MINA' TRENTAI UNU NA LIHESLATURAN GUÅHAN
2011 (FIRST) Regular Session

2011 MAR 25 PM 1:48

Bill No. 125 (LS)

Introduced by: B.J.F.Cruz
T.R. Muña Barnes

AN ACT AMEND §4302(G), CHAPTER 4, ARTICLE 3, TITLE 4, GUAM CODE ANNOTATED; RELATIVE TO THE TERMINATION OF HEALTH INSURANCE PROVIDERS THAT PROVIDE SERVICES TO GOVERNMENT OF GUAM EMPLOYEES AND RETIREES.

BE IT ENACTED BY THE PEOPLE OF GUAM:

Section1. §4302(g), Chapter 4, Article 3, Title 4, Guam Code Annotated, is hereby *amended* to read as follows:

"(g) All health insurance companies or health care providers contracted to provide health care to government of Guam employees and retirees *shall* provide to the negotiating team, defined in §4302(c), and the Office of Finance and Budget, fifteen (15) months of detailed claims utilization and cost information from period October 1 to September 30 of the previous fiscal year, and October 1 to December 31 of the current fiscal year, *no later than* March 1 for the final updated data for the previous fiscal year in electronic database file format such as Microsoft Access or Microsoft Excel. The detailed claims utilization and cost information must total in aggregate all the experience data used to calculate government of Guam insurance rates for the fiscal year following the current fiscal year. Claims

incurred but not received calculations shall be reported separately and must be derived from detailed claims utilization and cost information submitted and reviewed and approved by a credentialed actuary from a recognized organization such as the American Academy of Actuaries or Society of Actuaries. The detailed claims utilization and cost information required under this Subsection shall include only de-identified health information as permitted under the Health Insurance Portability and Accountability Act of 1996 and shall not include any protected health information, as defined in the Health Insurance Portability and Accountability Act of 1996. Detailed demographic and claims utilization and cost information shall include the following information with a unique contract identifier that links all the following data to the same contract:

(1) Type of contract based on all tiers used in program design (EE,EE + SPOUSE, FAMILY, etc.);

(2) Patient demographics, date of birth, gender, relationship to subscriber;

(3) Medical, Dental and Vision claims, line detail including Diagnosis code (ICD9 or ICDIO), Procedure codes (CPT,HCPC, CDT), Revenue codes, Service dates, Service provider (name, tax id, provider id, specialty code, city, state, zip code), Plan payments, Member payment responsibility (copay, coinsurance, deductible), Claim paid date, Type of bill and Facility type;

(4) Prescription Drug claims, to include NDC codes, Formulary tier identifier, pharmacy (name, provider id, city, state, zip code), Plan payments, member payment responsibility (copay, coinsurance, deductible) Claim paid date, Injectable drug indicator, GPI number, ingredient cost, dispensing fee and rebates; and

(5) Any other detailed demographic and claims utilization and cost information as requested by the negotiation team in the Invitation to Bid (ITB) for the fiscal year following the current fiscal year. Failure to comply with requirements of this Section will result in a 2.5% reduction of the quarterly premiums from the non-compliant health insurance carrier. The information shall be provided quarterly. The reduction shall be deducted from the premiums due to the carrier in the succeeding quarter, if the information is not received within forty-five (45) days of the end of the quarter. The negotiating team defined in §4302(c)~~at their discretion, at any time~~ during the following fiscal year health insurance negotiations, ~~may~~ ***shall*** disqualify proposals from health insurance carriers not in compliance with this Section for their in force contract."