EDDIE BAZA CALVO
Governor

RAY TENORIO
Lieutenant Governor

Office of the Governor Of Guam.

GH#34-17-1230
Speaker Benjamin J.F. Cruz

NOV 15 2017

NOV 15 2017
Time: 3:48 [ ] AM [✓] PM File No ____
Received By: ____

Honorable Benjamin J.F. Cruz
Speaker
I Mina'trentai Kuåttro Na Liheslaturan Guåhan
Guam Congress Building
163 Chalan Santo Papa
Hagåtña, Guam 96910

Dear Mr. Speaker:

Transmitted herewith is Substitute Bill No. 132-34 (COR), **"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,"** which was signed on November 9, 2017, as **Public Law 34-59.**

Senseramente,

EDDIE BAZA CALVO

2017 NOV 15 PM 4:11
Speaker Benjamin J.F. Cruz
NOV 15 2017
Time: 3:47 [ ] AM [✓] PM File No. ____
Received By: ____

1230

I MINA'TRENTAI KUÅTTRO NA LIHESLATURAN GUÅHAN
2017 (FIRST) Regular Session

CERTIFICATION OF PASSAGE OF AN ACT TO *I MAGA'LÅHEN GUÅHAN*

This is to certify that **Substitute Bill No. 132-34 (COR), "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,"** was on the 27th day of October 2017, duly and regularly passed.

Benjamin J.F. Cruz
Speaker

Attested:

Régine Biscoe Lee
Legislative Secretary

This Act was received by *I Maga'låhen Guåhan* this 30th day of Oct, 2017, at 11:31 o'clock a .M.

Assistant Staff Officer
Maga'låhi's Office

APPROVED:

EDWARD J.B. CALVO
I Maga'låhen Guåhan

Date: NOV 09 2017

Public Law No. 34-59

I MINA'TRENTAI KUÅTTRO 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.
Thomas C. Ada
FRANK B. AGUON, JR.
William M. Castro
B. J.F. Cruz
James V. Espaldon
Fernando Barcinas Esteves
Régine Biscoe Lee
Tommy Morrison
Louise B. Muña
Telena Cruz Nelson
Joe S. San Agustin
Therese M. Terlaje
Mary Camacho Torres

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 Findings and 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 intent of *I Liheslaturan Guåhan* to focus efforts on these two (2) populations in order to significantly decrease the number of uninsured; and, 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 further finds that in 10 GCA (Health and Safety), Chapter 6 (Guam Medical Assistance Plan), §§ 6101 through 6105, it is the desire to give persons under the Medicaid Program the opportunity to be enrolled in prepaid health plans. This law gives the Department of Public Health and Social Services the authority to contract with health care providers to establish pilot programs that show value. In the research, it is discovered that significant cost savings and quality improvements may be achieved in the commercial managed care arena and that this initiative is a first step toward evolving into future innovative practices, such as accountable care organizations.

The assumption is that this group consists of people between 108% and 200% of the Guam-adjusted 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 individual program participation and an employer mandate should require the financial contribution of employees, employers, and government entities.

It is, therefore, the intent to facilitate the application of Section 1115 of the Social Security Act (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. It is estimated that an additional 15,000 to 16,000 lives will be eligible for health insurance. It is also the intent to allow flexibility to the Director, Department of Public Health and Social Services, in the Section 1115 application process and the ever-changing federal rules, to coordinate and amend specific idiosyncrasies of the plan in order to align with current federal policy.

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

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.

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.

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

EXHIBIT "A"

AN ACT TO *AMEND* §§ 6101, 6102, 6103, AND 6104, AND TO *ADD* NEW §§ 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 OF CHAPTER 6, DIVISION 1, TITLE 10, 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. § 6101 of Chapter 6, Division 1, Title 10, Guam Code Annotated, is hereby *amended* to read:

"**§ 6101. Statement of Policy.**

I Liheslatura (the Legislature) declares that Medicaid recipients receiving medical assistance under Title XIX [federal law] and those persons enrolled under the Medicaid Program of the Social Security Act whose premiums are being paid for by the government of Guam *shall* be given the opportunity to be enrolled in prepaid health plans as a means of affording them comprehensive health care and related remedial and preventive services.

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

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

"**§ 6102. Responsibility.**

The Department *shall*, in carrying out the intent of this Chapter, contract with a qualified health care plan contractor(s) through a prepaid health care plan to establish pilot programs which demonstrate the value or lack thereof of such a program in delivering or financing health care services in such a manner. Each pilot program is for a specified duration not to exceed four (4) years, and each pilot program *shall* be evaluated annually for its efficiency, effectiveness, and quality.

The Department *shall* establish, through contracts, health service delivery systems as pilot programs to determine whether high-quality comprehensive Medicaid benefits can be provided at a reasonable cost on a prepayment basis on such a system.

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

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

Medicaid recipients enrolling in a pilot program pursuant to this Chapter *shall* be offered a choice of qualified primary care physicians employed or under contractual arrangements with the prepaid health plan to be the recipients' designated primary care physicians."

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

"**§ 6103. Plan.**

The government of Guam *shall* take an integrated, employer sponsored, market-based approach to covering low income residents by offering new coverage opportunities, stimulating market competition, and offering alternatives via a pilot project to eligible beneficiaries with income between 108% to 200% of the Guam adjusted federal poverty level. This prepaid health plan *shall* be known as the Health Care *Para Todu* Plan. This program is not considered an entitlement program and is subject to cancellation upon appropriate notice. It is employer-sponsored coverage as referred in Section 1906A of the Social Security Act, Health Insurance Premium Payment Programs. Prepaid health plans contracting under this Chapter *shall* guarantee and provide assurances to the Department of Public Health and Social Services that all services contracted for *shall* be readily available and accessible and that further, all medical services covered under the contract which are required on an emergency basis be available on a twenty-four (24)-hour, seven (7) days a week basis, either in the prepaid health plans own facilities or through arrangements with another provider which has been approved by the Department. The Department is hereby directed to establish standards of care and to conduct testing and review procedures to assure compliance with such standards.

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

All administrative powers and duties with respect to prepaid health plans, including determination of per capita payment rates,

approval of prepaid health contracts and pilot programs which provide health care services pursuant to prepaid health contracts is hereby vested with the Director of the Department of Public Health and Social Services, herein referred to as Director.

The Director is hereby empowered to establish a basic schedule of benefits for prepaid plans conforming to the scope and duration of Medicaid health services as set forth in federal requirements for Guam to enumerate standards of participation for such prepaid health plans and pilot programs, and subject to this Chapter.

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

No contract between the Director and a prepaid health plan shall be approved unless the plan and its facilities meet quality program standards. These standards *shall* require the prepaid health plan to demonstrate to the Department that it has adequate financial resources, physical facilities, organizational and administrative capacities, and a sound program design to discharge its contractual obligations.

The prepaid health plan will maintain financial records in accordance with applicable federal guidelines and will also have annual audits performed by an independent certified public accountant. Certified financial statements *shall* be filed annually as soon as practical after the close of the plan's fiscal year, and in any event within a period not to exceed one hundred twenty (120)

days thereafter. For good cause, the Department may grant exceptions to the time within which annual financial statements are to be submitted to the Department.

The prepaid health plan *shall* be liable for all valid out-of-area emergency services that are required by the contract and rendered by another provider. Payment for such services *shall* cover treatment of emergency conditions; provided, the plan has been notified within seventy-two (72) hours of occurrence until such time as the patient may reasonably be transferred to the prepaid health plan's facilities.

The prepaid health plan *shall* establish procedures for continuously reviewing the quality of care, the utilization of services and facilities and costs. Information derived from such review *shall* be made available to the Department.

If the enrollee has an unresolved grievance, a fair hearing *shall* be made available under appropriate provisions of the Administrative Adjudication Law to resolve all grievances regarding care and administration of the plan. Findings and recommendations of the Director based on the results of the fair hearing *shall* be binding on the plan and the enrollees.

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

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

"**§ 6104. Program Availability.**

Any provider of medical assistance under the Guam Medical Assistance Plan that has entered into a contract with the Department of Public

Health and Social Services pursuant to this Chapter, may make the benefits known to enrollees by means of relevant methods and materials. The materials may be disseminated to enrollees by the Department at the contractor's expense. The contractor *shall* be responsible for all presentations by such representatives and for all ethical and professional content of the plans materials. Examples of all printed or illustrated material prepared by the contractor *shall* be submitted prior to dissemination.

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 as provided in 42 CFR 438.206- 207 and 42 CFR 438.52. Medicaid managed care plans also must provide access to essential community providers per 45 CFR 156.235. However, patients seeking care "out-of-network" when there are "in-network" providers available is *not* an option in Medicaid managed care. Medicaid managed care plans *shall* contract with at least one (1) federally qualified health center (FQHC) or rural health center (RHC)."

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

"**§ 6106. Definitions, Terms and Concepts.**

Unless the context otherwise requires, the definitions contained in this Section *shall* govern the provisions of this Chapter:

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

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

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

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

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

(f) *Delivery system* means that Medicaid benefits under this expansion plan are offered via a managed care plan. Fees for the plan will be taken from the *Para Todu* Fund.

(g) *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 (1) or more regular employees in the employer's employment. *Employe*r does *not* include:

(1) the government of Guam, any of its political subdivisions, or any instrumentality of the government of Guam or its political subdivisions;

(2) the United States government or any instrumentality of the United States;

(3) any other state or political subdivision thereof or instrumentality of such state or political subdivision;

(4) any foreign government or instrumentality wholly owned by a foreign government, if [:]

(5) 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.

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

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

(j) *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.

(k) *Federal poverty guidelines* means the poverty guidelines updated annually in the Federal Register by the U.S. Department of Health and Human Services under authority of § 673(2) of the Omnibus Budget Reconciliation Act of 1981.

(l) *Guâm income guidelines* means the federal poverty guidelines adjusted for the higher cost of living on Guam relative to the national standard.

(m) *Health Savings Account* (*HSA*). 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 federal requirements to be eligible for HSAs:

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

(2) 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.)

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

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

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

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

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

(o) *Medical Home*, also known as the *Patient-Centered Medical Home (PCMH)*, is a team-based health care delivery model led by a health care provider that is intended to provide comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes

(p) *Medical necessity* or *medically necessary* is a condition that must be determined on an individual basis and must consider available research findings, health care practice guidelines, and standards issued by professionals, recognized organizations or government agencies. *Medical necessity* or *medically necessary* means the treatment must be certain to save lives or significantly alter an adverse prognosis:

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

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

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

(r) *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.

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

(t) *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.

(u) *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.

(v) *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.

(w) *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.

(x) *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.

(y) *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.

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

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

(bb) *Provider sponsored health plan* means a health insurance company owned by a health system, physicians group, or hospital.

(cc) *Program* means the Health Care *Para Todu* Plan established by this Chapter.

(dd) *Required health care benefits* refer to the PPACA List of Ten Essential Health Benefits. Additional benefits mandated under Guam law may also be applied.

(ee) *Regular employee* means a person employed in the employment of any one (1) employer for at least twenty (20) hours per week, but does *not* include a person employed in seasonal employment.

(ff) *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."

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

"**§ 6107. Health Care *Para Todu* Pilot Project.**

The Health Care *Para Todu* pilot project is an Employer Sponsored Insurance (ESI) Premium Assistance Medicaid expansion program with employee contributions via a health savings account. The primary objective of this pilot project 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.

The government of Guam will apply for a Medicaid Section 1115 waiver to complete a three (3)-year pilot project in support of this program. This approach uses a combination of federal and local Medicaid dollars in addition to employer and employee contributions 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 Guam adjusted federal poverty level (FPL). Upon successful completion and approval of the Section 1115 waiver, government of Guam will conduct a

competitive managed care bid process to implement the plan in the managed care arena."

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

"**§ 6107.1. Health Care *Para Todu* Pilot Project Goals.**

The goals of the *Para Todu* pilot project include:

(a) promote member engagement in health and personal responsibility, including the appropriate use of health care services;

(b) increase the use of preventive services;

(c) increase provider engagement in member healthy behaviors and participation in the Medicaid community;

(d) reduce the number of uninsured low-income island residents and increase access to healthcare services;

(e) reduce the number of uninsured, therefore increasing the reimbursement of care provided by Guam Memorial Hospital Authority and local providers;

(f) 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;

(g) promote value-based decision making and personal health responsibility;

(h) promote disease prevention and health promotion to achieve better health outcomes; and

(i) provide *Para Todu* members with opportunities to seek job training and stable employment to reduce dependence on public assistance."

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

"**§ 6107.2. Employer Mandate.**

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

This Chapter *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 this Chapter or at least equivalent thereto, provided that presently existing collective bargaining agreements *shall not* be affected by the provisions of this Section."

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

"**§ 6107.2.1. Place of Performance.**

Employment includes an individual's entire service, performed within or both within and without Guam, if:

(a) the service is localized in Guam; or

(b) the service is not localized in any state but some of the service is performed in Guam, and [:]

(1) 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 Guam; or

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

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

"**§ 6107.2.2. Excluded Employment Service.**

Employment as defined in § 6106 does *not* include:

(a) 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; or

(b) 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 (21) in the employ of the individual's father or mother; or

(c) 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:

(1) admission to membership in the association is limited to individuals who are officers or employees of the United States government; and

(2) no part of the net earnings of the association inures (other than through such payments) to the benefits of any private shareholder or individual; or

(d) 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; or

(e) 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; or

(f) 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; or

(g) 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 state-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; or

(h) 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 state-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 Subsection (h) 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."

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

"**§ 6107.2.3. Principal and Secondary Employer Defined; Coercion, Interference, etc. Prohibited.**

If an individual is concurrently a regular employee of two (2) 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 (1) 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. The employee's other employers are secondary employers. An employer so designated as the principal employer *shall* remain as such principal employer for one (1) year or until change of employment, whichever is earlier. If an individual is concurrently a regular employee of a public entity that is not an employer as defined in § 6106, and of an employer as defined in § 6106, the latter *shall* be deemed to be a secondary employer. An employer who, directly or indirectly, interferes with or coerces or attempts to coerce an employee in making a determination under this Section *shall* be subject to the penalty provided under this Chapter."

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

"**§ 6107.2.4. Choice of Plan Type and of Contractor.**

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

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

"**§ 6107.2.5. Liability for Payment of Premium; Withholding; Recovery of Premium.**

Every employer *shall* contribute the applicable premium slated at sixty-five percent (65%) with the government contributing the balance as defined in the final Section 1115 Waiver. The employer *shall* withhold the employee's HSA contribution from the employee's wages with respect to pay periods as specified by the Director. If an employee separates from the employee's employment after the employee's employer has prepaid the employee's share of the cost of providing health care coverage, the employer may deduct an amount not to exceed one-half of the premium cost, but without regard to the 1.5 percent limitation, from the last salary or wages due the employee, or seek other appropriate means to recover the premium."

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

"**§ 6107.2.6. 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 (4) 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."

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

"§ 6107.2.7. Continuation of Coverage in Case of Inability to Earn Wages.

If an employee is hospitalized or otherwise prevented by sickness from working, the employer *shall* enable the employee to continue the employee's coverage by contributing to the premium the amounts paid by the employer toward such premium prior to the employee's sickness for the period that such employee is hospitalized or prevented by sickness from working. This obligation *shall not* exceed a period of three (3) months following the month during which the employee became hospitalized or disabled from working, or the period for which the employer has undertaken the payment of the employee's regular wages in such case, whichever is longer."

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

"§ 6107.2.8. 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 in § 6107.2.3 *shall* be relieved of the duty of providing the coverage required by this Chapter. 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."

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

"**§ 6107.2.9. Exemption of Certain Employees.**

(a) In addition to the exemption specified in § 6107.2.2, an employer *shall* be relieved of the employer's duty under § 6107.2 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; or

(3) a recipient of public assistance or covered by a prepaid health care plan established under the laws of the state governing medical assistance.

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

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

"**§ 6107.2.10. Termination of Exemption.**

If an exemption, which has been claimed by an employee pursuant to § 6107.2.9, 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 as provided in § 6107.2.3, 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."

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

"**§ 6107.2.11. 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."

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

"**§ 6107.2.12. Penalties.**

Any person who, after twenty-one (21) 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 Two Hundred Fifty Dollars ($250) for each offense. All fines collected pursuant to this Chapter *shall* be deposited in the *Para Todu* Fund."

Section 21. A new § 6107.2.13 of Chapter 6, Division 1, Title 10, Guam Code Annotated, is hereby *added* to read:

"**§ 6107.2.13. Penalties; Injunction.**

If an employer fails to comply, the employer *shall* pay a penalty of not less than Twenty-five Dollars ($25.00) or One Dollar ($1.00) 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 Two Hundred Dollars ($200.00) for each such violation. Any employer who fails to initiate compliance with the coverage requirements for a period of thirty (30) 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 Guam 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."

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

"**§ 6107.3. Freedom of Collective Bargaining.**

In addition to the policy stated in § 6107.2, 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. If the health care provisions of the applicable collective bargaining agreements to which their employer is a party do not cover the employees rendering particular types of services, the provisions of this Chapter *shall* be applicable with respect to them. An employer or group of employers *shall* be deemed to have complied with the provisions of this Chapter if they undertake to provide health care services pursuant to a collective bargaining agreement, and the services are available to all other employees not covered by such agreement."

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

"**§ 6107.4. 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."

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

"**§ 6107.5. Funding.**

The *Para Todu* Pilot Project *shall* use the current Federal Medical Assistance Percentages (FMAP) of fifty-five percent (55%) federal, and forty-five percent (45%) local to fund the expansion population. The government of Guam (local) portion *shall* be funded by a combination of the health insurance premium fee per § 6107.5.5, and an employer contribution of sixty-five percent (65%) of the government of Guam premium portion. 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."

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

"**§ 6107.5.1. Guam Health Insurance *Para Todu* Fund.**

The Director of the Department of Administration *shall* establish a Guam Health Insurance *Para Todu* Fund for the purpose of collecting funds for the payment of premiums. The Fund is created separate and apart from other funds and accounts of the government of Guam, and *shall* be 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 Chapter, *shall not* be subject to the transfer authority of *I Maga'låhen Guåhan.* All premiums payable under this Chapter *shall* be paid from this Fund. The Fund *shall* consist of:

(a) all money appropriated by *I Liheslaturan Guåhan,* 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; and

(d) all fines and penalties collected pursuant to this Chapter."

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

"**§ 6107.5.2. Management of the Fund.**

The Director of the Department of Administration (DOA) *shall* be the treasurer and custodian of the *Para Todu* Fund and *shall* administer the Fund in accordance with the directions of the Director of the Department of Public Health and Social Services (DPHSS). All moneys in the Fund *shall* be held in trust for the purposes of this Chapter only, and *shall not* be expended, released, or appropriated or otherwise disposed of for any other purpose. Monies in the fund may be deposited in any depositary bank in which general funds of Guam may be deposited, but such monies *shall not* be commingled with other Guam funds and *shall* be maintained in separate accounts on the books of the depositary bank. Such monies *shall* be secured by the depositary bank to the same extent and in the same manner as required by the general depositary law of Guam; and collateral pledged for this purpose *shall* be kept separate and distinct from any other collateral pledged to secure other funds of Guam."

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

"**§ 6107.5.3. Disbursements from the Fund.**

Expenditures of monies in the *Para Todu* Fund *shall not* be subject to any provisions of law requiring specific appropriations or other formal release by the government officers of money in their custody. All payments from the Fund *shall* be made upon warrants drawn upon the Director of DOA supported by vouchers approved by the Director."

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

"**§ 6107.5.4. Investment of Monies.**

With the approval of the Director of DPHSS, the Director of DOA may, from time to time, invest such monies in the *Para Todu* Fund as are in excess

of the amount deemed necessary for the payment of benefits for a reasonable future period. Such monies may be invested in bonds of any political or municipal corporation or subdivision of Guam, or any of the outstanding bonds of Guam, or invested in bonds or interest-bearing notes or obligations of Guam or of the United States, or those for which the faith and credit of the United States are pledged for the payment of principal and interest. The investments *shall* at all times be so made that all the assets of the Fund *shall* always be readily convertible into cash when needed for the payment of benefits. The Director of DOA *shall* dispose of securities or other properties belonging to the Fund *only* under the direction of the Director of DPHSS."

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

"**§ 6107.5.5. Health Insurance Premium Fee.**

There is established a four percent (4%) health insurance premium 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. The Director of the Department of Revenue and Taxation (DRT) *shall* collect such fees from insurance providers and transmit them to the Treasurer of Guam for deposit in the Fund.

(a) The Director of DRT *shall* 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 on Guam.

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

(c) The Director of DOA *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 DOA *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."

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

"**§ 6107.5.6. Health Savings Account.**

There is established a health savings account (HSA) as a method to create an avenue for beneficiaries to save money to pay for medical costs. The HSA may be established with local banking institutions or the Department of Administration may establish a program similar to a health savings account within the Treasury of the government of Guam. The option to create a government-sponsored HSA *shall only* be initiated if federal policy precludes it, or no banking institution provides such health savings accounts. The core of the intent is to enable the individual beneficiary to share in the cost of healthcare based on their means. Both the government and the member contribute to the account and the account is used to pay for the plan's deductible and copayment. A review of Internal Revenue Service HSA requirements requires the *Para Todu* program to use a High Deductible Health

Plan (HDHP) option. Therefore, the deductible for the plan is set at One Thousand Five Hundred Dollars ($1500). The HSA will consist of two (2) portions: a Core and Non-Core portion. Participant contributions will go to the Core portion and government contributions will go into the Non-Core portion.

To meet the deductible, the federal and local government will contribute One Thousand Dollars ($1,000) in the 55/45 FMAP split and placed in the Non-Core portion of the HSA. The employee beneficiary would be responsible for the remaining Five Hundred Dollars ($500) of the deductible. However, employee beneficiaries may earn up to Three Hundred Fifty Dollars ($350) by completing a variety of free preventive health items, for instance - completing a health risk assessment, completing a physical examination, etc. The Director of the Department of Public Health and Social Services will determine the specific events and dollar amounts associated up to the Three Hundred Fifty Dollars ($350) limit set in this Subsection. The remaining One Hundred Fifty Dollars ($150) would be a cash contribution via payroll deduction or direct cash contribution into the HSA by the participant. The Non-Core portion *shall* go to the payment of the One Thousand Five Hundred Dollars ($1500) deductible and supplemented by funds in the Core portion. The Core portion, once the deductible is met, then may be used to fund co-payments and other such specific qualifying and medically necessary healthcare goods and services, as established by the Director of DPHSS. The minimum participant required payments into the HSA are equal to the lesser of two percent (2%) of their annual household income or Ninety-nine Dollars ($99.00) per year. Members "own" their contributions in the Core portion, and therefore, funds are eligible to be carried forward if the members benefit

eligibility changes."

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

"§ 6107.5.7. Employee Contribution via Health Savings Account.

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

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

"§ 6107.5.8. 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 *Para Todu* Fund or as determined by the Section 1115 Demonstration Waiver

process. Employer contributions may be included in addition to the Santos Act deduction."

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

"**§ 6107.5.9 Employee Contribution.**

The notion of personal responsibility in the form of financial contribution resonates deeply with some policymakers and constituents. Employee contributions in the *Para Todu* project do not include premium payments but do include a portion of the deductible and payment of certain service copays.

Current federal law allows for Medicaid enrollees to pay cost sharing, but is precluded from charging premiums for enrollees with income at or below one hundred fifty percent (150%) 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 one hundred percent (100%) 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 five percent (5%) of the family's income, and the government 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)). The approved amendment stipulates that no household shall pay more than two percent (2%) of income toward the monthly contributions, and cost sharing provisions are consistent with Medicaid requirements (CMS 2014a). In both, the five percent (5%) of income aggregate cap remains in force."

Section 34. A new § 6107.6 of Chapter 6, Division 1, Title 10, 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 of DOA, in coordination with the Director of 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) the Director of Administration, who *shall* serve as Chairperson;

(b) the Director of the Bureau of Budget and Management Branch, or designee;

(c) the Director of Public Health and Social Services, or designee;

(d) the Chairperson of the Committee on Health of *I Liheslaturan Guåhan*, or designee;

(e) the Chairperson of the Committee on Appropriations of *I Liheslaturan Guåhan*, or designee; and

(f) a member of the general public, appointed by *I Maga'låhen Guåhan.*"

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

"**§ 6107.6.1. Authority to Contract for Consultant.**

The Negotiating Team may obtain technical support from other financial and health-related agencies. The Negotiating Team *shall* develop its rules of procedure in accordance with the Administrative Adjudication Law. The Negotiating Team, with the approval of *I Maga'låhen Guåhan*, is authorized to contract an actuary competent to develop proposed health insurance rates, or other recognized expert to train and/or advise the

Negotiating Team. The Negotiating Team and its consultant will review all proposals. The consultant is authorized to communicate with any offeror or registered party and to request and obtain information. The Negotiating Team *shall* issue a Request for Proposal (RFP) subject to the competitive selection procedures for professional services found in the Guam Procurement Law (Title 5 GCA § 5001, *et seq.*) and its regulations (Title 2 GAR Div. 4 § 1101, *et seq.*). Specifically, the procedure for this RFP is found at Title 2 GAR Div. 4, § 3114 and its subsections. The Negotiating Team *shall* follow a process similar to that of the Government of Guam Employee Health Insurance negotiating process. The Negotiating Team's desired plan designs and alternatives *shall* follow the provisions of the approved Section 1115 Demonstration Waiver. The Offeror must specify in their proposal any component to which they cannot comply and any changes they desire to the proposed plan design. The Negotiating Team's decision on any interpretation of the benefit plan design *shall* be final. The duration of any contract resulting from the RFP *shall* be for three (3) years or as approved in the Section 1115 waiver."

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

"**§ 6107.6.2. Authority to Contract for Managed Care System.**

The Department of Public Health and Social Services, in coordination with the Department of Administration and other government of Guam agencies as required, may enter into contracts with managed care organizations, including health insurance corporations, to provide health care services to Medicaid recipients. In connection with such group benefits, the government of Guam (government) will accept proposals from interested and

qualified health insurance companies (including health maintenance organizations, preferred provider networks, accountable care organizations, and provider sponsored health plans), and/or Third Party Administrators coupled with Reinsurance, licensed under applicable Guam laws, to provide health insurance coverage for eligible residents of Guam under the *Para Todu* Health pilot project. All health insurance companies and/or Third Party Administrators coupled with Reinsurance must be licensed and comply with all regulatory requirements as promulgated by the Guam Insurance Commissioner, pursuant to the insurance statutes of Guam and other applicable laws. The intent, pursuant to this Chapter, is to present to *I Maga'låhen Guåhan* (the Governor of Guam) negotiated proposed contracts for consideration for the requested services. *I Maga'låhi* (the Governor) will then choose to enter into contracts from the bids provided. All qualified proposals will be reviewed, evaluated, and scored separately by the Negotiating Team. It is *not* the intent of this Chapter to enter into an exclusive contract. As the Health Care *Para Todu* Pilot Project is an employer, it is the intent to offer choice. Employers have a choice of plans currently offered to their employees, as such it is the intent to allow this choice in this plan. The *Para Todu* Negotiating Team is established pursuant to this Chapter. The top ranked eligible proposals will be chosen, and those offerors will enter into negotiations with the Negotiating Team. At the time of enrollment, the contractor *shall* provide enrollees, at a minimum, with the following:

(a) explanation of the plan and benefit schedule;

(b) selection, assignment, and contact information of a primary care provider; and

(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 of Chapter 6, Division 1, Title 10, 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) nineteen (19) through sixty-four (64) years of age;

(c) be a resident of Guam and a 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) must have been uninsured for three (3) months, and/or have had no employer-sponsored insurance for six (6) months;

(f) the employee must agree to participate in the health savings account; and

(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

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

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
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 of Chapter 6, Division 1, Title 10, Guam Code Annotated, is hereby *added* to read:

"**§ 6107.7.1. Presumptive Eligibility.**

The presumptive eligibility process includes two (2) 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 serves as their proof of coverage. 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 Medicaid. The Director of DPHSS *shall* determine the process for determination of a QP and further refine the PE function."

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

"**§ 6107.8. Eligibility of Participating Health Care Providers.**

Health Care Providers may participate in this expansion program if their practice maintains at least a fifteen percent (15%) patient mix of standard Medicaid, Medicare, and/or Medically Indigent Program patients."

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

"**§ 6107.9. Enrollment for *Para Todu* Participants.**

A *Para Todu* program participant *shall* enroll in a comprehensive health plan offered by a managed care organization under contract with the DPHSS. All of the following apply to the health plan:

(a) it *shall* cover physician, hospital inpatient, hospital outpatient,

pregnancy-related, mental health, pharmaceutical, laboratory, and other health care services that the Director of DPHSS determines is necessary;

(b) it *shall not* begin to pay for any services it covers until the required deductible is met; and

(c) it *shall* require copayments for certain services covered by the health plan."

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

"**§ 6107.9.1. Program Participation and Eligibility Process Standards.**

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

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

"**§ 6107.9.2. Individual Waivers.**

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

(a) requesting the waiver in writing submitted to the employer; and

(b) 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.

The employer who receives from an employee a written request for a waiver under this Subsection *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.

A waiver under this Subsection is binding for one (1) year and is renewable for subsequent one (1)-year periods.

An employer who, directly or indirectly, coerces or attempts to coerce an employee in making a waiver under this Subsection *shall* be subject to penalty."

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

"**§ 6107.10. Health Care *Para Todu* Program Copayments.**

The general co-payment schedule for services provided is shown below. See the Schedule of Benefits for specifics.

(a) Outpatient Services	$4.00
(b) Inpatient Services	$75.00
(c) Preferred RX	$4.00
(d) Non-preferred RX	$8.00
(e) Non-emergency use of the ER	$8.00."

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

"**§ 6107.11. General Health Benefits.**

Members receive benefits under the *Para Todu* Program up to a maximum value of Three Hundred Thousand Dollars ($300,000) per year, and up to One Million Dollars ($1,000,000) lifetime."

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

"**§ 6107.11.1. Schedule of Benefits.**

The following chart depicts a quick reference to the general health benefits the Health Care *Para Todu* Plan covers. Specific benefits will be

contained in the beneficiary document provided by the contractor upon finalization of the Section 1115 waiver process and contract negotiation processes. Some items may change during 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 Per Family per policy year	**None**	**None**	**None**	**None**
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 Providers				

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Preventive Services (Out-Patient Only)				
Includes Annual Preventive Exams, Health Risk Appraisal 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%,**	**Plan pays 100%,**
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 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%**	**Plan pays 100%**	**Plan pays 100%**	**Plan pays 100%**

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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**

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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)**	**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.**

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5. Specialty Drugs **(Medically Necessary Only and Pre-Certification Required)**	**Plan pays 100%**	**Plan pays 100% COST-SHARING POPULATION: *Prescription Drugs - $2.50 co-payment per prescription drug that agency pays $25 & above per prescription drug.**	**Plan pays 100% COST-SHARING POPULATION: *Prescription Drugs - $8.00 co-payment per prescription drug that agency pays $25 & above per prescription drug.**	**Plan pays 100% COST-SHARING POPULATION: *Prescription Drugs - $8.00 co-payment per prescription drug that agency pays $25 & above per prescription drug.**
Deductible must be met for the following services:				
	Acupuncture			
30 visits per member per plan year	**Not covered**	**Plan pays 100% 30 visits per fiscal year**	**30 visits per fiscal year, $4.00 copay per visit**	**30 visits per fiscal year, $4.00 copay per visit**
	AIDS Treatment			
Exclusive of Experimental drugs	**Plan pays 100%**	**Plan pays 100% Approved FDA treatment and drugs**	**Plan pays 100% Approved FDA treatment and drugs**	**Plan pays 100% Approved FDA treatment and drugs**
	Airfare Benefit to Centers of Excellence only			
For members who meet qualifying conditions, Plan provides round-trip airfare **(Plan Approval Required)**	**Plan pays 100% for medically necessary services that are not available on island. (PA required) Round trip air transportation to an eligible patient, one (1) parent/guardian if patient is a minor.**	**Covered at a participating provider for services not available on Guam.**	**(PA required) Round trip air transportation to an eligible patient, one (1) parent/guardian if patient is a minor.**	**(PA required) Round trip air transportation to an eligible patient, one (1) parent/guardian if patient is a minor.**
	Allergy Testing			
	For medically necessary service	**$500.00 annually (PA required)**	**$500.00 annually (PA required)**	**$500.00 annually (PA required)**

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

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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 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%. 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				

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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	**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.**
End Stage Renal Disease / Hemodialysis	**Plan pays 100%**	**Plan pays 100%**	**Plan pays 100%**	**Plan pays 100%**
Audiological examinations, Hearing Aids Maximum $500 per member per plan year	**Plan pays 100%. Limited every 3yrs (PA required)**	**$500 every 3yrs (PA required)**	**$500 every 3yrs (PA required)**	**$500 every 3yrs (PA required)**
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.**	**$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.**

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Implants Limited to cardiac pacemakers, heart valves, stents, Intraocular lenses, orthopedic internal prosthetic devices **(Limitations apply, please refer to contract)**	**Plan pay 100%. Orthopedic internal and external prosthetic devices not covered**	**Plan pay 100%. And an orthopedic external prosthetic device is covered.**	**Plan pay 100%. And an orthopedic external prosthetic device is covered.**	**Plan pay 100%. And an orthopedic external prosthetic device is covered.**
Inhalation Therapy	**Plan pays 100%**	**Plan pays 100%**	**$4.00 copay**	**$4.00 copay**
Maternity Care Labor and Delivery	**Plan pays 100%**	**Plan pays 100%**	**$75 copay**	**$75 copay**
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 **(Pre-Certification Required)**	**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)**

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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 Internal and External Prosthesis	**Plan pay 100%. Orthopedic internal and external prosthetic devices are not covered.**	**Plan pay 100%.**	**Plan pay 100%.**	**Plan pay 100%.**
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)**	**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 **(Pre-Certification Required)**	**Plan pays 100%**	**Plan pays 100%**	**$4.00 copay**	**$4.00 copay**
Robotic Surgery/Robotics Suite **(Pre-Certification Required)**	**not covered**	**not covered**	**not covered**	**not covered**

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Skilled Nursing Facility **(Pre-Certification Required)**	**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**
Sleep Apnea Diagnostics and Therapeutic Procedure **(Pre-Certification Required)**	**Plan pays 100% (PA required)**	**Plan pays 100% (PA required)**	**$4.00 copay**	**$4.00 copay**
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	**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**	**Corrective Lenses: Maximum $100 every two (2) years.** **Bi-focal Lenses: Maximum $135 every two (2) years.**	**Corrective Lenses: Maximum $100 every two (2) years.** **Bi-focal Lenses: Maximum $135 every two (2) years.**

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Section 46. A new § 6107.11.2 of Chapter 6, Division 1, Title 10, Guam Code Annotated, is hereby *added* to read:

"**§ 6107.11.2. Essential Health Benefits.**

The Affordable Care Act's ten (10) essential health benefits are part of the Health Care *Para Todu* plan and include:

(a) 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.

(b) 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.

(c) 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.

(d) Maternity and newborn care - care that women receive during pregnancy (prenatal care), throughout labor, delivery and post-delivery, and care for newborn babies.

(e) 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.

(f) Prescription drugs - medications that are prescribed by a doctor to treat an illness or condition. Examples include prescription antibiotics to treat an infection or medication used to treat an ongoing condition, such as high cholesterol. At least one (1) prescription drug must be covered for each category and classification of federally approved drugs, however limitations do apply. Some prescription drugs can be excluded. "Over the counter" drugs are usually not covered even if a doctor writes you a prescription for them. The *Para Todu* plan limits the drugs covered, covering only generic versions of drugs where generics are available. Some medicines are excluded where a cheaper equally effective medicine is available, or the insurer may impose "Step" requirements (expensive drugs can only be prescribed if doctor has tried a cheaper alternative and found that it was not effective). Some expensive drugs will need special approval

(g) Rehabilitative services and devices – rehabilitative services (help recovering skills, like speech therapy after a stroke), 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 thirty (30) visits each year for either physical or occupational therapy, or visits to the chiropractor. Plans must also cover thirty (30) visits for speech therapy, as well as thirty (30) visits for cardiac or pulmonary rehab.

(h) Laboratory services - testing provided to help a doctor diagnose an injury, illness or condition, or to monitor the effectiveness of a particular treatment. Some preventive screenings, such as breast cancer screenings and prostrate exams, are provided free of charge.

(i) 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.

(j) 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 nineteen (19) years of age. This includes two (2) routine dental exams, an eye exam and corrective lenses each year."

Section 47. A new § 6107.11.3 of Chapter 6, Division 1, Title 10, Guam Code Annotated, is hereby *added* to read:

"**§ 6107.11.3. Adult Preventive Care Benefits.**

The fifteen (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), and include:

(a) abdominal aortic aneurysm – one (1)-time screening for men of specified ages that have ever smoked;

(b) alcohol misuse screening and counseling;

(c) aspirin use to prevent cardiovascular disease for men and women of certain ages;

(d) blood pressure screening for all adults;

(e) cholesterol screening for adults of certain ages or at higher risk;

(f) colorectal cancer screening for adults over fifty (50) years of age;

(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 fifteen (15) to sixty-five (65), and

other ages at increased risk;

(k) immunization vaccines for adults - doses, recommended ages, and recommended populations vary, for:

(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; and

(o) tobacco use screening for all adults and cessation interventions for tobacco users."

Section 48. A new § 6107.11.4 of Chapter 6, Division 1, Title 10, Guam Code Annotated, is hereby *added* to read:

"**§ 6107.11.4. Women Preventive Care Benefits.**

These provisions include well-woman visits, counseling for domestic violence victims, domestic violence screenings, and contraception counseling and dispensing:

(a) anemia screening on a routine basis for pregnant women;

(b) breast cancer genetic test counseling (BRCA) for women at higher

risk for breast cancer;

(c) breast cancer mammography screenings every one (1) to two (2) years for women over forty (40);

(d) breast cancer chemoprevention counseling for women at higher risk;

(e) breastfeeding comprehensive support and counseling from trained providers, and access to breast-feeding supplies, for pregnant and nursing women;

(f) cervical cancer screening for sexually active women;

(g) chlamydia infection screening for younger women and other women at higher risk;

(h) 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";

(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 twenty-four (24) to twenty-eight (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 three (3) years for women with normal cytology results who are thirty (30) years of age or older;

(p) Osteoporosis screening for women over age sixty (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; and

(s) syphilis screening for all pregnant women or other women at increased risk."

Section 49. A new § 6107.11.5 of Chapter 6, Division 1, Title 10, 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 in the *Para Todu* Pilot Project.

(a) The HRA *shall* have either National Committee for Quality Assurance (NCQA) Wellness and Health Promotion (WHP) Certification or Health Information Products (HIP) Certification.

(b) The member *shall* be provided a copy of the HRA and encouraged to take the HRA to their first appointment.

(c) The contractor *shall* have a process to recall an individual member's HRA in the event that the HRA is misplaced.

(d) The contractor *shall* establish a process to provide the HRA to the member's PCP/Medical Home.

(e) The contractor *shall* aggregate the HRA data and provide a report of de-identified aggregated information to the Director of DPHSS, and the Chairperson of the Guam Legislature's Health Care Committee.

(f) The contractor *shall* provide aggregate data reports to network providers."

Section 50. A new § 6107.12 of Chapter 6, Division 1, Title 10, Guam Code Annotated, is hereby *added* to read:

"**§ 6107.12. Medical Exclusions.**

(a) No benefits will be paid for injury or illness, (1) when the covered person is entitled to receive disability benefits or compensation (or forfeits his or her right thereto) under Worker's Compensation or Employer's Liability Law for such injury or illness; or (2) when services for an injury or illness are rendered to the covered person by any federal, state, territorial, municipal or other governmental instrumentality or agency without charge; or (3) when such services would have been rendered without charge but for the fact that the person is a covered person under the plan.

(b) No benefits will be paid if any material statement made in an application for coverage, enrollment of any dependent or in any claim for benefits is false. Upon identifying any such false statement, the company *shall* give the covered person at least thirty (30) days' notice that his or her benefits have been suspended and that his or her coverage is to be terminated. If the false statement is fraudulent or is an intentional misrepresentation of a material fact, such termination shall be retroactive to the date coverage was provided or continued based on such fraudulent statement or intentional misrepresentation of material fact. If the false statement was not a fraudulent statement or intentional misrepresentation of material fact, termination of coverage *shall* be effective no earlier than the date of the suspension.

The covered person may dispute any termination of coverage by filing a claim under the grievance procedure provided for in the agreement. If a grievance is filed, the resolution of the matter *shall* be in accordance with the outcome of the grievance proceedings. If no grievance is filed for any retroactive termination and the company paid benefits prior to learning of any such false statement, the subscriber must reimburse the company for such payment. Terminations of coverage *shall* be handled in accordance with the applicable claims procedure requirements of Section 2719 of the PHSA, as added by PPACA. Retroactive terminations of coverage *shall not* violate the applicable prohibitions on rescissions of Section 2712 of the PHSA, as added by PPACA, and rescissions *shall* be handled in compliance with PPACA's applicable claim denial requirements.

(c) No benefits will be paid for confinement in a hospital or in a skilled nursing facility if such confinement is primarily for custodial or domiciliary care. (Custodial or domiciliary care includes that care which consists of training in personal hygiene, routine nursing services and other forms of self-care. Custodial or domiciliary care also includes supervisory services by a physician or nurse for a person who is not under specific medical or surgical treatment to reduce his or her disability and to enable that person to live outside an institution providing such care.) The company and not the covered person *shall* be liable if the company approves the confinement, regardless of who orders the service.

(d) No benefits will be paid for nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities).

(e) No benefits will be paid for private duty nursing. This provision does not apply to home health care.

(f) No benefits will be paid for special medical reports, including those not directly related to treatment of the member (e.g., employment or insurance physicals, and reports prepared in connection with litigation).

(g) No benefits will be paid for services required by third parties, including, but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, obtaining or maintaining any license issued by a municipality, state, or federal government, securing insurance coverage, travel, school admissions or attendance, including examinations required to participate in athletics, *except* when such examinations are considered to be part of an appropriate schedule of wellness services.

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

(i) No benefits will be paid for services and supplies provided to a covered person for an injury or illness resulting from an attempted suicide by that covered person unless resulting from a medical condition (including physical or mental health conditions) or from domestic violence.

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

(k) No benefits will be paid for services and supplies provided to a covered person for injuries incurred while the person was committing a criminal act.

(l) Unless otherwise specifically provided in the agreement, no benefit will be paid for, or in connection with, airfare, and the company will not pay for the transportation from Guam to any off-island facility, nor for any other non-medical expenses such as taxes, taxis, hotel rooms, etc. In no event will the company pay for air ambulance or for the transportation of the remains of any deceased person.

(m) No benefits will be paid for living expenses for covered persons who require, or who of their own accord seek, treatment in locations removed from their home.

(n) No benefits will be paid for services and supplies provided to a dependent of a non-spouse dependent. Dependents of non-spouse dependents are not eligible for coverage. For example, when a dependent, other than a spouse of the subscriber, has a child, that child is a dependent of a non-spouse dependent and is not eligible to become covered under the plan, unless such child otherwise becomes eligible for enrollment.

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

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

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

under the Group Health Insurance Certificate for members eligible for Workers' Compensation are not designed to duplicate any benefit to which they are entitled under the Workers' Compensation Law. All sums payable for Workers' Compensation services provided under the Group Health Insurance Certificate shall be payable to, and retained by the company. Each member shall complete and submit to the company such consents, releases, assignments, and other documents reasonably requested by the company in order to obtain or assure reimbursement under the Workers' Compensation Law.

(r) No benefits will be paid for:

(1) drugs or substances not approved by the Food and Drug Administration (FDA), or

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

(s) No benefits will be paid for experimental or investigational treatments and procedures, or ineffective surgical, medical, psychiatric, or dental treatments or procedures, research studies, or other experimental or investigational treatments and procedures or pharmacological regimes, unless deemed medically necessary by the patient's physician and pre-authorized by the company. Experimental and investigational treatments and procedures are those medical treatments and procedures that have not successfully completed a Phase III trial, have not been approved by the FDA, and are not generally recognized as the accepted standard treatment for the disease or condition from which the patient suffers. Experimental and investigational treatments include off label therapies. Off-label therapies are those medical therapies that

use a FDA approved drug or procedure for a non-indicated use. Also, these experimental or investigational medical and surgical procedures, equipment, and items or medications, are otherwise not covered by Medicare or covered under qualifying clinical trials.

(t) No benefits will be paid for services or supplies related to genetic testing.

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

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

(w) No benefits will be paid for any medical service or supply which is available to the covered person on Guam and which is paid by or reimbursable through a governmental agency or institution. However, notwithstanding the aforesaid, in no event will the company consider the availability of benefits under Medicaid or the *Para Todu* Health Plan when paying benefits under this Agreement.

(x) No benefits will be paid in connection with elective abortions unless medically necessary.

(y) No benefits will be paid for vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the

visual axes of eyes not properly coordinated for binocular vision), Lasik, keratoplasty, and radial keratotomy, including related procedures designed to surgically correct refractive errors, except as provided in the covered benefits section of the group health insurance certificate.

(z) No benefits will be paid in connection with any injuries sustained while the covered person is operating any wheeled vehicle during an organized, off-road, competitive sporting event.

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

(bb) No benefits will be paid for hypnotherapy.

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

(dd) No benefits will be paid for cosmetic surgery, or other services intended primarily to improve the member's appearance or treatment relating to the consequences of, or as a result of, cosmetic surgery. This exclusion does not apply to:

(1) medically necessary reconstructive surgery as described in the covered benefits sections, mastectomy and reconstructive breast surgery or reconstructive surgery;

(2) surgery to correct the results of injuries causing an impairment;

(3) surgery as a continuation of a staged reconstruction procedure, includingm but not limited to, post-mastectomy reconstruction; and

(4) surgery to correct congenital defects necessary to restore normal bodily functions, including, but not limited to, cleft lip and cleft palate.

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

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

(gg) No benefits will be paid for services and supplies associated with growth hormone treatment unless the covered person is proven to have growth hormone deficiency using accepted stimulated growth hormone analyses and also shows an accelerated growth response to growth hormone treatment. Under no circumstances will growth hormone treatment be covered to treat short stature in the absence of proven growth hormone deficiency.

(hh) No benefits will be paid for services and supplies provided for liposuction.

(ii) No benefits will be paid for weight reduction programs, or dietary supplements, except as pre-authorized by the company for the medically necessary treatment of morbid obesity.

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

(kk) Except as provided in this agreement, or unless medically necessary for the treatment of morbid obesity or other disease, no benefits will be paid in connection with gastric bypass, stapling or reversal if for the purpose of weight reduction or aesthetic purposes.

(ll) No benefits will be paid for surgical operations, procedures or treatment of obesity, except when pre-authorized by the company.

(mm) No benefits will be paid for the treatment of male or female 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;

(10) reversal of sterilization surgery; and

(11) any charges associated with obtaining sperm for ART procedures.

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

(1) equipment and supplies used in a hospital or skilled nursing facility or in conjunction with an approved hospital or skilled nursing facility confinement or as otherwise noted in the agreement; or

(2) items covered as preventive care under well-women coverage, such as breastfeeding supplies in accordance with reasonable medical management techniques.

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

(pp) No benefits will be paid for services and supplies provided for penile implants of any type.

(qq) No benefits will be paid for services and supplies to correct sexual dysfunction.

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

(ss) Except as specifically provided in this agreement, no benefits will be provided for services and supplies not ordered by a physician or not medically necessary.

(tt) No benefits will be paid for temporomandibular joint disorder treatment (TMJ), including treatment performed by prosthesis placed directly on the teeth, except as covered in the covered benefits section.

(uu) Except as specifically provided in this agreement, no benefits will be paid for corrective appliances, artificial aids and durable equipment.

(vv) No benefits will be paid for services for which the covered person or subscriber is not legally obligated to pay.

(ww) No benefit will be paid for ambulance services when used for routine and convenience transportation to receive outpatient or inpatient services, unless deemed medically necessary with prior authorization obtained from the company.

(xx) No benefit will be paid for elective or voluntary enhancement procedures, surgeries, services, supplies and medications, including, but not limited to, hair growth, hair removal, hair analysis, sexual performance, athletic performance, anti-aging, and mental performance, even if prescribed by a physician.

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

(zz) No benefits will be paid for fees for any missed appointments or voluntary transfer of records as requested by the covered person.

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

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

(ccc) No benefits will be paid for psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms or whether providing or receiving the service.

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

(1) which are not medically necessary for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services;

(2) that do not require the technical skills of a medical, mental health or a dental professional;

(3) furnished mainly for the personal comfort or convenience of the member, or any person who cares for the member, or any person who is part of the member's family, or any provider;

(4) furnished solely because the member is an inpatient on any day in which the member's disease or injury could safely and adequately be diagnosed or treated while not confined; or

(5) furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

(eee) As required by HIPAA, no source-of-injury exclusion, such as Exclusion (z) for off-road sporting events, will apply if the accident resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).

(fff) No benefits will be paid for elective cosmetic surgery, except as provided for in the Women's Health Act.

(ggg) No benefits will be paid for custodial care, domiciliary care, private duty nursing services or rest cures, except as provided for in hospices.

(hhh) No benefits will be paid for personal comfort or convenience items.

(iii) No benefits will be paid for any service not medically necessary for the diagnosis or treatment of a disease, injury or condition.

(jjj) No benefits will be paid for over-the-counter drugs not listed in the Drug Formulary.

(kkk) No benefits will be paid for drugs not listed in the Drug Formulary, unless otherwise provided in this Act.

(lll) No benefits will be paid for experimental drugs, experimental and palliative treatments or procedures, unless approved by the Administrator.

(mmm) No benefits will be paid for fertility procedures, reversal of sterilization and services related to artificial conception.

(nnn) No benefits will be paid for treatment, services and supplies related to sexual dysfunction.

(ooo) No benefits will be paid for trans-sexual surgery and related services.

(ppp) No benefits will be paid for motorized limbs.

(qqq) No benefits will be paid for services for any incarcerated person.

(rrr) No benefits will be paid for care or services furnished by immediate relatives or members of the patient's household, unless rendered as a duly licensed medical practitioner employed by a health care provider.

(sss) No benefits will be paid for health care services, which are provided and reimbursed by other local or federal programs; the *Para Todu* pilot project is the payer of last resort.

(ttt) No benefits will be paid for tissue and organ transplants, and any other related hospital, surgical drug, radiology, laboratory or other medical services before, during and after transplant.

(uuu) No benefits will be paid for treatment and services for artificial weight reduction, including gastric bypass stapling or reversal, or liposuction.

(vvv) No benefits will be paid for treatment by any method for temporomandibular joint disorders, including, but not limited to, crowning, wiring or repositioning of teeth.

(www) No benefits will be paid for treatment for injuries sustained in the commission of an illegal or criminal act, including driving under the influence.

(xxx) No benefits will be paid for any work-related injury, subject to compensation pursuant to the Workers Compensation Law.

(yyy) No benefits will be paid for care for military service-connected disabilities to which the patient is legally entitled to government benefits or care.

(zzz) No benefits will be paid for orthopedic footwear, unless attached to an artificial foot or unless attached as a permanent part of a leg brace.

No benefits will be paid for benefits and services not specifically listed as covered."

Section 51. A new § 6107.13 of Chapter 6, Division 1, Title 10, 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 of Chapter 6, Division 1, Title 10, Guam Code Annotated, is hereby *added* to read:

"**§ 6107.14. Dental Exclusions.**

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

(1) a prosthetic or other appliance, or modification of one, where an impression was made before the patient was covered; or

(2) a crown, bridge, or cast restoration for which the tooth was prepared before the patient was covered; or

(3) root canal therapy, if the pulp chamber was opened before the patient was covered.

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

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

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

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

(f) Precision attachments, interlocking device, one component of which is fixed to an abutment or abutments the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it; or stress breakers, part of a tooth-borne and/or prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stress.

(g) Replacement of lost or stolen appliance, or replacement of any appliance damaged while not in the mouth.

(h) Any service for which the enrollee received benefits under any other coverage offered by the company.

(i) Spare or duplicate prosthetic devices.

(j) Services included, related to, or required for:

(1) implants;

(2) cosmetic purposes;

(3) services or appliances to change the vertical dimension or to restore or maintain the occlusion, including but not limited to equilibrium, full mouth rehabilitation and restoration for malalignment of teeth;

(4) temporomandibular joint (TMJ) or craniomandibular disorders, myofunctional therapy or the correction or harmful habits;

(5) experimental procedures; and

(6) intentionally self-inflicted injury, unless resulting from a medical condition (including physical or mental conditions) or from domestic violence.

(k) Any over the counter drugs or medicine, unless prescribed by a dentist or physician.

(l) Fluoride varnish.

(m) Charges for finance charge, broken appointments, completion of insurance forms or reports, providing records, oral hygiene instruction, pit and fissure sealants and dietary instruction, or lack of cooperation on the part of the patient.

(n) Charges in excess of the amount allowed by the plan for a covered service.

(o) Any treatment, material, or supplies that are for orthodontic treatment, including extractions for orthodontics.

(p) Services for which no charge would have been made had the agreement not been in effect.

(q) Surgical grafting procedures.

(r) General anesthetic, conscious sedation, and other forms of relative analgesia, except as otherwise specifically provided herein, unless deemed

medically necessary by patient's dentist or physician and pre-authorized by the company.

(s) Services paid for by Workers' Compensation.

(t) Charges incurred while confined as an inpatient in a hospital, unless such charges would have been covered had treatment been rendered in a 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 three (3) years from the covered person's last full mouth x-ray; and full mouth x-rays if provided less than three (3) years from covered person's last panoramic x-ray."

Section 53. A new § 6107.15 of Chapter 6, Division 1, Title 10, 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 54. A new § 6107.16 of Chapter 6, Division 1, Title 10, 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 patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care.

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

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

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

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

"**§ 6107.17. Community Health Centers (CHC).**

The contractor *shall* utilize the CHCs as a network provider."

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

"**§ 6107.18. Member Use of Primary Care Physicians (PCP).**

The contractor *shall* provide a list of network primary care physicians from which members may select for their "medical home". The list will contain the physicians name, clinic name if available, location, phone number and specialty. The contractor *shall* coordinate with the PCP on the number of new members the PCP will accept and manage the enrollment to that PCP."

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

"**§ 6107.19. Change in Primary Care Physician.**

The contractor *shall* develop processes for members to change their primary care physician/medical home to include a satisfaction survey that addresses the reason for change. The de-identified information from this survey will be shared with the PCP and the Administrator of DPHSS."

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

"**§ 6107.20. Reports and Surveys.**

The contractor *shall* provide the reports and surveys required and described pursuant to this Chapter to the Director of Public Health and Social Services, and to *I Liheslaturan Guåhan* (the Guam Legislature) through the chairperson of the legislative health care committee. The contractor *shall* also provide information to the appropriate network providers."

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

"**§ 6107.20.1. Healthcare Effectiveness Data and Information Set (HEDIS).**

The contractor *shall* participate in the United States Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ), HEDIS clinical performance program."

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

"**§ 6107.20.2. Consumer Assessment of Healthcare Providers and Systems (CAHPS).**

The contractor *shall* participate in the United States Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ), CAHPS consumer experience survey program. Participation in the CAHPS database is

entirely free to sponsors. By participating, survey sponsors contribute to a national database that confers many benefits related to benchmarking for quality improvement and ongoing research.

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

(b) Specific benefits for sponsors of the Health Plan Survey (in the Medicaid and CHIP sectors) include receiving a customized case-mix adjusted sponsor report comparing results to appropriate benchmarks. All sponsors also have access to annual chart books that present summary-level comparisons of survey results by selected characteristics (region, sector, facility size, etc.). The contactor *shall* maintain information as provided in the CAHPS guidelines and share access information to the public. Specifically, the contractor *shall* inform the Director, DPHSS and the chairperson of the legislative committee on health on the process to access this database.

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

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

"**§ 6107.20.3. Claims Reports.**

The contractor *shall* provide the following reports:

Medical Claims Report

(a) claim by type of service;

(b) large claim report;

(c) number of days hospitalized;

(d) average days of confinement;

(e) average hospital charges;

(f) average hospital payments;

(g) number of outpatient physician visits;

(h) average cost of outpatient physician visits;

(i) average hospital charges;

(j) average hospital payments;

(k) professional procedures; and

(l) average cost of professional procedures.

Pharmacy Claims Report

(a) prescription utilization report;

(b) number of brand prescriptions filled;

(c) number of generic prescriptions filled;

(d) average brand prescriptions cost;

(e) average brand generic cost;

(f) top 50 prescribed prescriptions; and

(g) top 50 high cost prescriptions.

Subject to 4 GCA § 4302(g), the contractor *shall* provide, at a minimum, the monthly data requirements outlined below, and plans must also submit a corresponding data dictionary describing the data provided:

(a) a unique contract identifier that links detailed demographic, claims utilization, and cost information;

(b) enrollment by plan, tier/class, employment status, and other subgroups as required by the government;

(c) patient demographics including date of birth, gender, and relationship to subscriber;

(d) medical, dental, vision and wellness claims by line detail, including:

(1) Diagnosis code (ICD9 or ICD10)

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

(3) Revenue codes

(4) Service dates

(5) Service provider, including:

(A) Name

(B) Tax ID

(C) Provider ID

(D) Specialty code

(E) City

(F) State

(G) Zip code;

(e) plan payments;

(f) member payment responsibility, including:

(1) copay;

(2) coinsurance; and

(3) deductible

(g) claim paid date;

(h) type of bill;

(i) facility type;

(j) prescription drug claims by line detail, including:

(1) NDC codes

(2) formulary tier identifier

(3) Pharmacy, including:

(A) Name

(B) Provider ID

(C) City

(D) State

(E) 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; and

(r) rebate."

Section 62. A new § 6107.21 of Chapter 6, Division 1, Title 10, 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 PCPs 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; and

(d) HRA."

Measure	Reference	Measure	Data Source
Completion of Contractor provided Health Risk Appraisal	§6107.11.5	Percent of members completed	HRA count
Number of members completing a physical examination.	Schedule of Benefits	Percent of members completed	Claims database
Getting Timely Care, Appointments, and Information	§ 6107.20.2	Clinician and Group survey	CAHPS
How Well Your Providers Communicate	§ 6107.20.2	Clinician and Group Survey	CAHPS
Patients Rating of Provider	§ 6107.20.2	Clinician and Group Survey	CAHPS
Health Status/Functional Status	§6107.11.5	Health Risk Appraisal	HRA
Tobacco use counseling and interventions: non-pregnant adults	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	Claims	USPSTF
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions	Claims	USPSTF
Obesity screening and counseling: children	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.	Claims	USPSTF

Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	Claims	USPSTF
Diabetes screening	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.	Claims	USPSTF
Hypertension (HTN): Controlling High Blood Pressure	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.	Claims	USPSTF
Colorectal Cancer Screening	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.	Claims	USPSTF
Breast Cancer Screening	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	Claims	USPSTF
Cervical cancer screening	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	Claims	USPSTF

Lung cancer screening	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.	Claims	USPSTF
Chlamydia screening: women	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.	Claims	USPSTF
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	Claims	USPSTF
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit	Claims	USPSTF
Breastfeeding interventions	The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.	Claims	USPSTF
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	Claims	USPSTF
Preeclampsia prevention: aspirin	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	Claims	USPSTF

Immunizations	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).	Database	DPHSS Immunization Database

Section 63. A new § 6107.22 of Chapter 6, Division 1, Title 10, 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 forty-five (45) days, but MCOs must have in place a process for expedited review (42 CFR 438.408-410)."

Section 64. Small Business Incentive Committee. The Director of the Department of Revenue and Taxation *shall* establish a Small Business Incentive Committee to provide recommendations on the creation of a program to provide small businesses an offset mechanism on the financial impact of the implementation of this program. The membership of the Small Business Incentive Committee *shall*

consist of the Director of the Department of Revenue and Taxation; the Chairman of the Committee on Appropriations and Adjudication of *I Liheslaturan Guahan* who may elect to delegate the Director of the Office of Finance and Budget of *I Liheslaturan Guåhan* as his or her alternate; the Director of the Department of Administration; the Director of the Bureau of Budget and Management Research; and a member of the Guam Chamber of Commerce as delegated by the President of the Guam Chamber of Commerce. The Committee *shall* submit, within ninety (90) days of enactment, their recommendations for the offset business program.

Section 65. Effective Date. Nothing herein shall be construed as to adopt the amendments proposed in this Act. This Act is 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.