Office of

the People

I Mina'trentai Unu Na Liheslaturan Guåhan

Senator Vicente (ben) Cabrera Pangelinan (D)

2011 MAY -2 PM 12:09

MAY 0 2 2011

The Honorable Judith T. Won Pat, Ed.D.
Speaker
I Mina' Trentai Una Na Liheslaturan Guåhan
155 Hesler Place
Hagåtña, Guam 96910

VIA: The Honorable Rory J. Respicio
Chairperson, Committee on Rules

RE: Committee Report on Bill No. 139-31 (COR), As Substituted

Dear Speaker Won Pat:

Transmitted herewith is the Committee Report on Bill No. 139-31 (COR), as Substituted, "An Act to add a new Article 3A to Chapter 4, Title 4 GCA Relative to Regulation for Uniform Definition and Standardized Methodologies for calculation of a medical loss ratio rebate for the Government of Guam Health Insurance Program", sponsored by Senator Vicente (ben) Cabrera Pangelinan, which was refereed to the Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, and Land.

Committee votes are as follows:

3 TO PASS

0 NOT TO PASS

3 TO REPORT OUT ONLY

0 TO ABSTAIN

0 TO PLACE IN INACTIVE FILE

Si Yu'os Ma'åse',

Vicente (ben) Cabrera Pangelinan
Chairman

Chairman
Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, and Land

Vice Chairman
Committee on Education

Member
Committee on Rules, Federal, Foreign & Micronesian Affairs and Human & Natural Resources

Member
Committee on Municipal Affairs, Tourism, Housing, and Recreation

Member
Committee on the Guam Military Buildup and Homeland Security

Member
Committee on Health and Human Services, Senior Citizens, Economic Development, and Election Reform

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COMMITTEE REPORT
ON

Bill No. 139-31 (COR), As Substituted

Sponsored by Senator Vicente (ben) Cabrera Pangelinan

An Act to add a new Article 3A to Chapter 4, Title 4 GCA Relative to Regulation for Uniform Definition and Standardized Methodologies for calculation of a medical loss ratio rebate for the Government of Guam Health Insurance Program

Office of
the People

I Mina'trentai Unu Na Liheslaturan Guåhan

Senator Vicente (ben) Cabrera Pangelinan (D)

MAY 0 2 2011

MEMORANDUM

To: **All Members**
Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, and Land

From: Senator Vicente (ben) Cabrera Pangelinan
Committee Chairperson

Subject: Committee Report on Bill No. 139-31 (COR), As Substituted

Transmitted herewith for your consideration is the Committee Report on Bill No. 139-31 (COR), as substituted, An Act to add a new Article 3A to Chapter 4, Title 4 GCA Relative to Regulation for Uniform Definition and Standardized Methodologies for calculation of a medical loss ratio rebate for the Government of Guam Health Insurance Program" sponsored by Senator Vicente (ben) Cabrera Pangelinan.

This report includes the following:

1. Committee Voting Sheet
2. Committee Report Narrative
3. Copy of Bill No. 139-31 (COR), as introduced
4. Copy of Bill No. 139-31 (COR), as substituted
5. Public Hearing Sign-in Sheet
6. Copy of COR referral Bill No. 139-31 (COR), as introduced
7. Notices of Public Hearing
8. Copy of the Public Hearing Agenda
9. Copy of letter from COR to BBMR requesting fiscal note

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

Si Yu'os Ma'åse',

Vicente (ben) Cabrera Pangelinan
Chairman

Chairman
Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, and Land

Vice Chairman
Committee on Education

Member
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I MINA' TRENTAI UNU NA LIHESLATURAN GUÅHAN

Committee Voting Sheet

Committee on Appropriations, Taxation, Banking, Public Debt, Insurance, Retirement, and Land

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Bill No. 139-31 (COR), as substituted, An Act to add a new Article 3A to Chapter 4, Title 4 GCA Relative to Regulation for Uniform Definition and Standardized Methodologies for calculation of a medical loss ratio rebate for the Government of Guam Health Insurance Program

Committee Members	To Pass	Not To Pass	Report Out Only	Abstain	Inactive File
Senator Vicente (ben) Cabrera Pangelinan **Chairman**	✓				
Speaker Judith T. Won Pat, Ed.D **Vice Chairperson**					
Vice Speaker Benjamin J. F. Cruz **Member**	5/2/11 ✓				
Senator Tina Rose Muña-Barnes **Member**	✓				
Senator Judith P. Guthertz **Member**					
Senator Dennis Rodriguez, Jr. **Member**			✓ 5/2/11		
Senator V. Anthony Ada **Member**			✓ 5/2/11		
Senator Christopher M. Duenas **Member**			5/2/11		
Senator Mana Silva Taijeron **Member**					

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the People

I Mina'trentai Unu Na Liheslaturan Guåhan

Senator Vicente (ben) Cabrera Pangelinan (D)

Chairman
Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, and Land

Vice Chairman
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Member
Committee on Rules, Federal, Foreign & Micronesian Affairs and Human & Natural Resources

Member
Committee on Municipal Affairs, Tourism, Housing, and Recreation

Member
Committee on the Guam Military Buildup and Homeland Security

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Committee Report

Bill No. 139-31 (COR) Bill No. 139-31, An Act to add a new Article 3A to Chapter 4, Title 4 GCA Relative to Regulation for Uniform Definition and Standardized Methodologies for calculation of a medical loss ratio rebate for the Government of Guam Health Insurance Program.

I. OVERVIEW

The Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, and Land convened a public hearing on April 26, 2011 at 2:00pm in *I Liheslatura's* Public Hearing Room.

Public Notice Requirements
Notices were disseminated via hand-delivery and e-mail to all senators and all main media broadcasting outlets on April 19, 2011 (5-Day Notice), and again on April 24, 2011 (48 Hour Notice).

(a) Committee Members and Senators Present

Senator Vicente "ben" Cabrera Pangelinan, Chairman
Speaker Judith Won Pat, Vice Chair
Vice Speaker BJ Cruz, Member
Senator Tina Muna Barnes
Senator Adolpho Palacios
Senator Frank Blas

(b) Appearing before the Committee

Mr. Frank Campillo, Select Care Insurance
Mr. Ray Schnabel, Select Care Insurance
Mr. Francis Santos, Stay Well Insurance

(c) Written Testimonies Submitted

Hay Group
Mr. Jerry Crisostomo, Plan Administrator, Net Care
Mr. Frank Campillo, Health Plan Administrator, Select Care

II. COMMITTEE PROCEEDINGS

(a) Bill Sponsor Summary

Chairman Pangelinan. We now come to Bill No. 139-31, An Act to add a new Article 3A to Chapter 4, Title 4 GCA Relative to Regulation for Uniform Definition and Standardized Methodologies for calculation of a medical loss ratio rebate for the Government of Guam Health Insurance Program.

We have signed up for testimony Mr. Frank Campillo, Mr. Ray Schnabel. Thank you very much.

The establishment of medical loss ratio as called for in the bill is patterned after and pursuant to the proposals that are contained in the National Health Care Act, the Obama Care Legislation and would set limits on the administrative costs and costs that are devoted to patient care and when certain provisions of those limits are exceeded or are not met, then the insurance company would rebate portions of the premium depending on where they stand whether it exceeds the loss ratio or lower than the lost ratio. So, that's the basic concept of the proposed legislation.

We will receive testimony from the gentlemen this afternoon. I thank you for your patience to ensure that we get to hear your testimony. Thank you very much.

(b) Testimonies

Mr. Frank Campillo. Thank you Senator. Buenas Senator Pangelinan and members of the Committee. We have provided written testimony to you but we would like to at least read most of our testimony, if you don't mind.

Again, Buenas Senator Pangelinan and Committee Members. Thank you very much for allowing our testimony regarding Bill 139-31, which creates a ceiling on the allowable retentions for the government of Guam program and is patterned after the Medical Loss Ratio sections of the Affordable Care Act (ACA). We oppose the aforementioned bill the following reasons:

Despite the fact that our local carriers embrace many of the ACA's requirements such as expanded benefits and the consumer protection requirements, the health insurers on Guam have sought relief from the Medical Loss Ratio Requirements of ACA and have petitioned the Department of Health and Human Services (HHS) for a full waiver or reduction on the medical loss ratio requirement.

That was also stated in Mr. Crisostomo's letter testifying to you and we have provided as an attachment, letters that was sent to Department of Health and Social Services.

As you may know the Affordable Care Act excluded… I am going to skip the next three paragraphs so I don't bore you guys to death.

I would like to take you to the fact that Guam insurers take part in a significant number of cases and duties that are not typically taken care of by health insurance companies in the continental United States.

Concerning the government of Guam the proposed bill will possibly deliver unintended consequences of preventing prospective carriers from entering the GovGuam market and may potentially cause a complete exodus of insurers from GovGuam. In addition to the aforementioned statements we oppose the bill based on the following…

And again as Mr. Crisostomo (Net Care) said in his testimony they possibly have somebody contemplating entering into the government of Guam market. But if this bill goes through, they believe that would not be a possibility.

The administrative expense percentages for Guam health insurers are higher than those compared to companies in the continental United States. The market lacks the integration of technologies typically found in macro markets and highly paperless environments that generate potential administrative cost savings.

Despite the hype with the FY 2011 premiums for GovGuam the fact remains that Guam's premiums are generally 50% to 55% lower than those charged in the continental United States and Hawaii. This is factual for both commercial or private markets as well as the government of Guam, where premiums for active employees are significantly lower than those charged to their counter part employees of most states and the Federal Government.

And we have included exhibits for your information. We provided you information on the state of Hawaii, what they are charged to the employees and the government of Hawaii, the state of Colorado, the state of California, the state of Texas, Florida and the local federal employees on Guam. So, gave you east coast, our closest state of Hawaii, west coast, middle of the country and our counterparts of the federal employees on Guam.

As a result of the above the retention amounts are significantly lower than those of micro markets. Fifteen percent of the average $200 in premium is not the same as fifteen percent of an average $450 in premiums that you have in the continental United States.

Guam's insurance laws does not allow insurance companies to write directly to businesses and it has to be conducted through an agent as opposed to most states where insurers are able to write businesses directly, consequently this creates additional cost to the insurance carrier.

Health insurers and their respective agents on Guam act as travel agents, medical appointment coordinators, medical referral coordinators, medical record trackers, coordinators of medical information between local physicians and/or specialists outside of Guam such as in the Philippines and Japan.

And I hope not to bore you, but I am going to tell you a little story that is going on right now. We have a case that went to the Philippines. The individual chose to go by himself – had open-heart surgery in the Philippines, but the individuals also had a psychiatric problem.

Subsequently to the open-heart surgery, he developed psychiatric problems and had to be moved. Our people, our employees here in Guam tried to connect with the family, tried to give us the right to allow the hospital to move the individual to a psychiatric unit. The individual is ok now and able to travel. We are now trying to get a doctor in the Philippines to travel with this individual because we are concerned - the family is also concerned that something might happen during the travel on the airplane. Well, we lost that doctor because now the doctor is saying, "Who is going to pay my malpractice if anything happens". Now, we are trying to get somebody from Guam to go there accompany that individual back to Guam.

I tell you that Aetna, Cigna or any of the large insurance companies in the continental United States don't even bother with cases like that. They are in the business of providing health insurance and they don't care about the rest. So, yes that illustrates what we do extra here in Guam.

The cost of coordinating claim payments in the Philippines and Japan is significant, especially since we have to translate their systems into the US healthcare system. The lack of resources for effective peer review and evidence based medicine guidelines require domestic companies to expend significant amounts of time with medical providers educating them and their staff on correct coding and billing guidelines. This is also more relevant in countries such as the Philippines.

The above points evidently illustrate our challenges when dealing with neighboring countries, which do not follow standards created by the American Medical Association and others. The cost of developing and managing effective medical provider networks is also higher as we must travel outside of Guam to seek contracts with providers in Hawaii, California, Washington State, Japan and other places. And you already know what the cost of flying outside of Guam is like.

Because of the lack of any relevant medical and industry training programs on Guam, our employees must travel to training programs outside of Guam. Again, more expensive than if they were here. Dealing with the fluctuation of foreign currency creates additional administrative expenses as our staff is tasked with calculating exchange rates in a manner that is also reasonable and not burdensome to members.

Another concern is that GovGuam has traditionally been very late in its premium remittances averaging 60 days on premiums receivables yet our carrier has to pay medical claims to providers within 45 days of receiving a bill. Most other states and jurisdictions pay premiums on time or within the current month.

Guam's insurers have been relatively successful at keeping health insurance premium rates low and they are significantly lesser than the premiums charged in most states, which is a testament to the resourcefulness of our competitive industry and we should not be penalized for providing the people of Guam with reasonable premiums. In fact, with the impending movement of Marines to Guam, many national companies have opted to cancel their national health programs and offer the local health alternatives to employees hired in the continental United States for services in Guam due to the significant savings generated by the least expensive premiums offered by the local carriers.

A looming situation that will possibly affect premiums in the future is the continued devaluations of the United States currency, which will put significant pressures on the successes of the local industry as the cost basis for services will increase and the consequences will be higher premiums.

About seven years ago we were paying services in the Philippines at 57 pesos to the dollar, now it's at 42, which means we are now paying about 30% higher.

Another factor to consider is that premium increase are reflective of cost increase for medical, hospital and prescription drug services and the Guam Legislature could significantly help the people of Guam and more importantly the government of Guam if it focuses its efforts in finding ways and means to mitigate and contain the cost of medical services.

We also have additional concerns with the proposed legislation and specifically some of the language and requirements in 4313 (2) (c)(ii), roman numeral II through XX that requires extensive and detailed disclosures, which are far and beyond those required in ACA. This will also discourage potential carriers from entering the market or trigger the opposite effect of creating greater competition.

In summary we oppose the percentage of the MLR requirement for GovGuam and the language in the portion of the bill as stated above, and we encourage the Committee to develop more reasonable requirements on both the medical loss ratios and the disclosure requirements in Section 4313 as stated above.

GovGuam employees and retirees are well represented in the negotiating committee and they are aided by a national recognized actuarial firm, and perhaps a better option is to allow the negotiating team to perform its duties as they have successfully done so in the past years. In fact, the team successfully negotiated rate reductions and improved benefits in the FY 2010 compared to FY 2009. In fact, some rates were reduced by 25%. And the reason for that was because the carrier had better medical loss ratios than those targeted by the insurance company.

We hope that the Guam Legislature finds wisdom in promoting competition rather than limiting the ceiling on the retention levels for health insurance and potentially closing the health insurance market in Guam.

Thank you and will be happy to answer any questions you may have. And we provided the enclosures.

Chairman Pangelinan: Thank you very much Mr. Campillo. Did you want to say anything Mr. Schnabel.

Mr. Ray Schnabel. I am here to answer any questions.

Chairman Pangelinan. Thank you. Just a couple of questions. If the medical loss ratio percentage as being proposed in the bill may be limiting, what would you propose would be an acceptable loss ratio percentage.

Mr. Ray Schnabel. We don't think the bill is necessary. We think there is enough competition in this market. We don't think the bill is necessary at all. Imposing any percentage is absolutely not necessary and imposes additional requirements and additional costs on running the government of Guam health insurance plan.

Chairman Pangelinan. Ok. So, where it says, "In summary we oppose the percentage of the MLR requirement"... I was thinking that if 15% is too low, would 20% be acceptable or reasonable or livable or 25% would be the ratio that would be acceptable, livable...

Mr. Ray Schnabel. For that paragraph, the translation would be no percentage is necessary.

Mr. Frank Campillo. But there is target loss ratio in every area. So a reasonable target loss ratio would be somewhere between 75-80%.

Chairman Pangelinan. Ok. Senator Cruz?

Senator BJ Cruz. What would be the affect of the federal statute be on that? Even if we didn't have this, wouldn't have to comply with federal statute, which says over a thousand enrollees, the medical loss ratio would be 15% and that is what you are trying to get a waiver for?

Mr. Frank Campillo. Correct. And we are trying to get a waiver for that.

Senator BJ Cruz. Even if you didn't get a waiver and we didn't pass the law, you would still have to do 15%.

Mr. Ray Schnabel. Absolutely. And the federal law already has a set of reporting requirements. Basically, we are already looking at having to hire extensive staff just to fulfill those reporting requirements. The reporting requirements on this bill are different and yet another set of reports to report out. All this thing seems to do is increase the cost on the admin side of the health plan and it doesn't go towards the care of members.

Mr. Frank Campillo. Could you clarify again....

Senator BJ Cruz. Well, it seems to me that even if we didn't pass this law the ACA would still require that your medical loss ratio be 15% because there are more than a thousand enrollees in GovGuam, right?

Mr. Frank Campillo. Correct. But waivers are being granted and as you know more than 900 waivers have been granted.

Senator BJ Cruz. Your application for waiver has not been granted, yet.

Mr. Frank Campillo. The application for waiver for all the Guam carriers have not been granted, yet.

Senator BJ Cruz. Ok. The other thing is – and I was willing to be quiet for a while until you said you were opposed to the disclosure. We've had discussions about your concerns about the disclosure and the fact that it would be unreasonable or leave people open to figuring out who is what. I am surprised that your example that you gave about the story you were going to give is probably more violative of any requirement than what we would possibly want to give. You've given the type of surgery that this person went off to, you've given the gender, you've given the time frame and you've even gone off and admitted that this person has psychological problems. I am shocked. And then you are telling us that our requirements for wanting to know how much was spent for medicine or how much was spent for medical care is violative of HIPPA requirements or possibly could be - I would think that your little story is grossly anything we could possibly ask. The only thing you didn't give us was his age and his village.

Mr Frank Campillo. Nothing that I said disclosed anything with HIPPA. What we are saying is some of the requirements that were placed in the bill that are far more stringent than the requirements that are put on the Medical Loss Ratio requirements by ACA. I am talking about this disclosure requirement. Not the other disclosure requirement that we discussed before.

Mr. Ray Schnabel. Our objection is centered mostly around information that is very proprietary. You are asking us to disclose what we pay providers, which is our whole cost structure, which is going to be available to all our competitors. You are asking us disclose salary information, all our expense information. It's all highly proprietary. We are not a government of Guam agency. This Legislature seems to at least lately seems to think that we are a GovGuam agency where we have to disclose everything we do. We are a private business.

Chairman Pangelinan. I just want to say for the record that these disclosure requirements would be part of the contract and these disclosure requirements are separate in terms of being available for the RFP. So, it's not our intention to say that the disclosure requirements here for the arrival at the medical loss ratio and whether or not a rebate should occur or not depending on the threshold is not the same as the RFP requirements.

Mr. Ray Schnabel. We understand that Senator. It may not be your intention now but neither was the intention of the original bill for all the data we had to submit. It was not to be submitted to our competitors. It was in later revisions, you guys amended the law to make it available to our competitors. So, just because the intention is not to be made available to our competitors today doesn't mean you guys can't make it that tomorrow, which you have done in the past – just recently.

Chairman Pangelinan. I agreeit can be changed. But just for the record on the original data requirements for the RFP, it was always the intention that that set of data de-identified and recognizing and respecting proprietary information was intended for the negotiation process and for the development of the RFP. I think it was the Attorney General who ruled that the language did not extend beyond the negotiating team itself. But I understand your concern and certainly would consider those.

Mr. Frank Campillo. And when we talk about this for instance, I think if you had a company like Aetna, which apparently are looking at the Guam market, I think they are going to have problems because it's going to be separated for now of the government of Guam enumerating how much they pay the Chief Executive Officer, how much stock options they give – I think they are going to walk away from the market. I don't think they will feel like – the market is not big enough for them to put up with all of this.

Chairman Pangelinan. But for Aetna, I get that on the Wall Street Journal when I google it.

Mr. Ray Schnabel. Those are all private companies but the market on Guam is made up of privately held companies.

Chairman Pangelinan. I understand. Senator Respicio?

Senator Rory Respicio. Thank you very much Mr. Chairman. I certainly understand the intent of the bill. But when you sit there and tell me, or tell us that the negotiating team successfully negotiated rates that actually resulted in lower percentages because of rate structure and the overall picture, the health insurance program and the cost went up by about $18M-$20M that is currently underfunded. So, those explanations can be for another time and place but that's why I have a hard time wrapping my mind around comments like that when the end result means that we're paying much more this fiscal year than we did last fiscal year.

Mr. Frank Campillo. I was talking about the fiscal year 2009 compared to 2010. In 2010 we made significant changes to the benefits.

Senator Rory Respicio. How come you didn't use the current year numbers?

Mr. Frank Campillo. With any year, you have good years, you have bad years. 2009 was a reasonable year. 2010 year was a bad year. I was using the fact that they also have done good for the community, they were able to reduce rates one year and negotiate better benefits. But when there are bad years, of course. But they are also a reasonable committee.

Senator Rory Respicio. I am also trying to wrap my mind around the unintended consequences that not only you pointed out but also your competitors in this business. Do you have any idea how long it takes for the waiver to be granted? It's either a waiver in reduction of the MLR or an outright exemption. Do you have any idea how long that process is?

Mr. Frank Campillo. It's being reviewed.

Mr. Ray Schnabel. We have been waiting over six months, at least.

Chairman Pangelinan. Did the CNMI ask for a waiver and got told, "No sir?"

Mr. Francis Santos. I am Francis Santos speaking for Stay Well. I think their case was a little different. According to Sixto Igisomar, Insurance Commissioner (CNMI), he stated that he was just…

Chairman Pangelinan. … going to grant waivers.

Mr. Francis Santos. Well, they felt that they were not going to comply with PACA period. And when he made the call to basically tell them that we're happy not to take the premium or the rate review money that we're getting, he was told under no circumstances would you do that and you will take this money that's being given to you. So right now as we speak my understanding is that their government plan is not PACA compliant. So, they've taken a stand that we will not apply PACA to our government plan. I just want to correct my good friend next to me that being mindful that the federal programs are exempt from PACA. So we cannot compare apples and apples to take our friends from Take Care and say that they are – they are not here – so that may explain why their position may be different from ours with regards to this piece of legislation. From our standpoint with StayWell, we oppose the legislation but based on the fact that there exists a federal law that we already are complying with as we speak. We fully intend to come back into GovGuam provided that my friends to the right here (Select Care) provide the data. If the data is not in the RFP I can publicly state on the record that Stay Well will not bid on the government of Guam group health again because our re-insurance carriers will not want to come back into GovGuam without adequate data. They are the risk takers in our business and without that we can't adequately convince them to enter into this market.

The market is so unique and different in GovGuam. We are going to sit here and legislate Select Care to death and that is really not our intent. Apparently it is not the intent of Senator Pangelinan. But I have seen this roundabout now for two years until our friends on my right (Select Care) share the data, that is really not theirs to begin with. I've always been in the position when you pay your premiums to a plan, the data that is derived from those premiums belong to the plan – the contract that you enter into that group with. So, I can't imagine that my friends to my right (Select Care) to hold this proprietary stuff. I agree your salaries are proprietary, your contracts with your doctors are proprietary – whatever you have, those are great. But at the end of the day, the utilization data is not proprietary. We are going to argue this theoretically but at the end of the day – Frank (Mr. Campillo) knows full well if our good friends and these large groups went up and said, "I need this data Frank to adequately look at the rates", Frank is going to say, "yes sir".

Mr. Ray Schnabel. We don't have any problems with the data. It's the extensiveness of the data. We feel that is has gone far beyond what's normally required and it's gone into highly proprietary information. Keep in mind that we had no data when we entered the market.

Mr. Frank Campillo. Exactly. Let me remind you a couple of things. When we entered the market, there was no data whatsoever. We have always said we would be happy to give the data to the owner – the government of Guam. We have always been opposed to the fact that it should not be disclosed to others. Continental, for instance does not give us any data. We have been trying to enter into the federal government, as you know – they don't give us any data what the other competitors pay locally on services. We are saying we will it to the government of Guam

as it is rightfully so. We don't believe that detailed data should be given to competitors. We believe that possibly consolidated data in regards to what is paid overall for hospital, what is paid overall for physicians, what is paid overall for prescription drugs – that we agree on.

Mr. Ray Schnabel. To go on record, we have provided the data. If the government has not provided it for you, come see us. We'll give you a copy.

Chairman Pangelinan. It's now the government's responsibility to compile the data, determine what data would be available for the development of RFP.

Mr. Frank Campillo. That type of data – for instance the federal government does not give that type of data in regards to losses to potential companies that would like to come in. The state of California doesn't do that. The state of Hawaii doesn't do that. Because it works both ways. When you have too much data, you could possibly say well… Or when you don't have enough data you can be a little more liberal and perhaps (?) your calculations or premiums as we did the first couple of years with GovGuam.

Senator Rory Respicio. Just to wrap up. A couple of things could happen if this bill became law and the waiver was still pending might hurt the chances of getting a waiver if this was enacted by statute locally. What are your thoughts on that?

Mr. Frank Campillo. It is a possibility, Senator. It will be a good idea to see what happens with the applications at the federal level because we cannot be talking on both sides of our mouth.

Senator Rory Respicio. Well, the other thing, Mr. Chairman we might be in litigation because if the waiver is granted at the federal level and a local statute is enacted, the federal government is supreme. Maybe. Maybe not. But that certainly is a legal question. Thank you.

Chairman Pangelinan. Let me tell you, I'd think you'd be happier with this than the federal government's loss ratio and requirements. I believe this would be more advantageous for local insurance companies the way we have structured this. Read it a little bit more carefully.

Mr. Ray Schnabel. We appreciate the tax implications, Senator. We really do. But we still feel that the legislation is not necessary. If both remain in place – if this legislation is enacted and the federal legislation remains in place, I don't know if this will supersede the federal act with regards to the calculation of the MLR.

Senator BJ Cruz. My only disappointment is that I was hoping that you would have taken up Senator Pangelinan on his question of what would be reasonable. Maybe 15% is too low? But to say we don't want any loss ratio and if it's 50% what we're going to have as our profit then more power to us. You guys lost me on that one. I was hoping you would come up with something. He offered 20% and 25% and to say, "no we don't want any of them" only hints to me that even 25% is too low and we want 50%.

Mr. Ray Schnabel. We could give you a more accurate answer. It would require me to hire a couple of cost accountants. We've avoided that expense and we're passing that expense on to the members of the government of Guam employees.

Mr. Frank Campillo. We did reply. We said somewhere between 20%-25% would be reasonable.

Senator BJ Cruz. Was that in the written testimony?

Mr. Frank Campillo. It was not in the written testimony. We have target loss ratios when we do price our benefits.

Mr. Ray Schnabel. Is 20 more reasonable to us than 15? Absolutely. Is 25 even more reasonable? Yes. Again, our stance is the legislation is not necessary. But if you had to impose a percentage, certainly a lower MLR percentage would be better for us. Keep in mind also that this relates to the government of Guam contract. The 15% or the 85% that is in the federal statute, that relates to overall market. We are talking large stable markets. The government of Guam contract and that market is a very volatile market.

Senator BJ Cruz. But part of that change is in some of the things we are negotiating. In 2009, we had to front all of our deductibles. In 2010 because of the campaign we dropped that and consequently when people didn't have to come up with their 2000 (deductible) immediately before they could get their 20%, they weren't going to the doctor in 2009 because of the 2,000, 6,000 or 10,000 (deductible), depending the size of the family but when it wasn't required they were running to the doctor to make sure that everything they neglected in 2009 was taken care of in 2010. So there were differences in those two years of how that was handled and I think affected the decisions that people who could not afford to come up with the 2,000 or the 10,000 or the 12,000 (deductible) made their decisions on whether or not they were or were not going to see the doctor.

Mr. Frank Campillo. You are somewhat right, Senator. The opposite side of that equation is evidently higher utilization was translating to higher rates. So, you are right. The fact that there is a possibility that people were not taking the medication when they should. But that also resulted on a utilization from a $1.7M in drugs in the first six months of fiscal year 2009 to $4.2M in fiscal year 2010. But again we don't oppose higher utilization. We're saying the consequences of higher utilization mean higher premiums.

Chairman Pangelinan. Thank you and Si Yu'os Ma'ase for your presence and testimony this afternoon and we will certainly will take all of the presentation today with due consideration as we continue to work on the bill.

III. FINDINGS & RECOMMENDATIONS

The Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, and Land hereby reports out Bill No. 139-31(COR), as substituted with the recommendation To Report Out Only.

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

2011 APR -5 PM 3:47

Bill No. 139-31 (COR)

Introduced by:

v.c. pangelinan
B.J.F. Cruz
D.G. Rodriguez, Jr.
T.R. Muna-Barnes
J.T. Won Pat, Ed.D.

AN ACT TO ADD A NEW ARTICLE 3A TO CHAPTER 4, TITLE 4 GCA RELATIVE TO REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATION OF A MEDICAL LOSS RATIO REBATE FOR THE GOVERNMENT OF GUAM HEALTH INSURANCE PROGRAM

Section 1. Legislative Findings and Intent. On March 23, 2010 the President of the United States of America created history by signing into law the Patient Protection and Affordable Care Act (PPACA). The act set into law a multi-component approach to reduce and stem the continued rising cost of health care, a problem that has plagued the United States of America and its Territories for decades.

Section 2718 of the Public Health Service Act (PHSA), as added by Section 1001 and amended by Section 10101 of the PPACA, requires health insurance issuers to offer coverage to meet specific medical loss ratio (MLR) standards as defined by the National Association of Insurance Commissioners (NAIC).

I' Liheslaturan Guahan finds that Guam's health insurance industry must comply with Section 2718 of the PHSA as a minimum standard for providing rebates to consumers when target MLR ratios are not reached.

The Government of Guam Health Insurance Program (Program) is the largest market on Guam. There are over 18,000 eligible employees and retirees of which less than 11,000 or 59% purchase health insurance. In FY 2011 the total amount of premiums paid to the government health insurance provider will exceed $78 million dollars. The people of Guam share of the cost is $59 million from the General Fund and through rates and tariffs assessed by the Guam Power Authority, Guam Waterworks Authority and the Jose D. Leon Guerrero Commercial Port. The remaining $19 million is paid by Government of Guam employees and retirees. The combination of high premiums and high deductible health plans make the insurance unaffordable and undesirable to many government employees and retirees.

I' Liheslaturan Guahan further finds that the cost of the Program is prohibitively expensive for both employees and retirees. The taxpayers and the Government of Guam and its employees and retirees are entitled to the best value for the public funds used to pay health insurance premiums.

I' Liheslaturan Guahan intends to promote high-value coverage through enhanced MLR requirements for the Program, as envision by the national program. The regulation outlined in this Act is specific to the Program and establish guidelines that provide a rebate to Government of Guam employees and retirees if the MLR ratios are less than required levels.

Section 2. A new Article 3A is hereby added to Chapter 4, Title 4 Guam Code Annotated to read:

"§4309. Short Title
§4310. Purpose
§4311. Definitions
§4312. Applicability and Scope
§4313. Bringing Down the Cost of Health Care Coverage
§4314. Levels of Aggregation for Medical Loss Ratio Rebate Calculations
§4315. Frequency and Timing of Medical Loss Ratio Rebate Calculations and Payments
§4316. Credibility Adjustments to Medical Loss Ratio
§4317. Medical Loss Ratio Rebate Calculation
Appendix A. Formats for Reporting Rebate Calculations
Appendix B. Credibility Tables
Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions

§4309. Short Title. This Regulation shall be known and may be cited as the Government of Guam Health Insurance Program Medical Loss Ratio Rebate Regulation.

§4310. Purpose. The purpose and intent of this Regulation are to promulgate uniform definitions and a standardized calculation methodology for rebates of health insurance premiums for the Government of Guam Health Insurance Program.

§4311. Definitions.

(a) "Earned premium" means the sum of all moneys paid by a policyholder as a condition of receiving coverage from a health insurance issuer subject to this Regulation, including any fees or other contributions associated with the health plan, such as non-premium revenue collected by the issuer and any subsidiary

holdings providing services to members under the health insurance issuer's products, inclusive of reinsurance receivables, deductibles, copayments, coinsurance, fee-for-service, administrative charges and investment income.

(b) "Expenses to improve health care quality" means those expenses as a defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on 8/17/10.

(c) "Incurred claims" means the sum of direct paid claims incurred in the applicable plan year, unpaid claim reserves associated with claims incurred during the applicable plan year, any experience rating refunds paid or received, and reserves for experience rating refunds.

(d) "Claims unpaid" means claims reported and in the process of adjustment, percentage withholds from payments made to contracted providers, incurred but not reported claims, and recoverables for anticipated claims.

(e) "Credibility adjustment" means the adjustment to account for random statistical fluctuations in claims experience.

(f) "Direct paid claims" means claim payments before ceded reinsurance and excluding assumed reinsurance except as follows: Paid claims for policies that were originally issued by one entity and later assumed by another entity via assumption reinsurance are to be treated as direct paid claims for the assuming entity's and excluded from the ceding entity's medical loss ratio rebate calculations.

(g) "Experience rating refund" means the return of a portion of premiums pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium, or the collection of

additional premiums by the issuer pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are greater than earned premium, plus any incurred state premium refunds.

(h) "Fully credible," as it relates to experience, means experience generated by 75,000 or more life years.

(i) "Life years" means the number of member months divided by 12.

(j) "Net healthcare receivables" means the change between prior year healthcare receivables and current year healthcare receivables. The amounts are the gross healthcare receivable assets, not just the admitted portion. This amount does not include those healthcare receivables, such as loans or advances to non-related party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

(k) "Non-credible," as it relates to experience, means experience generated by less than 1,000 life years.

(l) "Partially credible," as it relates to experience, means experience generated by at least 1,000 life years but less than 75,000 life years.

(m) "PHSA" means Public Health Service Act.

(n) "Policyholder" means any entity that has entered into a contract with a health insurance issuer to receive health insurance coverage as defined in Section 2791 (b) of the PHSA.

(o) "Reserves for experience rating refunds" means an estimate of amounts due but unpaid under a retrospectively rated funding arrangement or due but unpaid for a state premium refund.

(p) "Unearned premium reserves" means reserves that are established to account for that portion of the premium paid in the plan year that is intended to provide coverage during a period which extends beyond the plan year.

(q) "Unpaid Claim Reserves" means reserves established to account for claims unpaid.

(r) "Program" means Government of Guam Health Insurance Program as defined in § 4301 of Chapter 3, Article 3 of Title 4 Guam Code Annotated and excluding all Government of Guam Departments, Agencies and Public Corporations that decline participation in the Program.

§4312. Applicability and Scope. The provisions of this Regulation concerning the calculation and payment of medical loss ratio rebates shall apply to any health insurance issuer that provides coverage to the Government of Guam.

§4313. Bringing Down the Cost of Health Care Coverage.

(1) Clear Accounting for Costs. A health insurance issuer offering health insurance coverage to the Government of Guam shall, with respect to each plan year, submit to the Guam Insurance Commissioner, the Office of Public Accountability and the Office of Finance and Budget a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense to earned premiums. The basis of the Medical Loss Ratio Calculation shall be according to provisions outlined in this Section and further defined in Section 9 of this Act. The report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, which such coverage expends:

(a) on reimbursement for clinical services provided to enrollees under such coverage;

(b) for activities that improve health care quality; and

(c) on all other non-claims costs, including an explanation of the nature of such costs.

The Public Auditor shall make reports received under this section available to the public on the Internet website of the Office of Public Accountability.

(2) Ensuring That the Government of Guam Receives Value for Premium Payments.

(a) Requirement to provide value for premium payments. Beginning October 1, 2011, a health insurance issuer offering health insurance coverage to the Government of Guam shall, with respect to each plan year, provide an annual rebate to each enrollee of the Program under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (a) and (b) of subsection (1) to the total amount of premium revenue for the plan year is less than 85 percent or a higher percentage contractually agreed to by the health insurance issuer.

(b) Calculation of Rebate amount. The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of:

(i) the amount by which the percentage described in subparagraph (a) exceeds the ratio described in such subparagraph; and

(ii) the total amount of premium revenue for such plan year.

(c) Certification of Loss Ratio Results and comparison of government of Guam performance relative to the overall health insurance issuer book of business.

(i) Certification of Loss Ratio Results. The actual loss ratio results for plan year the rates are in effect shall be independently audited by the Office of Public Accountability during the first quarter of the following year at the expense of the insurer. The audited results shall be reported to *I Maga'lahi* and the Speaker of *I Liheslaturan Guåhan* no later than April 1 of the following year. The audit shall be conducted in accordance with generally accepted auditing or actuarial standards and shall be signed by a certified public accountant or a member of the American Academy of Actuaries.

(ii) Comparison of Government of Guam Performance Relative to the Overall Health Insurance Issuer Book of Business. In a separate report during the first quarter of the following year the insurer shall produce a report that isolates the following information for the Government of Guam contract and compares the information to the insurers overall book of business:

(I) Medical trend itemized by medical provider price increases, utilization changes and new medical procedures and technology;

(II) Medical trend itemized by pharmaceutical price increases, utilization changes and the introductions of new brand and generic drugs;

(III) Dividends paid;

(IV) Executive salaries, stock options and bonuses;

(V) Insurance producer commissions;

(VI) Payments to legal counsel;

(VII) Provision for profit and contingencies;

(VIII) Administrative expenditures with breakdowns for advertising or marketing expenditures paid lobbying expenditures, and staff salaries;

(IX) Expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses;

(X) Charitable contributions;

(XI) Losses on investments or investment income;

(XII) Reserves on hand;

(XIII) The amount of surplus and the amount of surplus relative to the carrier's risk-based capital requirement;

(XIV) Taxes itemized by category;

(XV) Administrative ratio;

(XVI) Actual benefits ratio;

(XVII) The number of lives insured;

(XVIII) The total cost of providing or arranging health care services for:

(1) Guam based expenses: total administrative cost and number of employees;

(2) Philippine based expenses: total administrative cost, number of employees, itemized transaction listing

of all currency deposits or payments to third party administrators;

(3) Other Location based expenses: total administrative cost, number of employees, itemized transaction listing of all currency deposits or payments to third party administrators.

(XIX) Other Income: Non-premium revenue collected by the issuer and any subsidiary holdings providing services to members under the health insurance issuer's products, inclusive of reinsurance receivables, deductibles, copayments, coinsurance, fee-for-service and administrative charges';

(XX) Total annual savings from discounted claims by the Guam Memorial Hospital.

§4314. Levels of Aggregation for Medical Loss Ratio Rebate Calculations. All Plans sold to a Policyholder in the same contract year shall be aggregated for purposes of calculating the Medical Loss Ratio Rebate.

§4315. Frequency and Timing of Medical Loss Ratio Rebate Calculations and Rebate Payments.

(1) Rebates shall be calculated annually by all health insurance issuers that provide coverage to the Government of Guam.

(2) Rebates must be calculated using data as of September 30 of the plan year except for incurred claims, which must be restated as of December 31 of the year following the plan year.

(3) Rebates must be reported to the Insurance Commissioner by February 28 of the year following the plan year using the appropriate reporting format in Appendix A.

(4) Rebates shall be paid annually by March 31 of the year following the plan year.

§4316. Credibility Adjustments to Medical Loss Ratio.

(1) A credibility adjustment is not applicable to any Medical Loss Ratio Calculations that is either non-credible or fully credible based on the Policyholder's aggregate of all plan year life years during the same contract year.

(2) The credibility adjustment for any Medical Loss Ratio Calculations as defined in §4313 and further defined in §4317 of this Act that is partially credible based on plan year life years is the unrounded product of the appropriate Table 1 and Table 2 factors. Table 1 and Table 2 are shown in Appendix B based on the Policyholder's aggregate of all plan year life years during the same contract year herein determined as:

(a) The Table 1 factor is determined using plan year life years. The Table 1 factor for a value that is between two life year categories is calculated by linearly interpolating the value between the lower and upper life year categories.

(b) The Table 2 factor may be determined using the plan year average plan deductible, weighted by life years. The Table 2 factor for a value that is between two deductible categories is calculated by linearly interpolating the value between the lower and upper deductible categories. A default value of 1.000 may be used as the Table 2 factor at the option of the issuer.

§4317. Medical Loss Ratio Rebate Calculation.

(1) A rebate is not payable for any aggregation that is non-credible based on plan year life years based on the Policyholder's aggregate of all plan year life years during the same contract year.

(2) If, for any level of aggregation as defined in Section 6, 50% or more of the total earned premium is attributable to policies newly issued with less than 12 months of experience, the experience of these policies can be excluded from the medical loss ratio calculation for plan year. For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

(3) The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality are:

(i) Incurred claims are those with incurral dates from October 1, YYYY to September 30, YYYY;

(ii) Expenses to improve health care quality are those expenses associated with incurral dates from October 1, YYYY to September 30, YYYY.

(4) The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums for the period from October 1, YYYY to September 30, YYYY.

(5) The medical loss ratio is calculated as the unrounded ratio of the numerator in (3) to the denominator in (4).

(6) The credibility-adjusted medical loss ratio is calculated as the unrounded sum of the medical loss ratio calculated in (5) and any applicable credibility adjustment.

(7) The credibility-adjusted medical loss ratio is subtracted from the applicable minimum medical loss ratio standard.

(8) If the result of (7) is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium The resulting amount is the rebate to be paid. If the result of (7) is zero or less, no rebate is to be paid."

Section 3. Severability. If any provision of this Law or its application to any person or circumstances is found to be invalid or contrary to law, such invalidity shall not affect other provisions or applications of this Law which can be given effect without the invalid provisions or application, and to this end the provisions of this Law are severable.

Appendix A. Formats for Reporting Rebate Calculations

REBATE CALCULATION FORM FOR PLAN YEAR

Company _____ NAIC Company Code _____

For the State of _____ NAIC Group Code _____

Line of Business _____ Minimum Medical Loss Ratio _____

Address _____ Person Completing Exhibit _____

Title _____ Telephone _____

USE GUAM SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1 & PART III TO ASSIST IN COMPLETION OF THIS DOCUMENT

(1) Line	(2) Description	(3) YYYY
1	Life Years	
2	Earned Premium	
3	Expenses to Improve Heath Care Quality	
4	Paid Claims	
5	Unpaid Claim Reserve	
6	Experience Rating Refunds and Reserves for Experience Rating Refunds	
7	Net Healthcare Receivables	
8	Incurred Claims	
9	Medical Loss Ratio	
10	Credibility Adjustment Factor	
11	Credibility Adjusted Medical Loss Ratio	
12	Rebate	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

Appendix A. Formats for Reporting Rebate Calculations (continued)

INSTRUCTIONS REBATE CALCULATION FORM FOR PLAN YEAR

Line 1: Life Years Rebate Supplemental Form for experience year

Line 2: Earned Premium Rebate Supplemental Form for experience year

Line 3: Expenses to Improve Health Care Quality Rebate Supplemental Form for experience year

Line 4: Paid Claims Rebate Supplemental Form for experience year

Line 5: Unpaid Claim Reserve Rebate Supplemental Form for experience year

Line 6: Experience Rating Refunds and Reserves for Experience Rating Refunds Rebate Supplemental Form for experience year

Line 7: Net Healthcare Receivables

Rebate Supplemental Form for experience year

Line 8: Incurred Claims as of 12/31= Line 5 + Line 6 + Line 7 + Line 8

Line 9: Medical Loss Ratio = (Line 4 + Line 9) / (Line 2 – Line 3)

Line 10: Credibility Adjustment based on the number of life years in Line 1 and the methodology in Section 8.

Line 11: Credibility Adjusted Medical Loss Ratio = Line 9 + Line 10 Line 12: If 2011 experience is non-credible as determined by Line 1, Rebate = 0, else,

If (Minimum Medical Loss Ratio - Line 12) is less than or equal to zero, Rebate = 0, else

Rebate = (Minimum Medical Loss Ratio - Line 11) / (Line 2),where (Minimum Medical Loss Ratio - Line 11) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

Appendix A. Formats for Reporting Rebate Calculations (continued)

REBATE CALCULATION SUPPLEMENTAL FORM Plan Year ____

Experience Year ____ Company _____ NAIC Company Code_____
For the State of_____ NAIC Group Code _____
Line of Business _____ Address _____
Person Completing Exhibit _____ Title _____
Telephone Number_____

REBATE CALCULATION SUPPLEMENTAL FORM

(1) Line	(2) Description	(3) 12/31	(4) Deferred	(5) Added	(6) Total
1	Life Years				
2	Earned Premium				
3	Expenses to Improve Heath Care Quality				
4	Paid Claims				
5	Unpaid Claim Reserve				
6	Experience Rating Refunds and Reserves for Experience Rating Refunds				
7	Net Healthcare Receivables				
8	Incurred Claims				

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

Appendix A. Formats for Reporting Rebate Calculations (continued)

INSTRUCTIONS REBATE CALCULATION SUPPLEMENTAL FORM

Column 3 is data from the Supplemental Health Care Exhibit in the NAIC Annual Statement for the experience year.

Column 4 is data for policies newly issued in the experience year with less than 12 months of experience in that year that are excluded from the medical loss ratio calculation for the plan year of issue and will be added back in the next plan year. Column 5 is data for policies newly issued in a prior experience year with less than 12 months of experience in that year that were excluded from the medical loss ratio calculation for a prior plan year and are added back in this plan year. See Sections 8.B., 9.B. for additional details.

Note that quantities in Lines 2 through 6 should be allocated to represent only the experience associated with the deferred business using reasonable methods.

Line 1: Life Years Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1 Other Indicators, Column(s) for applicable line of business - Line 4 divided by 12 and rounded to zero decimal places.

Line 2: Earned Premium -- Column 3 is from the Supplemental Health Care Exhibit for the experience year –

Line 3: Expenses to Improve Health Care Quality -- Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 4 + Line 6.3

Line 4: Paid Claims -- Amounts paid on claims incurred in the experience year as of December 31 of the year following the plan year.

Line 5: Unpaid Claim Reserve -- The reserve for amounts unpaid on claims incurred in the experience year as of December 31 of the year following the plan year.

Line 6: Experience Rating Refunds and Reserves for Experience Rating Refunds Experience rating refunds incurred in the experience year and paid through December 31 of the year following the plan year, plus the estimate as of December 31 of the year following the plan year for any reserves experience rating refunds

incurred in the experience year, plus any state premium refunds incurred in the experience year.

Line 7: Net Healthcare Receivables Net Healthcare Receivables incurred in the experience year as of March 31 of the year following the plan year.

Line 8: Line 4 + Line 5 + Line 6 + Line 7.

Appendix B. Credibility Tables

Table 1	
Base Credibility Additive Adjustment Factors	
Life Years	**Additive Adjustment**
< 1,000	No Credibility
1,000	8.30%
2,500	5.20%
5,000	3.70%
10,000	2.60%
25,000	1.60%
50,000	1.20%
75,000	0.00%

Table 2	
Deductible Range	**Adjustment Factor**
< $2,500	1
$2,500	1.164
$5,000	1.402
>= $10,000	1.736

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions

Expenses to Improve Health Care Quality:

Derived from GUAM SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3:

Improving Health Care Quality Expenses – General Definition: Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self-insured plans. Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, transparency, and outcomes.

NOTE: Expenses which otherwise meet the definitions for QI but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.

PARTS 3A and 3B COLUMNS:

Column 1 – Improve Health Outcomes Expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined above. This category can include costs for associated activities such as:

- Effective case management, Care coordination, and Chronic Disease Management, including:

Patient centered intervention such as:

-Making/verifying appointments,

-Medication and care compliance initiatives,

-Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center),

-Programs to support shared decision making with patients, their families and the patient's representatives; and

-Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers;

- Incorporating feedback from the insured to effectively monitor compliance;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

- Providing coaching or other support to encourage compliance with evidence based medicine;

- Activities to identify and encourage evidence based medicine;

- Use of the medical homes model as defined for purposes of section 3602 of PPACA);

- Activities to prevent avoidable hospital admissions;

- Education and participation in self-management programs; and

- Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance;

- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;

- Quality reporting and documentation of care in non-electronic format; and

- Health information technology expenses to support these activities (report in Column 5 - see instructions) including:

  -Data extraction, analysis and transmission in support of the activities described above, and

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

-Activities designed to promote sharing of medical records to ensure that all clinical providers and accurate records from all participants in a patient's care; and

Column 2 – Activities to Prevent Hospital Readmission Expenses for implementing activities to prevent hospital readmissions as defined above, including:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
- Personalized post discharge counseling by an appropriate health care professional;
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including.
- Data extraction, analysis and transmission in support of the activities described above, and
- Activities designed to promote sharing of medical records to ensure that all clinical providers rate records from all participants in a patient's care; and

Column 3 – Improve Patient Safety and Reduce Medical Errors Expenses for implementing activities to improve patient safety and reduce medical errors as defined above through:

- The appropriate identification and use of best clinical practices to avoid harm;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns;
- Activities to lower risk of facility acquired infections;
- Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions;
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and
- Health information technology expenses to support these activities (report in Column 5 – See instructions), including:

  -Data extraction, analysis and transmission in support of the activities described above, and

  -Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; or

Column 4 – Wellness & Health Promotion Activities Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or web-based interactions or other forms of communication), including:

- Wellness assessment;
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
- Public health education campaigns that are performed in conjunction with state or local health departments;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

- Actual rewards/incentives/bonuses/reductions in copays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI with the following restrictions:

  -Only allowed for small and large employer groups, not individual business; and the expense amount is limited to the same percentage as the HIPAA incentive amount limit; Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

  -Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and

  -Health information technology expenses to support these activities (Report in Column 5 – See instructions).

Column 5 – HIT Expenses for Health Care Quality Improvements -- The PPACA also contemplates "Health Information Technology" as a function that may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements, in the following ways;

1. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., chart review of HEDIS measures and costs for public reporting mandated or encouraged by law;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

2. Advancing the ability of enrollees, providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history;

3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

4. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of indentifying or treating specific conditions or controlling the spread of disease; or

5. Provision of electronic health records and patient portals.

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements.

Expense Allocation

Supplemental Filing: Companies report QI expenses in Part 3, Columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above. The definitions established in the Supplemental Health Care Exhibit apply to this supplemental filing as well. For a **new initiative** that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an "X" in the "New"

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

column of the supplement and include in the description the expected timeframe for the activity to accomplish the objective, verifiable results. Expenses for prospective Utilization Review and the costs of reward or bonuses associated with wellness and health promotion that are included in QI should include an "E" in the "New" column. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.

Notes: a. *Healthcare Professional Hotlines*: Expenses for healthcare professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities.

b. *Prospective Utilization Review*: Expenses for prospective Utilization Review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

The following items are broadly excluded as not meeting the definitions above:

- All retrospective and concurrent Utilization Review;
- Fraud Prevention activities (all are reported as cost containment, but Part 1, Line 4 includes MLR recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- Provider Credentialing;
- Marketing expenses;

- All Accreditation Fees;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- Any function or activity not expressly included in Columns 1 through 5.

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

SBill No. 139-31 (COR)
As substituted by Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, and Land.

Introduced by: **v.c. pangelinan**
B.J.F. Cruz
D.G. Rodriguez, Jr.
T.R. Muna-Barnes
J.T. Won Pat, Ed.D.

AN ACT TO ADD A NEW ARTICLE 3A TO CHAPTER 4, TITLE 4 GCA RELATIVE TO REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATION OF A MEDICAL LOSS RATIO REBATE FOR THE GOVERNMENT OF GUAM HEALTH INSURANCE PROGRAM

Section 1. Legislative Findings and Intent. On March 23, 2010 the President of the United States of America created history by signing into law the Patient Protection and Affordable Care Act (PPACA). The act set into law a multi-component approach to reduce and stem the continued rising cost of health care, a problem that has plagued the United States of America and its Territories for decades.

Section 2718 of the Public Health Service Act (PHSA), as added by Section 1001 and amended by Section 10101 of the PPACA, requires health insurance

issuers to offer coverage to meet specific medical loss ratio (MLR) standards as defined by the National Association of Insurance Commissioners (NAIC).

I' Liheslaturan Guahan finds that Guam's health insurance industry must comply with Section 2718 of the PHSA as a minimum standard for providing rebates to consumers when target MLR ratios are not reached.

The Government of Guam Health Insurance Program (Program) is the largest market on Guam. There are over 18,000 eligible employees and retirees of which less than 11,000 or 59% purchase health insurance. In FY 2011 the total amount of premiums paid to the government health insurance provider will exceed $78 million dollars. The people of Guam share of the cost is $59 million from the General Fund and through rates and tariffs assessed by the Guam Power Authority, Guam Waterworks Authority and the Jose D. Leon Guerrero Commercial Port. The remaining $19 million is paid by Government of Guam employees and retirees. The combination of high premiums and high deductible health plans make the insurance unaffordable and undesirable to many government employees and retirees.

I' Liheslaturan Guahan further finds that the cost of the Program is prohibitively expensive for both employees and retirees. The taxpayers and the Government of Guam and its employees and retirees are entitled to the best value for the public funds used to pay health insurance premiums.

I' Liheslaturan Guahan intends to promote high-value coverage through enhanced MLR requirements for the Program, which is a modified version of the national program. The regulation outlined in this Act is specific to the Program and establish guidelines that provide a rebate to Government of Guam, Taxpayers, employees and retirees if the MLR ratios are less than required levels.

Section 2. A new Article 3A is hereby added to Chapter 4, Title 4 Guam Code Annotated to read:

"§4309. Short Title

§4310. Purpose

§4311. Definitions

§4312. Applicability and Scope

§4313. Bringing Down the Cost of Health Care Coverage

§4314. Levels of Aggregation for Medical Loss Ratio Rebate Calculations

§4315. Frequency and Timing of Medical Loss Ratio Rebate Calculations and Payments

§4316. Medical Loss Ratio Rebate Calculation

Appendix A. Formats for Reporting Rebate Calculations

Appendix B. Credibility Tables

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions

§4309. Short Title. This Regulation shall be known and may be cited as the Government of Guam Health Insurance Program Medical Loss Ratio Rebate Regulation.

§4310. Purpose. The purpose and intent of this Regulation are to promulgate uniform definitions and a standardized calculation methodology for rebates of health insurance premiums for the Government of Guam Health Insurance Program.

§4311. Definitions.

(a) "Earned premium" means the sum of all moneys paid by a policyholder as a condition of receiving coverage from a health insurance issuer subject to this Regulation, including any fees or other contributions associated with the health

plan by subscribers, such as non-premium revenue collected by the issuer and any subsidiary holdings providing services to members under the health insurance issuer's products, inclusive of reinsurance receivables, deductibles, copayments, coinsurance, fee-for-service, administrative charges and investment income.

(b) "Expenses to improve health care quality" means those expenses as a defined in Appendix C and derived from the NAIC Supplemental Health Care Exhibit as adopted by the National Association of Insurance Commissioners on 8/17/10.

(c) "Incurred claims" means the sum of direct paid claims incurred in the applicable plan year, unpaid claim reserves associated with claims incurred during the applicable plan year.

(d) "Claims unpaid" means claims reported and in the process of adjustment, percentage withholds from payments made to contracted providers, incurred but not reported claims, and recoverables for anticipated claims.

(e) "Credibility adjustment" means the adjustment to account for random statistical fluctuations in claims experience.

(f) "Direct paid claims" means claim payments before ceded reinsurance and excluding assumed reinsurance.

(g) "Fully credible," as it relates to experience, means experience generated by 75,000 or more life years.

(h) "Life years" means the number of member months divided by 12.

(i) "Net healthcare receivables" means the change between prior year healthcare receivables and current year healthcare receivables. The amounts are the gross healthcare receivable assets, not just the admitted portion. This amount does not include those healthcare receivables, such as loans or advances to non-related

party hospitals, established as prepaid assets that are not expensed until the related claims have been received from the provider.

(j) "Non-credible," as it relates to experience, means experience generated by less than 1,000 life years.

(k) "Partially credible," as it relates to experience, means experience generated by at least 1,000 life years but less than 75,000 life years.

(l) "PHSA" means Public Health Service Act.

(m) "Policyholder" means any entity that has entered into a contract with a health insurance issuer to receive health insurance coverage as defined in Section 2791 (b) of the PHSA.

(n) "Unearned premium reserves" means reserves that are established to account for that portion of the premium paid in the plan year that is intended to provide coverage during a period which extends beyond the plan year.

(o) "Unpaid Claim Reserves" means reserves established to account for claims unpaid.

(p) "Program" means Government of Guam Health Insurance Program as defined in § 4301 of Chapter 3, Article 3 of Title 4 Guam Code Annotated and excluding all Government of Guam Departments, Agencies and Public Corporations that decline participation in the Program.

(q) "Health plan" means health insurance coverage and a group health plan.

(r) "Minimum medical loss ratio standard" means the percentage determined in accordance with §4313(2)(a).

§4312. Applicability and Scope. The provisions of this Regulation concerning the calculation and payment of medical loss ratio rebates shall apply to any health insurance issuer that provides coverage to the Government of Guam.

§4313. Bringing Down the Cost of Health Care Coverage.

(1) Clear Accounting for Costs. A health insurance issuer offering health insurance coverage to the Government of Guam shall, with respect to each plan year, submit to the Guam Insurance Commissioner, the Office of Public Accountability and the Office of Finance and Budget a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense to earned premiums. The basis of the Medical Loss Ratio Calculation shall be according to provisions outlined in this Section and further defined in §4316. The report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, which such coverage expends:

(a) on reimbursement for clinical services provided to enrollees under such coverage;

(b) for activities that improve health care quality; and

(c) on all other non-claims costs, including an explanation of the nature of such costs.

The Public Auditor shall make reports received under this section available to the public on the Internet website of the Office of Public Accountability.

(2) Ensuring That the Government of Guam Receives Value for Premium Payments.

(a) Requirement to provide value for premium payments. Beginning October 1, 2011, a health insurance issuer offering health insurance

coverage to the Government of Guam shall, with respect to each plan year, provide an annual rebate to the Government of Guam, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (a) and (b) of subsection (1) to the total amount of premium revenue for the plan year is less than Eighty two (82%) percent or a higher percentage contractually agreed to by the health insurance issuer.

(b) Calculation of Rebate amount. The total amount of an annual rebate required under this paragraph shall be in an amount equal to the product of:

(i) the amount by which the percentage described in subparagraph (a) exceeds the ratio described in such subparagraph; and

(ii) the total amount of premium revenue for such plan year.

(c) Certification of Loss Ratio Results and comparison of government of Guam performance relative to the overall health insurance issuer book of business.

(i) Certification of Loss Ratio Results. The actual loss ratio results for plan year the rates are in effect shall be independently audited by the Office of Public Accountability during the first quarter of the following year at the expense of the issuer. The audited results shall be reported to *I Maga'lahi* and the Speaker of *I Liheslaturan Guåhan* no later than April 1 of the following year. The audit shall be conducted in accordance with generally accepted auditing or actuarial standards and shall be signed by a certified public accountant or a member of the American Academy of Actuaries.

(ii) Comparison of Government of Guam Performance Relative to the Overall Health Insurance Issuer Book of Business. In a separate report during the first quarter of the following year the issuer shall produce a report that isolates the following information for the Government of Guam contract and compares the information to the issuers overall book of business:

(I) Medical trend itemized by primary care, specialty care and facility care price increases, utilization changes and new medical procedures and technology;

(II) Medical trend itemized by pharmaceutical price increases, utilization changes and the introductions of new brand and generic drugs;

(III) Insurance producer commissions;

(IV) Expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses;

(V) Losses on investments or investment income;

(VI) Reserves on hand;

(VII) The amount of surplus and the amount of surplus relative to the carrier's risk-based capital requirement;

(VIII) The number of lives insured;

(IX) The total cost of providing or arranging health care services for:

(1) Guam based expenses: total administrative cost and number of employees;

(2) Philippine based expenses: total administrative cost, number of employees, itemized transaction listing of all currency deposits or payments to third party administrators;

(3) Other Location based expenses: total administrative cost, number of employees, itemized transaction listing of all currency deposits or payments to third party administrators.

(X) Other Income: Non-premium revenue collected by the issuer and any subsidiary holdings providing services to members under the health insurance issuer's products, inclusive of reinsurance receivables, deductibles, copayments, coinsurance, fee-for-service and administrative charges';

(XI) Total annual savings from discounted claims by the Guam Memorial Hospital.

§4314. Levels of Aggregation for Medical Loss Ratio Rebate Calculations. All Plans sold to a Policyholder in the same contract year shall be aggregated for purposes of calculating the Medical Loss Ratio Rebate.

§4315. Frequency and Timing of Medical Loss Ratio Rebate Calculations and Rebate Payments.

(1) Rebates shall be calculated annually by all health insurance issuers that provide coverage to the Government of Guam.

(2) Rebates must be calculated using data as of September 30 of the plan year except for incurred claims, which must be restated as of December 31 of the year following the plan year.

(3) Rebates must be reported to the Insurance Commissioner by February 28 of the year following the plan year using the appropriate reporting format in Appendix A.

(4) Rebates shall be paid annually by March 31 of the year following the plan year and deposited into the Government of Guam Employee Health Benefits Trust Fund Accounts for payment of Self Funded claims or future premium payments.

§4316. Medical Loss Ratio Rebate Calculation.

(1) A rebate is not payable for any aggregation that is non-credible based on plan year life years based on the Policyholder's aggregate of all plan year life years during the same contract year.

(2) If, for any level of aggregation as defined in §4314, 50% or more of the total earned premium is attributable to policies newly issued with less than 12 months of experience, the experience of these policies can be excluded from the medical loss ratio calculation for plan year. For purposes of this subsection, "experience" means all of the elements used to calculate the numerator and denominator.

(3) The numerator used to determine the medical loss ratio for the plan year is calculated as incurred claims plus any expenses to improve health care quality are:

(i) Incurred claims are those with incurral dates from October 1, YYYY to September 30, YYYY;

(ii) Expenses to improve health care quality are those expenses associated with incurral dates from October 1, YYYY to September 30, YYYY.

(4) The denominator used to determine the medical loss ratio for the plan year is calculated as earned premiums for the period from October 1, YYYY to September 30, YYYY.

(5) The medical loss ratio is calculated as the unrounded ratio of the numerator in (3) to the denominator in (4).

(6) The medical loss ratio is subtracted from the applicable minimum medical loss ratio standard.

(7) If the result of (6) is greater than zero, this number is rounded to the nearer one-tenth of one percentage point and multiplied by the earned premium. The resulting amount is the rebate to be paid. If the result of (6) is zero or less, no rebate is to be paid."

Section 3. § 4302.2. of Article 3, Chapter 4 of Title 4, Guam Code Annotated is amended to read:

"§ 4302.2. Creation of the Government of Guam ~~Self-Funded~~ Employee Health Benefits Trust Fund Accounts, Herein Referred to as "Trust Fund Accounts".

(a) The Trust Fund Accounts are hereby created and *shall not* be commingled with the General Fund *or* any other funds of the government of Guam;

(b) A separate bank account for all Trust Fund Accounts *shall* be established for each Self Funded Health Benefits Plan and premium payments for fully insured benefit plans;

(c) All employer and employee premium payments for Self Funded Employee Health Benefit Plans and any Medical Loss Ratio rebates *shall* be

deposited in the respective ~~Self-Funded~~ Health Benefits Plan Trust Fund Account;

(d) Moneys in the Trust Fund Accounts *shall* be used by the Department of Administration to pay health benefit related claims and associated administrative costs for any Self Funded Health Benefits Plan or premium payments for fully insured benefit plans negotiated by the team authorized in § 4302 (c) of Chapter 4, Article 3, Title 4, Guam Code Annotated;

(e) Income earned on the moneys in the Trust Fund Accounts *shall* be credited to the respective ~~Self-Funded~~ Health Benefits Plan's Trust Fund Account;

(f) Moneys in the Trust Fund Accounts are continuously appropriated in accordance with this Section and are *not* subject to any transfer authority of *I Maga'lahi*;

(g) The Trust Fund Accounts shall maintain a minimum reserve equal to twenty-five percent (25%) of prior fund year coverage claim payments including incurred but *not* reported (IBNR) claim liability for the same period for Self Funded Health Benefits Plan's;

(h) There *shall* be an annual audited report based on generally accepted accounting principles and generally accepted auditing standards, and supported by actuarial review and opinion of IBNR claims and other future contingent liabilities. The report *shall* include at a minimum, but *not limited to*, the following:

(1) Opinion of Independent Certified Public Accountant;

(2) Balance Sheet;

(3) Statement of Revenues and Expenses;

(4) Statement of Changes in Fund Balances;

(5) Statement of Cash Flows, direct method;

(6) Notes to Financial Statements; and

(7) A premium equivalency charge developed from total fund year expenditures, including an estimate for IBNR claim cost for Self Funded Health Benefits Plan's.

(8) Application of funds deposited as a result of a Medical Loss Ratio rebate shall be credited equally to premium payments for all government of Guam employees and retirees, inclusive of autonomous agencies."

Section 4. Severability. If any provision of this Law or its application to any person or circumstances is found to be invalid or contrary to law, such invalidity shall not affect other provisions or applications of this Law which can be given effect without the invalid provisions or application, and to this end the provisions of this Law are severable.

Appendix A. Formats for Reporting Rebate Calculations

REBATE CALCULATION FORM FOR PLAN YEAR

Company _____ NAIC Company Code _____

For the State of_____ NAIC Group Code _____

Line of Business _____ Minimum Medical Loss Ratio_____

Address _____ Person Completing Exhibit _____

Title _____ Telephone_____

USE GUAM SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 1 & PART III TO ASSIST IN COMPLETION OF THIS DOCUMENT

(1) Line	(2) Description	(3) YYYY
1	Life Years	
2	Earned Premium	
3	Expenses to Improve Heath Care Quality	
4	Paid Claims	
5	Unpaid Claim Reserve	
6	Net Healthcare Receivables	
7	Incurred Claims	
8	Medical Loss Ratio	
9	Rebate	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

Appendix A. Formats for Reporting Rebate Calculations (continued)

INSTRUCTIONS REBATE CALCULATION FORM FOR PLAN YEAR

Line 1: Life Years Rebate Supplemental Form for experience year

Line 2: Earned Premium Rebate Supplemental Form for experience year

Line 3: Expenses to Improve Health Care Quality Rebate Supplemental Form for experience year

Line 4: Paid Claims Rebate Supplemental Form for experience year

Line 5: Unpaid Claim Reserve Rebate Supplemental Form for experience year

Line 6: Net Healthcare Receivables

Rebate Supplemental Form for experience year

Line 7: Incurred Claims as of 12/31= Line 5 + Line 6 + Line 7 ~~+ Line 8~~

Line 8: Medical Loss Ratio = (Line 34 + Line 79) / (Line 2~~— Line 3~~)

Line 9: If 2011 experience is non-credible as determined by Line 1, Rebate = 0, else,

If (Minimum Medical Loss Ratio - Line 8) is less than or equal to zero, Rebate = 0, else

Rebate = (Minimum Medical Loss Ratio - Line 8) x (Line 2), where (Minimum Medical Loss Ratio - Line 8) has been rounded to the nearer one-tenth of one percentage point and Rebate is rounded to the nearer dollar.

Appendix A. Formats for Reporting Rebate Calculations (continued)

REBATE CALCULATION SUPPLEMENTAL FORM Plan Year ____

Experience Year ____ Company _____ NAIC Company Code_____
For the State of_____ NAIC Group Code _____
Line of Business _____ Address _____
Person Completing Exhibit _____ Title _____
Telephone Number_____

REBATE CALCULATION SUPPLEMENTAL FORM

(1) Line	(2) Description	(3) 12/31	(4) Deferred	(5) Added	(6) Total
1	Life Years				
2	Earned Premium				
3	Expenses to Improve Heath Care Quality				
4	Paid Claims				
5	Unpaid Claim Reserve				
6	Net Healthcare Receivables				
7	Incurred Claims				

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

Appendix A. Formats for Reporting Rebate Calculations (continued)

INSTRUCTIONS REBATE CALCULATION SUPPLEMENTAL FORM

Column 3 is data from the Supplemental Health Care Exhibit in the NAIC Annual Statement for the experience year.

Column 4 is data for policies newly issued in the experience year with less than 12 months of experience in that year that are excluded from the medical loss ratio calculation for the plan year of issue and will be added back in the next plan year. Column 5 is data for policies newly issued in a prior experience year with less than 12 months of experience in that year that were excluded from the medical loss ratio calculation for a prior plan year and are added back in this plan year. See Sections 8.B., 9.B. for additional details.

Note that quantities in Lines 2 through 6 should be allocated to represent only the experience associated with the deferred business using reasonable methods.

Line 1: Life Years Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1 Other Indicators, Column(s) for applicable line of business - Line 4 divided by 12 and rounded to zero decimal places.

Line 2: Earned Premium -- Column 3 is from the Supplemental Health Care Exhibit for the experience year –

Line 3: Expenses to Improve Health Care Quality -- Column 3 is from the Supplemental Health Care Exhibit for the experience year – Part 1, Column(s) for applicable line of business – Line 4 + Line 6.3

Line 4: Paid Claims -- Amounts paid on claims incurred in the experience year as of December 31 of the year following the plan year.

Line 5: Unpaid Claim Reserve -- The reserve for amounts unpaid on claims incurred in the experience year as of December 31 of the year following the plan year.

Line 6: Net Healthcare Receivables Net Healthcare Receivables incurred in the experience year as of March 31 of the year following the plan year.

Line 7: Line 4 + Line 5 + Line 6.

Appendix B. Credibility Table

Table 1	
Base Credibility	
Life Years	
< 1,000	No Credibility

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions

Expenses to Improve Health Care Quality:

Derived from GUAM SUPPLEMENTAL HEALTH CARE EXHIBIT – PART 3:

Improving Health Care Quality Expenses – General Definition: Quality Improvement (QI) expenses are expenses, other than those billed or allocated by a provider for care delivery (i.e., clinical or claims costs), for all plan activities that are designed to improve health care quality and increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements. The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self-insured plans. Qualifying QI expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. They should not be designed primarily to control or contain cost, although they may have cost reducing or cost neutral benefits as long as the primary focus is to improve quality. Qualifying QI activities are primarily designed to achieve the following goals set out in Section 2717 of the PHSA and Section 1311 of the PPACA:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reducing health disparities among specified populations;
- Prevent hospital readmissions;
- Improve patient safety and reduce medical errors, lower infection and mortality rates;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

- Increase wellness and promote health activities; or
- Enhance the use of health care data to improve quality, transparency, and outcomes.

NOTE: Expenses which otherwise meet the definitions for QI but which were paid for with grant money or other funding separate from premium revenues shall NOT be included in QI expenses.

PARTS 3A and 3B COLUMNS:

Column 1 – Improve Health Outcomes Expenses for the direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes as defined above. This category can include costs for associated activities such as:

- Effective case management, Care coordination, and Chronic Disease Management, including:

Patient centered intervention such as:

-Making/verifying appointments,

-Medication and care compliance initiatives,

-Arranging and managing transitions from one setting to another (such as hospital discharge to home or to a rehabilitation center),

-Programs to support shared decision making with patients, their families and the patient's representatives; and

-Reminding insured of physician appointment, lab tests or other appropriate contact with specific providers;

- Incorporating feedback from the insured to effectively monitor compliance;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

- Providing coaching or other support to encourage compliance with evidence based medicine;

- Activities to identify and encourage evidence based medicine;

- Use of the medical homes model as defined for purposes of section 3602 of PPACA);

- Activities to prevent avoidable hospital admissions;

- Education and participation in self-management programs; and

- Medication and care compliance initiatives, such as checking that the insured is following a medically effective prescribed regimen for dealing with the specific disease/condition and incorporating feedback from the insured in the management program to effectively monitor compliance;

- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;

- Quality reporting and documentation of care in non-electronic format; and

- Health information technology expenses to support these activities (report in Column 5 - see instructions) including:

-Data extraction, analysis and transmission in support of the activities described above, and

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

-Activities designed to promote sharing of medical records to ensure that all clinical providers and accurate records from all participants in a patient's care; and

Column 2 – Activities to Prevent Hospital Readmission Expenses for implementing activities to prevent hospital readmissions as defined above, including:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;
- Personalized post discharge counseling by an appropriate health care professional;
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and
- Health information technology expenses to support these activities (report in Column 5 – see instructions) including.
- Data extraction, analysis and transmission in support of the activities described above, and
- Activities designed to promote sharing of medical records to ensure that all clinical providers rate records from all participants in a patient's care; and

Column 3 – Improve Patient Safety and Reduce Medical Errors Expenses for implementing activities to improve patient safety and reduce medical errors as defined above through:

- The appropriate identification and use of best clinical practices to avoid harm;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns;
- Activities to lower risk of facility acquired infections;
- Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions;
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and
- Health information technology expenses to support these activities (report in Column 5 – See instructions), including:

  -Data extraction, analysis and transmission in support of the activities described above, and

  -Activities designed to promote sharing of medical records to ensure that all clinical providers have access to consistent and accurate records from all participants in a patient's care; or

Column 4 – Wellness & Health Promotion Activities Expenses for programs that provide wellness and health promotion activity as defined above (e.g., face-to-face, telephonic or web-based interactions or other forms of communication), including:

- Wellness assessment;

- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

- Public health education campaigns that are performed in conjunction with state or local health departments;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

- Actual rewards/incentives/bonuses/reductions in copays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI with the following restrictions:

  -Only allowed for small and large employer groups, not individual business; and the expense amount is limited to the same percentage as the HIPAA incentive amount limit; Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

  -Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity); and

  -Health information technology expenses to support these activities (Report in Column 5 – See instructions).

Column 5 – HIT Expenses for Health Care Quality Improvements -- The PPACA also contemplates "Health Information Technology" as a function that may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current QI or make new QI initiatives possible. Include HIT expenses required to accomplish the activities reported in Columns 1 through 4 that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information,

consistent with Medicare/Medicaid meaningful use requirements, in the following ways;

1. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC; or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., chart review of HEDIS measures and costs for public reporting mandated or encouraged by law;

Appendix C. Excerpts from the Supplemental Health Care Exhibit Instructions (continued)

2. Advancing the ability of enrollees, providers, insurers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history;

3. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

4. Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of indentifying or treating specific conditions or controlling the spread of disease; or

5. Provision of electronic health records and patient portals.

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (e.g., costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, including the new ICD-10 requirements.

Expense Allocation

Supplemental Filing: Companies report QI expenses in Part 3, Columns 1 through 5 must include a detailed description of such expense elements, including how the specific expenses meet the definitions above. The definitions established in the Supplemental Health Care Exhibit apply to this supplemental filing as well. For a **new initiative** that otherwise meets the definition of QI above but has not yet met the objective, verifiable results requirement, include an "X" in the "New"

column of the supplement and include in the description the expected timeframe for the activity to accomplish the objective, verifiable results. Expenses for prospective Utilization Review and the costs of reward or bonuses associated with wellness and health promotion that are included in QI should include an "E" in the "New" column. These will be reviewed for adherence to the definition and standards of QI and may be specifically incorporated into, or excluded from, the instructions for QI for future reporting purposes.

Notes: a. *Healthcare Professional Hotlines*: Expenses for healthcare professional hotlines should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities.

b. *Prospective Utilization Review*: Expenses for prospective Utilization Review should be included in Claims Adjustment Expenses to the extent they do not meet the criteria for the above defined columns of Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, and Wellness & Health Promotion Activities, AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

The following items are broadly excluded as not meeting the definitions above:

- All retrospective and concurrent Utilization Review;
- Fraud Prevention activities (all are reported as cost containment, but Part 1, Line 4 includes MLR recognition of fraud detection/recovery expenses up to the amount recovered that reduces incurred claims);
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network;
- Provider Credentialing;

- Marketing expenses;
- All Accreditation Fees;
- Costs associated with calculating and administering individual enrollee or employee incentives; and
- Any function or activity not expressly included in Columns 1 through 5.

Mina'trentai Unu Na Liheslaturan Guahan
THIRTY-FIRST GUAM LEGISLATURE

Senator Vicente "ben" Cabrera Pangelinan

COMMITTEE ON APPROPRIATIONS, TAXATION, PUBLIC DEBT, BANKING, INSURANCE, RETIREMENT AND LAND
Tuesday, April 26, 2011
Bill No. 139-31 (COR)
SIGN UP SHEET

NAME	ADDRESS	PHONE	EMAIL	WRITTEN	ORAL	SUPPORT Yes No
Frank Camacho		687-1561		✓	✓	NO
Ray Sablan		687-0973		✓	✓	NO

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Ph. 473-4236 Fax. 473-4238
Email: senbenp@guam.net

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USA

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www.haygroup.com

April 25, 2011

Senator Pangelinan
324 W. Soledad Avenue
Suite 100
Hagatna, Guam 96910

Dear Senator Pangelinan,

Thank you for asking Hay Group to provide comments on Bill No. 139-131.

We would like to make the following comments as related specifically to our knowledge of the Government of Guam Healthcare Program as it stands currently, and as we begin to prepare for this year's annual Request for Proposal (RFP) and health insurance vendor selection process.

During this RFP process, we are requiring more detailed claims information from all future carriers/vendors as well as considering a variety of plan design options under both insured and self-insured approaches. The intent of this exercise is to attempt to make the plans more attractive to employees and to reduce where possible, costs for both employees and the Government for the future. This will also involve, over time, development of wellness programs that should promote better health and thus lower claim costs for the future as well.

With this as background, we have been asked to comment on the proposed legislation Bill 139-131.

The proposed legislation seems to be focused on the Government of Guam program only, and also seems to be strongly based on the language and approach taken by the recently passed Patient Protection and Affordable Care Act (PPACA). Our comments and a few suggestions are as follows:

- ***The regulation outlined in this Act is specific to the Program and establish guidelines that provide a rebate to Government of Guam employees and retirees if the MLR ratios are less than required level.***

    - It is rare to see direct rebates paid to individuals enrolled in a health plan except through reduction or maintenance of future premium rates. The reasons for this are because when any rebate is divided among so many people, it could become a negative when someone receives a very small check (e.g. $1 to $2) and the administrative expenses of paying out individual rebates is often more expensive than the rebate itself.

    - Additionally, since the Government of Guam contributes a large percentage of the cost of this program, it should also receive a large portion of the rebate.

      Thus our two suggestions regarding payment of rebates are as follows:

- Clarify in the Bill that the Government of Guam receives a prorata portion of the rebate, based on the percentage of the applicable premium rate that is paid by the government; and

- Rather than specify that a direct cash payment is made to each plan participant, allow the Government of Guam to use the aggregate amount of rebates received to reduce future premium costs, in a prorata manner between the plan participants and the Government

- **§4311. Definitions**

  - This section seems to be trying to take the place of an insurance companies rating manual and we would suggest that it could cause some carriers not to quote on the GovGuam plan because it is too detailed in its requirements. We feel that the better approach is to be sure you are able to bring to the table viable carriers to compete for the business as well as one that negotiates the rates and plan designs based on knowledge of what can and cannot be accomplished by viable carriers.

    Note that in Group Insurance – the Government of Guam is the Policyholder, not the individual employees, etc. Many of the rules outlined in PPACA are directed at small group (under 200 lives) and individual coverages. The Government of Guam Healthcare plan does not fit into either of these categories, so there is more room for different definitions and approaches. Some of these definitions would not normally apply in large Employer groups insured policies and none would apply for self-insured programs except to the reinsurance portions of the plans.

    As an example, in working with the Government of Guam for the 10-1-11 renewal, Hay Group has been working to assist staff in acquiring actual claim data from the last year – one issue that was a problem in getting competitive quotes in the past.

    Additionally, we are requesting both insured and self-insured approaches to the program for future which will provide competitive information related to carrier administrative/retention costs in a comparative way, thus allowing for better negotiations of these variable amounts.

    It is critical to understand that the makeup of premiums should be 2 major items, Claims Payments (based on the designs included in the plan and the needs of the employees (these are not easy to control nor predict) and retention/administration costs that include taxes, administration costs for processing claims and managing provider networks, communication assistance, customer service, etc. provided by the vendor/insurer, and claim fluctuation plus commissions and profit.

- (k) "Non-credible," as it relates to experience, means experience generated by less than 1,000 life years.

    - In Group Insurance, credibility would never come into play for a group the size of the Government of Guam – all quotes and rates should be based 100% on the groups actual historical claim experience and the plan design. Thus this section specifically for the Government of Guam should be an automatic situation without it needing to be in the "law".

- **§4313. Bringing Down the Cost of Health Care Coverage**

    - The items listed here should always be a part of any well designed and managed account and every carrier has the responsibility to report this information on a monthly or quarterly basis. Otherwise, they should not be considered a viable provider of services.

- The Public Auditor shall make reports received under this section available to the public on the Internet website of the Office of Public Accountability. (2) Ensuring That the Government of Guam Receives Value for Premium Payments.

    - We suggest that you could be running against HIPAA compliance rules by making some of this data available to all especially via the internet and not secure sites. This should be removed. It can be supplied in an appropriately cleaned basis as needed to insured if needed..

- (a) Requirement to provide value for premium payments. Beginning October 1, 2011, a health insurance issuer offering health insurance coverage to the Government of Guam shall, with respect to each plan year,

    - See earlier note suggesting this is a costly, difficult and approach that might be better handled through reduction in future rate increases.

- (c) Certification of Loss Ratio Results and comparison of government of Guam performance relative to the overall health insurance issuer book of business.

    - Depending on the size of the carrier's entire book of business" excluding GovGuam, this might not prove any particular benefit. It should be noted that when comparing to other "books of business" they should have comparable benefits as well as having enough volume to truly be a comparison and this may not be the case with all carriers.

We sincerely appreciate the opportunity to comment on the legislation and hope that our comments and suggestions prove beneficial.

Sincerely,

Marie R. Dufresne

Robert E. Russell

Marie R. Dufresne, CCP, CBP, GRP
Senior Principal
Hay Group

Robert Russell, ASA, EA, MAAA
Senior Consultant
Hay Group

NetCare
Life & Health Insurance

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Telephone: 671-472-3610
Facsimile: 671-472-3615
www.netcarelifeandhealth.com

April 26, 2011

The Honorable Vicente C. Pangelinan
Chairman, Committee on Appropriations, Taxation,
Public Debt, Banking, Insurance, Retirement and
Land
I Mina'trentai Unu Na Liheslaturan Guahan
324 W. Soledad Avenue, Suite 100
Hagatna, Guam 96910

Re: Bill 139-31(COR)

Dear Mr. Chairman and Members of the Committee:

Thank you for the invitation and opportunity to submit written testimony on Bill 139-31. My name is Jerry Crisostomo and I serve as the Plan Administrator for Moylan's Health Insurance/NetCare Life & Health Insurance Company. I am submitting written testimony in opposition to the proposed legislation for the following two reasons:

1. Although, NetCare is currently not a carrier for the Government of Guam market, Moylan's Insurance, however, as the general agent and owner of NetCare represents other international health carriers that have expressed strong interest in underwriting the Government of Guam group health business in the upcoming fiscal year. The proposed legislation if enacted into law will likely diminish any interest by these carriers to consider entering the Government of Guam market in order to provide employees with as much choices in health care coverage as possible.

2. NetCare as a member of the Guam Association of Health Plans (Currently in formation), has submitted letters to the Secretary of the U.S. Department of Health and Human Services (HHS) as well as the Governor of Guam and the Guam Insurance Commissioner requesting for a either full waiver, exemption or adjustment of the Medical Loss Ratio (MLR) requirements as mandated by the Patient Protection and Affordable Care Act. We believe that Guam's health

Our local health insurance industry, albeit small and highly competitive have a lot to offer to make the health care system work better. We want to work with all parties and stakeholders involved in this reform effort and hope you will assume our positive intent.

We are as concerned as you are about premium rate increases. But if you want to control our prices, then you have to control those prices being charged by suppliers, hospitals, pharmaceutical companies, doctors and others as well.

Thank you for the opportunity to share my thoughts and concerns and we look forward to a constructive discussion on this very important health care issue.

Sincerely,

Jerry Crisostomo, MHP
Plan Administrator

CALVO'S Select Care HEALTH PLANS

115 Chalan Santo Papa Hagåtña • P.O. Box FJ Hagåtña, Guam 96932 • Phone: (671) 477-9808 • Fax: (671) 477-4141

April 26, 2011

The Honorable Vicente C. Pangelinan
Chairman, Committee on Appropriations, Taxation,
Public Debt, Banking, Insurance, Retirement and Land
I Mina'trentai Unu Na Liheslaturan Guahan
324 W. Soledad Avenue, Suite 100
Hagatna, Guam 96910

Re: BILL 139-31(COR)

Buenas Senator Pangelinan and Committee Members:

Thank you very much for allowing our testimony regarding bill, 139-31(COR which creates a ceiling on the allowable retentions for the Government of Guam program and it is patterned after the Medical Loss Ratio (MLR) sections of the Affordable Care Act (ACA). We oppose the aforementioned bill for the following reasons:

Despite the fact that our local health carriers embrace many of ACA's requirements such as expanded benefits and the consumer protection requirements, the health insurers on Guam have sought relief from the Medical Loss Ratio Requirements of ACA and have petitioned the Department of Health and Human Services (HHS) for full waiver or a reduction on the MLR requirement. (Please reference the attached exhibits).

As you may know, the Affordable Care Act excluded the Territories from the employer and individual mandates, excluded Guam from the early retiree reinsurance and high risk pool programs, and placed significant new requirements on the health insurance industry; it also overlooked our reasonably small market size, our isolated geographical location, and more importantly the unavailability of many medical services.

Guam's health insurance market is comparatively small and the new requirements will significantly impair the local health insurance industry, especially since administrative costs are typically higher on our Island due to our isolated geographical location and many requirements and services that are rarely provided by insurance companies in the United States.

As you also know, Guam residents have been excluded from some of the Federal Programs including Medicare, Social Security and others that do not cover Guam residents when seeking care at the closest and better equipped facilities in Manila, Philippines. Our Island is closer to the Philippines and Japan than to the nearest State, Hawaii, by more than 2,100 nautical miles, and, as you may be aware, a significant number of our Island residents seek healthcare services in those countries due to their proximity and the availability of medical specialties not available on Guam.

However, programs such as Medicare do not extend or cover medical services rendered in the Philippines or Japan, and only covers emergencies under very strict and difficult guidelines. Medicare beneficiaries often experience a process of lengthy nightmares when trying to seek reimbursements.

In fact, Guam insurers take part in a number of cases being appealed to Medicare for Coordination of Benefits with little or no luck, and we also aid Medicare qualifiers to obtain the reimbursements that they rightfully deserve.

Concerning the Government of Guam, the proposed bill will possibly deliver unintended consequences of preventing prospective carriers from entering the GovGuam market and may potentially cause a complete exodus of insurers from GovGuam. In addition to the aforementioned statements, we oppose the bill based on the following:

- Administrative expense percentages for Guam health insurers are higher than those for companies in the United States and macro markets

- The market lacks integration of technologies typically found in Macro markets and highly paperless environments that generates potential administrative cost savings

- Despite the hype with the FY 2011 premiums for GovGuam, the fact remains that Guam's premiums are generally 50% to 55% lower than those charged in the States including Hawaii. This is factual for both commercial or private markets as well as the Government of Guam, where premiums for active employees are significantly lower than those charged to counter part employees of most States and the Federal Government. (Please reference the attached premium exhibits)

- As a result of the above, the retention amounts are significantly lower than that of Macro markets or markets with higher health insurance premiums

- Guam Insurance laws do not allow insurers to write direct business and it has to be conducted through an agent as opposed to most States where insurers are able to write business direct, consequently this creates additional cost to the insurance carrier

- Health insurers and their representative agents on Guam act as travel agents, medical appointment coordinators, medical referral coordinators, medical record trackers, coordinators of medical information between local physicians and/or specialists outside of Guam such as in the Philippines and Japan

- In many instances, Insurers and the administrative agents serve as the humanitarian contact between the patients obtaining care in the mainland USA, Japan, the Philippines, and their families

- The cost of coordinating claims payments in the Philippines or Japan to mitigate fraud is significant, especially since we have to translate their systems into the U.S. Healthcare system

- The lack of local resources for effective peer review and evidence based medicine guidelines require domestic companies to expend significant amounts of time with medical providers educating them and their staff on correct coding and billing guidelines. This is also more relevant in countries such as the Philippines

- The above points evidently illustrate our challenges when dealing with neighboring countries, which do not follow many of the American Medical Association guidelines or any other evidence based medical measures

- The cost of developing and managing effective medical provider networks is also higher as we must travel outside of Guam to seek contracts with providers in Hawaii, California, Washington State, Japan, the Philippines, and other places

- Because of the lack of any relevant medical and industry training programs on Guam, our employees must travel to training programs outside of Guam, and, as you may know, air transportation to travel to the nearest U.S. State, Hawaii, is quite expensive

- Dealing with the fluctuation of foreign currency creates additional administrative expenses as our staff is tasked with calculating exchange rates in a manner that is also reasonable and not burdensome to members

- Another concern is that GovGuam has traditionally been late in its premium remittances averaging 60 days on premiums receivable, yet our carrier has to pay medical claims to providers within 45 days of receiving a bill. Most other States and jurisdictions pay premiums on time or within the current month

Guam's insurers have been relatively successful at keeping health insurance premium rates low and they are significantly lesser than the premiums charged in most States, which is a testament to the resourcefulness of our competitive industry and we should not be penalized for providing the people of Guam with reasonable premiums. In fact, with the impending movement of Marines to Guam, many national companies have opted to cancel their national programs and offer the local health alternatives to employees hired even in the CONUS for services in Guam due to the significant savings generated by the least expensive premiums offered by the local carriers.

A looming situation that will possibly affect premiums in the future is the continued devaluations of the United States Currency, which will put significant pressures on the successes of the local industry as the cost basis for services will increase and the consequence will be higher premiums.

Another factor to consider is that premium increases are reflective of cost increase for medical, hospital and prescription drug services, and the Guam Legislature could significantly help the people of Guam and more importantly the Government of Guam if it focuses its efforts in finding ways and means to mitigate and contain the cost of medical services.

We also have additional concerns with the proposed legislation and specifically some of the language and requirements of 4313 (2) (c) (ii) (II) through (XX) that requires extensive and detailed disclosures, which are far and beyond those required in ACA. This will also discourage potential carriers from entering the market or trigger the opposite effect of creating greater competition.

In summary, we oppose the percentage of the MLR requirement for GovGuam and the language in the portion of the bill as stated above, and we encourage the committee to develop more reasonable requirements on both the medical loss ratios and the disclosure requirements on section 4313 as stated above.

GovGuam employees and retirees are well represented in the negotiating committee and they are aided by a nationally recognized actuarial firm, and perhaps a better option is to allow the negotiating team to perform its duties as they have successfully done so in past years. In fact, the team successfully negotiated rate reductions and improved benefits in the FY 2010 contract after the expiring FY 2009 agreement delivered better underwriting results or MLRs than the targeted ratios. (Please reference the attached exhibit)

We hope that the Guam Legislature finds wisdom in promoting competition rather than limiting the ceiling on the retention levels for health insurance and potentially closing the health insurance market.

Please let us know of any questions that you may have.

Senceramente,

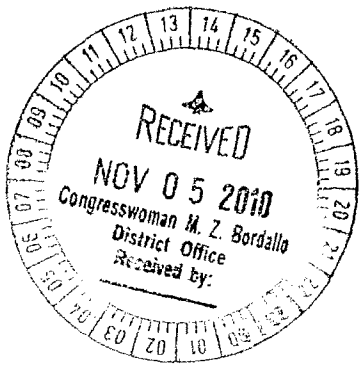
Frank J. Campillo
Health Plan Administrator
Calvo's SelectCare

Attachments: Exhibit 1: Copies of letters sent to HHS
Exhibit 2: Premium exhibits of various States and Federal Government employees
Exhibit 3: Premiums exhibits on GovGuam

EXHIBIT 1A

GUAM ASSOCIATION OF HEALTH PLANS

430 W. Soledad Ave, Hagatna, Guam 96910



November 4, 2010

Mr. Steve Larsen
Deputy Director for Oversight,
Office of Consumer Information and Insurance Oversight
The U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

DELIVERED THROUGH THE OFFICE OF CONGRESSWOMAN MADELINE BORDALLO

Dear Mr. Larsen:

Thank you very much for making time to meet with our association through the video conference arranged by Congresswoman Bordallo's office. As stated in the letter written by the Insurance Association of Guam, there are significant similarities between our market and the health insurance policies issued to expatriates.

As you may know, PPACA excluded the territories from the employer and individual mandates, excluded Guam from the early retiree reinsurance and high risk pool programs, and placed significant new requirements on the insurance industry; it overlooked our reasonably small market size, our isolated geographical location, and more importantly availability of medical services.

Guam's health insurance market is relatively small and the new requirements will significantly impair the local health insurance industry, especially since administrative costs are typically higher on our Island due to our isolated geographical location and other requirements and services that are rarely provided by insurance companies in the United States and the District of Columbia.

As you may also know, Guam residents are not always able to receive the full benefits of some Federal Programs including Medicare, Social Security and others that do not cover Guam residents when seeking care at the closest and better equipped facilities in Manila, Philippines. Our Island is closer to the Philippines, Japan, and other Asian destinations than the nearest State, Hawaii, by more than 2,100 nautical miles, and, as you may be aware, a significant number of our island residents seek healthcare services in neighboring Asian countries due to their proximity and the availability of medical specialties not available on Guam. Programs such as Medicare do not extend or cover medical services rendered in the Philippines or Japan, and only covers emergencies under very strict and difficult to follow guidelines. Medicare beneficiaries often experience a process of lengthy challenges when trying to seek reimbursements.

In fact, Guam insurers take part in a number of cases being appealed to Medicare for Coordination of Benefits with little or no luck, and we also help Medicare qualifiers seek the reimbursements that they rightfully deserve.

GUAM ASSOCIATION OF HEALTH PLANS

430 W. Soledad Ave, Hagatna, Guam 96910

We would like to let you know that we embrace many of PPACA's requirements such as expanded benefits and the consumer protection requirements. However, we have concerns with some of the regulatory changes.

One particular concern of our local domestic insurance industry is the rigid interpretation of the PPACA language relative to the Medical Loss Ratio Rule (MLR), specifically what may be included in the numerator such as only medical expenses, reinsurance, and "quality improvement". This rigid interpretation could mean the end for some insurance programs on Guam. We respectfully request a full waiver from the "MLR" rule due to disruptive market forces it may cause and our request is based on the following factors:

- Administrative expense percentages for Guam health insurers are higher than those for companies in the United States and macro markets. We are enclosing the attached exhibit illustrating the average retention required for Guam companies

- Because of Guam Insurance laws, health insurers are required to conduct business through an agent as opposed to most States where insurers are able to write business direct, consequently this creates another cost not usually incurred in other locations

- Health insurers often act as travel agents, medical appointment coordinators, medical referral coordinators, medical record trackers, coordinators of medical information between local physicians and physicians or specialists outside of Guam such as in the Philippines and Japan

- In many instances, Insurers serve as the humanitarian contact between the patients obtaining care in the mainland USA, Japan, the Philippines, and their families

- The cost of coordinating claims payments in the Philippines or Japan to mitigate fraud is significant; translate their billing systems into our U.S. Healthcare system

- The lack of local resources for effective peer review and evidence based medicine guidelines require domestic companies to expend significant amount of time with medical providers educating them and their staff on correct coding and billing guidelines

- The above points illustrate our challenges when dealing with these neighboring countries, which follow standards that may be different than those of the American Medical Association.

GUAM ASSOCIATION OF HEALTH PLANS

430 W. Soledad Ave, Hagatna, Guam 96910

- The cost of developing and managing effective medical networks is also higher as we must fly outside of Guam to seek contracts with providers in Hawaii, California, Washington State, Japan and the Philippines

- Because of the lack of any relevant medical and industry training programs on Guam, our employees must go through training programs outside of Guam, and, as you may know, air transportation to travel to the nearest U.S. State, Hawaii, is quite expensive

The above are just a few items that differentiate the administrative cost of the domestic Guam companies in comparison to the expenses of a typical Continental USA company. Furthermore, several of our cost factors are susceptible to high volatility such as currency exchange factors, cost of air transportation, and the potential of political risk. A second set of issues revolves around the definition of a health plan, which appears to indicate that an insurer may not be able to segregate high administrative expense groups into separate "plans," in order to insulate other business from the possibility of rebates.

Since Guam was excluded from the employer and individual mandates, and based on the above issues and to prevent critical disruptions in the local healthcare market, we respectfully ask that you include Guam as part of the expatriate market and allow a waiver to Guam domestic insurers from any of the MLRs requirements. Your immediate attention to this matter is greatly appreciated.

Please let us know of any questions that you may have.

Respectfully yours,

Frank J. Campillo
Health Plan Administrator
Calvo's SelectCare
Frank.campillo@calvosinsurance.com

Don Davis
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Gina Ramos
Chief of Staff
TakeCare Insurance
Gina.Ramos@takecareasia.com

Cc: Mr. Art Ilagan
Mr. John Carlos

EXHIBIT 1B

Congress of the United States
Washington, DC 20515

December 13, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius,

I write to inquire about the status of a the Guam Health Insurance Association's request of exemption from the Minimum Loss Ratio (MLR) requirements referenced in Section 2718 of the Public Health Service Act (PHSA) and in Sec. 10101(f) of the Patient Protection and Affordable Care Act (ACA). In a meeting on October 21 of this year, the Guam Health Insurance Association (GHIA), made up of the island's local health insurance providers met with Mr. Steve Larsen through a video conference facilitated by my office. The GHIA raised several important justifications on why an exemption is needed at this time and have provided additional information to warrant this exemption.

Since this initial meeting, the U.S. Department of Health and Human Services (HHS) has not informed the GHIA or my office about any decisions for an MLR exemption. Given that the calendar year will be ending soon, a decision by HHS will help inform any strategic plans for the coming year by the insurance industry on Guam, whose plans cover a significant number of the island's approximately 170,000 residents. Resolution of this matter is important considering that these local businesses are the only private health insurance options for Guam.

Given Guam's unique health insurance profile and its connection to the international market, the MLR calculations within the ACA do not accurately assess the value of our local health care plans and their unique cost structures. Our island's health insurance industry is comprised of four local companies which have established and utilized multiple provider networks in the U.S. and foreign countries in the region. Taking into account our geographic isolation, relatively small market size and the regular cost of coordinating care, payments and managing effective medical networks in the Philippines, Japan, Hawai'i and the continental United States, absent a MLR waiver, Guam's market will be faced with uncertainty and some providers may not be able to remain financially viable.

A temporary waiver from the MLR requirements would give local leaders and stakeholders the additional time to conduct assessments and cost analyses of the Guam health insurance market. These discussions continue with local leaders and the GHIA as the island implements several components of the Affordable Care Act. Like many state and territorial governments, local leaders and agencies stand ready to work collaboratively with the HHS in ensuring that residents of Guam benefit from the new law.

I would appreciate an update and place this request with you consistent with all applicable laws, regulations, and agency guidelines. Timely resolution of this matter would benefit many of my constituents as we enter the new calendar year. Thank you for your consideration of this request.

Sincerely,

MADELEINE Z. BORDALLO
Member of Congress

Colorado Health Insurance Premiums: FY 2011

FY11 MEDICAL OPTIONS					
OPTION	**TIER**	**Total Premium**	**State Contribution**	**Additional Funding***	**Employee Contribution**
Choice Plus Definity HSA-qualified option	Employee Only	$376.98	$356.92	$13.06	$7.00
	Employee + Spouse	$823.54	$602.82	$22.04	$198.68
	Employee + Child(ren)	$674.68	$637.96	$23.32	$13.40
	Ee + Sp + Child(ren)	$1,121.26	$883.84	$32.32	$205.10
Choice Plus	Employee Only	$439.10	$356.92	$13.06	$69.12
	Employee + Spouse	$960.08	$602.82	$22.04	$335.22
	Employee + Child(ren)	$786.42	$637.96	$23.32	$125.14
	Ee + Sp + Child(ren)	$1,307.44	$883.84	$32.32	$391.28
Kaiser HDHP HSA-qualified option (Denver/Boulder & Southern Colorado)	Employee Only	$379.36	$356.92	$13.06	$9.38
	Employee + Spouse	$828.36	$602.82	$22.04	$203.50
	Employee + Child(ren)	$678.36	$637.96	$23.32	$17.08
	Ee + Sp + Child(ren)	$1,127.36	$883.84	$32.32	$211.20
Kaiser HMO (Denver/Boulder & Southern Colorado)	Employee Only	$454.36	$356.92	$13.06	$84.38
	Employee + Spouse	$993.36	$602.82	$22.04	$368.50
	Employee + Child(ren)	$813.36	$637.96	$23.32	$152.08
	Ee + Sp + Child(ren)	$1,352.36	$883.84	$32.32	$436.20

REFERENCE: http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251646676390&ssbinary=true

EXHIBIT 2B

Texas Health Insurance Premiums

Effective: September 1, 2010 - August 31, 2011

Note: These premiums are monthly and include basic term life rate of $2.22

HEALTHSELECT OF TEXAS

Coverage	Premium	State Pays	Member Pays
You Only	$413.26	$413.26	$0.00
You and Spouse	$885.94	$649.60	$236.34
You and Children	$729.78	$571.52	$158.26
You and Family	$1,202.46	$807.86	$394.60

COMMUNITY FIRST/SAN ANTONIO

Coverage	Premium	State Pays	Member Pays
You Only	$360.22	$360.22	$0.00
You and Spouse	$771.94	$566.08	$205.86
You and Children	$635.90	$498.06	$137.84
You and Family	$1,047.62	$703.92	$343.70

SCOTT & WHITE HEALTH PLAN

Coverage	Premium	State Pays	Member Pays
You Only	$438.02	$438.02	$0.00
You and Spouse	$939.18	$688.60	$250.58
You and Children	$773.58	$605.80	$167.78
You and Family	$1,274.74	$856.38	$418.36

REFERENCE: http://www.ers.state.tx.us/insurance/rates/health_rates_fte.aspx

EXHIBIT 2C

California Monthly Premiums FY2011 and FY2010

PLAN	2011 MONTHLY PREMIUMS			2010 MONTHLY PREMIUMS			DOLLAR CHANGE	
	TOTAL PREMIUM	EMPLOYEE SHARE	STATE SHARE	TOTAL PREMIUM	EMPLOYEE SHARE	STATE SHARE	STATE	EMPLOYEE
Blue Shield								
Employee Only	$602	$169	$433	$517	$124	$393	+ $40	+ $45
Employee & 1 Dep.	$1203	$337	$866	$1034	$247	$787	+ $79	+ $90
Employee & 2+ Dep.	$1564	$435	$1129	$1344	$320	$1024	+ $105	+ $115
Blue Shield NetValue								
Employee Only	$518	$85	$433	$448	$55	$393	+ $40	+ $30
Employee & 1 Dep.	$1035	$169	$866	$896	$109	$787	+ $79	+ $61
Employee & 2+ Dep.	$1346	$217	$1129	$1164	$140	$1024	+ $105	+ $77
Kaiser								
Employee Only	$523	$90	$433	$495	$102	$393	+ $40	- $12
Employee & 1 Dep.	$1045	$179	$866	$990	$203	$787	+ $79	- $24
Employee & 2+ Dep.	$1359	$230	$1129	$1289	$263	$1024	+ $105	- $33

Reference Information provided on: http://www.dpa.ca.gov/benefits/coben-and-health-contributions/main.htm

EXHIBIT 2D

Florida Health Insurance Rates- 2011

Premium Rate Table

Effective December 2010 for January 2011 Coverage

(COBRA premium rates remain unchanged from May 2010

Subscriber Category / Contribution Cycle		Coverage Type	PPO/HMO Standard Employer	PPO/HMO Standard Enrollee	PPO/HMO Standard Total	PPO/HMO HIHP Employer	PPO/HMO HIHP Enrollee	PPO/HMO HIHP Total
Career Service	Monthly Full-Time Employees [1]	Single	499.80	50.00	549.80	499.80	15.00	514.80
		Family	1,063.34	180.00	1,243.34	1,063.34	64.30	1,127.64
		Spouse [5]	1,243.32	30.00	1,273.32	1,097.64	30.00	1,127.64
	Bi-Weekly Full-Time Employees [1]	Single	249.90	25.00	274.90	249.90	7.50	257.40
		Family	531.67	90.00	621.67	531.67	32.15	563.82
		Spouse [5]	621.66	15.00	636.66	548.82	15.00	563.82
Payless	Monthly Full-Time Employees [1,2]	Single	541.46	8.34	549.80	505.46	8.34	514.80
		Family	1,213.34	30.00	1,243.34	1,097.64	30.00	1,127.64
	Bi-Weekly Full-Time Employees [1,2]	Single	270.73	4.17	274.90	253.23	4.17	257.40
		Family	606.67	15.00	621.67	548.82	15.00	563.82
COBRA	Monthly [3]	Single	0.00	534.09	534.09	0.00	455.80	455.80
		Family	0.00	1,207.82	1,207.82	0.00	1,004.81	1,004.81
Early Retirees	Monthly	Single	0.00	549.80	549.80	0.00	473.12	473.12
		Family	0.00	1,243.34	1,243.34	0.00	1,044.32	1,044.32
Medicare	Monthly [4]	(i) One Eligible [7]	0.00	305.82	305.82	0.00	230.62	230.62
		(ii) One Under Over [7]	0.00	661.80	661.80	0.00	722.16	722.16
		(iii) Both Eligible [7]	0.00	611.64	611.64	0.00	461.04	461.04
Overage Dependents		Single	0.00	549.80	549.80	0.00	473.14	473.14

Reference: http://www.myflorida.com/mybenefits/Tools/Premiums.htm

Hawaii Health Insurance Rates

Hawaii employer union health benefits trust fund –Active Employees

Effective March 1, 2011

Benefit Plan	Type of Enrollment	*Monthly Employer Contribution	Monthly Employee Contribution	Total Contribution Required
MEDICAL PLANS				
EUTF PPO (HMA) - 90/10 Plan RSN Chiropractic	Self	$189.34	$124.80	$314.14
	Two-Party	$459.32	$303.22	$762.54
	Family	$586.10	$386.36	$972.46
EUTF PPO (HMSA) - 80/20 Plan RSN Chiropractic	Self	$189.34	$114.58	$303.92
	Two-Party	$459.32	$278.40	$737.72
	Family	$586.10	$354.70	$940.80
EUTF Prescription Drug (informedRx)	Self	$42.74	$28.08	$70.82
	Two-Party	$103.68	$68.28	$171.96
	Family	$132.48	$87.06	$219.54
EUTF HMO (HMSA) Prescription Drug RSN Chiropractic	Self	$232.08	$194.06	$426.14
	Two-Party	$563.00	$471.50	$1,034.50
	Family	$718.58	$600.96	$1,319.54
Kaiser Comprehensive Prescription Drug RSN Chiropractic	Self	$232.08	$149.14	$381.22
	Two-Party	$563.00	$361.72	$924.72
	Family	$718.58	$461.54	$1,180.12
Kaiser Basic Prescription Drug RSN Chiropractic	Self	$232.08	$90.46	$322.54
	Two-Party	$563.00	$219.20	$782.20
	Family	$718.58	$279.74	$998.32
EUTF Supplemental (HMSA) informedRx Prescription Drug RSN Chiropractic	Self	$136.02	$88.86	$224.88
	Two-Party	$329.94	$216.12	$546.06
	Family	$421.24	$275.22	$696.46
Royal State Supplemental Prescription Drug RSN Chiropractic	Self	$27.20	$16.30	$43.50
	Two-Party	$66.50	$40.48	$106.98
	Family	$75.92	$45.00	$120.92
EUTF High Deductible Health Plan (HMSA) Prescription Drug	Self	$232.08	$56.56	$288.64
	Two-Party	$563.00	$138.50	$701.50
	Family	$718.58	$176.72	$895.30

Reference: http://eutf.hawaii.gov/records-and-references/2011-rates-and-contribution-information-eff-mar-01-2011/oe2011-active/Active_Rates_All_bus.pdf

FY2011 Guam Federal Employees Premiums

Postal Premium Rates for the Federal Employees Health Benefits Program

Health Management Organizations (HMO)			2010 Total Biweekly Premium	2011 Biweekly Postal Premium Rates			
Plan • Option • Enrollment Code				Total Premium	Govt Pays	Empl. Pays	Change in empl. payment
Guam TakeCare							
	High Self	JK*	229.79	229.79	*94.*7	35.62	-3.28
	High Family	JK2	603.66	603.66	454.46	*49.38	-26.2*
	Standard Self	JK4	207.69	203.67	*72.27	3*.60	*.46
	Standard Family	JK5	546.97	536.37	454.48	63.89	-36.8*
Guam TakeCare							
	HDHP Self	KX*	*59.**	*50.24	*26.96	23.29	.22
	HDHP Family	KX2	4**.26	395.42	334.*3	6*.29	*.66

Non-Postal Premium Rates for the Federal Employees Health Benefits Program

Health Management Organizations (HMO)			2010 Total Biweekly Premium	2011 Biweekly premium rates				2010 Total Monthly Premium	2011 Monthly premium rates			
Plan • Option • Enrollment Code				Total Premium	Govt Pays	Empl Pays	Change in empl payment		Total Premium	Govt Pays	Empl Pays	Change in empl payment
Guam TakeCare												
	High Self	JK*	229.79	229.79	*72.34	57.45	-4.73	497.86	497.86	373.4*	*24.47	-*0.25
	High Family	JK2	603.66	603.66	403.96	*99.66	-27.94	*308.36	*308.36	875.29	433.07	-60.54
	Standard Self	JK4	207.69	203.67	*52.90	50.97	-*.00	450.43	44* 72	33*.29	**0.43	-2.*6
	Standard Family	JK5	546.97	536.37	403.76	*34.59	-38.34	**69.44	**66.47	874.65	29* 82	-83.07
Guam TakeCare												
	HDHP Self	KX*	*59.**	*50.24	**2.66	37.56	-2.22	344.74	325.52	244.*4	6*.36	-4.60
	HDHP Family	KX2	4**.25	395.42	296.57	96.66	-3.96	69*.04	656.74	642.66	2*4.*8	-6.56

Reference: http://www.opm.gov/insure/health/rates/postalhmo2011.pdf

EXHIBIT 2G

Government of Guam
FY2011 Health Insurance Premiums

ACTIVE EMPLOYEE			
HSA2000 Medical			
	Gov	Emp	Total
Class I	$ 79.38	$ 4.62	$ 84.00
Class II	$ 114.30	$ 61.55	$ 175.85
Class III	$ 96.00	$ 51.69	$ 147.69
Class IV	$ 159.90	$ 86.10	$ 246.00
Class V	$ 167.92	$ 80.85	$ 248.77

RETIREE EMPLOYEE			
HSA2000 Medical			
	Gov	Emp	Total
Class I	$ 268.00		$ 273.00
Class II	$ 515.33		$ 582.00
Class III	$ 420.50		$ 476.50
Class IV	$ 714.73		$ 808.00
Class V	$ 723.42		$ 811.00

ACTIVE EMPLOYEE			
SC1500 Medical			
	Gov	Emp	Total
Class I	$ 96.28	$ 41.26	$ 137.54
Class II	$ 185.19	$ 111.12	$ 296.31
Class III	$ 155.19	$ 93.12	$ 248.31
Class IV	$ 258.18	$ 154.90	$ 413.08
Class V	$ 270.00	$ 145.38	$ 415.38

RETIREE EMPLOYEE			
SC1500 Medical			
	Gov	Emp	Total
Class I	$ 315.30	$ 44.70	$ 360.00
Class II	$ 673.13	$ 120.38	$ 793.51
Class III	$ 548.13	$ 100.88	$ 649.01
Class IV	$ 931.69	$ 167.81	$1,099.50
Class V	$ 944.50	$ 157.50	$1,102.00

EXHIBIT 2H

Consolidated Rate Information

State	Plan	Total Monthly Premium	Employee Share	Employer Share
CALIFORNIA	**Blue Shield**			
	Employee Only	$602.00	$169.00	$433.00
	Employee & 1 Dep.	$1,203.00	$337.00	$866.00
	Employee & 2+ Dep.	$1,564.00	$435.00	$1,129.00
	Kaiser			
	Employee Only	$523.00	$90.00	$433.00
	Employee & 1 Dep.	$1,045.00	$179.00	$866.00
	Employee & 2+ Dep.	$1,359.00	$230.00	$1,129.00
TEXAS	**HealthSelect**			
	Employee Only	$413.26	$0.00	$413.26
	Employee & Spouse	$885.94	$236.34	$649.60
	Employee & Children	$729.78	$158.26	$571.52
	Employee & Family	$1,202.46	$394.60	$807.86
HAWAII	**EUTF PPO (HMSA) 80/20 Plan**			
	Self	$303.92	$114.58	$189.34
	Two-Party	$737.72	$278.40	$459.32
	Family	$940.80	$354.70	$586.10
	EUTF (HSMA) High Deductible			
	Self	$288.64	$56.56	$232.08
	Two-Party	$701.50	$138.50	$563.00
	Family	$895.30	$176.72	$718.58

EXHIBIT 2I

Consolidated Rate Information

State	Plan	Total Monthly Premium	Employee Share	State Share
GUAM- Federal Employees	TakeCare High/ Standard			
	High Self	$497.88	$124.47	$373.41
	High Family	$1,308.36	$433.07	$875.29
	Standard Self	$441.72	$110.43	$331.29
	Standard Family	$1,166.47	$291.62	$874.85
	TakeCare High Deductible			
	Self	$325.52	$81.38	$244.14
	Family	$856.74	$214.18	$642.56
GUAM- Government of Guam Employees	SelectCare HSA 2000			
	Class I	$84.00	$4.62	$79.38
	Class II	$175.85	$61.55	$114.30
	Class III	$147.69	$51.69	$96.00
	Class IV	$246.00	$86.10	$159.90
	Class V	$248.77	$80.85	$167.92
	SelectCare SC1500			
	Class I	$137.54	$41.26	$96.28
	Class II	$296.31	$111.12	$185.19
	Class III	$248.31	$93.12	$155.19
	Class IV	$413.08	$154.90	$258.18
	Class V	$415.38	$145.38	$270.00

Exhibit 3

GovGuam Monthly Active

SC2000

	FY2009	FY2010	Diff
Employee	$ 110.00	$ 104.00	$ (6.00)
Employee + Spouse	$ 243.00	$ 224.00	$ (19.00)
Employee + Child(ren)	$ 198.00	$ 184.00	$ (14.00)
Employee + Family	$ 341.00	$ 313.00	$ (28.00)
2 GG + Family	$ 341.00	$ 317.00	$ (24.00)

SC1500

	FY2009	FY2010	Diff
Employee	$ 129.00	$ 155.00	$ 26.00
Employee + Spouse	$ 285.00	$ 333.00	$ 48.00
Employee + Child(ren)	$ 232.00	$ 279.00	$ 47.00
Employee + Family	$ 401.00	$ 465.00	$ 64.00
2 GG + Family	$ 401.00	$ 470.00	$ 69.00

GovGuam Monthly Retiree

SC2000

	FY2009	FY2010	Diff
Employee	$ 386.00	$ 292.00	$ (94.00)
Employee + Spouse	$ 848.00	$ 642.00	$ (206.00)
Employee + Child(ren)	$ 694.00	$ 525.00	$ (169.00)
Employee + Family	$ 1,196.00	$ 890.00	$ (306.00)
2 GG + Family	$ 1,196.00	$ 895.00	$ (301.00)

SC1500

	FY2009	FY2010	Diff
Employee	$ 468.00	$ 457.00	$ (11.00)
Employee + Spouse	$ 1,036.00	$ 1,005.00	$ (31.00)
Employee + Child(ren)	$ 846.00	$ 822.00	$ (24.00)
Employee + Family	$ 1,455.00	$ 1,394.00	$ (61.00)
2 GG + Family	$ 1,455.00	$ 1,399.00	$ (56.00)

COMMITTEE ON RULES

I Mina'trentai Unu na Liheslaturan Guåhan • The 31st Guam Legislature
155 Hesler Place, Hagåtña, Guam 96910 • *www.guamlegislature.com*
E-mail: *roryforguam@gmail.com* • Tel: (671)472-7679 • Fax: (671)472-3547

2011 APR 12 AM 11:13

April 12, 2011

VIA FACSIMILE
(671) 472-2825

Ms. Benita Manglona
Director
Bureau of Budget & Management Research
P.O. Box 2950
Hagåtña, Guam 96910

RE: Request for Fiscal Note –
Bill Nos. 139-31 (COR) through 142-31 (COR)

Hafa Adai Ms. Manglona:

Transmitted herewith is a listing of *I Mina'trentai Unu na Liheslaturan Guåhan's* most recently introduced bills. Pursuant to 2 GCA §9103, I respectfully request the preparation of fiscal notes for the referenced bills.

Si Yu'os ma'åse' for your attention to this matter.

Very Truly Yours,

Rory J. Respicio

Attachments

Cc: Clerk of the Legislature

BUREAU OF BUDGET & MANAGEMENT RESEARCH

OFFICE OF THE GOVERNOR
Post Office Box 2950, Hagåtña Guam 96932

EDDIE BAZA CALVO
GOVERNOR

RAY TENORIO
LIEUTENANT GOVERNOR

BENITA A. MANGLONA
DIRECTOR

STEPHEN J. GUERRERO
DEPUTY DIRECTOR

APR 29 2011

Senator Rory J. Respicio
Chairperson, Committee on Rules
I Mina'trentai Unu na Liheslaturan Guåhan
The 31st Guam Legislature
155 Hesler Place
Hagåtna, Guam 96932

Hafa Adai Senator Respicio:

Transmitted herewith are Fiscal Notes on the following Bill Nos.: **111-31(COR), 120-31(LS), 132-31(COR), 139-31(COR), 140-31(COR), 141-31(COR), 147-31(COR), 149-31(COR), 150-31(COR), 151-31(COR), 154-31(COR)** and Fiscal Note Waiver on Bill No.: **161-31(COR).**

If you have any question(s), please do not hesitate to call the office at 475-9412/9106.

Benita A. Manglona
BENITA A. MANGLONA
Director

Enclosures

cc: Senator Vicente (ben) Pangelinan

Bureau of Budget & Management Research
Fiscal Note of Bill No. 139-31 (COR)

AN ACT TO ADD A NEW ARTICLE 3A TO CHAPTER 4, TITLE 4, GUAM CODE ANNOTATED; RELATIVE TO REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZE METHODOLOGIES FOR CALCULATION OF A MEDICAL LOSS RATION REBATE FOR THE GOVERNMENT OF GUAM HEALTH INSURANCE PROGRAM.

Department/Agency Appropriation Information	
Dept./Agency Affected: DEPARTMENT OF ADMINISTRATION	Dept./Agency Head: Benita A. Manglona, Acting Director
Department's General Fund (GF) appropriation(s) to date:	-
Department's Other Fund (Specify) appropriation(s) to date:	-
Total Department/Agency Appropriation(s) to date:	$0

Fund Source Information of Proposed Appropriation	General Fund:	(Specify Special Fund):	Total:
FY 2010 Unreserved Fund Balance[1]		$0	$0
FY 2011 Adopted Revenues	$535,231,228	$0	$535,231,228
FY 2011 Appro. (P.L. 30-196)	($535,492,693)	$0	($535,492,693)
Sub-total:	($261,465)	$0	($261,465)
Less appropriation in Bill	$0	$0	$0
Total:	($261,465)	$0	($261,465)

Estimated Fiscal Impact of Bill	One Full Fiscal Year	For Remainder of FY 2011 (if applicable)	FY 2012	FY 2013	FY 2014	FY 2015
General Fund	$0	$0	$0	$0	$0	$0
(Specify Special Fund)	$0	$0	$0	$0	$0	$0
Total	$0	$0	$0	$0	$0	$0

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

Analyst: _____ Date: 4/12/11 Director: _____ Date: APR 27 2011
Benita A. Manglona, Director

Footnotes:

The new Article 3A establishes the GovGuam Health Insurance Program Medical Loss Ratio (MLR) Rebate Regulation required under Section 2718 of the Public Health Service Act (PHSA). The fiscal impact on revenue or cost, however, cannot be determined at this time.

COMMITTEE ON RULES

I Mina'trentai Unu na Liheslaturan Guåhan • The 31st Guam Legislature
155 Hesler Place, Hagåtña, Guam 96910 • *www.guamlegislature.com*
E-mail: *roryforguam@gmail.com* • Tel: (671)472-7679 • Fax: (671)472-3547

April 6, 2011

MEMORANDUM

To: **Pat Santos**
Clerk of the Legislature

Attorney Therese M. Terlaje
Legislative Legal Counsel

From: **Senator Rory J. Respicio**
Chairperson, Committee on Rules

RECEIVED
APR 6 2011
2:35

Subject: **Referral of Bill No. 139-31 (COR)**

As Chairperson of the Committee on Rules, I am forwarding my referral of Bill No. 139-31 (COR).

Please ensure that the subject bill is referred, in my name, to the respective committee, as shown on the attachment. I also request that the same be forwarded to all Senators of *I Mina'trentai Unu na Liheslaturan Guåhan*.

Should you have any questions, please feel free to contact our office at 472-7679.

Si Yu'os ma'åse!

(7) Attachments

I Mina'Trentai Unu Na Liheslaturan Guåhan
Bill Log Sheet
April 05 2011

Bill No.	Sponsor(s)	Title	Date Introduced	Date Referred	120 Day Deadline	Committee Referred	Public Hearing Date	Date Committee Report Filed	Status (Date) Passed? Failed? Vetoed? Overridden? Public Law?
139-31 (COR)	v. c. pangelinan, B. J.F. Cruz, D. G. Rodriguez, Jr., T. R. Muna-Barnes, J. T. Won Pat, Ed.D.	AN ACT TO ADD A NEW ARTICLE 3A TO CHAPTER 4, TITLE 4 GCA RELATIVE TO REGULATION FOR UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATION OF A MEDICAL LOSS RATIO REBATE FOR THE GOVERNMENT OF GUAM HEALTH INSURANCE PROGRAM	04/05/11 3:47 p.m.	4/6/11		Committee on Appropriation, Taxation, Public Debt, Banking, Insurance, Retirement and Land			

Office of
the People

I Mina'trentai Unu Na Liheslaturan Guåhan

Senator Vicente (ben) Cabrera Pangelinan (D)

April 19, 2011

Memorandum

To: All Media

From: Senator Vicente (ben) Cabrera Pangelinan

Re: Public Hearing Notice – FIRST NOTICE

The Committee on Appropriations, Taxation, Public Debt, Banking, Insurance and Land will conduct a public hearing beginning at **2:00pm, Tuesday, April 26 2011** at the Guam Legislature's Public Hearing Room. The following is on the agenda:

Confirmation:
Beatrice P. Limtiaco, Appointee for the Guam Land Use Commission

Bills:

Bill No. 2-31 (COR) Introduced by Senator Frank Blas, Jr.
An Act to *add* Chapter 14 to title 2 of the Guam Code Annotated relative to and affecting Guam and its representation before the House and Senate of the United States Congress and to cite the act as *"The Guam Self-Determination and Self-Representation Act of 2011".*

Bill No. 15-31 (COR) Introduced by Sen. Frank Blas, Jr.
An act to establish a policy for the approval of workforce housing facilities for temporary workers.

Bill No. 65-31 (COR) Introduced by Speaker Judith Won Pat
An act authorizing the governor of Guam to utilize Lot Number 5138-2-R3NEW-1-1, Lot Number 5138-2-R3NEW-1-2 and Lot Number 5138-2-R3NEW-1-R2 for the new headquarters facility of the Guam Police Department.

Bill No. 116-31 (COR) Introduced by Senator Tina Muna Barnes
An Act to approve the lease by and between the government of Guam and the Guam National Tennis Federation.

Chairman
Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, and Land

Vice Chairman
Committee on Education

Member
Committee on Rules, Federal, Foreign & Micronesian Affairs and Human & Natural Resources

Member
Committee on Municipal Affairs, Tourism, Housing, and Recreation

Member
Committee on the Guam Military Buildup and Homeland Security

Member
Committee on Health and Human Services, Senior Citizens, Economic Development, and Election Reform

324 W. Soledad Ave. Suite 100, Hagåtña, Guam 96910
Tel: (671) 473-(4BEN) 4236 - Fax: (671) 473-4238 - Email: senbenp@guam.net
Website: http://senbenp.com

Bill No. 139-31 (COR) Introduced by Senator Vicente Pangelinan
An Act to add a new Article 3A to Chapter 4, Title 4 GCA Relative to Regulation for Uniform Definition and Standardized Methodologies for calculation of a medical loss ratio rebate for the Government of Guam Health Insurance Program.

Bill No. 140-31 (COR): Introduced by Senator Vicente Pangelinan
An Act relative to prioritizing the payment of Income Tax Refunds in accordance with the provisions of Annual Appropriations Acts at a rate proportional to revenue collections by establishing the "Pay Income Tax Refunds First Act of 2011".

Yanggen un nisisita espesiåt na setbisio put fabot ågang i Ifisinan Senadot ben pangelinan gi 473-4236/7, i-mel si senbenp@guam.net , patsino hålom gi i uepsait gi www.senbenp.com. Este na nutisiu inapåsi nu i fendon gubetnamento.

If you require any special accommodations, please contact the Office of Senator ben pangelinan at 473-4236 , email at senbenp@guam.net or log onto www.senbenp.com

Public Hearing - FIRST NOTICE

from Lisa Cipollone <cipo@guamlegislature.org> 4:32 PM (47 minutes ago) Reply
to phnotice@guamlegislature.org
date Tue, Apr 19, 2011 at 4:32 PM
subject Public Hearing - FIRST NOTICE
mailed-by guamlegislature.org

Hafa Ada,
Senator Vicente (ben) Cabrera Pangelinan will hold a public hearing on Tuesday, April 26, 2011 beginning at 2:00pm at the Guam Legislature Public Hearing Room.

INEKUNGOK PUPBLEKO
(PUBLIC HEARING)

gi Mattes, gi diha 26 gi Abrit, 2011
(Tuesday, April 26, 2011)

Kuåtton Inekungok Pupbleko gi I Liheslaturan Guåhan
(Guam Legislature Public Hearing Room)

Alas dos gi despues di talo'åni
(2:00 PM)

TAREHA
(AGENDA)

Komfitmasioon
(Confirmation Hearing)

Beatrice P. Limtiaco, Appointee for the Guam Land Use Commission

Priniponi Siha
(Bills)

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Public Hearing Notice - Senator Pangelinan

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from Lisa Cipollone <cipo@guamlegislature.org> Apr 19 (8 days ago) Reply

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date Tue, Apr 19, 2011 at 4:29 PM

subject Public Hearing Notice - Senator Pangelinan

mailed-by guamlegislature.org

Hafa Adai,
Senator Vicente (ben) Cabrera Pangelinan will hold a public hearing on Tuesday, April 26, 2011 beginning at 2:00pm at the Guam Legislature Public Hearing Room. Please see details for the hearing. Also for your convenience, we have attached a copy of the memo to the media with easy access to the bills on the agenda. Just click on the box of the bill number and you can view the bill. If you have any problems with this email, please let me know.

INEKUNGOK PUPBLEKO
(PUBLIC HEARING)

gi Mattes, gi diha 26 gi Abrit, 2011
(Tuesday, April 26, 2011)

Kuåtton Inekungok Pupbleko gi I Liheslaturan Guåhan
(Guam Legislature Public Hearing Room)

Alas dos gi despues di talo'åni
(2:00 PM)

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I Mina' Trentai Unu Na Liheslaturan Guahan
THIRTY-FIRST GUAM LEGISLATURE
Senator Vicente "ben" Cabrera Pangelinan
Office of the People

INEKUNGOK PUPBLEKO
(PUBLIC HEARING)

gi Mattes, gi diha 26 gi Abrit, 2011
(Tuesday, April 26, 2011)

Kuåtton Inekungok Pupbleko gi I Liheslaturan Guåhan
(Guam Legislature Public Hearing Room)

Alas 2 gi ega'an
(2:00 PM)

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THIRTY-FIRST GUAM LEGISLATURE
Senator Vicente "ben" Cabrera Pangelinan
Office of the People

***INEKUNGOK PUPBLEKO* (PUBLIC HEARING)**
***gi Mattes, gi diha 26 gi Abril, 2011* (Tuesday, April 26, 2011)**
Kuåtton Inekungok Pupbleko gi I Liheslaturan Guåhan
(Guam Legislature Public Hearing Room)
***Alas dos gi despues di talo'åni* (2:00 PM)**
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I Mina'trentai Unu Na Liheslaturan Guåhan

Senator Vicente (ben) Cabrera Pangelinan (D)

April 24, 2011

Memorandum

To: All Senators

From: Senator Vicente (ben) Cabrera Pangelinan

Re: Public Hearing Notice – SECOND NOTICE

The Committee on Appropriations, Taxation, Public Debt, Banking, Insurance and Land will conduct a public hearing beginning at **2:00pm, Tuesday, April 26 2011** at the Guam Legislature's Public Hearing Room. The following is on the agenda:

Confirmation:
Beatrice P. Limtiaco, Appointee for the Guam Land Use Commission

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Chairman
Committee on Appropriations, Taxation, Public Debt, Banking, Insurance, Retirement, and Land

Vice Chairman
Committee on Education

Member
Committee on Rules, Federal, Foreign & Micronesian Affairs and Human & Natural Resources

Member
Committee on Municipal Affairs, Tourism, Housing, and Recreation

Member
Committee on the Guam Military Buildup and Homeland Security

Member
Committee on Health and Human Services, Senior Citizens, Economic Development, and Election Reform

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Tel: (671) 473-(4BEN) 4236 - Fax: (671) 473-4238 - Email: senbenp@guam.net
Website: http://senbenp.com

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Public Hearing - Second Notice

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to phnotice@guamlegislature.org
date Sun, Apr 24, 2011 at 9:37 AM
subject Public Hearing - Second Notice
mailed-by guamlegislature.org

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Lisa Cipollone

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Tony Sanchez Apr 24 (3 days ago)

senatorsam@senatormabini.com to **Leslie**, **Jeff**, me Apr 24 (3 days ago) Reply

Hafa Adai Lisa,
I'd appreciate your assistance in scheduling a meeting with Senator Ben regarding Bill 144.
Thank you, and Happy Easter.
Senator Sam

Sent from my BlackBerry® smartphone

From: Lisa Cipollone <cipo@guamlegislature.org>
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Public Hearing - SECOND NOTICE

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date Sun, Apr 24, 2011 at 9:39 AM

subject Public Hearing - SECOND NOTICE

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Hafa Adai,
Senator Pangelinan will hold a public hearing on Tuesday, April 26, 2011 beginning at 2:00pm at the Guam Legislature Public Hearing Room.

INEKUNGOK PUPBLEKO
(PUBLIC HEARING)

***gi Mattes, gi diha 26 gi Abrit*, 2011**
(Tuesday, April 26, 2011)

Kuåtton Inekungok Pupbleko gi I Liheslaturan Guåhan
(Guam Legislature Public Hearing Room)

Alas dos gi despues di talo'åni
(2:00 PM)

TAREHA
(AGENDA)

Komfitmasioon
(Confirmation Hearing)

Beatrice P. Limtiaco, Appointee for the Guam Land Use Commission

Priniponi Siha
(Bills)

Bill No. 2-31 (COR) Introduced by Senator Frank Blas, Jr.
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Bill No. 116-31 (COR) Introduced by Senator Tina Muna Barnes
An Act to approve the lease by and between the government of Guam and the Guam National Tennis Federation.

Bill No. 139-31 (COR) Introduced by Senator Vicente Pangelinan
An Act to add a new Article 3A to Chapter 4, Title 4 GCA Relative to Regulation for Uniform Definition and Standardized Methodologies for calculation of a medical loss ratio rebate for the Government of Guam Health Insurance Program.

Bill No. 140-31 (COR): Introduced by Senator Vicente Pangelinan
An Act relative to prioritizing the payment of Income Tax Refunds in accordance with the provisions of Annual Appropriations Acts at a rate proportional to revenue collections by establishing the "Pay Income Tax Refunds First Act of 2011".

Yanggen un nisisita espesiåt na setbisio put fabot ågang i ifisinan Senadot ben pangelinan gi 473-4236/7, i-mel si senbenp@guam.net , patsino hålom gi i uepsait gi www.senbenp.com. Este na nutisiu inapåsi nu i fendon gubetnamento.

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Lisa Cipollone
Chief of Staff
Office of Senator ben c. pangelinan
(671) 473-4236
cipo@guamlegislature.org

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I Mina'Trentai Unu Na Liheslaturan Guahan
THIRTY-FIRST GUAM LEGISLATURE
Senator Vicente "ben" Cabrera Pangelinan
Office of the People

***INEKUNGOK PUPBLEKO* (PUBLIC HEARING)**
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I Mina'Trentai Unu Na Liheslaturan Guahan

THIRTY-FIRST GUAM LEGISLATURE

Senator Vicente "ben" Cabrera Pangelinan Office of the People

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324 W. Soledad Ave. Hagatna, Guam 96910
Ph. 473-4236 Fax. 473-4238
Email: senbenp@guam.net

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