16.** A new § 6107.2.8, Chapter 6, Division 1, Title 10 of the
20 Guam Code Annotated is hereby *added* to read:

21 “§6107.2.8 Liability of secondary employer. An employer
22 who has been notified by an employee, in the form prescribed by the
23 Director, that the employer is not the principal employer as defined in
24 §6107.2.3 shall be relieved of the duty of providing the coverage required by
25 this Chapter. The employer shall notify the director, in the form prescribed
26 by the director, that the employer is relieved from the duty of providing
27 coverage or of any change in that status.”

EXHIBIT "A"

1 **Section 17.** A new § 6107.2.9, Chapter 6, Division1, Title 10 of the
2 Guam Code Annotated is hereby *added* to read:

3 **"§6107.2.9 Exemption of certain employees.**

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

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

10 2) Covered as a dependent under a prepaid health care plan,
11 entitling the employee to the health benefits required by this
12 Chapter;

13 3) A recipient of public assistance or covered by a prepaid health
14 care plan established under the laws of the State governing
15 medical assistance.

16 b) Employers receiving notice of a claim of exemption under this
17 Subsection shall notify the Director of such claim in the form
18 prescribed by the Director."

19 **Section 18.** A new § 6107.2.10, Chapter 6, Division 1, Title 10 of the
20 Guam Code Annotated is hereby *added* to read:

21 **"§6107.2.10 Termination of Exemption.** If an exemption,
22 which has been claimed by an employee pursuant to §6107.2.9 terminates
23 because of any change in the circumstances entitling the employee to claim
24 such exemption, the employee shall promptly notify the principal employer
25 of the termination of the exemption and the employer thereupon shall
26 provide coverage as required by this Chapter. If because of a change in the
27 employment situation of an employee or a redetermination by an employee

EXHIBIT “A”

1 as provided in §6107.2.3, a principal employer becomes a secondary
2 employer or a secondary employer becomes the principal employer, the
3 employee shall promptly notify the employers affected of such change and
4 the new principal employer shall provide coverage as required by this
5 Chapter.”

6 **Section 19.** A new § 6107.2.11, Chapter 6, Division 1, Title 10 of the
7 Guam Code Annotated is hereby *added* to read:

8 “§ 6107.2.11 Non-complying employer held liable for
9 employee's health care costs. Any employer who fails to provide coverage
10 as required by this chapter shall be liable to pay for the health care costs
11 incurred by an eligible employee during the period in which the employer
12 failed to provide coverage.”

13 **Section 20.** A new § 6107.2.12, Chapter 6, Division 1, Title 10 of the
14 Guam Code Annotated is hereby *added* to read:

15 “§ 6107.2.12 Penalties. Any person who, after twenty-one
16 (21) days written notice and the opportunity to be heard by the Director, is
17 found to have violated any provision of this Chapter or rule adopted
18 hereunder for which no penalty is otherwise provided, shall be fined not
19 more than \$250 for each offense. All fines collected pursuant to this Chapter
20 shall be deposited into the Para Todu fund.”

21 **Section 21.** A new § 6107.2.13, Chapter 6, Division1, Title 10 of the
22 Guam Code Annotated is hereby *added* to read:

23 “§ 6107.2.13 Penalties; injunction. If an employer fails to
24 comply, the employer shall pay a penalty of not less than \$25 or \$1 for each
25 employee for every day during which such failure continues, whichever sum
26 is greater. The penalty shall be assessed under rules and regulations
27 promulgated by the Director and shall be collected by the Director and paid

EXHIBIT "A"

1 into the fund for premium payments established by this plan. The Director
2 may, for good cause shown, remit all or any part of the penalty. Any
3 employer, employee, or prepaid health care plan contractor who willfully
4 fails to comply with any other provision of this Chapter or any rule or
5 regulation hereunder may be fined not more than \$200 for each such
6 violation. Any employer who fails to initiate compliance with the coverage
7 requirements for a period of thirty (30) days, may be enjoined by the circuit
8 court of the circuit in which the employer's principal place of business is
9 located from carrying on the employer's business any place in Guam so long
10 as the default continues, such action for injunction to be prosecuted by the
11 attorney general or any county attorney if so requested by the director."

12 **Section 22.** A new § 6107.3, Chapter 6, Division 1, Title 10 of the
13 Guam Code Annotated is hereby *added* to read:

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

EXHIBIT “A”

1 collective bargaining agreement and the services are available to all other
2 employees not covered by such agreement.”

3 **Section 23.** A new § 6107.4, Chapter 6, Division 1, Title 10 of the
4 Guam Code Annotated is hereby *added* to read:

5 “§6107.4 Exemption of followers of certain teachings or
6 beliefs. This Chapter shall not apply to any individual who pursuant to the
7 teachings, faith, or belief of any group, depends for healing upon prayer or
8 other spiritual means.”

9 **Section 24.** A new § 6107.5, Chapter 6, Division 1, Title 10 of the
10 Guam Code Annotated is hereby *added* to read:

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

19 **Section 25.** A new § 6107.5.1, Chapter 6, Division 1, Title 10 of the
20 Guam Code Annotated is hereby *added* to read:

21 “§6107.5.1 Guam Health Insurance Para Todu Fund. The Director,
22 Department of Administration shall establish a Guam Health Insurance Para
23 Todu Fund for the purpose of collecting funds for the payment of premiums.
24 The Fund created, is separate and apart from other funds and accounts of the
25 Government of Guam, a fund known as the Guam Health Insurance Para
26 Todu Fund ('Fund'). The Fund shall not be commingled with the General

EXHIBIT "A"

1 Fund or any other fund or account of the Government of Guam, and shall be
2 kept in a separate bank account. This fund is established to pay for
3 premiums, which shall be administered exclusively for the purposes of this
4 Chapter. The Fund, to include any monies in the Fund dedicated and
5 dispersed for purposes specified in this Act, shall not be subject to the
6 transfer authority of *I Maga'lahan Guåhan*. All premiums payable under this
7 Act shall be paid from this fund. The fund shall consist of:

- 8 a) All money appropriated by *I Liheslaturan Guåhan*, if any, in support
9 of the Para Todu Program.
- 10 b) All money collected from the Guam Health Insurance Premium Fee.
- 11 c) Federal Government contributions for the purposes of premium
12 payments.
- 13 d) All fines and penalties collected pursuant to this Chapter."

14 **Section 26.** A new § 6107.5.2, Chapter 6, Division 1, Title 10 of the
15 Guam Code Annotated is hereby *added* to read:

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

EXHIBIT "A"

1 Guam; and collateral pledged for this purpose shall be kept separate and
2 distinct from any other collateral pledged to secure other funds of Guam."

3 **Section 27.** A new § 6107.5.3, Chapter 6, Division 1, Title 10 of the
4 Guam Code Annotated is hereby *added* to read:

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

11 **Section 28.** A new § 6107.5.4, Chapter 6, Division 1, Title 10 of the
12 Guam Code Annotated is hereby *added* to read:

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

26 **Section 29.** A new § 6107.5.5, Chapter 6, Division 1, Title 10 of the
27 Guam Code Annotated is hereby *added* to read:

EXHIBIT “A”

1 “§6107.5.5 Health Insurance Premium Fee. There is established a
2 4% health insurance premium fee on all healthcare insurance premiums paid
3 in Guam for the coverage of company employees and their dependents', or
4 individuals. Such fees shall be collected from the healthcare insurance
5 companies providing such coverage on Guam. The Director, Department of
6 Revenue and Taxation (DRT), shall collect such fees from insurance
7 providers and transmit them to the Treasurer of Guam for deposit in the
8 Fund. The Director DRT shall:

- 9 a) Develop the necessary forms and instructions to be sent to all
10 insurance companies issuing healthcare insurance. Such forms and
11 instructions shall direct these insurance companies to pay the four
12 percent (4%) assessment as a condition of continuing to do business
13 of Guam;
- 14 b) The DOA shall act as the repository for the Fund as set forth in
15 §6107.5 of this Chapter for use as authorized pursuant to this Chapter
16 in carrying out the purpose of the Fund.
- 17 c) The Director DOA shall be the disbursing and certifying officer for
18 the Fund, and shall comply with the provisions of Chapter 14 of Title
19 46, Guam Code Annotated.
- 20 d) The Director, DOA shall maintain appropriate records of the Fund and
21 shall provide accounting and auditing services for the Fund.
- 22 e) Insurance companies shall be allowed to include the “Health
23 Insurance Premium Fee in the administration deduction portion of the
24 medical loss ratio (MLR) calculations.”

25 **Section 30.** A new § 6107.5.6, Chapter 6, Division, 1, Title 10 of the
26 Guam Code Annotated is hereby *added* to read:

EXHIBIT "A"

1 "§6107.5.6 Health Savings Account. There is established a health
2 savings account (HSA) as a method to create an avenue for beneficiaries to
3 save money to pay for medical cost. The HSA may be established with local
4 banking institutions or the Department of Administration may establish a
5 program similar to a health savings account within the Treasury of the
6 Government of Guam. The option to create a government sponsored HSA
7 shall only be initiated if Federal policy precludes or no banking intuition
8 provides such health savings accounts. The core of the intent is to enable the
9 individual beneficiary to share in the cost of healthcare based on their
10 means. Both the Government and the member contribute to the account and
11 the account is used to pay for the plan's deductible and copayment. A
12 review of Internal Revenue Service, HSA requirements requires the Para
13 Todu program use a High Deductible Health Plan (HDHP) option.
14 Therefore, the deductible for the plan is set at \$1500. The HSA will consist
15 of two portions; a Core and Non-Core portion. Participant contributions will
16 go to the Core portion and government contributions will go into the non-
17 core portion.

18 To meet the deductible, the federal and local government will
19 contribute \$1,000 in the 55/45 FMAP split and placed in non-core portion of
20 the HSA. The employee beneficiary would be responsible for the remaining
21 \$500 of the deductible. However, employee beneficiaries may earn up to
22 \$350 by completing a variety of free preventive health items. For instance-
23 completing a health risk assessment, completing a physical examination, etc.
24 The Director, Department of Public Health and Social Services, will
25 determine the specific events and dollar amounts associated up to the
26 \$350.00 limit set in this Subsection. The remaining \$150 dollars would be a
27 cash contribution via payroll deduction or direct cash contribution into the

EXHIBIT “A”

1 HSA by the participant. The non-core portion shall go to the payment of the
2 \$1500 deductible and supplemented by funds in the core portion. The core
3 portion, once the deductible is met, then may be used to fund co-payments
4 and other such specific qualifying and medically necessary healthcare goods
5 and services, as established by the Director, DPHSS. The minimum
6 participant required payments into the HSA are equal to the lesser of two
7 percent (2%) of their annual household income or ninety-nine dollars (\$99)
8 per year. Members “own” their contributions in the core portion, and
9 therefore, funds are eligible to be carried forward if the members benefit
10 eligibility changes.

11 **Section 31.** A new § 6107.5.7, Chapter 6, Division 1, Title 10 of the
12 Guam Code Annotated is hereby *added* to read:

13 **“§6107.5.7 Employee Contribution via Health Savings Account.**

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

EXHIBIT “A”

1 amounts will be effective the first day of the month following the
2 recalculation.”

3 **Section 32.** A new § 6107.5.8, Chapter 6, Division 1, Title 10 of the
4 Guam Code Annotated is hereby *added* to read:

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

10 **Section 33.** A new § 6107.5.9, Chapter 6, Division 1, Title 10 of the
11 Guam Code Annotated is hereby *added* to read:

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

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

EXHIBIT "A"

income toward the monthly contributions and cost sharing provisions are consistent with Medicaid requirements (CMS 2014a). In both, the 5 percent of income aggregate cap remains in force."

Section 34. A new § 6107.6, Chapter 6, Division 1, Title 10 of the Guam Code Annotated is hereby *added* to read:

"§6107.6 Health Care Para Todu Pilot Project Implementation.

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

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

Section 35. A new § 6107.6.1, Chapter 6, Division 1, Title 10 of the Guam Code Annotated is hereby *added* to read:

EXHIBIT "A"

1 "§6107.6.1 Authority to contract for consultant. The Negotiating
2 Team may obtain technical support from other financial and health- related
3 agencies. The Negotiating Team shall develop its rules of procedure in
4 accordance with the Administrative Adjudication Law. The Negotiating
5 Team with the approval of *I Maga 'lahi Guåhan* is authorized to contract an
6 actuary competent to develop proposed health insurance rates *or* other
7 recognized expert to train *and/or* advise the Negotiating Team." The
8 Negotiating Team and its consultant will review all proposals. The
9 consultant is authorized to communicate with any offeror or registered party
10 and to request and obtain information. The Negotiating Team shall issue a
11 Request for Proposal (RFP) subject to the competitive selection procedures
12 for professional services found in the Guam Procurement Law (Title 5 GCA
13 § 5001, *et seq.*) and its regulations (Title 2 GAR Div. 4 § 1101, *et seq.*)
14 Specifically, the procedure for this RFP is found at Title 2 GAR Div. 4, §
15 3114 and its subsections. The Negotiating Team shall follow a process
16 similar to that of the Government of Guam Employee Health Insurance
17 negotiating process. The Negotiating Team's desired plan designs and
18 alternatives shall follow the provisions of the approved Section 1115
19 Demonstration Waiver. Offeror must specify in their proposal any
20 component to which they cannot comply and any changes they desire to the
21 proposed plan design. The Negotiating Teams decision on any interpretation
22 of the benefit plan design shall be final. The duration of any contract
23 resulting from the RFP shall be for three years or as approved in the Section
24 1115 waiver."

25 **Section 36.** A new § 6107.6.2, Chapter 6, Division 1, Title 10 of the
26 Guam Code Annotated is hereby *added* to read:

EXHIBIT "A"

1 **"§6107.6.2 Authority to contract for managed care system. The**
2 Department of Public Health and Social Services in coordination with the
3 Department of Administration and other Government of Guam agencies as
4 required may enter into contracts with managed care organizations,
5 including health insuring corporations, to provide health care services to
6 Medicaid recipients. In connection with such group benefits, the
7 Government of Guam (Government) will accept proposals from interested
8 and qualified health insurance companies (including health maintenance
9 organizations, preferred provider networks, accountable care organizations
10 and provider sponsor health plans), and/or Third Party Administrators
11 coupled with Reinsurance, licensed under applicable Guam laws, to provide
12 health insurance coverage for eligible residents of Guam under the Para
13 Todu Health pilot project. All health insurance companies and/or Third Party
14 Administrators coupled with Reinsurance must be licensed and comply with
15 all regulatory requirements as promulgated by the Guam Insurance
16 Commissioner, pursuant to the Insurance Statute of Guam and other
17 applicable laws. The intent, pursuant to this Article is to present to the
18 Governor of Guam negotiated proposed contracts for consideration for the
19 requested services. The governor will then choose to enter into contracts
20 from the bids provided. All qualified proposals will be reviewed, evaluated
21 and scored separately by the Negotiating Team. It is not the intent of this
22 article to enter into an exclusive contract. As the Health Care Para Todu
23 Pilot Project is an Employer it is the intent to offer choice. Employers have
24 choice of plans currently offered to their employees, as such it is the intent to
25 allow this choice in this plan. The Para Todu Negotiating Team is
26 established pursuant to this Article. The top ranked eligible proposals will
27 be chosen, and those offerors will enter into negotiations with the

EXHIBIT "A"

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

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

Section 37. A new § 6107.7, Chapter 6, Division1, Title 10 of the Guam Code Annotated is hereby *added* to read:

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

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

EXHIBIT “A”

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)

Guam Medicaid Poverty (GMPL) Level 100%		GMPL @108%	GMPL @ 138%	GMPL @ 150%	GMPL @ 200%
Household size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	\$775	\$837	\$1,070	\$1,163	\$1,550
2	\$1,049	\$1,133	\$1,448	\$1,574	\$2,098
3	\$1,323	\$1,429	\$1,826	\$1,985	\$2,646
4	\$1,596	\$1,724	\$2,202	\$2,394	\$3,192
5	\$1,870	\$2,020	\$2,581	\$2,805	\$3,740
6	\$2,144	\$2,316	\$2,959	\$3,216	\$4,288
7	\$2,418	\$2,611	\$3,337	\$3,627	\$4,836
8	\$2,692	\$2,907	\$3,715	\$4,038	\$5,384
9	\$2,966	\$3,203	\$4,093	\$4,449	\$5,932
10	\$3,240	\$3,499	\$4,471	\$4,860	\$6,480
11	\$3,514	\$3,795	\$4,849	\$5,271	\$7,028
12	\$3,788	\$4,091	\$5,227	\$5,682	\$7,576
13	\$4,062	\$4,387	\$5,606	\$6,093	\$8,124
14	\$4,336	\$4,683	\$5,984	\$6,504	\$8,672
15	\$4,610	\$4,979	\$6,362	\$6,915	\$9,220

EXHIBIT “A”

Guam Medicaid Poverty Level (GMPL) 100%		GMPL@108 %	GMPL @ 138%	GMPL @ 150%	GMPL @ 200%
Household size	Yearly Income	Yearly Income	Yearly Income	Yearly Income	Yearly Income
1	\$9,300	\$10,044	\$12,834	\$13,950	\$18,600
2	\$12,588	\$13,595	\$17,371	\$18,882	\$25,176
3	\$15,876	\$17,146	\$21,909	\$23,814	\$31,752
4	\$19,152	\$20,684	\$26,430	\$28,728	\$38,304
5	\$22,440	\$24,235	\$30,967	\$33,660	\$44,880
6	\$25,728	\$27,786	\$35,505	\$38,592	\$51,456
7	\$29,016	\$31,337	\$40,042	\$43,524	\$58,032
8	\$32,304	\$34,888	\$44,580	\$48,456	\$64,608
9	\$35,592	\$38,439	\$49,117	\$53,388	\$71,184
10	\$38,880	\$41,990	\$53,654	\$58,320	\$77,760
11	\$42,168	\$45,541	\$58,192	\$63,252	\$84,336
12	\$45,456	\$49,092	\$62,729	\$68,184	\$90,912
13	\$48,744	\$52,644	\$67,267	\$73,116	\$97,488
14	\$52,032	\$56,195	\$71,804	\$78,048	\$104,064
15	\$55,320	\$59,746	\$76,342	\$82,980	\$110,640

1
2

Guam Medicaid Poverty Level (GMPL) 100%		GMPL@108 %	GMPL @ 138%	GMPL @ 150%	GMPL @ 200%
Household size	Hourly Wage	Hourly Wage	Hourly Wage	Hourly Wage	Hourly Wage
1	\$4.47	\$4.83	\$6.17	\$6.71	\$8.94
2	\$6.05	\$6.54	\$8.35	\$9.08	\$12.10
3	\$7.63	\$8.24	\$10.53	\$11.45	\$15.27
4	\$9.21	\$9.94	\$12.71	\$13.81	\$18.42
5	\$10.79	\$11.65	\$14.89	\$16.18	\$21.58

EXHIBIT “A”

6	\$12.37	\$13.36	\$17.07	\$18.55	\$24.74
7	\$13.95	\$15.07	\$19.25	\$20.93	\$27.90
8	\$15.53	\$16.77	\$21.43	\$23.30	\$31.06
9	\$17.11	\$18.48	\$23.61	\$25.67	\$34.22
10	\$18.69	\$20.19	\$25.80	\$28.04	\$37.38
11	\$20.27	\$21.89	\$27.98	\$30.41	\$40.55
12	\$21.85	\$23.60	\$30.16	\$32.78	\$43.71
13	\$23.43	\$25.31	\$32.34	\$35.15	\$46.87
14	\$25.02	\$27.02	\$34.52	\$37.52	\$50.03
15	\$26.60	\$28.72	\$36.70	\$39.89	\$53.19

Section 38. 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 information is quickly assessed and a determination regarding their eligibility for coverage is made. Individuals who are found eligible have coverage starting that same day. They are given a PE Acceptance letter that

EXHIBIT “A”

1 serves as their proof of coverage. PE is intended to help individuals that may
2 be eligible for coverage who are facing acute health care issues and is not
3 intended to be a primary method of enrollment into Medicaid. The Director,
4 DPHSS. shall determine the process for determination of a QP and further
5 refine the PE function.”

6 **Section 39.** A new § 6107.8, Chapter 6, Division 1, Title 10 of the
7 Guam Code Annotated is hereby *added* to read:

8 **“§6107.8 Eligibility of Participating Health Care Providers.**
9 Health Care Providers may participate in this expansion program if their
10 practice maintains at least a 15% patient mix of standard Medicaid,
11 Medicare and/or Medically Indigent Program patients.”

12 **Section 40.** A new § 6107.9, Chapter 6, Division 1, Title 10 of the
13 Guam Code Annotated is hereby *added* to read:

14 **“§6107.9 Enrollment for Para Todu participants. A Para Todu**
15 program participant shall enroll in a comprehensive health plan offered by a
16 managed care organization under contract with the DPHSS. All of the
17 following apply to the health plan:

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

25 **Section 41.** A new § 6107.9.1, Chapter 6, Division 1, Title 10 of the
26 Guam Code Annotated is hereby *added* to read:

27 **“§6107.9.1 Program Participation and Eligibility Process**

EXHIBIT "A"

1 **Standards.** The Director, DPHSS shall establish a process to validate
2 eligibility for participation of individuals in the Para Todu Pilot Project
3 according to this Chapter."

4 **Section 42.** A new § 6107.9.2, Chapter 6, Division 1, Title 10 of the
5 Guam Code Annotated is hereby *added* to read:

6 **"§6107.9.2 Individual waivers.** An employee may waive
7 individually all of the required health care benefits pursuant to this chapter
8 by:

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

22 **Section 43.** A new § 6107.10, Chapter 6, Division 1, Title 10 of the
23 Guam Code Annotated is hereby *added* to read:

24 **"§6107.10 Health Care Para Todu Program Copayments.** The
25 general co-payment schedule for services provided is shown below. See the
26 Schedule of Benefits for specifics.

- 27 a) Outpatient Services \$4.00

EXHIBIT “A”

1	b) <u>Inpatient Services</u>	<u>\$75.00</u>
2		
3	c) <u>Preferred RX</u>	<u>\$4.00</u>
4	d) <u>Non-preferred RX</u>	<u>\$8.00</u>
5	e) <u>Non-emergency use of the ER</u>	<u>\$8.00”</u>

6 **Section 44.** A new § 6107.11 Chapter 6, Division 1, Title 10 of the
7 Guam Code Annotated is hereby *added* to read:

8 **“§6107.11 General Health Benefits**

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

12 **Section 45.** A new § 6107.11.1, Chapter 6, Division 1, Title 10 of the
13 Guam Code Annotated is hereby *added* to read:

14 **“§6107.11.1 Schedule of Benefits.** The following chart depicts a
15 quick reference to the general health benefits the Health Care Para Todu
16 Plan covers. Specific benefits will be contained in the Beneficiary document
17 provided by the contractor upon finalization of the Section 1115 waiver
18 process and contract negotiation processes. Some items may change during
19 this period.

EXHIBIT "A"

Schedule of Benefits					
	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					
If a member meets their \$1,500 deductible, the plan begins to pay for covered services for that individual	Not Applicable	Not Applicable	Applies	Applies	
Coverage Maximums					
Individual member annual maximum	None	None	\$300,000	\$300,000	
Out of Pocket Maximums (including accumulated deductible and copays)					
Per Individual member per policy year	None	None	None	None	
Per Family per policy year					

EXHIBIT “A”

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	For services not available on island; Prior Authorization required
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%,	Plan pays 100%,

EXHIBIT “A”

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				

EXHIBIT “A”

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%
Annual Eye Exam				

EXHIBIT “A”

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 ≥ \$50 (applicable to clients with income beyond 100% FPL)	Plan pays 100%; \$5 co-pay per visit for services a ≥ \$50 (applicable to clients with income beyond 100% FPL)	Plan pays 100%; \$5 co-pay per visit for services a ≥ \$50 (applicable to clients with income beyond 100% FPL)

EXHIBIT “A”

8. X-Ray Services	Plan pays 100%	Plan pays 100% ; \$5 co-pay per visit for services a ≥ \$50 (applicable to clients with income beyond 100% FPL)	Plan pays 100% ; \$5 co-pay per visit for services a ≥ \$50 (applicable to clients with income beyond 100% FPL)	Plan pays 100% ; \$5 co-pay per visit for services a ≥ \$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
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 ≥\$25 per drug (applicable to clients with income beyond 100% FPL)	Plan pays 100% \$4.00 co-payment per drug prescription that agency pays ≥\$25 per drug (applicable to clients with income beyond 100% FPL)	Plan pays 100% \$4.00 co-payment per drug prescription that agency pays ≥\$25 per drug (applicable to clients with income beyond 100% FPL)

EXHIBIT “A”

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.

EXHIBIT "A"

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)

EXHIBIT "A"

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

EXHIBIT “A”

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.

EXHIBIT "A"

Durable Medical Equipment (DME)		Plan pays 100%. Medical equipment/machine is limited to every five years. 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.	Plan pays 100%. One (1) of each type DME Every Five Years: Standard wheelchair, standard 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.	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.	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.
	Elective Surgery PA Required	Plan pays 100%. PA is required for elective surgery with one or more day admission prior to surgery.	Plan pays 100%. Non-emergency Outpatient Surgeries.	\$75.00 copay, PA required	\$75.00 copay, PA required
	Emergency Care	Plan pays 100%. PA is required for medically necessary services that are not available on island.	Plan pays 100%. PA is required for medically necessary services that are not available on island.	\$4.00 copay, PA is required for medically necessary services that are not available on island.	\$4.00 copay, PA is required for medically necessary services that are not available on island.
1. On/Off Island emergency facility, physician services, laboratory, X-rays					
2. Ambulance Services (Ground Transportation Only)					

EXHIBIT "A"

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%	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)	\$500 every 3yrs (PA required)
Maximum \$500 per member per plan year					
Hospitalization & Inpatient Benefits					
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	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.	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.
Implants	Plan pay 100%. Orthopedic	Plan pay 100%. And an	Plan pay 100%. And an	Plan pay 100%. And an	Plan pay 100%. And an

EXHIBIT “A”

Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopedic internal prosthetic devices (Limitations apply, please refer to contract)	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.
	Plan pays 100%	Plan pays 100%	\$4.00 copay	\$4.00 copay
Inhalation Therapy	Plan pays 100%	Plan pays 100%	\$75 copay	\$75 copay
Maternity Care	Plan pays 100%	Plan pays 100%	\$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.
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.	\$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)
Nuclear Medicine	Plan pays 100%	COST-SHARING POPULATION: Nuclear Medicine - \$5.00 co-payment for visit that agency pays \$50 & above (Prior Authorization Required)		
(Pre-Certification Required)				

EXHIBIT "A"

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)				

EXHIBIT "A"

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				
Diagnostics and Therapeutic Procedure	Plan pays 100% (PA required)	Plan pays 100% (PA required)	\$4.00 copay	\$4.00 copay
(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.

EXHIBIT “A”

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>

EXHIBIT “A”

EXHIBIT “A”

1 **Section 46.** A new § 6107.11.2, Chapter 6, Division 1, Title 10 of the Guam
2 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

EXHIBIT “A”

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

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

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

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

EXHIBIT “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 47.** A new § 6107.11.3, Chapter 6, Division 1, Title 10 of the
14 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

EXHIBIT “A”

- 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

EXHIBIT “A”

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

3 **Section 48.** A new § 6107.11.4, Chapter 6, Division 1, Title 10 of the
4 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.”

EXHIBIT “A”

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

Section 49. A new § 6107.11.5, Chapter 6, Division 1, Title 10 of the Guam Code Annotated is hereby *added* to read:

“§ 6107.11.5 Health Risk Appraisal. The Contractor shall administer a Health Risk Appraisal (HRA) at the time of member enrollment into the Para Todu Pilot Project.

EXHIBIT "A"

- 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 50.** 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.

EXHIBIT "A"

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.

EXHIBIT "A"

- 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

EXHIBIT "A"

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

EXHIBIT "A"

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

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

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

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

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

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

EXHIBIT "A"

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

11 r) No benefits will be paid for:

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

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

18 s) No benefits will be paid for experimental or Investigational treatments
19 and Procedures, or ineffective surgical, medical, psychiatric, or dental
20 treatments or procedures, research studies, or other experimental or
21 investigational treatments and procedures or pharmacological
22 regimes, unless deemed medically necessary by patient's physician
23 and pre-authorized by Company. Experimental and investigational
24 treatments and procedures are those medical treatments and
25 procedures that have not successfully completed a Phase III trial, have

EXHIBIT "A"

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

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

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

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

24 w) No benefits will be paid for any medical Service or supply which is
25 available to the Covered Person on Guam and which is paid by or

EXHIBIT "A"

1 reimbursable through a governmental agency or institution. However,
2 notwithstanding the aforesaid, in no event will the Company consider
3 the availability of benefits under Medicaid or Para Todu Health Plan
4 when paying benefits under this Agreement.

5 x) No benefits will be paid in connection with elective abortions
6 unless Medically Necessary.

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

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

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

22 bb) No benefits will be paid for hypnotherapy.

23 cc) No benefits will be paid for religious, marital and sex counseling,
24 including services and treatment related to religious counseling,
25 marital/relationship counseling, and sex therapy.

EXHIBIT "A"

1 dd) No benefits will be paid for cosmetic Surgery, or other services
2 intended primarily to improve the Member's appearance or
3 treatment relating to the consequences of, or as a result of,
4 Cosmetic Surgery. This exclusion does not apply to:

5 1) Medically Necessary reconstructive surgery as described in
6 the Covered Benefits sections Mastectomy and
7 Reconstructive Breast Surgery or Reconstructive Surgery.

8 2) Surgery to correct the results of injuries causing an
9 impairment;

10 3) Surgery as a continuation of a staged reconstruction
11 procedure, including but not limited to post-mastectomy
12 reconstruction;

13 4) Surgery to correct congenital defects necessary to restore
14 normal bodily functions, including but not limited to, cleft lip
15 and cleft palate.

16 ee) No benefits will be paid for routine foot/hand care, including
17 routine reduction of nails, calluses and corns

18 ff) Except as otherwise provided in this agreement, no benefit will be
19 paid for specific non-standard allergy services and supplies,
20 including but not limited to, skin titration (wrinkle method),
21 cytotoxicity testing (Bryan's Test), treatment of non-specific
22 candida sensitivity, and urine autoinjections.

23 gg) No benefits will be paid for Services and supplies associated with
24 growth hormone treatment unless the Covered Person is proven to
25 have growth hormone deficiency using accepted stimulated growth

EXHIBIT "A"

1 hormone analyses and also shows an accelerated growth response to
2 growth hormone treatment. Under no circumstances will growth
3 hormone treatment be covered to treat short stature in the absence
4 of proven growth hormone deficiency.

5 hh) No benefits will be paid for Services and supplies provided for
6 liposuction.

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

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

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

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

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

22 1) The purchase of donor sperm and any charges for the storage
23 of sperm;

EXHIBIT "A"

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

EXHIBIT "A"

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

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

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

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

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

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

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

EXHIBIT "A"

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

EXHIBIT "A"

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;

EXHIBIT "A"

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.

EXHIBIT "A"

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

3
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;

EXHIBIT "A"

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

"§ 6107.14 Dental Exclusions

EXHIBIT "A"

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

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

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

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

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

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

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

23 e) Replacement of existing dentures, crowns or fixed bridgework if the
24 existing dentures, crowns or fixed bridgework can be made
25 serviceable.

EXHIBIT "A"

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

EXHIBIT "A"

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

EXHIBIT "A"

1 v) All surgical procedures except for surgical extractions of teeth and
2 periodontal surgeries performed by a dentist.

3 w) Panoramic x-ray or full mouth x-ray if provided less than 3 years
4 from the covered person's last full mouth x-ray; and full mouth x-
5 rays if provided less than three years from Covered Person's last
6 panoramic x-ray".

7 **Section 52.** A new § 6107.15, Chapter 6, Division 1, Title 10 of the
8 Guam Code Annotated is hereby *added* to read:

9 **"§6107.15 Non- Emergency Medical Transportation (NEMT).** The
10 Contractor shall develop a process that ensures that Health Care Para Todu
11 plan enrollees have the necessary transportation to medical examinations and
12 treatment (42 CFR 440.170(a))."

13 **Section 54.** A new § 6107.16, Chapter 6, Division 1, Title 10 of the
14 Guam Code Annotated is hereby *added* to read:

15 **"§ 6107.16 Patient Centered Medical Home.** Network primary care
16 providers shall strive to provide the concepts of a patient centered medical
17 home as provided below:

18 a) Patient-centered: A partnership among practitioners, patients, and
19 their families ensures that decisions respect patients' wants, needs,
20 and preferences, and that patients have the education and support they
21 need to make decisions and participate in their own care.

22 b) Comprehensive: A team of care providers is wholly accountable for a
23 patient's physical and mental health care needs, including prevention
24 and wellness, acute care, and chronic care.

25 c) Coordinated: Care is organized across all elements of the broader
26 health care system, including specialty care, hospitals, home health

EXHIBIT "A"

1 care, community services and supports.

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

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

8 **Section 55.** A new § 6107.17, Chapter 6, Division 1, Title 10 of the
9 Guam Code Annotated is hereby *added* to read:

10 **"§ 6107.17 Community Health Centers (CHC).** The contractor shall
11 utilize the CHC's as a network provider."

12 **Section 56.** A new § 6107.18, Chapter 6, Division 1, Title 10 of the
13 Guam Code Annotated is hereby *added* to read:

14 **"§ 6107.18 Member Use of Primary Care Physicians (PCP).** The
15 contractor shall provide a list of network primary care physicians from
16 which members may select for their "medical home". The list will contain
17 the Physicians name, clinic name if available, location, phone number and
18 specialty. The contractor shall coordinate with the PCP on the number of
19 new members the PCP will accept and manage the enrollment to that PCP."

20 **Section 57.** A new § 6107.19, Chapter 6, Division 1, Title 10 of the
21 Guam Code Annotated is hereby *added* to read:

22 **"§ 6107.19 Change in Primary Care Physician.** Contractor shall
23 develop processes for members to change their primary care
24 physician/medical home to include a satisfaction survey that addresses the
25 reason for change. The de-identified information from this survey will be
26 shared with the PCP and the Administrator, DPHSS."

EXHIBIT "A"

1 **Section 58.** A new § 6107.20, Chapter 6, Division 1, Title 10 of the
2 Guam Code Annotated is hereby *added* to read:

3 **"§ 6107.20 Reports and Surveys.** The Contractor shall provide the
4 reports and surveys required and described pursuant to this Article to the
5 Director, Department of Public Health and Social Services, and to the Guam
6 Legislature through the Chairperson of the Health Care Committee. The
7 contractor shall also provide information to the appropriate network
8 providers."

9 **Section 59.** A new § 6107.20.1, Chapter 6, Division 1, Title 10 of the
10 Guam Code Annotated is hereby *added* to read:

11 **"§ 6107.20.1 Healthcare Effectiveness Data and Information Set**
12 **(HEDIS).** The contractor shall participate in the United States Department
13 of Health and Human Services, Agency for Healthcare Research and Quality
14 (AHRQ), HEDIS clinical performance program."

15 **Section 60.** A new § 6107.20.2, Chapter 6, Division 1, Title 10 of the
16 Guam Code Annotated is hereby *added* to read:

17 **"§ 6107.20.2 Consumer Assessment of Healthcare Providers and**
18 **Systems (CAHPS).** The contractor shall participate in the United States
19 Department of Health and Human Services, Agency for Healthcare Research
20 and Quality (AHRQ), CAHPS consumer experience survey program.
21 Participation in the CAHPS Database is entirely free to sponsors. By
22 participating, survey sponsors contribute to a national database that confers
23 many benefits related to benchmarking for quality improvement and ongoing
24 research.

EXHIBIT “A”

- 1 a) At a minimum, the contractor shall conduct the CAHPS survey
2 modules, CAHPS Health Plan Survey Measures and the Clinician and
3 Group Survey.
4
- 5 b) Specific benefits for sponsors of the Health Plan Survey (in the
6 Medicaid and CHIP sectors) include receiving a customized case-mix
7 adjusted sponsor report comparing results to appropriate benchmarks.
8 All sponsors also have access to annual chart books that present
9 summary-level comparisons of survey results by selected
10 characteristics (region, sector, facility size, etc.). The contractor shall
11 maintain information as provided in the CAHPS guidelines and share
12 access information to the public. Specifically, the contractor shall
13 inform the Director, DPHSS and Chairperson, Guam Legislature,
14 Committee on Health on the process to access this database.
- 15 c) The Contractor and network providers are encouraged to ensure
16 CAHPS surveys are accessible, standardized, health plans, providers,
17 and other sponsoring organizations are able to use the results to
18 compare and assess their performance vis-à-vis similar organizations
19 and pinpoint strengths and weaknesses in patients’ experiences.
20 Sponsoring organizations can also use the results to evaluate the
21 effectiveness of interventions to improve specific aspects of patients’
22 experiences.”

23 **Section 61.** A new § 6107.20.3, Chapter 6, Division 1, Title 10 of the
24 Guam Code Annotated is hereby *added* to read:

25 **“§ 6107.20.3 Claims Reports.** The contractor shall provide the
26 following reports:

27 **Medical Claims Report**

EXHIBIT "A"

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

Pharmacy Claims Report

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

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

- 24 a) A unique contract identifier that links detailed demographic, claims
25 utilization, and cost information
- 26 b) Enrollment by Plan, Tier/Class, Employment Status, and other
27 Subgroups as required by the Government

EXHIBIT "A"

1 c) Patient demographics including date of birth, gender, and relationship
2 to subscriber

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

4 1) Diagnosis code (ICD9 or ICD10)

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

6 3) Revenue codes

7 4) Service dates

8 5) Service provider, including:

9 i. Name

10 ii. Tax ID

11 iii. Provider ID

12 iv. Specialty code

13 v. City

14 vi. State

15 vii. Zip code

16 e) Plan payments

17 f) Member payment responsibility, including:

18 1) Copay

19 2) Coinsurance

20 3) Deductible

21 g) Claim paid date

22 h) Type of bill

23 i) Facility type

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

25 1) NDC codes

26 2) Formulary tier identifier

27 3) Pharmacy, including:

EXHIBIT “A”

- 1 i. Name
- 2 ii. Provider ID
- 3 iii. City
- 4 iv. State
- 5 v. Zip code

6 k) Plan payments

7 l) Member payment responsibilities, including:

8 1) Copay

9 2) Coinsurance

10 3) Deductible

11 m) Claim paid date

12 n) Injectable drug indicator

13 o) GPI number

14 p) Ingredient cost

15 q) Dispensing fee

16 r) Rebate.”

17 **Section 62.** A new § 6107.21, Chapter 6, Division 1, Title 10 of the
18 Guam Code Annotated is hereby *added* to read:

19 **“§ 6107.21 Quality of Care, Performance and Outcomes**

20 **Measures.** The following performance goals are given. Participation in
21 achieving these performance goals is voluntary though encouraged to
22 network providers. They are provided as a measure to improve quality of
23 care. The Health Insurance Contractor shall develop a process for PCP’s to
24 participate. At a minimum, the following resources shall be used in
25 determining performance incentives.

26 a) CAHPS survey results

27 b) USPTF measures

EXHIBIT “A”

1 c) Claims data

2 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>

EXHIBIT “A”

<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>

EXHIBIT “A”

<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>

EXHIBIT “A”

<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 63. 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 procedures to appeal decisions made by the MCO, for example, denial of a requested service (42 CFR 438.400-424). Standard appeals should be resolved within 45 days, but MCOs must have in place a process for expedited review (42 CFR 438.408-410).”

EXHIBIT "A"

1 **Section 64. Small Business Incentive Committee.** The Director of
2 the Department of Revenue and Taxation *shall* establish a Small Business
3 Incentive Committee to provide recommendations on the creation of a
4 program to provide small businesses an offset mechanism on the financial
5 impact of the implementation of this program. The membership of the Small
6 Business Incentive Committee shall consist of the Director of the
7 Department of Revenue and Taxation; the Chairman of the Committee on
8 Appropriations and Adjudication of *I Liheslaturan Guahan* who may elect to
9 delegate the Director of the Office of Finance and Budget of *I Liheslaturan*
10 *Guåhan* as his or her alternate; the Director of the Department of
11 Administration; the Director of the Bureau of Budget and Management
12 Research; and, a Member of the Guam Chamber of Commerce as delegated
13 by the President of the Guam Chamber of Commerce. The Committee *shall*
14 submit, within 90 days of enactment, their recommendations for the offset
15 business program.

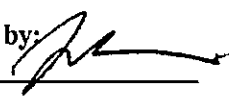
16 **Section 65. Effective Date.** Nothing herein *shall* be construed as to
17 adopt the amendments proposed in this Act. This Act is by way of example
18 and *shall* serve as the proposed statutory framework for a waiver application
19 under Section 1115 of the Social Security Act, 42 U.S.C. §1315



COMMITTEE ON RULES

I Mina'Trentai Kuåttro na Liheslaturan Guåhan • 34th Guam Legislature

PRE-REFERRAL CHECKLIST

BILL NO. 132-34 (COR) 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".		
(A) Legal Bureau	(1) One subject matter? [SR § 6.01(a), 2 GCA § 2108(a)] <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (Return to Prime Sponsor) (2) Conform to Standing Rules as to form and style? [SR §§ 6.02(b) and (d), 6.03(d)] <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (Return to Prime Sponsor)	Notice to Legal Bureau: <u>6/26/17</u> Completed by Legal Bureau: <u>7/3/17 5:54 pm</u>
(B) Office of Finance & Budget (OFB)	(1) Does the Bill contain appropriations or authorizations for appropriations from any fund sources? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (2) Does the Bill contain an authorization to expend government funds? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A (3) Does the Bill contain provisions that have <u>potential</u> fiscal impacts on the government of Guam budget? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	Notice to OFB: <u>6/26/17</u> Completed by OFB: <u>6/27/17 9:43 am</u>
COR Action	Is the fiscal impact revenue negative to the government of Guam budget? <input checked="" type="checkbox"/> YES (Refer to Committee on Appropriations) <input type="checkbox"/> NO <input type="checkbox"/> N/A	Completed by: 



PRE-REFERRAL CHECKLIST

BILL NO. 132-34 (COR) <small>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".</small>		
(C) DEBT		
(1) SR § 6.01 (b)(1)(A) Land, Infrastructure, Building Projects, Capital Improvement Projects	<input checked="" type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO (Return to Prime Sponsor)	Received by: (Signature, Date & Time) <i>[Signature]</i> 7/5/17 Completed by: 14:16 (Signature, Date & Time) <i>[Signature]</i> 7/5/17 14:16
(2) SR § 6.01 (b)(1)(B) Refinancing of existing debt (not less than 2%)	<input checked="" type="checkbox"/> N/A <input type="checkbox"/> YES <input type="checkbox"/> NO (Return to Prime Sponsor)	
(3) SR § 6.01 (b)(2) Authorize public debt to fund operations of agency, instrumentality, public corporation	<input checked="" type="checkbox"/> N/A <input type="checkbox"/> YES (Return to Prime Sponsor) <input type="checkbox"/> NO <input type="checkbox"/> Waived (per official state of emergency, as attached)	
COR Action	<input type="checkbox"/> Return to Prime Sponsor <input checked="" type="checkbox"/> Refer to: <i>Committee on Appropriations</i> <i>BSC</i> <i>B(2) and B(3)</i>	Date & Time: <i>7/5/17 14:16</i>

For COR Office Use Only	Pursuant to COR decision (COR Meeting, April 3, 2017): Completed within five (5) working days? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Initial: <i>[Signature]</i> If NO: Provide letter of explanation (see attached).
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Speaker Benjamin J.F. Cruz,
Member

Vice Speaker Therese M. Tertaje,
Member

Senator Thomas C. Ada,
Member

Senator Frank B. Aguon, Jr.,
Member

Senator Telenia C. Nelson,
Member



Senator Dennis G. Rodriguez, Jr.,
Member

Senator Joe S. San Agustin,
Member

Senator Michael F.Q. San Nicolas,
Member

Senator James V. Espaldon,
Member

Senator Mary C. Torres,
Member

COMMITTEE ON RULES
SENATOR RÉGINE BISCOE LEE, CHAIR
SIKRITARIAN LIHESLATURAN GUAHAN
I MINA'TRENTAI KUATTRO NA LIHESLATURAN GUAHAN
LEGISLATIVE SECRETARY • 34TH GUAM LEGISLATURE

July 27, 2017

MEMO

To: **Rennae Meno**
Clerk of the Legislature

From: **Senator Régine Biscoe Lee**
Chairperson, Committee on Rules

Re: **Fiscal Note**

Buenas yan Håfa adai.

Attached, please find the fiscal note for the following bill:

Bill No. 132-34 (COR)

Please forward the same to Management Information Services (MIS) for posting on our website.

For any questions or concerns, please feel free to contact Jean Cordero, Committee on Rules Director, at 472-3455.

Thank you for your attention to this important matter.

Respectfully,


Senator Régine Biscoe Lee
Chairperson, Committee on Rules

**Bureau of Budget & Management Research
Fiscal Note of Bill No. 132-34 (COR)**

AN ACT TO AMEND SECTIONS § 6101, § 6102, § 6103, AND § 6104, AND TO ADD §§ 6102.1, 6105, 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 AND IN PROGRAM OPERATIONS AND THE EXPANDING HEALTH CARE ACCESS TO THE GUAM MEDICAID PROGRAM BY ESTABLISHING A MANAGED CARE PILOT PROGRAM TO BE KNOWN AS "THE HEALTH CARE PARA TOTDI"

Department/Agency Appropriation Information	
Dept./Agency Affected: Public Health & Social Services	Dept./Agency Head: James Gillan
Department's General Fund (GF) appropriation(s) to date:	60,686,706
Department's Other Fund (Specify) appropriation(s) to date: HFF (\$5,280,202), EHF (\$1,311,615), SRF (\$134,588)	6,726,405
Total Department/Agency Appropriation(s) to date:	\$67,413,111

Fund Source Information of Proposed Appropriation			
	General Fund:	(Specify Special Fund):	Total:
FY 2016 Unreserved Fund Balance		\$0	\$0
FY 2017 Adopted Revenues	\$681,271,974	\$0	\$681,271,974
FY 2017 Appro. (P.L. 33-185 thru P.L. 33-240)	(\$681,271,973)	\$0	(\$681,271,973)
Sub-total:	\$1	\$0	\$1
Less appropriation in Bill	(\$100,000)	\$0	(\$100,000)
Total:	(\$99,999)	\$0	(\$99,999)

Estimated Fiscal Impact of Bill						
	One Full Fiscal Year	For Remainder of FY 2017 (if applicable)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund	\$0	\$100,000	\$0	\$0	\$0	\$0
(Specify Special Fund)	\$0	\$0	\$0	\$0	\$0	\$0
Total	\$0	\$100,000	\$0	\$0	\$0	\$0

- Does the bill contain "revenue generating" provisions?
If Yes, see attachment / x / Yes / / No
- Is amount appropriated adequate to fund the intent of the appropriation?
If no, what is the additional amount required? \$ _____ / x / N/A / / Yes / / No
- Does the Bill establish a new program/agency?
If yes, will the program duplicate existing programs/agencies? / x / Yes / / No
Is there a federal mandate to establish the program/agency? / / N/A / / Yes / x / No
- Will the enactment of this Bill require new physical facilities? / / Yes / x / No
- Was Fiscal Note coordinated with the affected dept/agency? If no, indicate reason: / x / Yes / / No
/ / Requested agency comments not received by due date / / Other:

Analyst: <u>John AB Pangolinan</u>	Date: <u>7/19/17</u>	Director: <u>Lester L. Carlson, Jr.</u>	Date: <u>JUL 25 2017</u>
John AB Pangolinan, Budget & Management Supervisor			

Footnotes:

Please see attached comment sheet.

and the employer contribution of 65% of the Government of Guam portion subject to the approval of this proposed Health Care Para Todu Health plan by the Federal Government.

13. To add a new § 6107.5.1 which would establish the Guam Health Insurance Para Todu Fund under the purview of the DOA, which is to be funded from the Government of Guam contribution received from the premiums paid-in by employers and their employees, who qualified for the program and from the Federal funding of Medicaid.
14. To add new § 6107.5.2 through § 6107.5.5 with respect to the management of the proposed Guam Health Insurance Para Todu Fund that would include the disbursement of funds from this proposed fund and its investment.
15. To add a new § 6107.5.6 to establish a Health Savings Account (HSA) for member beneficiaries to be used to help defray the costs of deductibles and co-payments as outlined in the proposed Guam Health Care Para Todu Plan.
16. To add new § 6107.5.8 and § 6107.5.9 with respect to employer contribution and employee contribution.
17. To add new § 6107.6 through § 6107.6.3 with respect to the implementation of the proposed Guam Health Care Para Todu Plan.
18. To add a new § 6107.7 and § 6107.7.1 regarding participant qualifications.
19. To add a § 6107.8 with respect to Eligibility of Participating Health Care Providers.
20. To add § 6107.9 through § 6107.9.2 with respect to participant enrollment, participation and eligibility standards and individual waivers.
21. To add a new § 6107.10 regarding Health Care Para Todu Program copayments.
22. To add new § 6107.11 through § 6107.11.5 regarding general health benefit.
23. To add a new § 6107.12 with respect to medical exclusion.
24. To add a new § 6107.13 with respect to dental services.
25. To add a new § 6107.14 regarding dental exclusions.
26. To add a new § 6107.15 regarding non-emergency medical transportation.
27. To add a new § 6107.16 regarding patient centered medical home.
28. To add a new § 6107.17 with respect to the use of DPHSS' Community Health Centers as a network provider for the proposed Guam Health Care Para Todu Plan.
29. To add a new § 6107.18 regarding the selection of primary care physicians by participating members of the proposed Guam Health Care Para Todu Plan.
30. To add a new § 6107.19 regarding the ability to change primary care physicians.
31. To add new § 6107.20 through § 6107.20.3 regarding the submissions of reports and the initiation of program surveys with respect to the proposed Guam Health Care Para Todu Plan.
32. To add a new § 6107.21 with respect to the quality of care, performance and outcome of the proposed Guam Health Care Para Todu Plan.
33. To add a new § 6107.22 regarding the appeal process of participants of the plan.

In collaboration with DPHSS, this proposed Guam Health Care Para Todu Plan is changing the Guam Medicaid State Plan from a "fee for service" to a "manage care" plan (Prepaid Health Plan), which is a stringent process that would require the approval of the Federal Grantor Agency, Center of Medicare and Medicaid Services. Such transition would completely replace the existing Guam Medicaid State

Plan. The funding of the Guam Medicaid program is federally capped; but the use of such Medicaid funding up to the capped level is dependent on the availability of the local matched funding. Historically, it has been difficult identifying the additional local funding needed to maximize the available federal matched funding for Medicaid currently and in the past. This same situation would continue in spite of the transition into a "managed care" plan, unless there is sufficient funding generated from the planned 65% of the Employer Premium Contribution (proposed § 6107.5.8 and § 6107.5.9) and the Health Insurance Premium Fee (proposed § 6107.5.5) that would be applied for the local match component. There are no other provisions in this proposed health plan that would identify other local funding sources needed to match the increased Federal funding provided for Medicaid. The dollar amount of the fiscal impact with respect to the Employer Contribution of 65% and the Health Insurance Premium Fee is pending until at such time the appropriate actuarial study has been completed for the development of each class premium. Such study would entail the hiring of a consultant. Therefore the actuarial review would probably be initiated in the coming fiscal year. This timeline would also apply to the transition of the Guam Medicaid State Plan from a "fee for service" program to the proposed "managed care" concept as proposed in this Bill.

Because of this proposed change, the revision of the current Guam Medicaid State Plan would probably require a professional consultant to set the pace of the transition to a "managed care" program. The cost of such a consultant may be as high as \$100,000. This new cost, now, becomes an unfunded mandate applied against the DPHSS' annual appropriation should this proposal be passed in FY 2017.

All other provisions of the Bill are administrative in nature.



Office of the Speaker
BENJAMIN J.F. CRUZ
I Mina'trentai Kuåtro na Liheslaturan Guåhan
Committee on Appropriations and Adjudication

MEMORANDUM

To: Senator Régine Biscoe Lee
Chair, Committee on Rules

From: Speaker Benjamin J.F. Cruz

Re: Waiver of Funding Availability Note for Bill No. 132-34 (COR)

Håfa Adai!

In accordance with Section 6.01(d)(1), Rule VI, Part B of *I Mina'trentai Kuåtro na Liheslaturan Guåhan*, the Committee on Appropriations and Adjudication (Committee), with the assistance of the Office of Finance and Budget, has reviewed **Bill No. 132-34 (COR)**.

The Committee has determined that the above-referenced bill does not contain an appropriation or an authorization for appropriation from a specified funding source. Therefore, a **Funding Availability Note has been waived**.

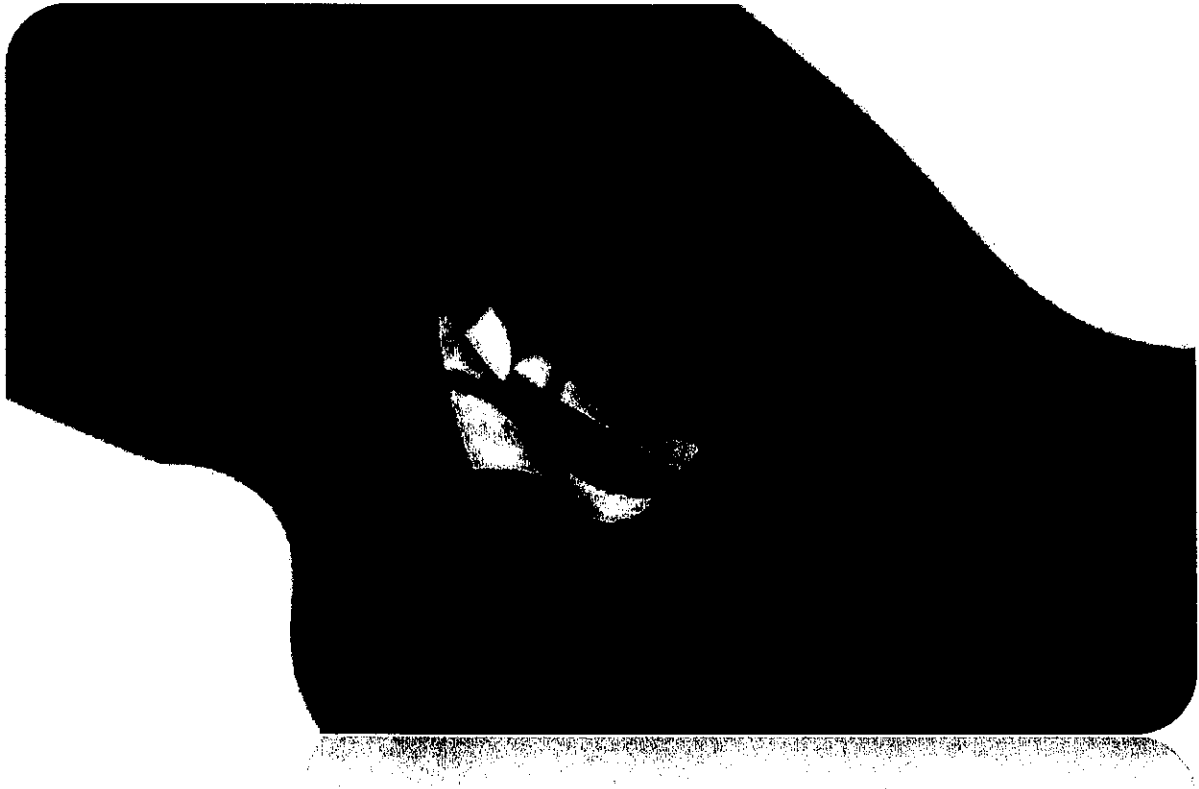
Si Yu'os Ma'ase,


Benjamin J.F. Cruz

Guam Health Insurance Expansion Program

Health Care "Para Todu"

Senator Dennis G. Rodriguez, Jr.



December 5, 2016

This report is prepared by:

**The Office of Senator Dennis G. Rodriguez, Jr.
33rd Guam Legislature
Chairman, Committee on Health, Economic Development,
Homeland Security and Senior Citizens**

Point of Contact for this report is:

Chuck Tanner, Chief of Staff

chuck@toduguan.com

chucktanner88@gmail.com

**Electronic copy available at
www.toduguan.com**

*Special thanks to
Mr. John Carlos, Consultant and
Mr. Chuck Tanner, MHA, M.Ed., FACHE*

Purpose.....	10
Goals	10
Findings	11
Medicaid Expansion - Premium Assistance of Employer Sponsored Insurance (ESI), Para Todu Program.....	12
Establishment of Para Todu fund	13
Management of the fund.....	13
Health Savings Account.....	15
Employer Contributions.....	16
Employee Contributions.....	16
Job Counseling and Referral.....	16
Healthy Behavior Incentives.....	16
Guam Insurance Commission.....	16
Address Homeless Individual Enrollment Challenges.....	16
Standard Medicaid Revision.....	17
Medically Indigent Program (MIP)	17
<i>Mañelu Care</i>	17
<i>Mañelu Plus</i>	17
<i>Mañaina Care</i>	18
Federal Medical Assistance Percentage	18
Table 1- Guam Federal Poverty Level FY 2016 Table.....	20
Table 2- Per Capita Money Income, Guam 2010	21
Table 3: Reference Information.....	22
Table 4. Impact on Uninsured	22
Table 5. Cost Projections	23
Definitions, Terms and Concepts	26
Appendix 1 Information on Guam Medicaid from DPHSS 2015 Annual Report.....	32
Appendix 2 Society of Human Resource Manager Survey Results	39
Appendix 3: Quality of Care in the US Territories	51
Appendix 4: 10 Point Plan from GMH Task Force Report (Jan 2016)	62
Appendix 5: Premium Assistance: Medicaid's Expanding Role in the Private Insurance Market.....	63
Appendix 6 Essential and Preventive Care Benefit.....	80
Appendix 7: Comparison of Average PPO 1500 Plan to MAP and MIP	85

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Executive Summary

We are many parts, we are all one body, and the gifts we have we are given to share. May the Spirit of love make us one indeed

(Marty Haugen)

Guam has approximately 32,465 uninsured residents or 21% of Guam's population according to the 2013 Guam Statistical Yearbook. Guam Memorial Hospital continues to struggle financially and operationally. The Asia Pacific Island communities, including Guam, face a crisis in non-communicable diseases and many of our residents are without means to afford needed healthcare. People put off getting care at early stages until they are forced to the emergency room. This spiral grows our healthcare costs and degrades our "population health" without an end in sight.

In the current system, people have a "right" to healthcare, but with that "right" you have to pay for it. However, you do not need to pay for it "up front". That means either a payment plan with the provider or buy insurance. Unfortunately not all can afford to buy insurance. In other countries, people pay for coverage in the form of taxes. In the United States we generally use insurance to pay. Federal insurance programs, Medicare and Medicaid, exist on Guam and are available for parts of the population. The Affordable Care Act changed many of the rules of these programs. However the Affordable Care Act operates under different rules on Guam. Those differences serve to perpetuate disparities and contribute to economic destabilization of the island.

My purpose, using the United States system, is to meet the "duty" of the citizenry to pay for healthcare via health insurance by making it affordable and available for everyone, "**Health Care Para Todu**". This initiative is derived from work accomplished between April and December 2015, culminating in the January 27, 2016, release of the Guam Memorial Hospital Task Force Report. Specifically, this document addresses points 7 and 8 of the recommendations contained in that report.

The program presented for discussion addresses one large portion of our population (approximately 15,000) and gives a solution and moves us closer to universal healthcare for all. It is one step in the right direction.

The goals of this initiative are multifold.

- Reduce the number of uninsured low-income island residents and increase access to healthcare services.
- Reduce the number of uninsured therefore increasing the reimbursement of care provided by Guam Memorial Hospital and local providers.
- Reduce the number of uninsured residents which may serve as a catalyst for local providers to expand their practice by participating in the National Health Service Corps program.
- Promote value-based decision making and personal health responsibility.
- Promote disease prevention and health promotion to achieve better health outcomes.
- Provide Para Todu members with opportunities to seek job training and stable employment to reduce dependence on public assistance. (All Program members working fewer than 20 hours a week will be offered a referral to a workforce development agency).

A limiting factor is that the financial resources of the Government of Guam are insufficient to provide coverage to this group. Our approach, in lieu of raising taxes, is to use the various mechanisms within the Affordable Care Act that apply to the Territories, coupled with existing Medicaid program parameters, to construct a plan that shares the burden of the cost of insurance among many, thus lowering the individual cost for each segment.

To accomplish this lofty goal requires the participation of several entities. My office is working with the United States Health and Human Services to flush out what may be accomplished under the Affordable Care Act. We are also working with Congresswoman Bordallo's office to access other federal agencies, which may be required, to engage in any final points of the plan. In addition to the Federal Government, I believe it is important to engage our local Government agencies, government representatives of the FAS, the insurance market, local businesses, and the general population, in order to develop a plan that is fair to all.

To that end, we have already collaborated with the Society of Human Resource Managers (SHRM) to survey the business community. What is telling about this survey is that many companies offer health insurance. Others only offer coverage to full-time employees. It seems that many people that lack insurance are part-time employees or those in smaller companies. These employees are within the target population of this initiative.

A typical scenario could go something like this.

It is tough to make ends meet when you are just starting out. As a high school graduate it is challenging to find a starting job that makes more than minimum wage. I am young and pretty healthy so health insurance is really not high on my list of priorities compared to other things I have to do. I want to get married, I want a family, and I want my own home. There are so many things to do to build a life. My youthful invincibility, though, may not be as reliable as I think. Though I know having an insurance plan to cover my health is important, it just is not realistic for me right now.

Time passes and I have been lucky, no major illness. Now I am looking at getting married and starting a family. How will I be able to afford the birth of a child? As someone making minimum wage or slightly above minimum wage I would qualify for the proposed expanded health insurance program. I would sign up for the mandated payroll deduction that would go into a Health Savings Account or HSA. The HSA could then be used to pay my required co-pay, deductible, or other health expenses. Of course on Day 1, I would not have any money in my HSA but what if I need care now? Wait, part of the plan would be to complete many of my preventive visits first, such as getting an assessment, a physical, and other things that I can do now while I start saving in my HSA. In other words I would not have to pay a co-pay and the deductible portion would not apply to the preventive visits. I understand that I need to develop a relationship with my doctor (primary care manager). Therefore my first visit would be a comprehensive physical examination. This physical would set the course for any treatment I may need. The physical examination would also identify what "free" preventive services I could be referred too. For instance, if I want to quit smoking or lose weight I could do that. While I am getting started, every pay period my HSA grows. If something worse happens I then have a "kitty" in which I can draw from. The HSA is mine so in a way I am not really losing any money; it is only going into my "healthcare budget".

Over time I will grow with my company and be promoted or find other jobs that further my career. At some point I will be making more money than what qualifies me for this "helper" program. Then I can transition to the company program. And guess what, my HSA goes with me. I am not asking for a handout, but a hand up.

Here are the key points of my proposal that are up for discussion.

MEDICAID Expansion

1. Employer Sponsored Insurance (ESI) Premium Assistance. The Government of Guam will apply for a Medicaid 1115 waiver to complete a 3-year pilot project in support of this program. This approach uses Medicaid dollars to pay the employee's share of premiums to employer-offered private health insurance coverage. The target demographic in this demonstration is 108% - 200% of the Federal Poverty Level (FPL) (Table 1 & 2). A good example of an employer-based premium assistance plan is Indiana.

Facilitate the following Premium Contribution Rates

- Federal Government: 55%
 - Government of Guam: 45%
 - Employer pays 65% of GovGuam Premium obligation
 - Employee contributes via Health Savings Account (co-pay and deductible)
2. Impose a 4 percent health insurance fee on insurers that are selling health insurance on Guam. The insurance premiums are around \$224 million. The estimated revenue from this fee therefore is around \$9 million. Legislation will be proposed to generate this revenue and be applied to the premium contribution obligation of GovGuam.
 3. Facilitate as part of these program options a mandatory Health Savings Account (HSA) function for beneficiaries. To be eligible to participate in the expansion program, the beneficiary must agree to participate in a Health Savings Account Program. The purpose of the payroll-deducted HSA is to provide funds to meet the copayment/deductible portion of the plan. It may also be used for other health-related purposes such as purchasing medical equipment or over-the-counter medications. A benchmark HSA contribution rate could be 2% of monthly income.
 4. Establish, if needed, the Guam Health Insurance Para Todu Fund that will be the repository of all funds generated for health insurance expansion.
 5. Strengthen the Guam Insurance Commission. A portion of funds from the Insurance Premium Fee or returned Health Insurance Tax (HIT) will be allocated to support and strengthen the Health Insurance Commission.
 6. Ensure healthy behavior incentives are included in the proposals. Include recommendations from the Non-Communicable Disease Consortium and other local healthcare organizations.
 7. Address challenges in the enrollment process for homeless individuals. Since the homeless do not have addresses, it is often a barrier to enrollment. Other challenges may exist and so it is my intent to collaborate with the Guam Homeless Coalition to address identified challenges. The concept of "Presumptive Eligibility" should be seriously considered.
 8. Employer Mandate. In order to meet the goals of this pilot project, the need to have an employer mandate shall be evaluated. We will also examine offsetting some cost by increasing the Santos Act exemption.
 9. Standard Medicaid Revision. During this pilot program we will evaluate moving from the current method of administering Medicaid toward a managed-care program. Though not a new idea, the environment we are in demands another look at this option. In this proposal, Medicaid enrollees will receive their care from a private managed-care plan that contracts directly with the local Medicaid office.

Medically Indigent Program (MIP)

This program is also in need of revision. Again, moving this program into the managed care arena has the potential to decrease cost, increase quality and access. The MIP program currently covers qualified individuals to 100% FPL. As of the 3rd quarter 2016, 11,034 participants are covered under MIP with an appropriation of \$13,168,453. The Government of Guam has a great deal of flexibility in modifying this program. A similar approach to the standard Medicaid transition to a managed-care program is again well worth examination. In the spirit of "Buen Binidu", we propose to convert MIP into 3 programs.

Mañelu Care

The first program would be Mañelu Care. We anticipate the target group will remain those that fall within the 0%-100% FPL. This program would mirror the existing MIP but be converted to a managed-care methodology. During the transition, specific benefits will be reviewed and adjusted to meet the current needs of this population.

Mañelu Plus

Working with representatives from our FAS/COFA neighbors we plan on providing Mañelu Plus. Mañelu Plus would expand the eligibility criteria to FAS/COFA citizens from the current maximum of 100% FPL to a level based on contributions from various FAS governments to the program up to 200% FPL. Benefits would remain the same as proffered in the Mañelu Care plan except more FAS/COFA citizens would be eligible.

Mañaina Care

Many of our manâmkos are not eligible for Medicare or have needs that are not covered by Medicare. A core principle in our culture is respect for our elders. Mañaina Care would provide coverage to our local, US citizens over the age of 65. Specifically, coverage would be provided for skilled nursing care to take care of the special needs of the elderly. Additional coverage/benefits will be reviewed to focus on the specific needs of the over-65 population.

Additional factors that are related to my proposal

1. Aggressively address the Federal levied 2% Health Insurance Tax (HIT). It is our position that this tax is unduly applied to the territories given the selective application of The Affordable Care Act. NO territory has participated fully in The Affordable Care Act due to the inconsistent rules that pertain to them. Thus it is our position that since we are challenged with sorting through the rules of The Affordable Care Act, and as evidenced by the lack of participation, that this HIT should be returned to the territories. It is our intention to use these funds to augment our plan.
2. Address Medicare reimbursement for Guam. We are keenly aware that adding ~15,000 beneficiaries to Medicaid may have an unintended consequence of exacerbating the financial condition of Guam Memorial Hospital unless we continue to work with our Congresswoman and others to bring to closure the seemingly never ending struggle for equity in Medicare reimbursements. A complete history and understanding of this issue may be found in the recently released Independent Audit for years ended September 30, 2014 and 2015. This audit is found at <http://www.opaguam.org/financial-audits/guam-memorial-hospital-authoritys-gmha-fy-2015-financial-audit> and provides an excellent narrative on the history and impact of this disparity.

3. Address Federal Medical Assistance Percentages. It is my intent to work with Congresswoman Bordallo in support of federal legislation, specifically **H.R. 2635 – Improving the Treatment of the U.S. territories Under Federal Health Programs Act of 2015**. This bill amends title XIX (Medicaid) of the Social Security Act to terminate the limitations on general Medicaid funding, as well as the specific federal medical assistance percentage (FMAP, or matching rate), beginning FY2017 for Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, and American Samoa (territories). We do not support S-1961 introduced by Senator Charles Schumer (D-NY) as we believe this bill is flawed in many ways. Further discussion is not within the scope of this paper.
4. Remain flexible to changes in the Affordable Care Act. Based on the transition from the Obama Administration to the Trump Administration, we anticipate changes but believe the concept of expanding healthcare coverage will continue. We also believe our public/private approach will receive support.

We will continue to work these issues but they will not impede the progress of the insurance expansion plan efforts. I look forward to your comments and participation in the further development of this plan.



Dennis G. Rodriguez, Jr.
Senator, 33rd Guam Legislature
Chairman, Committee on Health, Economic Development,
Homeland Security and Senior Citizens.



Guam Health Insurance Expansion Program

Purpose

The purpose of this paper is to present a plan that would expand health care coverage to the people of Guam using the intent of the Patient Protection and Affordable Care Act. The initiatives described match our philosophy of Health Care "Para Todu" or Health Care for All and takes a major leap in realizing that vision. It is purposefully meant to stir discussion.

Goals

The goals of this initiative are multifold.

- Reduce the number of uninsured low income island residents and increase access to Healthcare services.
- By reducing the number of uninsured therefore increasing the reimbursement of care provided by Guam Memorial Hospital and local providers.
- By reducing the number of uninsured, serve as a catalyst for local provider to expand their practice by participating in the National Health Service Corps program.
- Promote value-based decision making and personal health responsibility.
- Promote disease prevention and health promotion to achieve better health outcomes.
- Provide Para Todu members with opportunities to seek job training and stable employment to reduce dependence on public assistance. All Program members working fewer than 20 hours a week will be offered a referral to a workforce development agency.

First and foremost is to provide access to affordable health insurance coverage to the people of Guam by providing assistance with the cost of the premiums. The focus of this plan is on those citizens that work but do not earn enough money to include health insurance in their family budget.

We believe that ensuring health care coverage to this population will contribute to improving the overall health of our people. With appropriate insurance coverage, citizens will not delay needed care. Early attention to health care issues normally leads to improved outcomes. Health insurance coverage also provides for screening and prevention practices that allow people to identify concerns earlier and thus can be treated with the potential for better and quicker outcomes. This coverage will enhance the health of our people and also reduce the overall cost.

One challenge we face, primarily at Guam Memorial Hospital, but also within the health care provider community, is the treatment and cost for providing that treatment to the uninsured. Often times this care is "written off" as bad debt. The compassion of our providers is put to the test having to decide between care to our people and the realities of keeping the "door open" to provide that care.

Though not an intended consequence of this plan primary care clinics may increase their participation in the National Health Service Corps program. A major barrier in private clinic participation is the requirement to see all patients. With the large amount of uninsured on Guam this presented a significant challenge to their business model. The cost of potentially un-reimbursed care more than offset the advantages of an additional provider. This plan will reduce the uninsured population thus making this program more viable. Guam is faced with a primary care provider shortage in the near future so this may avert this dilemma.

The initiative described herein will draw from many resources; Federal, Territorial, Insurance providers, health care providers, employers and employees. Our approach requires the collaboration of these entities to contribute in an appropriate way to achieve our goals.

Findings

Senator Dennis G. Rodriguez, Chairman Health Committee finds that not since “*Johnson’s Great Society*” has the United States government undertaken such a broad reaching expansion of healthcare to its citizens. The inception of the Patient Protection and Affordable Care Act (PPACA) in March of 2010 changed the landscape of providing healthcare to the people. This large endeavor rolled across the United States but not all States jumped on board immediately. The complexity of the system caused many to take pause. This was especially true in the territories. Now that PPACA is in its 6th year, we have had the luxury of seeing the approaches taken by different States and the knowledge of lessons learned. We find that one size does not fit all and each State and Territory has unique variables that need to be addressed. Comparing what would work in Puerto Rico with a population of 3.5 million is not the same as Guam with a population of 172,326. In addition to the challenges of instituting a complex expansion program it is further complicated by the fact that not all of PPACA rules apply to the territories. This situation causes extreme problems for the territories as PPACA is a systems approach and each part works in tandem with the other parts. Unfortunately many of these “parts” are missing for the territories. Thus a considerable amount of innovation and research is required to develop and meet the intent of PPACA for the Territorial citizens. (An excellent report on the disparity of care for the territories is included at Appendix 3.) In developing this plan we looked at many projects but mainly the Indiana Premium Assistance ESI Program (HIP) and the Hawaii Prepaid Insurance program. Many of the concepts of these plans are found in the Para Todu Program.

Senator Dennis G. Rodriguez, Chairman Health Committee further finds the Health Insurance Premium Payment (HIPP) program was enacted into law as part of the Omnibus Budget Reconciliation Act of 1990. Under the HIPP program, States could use their Medicaid funds to pay premiums for employer-sponsored health insurance on behalf of Medicaid-eligible individuals and their families. Congress had hoped that HIPP would expand employment-based coverage, save money for the States, and keep families together in the same insurance plan. To date, only six States have implemented HIPP plans, and even the most aggressive of these States have enrolled only small numbers of Medicaid recipients. This initiative however holds merit for Guam and further research ensued and we are pursuing this path. In addition is the fact that the cost of medical care, in cases of sudden need, may consume all or an excessive part of a person's resources. Prepaid health care plans offer a certain measure of protection against such emergencies. It is our purpose, in view of the spiraling cost of comprehensive medical care, to provide this type of protection for the people and employees in Guam falling between the 108% and 200% range of the appropriate Federal Poverty Level as it applies to Guam. *Note: Guam is also treated differently in the actual dollar ranges of the FPL see Table one.*

Senator Dennis G. Rodriguez, Chairman Health Committee 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. The plan presented shall not be construed to diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that is more favorable to the employees benefited thereby than the protection provided by the health insurance expansion plan or at least equivalent thereto, provided that presently existing collective bargaining agreements shall not be affected by the provisions of this section.

References:

1. The Medicaid enrollment in Guam for fiscal years
 - 2013 is 43,969
 - 2014 is 44,528
 - 2015 is 44,033.
 - 2016 is 41,706 (3rd qtr.)
2. There are an estimated 32,465 uninsured people on Guam (21%)
3. ~260 million of ACA funding of which ~160 million remain.
4. Medicaid on Guam currently covers up to 108% FPL and also includes an alternative benefit plan "Medicaid New Adult Group Coverage" effective Feb 1 2016. This covers childless adults ages 19-64 at or below 133% FPL.

Medicaid Expansion - Premium Assistance of Employer Sponsored Insurance (ESI), Para Todu Program.

In examining the uninsured in Guam, both the low-income and employees of small businesses clearly stand out as having high rates of un-insurance. It is therefore our intention to focus efforts on these two populations in order to significantly decrease the number of uninsured. Our assumption is that this group consists of people between 108% and 200% of the federal poverty level. With increasing health care costs and premiums, health insurance can be out of reach for families earning less than 200% of the federal poverty level. Subsidization options should be considered for this population to make coverage more affordable. Voluntary program participation or an employer mandate should require the financial contribution of employees, employers, and government entities.

We should investigate the possibility of using these contributions as the required Medicaid State match to leverage federal dollars, as is being tested in other states. Use of Medicaid funds to purchase private market plans—is one approach that states may use to expand the program to previously ineligible, low-income adults. Indiana, Arkansas and Iowa are using premium assistance to purchase or subsidize plans on the exchange through Section 1115 research and demonstration waivers, and other states have expressed interest in this approach. Since Guam does not have an "exchange" we should look at the employer sponsored methodology rather than an exchange methodology.

One tool to build is the establishment of the Guam Health Insurance **Para Todu Program** that targets those people and families that earn between the 108% and 200% rate of the Federal Poverty Level. It is therefore the intent of *Senator Dennis G. Rodriguez* to facilitate the application of a Section 1115 Medicaid waiver in order to provide expansion of the Medicaid program to eligible beneficiaries not currently covered, within the range of **108% to 200%** of the applicable Guam Federal Poverty Level (Table 1 & 2). It is estimated that an additional 15,000 to 16,000 lives will be eligible.

Under PPACA for the period of July 1, 2011 through September 30, 2019, Section 2005 of the Affordable Care Act provided an additional **\$268,343,113 in Medicaid** funding to Guam. Approximately **168 million dollars** remain, and as part of this initiative, Senator Rodriguez plans to take advantage of this funding. (Of note, Guam is 100% fee-for-service (FFS) and does not offer managed care services to its beneficiaries. Currently, Guam has no demonstrations or waivers but has elected to operate a title XXI funded Medicaid Expansion program.)

Facilitate the following Premium Contribution Rates (Table 3)

- Employer- 65% of premium

- Federal Government: 55% of the remainder
- Government of Guam: 45% of the remainder
 - Employee- Contribution via Health Savings Account
 - Insurance Company: 4% Health insurance premium tax yielding ~8.5 Million.

Establishment of Para Todu fund.

There is hereby created, separate and apart from other funds and accounts of the government of Guam, a fund known as the Guam Health Insurance Para Todu Fund ('Fund'). The Fund shall not be commingled with the General Fund or any other fund or account of the government of Guam, and shall be kept in a separate bank account. This fund is established to pay for premiums, which shall be administered exclusively for the purposes of this chapter. The Fund, to include any monies in the Fund dedicated and dispersed for purposes specified in this Act, *shall not* be subject to the transfer authority of *I Maga 'lahan Guåhan*. All premiums payable under this part shall be paid from this fund. The fund shall consist of:

- a. All money appropriated by the Territory if any, in support of the Para Todu Program.
- b. All money collected from the Guam Health Insurance Premium Fee
- c. Federal Government contributions for the purposes of premium payments.
- d. All fines and penalties collected pursuant to this chapter.

Management of the fund.

The Department of Administration shall be the treasurer and custodian of the Guam Health Insurance Para Todu Fund and shall administer the fund in accordance with the directions of the director of public health and social services. All moneys in the fund shall be held in trust for the purposes of this part only and shall not be expended, released, or appropriated or otherwise disposed of for any other purpose. Moneys in the fund may be deposited in any depository bank in which general funds of the Territory may be deposited but such moneys shall not be commingled with other Territory funds and shall be maintained in separate accounts on the books of the depository bank. Such moneys shall be secured by the depository bank to the same extent and in the same manner as required by the general depository law of the Territory; and collateral pledged for this purpose shall be kept separate and distinct from any other collateral pledged to secure other funds of the Territory. The director of administration shall be liable for the performance of the director of public health and social services duties under this section as provided.

4% Health Insurance Premium Fee

It is the intent of *Senator Dennis G. Rodriguez* to sponsor legislation to *I Liheslaturan Guåhan* to assess a "Guam Health Insurance Premium fee of four percent (4%) upon all health care insurance premiums for the purpose of establishing a **Guam Health Insurance Para Todu Fund** (Fund), apart and separate from all other funds and accounts of the government of Guam to facilitate and supplement the development and maintenance of the health insurance expansion program. This has the potential to annually generate approximately \$9 Million in revenue for the **Guam Health Insurance Para Todu Program** (Program) for expenditure on the development and provision of healthcare services for the people of Guam.

The Fund shall be financed by the collection of a four percent (4%) assessment fee on all healthcare insurance premiums paid in Guam for the coverage of company employees and their dependents', or individuals. Such fees shall be collected from the healthcare insurance companies providing such coverage on Guam.

For purposes of this section, *healthcare insurance* is defined as health insurance against sickness or injury of persons or companies employees, with the insured being engaged in activities within Guam, such activities being included in the definition of *healthcare insurance provider* or *health maintenance organization* (HMO) defined in Title 11, Guam Code Annotated.

The Department of Revenue and Taxation (the *Department*) shall collect such fees from insurance providers and transmit them to the Treasurer of Guam for deposit in the Fund. The Department shall:

- a. Develop the necessary forms and instructions to be sent to all insurance companies issuing healthcare insurance. Such forms and instructions shall direct these insurance companies to pay the four percent (4%) assessment as a condition of continuing to do business of Guam;
- b. Act as the repository for the Fund for use as authorized pursuant to this Article in carrying out the purpose of the Fund.
- c. The Department of Administration shall be the disbursing and certifying officer for the Fund, and shall comply with the provisions of Chapter 14 of Title 46, Guam Code Annotated.
- d. The Director of Administration shall maintain appropriate records of the Fund and shall provide accounting and auditing services for the Fund.
- e. Insurance companies **shall be allowed to include the "Health Insurance Premium Fee in the administration deduction portion of the medical loss ratio (MLR) calculations.**

Senator Dennis G. Rodriguez finds that the following amounts of health insurance premiums written by domestic, Guam based health care insurance providers and health maintenance organizations.

Year	2007	2008	2009	2010	2011	2012	2013	2014
Health Premiums	188,754,983	197,074,603	203,505,434	227,483,705	251,984,630	244,127,300	236,412,605	249,638,016

Total \$1,798,981,276

(There is an additional annual average of over \$2,605,262 in health insurance premiums written by non-domestic health insurance providers (2007 - 3rd quarter 2011 only).

With a total of \$1,798,981,276 (not including non-domestic) in health insurance premiums paid over the past 8 years; without domestic healthcare administrators having to pay a 4% Business Privilege Tax and limited taxation on non-domestic providers.

Put another way, in lieu of a 4% Business Privilege Tax not being applied, the aggregate sum of **\$1.7 Billion** equates to approximately **\$72 Million** in tax revenues not being realized by the government. (~9 Million @yr.) Further, Domestic Health Insurers continue to hold Qualifying Certificates and a Grant of Benefit pursuant to §§58105.6, 58128.4, QC Law] for ONE HUNDRED PERCENT (100%) rebates for Income Tax [§58128.4(a), QC Law], Income Tax on Dividends [§58130, 58128.4(b), QC Law], and Abatement of Gross Receipt Taxes on Premiums [§58127.5, QC Law], pursuant to which they continue to enjoy significant tax relief. Due note that with the implementation of issuing Qualifying Certificates to health care insurance providers, as well as the Captive Insurance Program pursuant to Chapter 23, Title 22, Guam Code Annotated, that the premiums for health care insurance are tax free. This has reduced the tax revenue to the government that is in need of funds for the provision of public health care services for the people of Guam.

Senator Dennis G. Rodriguez takes note of the fact that when the healthcare insurance industry utilized the benefits of the available qualifying certificates and the captive insurance program, they realized a significant financial windfall. However, he also takes due note that there were no commensurate reductions in the cost of insurance premiums passed on to consumers.

Further, *Senator Dennis G. Rodriguez* gives due consideration that of the four domestic healthcare insurance companies, they collectively maintained a significant book-of-business, allowing them for many years to make substantial profits, regardless of whether or not they paid

out Medical Loss Ratio rebates to their subscribers, and therefore, should not now be overly burdened or impacted by the application of a four percent (4%) fee upon health care insurance premiums for the purpose of establishing a Guam Health Insurance Para Todu Program, which would be utilized for the public's benefit by way of improving and supporting the government provision of health care services. Their years of exemptions from the business privilege tax have already served its stated purpose of bolstering their businesses, but unfortunately, without a reciprocal corresponding effort by them to reduce costs to their subscribers. Further, and notwithstanding the issues of tax abatements, in 2012, that at least two Guam based HMO's issued over Fourteen Million Dollars (\$14,000,000.00+) in medical loss ratio refunds to subscribers; while another issued corporate dividends, also, in the amount of approximately \$14 Million dollars.

Health Savings Account

The goal in considering a health savings account (HSA) within the proposal is to create an avenue for beneficiaries to save money to pay for medical cost. At the core of the intent is to enable the individual beneficiary to share in the cost of healthcare based on their means.

An HSA is a tax-exempt trust or custodial account set up with a qualified HSA trustee to pay or reimburse certain medical expenses incurred.

There are four federal requirements to be eligible for HSAs:

- I. A person must be covered simultaneously by a qualified "high-deductible" health insurance policy (HDHP).*
- II. For 2015, and 2016 participants in qualified HDHPs are required to pay the first \$1,300 of their medical expenses (\$2,600 for family coverage) before insurance benefits begin. (Conventional insurance plans, whose participants cannot contribute to HSAs, typically have had deductibles of about one-third to one-half these amounts; however many new health plans sold through ACA health exchanges have deductibles of \$1,000 to \$6,000 for 2014 through 2016.)*
- III. The HSA enrollee cannot be covered by any other health insurance plan, such as a spouse's plan.*
- IV. The HSA enrollee must be under age 65.*
- V. The HSA enrollee cannot be claimed as a dependent on someone else's federal income tax return.*
- VI. (IRS Tip) You are considered to be an eligible individual for the entire year if you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers). If you meet these requirements, you are an eligible individual even if your spouse has non-HDHP family coverage, provided your spouse's coverage does not cover you. There is no income, employment or other age limits in the federal law.*

A review of these requirements requires the program to use a High Deductible Health Plan (HDHP) option. We plan to set the deductible at \$1500. To meet the deductible the federal and local government will contribute \$1,000 in the 55/45 FMAP split. The employee beneficiary would be responsible for the remaining \$500. However, employee beneficiaries may earn up to \$350 in points by completing a variety of free preventive health items. For instance- completing a health risk assessment, completing a physical examination, etc. The remaining \$150 dollars would be a cash contribution via the HSA.

Federal Medicaid Contribution

Funds allocated to Guam during the PPACA process shall be used to support the Para Todu Program. These funds will be transmitted to the Government of Guam and deposited in the Fund.

Employer Contributions

Employers of beneficiaries will make payment directly to the Managed Care Organization (Insurance Company) they choose and is part of the Para Todu program.

Employee Contributions

Employers of Para Todu Program beneficiaries will set up a payroll deduction into a health savings account. Coordination with the MCO and employee is required.

Job Counseling and Referral

On request, beneficiaries of the Para Todu Program will be offered job counseling and/or referral to the Guam Department of Labor or other agency.

Healthy Behavior Incentives

A great deal of work is accomplished on Guam by collaborations between the not for profit sector, the private healthcare sector and the public health sector. One example is the Non-Communicable Disease Consortium. This organization gathers several health related not-for profit organizations together and with direct support from the Guam Department of Public Health and Social Services they develop innovative programs to decrease the incidence of NCD's on Guam. The development of any insurance expansion program will join the effort by providing incentives in the program.

Guam Insurance Commission

The Banking and Insurance Board consists of the Commissioner who is the Chairman, and nine members who are appointed by the Governor with the advice and consent of the Guam Legislature. The Banking and Insurance Board has the power to define any term as maybe reasonably necessary or appropriate for the administration of laws relating to banking and insurance in accordance with the Administrative Adjudication Act.

Given the complexity of this endeavor and future endeavors we recognize the need to strengthen the Commission. Therefore a portion of the fees collected in the Program will be allocated to this end.

Address Homeless Individual Enrollment Challenges

The Homeless population is not a specific goal or demographic in the Para Todu Program. However we understand that enrolling the homeless in any program can be difficult: they can be hard to find, hard to convince to apply, and hard to enroll because they lack such basics as a mailing address and telephone number.

Research has shown great advances in enabling patients to access many services. Of note are examples of improvements in the person's ability to work and maintain stable housing due to better management of health conditions. However this population is complex and requires special attention. One issue is transportation; another is the limited experience among providers in working with this population.

Fortunately Guam has an effective Homeless Coalition. It is our plan to collaborate with them in the development and roll out of the final plan. One such plan could be the incorporation of Presumptive Eligibility. We can authorize "qualified entities" – health care providers, community-based organizations, and schools, among others -- to screen for Medicaid and CHIP eligibility and immediately enroll people who appear to be eligible.

ETHNIC GROUP	NUMBER COUNTED
Chamorro	536
Chuukese	369
Yapese	94
Pohnpeian	81
Mixed ethnicity	66
Palauan	58
Filipino	42
Caucasian	9
Kosraean	7
Marshallese	6
Carolinian	5
African American	3
Chinese	2
Korean	2
Total	1,280

Source: 2015 Guam Homeless Point-in Time Count Report

Standard Medicaid Revision

The plan to examine transitioning away from a fee-for-service (FFS) payment and delivery system to one that relies on risk-based managed care is worth examination. Under the FFS system, beneficiaries could see any provider who accepted Medicaid, and providers are reimbursed for each individual service or visit. Under managed care, we contract with health plans to deliver Medicaid benefits to enrollees in exchange for a monthly premium, or "capitation" payment for each enrollee. The plans are accountable for and at financial risk for providing the services in the contract. Working with all plan providers initially will be essential to see if this path is viable. Current appropriation as of the 3rd Quarter 2016 is \$89,163,041 with a population served of 41,706.

Medically Indigent Program (MIP)

MIP is supported by local funds and covers eligible individuals up to 100% FPL. Government of Guam has a great deal of flexibility in modifying this program. A similar approach to the standard Medicaid transition to a managed care program is again well worth examination. The current appropriation for MIP is \$13,168,453 as of the 3rd Quarter 2016 serving a population of 11,034. In the spirit of "Buen Binidu", we propose to convert MIP into 3 programs.

Mañelu Care

The first program would be Mañelu Care. This program would mirror the existing program but be converted to a managed care methodology. During the transition specific benefits will be reviewed and adjusted to meet the current needs of this population. We anticipate the target group will remain those that fall within the 0%-100% FPL. Additional modifications to the MIP/Mañelu Care being discussed are not within the scope of this paper with the exception that follows.

Mañelu Plus

Working with representatives from our FAS/COFA neighbors we plan on providing Mañelu Plus. Mañelu Plus would expand the eligibility criteria to FAS/COFA citizens from the current maximum of 100% FPL to a level based on contributions from various FAS governments to the program up to 200% FPL. Benefits would remain the same as proffered in the Mañelu Care plan except more FAS/COFA citizens would be eligible. This approach mirrors the concept presented for the Medicaid ESI expansion plan described in this paper. The heart of the COFA agreement is to give a hand up to our neighboring islands. The citizens of our fellow islands

come to Guam seeking education and an improved lifestyle. Unfortunately, they are embroiled in politics which limit the funding for the full realization of this dream. Since 2009 they were removed from eligibility for Medicaid and thus cannot be included in the current plan presented, we look to the host nations to partner with us. Many hardworking COFA migrants contribute to the economy of Guam. However, they often fall within the minimum wage and thus are penalized by making "too much" money to qualify for current MIP (100% FPL) yet not enough to pay for a commercial plan. We believe that by partnering with the host nations to supplement our Compact Impact funding with Compact funding we can improve the health of this population.

Mañaina Care

Many of our manámko' are not eligible for Medicare or have needs that are not covered by Medicare. A core principle in our culture is respect for our elders. Mañaina Care would provide coverage to our local, US citizens over the age of 65. Specifically, coverage would be provided for skilled nursing care to take care of the special needs of the elderly. Additional coverage/benefits will be reviewed to focus on the specific needs of the over 65 population.

Aggressively address the Federal levied 2% Health Insurance Tax (HIT).

Section 9010 of the Patient Protection and Affordable Care Act (ACA) imposed a fee on each covered entity engaged in the business of providing health insurance for United States health risks. The logic behind this tax is that insurance companies will make money from increased enrollment due to the ACA, and therefore should pay more to the federal government. The Consolidated Appropriations Act of 2016, Title II, § 201, Moratorium on Annual Fee on Health Insurance Providers, suspends collection of the health insurance provider fee for the 2017 calendar year. Thus, health insurance issuers are not required to pay these fees for **2017**.

It is our position that this tax is unduly applied to the territories given the selective application of PPACA. NO territory has participated fully in PPACA due to the inconsistent rules that pertain to them. Thus, it is our position since we are challenged with sorting through the rules of PPACA and as evidenced by the lack of participation that this HIT should be returned to the territories. It is our intention to use these funds to augment our plan.

Address Medicare reimbursement for Guam.

We are keenly aware that adding ~15,000 beneficiaries to Medicaid may have an unintended consequence of exacerbating the financial condition of Guam Memorial Hospital unless we continue to work with our Congresswoman and others to bring to closure the seemingly never ending struggle for equity in Medicare reimbursements. A complete history and understanding of this issue may be found in the recently released Independent Audit for years ended September 30 2015, 2014. This audit is found at <http://www.opaguam.org/financial-audits/guam-memorial-hospital-authoritys-gmha-fy-2015-financial-audit> and provides an excellent narrative on the history and impact of this disparity.

Federal Medical Assistance Percentage

It is the intent of *Senator Dennis G. Rodriguez* to work with Congresswoman Bordallo in support of federal legislation, specifically **H.R. 2635 – Improving the Treatment of the U.S. territories Under Federal Health Programs Act of 2015**. This bill amends title XIX (Medicaid) the Social Security Act (SS Act) to terminate the limitations on general Medicaid funding, as well as the specific federal medical assistance percentage (FMAP, or matching rate), beginning FY2017 for Puerto Rico, the Virgin Islands of the United States, Guam, the Northern Mariana Islands, and American Samoa (territories).

The FMAP's for Guam and the territories are set at 55% per section 2005(c) of the Patient Protection and Affordable Care Act, P.L. 111-148. The FMAP formula

$1 - \left[\left(\frac{(\text{state per capita income})^2}{(\text{national per capita income})^2} \right) * 0.45 \right]$ is used by the 50 states. The formula **does not** determine the FMAPs for the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands; for these jurisdictions, the FMAPs are **fixed in statute**. (The FMAP for the District of Columbia is set at 70 percent per section 4725(b) of the Balanced Budget Act of 1997, P.L. 105-33.) We view this as an obvious disparity in treatment to the territories. Though grateful for the 5% increase, if the formula was applied, using 2010 per capita figures, the FMAP, using the same formula as applied to the states, would be ~95% federal match! With an upper limit set in statute of 83% Guam and the other territories still fall way short of and equitable treatment.

It is the intent of *Senator Dennis G. Rodriguez* to continue the work illuminated by Resolution 433-31 COR to address MEDICARE reimbursement disparity. To work with Congresswoman Bordallo and Governor Calvo in seeking relief of Medicare reimbursement rates under the Tax Equity and Fiscal Responsibility Act of 1982. This disparity shows that Guam Memorial Hospital is reimbursed at rates lower than the actual cost of treatment.

It is the intent of *Senator Dennis G. Rodriguez* to facilitate partnerships with local insurance carriers to provide plans under this program. This Insurance Partnership is explained below.

Senator Rodriguez takes note that the Government of Guam may lack expertise in the administration of this program and thus authorizes a contract for the use of a Billing and Enrollment Intermediary (BEI) to enroll eligible employers/employees. It will be the BEI responsibility to perform all administrative activities associated with health insurance for their client firms, including plan enrollment and billing and collection of premiums on behalf of insurance plans.

Senator Rodriguez also takes due note and anticipates the need for large-scale education and marketing of this plan within the community.

Table 1- Guam Federal Poverty Level FY 2016 Table

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

**Table 2- Per Capita Money Income, Guam
2010**

			TOTAL 118,114		
Income Category		Number	Income category		Number
0	0	33306	\$28,000	\$28,999	1456
\$1,000	\$1,999	1966	\$29,000	\$29,999	1019
\$2,000	\$2,999	1310	\$30,000	\$30,999	1856
\$3,000	\$3,999	1856	\$31,000	\$31,999	1128
\$4,000	\$4,999	1929	\$32,000	\$32,999	837
\$5,000	\$5,999	2148	\$33,000	\$33,999	801
\$6,000	\$6,999	2184	\$34,000	\$34,999	764
\$7,000	\$7,999	2111	\$35,000	\$35,999	1602
\$8,000	\$8,999	2075	\$36,000	\$36,999	1056
\$9,000	\$9,999	1674	\$37,000	\$37,999	182
\$10,000	\$10,999	2657	\$38,000	\$38,999	764
\$11,000	\$11,999	2948	\$39,000	\$39,999	728
\$12,000	\$12,999	1492	\$40,000	\$40,999	2293
\$13,000	\$13,999	2803	\$41,000	\$41,999	364
\$14,000	\$14,999	2512	\$42,000	\$42,999	910
\$15,000	\$15,999	2366	\$43,000	\$43,999	255
\$16,000	\$16,999	3895	\$44,000	\$44,999	582
\$17,000	\$17,999	2839	\$45,000	\$45,999	1092
\$18,000	\$18,999	1820	\$46,000	\$46,999	218
\$19,000	\$19,999	1929	\$47,000	\$47,999	255
\$20,000	\$20,999	2330	\$48,000	\$48,999	582
\$21,000	\$21,999	1602	\$49,000	\$49,999	328
\$22,000	\$22,999	1674	\$50,000	\$59,999	2584
\$23,000	\$23,999	1383	\$60,000	\$69,999	2475
\$24,000	\$24,999	2075	\$70,000	\$79,999	1019
\$25,000	\$25,999	1929	\$80,000	\$89,999	1092
\$26,000	\$26,999	1565	\$90,000	\$99,999	655
\$27,000	\$27,999	1347	\$100,000		1492

Souls

Light Blue	Single person, inc spread for 100% FPL	56,164
Medium Green	Single person, inc spread for 108% FPL	n/a
Light Green	Single person, inc spread for 200% FPL	26,645
Rose	Guam Median Household income level	19,109
		101,918

Table 3: Reference Information

# Uninsured	32,465
# Homeless	1,280
Number below \$11,770 or 100% FPL	56,164
Number between 108% - 200% FPL	26,645
Median Age	30
Median HH Income	\$39,052
Per Capita Income	\$12,864
Civilian Total Labor	72,070
Total Employed	66,720
Unemployed	5,350
Not in labor force	49,300
Medicaid Enrolled	41,706
MIP Enrolled	11,304
	53,010

Table 4. Impact on Uninsured

Guam Estimated Population	159,914	
# Uninsured	32,465	20.30%
Para Todu Program Estimate	15,000	9.38%
Remaining uninsured	17,465	10.92%
Percent reduction in uninsured		46.20%
Remaining uninsured percentage		10.92%

Source Pop : Guam 2013 Stat year book

Table 5. Cost Projections

Financial Projections for Para Todu expansion Program	
\$3,000	Premium
\$1,500	Deductible
\$4,500	Total Individual Cost
15,000	Estimated Eligible's
\$67,500,000	Total Estimated Program Cost
55%	Federal Contribution (FMAP)
45%	Government of Guam Contribution (FMAP)
\$37,125,000	Cost to Federal Government 55%
\$30,375,000	Cost to Government of Guam 45%
Breakdown of Government of Guam Contributions to FMAP	
\$30,375,000	Cost to Government of Guam 45%
<u>\$7,500,000</u>	Minus 500 deductible portion of employee
\$22,875,000	remainder
<u>\$14,868,750</u>	Employer Group Contribution of 65%
\$8,006,250	Remainder of Government of Guam Obligation

EMPLOYER COST FOR PROGRAM	
\$991.25	Individual Employer annual cost per person
\$82.60	monthly cost per person
\$38	bi weekly cost per person
EMPLOYEE COST FOR PROGRAM	
\$350	Number of points converted to dollars when placed in Health Savings account to be applied toward deductible
\$150	Out of Pocket cash contribution of beneficiary
\$12.50	Monthly cost to employee
\$6	bi weekly payroll deduction to H.S.A.
GOVERNMENT OF GUAM COST FOR PROGRAM	
9,000,000	4% Health Insurance Premium Fee estimated revenue
\$8,006,250	Cost to Gov Guam (see above)
\$993,750	remainder
FEDERAL GOVERNMENT PROGRAM COSTS	
\$37,125,000	Annual cost to Feds
\$168,000,000	Estimated amount remaining in ACA money for Guam
4.5	Years program could run on existing Federal allocation

Minimum Wage Increase	
2080	Hours for full time employee
\$8.25	Current Minimum Wage
\$9.25	1st increase
\$1.00	Additional amount
\$10.10	2nd increase
\$0.85	Additional amount
EMPLOYER INSURANCE COST FOR PARA TODU PROGRAM	
\$991.25	Individual Employer annual cost per person
\$82.60	monthly cost per person
\$38	bi weekly cost per person
EMPLOYER MINIMUM WAGE COST 1ST YR	
	1st year employer costs
\$2,080.00	Annual per employee
\$173.33	Monthly per employee
\$80.00	bi weekly per employee
EMPLOYER MINIMUM WAGE COST 2ND YR	
	2nd year employer incremental cost addition
\$1,768.00	Annual per employee
\$147.33	Monthly per employee
\$68.00	bi weekly per employee
EMPLOYER MINIMUM WAGE COST	
	Total Cost
\$3,848.00	Annual increase upon completion: 10.10 - 8.25
\$320.67	Monthly
\$148.00	bi weekly

Definitions, Terms and Concepts

The following definitions, terms and concepts may be used in the development of the final plan. They are provided here for reference in the development of the final plan.

Adjustment of Employer-sponsored Plans. Where employees subject to the coverage of this chapter are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the Territory and the majority of such employees are not subject to this chapter, the benefits applicable to the employees covered by this chapter shall be adjusted within one year after the effective date of this chapter so as to meet the requirements of this chapter.

Beneficiary Qualifications

To be eligible for this program a person must meet the following criteria-

- a. Be employed
- b. Be a resident of Guam and United States citizen.
- c. Have an annual total income between 108% and 200% of the FPL
- d. Employees must have been uninsured for 3 months and/or have had no employer-sponsored insurance for 6 months.**
- e. Must agree to participate in a Health Savings Account.

Beneficiary Contribution.

The employer of an eligible employee shall establish a payroll deduction process for the employee, in order to participate in a Health Savings Account.

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

Coinsurance in health insurance, coinsurance is your share of costs of the allowed amount for a covered service after you reach your deductible.

Commencement of Coverage. The employer shall provide the coverage required by this chapter for any regular employee, who has been in the employer's employ for four consecutive weeks, at the earliest time thereafter at which coverage may be provided with the prepaid health care plan contractor selected pursuant to this chapter.

Deductible your health insurance deductible is the amount you have to pay out-of-pocket for covered services before your insurance begins to pay.

Director: Enforcement The director shall administer and enforce this chapter. The director may appoint such assistants and such clerical, stenographic, and other help as may be necessary for the proper administration and enforcement of this chapter subject to any civil service act relating to Territory employees.

Director: Rulemaking and other powers . The director may adopt, amend, or repeal, such rules and regulations, as the director deems necessary or suitable for the proper administration and enforcement of this chapter. The director may round off the amounts specified in this chapter for the purpose of eliminating payments from the Para Todu fund in other than even dollar amounts or other purposes. The director may prescribe the filing of reports by prepaid health care plan contractors and prescribe the form and content of requests by employers.

Eligibility of Participating Health Care Providers. Health Care Providers (HCP) may participate in this expansion program if their practice maintains at least a 15% patient mix of standard Medicaid, Medicare and/or MIP patients.

Employer means any individual or type of organization, including any partnership, association, trust, estate, joint stock company, insurance company, or corporation, whether domestic or foreign, a debtor in possession or receiver or trustee in bankruptcy, or the legal representative of a deceased person, who has one or more regular employees in the employer's employment. "Employer" does not include:

- b. The Territory, any of its political subdivisions, or any instrumentality of the Territory or its political subdivisions;
- c. The United States government or any instrumentality of the United States;
- d. Any other Territory or political subdivision thereof or instrumentality of such Territory or political subdivision;
- e. Any foreign government or instrumentality wholly owned by a foreign government, if:
 1. The service performed in its employ is of a character similar to that performed in foreign countries by employees of the United States government or of an instrumentality thereof; and
 2. The United States Secretary of States has certified or certifies to the United States Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemption with respect to similar service performed in the foreign country by employees of the United States government and of instrumentalities thereof.

Employer Mandate. Employers of any employee meeting the beneficiary criteria must provide health insurance coverage under this plan or a similar commercially available plan.

Employee Participation. Individual employees eligible for this program are not required to participate. 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.

Employer Contribution. The employer of an eligible employee shall contribute on a monthly basis a percentage (planned 65%) of the premium for that employee to the Fund. **Employer contributions to the Fund may be included in addition to the Santos Act deduction. The specific percentage will be determined upon development of the financial projections of this plan.**

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

Excluded (employment) services.

"Employment" as defined in the definitions section does not include:

1. Service performed by an individual in the employ of an employer who, by the laws of the United States, is responsible for care and cost in connection with such service;
2. Service performed by an individual in the employ of [the] individual's spouse, son, or daughter, and service performed by an individual under the age of twenty-one in the employ of the individual's father or mother;
3. Service performed in the employ of a voluntary employee's beneficiary association providing for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or their designated beneficiaries, if:
 - a. Admission to membership in the association is limited to individuals who are officers or employees of the United States government; and

- b. No part of the net earnings of the association inures (other than through such payments) to the benefits of any private shareholder or individual;
- (1) Service performed by an individual for an employer as an insurance agent or as an insurance solicitor if all service performed by the individual for the employer is performed for remuneration by way of commission.
 - (2) Service performed by an individual for an employer as a real estate salesperson or as a real estate broker if all service performed by the individual for the employer is performed for remuneration by way of commission.
 - (3) Service performed by an individual who, pursuant to the federal Economic Opportunity Act of 1964, is not subject to the provisions of law relating to federal employment, including unemployment compensation;
 - (4) Domestic in-home and community-based services for persons with developmental and intellectual disabilities under the Medicaid home and community-based services program pursuant to title 42 Code of Federal Regulations sections 440.180 and 441.300, and title 42 Code of Federal Regulations, part 434, subpart A, as amended, or when provided through Territory funded medical assistance to individuals ineligible for Medicaid, and identified as chore, personal assistance and habilitation, residential habilitation, supported employment, respite, and skilled nursing services, as the terms are defined and amended from time to time by the department of human services, performed by an individual whose services are contracted by a recipient of social service payments and who voluntarily agrees in writing to be an independent contractor of the recipient of social service payments; and
 - (5) Domestic services, which include attendant care, and day care services authorized by the department of human services under the Social Security Act, as amended, or when provided through Territory-funded medical assistance to individuals ineligible for Medicaid, when performed by an individual in the employ of a recipient of social service payments. For the purposes of this paragraph only, a "recipient of social service payments" is a person who is an eligible recipient of social services such as attendant care or day care services.

Exemption of Certain Employees. In addition to the exemption specified above, an employer shall be relieved of the employer's duty, with respect to any employee who has notified the employer, in the form specified by the director, that the employee is:

1. Protected by health insurance or any prepaid health care plan established under any law of the United States;
2. Covered as a dependent under a prepaid health care plan, entitling the employee to the health benefits required by this chapter;
3. A recipient of public assistance or covered by a prepaid health care plan established under the laws of the Territory governing medical assistance.
4. Employers receiving notice of a claim of exemption under this section shall notify the director of such claim in the form prescribed by the director.

Exemption of followers of certain teachings or beliefs. This chapter shall not apply to any individual who pursuant to the teachings, faith, or belief of any group, depends for healing upon prayer or other spiritual means.

Freedom of Collective Bargaining. Nothing in this chapter shall be construed to limit the freedom of employees to bargain collectively for different prepaid health care coverage, if the protection provided by the negotiated plan is more favorable to the employees benefited than

the protection provided by this chapter or at least equivalent thereto, or for a different allocation of the costs thereof. A collective bargaining agreement may provide that the employer oneself undertakes to provide the health care specified in the agreement.

Individual waivers; additional withholding for dependents.

An employee may waive individually all of the required health care benefits pursuant to this chapter by:

1. Requesting the waiver in writing submitted to the employer; and
2. Receiving approval of the waiver from the director upon the director determining that the employee has other coverage under a prepaid health care plan, which provides benefits that meet the standards.
3. The employer who receives from an employee a written request for a waiver under this section shall transmit to the director a copy of the waiver; on a form prescribed by the director, and a copy of the prepaid health care plan on the basis of which the waiver is requested.
4. A waiver under this section is binding for one year and is renewable for subsequent one-year periods.
5. An employer who, directly or indirectly, coerces or attempts to coerce an employee in making a waiver under this section shall be subject to penalty.
6. An employee may not agree to pay a greater share of the premium for such benefits than is required by this chapter.
7. An employee may consent to pay a greater share of the employee's wages and to a withholding of such share by the employer for the purpose of providing prepaid health care benefits of the employee's dependents under the plan providing such benefits for the employee's self.

Joint provision of coverage. Employers may form associations for the purpose of jointly providing prepaid health care protection under this chapter for their employees with the contractors authorized to provide such coverage in the Territory.

Liability of Secondary Employer. An employer who has been notified by an employee, in the form prescribed by the director, that the employer is not the principal employer as defined shall be relieved of the duty of providing the coverage required by this chapter until the employer is notified by the employee pursuant to that the employer has become the principal employer. The employer shall notify the director, in the form prescribed by the director, that the employer is relieved from the duty of providing coverage or of any change in that status.

Non-complying employer held liable for employee's health care costs . Any employer who fails to provide coverage as required by this chapter shall be liable to pay for the health care costs incurred by an eligible employee during the period in which the employer failed to provide coverage.

Penalties. Any person who, after twenty-one days written notice and the opportunity to be heard by the director, is found to have violated any provision of this chapter or rule adopted hereunder for which no penalty is otherwise provided, shall be fined not more than \$250 for each offense. All fines collected pursuant to this chapter shall be deposited into the Para Todu fund.

Penalties; injunction. If an employer fails to comply the employer shall pay a penalty of not less than \$25 or of \$1 for each employee for every day during which such failure continues, whichever sum is greater. The penalty shall be assessed under rules and regulations promulgated by the Director and shall be collected by the Director and paid into the fund for

premium payments established by this plan. The Director may, for good cause shown, remit all or any part of the penalty.

Any employer, employee, or prepaid health care plan contractor who willfully fails to comply with any other provision of this chapter or any rule or regulation hereunder may be fined not more than \$200 for each such violation.

Any employer who fails to initiate compliance with the coverage requirements for a period of thirty days, may be enjoined by the circuit court of the circuit in which the employer's principal place of business is located from carrying on the employer's business any place in the Territory so long as the default continues, such action for injunction to be prosecuted by the attorney general or any county attorney if so requested by the director.

Premium means the amount payable to a prepaid health care plan contractor as consideration for the contractor's obligations under a prepaid health care plan.

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.

Prepaid health care plan contractor means:

1. Any medical group or organization which undertakes under a prepaid health care plan to provide health care;
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.

Presumptive Eligibility. The presumptive eligibility process includes two programs: Hospital Presumptive Eligibility (HPE) and Presumptive Eligibility (PE). With the expansion of the presumptive eligibility process to include new provider types and specialties, the process is referred to as 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 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 information is quickly assessed and a determination regarding their eligibility for coverage is made. Individuals who are found eligible have coverage starting that same day. They are given a PE Acceptance letter that serves as their proof of coverage.

Place of performance. "Employment" includes an individual's entire service, performed within or both within and without this Territory if:

1. The service is localized in this Territory; or
2. The service is not localized in any Territory but some of the service is performed in this Territory and:
 - a. The individual's base of operation, or, if there is no base of operation, the place from which such service is directed or controlled, is in the Territory; or

- b. The individual's base of operation or place from which the service is directed or controlled is not in any Territory in which some part of the service is performed but the individual's residence is in this Territory.

Required health care benefits.

The plan should follow, at a minimum, the PPACA List of Ten Essential Health Benefits. Additional benefits mandated under Guam Law may also be applied.

Required Preventive Care Benefit

Waiting to treat illness until a person is sick, instead of focusing on prevention, has had a direct effect on the rising health care costs on Guam. Many Guamanians put off seeing a doctor until it's too late due to cost. By making key preventive services free it helps Guamanians stay healthy. A doctor shouldn't be someone to see only when you're sick. Doctors also provide services that help keep you healthy (See Appendix 6)

Regular employee means a person employed in the employment of any one employer for at least twenty hours per week but does not include a person employed in seasonal employment.

Seasonal employment for the purposes of this paragraph means employment in a seasonal pursuit, by a seasonal employer during a seasonal period or seasonal periods for the employer in the seasonal pursuit or employment by an employer engaged in the cultivating, harvesting, processing, canning, and warehousing of pineapple during its seasonal periods. The director by rule and regulation may determine the kind of employment that constitutes seasonal employment.

Termination of Exemption. If an exemption, which has been claimed by an employee, terminates because of any change in the circumstances entitling the employee to claim such exemption, the employee shall promptly notify the principal employer of the termination of the exemption and the employer thereupon shall provide coverage as required by this chapter. If because of a change in the employment situation of an employee or a redetermination by an employee, a principal employer becomes a secondary employer or a secondary employer becomes the principal employer, the employee shall promptly notify the employers affected of such change and the new principal employer shall provide coverage as required by this chapter.

Wages means all remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of the individual's employer, and the cash value of all remuneration in any medium other than cash.

Appendix 1 Information on Guam Medicaid from DPHSS 2015 Annual Report

The Bureau of Health Care Financing Administration administers the following medical assistance program:

- VII. Medicaid Assistance Program (MAP), Title XIX of the Social Security Act –Initially the federal medical assistance percentage (FMAP) was 50% for both administration and payments. Effective, July 1, 2011, Medicaid FMAP is 55% as a result of Affordable Care Act (ACA). The program provides medical care for persons receiving welfare benefits and low-income individuals and families who meet the Medically Categorically Needy Expansion and New Adults Group income and resource guideline. The Federal and Local Government share the cost of the program equally.
- VIII. State Children's Health Insurance Program (SCHIP), Title XXI - SCHIP later known as Children's Health Insurance Program was established by the federal government to provide health insurance to children in families at or below 200 percent of the federal poverty line. Guam, along with the other territories, has opted to implement CHIP as an expansion to Medicaid because the initial federal allotment was inadequate to implement a stand-alone State Children's Health Insurance Program.
- IX. Medicare Modernization Act (MMA), Enhanced Allotment Plan – The Medicare Prescription Drug Improvement and Modernization Act of 2003, also known as the Medicare Modernization Act (MMA) established the Medicare Prescription Drug Program (Medicare Part D), making prescription drug coverage available to individuals entitled to Medicare Benefits under Part A or B beginning January 1, 2006. The Guam EAP grant was approved and awarded by CMS in Fiscal Year 2006 to DPHSS Guam Medicaid Program to pay for Medicare covered medications of Medicaid clients with Medicare insurance. The grant allows the use of funding for administration of the program up to 10% of the total grant award.
- X. Medically Indigent Program (MIP), P.L. 27-30 - 100% locally funded program established by P.L. 17-83 in October 1983 to provide financial assistance with health care costs to individuals who meet the necessary income, resource and residency requirements. Public Law 18-31 authorizes the Department of Public Health and Social Services, Division of Public Welfare (DPW), Bureau of Health Care Financing (BHCF) to administer the MIP. This law was revised by P.L. 27-30, which was signed into law September 30, 2003.
- XI. The Medicaid Program offers mandated services and a number of optional services such as dental, optical, pharmacy, off-island medical services, including round-trip airfare for patients referred for off- island medical treatment. Over the past years, Guam was able to receive increases in its federal grant funds brought about by a formula using the Medical Consumer Price Index for the Urban (MCPIU) poor. Additionally, Guam received funding of \$268 million beginning, July 1, 2010 that can be utilized if needed, and the local match is available. This funding is brought about by the Patient Protection Affordable Care Act (PPACA) of 2010.
- XII. The bureau amended the Medicaid State Plan based on PPACA to include childless adults. This was approved by Centers of Medicare and Medicaid Services (CMS) and

became effective on January 1, 2012. This group of clients is categorized as New Eligibility Group (ACA), which totals 4,020 in FY 2014.

The bureau continues to maintain the CHIP and EAP, which are expansions to the Medicaid Program. As such, CHIP funding is available to Regular Medicaid children and EAP is available to Medicaid and Medicare dual eligible beneficiaries for payment of prescription drugs.

Furthermore, the bureau continues to implement and administer the MIP Program, which is a 100% locally funded program despite the lack of administrative funding. The MIP Program provides inpatient and outpatient Hospital, Clinic, Laboratory, Equipment and Supplies, Prescribed Medications and other medical assistance as specified under the MIP P.L. 27-30 to low income individuals and families who are not eligible under Medicaid.

The bureau requires the full complement of thirty-one (32) budgeted full time positions or FTE's for the aforementioned programs to effectively implement benefits coordination, utilization review/quality control and claims processing, prior authorization, fiscal management and federal reporting. In Fiscal Year 2014, only twenty (22) out of thirty-two (32) positions were filled. In Fiscal year 2015, the bureau was able to add additional employees. Currently, the bureau has 28 FTE, which gave them 88% available manpower to implement the required program functions and mandates. As a result of additional staffing, the bureau is able to catch up with the review and processing of claims within 45 days processing time. Also, the Bureau continuously maintains its zero federal program single audit findings.

Provided below are tables of total Medicaid caseloads and the number of eligible beneficiaries to whom we provide with full array of medical, social, and related health care services from FY 2011 to FY 2015.

Program	Number of Caseload				
	FY2011	FY 2012	FY 2013	FY2014	FY 2015
Medicaid Program (MAP)	11,935	14,675	16,693	17,186	16,739
Medically Indigent Program (MIP),	9,156	8,659	6,785	6,454	6,227
Total	21,091	23,334	23,478	23,640	22,966

FIVE-YEAR EXPENDITURE BY PROGRAM

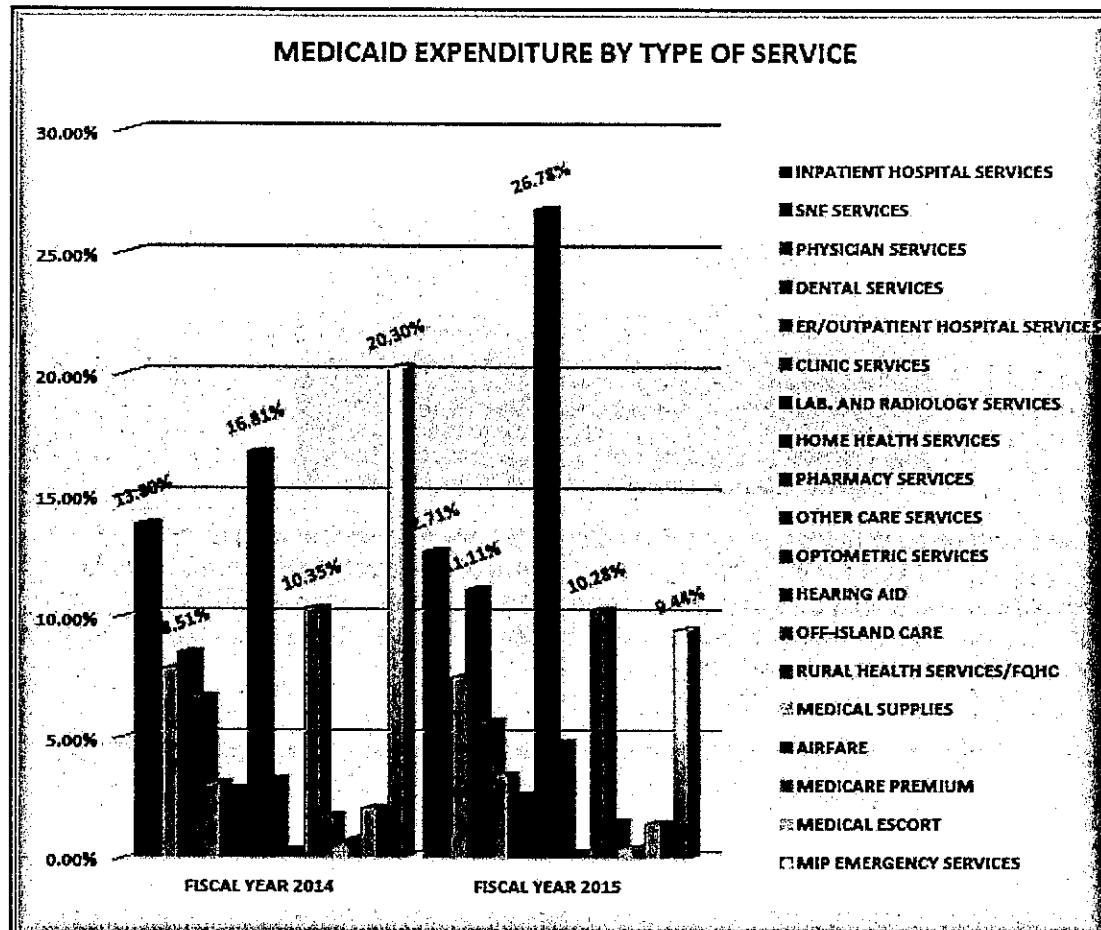
Program	Expenditures				
	FY2011	FY 2012	FY 2013	FY2014	FY 2015
Medicaid Program (MAP)	\$26,315,501	\$24,565,396	\$24,872,727	\$25,143,635	\$25,506,993
Enhanced Allotment Plan (EAP)	\$ 797,859	\$ 1,402,143	\$1,405,630	\$1,335,320	\$1,375,872
Children's Health Insurance Plan (CHIP)	\$ 6,427,134	\$ 6,364,832	\$ 6,354,278	\$7,030,791	\$8,427,445
ARRA/ACA Medicaid Program	\$ 3,535,785	\$14,545,012	\$33,636,330	\$46,842,871	\$46,286,117
Medically Indigent Program (MIP),	\$15,628,000	\$12,100,755	\$ 9,471,696	\$9,486,159	\$10,651,693
MIPPR Cancer	\$-	\$ 604,285	\$ 589,817	\$283,270	\$420,021
Total	\$52,704,279	\$59,582,423	\$76,330,478	\$92,122,047	\$92,668,141

The above expenditure is based on the local appropriation. It does not reflect the actual provider claims for the year. The federal funding drawdown is dependent on the available of local match. Any unpaid services incurred during the prior year are carried over to the next fiscal year.

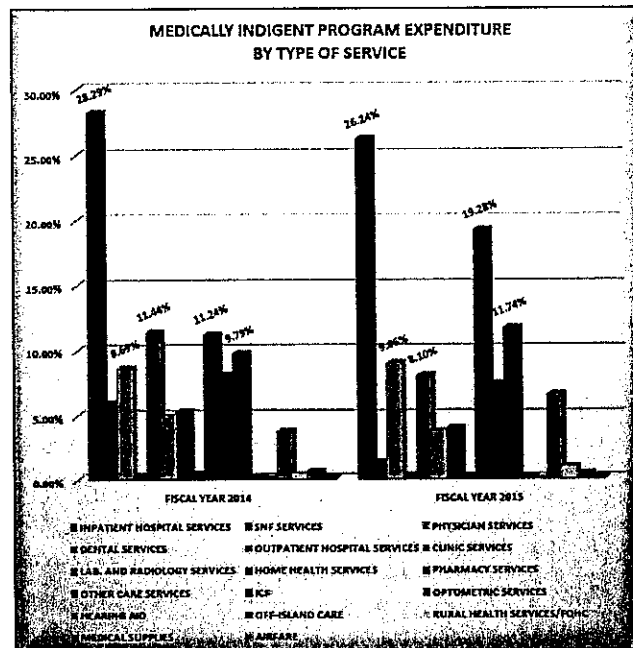
Program	Number of Eligible Beneficiaries				
	FY2011	FY 2012	FY 2013	FY2014	FY 2015
Medicaid Program (MAP)	35,702	40,433	43,969	44,528	44,033
Medically Indigent Program (MIP),	14,876	14,375	12,800	12,471	12,033
Total	50,578	54,808	56,769	56,999	56,066

The number of Medicaid and MIP eligible beneficiaries decreased by 1.11% and 3.51%, respectively in fiscal year 2015 as compared to fiscal year 2014. This decrease in number of

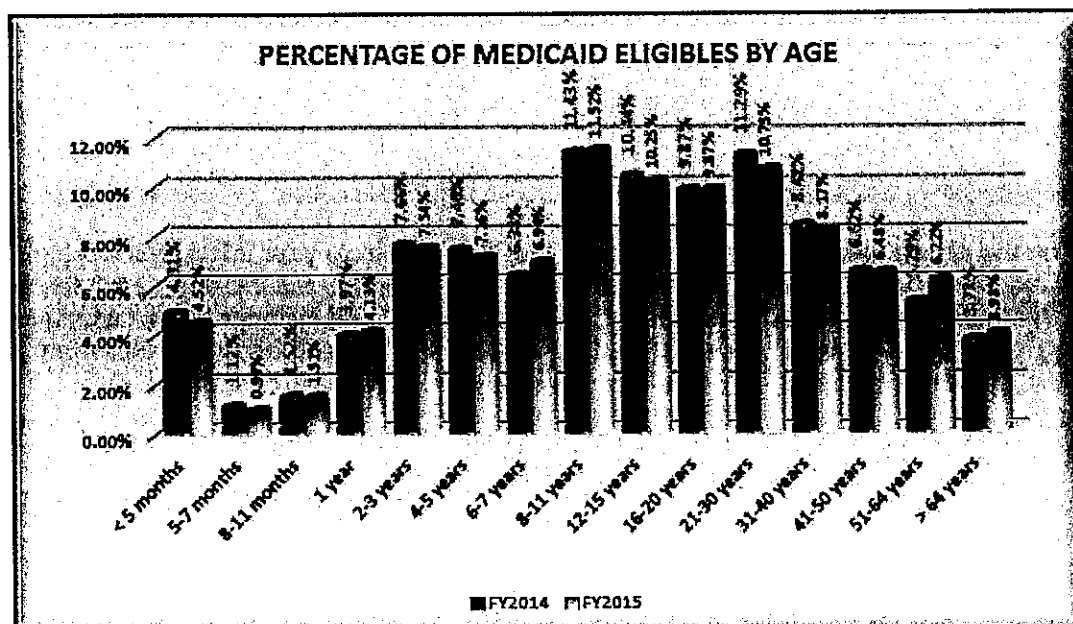
eligible beneficiaries can be attributed to the increase in Guam Minimum Wage and the decrease in unemployment rate. Provided below is the ranking of Medicaid and MIP expenditures in percentage by type of services. The data below is based on the provider submission of claims. The Medicaid and MIP has one year billing limitation within which the program can process claims and reimburse providers for services rendered to program recipients.

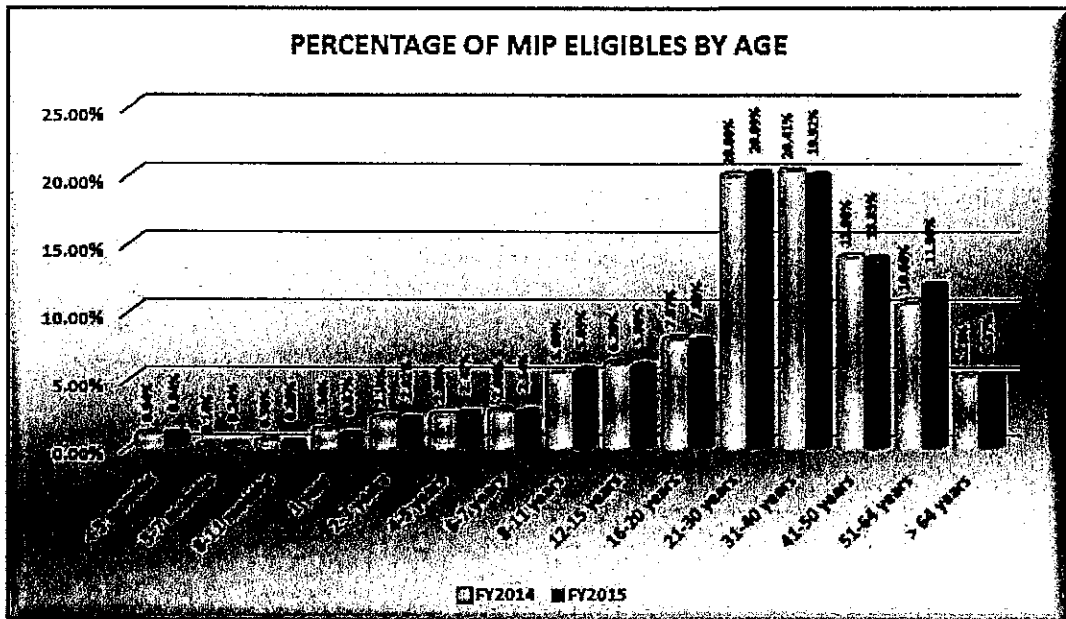


Based on the above graph, pharmacy services (26.78%) for fiscal year 2015 rank the highest cost among the type of services rendered to clients. This is due to the increasing prices of drugs for the treatment of disease such as cancer, HIV, hepatitis C, and hemophilia. An example of this drug is "sofosbuvir" which cost \$113,400 for a standard 12-week course of treatment for hepatitis C. That breaks down to \$1,350 per pill based on acquisition cost, taken daily. Next to pharmacy services in ranking are the inpatient services (12.71%), followed by dental services (11.11%) and ER/outpatient service (10.28%).



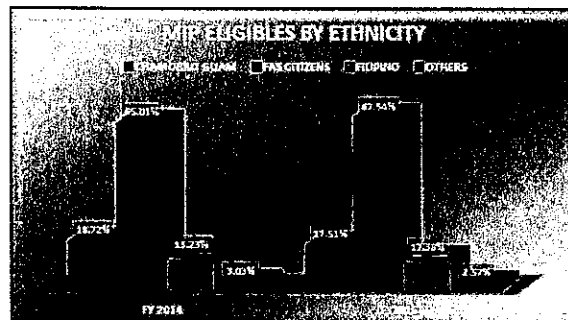
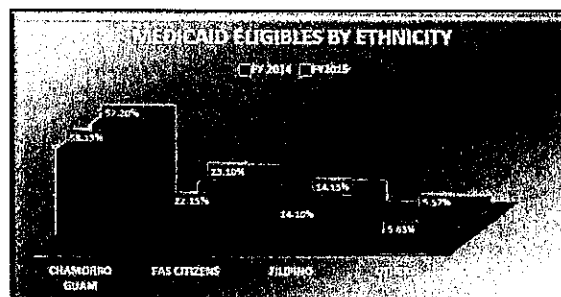
The graph above showed that inpatient services (26.24%) are the highest cost of medical service for clients under MIP for FY 2015. However, some of the inpatient services are now being charged as an allowable cost under Medicaid Program, categorized as MIP Emergency services for undocumented aliens. This is followed by pharmacy services (19.28%), ICF level of care (11.74%), and physician services (9.05%).



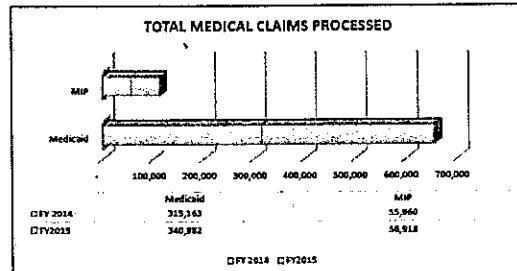


The age percentages of MIP Clients above age 21 are higher in comparison to Medicaid Program because more than 50% of clients under MIP are FAS citizens who are not qualified under Medicaid.

The graph below showed that the highest ethnic group of eligible beneficiaries under the Medicaid Program is Chamorro, which constitutes an average of 58 % of the total Medicaid population, followed by FAS Citizens. Under MIP, the FAS Citizens rank number one (1) as the highest percentage of eligible beneficiaries followed by Chamorro. The combined total Medicaid and MIP eligible beneficiaries are 28% of the total population in Guam based on FY 2010 Census.



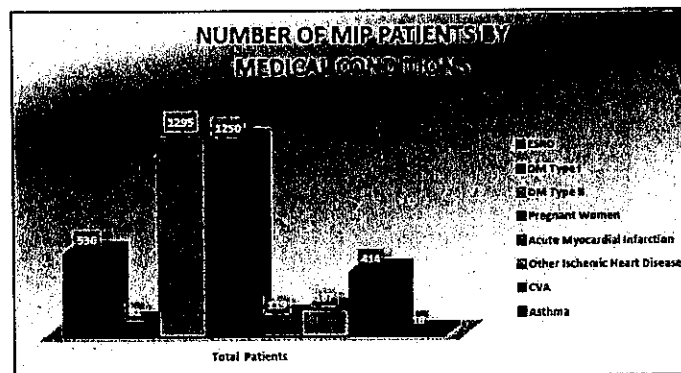
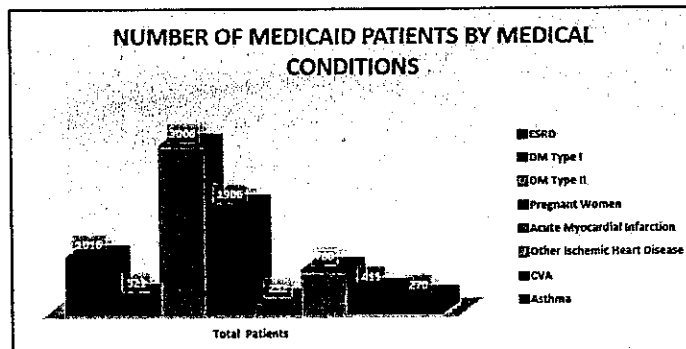
The total number of Medicaid and MIP claims processed in FY 2015 is 8.16% and 1.71% higher in comparison with FY 2014, respectively. This could be attributed to the additional staff that the bureau hired in FY 2015. As a result of additional staff, the bureau was able to alleviate the backlog on claims processing.



The medical condition data is based on claims submitted and processed for FY 2015. Based on the total number of Medicaid eligible beneficiaries (44,033), patients with diabetes mellitus Type II was 6.83% of the total population of Medicaid and the total number of women who underwent prenatal care was 4.33%.

Whereas under MIP the total number of patients with diabetes mellitus Type II and women who underwent prenatal care were 10.76% and 10.39% of the total MIP eligible beneficiaries (12,033), respectively.

Based on the statistics provided, there are more diabetic patients under MIP than Medicaid Program. This may be attributed to the higher income eligibility requirements of MIP for clients afflicted with diabetes. Women of childbearing age are also higher under MIP. This may be due to the influx of FAS citizens who are not qualified under Medicaid.

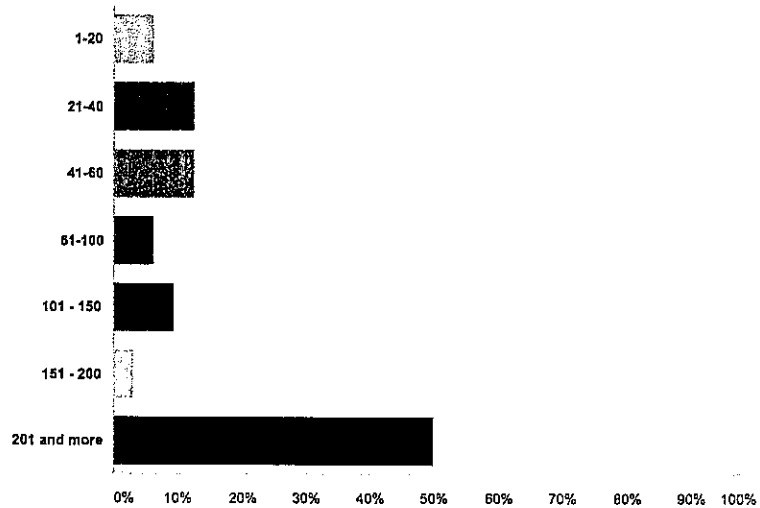


Appendix 2 Society of Human Resource Manager Survey Results

Employer Insurance Mandate Survey

Q1 How many employees do you have?

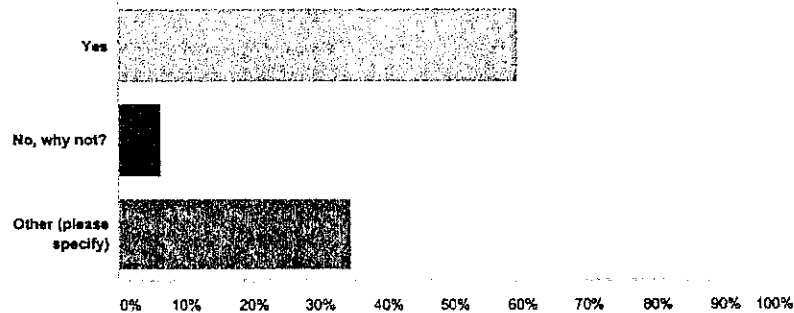
Answered: 32 Skipped: 0



Answer Choices	Responses	
1-20	6.25%	2
21-40	12.50%	4
41-60	12.50%	4
61-100	6.25%	2
101 - 150	9.38%	3
151 - 200	3.13%	1
201 and more	50.00%	16
Total		32

Q2 Does your company offer health insurance to all employees?

Answered: 32 Skipped: 0

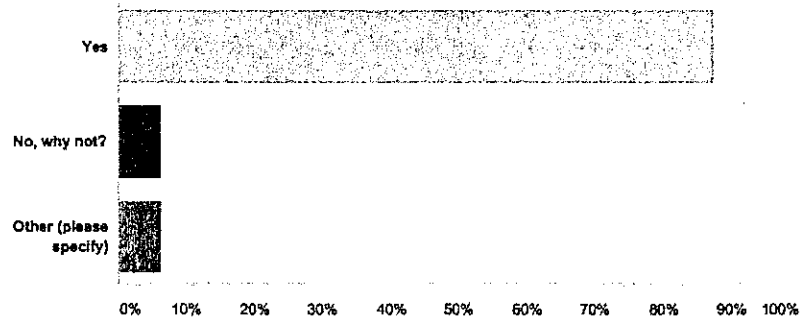


Answer Choices	Responses	
Yes	59.38%	19
No, why not?	6.25%	2
Other (please specify)	34.38%	11
Total		32

#	Other (please specify)	Date
1	Temporary, part-time (less than 30 hours per week) or on-call employees are not eligible. 85% of our employees are eligible.	8/4/2016 12:14 PM
2	All full time employees (defined as working an average of 30 or more hours per week).	7/28/2016 6:41 PM
3	All regularly employed staff are offered health insurance options	7/28/2016 2:24 PM
4	Small, new office with a limited budget.	7/28/2016 1:56 PM
5	All FTs are offered but not PTs	7/28/2016 1:34 PM
6	We offer health insurance to Full Time and Part Time employees. Temporary, Casual and On Call employees are not offered health insurance.	7/28/2016 1:23 PM
7	Self Employed and mostly retired. Have Medicare	7/28/2016 12:49 PM
8	Only full-time employees	7/28/2016 12:04 PM
9	Government of Guam Health Insurance	7/28/2016 11:57 AM
10	Health insurance is only offered to Full Time employees.	7/28/2016 11:53 AM
11	all full time employees effective upon hire	7/27/2016 9:06 AM

Q3 Does your company offer health insurance to dependents?

Answered: 32 Skipped: 0

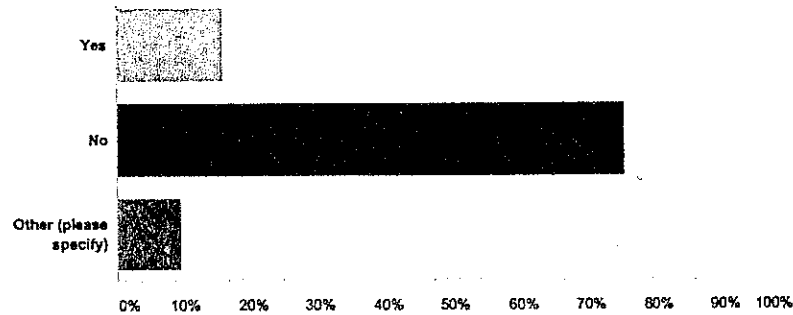


Answer Choices		Responses	
Yes		87.50%	28
No, why not?		6.25%	2
Other (please specify)		6.25%	2
Total			32

#	Other (please specify)	Date
1	Self Employed and mostly retired. Have Medicare. No employees	7/28/2016 12:49 PM
2	for manager's only	7/28/2016 12:25 PM

Q4 Does your company only offer health insurance to employee dependents if they are married?

Answered: 32 Skipped: 0

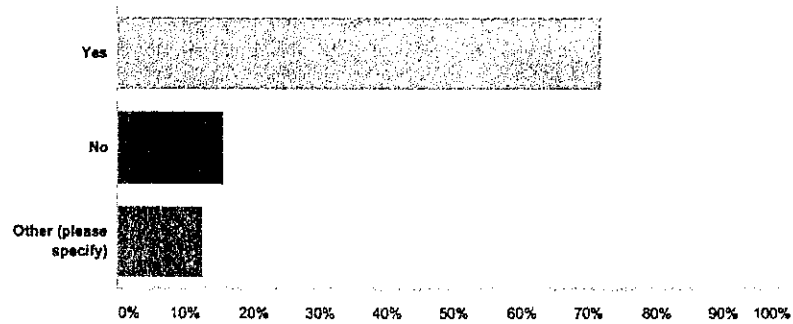


Answer Choices		Responses	
Yes		15.63%	5
No		75.00%	24
Other (please specify)		9.38%	3
Total			32

#	Other (please specify)	Date
1	We honor common-law arrangements with documentation (affidavit) as per insurance company policy.	8/4/2016 12:14 PM
2	Common law accepted	7/28/2016 6:41 PM
3	Self Employed and mostly retired. Have Medicare. No employees	7/28/2016 12:49 PM

Q5 Does your company offer health insurance to employee dependents who are domestic partner?

Answered: 32 Skipped: 0

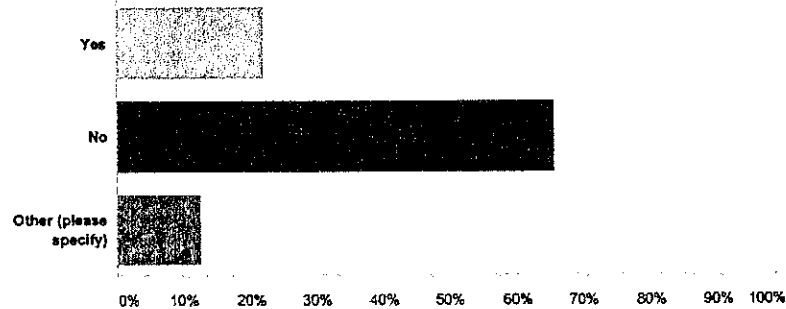


Answer Choices		Responses	
Yes		71.88%	23
No		15.63%	5
Other (please specify)		12.50%	4
Total			32

#	Other (please specify)	Date
1	Dependents must meet the criteria as set forth in the plan coverage, employee's own child/adopted, legal guardian	8/17/2016 2:26 PM
2	We allow all who qualify as dependents by the insurance carrier	7/28/2016 1:34 PM
3	Self Employed and mostly retired. Have Medicare. No employees	7/28/2016 12:49 PM
4	significant other as long as a common law affidavit is notarized	7/27/2016 9:06 AM

Q6 Does your company cover health insurance cost at 100% for all employees?

Answered: 32 Skipped: 0

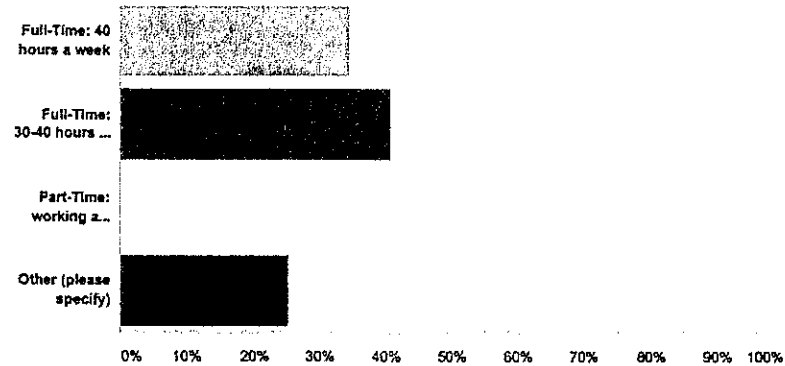


Answer Choices		Responses	
Yes		21.58%	7
No		65.63%	21
Other (please specify)		12.50%	4
Total			32

#	Other (please specify)	Date
1	Our company pays 100% of the premiums for Full Time employees. For Part Time employees, they pay 100% of the premiums, at group rates, through payroll deductions.	7/28/2016 1:23 PM
2	Self Employed and mostly retired. Have Medicare. No employees	7/28/2016 12:49 PM
3	Admin employees are covered 100% on the LOWEST Plan only (Medical w/o Dental)	7/28/2016 12:00 PM
4	Government of Guam Health Insurance	7/28/2016 11:57 AM

Q7 Does your company offer health insurance to: Please check all that apply

Answered: 32 Skipped: 0



Answer Choices		Responses	
Full-Time: 40 hours a week		34.38%	11
Full-Time: 30-40 hours a week		40.63%	13
Part-Time: working a minimum of 20 hours a week		0.00%	0
Other (please specify)		25.00%	8
Total			32

#	Other (please specify)	Date
1	PT and FT employees are offered	7/28/2016 2:24 PM
2	Per above we don't offer any	7/28/2016 1:58 PM
3	The survey does not allow you to click on more than one answer. We offer health insurance to all of the above.	7/28/2016 1:23 PM
4	Full-time employees receive company-share. Part-time employees do not.	7/28/2016 1:03 PM
5	Self Employed and mostly retired. Have Medicare. No employees	7/28/2016 12:49 PM
6	Health insurance is offered to all employees, except temporary employees.	7/28/2016 12:30 PM
7	We offer to full-time - 33-40 hrs/week and Part-time: 20-32 hrs/week (won't allow me to check all that apply)	7/28/2016 12:26 PM
8	Full-time 32 hours or more a week	7/28/2016 12:00 PM

Q8 What percentage of your employees are:

Answered: 32 Skipped: 0

Answer Choices		Responses	
Full-Time		100.00%	32
Part-Time		65.63%	21

#	Full-Time	Date
1	100	8/17/2016 2:26 PM
2	85%	8/4/2016 12:14 PM
3	91%	8/3/2016 11:45 AM
4	100	8/2/2016 10:01 AM
5	85	7/31/2016 1:38 PM
6	99	7/30/2016 5:56 AM
7	100%	7/29/2016 12:09 PM
8	80%	7/28/2016 6:41 PM
9	100	7/28/2016 5:38 PM
10	40%	7/28/2016 4:16 PM
11	100%	7/28/2016 3:36 PM
12	100	7/28/2016 2:38 PM
13	100%	7/28/2016 2:30 PM
14	89%	7/28/2016 2:24 PM
15	75	7/28/2016 2:01 PM
16	50%	7/28/2016 1:56 PM
17	65%	7/28/2016 1:40 PM
18	70	7/28/2016 1:34 PM
19	84%	7/28/2016 1:23 PM
20	95%	7/28/2016 1:15 PM
21	80	7/28/2016 1:03 PM
22	0	7/28/2016 12:49 PM
23	90%	7/28/2016 12:45 PM
24	96%	7/28/2016 12:30 PM
25	70.5	7/28/2016 12:26 PM
26	95%	7/28/2016 12:25 PM
27	75	7/28/2016 12:04 PM
28	Around 85%	7/28/2016 12:00 PM
29	100%	7/28/2016 11:58 AM
30	100%	7/28/2016 11:57 AM
31	89	7/28/2016 11:53 AM
32	80	7/27/2016 9:08 AM

#	Part-Time	Date
1	3% part-time, 8% on-call, 4% temporary	8/4/2016 12:14 PM
2	9%	8/3/2016 11:45 AM
3	15	7/31/2016 1:38 PM
4	1	7/30/2016 5:56 AM
5	20%	7/28/2016 6:41 PM
6	60%	7/28/2016 4:16 PM
7	11%	7/28/2016 2:24 PM
8	25	7/28/2016 2:01 PM
9	50%	7/28/2016 1:56 PM
10	35%	7/28/2016 1:40 PM
11	30	7/28/2016 1:34 PM
12	6%	7/28/2016 1:23 PM
13	5%	7/28/2016 1:15 PM
14	20	7/28/2016 1:03 PM
15	0	7/28/2016 12:49 PM
16	10%	7/28/2016 12:45 PM
17	4%	7/28/2016 12:30 PM
18	29.5	7/28/2016 12:26 PM
19	5%	7/28/2016 12:25 PM
20	Around 15%	7/28/2016 12:00 PM
21	11	7/28/2016 11:53 AM

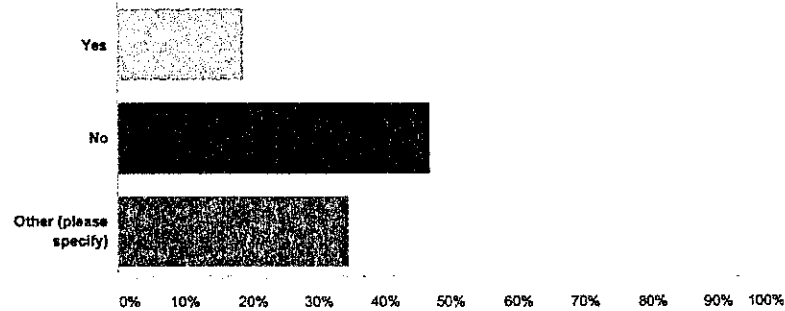
Q9 What are some reasons that your company may not offer health insurance to all employees?

Answered: 32 Skipped: 0

#	Responses	Date
1	At this time, there is no reason.	8/17/2016 2:26 PM
2	Less contribution to company's revenue. Note, those not eligible for health insurance do have other benefits (life insurance at no cost, free meals, gasoline discount, etc.)	8/4/2016 12:14 PM
3	If they are on a part-time basis.	8/3/2016 11:45 AM
4	We offer to all	8/2/2016 10:01 AM
5	cost	7/31/2016 1:38 PM
6	Na	7/30/2016 5:58 AM
7	no benefit for part time workers	7/29/2016 12:09 PM
8	Cost versus their contribution to the business	7/28/2016 6:41 PM
9	We offer health insurance to all employees. They may cover their children if they wish.	7/28/2016 5:38 PM
10	temporary or part time that do not have this benefit	7/28/2016 4:16 PM
11	not available to temporary employees and part time employees.	7/28/2016 3:36 PM
12	Unpaid leave	7/28/2016 2:38 PM
13	we offer to all employees	7/28/2016 2:30 PM
14	all regularly staffed employees are offered insurance	7/28/2016 2:24 PM
15	employee partner's employer may provide coverage military retirees may have other coverage	7/28/2016 2:01 PM
16	Budget	7/28/2016 1:56 PM
17	They are on part time basis.	7/28/2016 1:40 PM
18	Part time status	7/28/2016 1:34 PM
19	Some employees are hired on a Temporary, Casual or On Call basis and therefore not entitled to benefits based on our company's policy. Employees in these classifications do not work regularly enough to receive the full range of benefits offered to Part Time and Full Time employees.	7/28/2016 1:23 PM
20	Temporary Part-time & Seasonal Employees	7/28/2016 1:15 PM
21	n/a	7/28/2016 1:03 PM
22	NA	7/28/2016 12:49 PM
23	Our part-time employees work less than 10 hours per week.	7/28/2016 12:45 PM
24	Our company offers health insurance to all employees.	7/28/2016 12:30 PM
25	none	7/28/2016 12:26 PM
26	cost; many are younger workers still under parental health care coverage	7/28/2016 12:25 PM
27	Some do not earn enough hours to pay for their share of the coverage.	7/28/2016 12:04 PM
28	Costs for both employer and the employees (cost of insurance will depend on the plan coverage); employment status or capacity to pay for employee	7/28/2016 12:00 PM
29	N/A	7/28/2016 11:58 AM
30	Government of Guam Health Insurance	7/28/2016 11:57 AM
31	Part Time employees are ineligible for benefits.	7/28/2016 11:53 AM

Q10 Would you support mandatory health insurance coverage?

Answered: 32 Skipped: 0



Answer Choices		Responses	
Yes		18.75%	6
No		46.88%	15
Other (please specify)		34.38%	11
Total			32

#	Other (please specify)	Date
1	We do what we can to take care of our employees. We do not need mandates to do this, but understand that not all companies feel the same, thus requiring mandates.	8/2/2016 10:01 AM
2	Depends on the type of plan	7/29/2016 12:09 PM
3	Need more details in order answer this question!	7/28/2016 6:41 PM
4	I would for regular staff only	7/28/2016 2:24 PM
5	In today's competitive world, many companies already offer insurance to their employees in order to attract and retain talent. Personally, I don't think it's necessary to make it mandatory. Instead of placing more mandates on employers, I personally think more mandates should be placed on the health insurance industry to provide more affordable coverage.	7/28/2016 1:23 PM
6	Self Employed and mostly retired. Have Medicare. No employees	7/28/2016 12:49 PM
7	No sure at this time. It would dependent on what the cost of mandatory health insurance will be for the employer and what type of coverage would be mandatory.	7/28/2016 12:45 PM
8	Not all employers can afford to do so	7/28/2016 12:04 PM
9	It will depend on the features of the program. It should have guidelines that will protect both employees and employers.	7/28/2016 12:00 PM
10	Government of Guam Health Insurance	7/28/2016 11:57 AM
11	unsure if the company can afford the coverage	7/27/2016 9:06 AM

Appendix 3: Quality of Care in the US Territories

Quality of Care in the US Territories

Dr Marcella Nunez-Smith, MD, MHS, Dr Elizabeth H. Bradley, PhD, Dr Jeph Herrin, PhD, Dr Calie Santana, MD, MHS, Dr Leslie A. Curry, PhD, MPH, Dr Sharon-Lise T. Normand, PhD, and Dr Harlan M. Krumholz, MD,

Background

Health care quality in the US territories is poorly characterized. We used process measures to compare the performance of hospitals in the US territories and in the US states.

Methods

Our sample included nonfederal hospitals located in the United States and its territories discharging Medicare fee-for-service (FFS) patients with a principal discharge diagnosis of acute myocardial infarction (AMI), heart failure (HF), or pneumonia (PNE) (July 2005–June 2008). We compared risk-standardized 30-day mortality and readmission rates between territorial and stateside hospitals, adjusting for performance on core process measures and hospital characteristics.

Results

In 57 territorial hospitals and 4799 stateside hospitals, hospital mean 30-day risk-standardized mortality rates were significantly higher in the US territories ($P < .001$) for AMI (18.8% vs. 16.0%), HF (12.3% vs. 10.8%), and PNE (14.9% vs. 11.4%). Hospital mean 30-day risk-standardized readmission rates (RSRRs) were also significantly higher in the US territories for AMI (20.6% vs. 19.8%; $P = .04$), and PNE (19.4% vs. 18.4%; $P = .01$) but was not significant for HF (25.5% vs. 24.5%; $P = .07$). The higher risk-standardized mortality rates in the US territories remained statistically significant after adjusting for hospital characteristics and core process measure performance. Hospitals in the US territories had lower performance on all core process measures ($P < .05$).

Conclusions

Compared with hospitals in the US states, hospitals in the US territories have significantly higher 30-day mortality rates and lower performance on every core process measure for patients discharged after AMI, HF, and PNE. **Eliminating the substantial quality gap in the US territories should be a national priority.**

The United States has jurisdiction over several unincorporated territories, including the Commonwealth of Puerto Rico, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the US Virgin Islands. These US territories are home to almost 5 million residents, almost all of whom self-identify as racial/ethnic minorities.¹

Despite a national commitment to eliminate health disparities, the territories are largely absent in national reports of health care equity and quality.^{2–4} Studies about hospital quality of care in the US typically exclude hospitals in the US territories or combine them with other US regional areas, masking potential differences between quality of care between the territories and states.⁵

The recent initiatives by the Centers of Medicare & Medicaid Services (CMS) to measure hospital outcomes (i.e., short-term mortality and readmission rates) and hospital processes of care (i.e., performance on a set of core process measures) for 3 acute conditions—acute

myocardial infarction (AMI), heart failure (HF), and pneumonia (PNE)—provide an opportunity to assess the overall quality of care in the territories.⁶ We sought to compare performance on the outcome and core process measures between hospitals in the US territories and those located in the US states. We also investigated whether hospital characteristics and core process measures accounted for differences in performance on outcome measures.

METHODS

STUDY COHORT

The study cohort included hospitals in the US territories and in the US states, inclusive of the District of Columbia, that discharged at least 1 Medicare fee-for-service (FFS) adult patient with a primary diagnosis of AMI, HF, or PNE between July 2005 and June 2008. Additional patient inclusion criteria included at least 12 months of continuous Medicare FFS coverage prior to the index admission in order to accurately capture patient comorbidity. We randomly selected 1 admission per year for patients with multiple admissions for the same diagnosis within any study year. Patients transferred between hospitals were assigned to the referring hospitals. Diagnosis was based on *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* diagnostic codes (eTable; <http://www.archinternmed.com>).

PERFORMANCE MEASURES

We included 2 types of performance measures, outcome measures and core process measures. The outcome measures included the hospital-specific 30-day risk-standardized rates for all-cause mortality (RSMR) and for all-cause readmission (RSRR), which were developed for CMS and endorsed by the National Quality Forum.^{7, 8} These rates are derived from CMS administrative data and have previously been demonstrated to produce estimates that are reliable approximations of models based on medical records; the detailed method for the derivation and validation of risk-standardized mortality and readmission rates included territorial data and is published elsewhere.^{9–14} Briefly, the risk-standardized rates are determined for each hospital and condition (AMI, HF, and PNE) by dividing the predicted number of deaths or readmissions by the expected number and multiplying this ratio by the national unadjusted 30-day mortality or 30-day readmission rate for the particular condition.

We also examined core process measures, which are publicly reported, evidence-based standards of care specific to each condition. Hospitals receive a financial incentive to voluntarily submit these data to the Hospital Quality Alliance; these data are reported publicly in the CMS Hospital Compare database. We used the CMS Hospital Compare database, based on medical records and administrative databases covering July 1, 2005, to June 30, 2008, for information about performance on AMI, HF, and PNE core process measures.¹⁵ Hospital performance for each outcome and process measure is determined using varying numbers of admissions within each hospital and, therefore, is based on different condition-specific patient populations. The method for the calculation of each core process measure is detailed elsewhere.¹⁶ Core process measures for AMI comprised appropriate angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker prescription at discharge, smoking cessation advice, aspirin at admission, aspirin at discharge, β -blocker at discharge, percutaneous coronary intervention for less than 90 minutes, and fibrinolytic therapy for less than 30 minutes). Quality measures for HF comprised appropriate angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker prescription at discharge, discharge instructions, smoking cessation advice, and assessment of left ventricular ejection fraction. Quality measures for PNE comprised influenza and pneumococcal vaccination, initial antibiotics within 6 hours, oxygenation assessment at admission, smoking cessation advice, most appropriate initial antibiotic, and blood culture in the emergency department.

TERRITORIES

The US territories included the 4 organized insular areas of the United States: Puerto Rico,

Guam, the Northern Mariana Islands, and the US Virgin Islands. An organized territory differs from a state in the allowance for relatively limited self-government under Organic Acts (formal congressional legislation to organize local government); ultimate authority is held by the US Congress, not the territorial government.¹⁷ Residents in these 4 territories are US citizens by birth. We also included American Samoa, an unorganized insular area of the United States. American Samoa is technically unorganized because it does not have an Organic Act despite having limited self-government; residents here are US nationals by birth and have to apply for US citizenship. We excluded territories that do not have civilian hospitals because they are uninhabited or only inhabited by military personnel or a small number of people with caretaking responsibilities for the island.

The US territories are largely viewed as 1 collective for the purpose of federal government policies but differ in population size and composition.¹⁸ American Samoa is the smallest territory by population with approximately 57 000 residents, most of whom (92%) self-identify as native Hawaiian and other Pacific Islander. Residents of the Northern Mariana Islands (population, n=69 000) primarily identify as Asian (55%), specifically Chinese or Filipino, or native Hawaiian and other Pacific Islander (32%). Guam (population, n=155 000) residents, similarly, identify as Asian (33%) or native Hawaiian and other Pacific Islander (45%). The US Virgin Islands has a population of 108 000, and 76% of residents identify as black or African American. Puerto Rico is the largest territory, with a population of 3.9 million; most people who reside in Puerto Rico identify as white (81%) and Hispanic (99%).

HOSPITAL CHARACTERISTICS

Hospital characteristics were derived from the 2007 American Hospital Association (AHA) Survey and selected based on findings from earlier work.^{19–22} We assessed the number of total staffed beds (≤ 50 , 51–100, 101–200, 201–300, and >300), ownership type (government owned, private not-for-profit, and private for-profit), cardiac facilities (no catheterization laboratory, catheterization laboratory but no open heart surgery, open heart surgery, unknown cardiac facilities), and The Joint Commission accreditation status (yes or no). We used CMS data to calculate the Medicare diagnosis-specific 3-year volume using the number of patients reported for each of the 3 mortality measures, categorized as quintiles of discharges (≤ 15 , 16–45, 46–150, 151–480, and >480).

STATISTICAL ANALYSIS

We described the distribution of patient-level characteristics including medical history and co-existing conditions across the cohort stratified by condition and location in the US states or in the US territories. In contrast, the hospital was the unit of analysis for all subsequent analyses. We compared hospital characteristics between hospitals located in the territories and those in the states using χ^2 tests among the subset of hospitals we could match with the AHA survey data. We compared core process measures and 30-day RSMRs and 30-day RSRRs for all reporting hospitals in the territories and in the states using linear regression, weighted for the hospital 3-year volume of the corresponding outcome measure (RSMR or RSRR), including an indicator for either all territories combined or separate indicators for Puerto Rico and the other territories; we report the corresponding Wald test statistic. Our early analyses demonstrated we could combine these 3 years of data because differences by territorial or stateside location did not vary significantly by year. We used box and whisker plots to illustrate the differences in RSMRs and RSRRs between hospitals in the territories and hospitals in the states.

We next used this AHA-matched group in multivariable analyses. We estimated similarly weighted linear regression models using mean RSMRs and RSRRs for hospitals in the AHA-matched group as our dependent variables and territory status as the independent variable; we included hospital core process measures and hospital structural characteristics as covariates. We included hospital core process measures in the final regression models to assess whether differences in process measure performance could account for any observed differences in the outcomes of interest; we included hospital structural characteristics based on previously

published work.^{19–23} We excluded percutaneous coronary intervention less than 90 minutes from multivariable analyses because fewer than 10% of hospitals in the US territories reported this measure. We chose 2 different strategies to handle missing data. In multivariable models, indicator variables were included for missing hospital characteristics (i.e., ownership and cardiac facilities) and multiple imputation was used to account for missing performance measures.²⁴ We used 2 approaches because the missing hospital characteristics data were typically missing for the same set of hospitals (e.g., not missing at random). For multiple imputation, we generated 20 imputed data sets for each outcome measure using linear regression of performance measures against the outcome measure and hospital characteristics; we then estimated the model on each of the 20 data sets and combined the results to produce a single set of estimates for the coefficients and standard errors.^{25–27} We repeated these analyses with data from the hospitals in Puerto Rico separated from the other territories to assess potential inter-territorial differences. All analyses were performed using SAS version 9.1 (SAS Institute Inc, Cary, North Carolina) and Stata 11 (StataCorp, College Station, Texas, 2009) statistical software.

RESULTS

HOSPITAL SAMPLE

The total sample included 4856 hospitals, 57 in the territories and 4799 in the states, reporting at least 1 admission for 1 of the 3 diagnoses over the study period. The total patient numbers for each outcome measure and geographic area are reported along with characteristics of the corresponding patient samples (Table 1). For the multivariable analyses, we excluded 204 hospitals in the US states and 4 hospitals in Puerto Rico because they could not be matched to the AHA survey data; therefore, these models included 53 hospitals in the territories and 4595 hospitals in the states.

Variable	AMI		Heart Failure		PNE	
	States	Territories	States	Territories	States	Territories
Total No. of patients	153	3695	183	2739	1154	41
Total No. of hospitals	4799	57	4799	57	4799	5
Demographics						
Age (mean [SD])	75.3 (8.1)	76.2 (7.9)	76.8 (7.7)	77.6 (7.7)	80.8 (7.8)	78.4 (8.4)
Male %	48.1	53.7	49.3	50.2	47.4	48.2
Cardiovascular						

Table 1

Patient Demographic Characteristics, Cardiovascular Medical History, and Comorbid Conditions for Fee-for-Service Medicare Beneficiaries Admitted for AMI, HF, and PNE (July 2005–June 2008), Stratified by Condition and Hospital Location in the US ...

HOSPITAL STRUCTURAL CHARACTERISTICS IN US TERRITORIES AND US STATES

The hospitals in the US territories differed significantly from hospitals in the US states on several structural characteristics (Table 2). Compared with the hospitals in the states, hospitals in the territories had fewer staffed beds, lower condition-specific volume over the study period, more for-profit ownership (relative to government or private not-for-profit ownership), and higher number of hospitals missing data on cardiac intervention facilities (vs. having open heart surgery facilities, having interventional catheterization laboratory facilities only, or having no open heart catheterization facilities) ($P < .001$). Although The Joint Commission accredited fewer hospitals in the territories, the difference was not statistically significant ($P = .08$).

Table 2
Hospital Characteristics for Hospitals That Admitted Fee-for-Service Medicare Beneficiaries for AMI, HF, and PNE (July 2005–June 2008), Stratified by Hospital Location in the US States or US Territories

Variable	US States No. (%)	Puerto Rico No. (%)	Other US Territories No. (%)	P Value ^a	All US Territories No. (%)
Total No. of Hospitals (N=485)	478	7	0		485
Total No. of studies beds	1,462 (30.7)	417 (7.7)	0		1,879 (38.4)
≤50	1,462 (30.7)	417 (7.7)	0		1,879 (38.4)
51–100	86 (1.8)	9 (0.2)	1 (2.0)		96 (2.0)
101–200	798 (16.7)	21 (0.4)	3 (6.0)		822 (17.0)

Table 2
Hospital Characteristics for Hospitals That Admitted Fee-for-Service Medicare Beneficiaries for AMI, HF, and PNE (July 2005–June 2008), Stratified by Hospital Location in the US States or in the US Territories

HOSPITAL CORE PROCESS MEASURE PERFORMANCE IN THE US TERRITORIES AND THE US STATES

Hospitals in the US territories demonstrated significantly worse performance compared with the US states on all core process measures ($P < .05$) (Table 3). Hospitals in Puerto Rico and hospitals in the other territories performed similarly on most core process measures (Table 3).

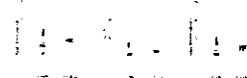
Table 3
Performance on Outcome Measures and Core Process Measures for Hospitals That Admitted Fee-for-Service Medicare Beneficiaries for AMI, HF, and PNE (July 2005–June 2008), Stratified by Hospital Location in the US States or in the US Territories

	US States No. (%)	Puerto Rico No. (%)	Other US Territories No. (%)	P Value ^a	All US Territories No. (%)	P Value ^b
RSMR	18.8	18.8	18.8		18.8	
No. of hospitals requiring	18.8	18.8	18.8		18.8	
Mean (SD)	18.8 (1.9)	18.8 (1.9)	18.8 (1.9)		18.8 (1.9)	
95% CI	16.1–24.5	16.1–24.5	16.1–24.5		16.1–24.5	
No. of hospitals requiring	18.8	18.8	18.8		18.8	
Mean (SD)	18.8 (1.9)	18.8 (1.9)	18.8 (1.9)		18.8 (1.9)	
95% CI	16.1–24.5	16.1–24.5	16.1–24.5		16.1–24.5	

Performance on Outcome Measures and Core Process Measures for Hospitals That Admitted Fee-for-Service Medicare Beneficiaries for AMI, HF, and PNE (July 2005–June 2008), Stratified by Hospital Location in the US States or in the US Territories.

HOSPITAL OUTCOME MEASURE PERFORMANCE IN US TERRITORIES AND US STATES

The hospital mean 30-day RSMR was significantly higher in the US territories compared with the US states for AMI (18.8% [range, 16.1%–24.5%] vs. 16.0% [range, 10.9%–24.9%]; $P < .001$), HF (12.3% [range, 10.3%–15.7%] vs. 10.8% [range, 6.6%–19.8%]; $P < .001$), and PNE (14.9% [9.2%–21.6%] vs. 11.4% [range, 6.4%–20.1%]; $P < .001$) (Table 3). After adjusting for condition-specific core process measures and hospital characteristics, mortality in territorial compared with stateside hospitals remained significant for all 3 conditions (Figure 1). After adjusting for hospital characteristics and core measure performance, 30-day RSMRs in the territories remained significantly worse for patients with AMI (19.1% vs. 17.3%; $P < .001$), HF (12.3% vs. 11.3%; $P < .001$), and PNE (15.3% vs. 12.0%; $P < .001$) (Table 4).



RSMRs for fee-for-service Medicare beneficiaries admitted for AMI, HF, and PNE, stratified by hospital location in the US states or the US territories. The upper boundaries of the boxes represent the 75th percentile; the black horizontal line within each box represents the median. The lower boundaries of the boxes represent the 25th percentile. The whiskers extend to the minimum and maximum values. The figure shows that RSMRs are generally higher in US territories compared to US states for all three conditions (AMI, HF, and PNE).

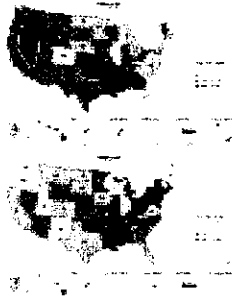
Table 4
Adjusted RSMR and 30-Day Mortality by Condition for Hospitals That Admitted Fee-for-Service Medicare Beneficiaries for AMI, HF, and PNE (July 2005–June 2008) in the US States or the US Territories

Outcome Measure	No. of Hospitals	Unadjusted Model		P Value	Fully Adjusted Model	
		US States	All US Territories		US States	All US Territories
AMI						
RSMR	485	16.0	18.8	< .001	17.3	19.1
95% CI		10.9–24.9	16.1–24.5		10.9–24.9	16.1–24.5
HF						
RSMR	485	10.8	12.3	.04	11.3	12.3
95% CI		6.6–19.8	10.3–15.7		6.6–19.8	10.3–15.7
PNE						
RSMR	485	11.4	14.9	< .001	12.0	15.3
95% CI		6.4–20.1	9.2–21.6		6.4–20.1	9.2–21.6

Adjusted a RSMR and 30-Day RSRR by Condition for Hospitals That Admitted Fee-for-Service Medicare Beneficiaries for AMI, HF, and PNE (July 2005–June 2008) in the US States and in the US Territories. The unadjusted hospital mean 30-day RSRR was significantly higher in the territories for 2 of the 3 conditions: AMI (20.6% [range, 18.7%–24.3%] vs. 19.8% [range, 15.3%–29.4%]; $P=.04$) and PNE (19.4% [range, 15.7%–22.5%] vs. 18.4% [range, 13.1%–27.6%]; $P=.01$) (Table 3). Differences in RSRR for the US territories compared with the US states were not statistically significant for HF (25.5% [range, 22.6%–29.1%] vs. 24.5% [range, 15.9%–34.4%]; $P=.07$). However, 30-day RSRRs in the US territories were not significantly different from readmission rates in the US states for any of the 3 conditions after adjustment for hospital structural characteristics and core process measure performance (Table 4 and Figure 2). Hospitals in Puerto Rico performed similarly to hospitals in the other US territories across all performance measures (Table 3).



RSRRs for fee-for-service Medicare beneficiaries admitted for AMI, HF, and PNE, stratified by hospital location in the US states or the US territories. The upper boundaries of the boxes represent the 75th percentile; the black horizontal line within each ...The percentage of hospitals in each decile of outcome measure performance (30-day RSMR and RSRR for the 3 conditions) differed greatly between hospitals in the US territories and hospitals in the US states across all 6 outcome measures (Table 5). Using RSMR after AMI as an example, we found that 10.3% of stateside hospitals fell within the first decile (lowest mortality rate) compared with 0% of territorial hospitals. Similarly, 9.5% of stateside hospitals fell within the top decile (highest mortality rate) compared with 37.7% of territorial hospitals. Overall, mean state-level and territorial-level performance on each of the 6 outcome measures varied across the country (Figures 3, 4, and 5).

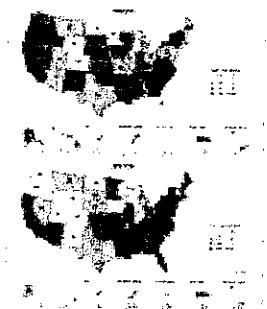


State-level and territorial-level mean RSMRs and RSRRs for fee-for-service Medicare beneficiaries admitted for AMI, presented by performance quintile. Quintiles were determined for each outcome measure. The fifth quintile represents the poorest performing ...fig ft0fig mode=article f1



State-level and territorial-level mean RSMRs and RSRRs for fee-for-service Medicare beneficiaries admitted for HF, presented by performance quintile. Quintiles were determined for

each outcome measure. The fifth quintile represents the poorest performing ...fig ft0fig mode=article f1



State-level and territorial-level mean RSMRs and RSRRs for fee-for-service Medicare beneficiaries admitted for PNE, presented by performance quintile. Quintiles were determined for each outcome measure. The fifth quintile represents the poorest performing ...table ft1table-wrap mode=article t1

Table 5
Percentage of Hospitals in Each Decile of Performance^a on RSMR and RSRR Outcome Measures for Hospitals That Admitted Fee-for-Service Medicare Beneficiaries for AMI, HF, and PNE (July 2005–June 2008), Stratified by Hospital Location in the US States

Decile	AMI				HF			
	RSMR		RSRR		RSMR		RSRR	
	States	Territory	States	Territory	States	Territory	States	Territory
1	18.3	0.0	18.9	3.8	10.3	0.0	10.4	0.0
2	10.5	0.0	12.3	3.9	10.8	0.0	10.2	0.0
3	15.2	0.0	21.9	6.6	10.2	2.6	9.4	0.0
4	6.5	3.9	14.3	6.6	12.5	6.1	11.6	0.0
5	11.5	15.1	7.1	17.3	10.3	14.6	8.9	0.0
6	10.0	6.0	11.8	17.0	6.0	10.0	11.4	0.0

Percentage of Hospitals in Each Decile of Performance on RSMR and RSRR Outcome Measures for Hospitals That Admitted Fee-for-Service Medicare Beneficiaries for AMI, HF, and PNE (July 2005–June 2008), Stratified by Hospital Location in the US States

COMMENT

Our findings reveal a marked geographic disparity that affects a subset of racial/ethnic minority populations in the United States. Hospitals in the US territories, on average, have significantly higher RSMRs than hospitals in the US states. The magnitude of differences across these rates raises concerns about differences in the quality of care. In comparison with the states, for every 100 AMI admissions in the US territories there are approximately 2 additional deaths, for every 100 HF admissions there is 1 additional death, and for every 100 pneumonia admissions there are 3 additional deaths. The types of hospitals included or their lower use of guideline-recommended therapies does not explain the higher mortality rates. Furthermore, the higher mortality rates observed in the US territories are not the result of a few outlier institutions; virtually all of the territorial hospitals performed below the US national averages.

Notably, the US territories have lower federal insurance reimbursement rates compared with all of the US states. In 2003, the General Accounting Office found that Medicare spending averaged \$6300 per enrollee in the US states compared with \$2800 in the US territories.²⁹ This study did not directly assess whether low reimbursement rates in the US territories contribute to low hospital performance in these regions. Still, it is important to consider the context of differential federal reimbursement policies. Specifically, the federal government has limited its Medicaid contribution to 50%, the lowest allowable percentage, for the US territories. In contrast to reimbursement policies for the US states, the federal government does not make any additional adjustments for lower per capita income in the US territories. The federal government also limits its contribution to a specific dollar amount in the US territories; there are no comparable “cap” policies in any US state or in the District of Columbia. Both of these discrepancies severely limit health care funding streams in the US territories, with consequences such as narrow Medicaid eligibility criteria and the elimination of Medicaid services that are commonly covered in many US states. Medicaid policies are particularly

relevant to the Medicare population, given the growth of dual eligible residents in the territories.³⁰ Puerto Rico faces additional policy challenges when compared with the US states and other territories because of Medicare policies that reimburse in-patient hospitalizations at rates lower than anywhere else in the nation.^{31, 32} In addition, the territories have a limited ability to shape the policies that may ultimately influence health care quality; the US territories lack voting representation in the US Congress and residents cannot vote in national elections.³³

We also found that risk-standardized readmission rates were higher in the US territories for AMI and PNE prior to adjustment. Again, almost all of the hospitals in the territories performed worse than the average in the US states, although these associations were not significant after adjusting for hospital characteristics and core process measure performance. Still, readmission rates for all the hospitals were high, and although the disparity was not as prominent as with the mortality measure, the need for improvement is clear.

Lastly, we found marked disparities in performance on the core process measures. These publicly reported measures assess compliance with a set of guideline-recommended therapies and actions that are associated with improved patient outcomes. They demonstrate lower quality care in the care of patients in the territories for each of the 3 conditions, representing substantial opportunities for improvement. As observed in prior work done in the United States, these differences in performance on core process measures explained only a small amount of the variation in mortality, indicating that many other factors play a role.^{34–37} Still, we included core process measures in our multivariable analysis because the association between processes of care and outcomes may have been different in the US territories and we could have missed important and potentially intervention-sensitive levers for change if they were not assessed. However, the fact that performance on these measures does not explain the higher mortality rates suggests that, beyond these processes, there are other aspects of care that are likely contributing to these differences.

Our study is one of the first to examine quality of care for hospitals located in the US territories; however, there are some limitations to consider when interpreting these findings. First, being located in a US territory may be a marker for geographic location on an island or unmeasured characteristics such as patient socioeconomic status; poverty is much more common in the territories.^{1, 6} Although there is evidence that hospitals disproportionately providing care for lower socioeconomic status populations have similar mortality rates to hospitals providing care to higher socioeconomic status populations, this evidence does not include US territories and their corresponding low reimbursements for Medicare.⁸ Second, we examined AMI, HF, and PNE and our results may not be generalizable to other conditions. Still, the existence of high-quality CMS data in these clinical areas represents an opportunity to investigate hospital performance in the territories and establishes the foundation for future work in this area. Third, our measures were based on the experience of patients in Medicare FFS and our results may not extend to younger populations. However, this is an appropriate group to investigate, given the expanding proportion of patients older than 65 years and associated increasing health care costs. Fourth, our outcomes measures were based on models using administrative claims data. We did not have extensive patient-level data for patients in the US states or in the US territories and therefore could not take into account health behaviors, health literacy, or adherence across these populations. However, we assessed acute care processes and short-term outcomes, and comorbid conditions were well captured in our administrative claims data. Although there may be unmeasured patient characteristics in the territorial populations for which we do not account, the statistical models used in the outcome measures produce estimates that are good surrogates for estimates from a medical record model.^{9, 11, 37} In addition, the mortality measure, which is approved by the National Quality Forum, is designed to convey information about hospital performance and already adjusts for hospital case-mix.^{7, 9} We also conducted several

secondary analyses to assess whether our findings primarily reflected the experience of Puerto Rico, since it has the largest population of the territories; we found the disparities were consistent across all US territories.

Despite the national effort to address health care disparities through increased public reporting and standardizing hospital performance, hospitals in the US territories have been largely neglected. Improving health care outcomes in the US territories should be included in any comprehensive effort to tackle national racial/ethnic and other health care disparities. The striking disparity revealed in this study demonstrates that people living in the US territories are at a notable disadvantage compared with those in the US states. Importantly, these US possessions are legally restricted from full participation in the shaping of relevant US health care policy. The nation has a great responsibility to guarantee that residents on these islands have access to care that is at least of the same quality as care in the US states.

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Footnotes

Author Contributions: Dr Nunez-Smith had full access to all the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. *Study concept and design:* Nunez-Smith, Bradley, Herrin, Santana, Normand, and Krumholz. *Acquisition of data:* Krumholz. *Analysis and interpretation of data:* Nunez-Smith, Bradley, Herrin, Santana, Curry, Normand, and Krumholz. *Drafting of the manuscript:* Nunez-Smith. *Critical revision of the manuscript for important intellectual content:* Nunez-Smith, Bradley, Herrin, Santana, Curry, Normand, and Krumholz. *Statistical analysis:* Nunez-Smith, Herrin, and Normand. *Administrative, technical, and material support:* Nunez-Smith. *Study supervision:* Nunez-Smith.

Financial Disclosure: Drs Normand and Krumholz report they developed RSMRs and RSRs for AMI, HF, and PNE under contract with the Colorado Foundation for Medical Care. Dr Krumholz reports he chairs a scientific advisory board for United Healthcare.

Disclaimer: The content of this publication does not necessarily reflect the views or policies of any of the sponsors.

Online-Only Material: The eTable is available at <http://www.archinternmed.com>.

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Appendix 4: 10 Point Plan from GMH Task Force Report (Jan 2016)

For the entire text of the report please visit www.toduguam.com

1. Introduce legislation to direct the Guam Economic Development Authority (GEDA) to develop and publish a request for information relative to how an interested contractor, hospital management team, or operator would transition government operation of the Guam Memorial Hospital to a public-private partnership while continuing to provide quality hospital services that are accessible to the people of Guam.
2. Proffer Bill 165-33 (LS) An Act to create the Guam Bureau of Health Planning and Development under the Office of the Governor of Guam (see Guam Legislature website).
3. Pursue Bill 80-33 funds to provide for short-term use for GMH capital outlay and operations (see attachment or Guam Legislature website).
4. Pursue Bill 240-33 relative to providing a mechanism to provide relief to health care providers of the MIP, Medicaid, and GMH for past due debts.
5. Work with GEDA to develop re-use plan of existing GMH facility, in the event option to relocate hospital is pursued from the RFI process. This will also provide an assessment of the best use of existing facility and property for the benefit of the people of Guam.
6. Work on analyzing and strengthening the procedures that need to be addressed in the event of an eventual transition into a PPP, such as current employee status, preservation of employee investments into the Government of Guam retirement fund, impact to retirement fund, and all other impacts to existing human resources.
7. Pursue reform of the MIP and Guam Medicaid Program in an effort to leverage additional federal matching funds that will increase the number of resident's access to primary health and wellness care.
8. Introduce legislation establishing local statute requiring employers to offer health insurance coverage to all of its employees by providing incentives and assistance.
9. Identify national health care and related safety net, research and educational programs and policies designed to ensure and catalog the health care needs of citizens are met and to promote healthy communities and evaluate whether such programs are available, and policies implemented, on Guam;
10. Ensure that information related to ensuring good and appropriate health care decisions and policies are available to our community and augment information and research capabilities.

Appendix 5: Premium Assistance: Medicaid's Expanding Role in the Private Insurance Market

<https://www.macpac.gov/.../Premium-Assistance-Medicaid's-Expanding-Role-in-the-Private-Insurance-Market.pdf>

Key Points

Premium assistance—the use of Medicaid funds to purchase private market plans—is one approach that states may use to expand the program to previously ineligible, low income adults. Arkansas and Iowa are using premium assistance to purchase plans on the exchange through Section 1115 research and demonstration waivers, and other states have expressed interest in this approach.

States cite various rationales for considering premium assistance, including easing the transition from Medicaid to exchange plan eligibility and improving access to care by enrolling individuals in private market plans. Additionally, relying on the private market could enable states with limited managed care or provider capacity to serve the influx of new enrollees. States also point to the potential for Medicaid enrollees to substantially increase enrollment in the exchanges, which in turn could improve the risk pool and encourage issuer participation.

Under premium assistance, state Medicaid programs do not retain authority over many aspects of care, which they would oversee under most Medicaid managed care contracts. Instead, they are essentially buying coverage in a separate system that was not specifically designed for a Medicaid population.

While the approved premium assistance waivers retain certain protections for exchange plan enrollees—including retroactive coverage, benefit appeals rights, and exemptions for medically frail enrollees—they have notable differences from traditional Medicaid. For example:

— Enrollees will no longer be entitled to non-emergency medical transportation in Iowa, although Medicaid will continue to provide certain benefits not covered by exchange plans, such as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for young adults in both states.

— Iowa and Arkansas also are instituting new approaches to cost sharing that could affect enrollment and utilization, although Medicaid's limit to 5 percent of income remains in force.

Federal policy requires Section 1115 waivers to be budget neutral, which means that federal Medicaid spending must be equal to or less than it would be without the demonstration. Whether states actually achieve budget neutrality will depend on the costs of coverage, the health of the population that enrolls, and the interactions with other federal programs.

Premium assistance, or the state purchase of private market plans on behalf of Medicaid enrollees, is attracting interest as an alternative to expanding traditional Medicaid coverage to previously ineligible low-income adults.

1. After the U.S. Supreme Court ruling in June 2012 effectively made Medicaid expansion an option for states, two of the 28 states moving forward have taken this approach. Through Section 1115 research and demonstration waivers, Arkansas and Iowa are using Medicaid funds to purchase exchange plans for residents who are newly eligible for Medicaid.

2. While the premium assistance approach is not new to Medicaid, it previously has

served a relatively small number of enrollees, with most programs covering fewer than 2,000 people and primarily those with employer-sponsored coverage (GAO 2010). The extension of premium assistance to the purchase of exchange plans raises a number of considerations for the program.

Medicaid has long served as a payer of last resort for low-income people who have limited insurance options, including families with children, pregnant women, individuals' age 65 and older, and people with disabilities. However, with the extension of Medicaid under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) to low-income adults, the majority of whom historically were excluded from the program, the role of Medicaid as a coverage source and a payer in the health care system has expanded.

Estimates suggest that almost half of those gaining health insurance coverage in 2015 (relative to the pre-ACA baseline) are expected to enroll in Medicaid and the State Children's Health Insurance Program (CHIP) (CBO 2014). With the movement of Medicaid enrollees into the exchange market through premium assistance, Medicaid will serve as a larger purchaser of coverage with the potential to alter exchange markets by broadening the risk pool and affecting premiums and competition.

The broader use of premium assistance also moves the program further away from a source or a negotiator of Medicaid-specific coverage toward more of a purchaser of private market coverage.

While most Medicaid enrollees currently receive their benefits through private managed care plans, the contracts give states control over how services are provided and access is assured. Additionally, states have oversight authority and can require certain data reporting to ensure program integrity.

In contrast, in the premium assistance approach, Medicaid agencies no longer have direct authority over the plans and are instead buying coverage in a separate system designed for a non-Medicaid population. This extension into the exchange market and the shift in the state agencies' role leads to a number of questions regarding the use of exchange plans to provide coverage for Medicaid enrollees.

While the approved waivers mostly maintain states' requirements to provide Medicaid benefits and cost-sharing protections to exchange plan enrollees, there are several notable differences from traditional Medicaid. These variations are not unique to the premium assistance approach as other states, such as Michigan and Pennsylvania, have secured waivers to test alternatives to a straight Medicaid expansion by altering their cost-sharing or benefit design. But as they are not purchasing exchange plans for Medicaid enrollees, they are not the focus of this chapter.

In the Arkansas and Iowa premium assistance waivers, there are some instances where Medicaid continues to provide benefits not covered by exchange plans, such as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19- and 20-year-olds. In other instances, benefits, such as non-emergency medical transportation (NEMT), were waived and the enrollees will no longer be entitled to them. In terms of cost sharing, Medicaid's limit to 5 percent of income remains, but both states are instituting new approaches to cost sharing that could affect enrollment and utilization.

Consumer protections, such as retroactive coverage, benefit appeals rights, and exemptions for the medically frail, remain in place in these waivers. Moreover, while press accounts and discussions of premium assistance often focus primarily on its appeal to voters and legislators in

some states, there are a number of other rationales that are driving interest in the approach. States cite the potential to smooth the transitions for individuals moving from Medicaid to exchange plan eligibility. States also have suggested that enrolling Medicaid-eligible individuals in private market plans with commercial provider networks will improve their ability to access care. States that have limited managed care or provider capacity may turn to the private market to serve the expanded Medicaid population. Finally, as mentioned, there is the potential for Medicaid enrollees to substantially increase enrollment in the exchanges, perhaps altering the risk pool and attracting additional issuers (Allison 2014, CMS 2014a, and CMS 2014b). The expanded use and mandatory nature of the recent premium assistance models raise a number of important policy considerations and areas for monitoring.³ While it will be several years before the data are available that can provide a full assessment, raising questions now can help guide future analysis and evaluation. This chapter provides a brief overview of the history of the use of private plans in Medicaid and then lays out questions surrounding the use of premium assistance for the new adult group as well as the possibility of extending it further.

Specifically, the chapter examines:

- Differences between the use of managed care in Medicaid and the use of premium assistance to purchase exchange plans;

Reasons states might choose premium assistance to expand Medicaid-

- Differences between Medicaid and premium assistance on benefits and cost sharing;
- Protections that remain available to Medicaid enrollees;
- Potential cost implications and effect on the broader exchange market; and
- The need for a thorough evaluation of this approach to expansion.

How Medicaid Managed Care and Premium Assistance Differ on State Oversight and Payment Policy

Medicaid has a long history of offering private insurance through managed care and premium assistance. However, while both approaches involve the purchase of coverage offered by private plans, there may be fundamental differences in terms of the state's oversight and management functions as well as the method for determining payments. The majority of Medicaid enrollees receive their benefits through private managed care plans, which contract directly with state Medicaid programs and must comply with state and federal Medicaid purchasing requirements. In contrast, in the premium assistance approach, states buy coverage through a separate system (such as the exchanges or employer-sponsored coverage) that was designed to serve a non-Medicaid population. Below we discuss the extent of the use of managed care compared to premium assistance, the varying degrees of oversight in each, and their differing methods for determining plan payments.

While a few states have been using managed care in Medicaid since the early years, many states instituted large expansions of Medicaid managed care beginning in the mid-1990s. As of fiscal year 2011, approximately half of Medicaid enrollees were in comprehensive risk-based managed care and 72 percent were served through some form of managed care arrangement (MACPAC 2014).⁵ Additionally, the vast majority of individuals made newly eligible for Medicaid in 2014 also are expected to obtain benefits under a managed care arrangement (Sommers et al. 2013). States have pursued the use of managed care for a number of reasons, including their belief that it provides better care coordination and improved program accountability for access and quality. By paying managed care organizations (MCOs) a set rate per member per month (or capitated payment), states can also capitalize on more predictable budgetary expenditures, while still maintaining program management and oversight (MACPAC 2011).

State contracts with MCOs establish the terms under which the plans will deliver services to

enrollees and serve as a mechanism to enforce both state and federal standards. Although the terms of each contract are governed in part by federal rules, states have considerable flexibility in determining particular parameters within established guidelines. As such, there is variation among the states as to the specificity and complexity of contract requirements. For example, the plans are responsible for establishing and maintaining provider networks, but the states can stipulate certain network standards and must ensure that the networks meet minimum federal requirements in order to assure appropriate access. States also establish contract provisions relating to improved care and accountability. For example, states can require plans to assign each member to a primary care physician and to provide care coordination and management. Additionally, states can establish quality and performance standards and data collection and reporting requirements in order to monitor whether the plans are meeting the contract requirements. Finally, state contracts with MCOs describe the sanctions or other enforcement mechanisms states can apply if the contract terms are not met. The direct purchase of private market plans through premium assistance has been relatively limited, despite having been permissible within federal requirements since the enactment of Medicaid.

While many states have chosen to implement premium assistance programs, most have enrolled fewer than 2,000 people and generally have been limited to employer-based plans, as very few states have chosen to provide assistance for the purchase of individual policies. The low enrollment likely is due to three key factors. The first relates to eligibility—a limited number of Medicaid-eligible persons have access to comprehensive employer sponsored coverage, and, prior to the ACA, it was difficult for many people to qualify for individual market coverage (GAO 2010 and GAO 2009).

Specifically, many individual market plans were not required to cover comprehensive benefits and were allowed to exclude persons for a variety of reasons, including pre-existing conditions (Doty et al. 2009).

Second, premium assistance requires states to make a determination of cost-effectiveness, meaning that covering an individual in an employer based or other private market plan would need to cost the same or less than providing comparable coverage in Medicaid. In making this assessment, states also need to factor in the administrative costs of the program as well as any costs to wrap around benefits or cost sharing. Cost-effectiveness often was hard to achieve as the use of deductibles and higher cost sharing has increased in employer-sponsored plans (KFF and HRET 2014). In the individual market, plans typically had high premiums and deductibles because they had been rated based on a person's demographic, health, and other characteristics (Doty et al. 2009). Finally, the programs were complicated to administer, as states are required to provide wrap-around coverage for benefits that are not covered in the private market plan, cover the cost of any additional premiums and cost sharing, and complete an assessment of cost effectiveness.

The ACA changed the insurance coverage landscape, making the use of premium assistance through the purchase of individual market plans a more viable option. By mandating a core set of comprehensive benefits and setting a cap on out-of-pocket costs, as well as restricting the use of individual rating and discrimination based on preexisting conditions, many of the earlier obstacles to the purchase of individual market plans faded.

The U.S. Department of Health and Human Services (HHS) issued regulations in July 2013 allowing for the enrollment of individuals eligible for Medicaid in plans in the individual market, including enrollment in exchange plans, under certain conditions (42 CFR 435.1015). While states can use existing statutory authority to enroll individuals into exchange plans, no state has done so in part because Section 1115 demonstration waivers allow them to test additional features, including mandatory enrollment of adults in the expansion group, imposition of higher cost sharing for some enrollees, restrictions on mandatory benefits, and changes to provider payment rules. Other states have expressed interest in using Section 1115 waiver authority for premium assistance demonstrations, although, as of January 2015, only Arkansas and Iowa

have received approval for their waivers.⁶

Typically, state Medicaid agencies have direct oversight of the Medicaid delivery system through agreements with fee-for-service providers or contracts with MCOs (42 CFR 438.6).⁷ However, in both traditional employer-focused premium assistance programs and exchange plan-based premium assistance demonstrations, Medicaid is purchasing another source of coverage and does not directly contract with the insurers; therefore, Medicaid regulations do not apply. Employers (in the case of employer-sponsored insurance), state departments of insurance, and state or federal exchanges (in the case of exchange plans) all have roles in establishing insurance standards such as provider network composition, claims payment timeliness and accuracy, utilization management, financial solvency, and customer service. While these standards may or may not align with state and federal Medicaid rules, a state Medicaid agency could, in its role as purchaser, establish an independent relationship with the plans to institute such standards.

In addition, state Medicaid agencies that provide direct Medicaid or contract with MCOs have access to a variety of data for monitoring and oversight, including claims or encounter data, provider enrollment data, and payment and coverage policies, although there are limitations and timeliness concerns with these data. Medicaid MCOs are required to collect and report on enrollee and provider characteristics, including encounter data that detail enrollee service use (42 CFR 438.242). Medicaid programs that purchase exchange plans may not have access to the same level of information on service use, provider payment, or coverage and utilization management policies. The waivers require the memoranda of understanding (MOU) between the state Medicaid agencies and the exchange plans to include reporting and data requirements that are necessary to monitor and evaluate the premium assistance approach. Since no such MOUs have yet been made public, however, it is not clear what level of data access and oversight authority the Medicaid agencies will have. Additionally beyond these MOUs, the state department of insurance could require exchange plans to share data and performance information with Medicaid.⁸

Medicaid managed care and premium assistance coverage also differ in how they set payments to plans. Medicaid programs use a variety of methods to set capitation rates for their managed care plans, but all are required to pay rates within an actuarially sound range (42 CFR 438.6(c)). Among 20 states with comprehensive managed care highlighted in a recent report, 13 used an administrative process in which a specific rate is set by the state and offered to plans, 4 used a competitive bidding process, and 3 used a negotiation process (Courtot et al. 2012). Regardless of the approach, the capitation rate for a Medicaid managed care plan is based on the estimated cost of serving a specific population of Medicaid enrollees. In contrast, premiums for exchange plans and other private market plans are determined using the rating rules that apply to that market, and their prices reflect the cost of the entire population—both Medicaid and non-Medicaid—in that market.

Reasons States Might Choose Premium Assistance

Most accounts of the adoption of premium assistance have highlighted some states' desire to rely on a private insurance model to provide coverage for the Medicaid expansion population. This private market focus also aligns with the view held by some that Medicaid was designed for the most vulnerable and that the private market may better serve the majority of adults. However, there are a number of other compelling rationales for choosing an alternative approach to the expansion that relies on exchange plans beyond the appeal of purchasing a private market plan. They include: reducing churning between plans, improving access to providers, supplying a delivery system in states that do not otherwise have the capacity in their Medicaid program, and strengthening the exchanges by increasing the number of enrollees and participating issuers.

Due to changes in income and family circumstances, an estimated 6.9 million people are expected to move from Medicaid coverage to exchange coverage or vice versa each year (Buettgens et al. 2012). Referred to as churning, this movement between programs increases

administrative costs and disrupts continuity of care (MACPAC 2013). Premium assistance may lessen the impact of churn because, if Medicaid-eligible individuals are enrolled directly into exchange plans, they can stay in the same plan even if their income increases and they lose Medicaid coverage. In Arkansas, enrollees have a choice of at least two exchange plans and the network are required to be the same as those offered to non-Medicaid enrollees (CMS 2014a). In Iowa, enrollment currently is limited to one exchange plan or the state's Wellness plan, following the withdrawal of one of its carriers from the market (Iowa 2014a and CMS 2014b).⁹ If enrollees choose to remain with the same exchange plan as their Medicaid eligibility changes and the transfer between Medicaid and exchange enrollment is seamless, gaps in coverage resulting from system or other coordination issues that might occur in other states could be minimized. At this point, no data are available that would allow for the examination of changes in eligibility between programs and continuity of coverage, although historically, transitions between Medicaid and CHIP have resulted in gaps in coverage (Harrington et. al.2014).

There are other approaches to minimizing the impact of churn besides premium assistance. For example, states could require or encourage health plans to offer products across payers.¹⁰ By encouraging issuers to offer plans in both the Medicaid and exchange markets, disruption in coverage and discontinuity of care for enrollees moving between Medicaid plans and exchange plans could be minimized. The extent to which this will actually work depends upon whether or not the plans offered to the Medicaid population are the same as those offered to consumers using premium tax credits to purchase exchange plans.

For example, if the networks are not the same in both plans, an enrollee might be forced to change providers when moving from Medicaid to exchange coverage, even if the individual stays with the same carrier. This same issue could arise in the premium assistance approach if the plans available to the Medicaid-eligible population are not the same as those available to the exchange-eligible population.

An alternative option for mitigating the impact of coverage changes is to establish transition plans for individuals moving between coverage sources.¹¹

Another argument often made in support of premium assistance is that it will improve Medicaid enrollees' access to providers. Medicaid must provide enrollees with access to care comparable to that of the general population (§1902(a) (30) (A)). Through the use of premium assistance, the assumption is that the purchase of a commercial product, by definition, is providing this equal access. Additionally, states have suggested that, by paying higher commercial or commercial-like rates to providers through the exchange plans, access will improve as a result (Allison 2014).

Just one-third of physicians accept new Medicaid patients, with payment rates that are typically below commercial levels cited as a reason for low participation (Decker 2012). While payment rates are proprietary, there have been indications that exchange plans may pay higher rates than Medicaid, but lower than other private payers, such as employer-based coverage (Pittman 2013).

When enrolling in an exchange plan, a Medicaid beneficiary could have more options for providers if there is a wide range of plans with robust networks to choose from. As mentioned, in the two existing waivers, enrollees are required to have the choice of at least two exchange plans, although, as noted above, currently only one exchange plan is available in Iowa (CMS 2014a and CMS 2014b).

There are yet little data to evaluate the extent to which premium assistance affects access, and despite regulatory protections, there have been reports of access and network limitations in both Medicaid and exchange plans.¹² For many services, Medicaid enrollees have access comparable to similarly situated adults with employer-based coverage, although there are areas for improvement (MACPAC 2012). (Comparisons to the individual market, which is most similar to exchange plan coverage, are not available.) Moreover, insurers often design exchange plans with narrower networks relative to other private plans as a cost containment strategy, having few other options to limit costs with the ACA's prohibition on preexisting condition exclusions and rate setting based on health status (Corlette et al. 2014 and McKinsey2013). As a result, in-network provider participation may be limited, and the cost sharing for out-of network care far higher.¹³ While there is anecdotal information, in the form of complaints, about the narrow networks and lack of transparency around which providers are in- or out-of-network, there is limited evidence yet as to the overall impact of these things on access and utilization.^{14, 15} Beyond provider participation and network assessments, another measure of the adequacy of Medicaid and exchange plan coverage may be whether or not enrollees are able to access the care they need in a timely fashion. Data made available through ongoing surveys of enrollees and comparisons across eligibility categories will be important to monitor whether access is a problem in Medicaid and exchange plans.

In addition to the potential to reduce churn and improve access, the use of premium assistance may be appealing for states because of constraints on existing Medicaid provider capacity and the composition of their exchange market. Specifically, in states where providers are unable to absorb the new patient population or in cases where there is limited or no managed care infrastructure, it may be difficult for a state to expand Medicaid using its existing provider network. Using exchange plans that may pull from a different provider pool could result in broader access for enrollees who otherwise may have difficulty finding a provider.

Additionally, premium assistance may be attractive to states as a means of expanding the risk pool purchasing coverage in the exchanges. For example, in states where the uninsured population is lower income, adding the Medicaid-eligible population to the exchange market may help bolster enrollment. Depending on the composition of the population, this may improve the risk pool (for example, if the Medicaid population is younger than other exchange enrollees) and may encourage additional insurers to join the exchange.

How Medicaid and Premium Assistance Differ on Benefits and Cost Sharing

Certain federal Medicaid benefit requirements and premium and cost-sharing protections are not mandated in exchange plans. In approving premium assistance waivers, however, the Centers for Medicare & Medicaid Services (CMS) has said states must arrange with exchange plans to provide any necessary wrap-around benefits and cost sharing, or seek to waive them (CMS 2013b).

Because of these conditions, premium assistance involves more than the purchase of a commercial insurance plan and differs from traditional Medicaid in several ways described in greater detail below. It also is important to note that benefit and cost-sharing waivers are not unique to the use of premium assistance.

Comparison of benefits in Medicaid and exchange plans. Medicaid enrollees who come in through the new adult eligibility pathway are statutorily required to receive the alternative benefit package (ABP). The ABP must cover certain services, such as family planning services and supplies, and EPSDT services for children under age 21. It also must comply with mental health parity rules and provide the 10 essential health benefits (EHB) also required in exchange plans (42 CFR 440.345 and 42 CFR 440.347). In contrast, exchange plans are required to offer only the 10 EHBs, although the package includes benefits that are optional under traditional Medicaid, such as rehabilitative services (45 CFR 156.110). By choosing to define the ABP as

the package covered by the exchange plans, states adopting the premium assistance approach to Medicaid expansion will either need to cover any missing benefits or secure a waiver of benefit requirements from CMS, in addition to the waiver of other provisions that may be required to provide exchange plan premium assistance.¹⁶

Medicaid includes benefits important to high need, low-income populations that are unavailable in exchange plans. For example, EPSDT includes periodic screening services, such as a comprehensive physical exam including a health and developmental history as well as vision, dental, and hearing services. Under EPSDT, states also are required to provide any additional services that are medically necessary to diagnose, treat, correct, or reduce any conditions discovered, regardless of whether or not these services are covered in the state's plan (42 CFR 441.50-441.62). Both Arkansas and Iowa are required to wrap EPSDT benefits, meaning that each state will provide unavailable services through their fee-for-service systems to those 19- and 20-year-olds enrolled in exchange plans. Enrollees will receive both an exchange plan insurance card and a Medicaid client identification number (CIN); information on how to use this number for wrapped benefits, as well as which services are covered directly through Medicaid, will be provided through the eligibility notice (CMS 2014a and CMS 2014b).¹⁷

States also must ensure that Medicaid enrollees have the necessary transportation to medical examinations and treatment (42 CFR 440.170(a)). This benefit is most often used to get to behavioral health (including mental health services and substance abuse treatment) and dialysis appointments (MJS & Company 2014). NEMT is not typically provided by commercial insurers and is important for Medicaid enrollees who may not be able to attend an appointment or face an increased financial burden if transportation is not provided (MACPAC 2012). Additionally, the lack of transportation may impact provider willingness to participate if large numbers of enrollees do not show up for scheduled appointments. Iowa secured a temporary, one-year waiver of NEMT and was required to evaluate the impact of the waiver on access to care (CMS 2014b). In its September 2014 request to continue the exclusion in year two, the state reported that enrollees are using services and therefore access has not been affected without NEMT. Even so, almost half (between 42 and 49 percent) of enrollees needed assistance, either from a friend or family member or through public transportation, to get to a health care visit in the last six months, and between 8 and 18 percent always needed assistance (Iowa 2014c). Despite the concerns these data raise regarding beneficiary access, CMS granted an extension of the NEMT waiver until July 31, 2015 to allow for additional data collection (CMS 2014b). Arkansas received approval for an amendment to require prior authorization for NEMT, but will continue to provide the benefit, when authorized, through its fee-for service system (CMS 2014a).

States adopting premium assistance also must make other operational decisions regarding benefits, including the approach to wrapping benefits and how to educate consumers and providers about accessing services. While Arkansas and Iowa are providing wrap-around coverage through their fee-for-service systems, states also could carve out certain benefits, such as NEMT, and offer them through a managed care organization. Arkansas and Iowa are required to send enrollees details on the services covered outside the exchange plans as well as post the information on their states' Medicaid websites and provide the information through call centers and exchange plan issuers. Medicaid's prior experience with premium assistance yielded little information regarding individuals' access to wrapped benefits or the administrative process that ensuring access entails. As such, examination of these will be important in monitoring and evaluating these demonstrations.

Cost-sharing requirements in premium assistance waivers.

States adopting the premium assistance approach to expansion also are pursuing waivers of

Medicaid premium and cost-sharing protections so that all enrollees pay something, even nominally, toward the cost of coverage.¹⁸

The notion of personal responsibility in the form of financial contribution resonates deeply with some policymakers, and the pursuit of financial responsibility among enrollees is not limited to the premium assistance approach to expansion. States already can require certain groups of Medicaid enrollees to pay cost sharing, but are precluded from charging premiums for enrollees with income at or below 150 percent of the federal poverty level (FPL) (42 CFR 447.55). Per-service charges are limited to nominal amounts for individuals with income at or below 100 percent FPL and are prohibited for certain services (42 CFR 447.56(a)(2)). Additionally, all cost sharing (including premiums and per-service charges) incurred by members of a family is subject to an aggregate limit of 5 percent of the family's income, and the state must have a process in place to track spending toward the limit that does not rely on documentation from the enrollee (42 CFR 447.56(f)).

While not fully aligning, a number of states have obtained waiver authority to alter the Medicaid premium requirements to be more consistent with exchange plan premium and cost sharing rules. For non-Medicaid exchange plan enrollees with household income less than 133 percent FPL, the expected contribution toward premiums is 2 percent of income (26 CFR §1.36B-3(g)(2)). In Iowa, beneficiaries with income between 100 and 138 percent FPL will pay \$10 per month.¹⁹ Premiums will be waived for all enrollees in the first year of eligibility and waived in subsequent years if enrollees self-attest to financial hardship or undertake certain healthy behaviors, such as a health risk assessment and an annual wellness exam (CMS 2014b).²⁰ The state will monitor who completes the assessment or exam through vendor and provider reports, claims submissions, and self-reports. Enrollees have the full year, plus a 30-day grace period, to comply. In future years, the state intends to add the ability for enrollees to earn financial rewards for completion of other healthy behaviors, such as a smoking cessation program (CMS 2014d).

States also are interested in testing different approaches to cost sharing that mimic private sector practices, such as requiring enrollees to contribute a certain amount toward an account similar to a health savings account (HSA) that can later be used to pay for per-service charges. Arkansas has received approval for an amendment to its waiver for the use of Independence Accounts for those enrolled in exchange plans. Enrollees will be charged monthly contributions ranging from \$5 for those with income above 50 percent FPL to \$25 for those at 133 percent FPL (CMS 2014a). Technically, the amounts paid into the savings account will go toward copayments that are in line with existing Medicaid requirements; however, requiring monthly payments regardless of service use is similar to charging premiums, although enrollees cannot be denied eligibility for nonpayment.

Both states are limiting enrollee exposure to out-of-pocket spending. In Iowa, the state will be charging premiums in lieu of other cost sharing (except for a copayment for non-emergency use of the emergency department). Additionally, individuals who participate in healthy behaviors will be exempt from premium payments. Arkansas secured an amendment to its waiver to implement an HSA like account. The approved amendment stipulates that no household shall pay more than 2 percent of income toward the monthly contributions and cost sharing provisions are consistent with Medicaid requirements (CMS 2014a). In both states, the 5 percent of income aggregate cap remains in force.

There is a potential risk to these approaches, as increased cost sharing can discourage people from seeking coverage and needed care, and financial incentives for healthy behaviors have shown limited success. Specifically, studies have found that charging low-income families premiums depresses enrollment by serving as a barrier to both obtaining and retaining coverage (Snyder and Rudowitz 2013, Abdus et al. 2014, and Wisconsin 2014); and although per-service

cost sharing has been shown to reduce the use of less-essential services, it can also serve as a deterrent to seeking needed care and may result in the use of more expensive services (Snyder and Rudowitz 2013 and Swartz 2010). Additionally, the use of financial incentives for healthy behaviors has had mixed results in other states (Blumenthal et al. 2013).

Close monitoring of the impact of premiums and other cost sharing on enrollment, access, and utilization, as well as the use of incentives to reduce enrollees' financial liability, will help inform further demonstrations.

Protections Available to Medicaid Enrollees

A number of consumer protections are preserved in the existing premium assistance waivers, and while important, these provisions may complicate program administration and raise costs. Specifically, although there is no consensus on the most accurate approach, states must establish policies and procedures to identify medically frail individuals, who are exempt from enrollment. Additionally, retroactive eligibility for Medicaid is maintained, and, in both Arkansas and Iowa, enrollees will access benefits through Medicaid until enrollment in the exchange plan is effectuated. Finally, despite enrollment in private exchange plans, enrollees retain their grievance and appeals rights, although states may delegate certain appeal responsibilities.

Exemptions for people identified as medically frail. States adopting premium assistance must identify medically frail individuals among those now eligible for Medicaid and give them the option of enrolling in the traditional Medicaid plan (42 CFR 440.315).²¹ States have discretion in determining how these individuals will be identified, which might include self-identification, provider identification, or a review of claims information by either the issuer or the state. In Iowa, there are three ways that an enrollee may become medically exempt—through a member survey, provider attestation or referral, or through a retrospective claims analysis (Iowa 2014d).

In Arkansas, applicants are identified through a screening questionnaire or must seek a determination of medical frailty (CMS 2014a). There are concerns about self-identification as an approach to identifying the medically frail because self-reports of health status may be unreliable when individuals are seeking benefits, especially given the historic exclusion of coverage for preexisting conditions in insurance. There also are concerns about relying on claims analyses. If this analysis is left to the plans, there is a financial incentive to move those with certain conditions to traditional Medicaid, regardless of whether or not they fit the criteria of medically frail.

Retroactive coverage.

Medicaid coverage is effective as of the date of application or the first day of the month in which an application is filed, whereas exchange plan eligibility is prospective, meaning that, coverage will begin, at the earliest, on the first day of the next month (42 CFR 435.915 and 45 CFR 155.420(b)(1)). As such, there is a potential for misalignment in coverage effectuation dates. In addition, Medicaid coverage must extend three months retroactively if the individual would have been eligible during that time—a requirement that remains in place for the premium assistance programs in Arkansas and Iowa (42 CFR 435.915).

This provision may protect beneficiaries from certain out-of-pocket costs by allowing medical care received prior to application to be covered by Medicaid, a benefit to the provider who saw these patients as well. As such, in a premium assistance approach to coverage, states may need to cover beneficiaries in their fee-for-service programs until exchange plan enrollment takes effect and also retrospectively. There is precedent for this as states using managed care or presumptive eligibility will typically cover individuals in fee for service while managed care enrollment or a full determination is effectuated. In both Arkansas and Iowa, enrollees are able

to access benefits through Medicaid retrospectively and until enrollment in the exchange plan is finalized (CMS 2014a and CMS 2014b).

Appeal rights.

Medicaid applicants and beneficiaries have a right to adequate notice and the opportunity to challenge an adverse state action before an impartial party. Enrollees also continue to receive treatment while an appeal is pending (42 CFR 431.200-250). In addition, Medicaid enrollees in managed care must have access to plan-level procedures to appeal decisions made by the MCO, for example, denial of a requested service (42 CFR 438.400-424). Standard appeals should be resolved within 45 days, but MCOs must have in place a process for expedited review (42 CFR 438.408-410). Exchange plans, like all individual and group plans, are required to have an internal claims process as well as to give access to an external review process (45 CFR 147.136). While eligibility appeals across programs are required to be coordinated, there is no such requirement for denial of benefits or claims appeals (45 CFR 155.510). States may delegate certain appeal responsibilities to the department of insurance or another state agency. As such, while enrollees' Medicaid appeals rights are maintained, it is unclear who appeals should be directed to, if and how they will be coordinated, and who bears ultimate responsibility for adjudication. Therefore, enrollees' ability to navigate the appeals process will need to be monitored.

Cost Implications of Premium Assistance

A key question about premium assistance models are their cost compared to that of traditional Medicaid. Federal policy requires Section 1115 demonstration waivers to be budget neutral, meaning that federal Medicaid spending under the demonstration is equal to or less than it would be in that state without the demonstration.²² Whether or not that proves to be the case will be a function of several factors, including the costs of coverage, impact on federal spending is considered.

Using premium assistance to purchase private market plans—which, historically, have been more expensive than Medicaid, due in part to higher provider payment rates—would likely be more costly (Ku and Broaddus 2008). On the other hand, by continuing to serve medically frail individuals (those with the highest needs) in traditional Medicaid, it is more likely that the cost per person will be higher in comparison to those enrolled through premium assistance.

Additionally, providing Medicaid enrollees coverage through an exchange plan might be a cost-effective approach if other factors, such as the composition of the exchange, are taken into consideration.²³ In the case of Arkansas, an additional 200,000 people who would have been covered in the Medicaid program are enrolled in exchange plans (Ramsey 2014). As a result, enrollment in the exchange substantially increased, which has the potential to lead to a healthier risk pool (ASPE 2014).²⁴ Additionally, if larger numbers of enrollees are expected in the exchange, more issuers may be interested in capturing a piece of the market, thereby increasing competition as they join. Finally, as a large purchaser in the exchange, Medicaid may be in a position to negotiate lower rates. These factors may lead toward lower premiums overall.²⁵

The impact on the broader exchange market suggested in Arkansas may not be the case for other states, in part due to the size and health status of the expansion group as compared to those enrolling in the exchange. In Iowa, only individuals between 100 and 138 percent FPL are enrolled in exchange plans, and an insurer participating in the premium assistance plan has reported that the population is higher cost than the company's other exchange business (Pradhan 2014). However, it is not known what impact this has had on the broader exchange market given the smaller share of enrollees the program represents.

The federal government currently is paying the full cost of coverage for newly eligible individuals

in the adult expansion group, although this matching rate will begin to decrease in 2017, requiring a state contribution of 10 percent in 2020 and onwards. Therefore, the cost of exchange plan coverage, with the added expense of benefit and cost sharing wraps—especially compared to traditional Medicaid on a per-person basis—is an important consideration for both states and the federal government as the merits of premium assistance are weighed.

Need for Thorough Evaluation

To date, premium assistance has never been attempted on such a scale, and this approach to coverage could be informed by a robust evaluation as required under the statute and regulations. Specifically, because Section 1115 waivers are experiments, pilots, or demonstration programs, they require evaluation (42 CFR 431.424). Important factors to consider in an evaluation of premium assistance include:

1. The extent to which the approach results in covering more individuals than would have been the case without the expansion;
2. The effect on access to care;
3. Whether enrollees are able to access necessary benefits through a wrap, and the process for administering the wrap;
4. The effect on access to care from restricting the use of non-emergency medical transportation;
5. The impact of premiums, cost sharing, and incentives for healthy behaviors on enrollment and service utilization;
6. Whether exchange plan enrollment eases transitions and improves continuity of coverage and care as enrollee income changes;
7. The accuracy of the medically frail exemption screening and the health of those enrolled in premium assistance compared to traditional Medicaid;
8. The larger effect on the exchange market in terms of competition and costs as a result of purchasing exchange plans for the Medicaid population; and
9. The overall costs to the state and federal Medicaid program and federal spending generally.

The terms and conditions of the waivers include evaluation requirements, although the specific research questions and design are settled through a subsequent approval process. States must submit an evaluation design plan that includes a discussion of the hypotheses, the data and methods of collection, how the impact of the waiver will be isolated, and a timeline (42 CFR 431.424). Updates on enrollment will occur earlier on in the evaluation process, with implementation updates and outcomes data coming later. Final reports will not be due to CMS until the end of 2017 and must be available publicly.

While not the only purpose, the evaluations will look at whether or not the waivers were cost effective in a manner that takes into account both the initial and the longer-term costs and implications, such as health outcomes. There also are specific research questions that the evaluations will be designed to answer, for example, whether premium assistance beneficiaries have equal or better access to care, fewer gaps in coverage, continuity of provider access, and satisfaction with services. Additionally, the evaluations will examine whether enrollees, such as young adults entitled to EPSDT, are able to access benefits through the wrap. In Iowa, the state will also investigate whether the lack of NEMT poses a barrier to access as well as the impact of premiums and the incentives for healthy behaviors (CMS 2014a, CMS 2014b, ACHI 2014, and IPPC 2014).²⁶

Neither the Arkansas nor the Iowa evaluation plan requires an examination of the effectiveness of their approaches to identifying the medically frail. However, Iowa is planning on examining the medically frail population to assess its access to care and detail the services provided that

would not have been provided under the waiver, and Arkansas indicates that additional refinements may be made to its screening approach after data on the results and actual utilization become available (IPPC 2014 and ACHI 2014). Arkansas also has identified a number of supplemental hypotheses for future examination, including looking at the impact on the exchange market (ACHI 2014).

Additionally, Mathematica Policy Research has been awarded a contract by CMS to conduct a national examination of Section 1115 waivers.²⁷ Initially, the evaluation will examine implementation, primarily through the use of interviews and state documents, to assess the variation in state designs. The outcome focus of the evaluation will not begin until 2016, with public results likely in 2019. This portion of the evaluation will assess the differences in outcomes between premium assistance and traditional Medicaid in terms of take-up, access, quality, and spending (Irvin 2014).

As with all evaluations, there will be limitations on the strength and generalizability of their conclusions. Both states have unique characteristics that make it difficult to extend conclusions to the country as a whole. For example, Arkansas was a fee-for-service state prior to the expansion, which may lead to differing results when comparing costs to what would have occurred in a managed care state. Iowa chose to enroll only those who would have been eligible to enroll in an exchange plan if there was no Medicaid expansion (those with income between 100 and 138 percent FPL), limiting the population subject to the demonstration, although perhaps to one that is more similar to a commercial population.

There also is the added difficulty of identifying and collecting data on an appropriate comparison group, which is especially acute in Arkansas given the state's low Medicaid eligibility thresholds prior to the expansion. Finally, isolating the effect of the premium assistance approach, or any other waiver feature, will be complex given the other payment initiatives (such as the State Innovation Models [SIM] grants) occurring at the same time.

Conclusion

The purchase of exchange plans for Medicaid enrollees is a new phenomenon, with coverage available in just two states since January 1, 2014. Therefore, little data are available to judge the relative impact. Each waiver includes an evaluation that will provide a more thorough assessment of the approach, and there is widespread interest among the research and policy community more generally to have a better understanding of the impact of premium assistance. As such, while data currently may be limited, it is expected that more will become available given this broad interest.

A complete assessment of the questions raised here regarding the adequacy, continuity, and cost of premium assistance also will help to address whether its use should be broadened in Medicaid and CHIP. Of the 22 states that have not expanded Medicaid, some may seek alternative approaches.

For example, the governor of Utah has proposed an expansion that would include the purchase of exchange plans for Medicaid enrollees (Utah 2014). The premium assistance model also is relevant beyond newly eligible adults. For example, there have been discussions of the use of premium assistance in the exchanges for children now covered by CHIP.²⁸ The experience of Medicaid eligible adults enrolled in exchange plans could help inform the viability of such an approach for children. In addition, beginning in 2017, states may seek innovation waivers to develop alternative approaches to meeting the ACA coverage goals.

The plan must be at least as comprehensive and affordable as coverage under the ACA and cover as many residents, and it must not increase the federal deficit. Premium assistance also could play a role in these so-called super waivers. Looking forward, MACPAC will continue to

monitor the implementation of the premium assistance option in Arkansas and Iowa, as well as any additional states that choose such an approach, reporting on any available data regarding the impact of the waivers and the potential implications for Medicaid and the broader exchange market.

Endnotes

1. The new adult group consists of non-elderly adults previously ineligible for Medicaid, specifically adults without dependent children with incomes at or below 138 percent FPL and parents with incomes above pre-ACA eligibility thresholds, but at or below 138 percent FPL.

2 Arkansas is enrolling all adults in the new adult group in exchange plans, except for the roughly 10 percent of individuals who qualify as medically frail. Iowa is purchasing exchange plans for Medicaid-eligible individuals with incomes between 100 and 138 percent FPL who do not have access to cost-effective employer-sponsored insurance (those who would have been eligible to enroll in exchange coverage if the state had chosen not to expand Medicaid), with traditional Medicaid covering those in the new adult group below 100 percent FPL.

3 In traditional premium assistance models, enrollment could be mandatory or voluntary depending upon the authority under which the program operated and state policy. For example, under Section 1906A Health Insurance Premium Payment Programs, individuals could be required to enroll in employer-sponsored coverage if the option was deemed cost effective by the state. Under the 1115 waiver in Arkansas, enrollment in an exchange plan is mandatory except for enrollees who are medically frail. In Iowa, after one of the two exchange plans withdrew from the market, the state will no longer require enrollees with income above 100 percent FPL to enroll in an exchange plan as a condition of eligibility. Instead, enrollees will have a choice between the remaining exchange plan or the state's Wellness plan, designed for those in the new adult group with income up to 100 percent FPL.

4 Other instances of overlap between Medicaid and the private market exist. For example, Medicaid serves as the payer of last resort for individuals who have another source of coverage, as statute requires health insurers and other third parties, such as workers' compensation, to pay claims prior to the Medicaid program covering the cost of any care received by the enrollee. Medicaid also provides supplemental coverage for individuals, such as children, who have special health care needs but whose private plans do not provide the depth of benefits they need. Additionally, Medicaid covers Medicare Part A and Part B premiums and cost sharing expenses for certain groups of low-income Medicare beneficiaries through the Medicare Savings Programs (MSPs).

5 This includes comprehensive risk-based plans, limited benefit plans, and primary care case management programs.

6 New Hampshire submitted a Section 1115 waiver request on November 20, 2014, to use a premium assistance model for its expansion beginning in 2016.

7 If the alternative benefit package is delivered through an MCO, states must comply with the managed care rules (42CFR 440.385).

8 Both Arkansas and Iowa are operating in partnership with the federal exchange and maintaining plan management functions for the exchange plans sold. This oversight authority would likely enable the department of insurance to require exchange plan issuers to share additional plan data with the Medicaid agency (CMS 2014c and CMS 2013a).

9 CoOpportunity Health withdrew its participation in the Iowa waiver as of the end of November 2014. The enrollees covered by the issuer were transitioned to the Iowa Wellness Plan (the portion of the waiver covering those with income below 100 percent FPL not enrolled in exchange plans) as of December 1. New enrollees will have the choice of receiving coverage through the remaining plan, Coventry, or enrolling in the Wellness Plan. As of December 2014, CoOpportunity Health is no longer offering plans for non-Medicaid individuals in the Iowa exchange either (Iowa 2014b).

10 In Minnesota, for example, HMOs cannot obtain a license to sell private plans unless they are fully participating in Medicaid (Buettgens et al. 2012). Considerable overlap already exists between the exchange markets and Medicaid. For the 2014 open enrollment period, 41 percent of exchange plans issuers also operated Medicaid managed care plans in the states, although in 18 states there was no overlap in issuers (ACAP 2013).

11 Another option is for states to establish transition plans for individuals moving between coverage sources. For example, Maryland recently enacted legislation that allows those with acute conditions or serious chronic conditions, pregnancy, or mental health or substance use disorders to continue to receive services from an out-of-network provider for a limited time (Maryland Health Progress Act of 2013, H.B. 228). In 2015, Delaware will require its exchange plans to have transition plans for those who become eligible or lose eligibility for a public health program, which must include a transition period for prescription drugs (Delaware 2014).

12 Medicaid must provide access to care comparable to that of the general population. Medicaid managed care plans must maintain a sufficient number, mix, and geographic distribution of providers and cover out-of-network services if the network is unable to provide them (42 CFR 438.206- 207 and 42 CFR 438.52). Federal rules require exchange plans to offer networks that are sufficient in number and types of providers, including those that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay, but do not require an out-of-network option except in cases of emergency (45 CFR 156.230). They also must provide access to essential community providers (45 CFR 156.235).

13 With prior plan approval in both Medicaid managed care and exchange plans, it is possible to obtain care outside of the network if there is no in-network provider who can provide the specific benefit or services needed; however, seeking care out of network when there are in-network providers available is not an option in Medicaid managed care, although may be an option in some exchange plans (typically with higher cost sharing).

14 Arkansas is among the states that require insurance carriers to include all providers in their networks if they meet certain conditions (including accepting the plan's rates as payment), and as a result, plans in Arkansas may be less likely to have narrow networks (Noble 2014). Access to providers may unfold differently in states that do not have such a requirement.

15 There is also a question of how to compare the adequacy of networks. Typical measures of network adequacy include time and distance standards to providers, wait times for appointments, provider to patient ratios, and the inclusion of certain safety net providers. However, there are no consistent standards for these measures used across states, such as one primary care provider for every 100 enrollees. A recent HHS Inspector General (OIG) report found that state provider access standards for Medicaid managed care vary widely and are not specific to the type of provider or area of the state (OIG 2014).

16 Access to out-of-network family planning services also is preserved. Specifically, if family planning services are sought from an out-of-network provider, the state's fee-for-service Medicaid program will cover those services. Premium assistance enrollees also must have

access to at least one exchange plan that contracts with at least one federally qualified health center (FQHC) or rural health center (RHC).

17 Iowa requested a waiver of EPSDT for 19- and 20-yearolds in its expansion population, but it was not granted (Iowa 2013).

18 Under Section 1115 authority, the Secretary can waive premium requirements; however, Section 1916(f) sets limits on changes that can be made to cost-sharing provisions through a waiver.

19 The premiums in Iowa constitute about 1 percent of an individual's income between 100 and 133 percent FPL. Iowa's original approval letter restricted the state from imposing premiums that exceeded those in the exchange and the special terms and conditions specified that premiums could not exceed 2 percent of income (CMS 2013c). The waiver terms were revised, allowing for the imposition of \$10 monthly premiums (CMS 2014b).

20 The hardship exemption in Iowa is only effective for the month requested and not for the entire year; however, enrollees are able to self-attest to a financial hardship each month.

21 Certain groups are exempt from enrollment in the ABP, an exemption that applies if a state adopts an ABP that does not align with the state's Medicaid program, including when the state is using an exchange plan premium assistance approach to coverage. Given that many exempt individuals may be eligible for coverage under another eligibility pathway (e.g., disability-related coverage), the exempt population most likely to be enrolled in the new adult group is the medically frail. The federal definition of medically frail includes individuals with disabling mental health disorders, chronic substance use, serious and complex medical conditions, a physical or mental disability that significantly impairs their ability to perform one or more activities of daily living, or other special medical needs (42 CFR 440.315(f)).

22 While the actual cost to enroll the demonstration population in exchange plans is known, it is not possible to compare the cost to the same population enrolled in direct Medicaid coverage because that group did not exist prior to 2014 (and will not exist in states that enroll the entire expansion population in exchange plans). Therefore, CMS has allowed states to estimate costs for the expansion population, then adjust that limit if actual costs under the demonstration are higher than initially projected. In September 2014, the U.S. Government Accountability Office (GAO) raised concerns that this approach increases the risk that these demonstrations will not be budget neutral (GAO 2014).

23 Under the regulations governing premium assistance in the individual market, the purchase of such coverage must also be cost effective (42 CFR 435.1015(a) (4)). This means that the total cost of purchasing such coverage, including administrative expenditures, the costs of paying all excess cost-sharing charges, and the costs of providing wrap-around benefits, must be comparable to the cost of providing direct coverage under the state plan. Both Arkansas and Iowa received waivers of this provision, although were required to establish an alternative method for determining cost effectiveness (CMS 2014a and CMS 2014b).

24 Outside the Medicaid expansion population, the number of individuals who had selected an exchange plan in Arkansas between October 1, 2013 and March 31, 2014 was 43,446.

25 While there is little evidence to this point, the Arkansas waiver suggests that the demonstration also will lead to more competitive premium pricing by doubling the size of the population enrolled (CMS 2014a). The idea of additional carriers joining the exchange market

has been discussed by former Arkansas Medicaid Director Andy Allison (Allison 2014).

26 Arkansas also is required to evaluate whether enrollees have appropriate access to NEMT. However, the amendment in Arkansas requiring the use of Independence Accounts did not require evaluation of the new cost-sharing approach, although it may be added into the evaluation plan at a later date.

27 The evaluation is examining four types of Section 1115 waivers, including premium assistance and healthy behaviors/value-based purchasing initiatives as well as delivery system reform incentive payments (DSRIP) and managed long-term services and supports (MLTSS).

28 For example, at its December 2014 meeting, the Commission discussed the use of a premium assistance approach to supplement the benefits and cost sharing for children who move from CHIP coverage to exchange plans following the expiration of CHIP funding.

Appendix 6 Essential and Preventive Care Benefit

The Affordable Care Act's Ten Essential health benefits include:

1. **Ambulatory patient services (Outpatient care).** Care you receive without being admitted to a hospital, such as at a doctor's office, clinic or same-day ("outpatient") surgery center. Also included in this category are home health services and hospice care (note: some plans may limit coverage to no more than 45 days).
2. **Emergency Services (Trips to the emergency room).** Care you receive for conditions that could lead to serious disability or death if not immediately treated, such as accidents or sudden illness. Typically, this is a trip to the emergency room, and includes transport by ambulance. You cannot be penalized for going out-of-network or for not having prior authorization.
3. **Hospitalization (Treatment in the hospital for inpatient care).** Care you receive as a hospital patient, including care from doctors, nurses and other hospital staff, laboratory and other tests, medications you receive during your hospital stay, and room and board. Hospitalization coverage also includes surgeries, transplants and care received in a skilled nursing facility, such as a nursing home that specializes in the care of the elderly (note: some plans may limit skilled nursing facility coverage to no more than 45 days).
4. **Maternity and newborn care.** Care that women receive during pregnancy (prenatal care), throughout labor, delivery and post-delivery, and care for newborn babies.
5. **Mental health services and addiction treatment.** Inpatient and outpatient care provided to evaluate, diagnose and treat a mental health condition or substance abuse disorder. This includes behavioral health treatment, counseling, and psychotherapy. (Note: some plans may limit coverage to 20 days each year. Limits must comply with state or federal parity laws. Read this document for more information on (mental health benefits and the Affordable Care Act))
6. **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. Insurers may limit drugs they will cover, 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
7. **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.
8. **Laboratory services.** Testing provided to help a doctor diagnose an injury, illness or condition, or to monitor the effectiveness of a particular treatment. Some preventive screenings, such as breast cancer screenings and prostate exams, are provided free of charge.
9. **Preventive services, wellness services, and chronic disease treatment.** This includes counseling, preventive care, such as physicals, immunizations and screenings,

like cancer screenings, designed to prevent or detect certain medical conditions. Also, care for chronic conditions, such as asthma and diabetes. (Note: please see our full list of **Preventive services** for details on which services are covered.)

10. **Pediatric services.** Care provided to infants and children, including well child visits and recommended vaccines and immunizations. Dental and vision care must be offered to children younger than 19. This includes two routine dental exams, an eye exam and corrective lenses each year.

Preventive Care Benefits

Adult Services

The 15 preventive services for adults are immunizations, screenings for depression, blood pressure, colorectal cancer, and high cholesterol. Diet and alcohol abuse counseling, though not screening services are also included as no out-of-pocket services.

1. **Abdominal Aortic Aneurysm one-time screening** for men of specified ages who have ever smoked
2. **Alcohol Misuse screening and counseling**
3. **Aspirin use** to prevent cardiovascular disease for men and women of certain ages
4. **Blood Pressure screening** for all adults
5. **Cholesterol screening** for adults of certain ages or at higher risk
6. **Colorectal Cancer screening** for adults over 50
7. **Depression screening** for adults
8. **Diabetes (Type 2) screening** for adults with high blood pressure
9. **Diet counseling** for adults at higher risk for chronic disease
10. **HIV screening** for everyone ages 15 to 65, and other ages at increased risk
11. **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**
12. **Obesity screening and counseling** for all adults
13. **Sexually Transmitted Infection (STI) prevention counseling** for adults at higher risk
14. **Syphilis screening** for all adults at higher risk

15. **Tobacco Use screening** for all adults and cessation interventions for tobacco users

Women's Preventive Services

These provisions include well-woman visits, counseling for domestic violence victims, domestic violence screenings, and contraception counseling and dispensing.

1. **Anemia screening** on a routine basis for pregnant women
2. **Breast Cancer Genetic Test Counseling (BRCA)** for women at higher risk for breast cancer
3. **Breast Cancer Mammography screenings** every 1 to 2 years for women over 40
4. **Breast Cancer Chemoprevention counseling** for women at higher risk
5. **Breastfeeding comprehensive support and counseling** from trained providers, and access to breast feeding supplies, for pregnant and nursing women
6. **Cervical Cancer screening** for sexually active women
7. **Chlamydia Infection screening** for younger women and other women at higher risk
8. **Contraception**: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
9. **Domestic and interpersonal violence screening and counseling** for all women
10. **Folic Acid** supplements for women who may become pregnant
11. **Gestational diabetes screening** for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
12. **Gonorrhea screening** for all women at higher risk
13. **Hepatitis B screening** for pregnant women at their first prenatal visit
14. **HIV screening and counseling** for sexually active women
15. **Human Papillomavirus (HPV) DNA Test** every 3 years for women with normal cytology results who are 30 or older
16. **Osteoporosis screening** for women over age 60 depending on risk factors
17. **Rh Incompatibility screening** for all pregnant women and follow-up testing for women at higher risk
18. **Sexually Transmitted Infections counseling** for sexually active women
19. **Syphilis screening** for all pregnant women or other women at increased risk

20. **Tobacco Use screening and interventions** for all women, and expanded counseling for pregnant tobacco users
21. **Urinary tract or other infection screening** for pregnant women
22. **Well-woman visits** to get recommended services for women under 65

Children's Preventive Services

2. **Autism screening** for children at 18 and 24 months
3. **Behavioral assessments** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
4. **Blood Pressure screening** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
5. **Cervical Dysplasia screening** for sexually active females
6. **Depression screening** for adolescents
7. **Developmental screening** for children under age 3
8. **Dyslipidemia screening** for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
9. **Fluoride Chemoprevention supplements** for children without fluoride in their water source
10. **Gonorrhea preventive medication** for the eyes of all newborns
11. **Hearing screening** for all newborns
12. **Height, Weight and Body Mass Index measurements** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
13. **Hematocrit or Hemoglobin screening** for children
14. **Hemoglobinopathies or sickle cell screening** for newborns
15. **HIV screening** for adolescents at higher risk
16. ****Hypothyroidism screening** for newborns
17. **Immunization vaccines** for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
 - a. Diphtheria, Tetanus, Pertussis
 - b. Haemophilus influenza type b
 - c. Hepatitis A
 - d. Hepatitis B
 - e. Human Papillomavirus
 - f. Inactivated Poliovirus
 - g. Influenza (Flu Shot)
 - h. Measles, Mumps, Rubella
 - i. Meningococcal

- j. Pneumococcal
- k. Rotavirus
- l. Varicella

- 18. **Iron supplements** for children ages 6 to 12 months at risk for anemia
- 19. **Lead screening** for children at risk of exposure
- 20. **Medical History** for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- 21. **Obesity screening and counseling**
- 22. **Oral Health risk assessment** for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
- 23. **Phenylketonuria (PKU) screening** for this genetic disorder in newborns
- 24. **Sexually Transmitted Infection (STI) prevention counseling and screening** for adolescents at higher risk
- 25. **Tuberculin testing** for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- 26. **Vision screening** for all children.

Appendix 7: Comparison of Average PPO 1500 Plan to MAP and MIP

PPO 1500 Schedule of Benefits

Your Benefits: What your plan covers	Participating Providers	Non-Participating Providers	Medicaid Benefits	Group VIII Medicaid Benefits	MIP Benefits	Proposed Para Todu Benefits
Deductible Per Individual Member (Class 1)	\$1,500	\$3,000	None	None	None	
Deductible Per Family (Classes 2-4) If a member meets their \$1,500 deductible, the plan begins to pay for covered services for that individual	\$3,000	\$9,000	Not Applicable	Not Applicable	Not Applicable	
Coverage Maximums Individual member annual maximum	None	None	None	None	None	
Out of Pocket Maximums (including accumulated deductible and copays) Per Individual member per policy year Per Family per policy year	\$3,000 \$9,000	No Maximum	None	None	None	
Any Services in the Philippines, Hawaii & the U.S. Mainland and any foreign participating providers. (Pre-Certification Required)	Requires a referral from your doctor and approval in advance from the plan		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:	Participating Providers (Deductible does not apply to this benefit)	Non-Participating Providers (After deductible is met)				
Preventive Services (Out-Patient Only)	Plan pays 100%	Not Covered	Preventive Services (Out-Patient Only)			

Includes Annual Preventive Exams and Preventive Lab Services (Guam and Philippines only) In accordance with the guidelines established by the U.S. Preventive Services Task Force (USPSTF) Grades A and B recommendations			Plan pays 100%,	Plan pays 100%,	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability	
Immunizations/Vaccinations			Immunizations/Vaccinations			
In accordance with the guidelines established by the Advisory Committee on Immunization Practices	Plan pays 100%	Not Covered	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability	
Pre-Natal Care			Pre-Natal Care			
Including Routine Labs and 1st Ultrasound	Plan pays 100%	Not Covered	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability	
Well-Child Care			Well-Child Care			
Infancy (Newborn to nine months) Maximum seven visits Early Childhood (One to four years old) Maximum seven visits Middle Childhood / Adolescence (Five to 17 years old) Maximum one visit/year	Plan pays 100%	Not Covered	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability	

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%	Not Covered	Well-Woman Care			
Deductible does not apply to these benefits when you go to a Participating Provider. Co-payments do not accrue towards the deductible:	Participating Providers (Deductible does not apply to this benefit)	Non-Participating Providers (After deductible is met)	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability	
Annual Eye Exam	\$20 Member Co-Pay	Not Covered	Annual Eye Exam			
Once per Member per Plan Year	Covered in Outpatient Only		Plan pays 100%	Not covered for age 21-64	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability	
Outpatient Physician Care & Services			Outpatient Physician Care & Services			
1. Primary Care Visits	\$20 Member Co-Pay	Plan pays 70%* Member pays 30%	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; 93%-55% for MIP with Liability	
2. Specialist Care Visits	\$40 Member Co-Pay	Plan pays 70%* Member pays 30%	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; 93%-	

88 [Guam Health Insurance Expansion Program]

					55% for MIP with Liability	
3. Urgent Care Centers	\$10 Member Co-pay	Plan pays 70% Member pays 30%	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; 93%-55% for MIP with Liability	
4. Voluntary Second Surgical Opinion	\$40 Member Co-pay	Plan pays 70% Member pays 30%	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; 93%-55% for MIP with Liability	
5. Home Health Care Visit	Plan pays 100%	Not Covered	Plan pays 100% (PA required)	Plan pays 100%	Plan pays 100% for MIP without Liability; 93%-55% for MIP with Liability (PA required)	
6. Hospice Care in Guam only, maximum 180 days at a maximum of \$150 per day (Pre-Certification Required)	\$40 Member Co-pay	Plan pays 70% Member pays 30%	Limited to two 90-day periods, PA required beyond 180 days.	Hospice Care, not covered off-island; maximum 180 days (PA required)	Maximum 180 days. (PA required)	
7. Outpatient Laboratory	\$20 Member Co-pay	Plan pays 70% Member pays 30%	Plan pays 100%	Plan pays 100%; \$5 co-pay per visit for services a ≥ \$50 (applicable to clients with Income beyond 100% FPL)	Plan pays 100% for MIP without Liability; 93%-55% for MIP with Liability	
8. X-Ray Services	\$20 Member Co-pay	Plan pays 70% Member pays 30%	Plan pays 100%	Plan pays 100%; \$5 co-pay per visit for services a ≥ \$50 (applicable to clients with Income beyond 100% FPL)	Plan pays 90%, member pays 10% for MIP without Liability; 83%-45% for MIP with Liability	

9. Injections (Does not include those on the Specialty Drugs List and Orthopedic Injections)	\$20 Member Co-Pay	Plan pays 70% Member pays 30%	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; 93%-55% for MIP with Liability	
Prescription Drugs			Prescription Drugs			
1. Formulary generic drugs per prescription unit	\$15 Member Co-Pay (\$0 day supply)	Plan pays 50% of Average Wholesale Price	Plan pays 100%	Plan pays 100% \$2.50 co-payment per drug prescription that agency pays ≥\$25 per drug (applicable to clients with Income beyond 100% FPL)	\$2.50 co-payment per prescription filled for MIP without Liability; \$2.50 per prescription filled plus 7%-45% for MIP clients with Liability.	
2. Formulary brand name drugs per prescription unit	\$30 Member Co-Pay (\$0 day supply)	Plan pays 50% of Average Wholesale Price Plan pays 50% of Average Wholesale Price	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.	If no generic available, \$2.50 co-payment per prescription filled for MIP without Liability; \$2.50 per prescription filled plus 7%-45% for MIP clients with Liability.	
3. Mail Order	Co-Pay waived		Not Applicable	Not Applicable	Not Applicable	

4. Non-Formulary (Medically Necessary Only and Pre- Certification Required)	\$30 Member Co-Pay (\$0 day supply)	Plan pays 50% of Average Wholesale Price	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.	\$2.50 co- payment per prescription filled for MIP without liability; \$2.50 per prescription filled plus 7%- 45% for MIP clients with liability. If no alternative drug listed on the drug formulary (Justification required)	
5. Specialty Drugs (Medically Necessary Only and Pre- Certification Required)	\$30 Member Co-Pay (\$0 day supply)	Not Covered	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.	\$2.50 co- payment per prescription filled for MIP without liability; \$2.50 per prescription filled plus 7%- 45% for MIP clients with liability	
Deductible must be met for the following services:	Participati ng Providers (After deductible is met)	Non- Participating Providers (After deductible is met)				
Acupuncture	Plan pays 60% Member pays 40%	Not Covered	Not covered	Acupuncture Plan pays 100% 30 visits per fiscal year	\$50.00 per visit, 10 visits per contract period	
30 visits per member per plan year						
AIDS Treatment	Plan pays	Not Covered		AIDS Treatment		

Exclusive of Experimental drugs	80% Member pays 20%		Plan pays 100%	Plan pays 100% Approved FDA treatment and drugs	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability	
Airfare Benefit to Centers of Excellence only			Airfare Benefit to Centers			
For members who meet qualifying conditions, Plan provides round-trip airfare (Plan Approval Required)	Plan pays 100%	Not Covered	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.	Plan pays 100% for MIP without Liability; 93%-55% for MIP with Liability (For services not available on Island)	
Allergy Testing	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Allergy Testing			
\$1000 per member per plan year			For medically necessary service	\$500.00 annually (PA required)	For medically necessary service	
Ambulatory Surgi-center Care (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Ambulatory Surgi-center Care			
			Plan pays 100%	Plan pays 100% (PA required)	Plan pays 100%	
Blood & Blood Derivatives	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Plan pays 100%	Plan pays 100%	Plan pays a maximum of \$50,000 per fiscal year excluding any person with hemophilia, or any hemophilia-related condition requiring the administration of blood and blood	

					products for MIP without liability; 93%-55% of the maximum limitation for MIP clients with liability.	
Breast Reconstructive Surgery (in accordance with 1998 W.H.C.R.A)	Plan pays 60% Member pays 20%	Plan pays 70%* Member pays 30%	Not Covered	Plan pays 100%(PA required)	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability (PA required)	
Cardiac Surgery	Plan pays 60% Member pays 20%	Plan pays 70%* Member pays 30%	Plan pays 100%	Plan pays 100%. PA required for off-island services not available on Guam.	Plan pays 90%, member pays 10% for MIP without Liability; 83%-45% for MIP with Liability	
Cataract Surgery Outpatient Only (including conventional lens)	Plan pays 60% Member pays 20%	Plan pays 70%* Member pays 30%	Plan pays 100%	Plan pays 100%. PA required for off-island services not available on Guam.	Plan pays 90%, member pays 10% for MIP without Liability; 83%-45% for MIP with Liability Lens not covered.	
Chemical Dependency	Plan pays 60% Member pays 20%	Plan pays 70%* Member pays 30%	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.	Maximum \$10,000 per fiscal year for MIP clients without liability; less 7%-45% for	

					MIP clients with liability	
Chemotherapy Benefit	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability	
Chiropractic Care	Plan pays 80% Member pays 20%	Not Covered	Not covered	30 visits per fiscal year	10 visits at \$25 per visit per fiscal year for MIP without Liability; 93%-55% of the limitation for MIP with Liability (PA required)	
30 visits per member per plan year	Plan pays 80% Member pays 20%	Not Covered	Plan pays 100%	Plan pays 100%	Plan pays 100%	
Congenital Anomaly Diseases Coverage	Plan pays 80% Member pays 20%	Not Covered	Plan pays 100%	Plan pays 100%	Plan pays 100%	
Diagnostic Testing	Plan pays 80% Member pays 20%	Plan pays 70%*	Diagnostic Testing			

MRI, CT scan, and other diagnostic procedures (Pre-Certification Required)	Plan pays 60% Member pays 20%	Member pays 30%	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.	Plan pays 90% for MIP without Liability; Plan pays 83%-45% for MIP with Liability (PA is required for CT scan, MRA and MRI)	
Durable Medical Equipment (DME) The lesser amount between the Purchase or Rental of crutches, walkers, wheelchairs, hospital beds, suction machines, nebulizer machine, or oxygen and accessories when prescribed by a Physician (Pre-Certification Required)	Plan pays 80% Member pays 20% of the total rental cost or purchase	Not Covered	Plan pays 100%. Medical equipment/machine is limited to every five years. 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.	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.	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability PA is required	
Elective Surgery (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Plan pays 100%. PA is required for elective surgery with one or more day admission prior to surgery.	Plan pays 100%. Non-emergency Outpatient Surgeries.	Plan pays 100%. PA is required for elective surgery with one or more day admission prior to surgery.	
Emergency Care	Plan pays 80%	Plan pays 80% Member pays	Plan pays 100%. PA is required for medically	Plan pays 100%. PA is required for medically	Plan pays 100%.	

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	Member pays 20%	20%	necessary services that are not available on island.	necessary services that are not available on island.	Maximum \$175,000 per year, including airfare/travel and escort fees. PA is required.	
End Stage Renal Disease / Hemodialysis	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability	
Hearing Aids Maximum \$500 per member per plan year	Plan pays 80% Member pays 20%	Not Covered	Plan pays 100%. Limited every 3yrs (PA required)	\$500 every 3yrs (PA required)	Maximum \$500.00. Plan pays 100% of the maximum amount for MIP without Liability, 93%-55% for MIP with Liability	
Hospitalization & Inpatient Benefits 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	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	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.	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability	
Implants	Plan pays	Plan pays 50%	Plan pay 100%. Orthopedic	Plan pay 100%. And	Plan pay	

Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopedic Internal prosthetic devices (Limitations apply, please refer to contract)	80% Member pays 20%	Member pays 50%	internal and external prosthetic devices not covered	orthopedic external prosthetic devices are covered.	100%. Cardiac pacemakers, heart valves, stents, intraocular lenses are not covered	
Inhalation Therapy	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability	
Maternity Care	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Plan pays 100%	Plan pays 100%	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability	
Labor and Delivery						
Mental Health Care	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	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.	Maximum of 30 days inpatient hospitalization per illness. Plan pays 100% of the limitation for MIP without Liability, 93%-55% for MIP with Liability	
Nuclear Medicine (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Plan pays 100%	COST-SHARING POPULATION: Nuclear Medicine - \$5.00 co-payment for visit that agency pays \$50 & above (Prior Authorization Required)	Plan pays 90% for MIP without Liability; Plan pays 93%-55% for MIP with Liability.	

Occupational Therapy 20 visits per Plan Year (Pre-Certification Required)	Plan pays 80% Member pays 20%	Not Covered	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)	Limited to 20 visits, thereafter 50% coinsurance. Plan pays 100% of the limitation for MIP without Liability, 93%- 55% for MIP with Liability	
Organ Transplant (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Not covered	Not covered	Not covered	
Orthopedic Conditions Internal and External Prosthesis	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Plan pay 100%. Orthopedic internal and external prosthetic devices are not covered.	Plan pay 100%.	Plan pays 90%, member pays 10%. Maximum \$50,000 per year.	
Physical Therapy (Pre-Certification Required)	Plan pays 80% for the first 20 visits and 50% thereafter	Plan pays 70% Member pays 30%	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)	Plan pays 100% (PA required) Limited to 20 visits, thereafter 50% coinsurance.	
Radiation Therapy (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Plan pays 100%	Plan pays 100%	Plan pays 90%, 10% co- pay	
Robotic Surgery/Robotics Suite (Pre-Certification Required)	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Not covered	Not covered	Not covered	
Skilled Nursing Facility Maximum 60 days per member per plan year	Plan pays 80% Member pays 20%	Plan pays 70% Member pays 30%	Plan pays 100%. Limited to 180 days maximum per fiscal year.	Plan pays 100%. 60 days max per fiscal year.	Limited to 180 days maximum per fiscal year.	

(Pre-Certification Required)	Plan pays 80% Member pays 20%				Plan pays 100% of the limitation for MIP without Liability, 93%-55% for MIP with Liability		
Sleep Apnea Diagnostics and Therapeutic Procedure		Not Covered	Plan pays 100% (PA required)	Plan pays 100% (PA required)	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability (PA required)		
(Pre-Certification Required)							
Sterilization Procedures	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%	Sterilization Procedures (Tubal Ligation and Vasectomy)				
			Plan pays 100% (PA required)	Plan pays 100% (PA required)	Plan pays 100% for MIP without Liability; Plan pays 93%-55% for MIP with Liability (PA required)		
Vasectomy (Outpatient Only)							
Vision Care	Plan pays 80% Member pays 20%	Plan pays 70%* Member pays 30%	Eye Exam: Limited to every two (2) years. (PA is required) Corrective Lenses: Maximum \$80 every two (2) years. Bi-focal Lenses: Maximum \$128 every two (2) years. (PA is required)	Eye Exam: Limited to every two (2) years. (PA is required) Corrective Lenses: Maximum \$80 every two (2) years. Bi-focal Lenses: Maximum \$128 every two (2) years. (PA is required) Not covered for ages 21-64	Eye Exam: Maximum \$50 every year. Corrective Lenses: Maximum \$100 every two (2) years. Bi-focal Lenses: Maximum \$100 every two (2) years. (PA is required) Plan pays 100% of the maximum limit for MIP		
Hardware up to \$150							
Additional Benefits: What the Plan Covers							

					without Liability, 93%-55% for MIP with Liability (PA required)	
Wellness and Fitness Benefit						
Wellness Benefit at a Wellness Center 1. Dr. Horinouchi's Wellness Center 2. Guam SDA Wellness Center	Plan pays 80% of the first \$200 Member pays 20% of the first \$200 Plan pays 80% of charges thereafter	Not Covered	Not covered	\$200.00 annually (PA required)	Not covered	
Fitness Benefit (Deductible not Required) 1. Custom Fitness 2. Paradise Fitness Center 3. Synergy Studios 4. Unified	Plan Pays 100%	Not Covered	Not covered	Plan pays 100% gym membership	Not covered	

End of report

Senator Thomas C. Ada,
Vice Chairperson

Speaker Benjamin J.F. Cruz,
Member

Vice Speaker Therese M. Terlaje,
Member

Senator Frank B. Aguon, Jr.,
Member

Senator Telenia C. Nelson,
Member



Senator Dennis G. Rodriguez, Jr.,
Member

Senator Joe S. San Agustin,
Member

Senator Michael F.Q. San Nicolas,
Member

Senator James V. Espaldon,
Member

Senator Mary Camacho Torres,
Member

COMMITTEE ON RULES SENATOR RÉGINE BISCOE LEE, CHAIR

SIKRITARIAN LIHESLATURAN GUAHAN
I MINA'TRENTAI KUATTRO NA LIHESLATURAN GUÁHAN
LEGISLATIVE SECRETARY • 34TH GUAM LEGISLATURE

COMMITTEE REPORT CHECKLIST

Part 1 / 1

Bill No. 132-34 (COR) As substituted by the Committee on Appropriations and Adjudication. AN ACT RELATIVE TO IMPROVING EFFICIENCY IN PROGRAM OPERATIONS AND EXPANDING HEALTHCARE ACCESS TO THE GUAM MEDICAID PROGRAM BY PURSUING A SECTION 1115 WAIVER UNDER 42 U.S.C. §1315 THEREBY AUTHORIZING THE ESTABLISHMENT OF A MANAGED CARE PILOT PROGRAM TO BE KNOWN AS "THE HEALTH CARE PARA TODU PLAN."		
REFERRED TO: Speaker Benjamin J.F. Cruz, Committee on Appropriations and Adjudication		
(A) FISCAL NOTE or WAIVER	(1) Requested by COR <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Date & Time: Wed., July 5, 2017 @ 3:26 p.m.
	(2) Received by COR <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	Date & Time: Tues., July 25, 2017 @ 4:57 p.m.
	(3) Waived by COR <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	Date & Time:
	(4) Bill contains appropriations or authorizations for appropriations from any fund sources? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	If YES: (4/5)(a) Funding Availability Note/Waiver (OFB) attached? <input checked="" type="checkbox"/> YES BBMR <input type="checkbox"/> NO (Unable to file CMTE Report)
	(5) Bill contains an authorization to expend government funds? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	(4/5)(b) Funding source identified? 2 GCA § 9101 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (Proceed to (A)(6))
	(6) Restrictions Against Unfunded Appropriations (2 GCA § 9101) <input type="checkbox"/> Identifies specific alternate funding source <input type="checkbox"/> De-appropriates from previous appropriation with available funds and fiscal note <input type="checkbox"/> Written certification by CMTE Chair that a situation exists which "threatens the safety, health and welfare of the community"	(4/5)(c) Funds available and sufficient? 2 GCA § 9101 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (Proceed to (A)(6))
If no boxes checked: UNABLE TO PLACE ON SESSION AGENDA 2 GCA § 9102		

Committee Report Checklist on
 Bill No. 132-34 (COR) As substituted by the Committee.
 Part 1 / 1

(B) PUBLIC HEARING	(1) HEARING NOTICES SR §§ 6.04(a)(1) and 6.04(a)(2), Open Government Law (5 GCA, Ch. 8)	
	<input checked="" type="checkbox"/> (a) Five (5) working days prior (A L Senators & ALL Media)	Date and Time of Notice: <i>Tues., September 12, 2017 @ 2:00 p.m.</i>
	<input checked="" type="checkbox"/> (b) Forty-eight (48) hours prior (ALL Senators & ALL Media)	Date and Time of Notice: <i>Sat., September 16, 2017 @ 5:00 p.m.</i>
	(2) Date and Time of Hearing: <i>Tues., September 19, 2017 @ 2:00 p.m.</i>	or (4) HEARING WAIVED by Speaker in case of emergency SR § 6.04(a)(1) <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A If YES: Attach memo indicating WAIVER
	(3) Location: Public Hearing Room, Guam Congress Building	
	(5) AMENDMENTS or SUBSTITUTIONS BY COMMITTEE SR § 6.04(b)	
	(a) Committee elects to substitute bill? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	If YES: Date and Time: <i>10.18.17 @ 10:59 a.m.</i> (a)(1) Vote sheet affirmative? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO (a)(2) Preliminary report filed with COR? SR § 6.04(b)(2) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO (a)(3) Public Hearing noticed? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
	(b) Bill materially different after committee amendment or substitution? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	If YES: SECONDARY PUBLIC HEARING MAY BE REQUIRED SR § 6.04(c)(3) <input type="checkbox"/> YES <input type="checkbox"/> NO <hr/> COR Chair

Committee Report Checklist on
 Bill No. 132-34 (COR) As substituted by the Committee.
 Part 1 / 1

(C) COMMITTEE REPORT	(1) Committee Report filed with COR? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If YES: Date & Time: <u>Wed., October 18, 2017</u> <u>@ 10:09 a.m.</u>	Notes:	If NO: UNABLE TO PLACE ON SESSION AGENDA SR § 6.04(d)(1)
	(1)(a) Secondary CMTE Report filed with COR? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A If YES: Date & Time:		
	(2) LAND LEGISLATION		
	(a) Bill involves government taking, transfer, purchase, or lease of land? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A	If YES: ATTACH TWO (2) PROPERTY APPRAISALS TO CMTE REPORT SR § 6.04(c)(4) 2 GCA § 2107(b)	
	(a)(1) Please indicate on both columns: <table border="1" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> (i) Type of transaction: <input type="checkbox"/> Taking <input type="checkbox"/> Transfer <input type="checkbox"/> Purchase <input type="checkbox"/> Lease </td> <td style="width: 50%; vertical-align: top;"> (ii) Type of entity: <input type="checkbox"/> Government <input type="checkbox"/> Non-government </td> </tr> </table>		
	(i) Type of transaction: <input type="checkbox"/> Taking <input type="checkbox"/> Transfer <input type="checkbox"/> Purchase <input type="checkbox"/> Lease	(ii) Type of entity: <input type="checkbox"/> Government <input type="checkbox"/> Non-government	
	(b) Bill involves legislative land rezoning? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A	If YES: INCLUDE Land Zoning Consideration Report 2 GCA § 2110	
	(b)(1) Bill involves legislative rezoning of property zoned Agricultural (A)? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A	If YES: INCLUDE Agricultural Consideration Report (Dept. of Agriculture) 2 GCA § 2110 [Proceed to (b)(2)]	
(b)(2) Proof of Agricultural consideration report reviewed by Guam Land Use Commission? 21 GCA § 61637 <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A			

Committee Report Checklist on
 Bill No. 132-34 (COR) As substituted by the Committee.
 Part 1 / 1

(D) COMMITTEE REPORT (continued)	(3) G.A.R.R. LEGISLATION SR § 6.04(c)(1) 5 GCA §§ 9301 and 9303	
	a) Bill involves approving or amending Rules and Regulations? <input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> N/A	If YES: INCLUDE Economic Impact Statement 5 GCA §§ 9301(d), 9301(e), 9301(f)
	(4) COMMITTEE REPORT COMPONENTS	
	(a) Front Page Transmittal to Speaker	<input checked="" type="checkbox"/>
	(a)(1) COR Chair Signature Line	<input checked="" type="checkbox"/>
	(b) Title Page	<input checked="" type="checkbox"/>
	(c) Committee Chair Memo to All Committee Members	<input checked="" type="checkbox"/>
	(d) COR Referral Memorandum	<input checked="" type="checkbox"/>
	(e) Notice of Public Hearing & Other Correspondence	<input checked="" type="checkbox"/>
	(f) Public Hearing Agenda	<input checked="" type="checkbox"/>
	(g) Public Hearing Sign-in Sheet	<input checked="" type="checkbox"/>
	(h) Written Testimonies & Additional Documents	<input checked="" type="checkbox"/>
	(i) Committee Vote Sheet(s)	<input checked="" type="checkbox"/>
	(j) Committee Report Digest(s)	<input checked="" type="checkbox"/>
	(k) Bill History	<input checked="" type="checkbox"/>
	(k)(1) Copy of Bill as introduced	<input checked="" type="checkbox"/>
	(k)(2) COR Pre-Referral Checklist	<input checked="" type="checkbox"/>
	(k)(3) Copy of Bill as corrected by Prime Sponsor (if applicable)	<input type="checkbox"/> N/A
	(k)(4) Copy of Bill as amended/substituted by Committee (if applicable) with Exhibit "A"	<input checked="" type="checkbox"/>
	Substitute/Amended Mark-Up Version	<input checked="" type="checkbox"/>
	Substitute/Amended Word-Version Emailed to COR?	<input checked="" type="checkbox"/>
	(l) Fiscal Note/Waiver and Funding Availability Note (OFB)	<input checked="" type="checkbox"/> OFB
	(m) Two (2) Property Appraisals (if applicable)	<input type="checkbox"/> N/A
	(n) Related News Reports (optional)	<input type="checkbox"/> N/A
	(o) Miscellaneous (optional)	<input checked="" type="checkbox"/>
	(p) Committee Report Checklist(s)	<input checked="" type="checkbox"/>
		<input checked="" type="checkbox"/>
	Originals	<input checked="" type="checkbox"/>
	Single-Sided	<input checked="" type="checkbox"/>
	Letter Size	<input checked="" type="checkbox"/>
	No Staples/ Paper Clips	<input checked="" type="checkbox"/>
(E) COR Action	<input checked="" type="checkbox"/> CMTE Report duly filed; Available for Placement on Session Agenda	COR CHAIR (Signature, Date & Time) 10/18/17 @ 12:13pm.
	<input type="checkbox"/> CMTE Report non-conforming for acceptance; Return to Committee	