



EDDIE BAZA CALVO
Governor

RAY TENORIO
Lieutenant Governor

Office of the Governor of Guam

October 1, 2013

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 Office of the Speaker
 Hon. Judith T. Won Pat, Ed.D.
 Date: 10/1/13
 Time: 3:34 PM
 Received by: [Signature]
 10/3 OCT - 9:00 PM 4:11

The Honorable Judith T. Won Pat, Ed.D.
Speaker, I Mina' Trentai Dos Na Liheslaturan Guahån
155 Hesler Place, Ste. 201
Hagåtña, Guam 96910

Hafa Adai Speaker Won Pat:

In accordance with Section 1323(b) (1) of the Patient Protection and Affordable Care Act (PPACA), I am submitting to Secretary Kathleen Sebelius, U.S. Health and Human Services (HHS), my decision on establishing a Health Insurance Exchange (Exchange) on Guam. I write to inform you that after careful deliberation, I have decided that under current circumstances, establishing an Exchange is not an option for Guam at this time.

The Guam Health Reform Task Force (Task Force), which I appointed on March 5, 2011, has diligently researched options, collected data and kept abreast of new federal regulations and requirements in an attempt to maximize all options available to Guam during the PPACA period of health care reform (2010-2019).

As computed by Department of Revenue and Taxation (DRT), Guam's current uninsured rate is 22.6%. We have experienced a loss of access to individual insurance policies being offered in our market, as well as an increase in the number of persons seeking insurance coverage in public sector programs through Medicare, Medicaid and the Medically Indigent Program. While the benefits of establishing a Health Insurance Exchange (Exchange) initially described by the U.S. Department of Health and Human Services (HHS) appeared an attractive solution to decrease our high, uninsured rate and provide affordable access to our residents, further investigation into this option determined that it is not feasible for the following reasons:

1. The federal allocation of \$24.4 million for premium and cost-share assistance provided to persons seeking enrollment in the Exchange, and eligible for Government subsidies, is not sufficient. The federal allocation is a one-time amount to cover health care reform years 2014-2019. DRT has looked into the feasibility and sustainability of establishing an Exchange. Based on Guam 2010 census data, the analysis included an estimate of Advance Premium Tax Credit (APTC) eligibility and subsidy levels. It was estimated



that a yearly subsidy of \$74.6 million for APTC will be needed to implement an Exchange, far in excess of the one-time \$24.4 million allocation that Guam is slated to receive under PPACA. If Guam used the entire allocation in the first year, the result would be an underfunding of \$50.2 million. There would be no federal assistance each year thereafter. If we were given the same levels of allocation provided to states, we would ensure subsidy coverage over the period of health care reform including yearly cost increases for subsidies due to people participating in the Exchange.

Aside from funding the majority of exchange subsidies on our own, Guam would also be required to cover the costs of developing and establishing an exchange out of our own funds as we were not eligible for the \$1 million planning grants the states used to fund their Exchange planning and analysis activities. However, Guam was eligible for a Level 1 Exchange Establishment Grant and did receive \$1 million. Unfortunately, unlike the states, these grant funds would have to be repaid if we did not establish an Exchange.

At the request of Senator Dennis Rodriguez, my staff worked with Congresswoman Bordallo's Office and HHS to try and change the terms of the grant but they unfortunately could not do so due to statutory constraints. Please note that the United States Virgin Islands (USVI) utilized their grant funds and now have to return their \$1 million grant as they have reviewed their consultant's study and determined that they will not establish an Exchange also due to cost.

Additionally, once an Exchange is implemented operational and governance costs would have to be borne by the local government and sustained by January 1, 2014. It is estimated that an Exchange infrastructure build-out, at a minimum, would cost Guam approximately \$30 million, not inclusive of staffing and ongoing operational costs.

In sum, the amount of this unfunded mandate would come to approximately \$104 million in the first year alone.

2. Guam was not able to secure a state willing to partner with to establish a regional or multi-state exchange. Due to restrictions placed under PPACA, Guam can only partner with states seeking to establish a State Based Exchange (SBE). We are precluded from joining states that have a federal partner and are not allowed to participate in a Federally Facilitated Exchange (FFE). DRT requested inclusion with Hawaii but was denied. There was initial talk of a establishing a Regional Exchange but American Samoa informed HHS that it was not going to establish an exchange and the CNMI was not engaged in pursuing Exchange initiatives with HHS.
3. Guam is held to the same Exchange deadlines as the 50 states. As a result, if implementing an Exchange, it would have required proven operations by October 1, 2013 with a first client enrollment date of January 1, 2014. This limits time needed for

Exchange build-out from scratch or even modifying an off-the-shelf vendor product with territorial system changes.

4. The federal allocation to Guam would not be sufficient to adequately fund an Exchange with the required and necessary premium and cost-sharing assistance to ensure that all individuals are able to access health coverage.

The Exchange study conducted by the USVI concluded that their federal allocation of \$24.9 million would cover less than 10% of the expected cost of providing premium and cost-sharing assistance through an Exchange. Specifically, the study concluded that it would cost the USVI between \$172.2 and \$226.6 million to provide the subsidies at the level required to allow USVI residents to acquire coverage through an Exchange. One estimate for Guam in a memorandum to the Guam Health Insurance Association, much like the USVI study, concludes the federal allocation would cover less than 10% of the projected annual premium subsidy costs.

Recently, as you may know, President Obama delayed the employer responsibility provisions that were to be implemented effective January 1, 2014 to mitigate the impact to small employers across our nation. About 85% of Guam's employer base is made up of small employers. More recently, the House of Representatives voted to move forward with a bill to delay PPACA implementation for one year. Although the future of PPACA remains unclear in the U.S., it is especially unclear for Guam as HHS has determined that PPACA market reforms will apply to health insurance coverage sold on Guam while the individual and employer mandates will not. The threat of adverse selection significantly driving up premiums as a result is almost a foregone conclusion, and has resulted in the announced pull-out of health insurance providers in the USVI.

As mentioned in the draft National Association of Insurance Commissioners discussion paper (Attachment A), HHS could help to alleviate this threat by reconsidering its determination that market reforms apply to Guam or phasing these reforms in over a period of several years. Congresswoman Madeleine Bordallo and I have been working together towards a waiver or delay in PPACA implementation for Guam. She and her fellow Delegates from American Samoa, the Commonwealth of the Northern Marianas and the U.S. Virgin Islands wrote to Secretary Kathleen Sebelius, HHS, and Secretary Sally Jewel, U.S. Department of the Interior (Attachment B), requesting for a meeting with the Interagency Group on Insular Affairs (IGIA) to discuss PPACA provisions that are either not applicable or treat Guam and the territories differently from the rest of the nation. I wholeheartedly endorse her request for the convening of this meeting to provide a forum for the federal government to hear first-hand from the governors of the territories about the unintended, though severe, consequences that will befall our territories with the disjointed application of PPACA.

Our ability to work toward more workable and appropriate healthcare reform requires that we work closely together, especially as it involves careful management of our limited resources. I

look forward to a closer working dialogue with you that will enable us to make decisions that will most effectively advance the goals of health care reform.

Should you have any questions, please feel free to contact Mr. Brian San Nicolas, Special Assistant for Health Care, at 475-3221. Your consideration is greatly appreciated. Si Yu'us Ma'ase.

Sincerely,

A handwritten signature in black ink, appearing to read 'EDDIE BAZA CALVO', written in a cursive style.

EDDIE BAZA CALVO

Attachments

Implementation of the Affordable Care Act in the U.S. Territories

Market Reforms without Individual Mandate, Sufficient Subsidies Could Destabilize Markets without Intervention

Executive Summary

While most of the focus in implementing the Affordable Care Act (ACA) has been on the costs and benefits that will accrue to residents of the 50 states and the District of Columbia, significant questions remain about how implementation of the ACA will affect consumers and insurance markets in the U.S. territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico and the U.S. Virgin Islands. Though the statute itself is unclear, the Department of Health and Human Services (HHS) has determined that the ACA's market reforms will apply to health insurance coverage sold in the territories, while the individual and employer mandates will not. If a territory elects to implement health insurance exchanges, they will receive a limited allotment of subsidy funding that only covers a fraction of needed funds. As a result, the threat of adverse selection driving up premiums is much higher than it is in the states. HHS could help alleviate this threat by reconsidering its determination that the market reforms apply to the territories or by phasing these reforms in over a period of several years. Congress could also address this problem by either clarifying that the reforms do not apply in the territories or by equalizing the treatment of the territories by applying the individual and employer mandates to the territories and providing sufficient subsidy funds. The territories may also address the issue themselves by adopting the mandate at a territorial level and funding subsidies themselves. This option will be politically difficult, however, and could strain the territories' resources.

Legal Treatment of the Territories under the ACA

The ACA is built upon a framework that has been compared to a three-legged stool. Market reforms, which include guaranteed issue, adjusted community rating, prohibitions on preexisting condition exclusions and other consumer protections, are intended to address problems that have been identified in the individual insurance market. In order for these provisions to work without driving up premiums, however, one must ensure that people do not wait until they become sick to purchase insurance. To achieve this goal, Congress included a requirement that most individuals obtain health coverage or pay a tax-penalty (the "individual mandate") and that larger employers provide coverage to their employees or pay a tax penalty (the "employer mandate"). In addition, the statute provided for open and special enrollment periods for coverage in the exchange, which HHS later extended to coverage sold outside the exchange. The third leg of the stool provides premium and cost-sharing subsidies to help low- and middle-income individuals afford coverage. In the territories, two legs of this stool will be weakened, as the individual and employer mandates will not apply, and the funds available for subsidies will not be

sufficient to cover all eligible individuals. As a result, the risk of adverse selection in the territories will be significantly higher than it is in the states.

Market Reforms

A great deal of confusion has arisen over the applicability of the ACA's market reforms in the territories. This confusion stems from two conflicting definitions of the term "state." Because health insurance is defined in federal law as being offered "in a state" and being "subject to state law which regulates insurance," whether coverage sold in the territories is subject to the reforms in the ACA hinges upon whether territories are considered states.

Title I of the Affordable Care Act (ACA), which includes the provisions applying to private health insurance, defines a "state" so as to exclude the territories:

In this Title, the term "State" means each of the 50 States and the District of Columbia.¹

Many of the most significant provisions in that title, however, take the form of amendments to the Public Health Service Act (PHSA), which itself defines the term "state" to include the territories:

The term "State" means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.²

How these conflicting definitions ought to be reconciled has been a subject of debate. Some have argued that the ACA's definition of a state ought to apply to all amendments in the statute, while others have argued that ACA amendments to the PHSA that use the term "state" ought to utilize the existing PHSA definition. The first option would exempt health insurance sold in the territories from many provisions of the law, such as guaranteed issue and adjusted community rating. The second would require coverage sold in the territories to meet all requirements of the ACA-amended PHSA. In response to an inquiry from the territories' Delegates to Congress, the Congressional Research Service (CRS) undertook an analysis of this issue. In its reply, the CRS advised the Delegates that "while it is possible that a court could find that, based on the definition in PPACA, a 'state' for purposes of the new PHSA provisions excludes the territories, reasonable arguments could also be made that the definition of 'state' in PPACA would not apply to these new PHSA provisions."³ The uncertainty caused by these two plausible interpretations of the interaction between the ACA and PHSA definitions required HHS to lay out its interpretation of how the market reforms added to the PHSA would apply to the territories, which will be discussed below.

Exchanges and Subsidies

In contrast, there is little debate regarding the application of Title I provisions that fall outside of the PHSA amendments. The ACA gives the territories the opportunity to establish exchanges, but does not require that they be established. If a territory does elect to establish an exchange, such an exchange

¹ ACA 1304(d)

² PHSA 2791(d)(14)

³ Staman, Jennifer. Congressional Research Service Memo to Hon. Madeleine Bordallo, Hon. Pedro Pierluisi, and Hon. Gregorio Kilili Sablan, Washington, DC. April 19, 2010

must meet the same exchange establishment, consumer choice, and financial integrity standards contained in part 2 of the subtitle dealing with exchanges as the states. These provisions, by referencing qualified health plan standards and market reform provisions, would also apply those requirements to qualified health plans sold in exchanges established in the territories. The ACA also provides a pool of \$1 billion, which may be expended over six years (2014-2019), to be split among the territories. These funds may be used to fund premium and cost-sharing subsidies for eligible individuals to enroll in qualified health plans through an exchange. In territories whose tax code mirrors the federal Internal Revenue Code, these subsidies must conform to the requirements outlined in the ACA and subsequent regulations. In territories with non-mirrored tax codes, they may determine the best way to distribute the subsidies among individuals purchasing qualified health plans on their exchanges. In either case, however, there may not be an eligibility gap between the territory's Medicaid program and subsidized coverage on the exchange.

If the territory elects not to establish an exchange these funds may be used to fund the territory's Medicaid program.⁴ Certain other exchange-related provisions, such as those creating Consumer Operated and Oriented Plans, the Basic Health Plan program, and the Multi-State Plan program will not apply to the territories because they fall outside of part 2 of the exchanges subtitle. In addition, the territories were not eligible to participate in the Preexisting Condition Health Insurance Plan, which provided coverage to individuals with preexisting conditions in the states beginning shortly after enactment of the ACA.

Risk Mitigation Provisions

The ACA contains a number of provisions designed to mitigate the risk of adverse selection that is likely to accompany the implementation of market reforms, such as guaranteed issue and adjusted community rating, that require greater pooling of risk. These provisions include the individual and employer mandates, a transitional reinsurance program, a temporary risk corridor program, and a risk adjustment mechanism. Individuals residing in the territories are specifically exempted from the individual mandate⁵. The employer mandate would also not apply in the territories.

The reinsurance and risk adjustment programs also do not appear in part 2 of the exchanges subtitle, and would therefore not be required of territories. However, because the risk corridors program does not reference states, but applies directly to qualified health plans that are sold on exchanges, it would apply in the territories that elect to establish exchanges, even though it also appears outside of part 2.

HHS Interpretation

A December 2012 letter from HHS Secretary Kathleen Sebelius to the territorial Governors, clarified HHS' interpretation of how the territories would be treated under the ACA⁶. In that letter, she informed the territories that HHS had decided to apply all of the provisions in the ACA that amend the PHSA to health insurance sold in the territories, including guaranteed issue, adjusted community rating,

⁴ ACA 1323(a)

⁵ IRC 5000A(f)(4), as added by ACA 1501(b).

⁶ Sebelius, Kathleen. Letter to Territorial Governors. December 10, 2012.

prohibitions on pre-existing condition exclusions, and other market reforms. The letter also provided the allocations for the funding appropriated under section 1323 of the ACA, to be used for QHP subsidies or for a territory's Medicaid program. These amounts are listed in Table 1 below.

Table 1: ACA Funding for Territories

Territory	Allocation
Puerto Rico	\$925 million
Virgin Islands	\$25 million
Guam	\$24 million
American Samoa	\$17 million
Northern Mariana Islands	\$9 million

In addition, the letter clarified that if a territory established an exchange, it could also establish reinsurance and risk corridor programs, meeting all requirements for these programs set by HHS, though the federal government would not step in to establish and operate them if the territory did not. Unfortunately, the Secretary's letter provided the territories with less than three months to determine whether they would implement either of these programs, setting a deadline of March 1 for them to notify HHS of their intent to do so. This was several months prior to the October 21, 2013 deadline to notify HHS if the territories would implement an Exchange. The letter did note, however, that territories retain the authority to establish their own reinsurance and risk adjustment programs, under territorial law. These territorial reinsurance and risk adjustment programs would not be required to meet federal requirements.

Current Market Conditions in the Territories

Most of the territories today have uninsurance rates that are significantly higher than those in the states. (See Table 2, below) The lone exception is Puerto Rico, which has covered many of its residents under a territorial coverage program called *Mi Salud* (see p. 6). The remaining four territories have rates of uninsurance that are 15-44 points higher than the U.S. average. While Guam and the U.S. Virgin Islands have a roughly comparable percentage of their populations enrolled in private coverage as the states, the other territories have significantly lower rates of private coverage. In American Samoa today, just 11% of the population has private health insurance coverage, including individual, small group, large group, and self-insured group coverage.

Table 2: Sources of Coverage

	American Samoa	CNMI	Guam	Puerto Rico	USVI	US Average
Private only	11.0%	31.1%	49.1%	34.7%	45.9%	54.8%
Public only	23.7%	32.1%	22.4%	51.6%	14.7%	18.7%
Private & public	6.1%	3.2%	7.4%	6.1%	8.6%	11.0%
Uninsured	59.2%	33.7%	21.1%	7.6%	30.8%	15.5%

Source: U.S. Census Bureau, 2010 Demographic Profile Data

Number of insurers in the market

The number of insurers selling coverage in most of the territories is somewhat limited, due to their remote locations and limited populations. Businesses of most of the territories have a handful of insurers to choose from when seeking to purchase a health insurance policy for employees. In the individual market, however, most territories have only a single carrier actively marketing policies to residents.

Table 3: Number of Insurers Selling Grandfathered and Non-Grandfathered Coverage

	American Samoa		CNMI		Guam		Puerto Rico		USVI	
	GF*	Non-GF**	GF	Non-GF	GF	Non-GF	GF	Non-GF	GF	Non-GF
Individual			0	1	1	1	4	6	4	0
Small Group			1	3	2	4	7	8	2	1
Large Group			1	3	3	4	8	9	1	1

*GF: Issuers maintaining grandfathered health plans

**Non-GF: Issuers selling or maintaining non-grandfathered health plans

Since the immediate market reforms went into place in 2010, however, residents of the U.S. Virgin Islands have been unable to purchase individual market coverage since the last insurer ceased selling new policies. In response to a survey of insurers conducted by Guam and the U.S. Virgin Islands, several insurers still selling new coverage indicated their intent to cease doing so without an individual and employer mandates in place to mitigate the risk of adverse selection.

Territorial Responses to the ACA

The five territories, spread across the globe, have very different health insurance markets and as a result have responded to passage of the ACA in different ways.

American Samoa

In March 2012, then Governor Togiola Tulafono informed HHS that, after evaluating the current territory’s existing healthcare system in the Territory, his administration had concluded that establishing a health insurance exchange would not be appropriate at this time. Instead, Governor Tulafono elected to use American Samoa’s allocation of funding for a Medicaid expansion.

Since that letter, American Samoa held gubernatorial elections, and the new governor, Lolo Matalasi Moliga has decided to reconsider the decision not to establish an exchange. No final determination has been made as to whether an exchange will be established in American Samoa.

Commonwealth of the Northern Mariana Islands (CNMI)

The passage of the Affordable Care Act (ACA) came at a time of tremendous fiscal stress in the Commonwealth of the Northern Mariana Islands (CNMI). The passage and subsequent planning for the ACA coincided with CNMI government austerity measures which impacted the CNMI’s Division of

Insurance's ability to adequately train and prepare for the full implementation of the ACA. Given the restricted resources and expertise in the jurisdiction's remote location, the CNMI has been relying heavily on federal guidance and national organizations including the National Association of Insurance Commissioners (NAIC) and the National Governors Association (NGA). While the CNMI was not fully prepared to decide on the establishment of a Health Insurance Exchange, it did apply for and receive both the rate review grant and the Consumer Assistance Program grant.

Rate review grant funds were used by the CNMI to establish an effective rate review program. The CNMI will put legislation in place which mandates insurance carriers to submit forms and rates to this new program. Prior to the establishment of this program, the CNMI Department of Insurance had very little regulatory control over health insurance rate increases and policy forms. Additionally, the CNMI used its Consumer Assistance Program grant award to open a health care consumer advocacy program, the first of its kind in the CNMI.

Because the CNMI's existing insurance regulatory and statutory environment requires significant changes to ensure full adherence to the ACA, the CNMI Office of the Insurance Commissioner has begun the process of introducing appropriate draft statutes for introduction into the CNMI Legislature. As such, the CNMI has aggressively leveraged resources to ensure full comprehension of the policy infrastructure that is required for market reform and consumer protection measures afforded by the ACA. The largest area of concern is the impact that the ACA will have on the public option and the trickle-down effect that expanded coverage and eligibility requirements will have on the small group and individual marketplaces in the CNMI.

Guam

Upon enactment of the ACA, Guam fully implemented the law's immediate market reforms that took effect prior to 2014 and required all health insurance contracts and policy forms to be in compliance with them prior to approval by the Commissioner. The territory also took the steps needed to ensure that it had an effective rate review program in place. Any requests for rate increase filings by health plan issuers are reviewed and all requests for ten percent or more above over current rates will receive additional review by contracted actuaries.

The Department of Revenue and Taxation, which oversees the insurance industry in Guam, has looked into the feasibility and sustainability of establishing an exchange in the territory. Based on 2010 Census data, the study included an estimate of Advance Premium Tax Credit eligibility and subsidy levels in Guam. It was estimated that a yearly subsidy of \$74 million for APTC will be needed to implement an exchange, far in excess of the \$24 million, six-year, allocation that Guam is slated to receive under the ACA. At this time Guam has not yet made a final decision to opt in or opt out of establishing a state based exchange.

Puerto Rico

Puerto Rico was probably in the best position to respond to the ACA. Due to a locally funded health coverage program, known as *Mi Salud*, providing coverage for approximately 1.4 million individuals

whose incomes exceeded the threshold for eligibility in its Medicaid program, Puerto Rico had an uninsured rate of 7.6% in 2010, well below that of most states. The lower level of uninsured residents in Puerto Rico could reduce the risk of adverse selection as the level of pent-up demand in the population from delayed medical care will likely be lower.

In July 2013, the Legislative Assembly adopted legislation amending Puerto Rico's Health Insurance Code to give its Insurance Department authority to enforce the ACA's market reforms and providing for the guaranteed issue and open and special enrollment periods for individual plans.

U.S. Virgin Islands

Following passage of the ACA, the U.S.V.I. created a 14-member Health Reform Implementation Task Force to provide guidance and recommendations to Governor de Jongh regarding initiatives to implement health reform and to improve quality and access health care. The task force sought and received funding from HHS to undertake a study to examine the feasibility of establishing a health insurance exchange, to conduct an analysis of its private health insurance market, and to identify gaps in information technology systems that will be needed to support ACA implementation activities. The Task Force concluded that "the disjointed application of the [ACA]'s provisions to the territories and its insufficient allocation of federal funds significantly limits the VI's opportunity to expand health care coverage to VI uninsured residents through the ACA." It therefore recommended that the governor utilize the funding provided under the law to expand Medicaid instead of establishing an Exchange.

In response to the implementation of the ACA's immediate reforms (prohibitions on lifetime limits, restrictions on annual limits, prohibitions on preexisting condition exclusions for children, etc.) the sole insurer providing coverage in the U.S.V.I.'s individual insurance market ceased issuing new policies in the territory, leaving residents of the territory unable to purchase individual health insurance for any price. The lack of insurers actively marketing coverage in the individual market will make an exchange impossible to establish in the U.S.V.I. unless new insurers enter the market, and leaves a large gap in coverage in the territory.

Likely Effects of Full Implementation of Market Reforms in the Territories

The market reforms that the ACA adds to the PHSA, such as guaranteed-issue, adjusted community rating, and the prohibition on preexisting condition exclusions, restrict or eliminate the ability of insurers to engage in practices that exclude individuals with health care conditions from risk pools or to charge them more for coverage. While these practices have made it impossible or very expensive for many individuals to purchase coverage, they have also kept premiums low for the young and those in good health. When premiums for these individuals rise, they are more likely than those with serious health conditions to forego coverage, causing the experience of risk pools to deteriorate over time. As one would expect, states that have eliminated medical underwriting and health status rating in the past have seen large increases in premiums, reductions in the number of insurers participating in their markets, and reductions in the number of people able to afford coverage.

In order to avoid these unintended consequences, the ACA put in place numerous provisions that encourage the young and healthy to remain in the marketplace and to maintain the health of the risk pools. These provisions include the individual mandate, generous subsidies for low- and middle-income individuals purchasing coverage through exchanges, transitional reinsurance and risk corridor programs, and a permanent risk adjustment program and are critically important to the success of the ACA's efforts to extend coverage to millions of Americans.

The critical importance of the individual mandate, in particular, was a key part of the administration's argument before the U.S. Supreme Court that the individual mandate was an appropriate exercise of Congress' powers under the Constitution's commerce clause:

Congress found that the minimum coverage provision was "essential" to the success of the measures it adopted to end insurance discrimination against those with pre-existing conditions. Those insurance reforms are unquestionably within Congress's powers under the Commerce Clause. The soundness of Congress's judgment about what was required for its insurance reforms to succeed is supported by the experience of States that tried—and failed—to effectively end such practices without an insurance requirement. Indeed, no party to this case has suggested that the guaranteed-issue and community-rating requirements could function effectively without the minimum coverage provision.⁷

In fact, individual market premiums in New York state, one of the states hardest hit by adverse selection that accompanied the kinds of reforms in the ACA, are expected to decrease by as much as 50% when the individual mandate and subsidies take effect in 2014.⁸

While these provisions will help mitigate adverse selection in the states, none of them are likely to be implemented in the territories, leaving their markets vulnerable. As was noted above, the individual and employer mandates do not apply in the territories, and while the territories may establish Exchanges and use their funding allocation provided under section 1323 to provide subsidies, funding levels are insufficient to meet the expected need. Over the six-year period for which funds have been appropriated, the U.S. Virgin Islands has estimated that an exchange would provide \$251.5 million in subsidies, more than ten times their allocation.⁹ Guam has estimated that it will need \$74.6 million to provide subsidies to its eligible population through an exchange in 2014 alone, more than three times its allocated funding for the entire six years from 2014-2019.

In addition to funding the majority of exchange subsidies themselves, the territories would also be required to cover the costs of developing and establishing an exchange out of their own funds, as the territories were not eligible for the \$1 million planning grants that states used to fund their exchange planning and analysis activities. They were, however, eligible for level 1 exchange establishment grants. These grants funds, however, must be repaid if the territory does not establish an exchange.

⁷ HHS v. Florida, Petition for Writ of Certiorari at 24

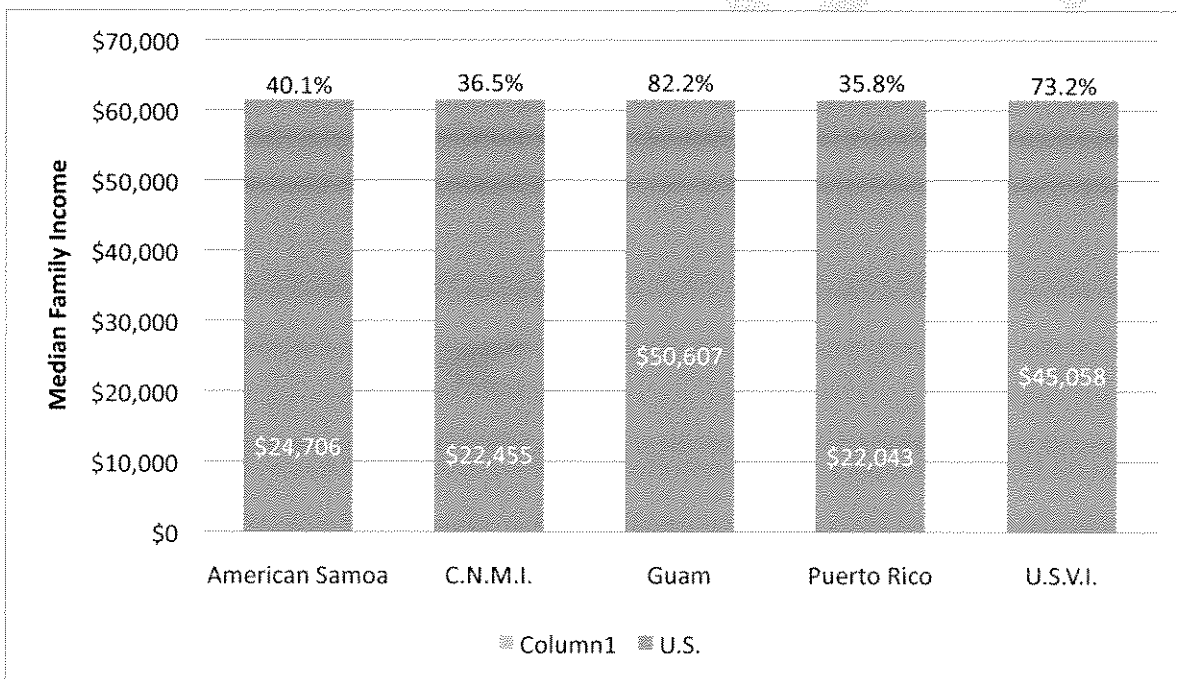
⁸ Rabin, R.C. and Abelson, R. "Health Plan Costs for New Yorkers to Fall 50%" 16 July, 2013. *The New York Times*, Web. 19 August, 2013

⁹ Milliman. "U.S. Virgin Islands Exchange Analysis" March 14, 2013. Accessed online <<http://www.governordejongh.com/healthreform/assets/documents/2013/appendices-a-g.pdf>>

Furthermore, while most states have elected to allow the federal government to operate the transitional reinsurance and risk adjustment programs on their behalf in 2014, the territories would have to operate these programs themselves, adding to the burden of establishing an exchange. As a result, many territories may be better served by using their allocated funds to provide coverage to additional residents through their Medicaid programs.

Implementing the market reforms without any of the mitigating provisions described above places individual and small group markets at severe risk for adverse selection that could undermine the intent of the ACA—making coverage more expensive for consumers who depend upon it. Compounding the risk of adverse selection that would be present in any of the states without the ACA’s mitigating provisions are the lower incomes found in the territories. Recent work suggests that lower-income individuals have a significantly higher sensitivity to health insurance premiums than those with higher incomes.¹⁰ Because median family incomes in the territories range from 36%-82% of the U.S. median family income, it is likely that territorial residents will be more likely to forego coverage as premiums increase than residents of the states.

Figure 1: Territorial Incomes Compared to States



As adverse selection pushes premiums higher, insurance issuers currently serving the individual and small group markets are likely to withdraw, making coverage unavailable at any price. This has already occurred in the U.S. Virgin Islands, where both issuers selling coverage in the individual market stopped selling new coverage when it became clear that it would have to comply with the market reforms without the benefit of the individual mandate or subsidies to protect the market against adverse

¹⁰Kruger, Alan B. and Kuziemko, Ilyana. “CEPS Working Paper No. 217: The Demand for Health Insurance among Uninsured Americans: Results of a Survey Experiment and Implications for Policy” April, 2011. Accessed online < <http://www.princeton.edu/ceps/workingpapers/217krueger.pdf>>.

selection. As a result, consumers in the U.S. Virgin Islands' individual market will not benefit from the majority of the ACA's reforms, which apply to non-grandfathered policies, as there will be no coverage for the reforms to apply to. Without some action to prevent a cycle of adverse selection in the territories, implementation of the ACA's market reforms is likely to lead to a result that is the opposite of what the ACA intended—higher premiums, less competition, and more Americans without health insurance coverage.

Possible Actions to Mitigate Adverse Selection in the Territories

Reconsideration or Delay of PHSA Amendment Applicability

The first option at the administration's disposal would be a reconsideration of its determination that all of the ACA's market reforms will apply in the territories. As the previously discussed Congressional Research Service memo noted, the interpretation that the ACA's PHSA amendments do not apply in the territories is a plausible one. Furthermore, it is the only interpretation that is consistent with the often-stated position taken by the ACA's congressional sponsors and the administration that these reforms are not possible without the individual mandate and the subsidies.

If the administration determines that a reconsideration of its position is not possible, a second option is a delay or phase-in of these provisions in the territories. This could be structured as a three-year delay of applicability for the guaranteed issue provision, followed by a phase-in of the ACA's rating rules over a five-year period. This sort of a phase-in would allow the markets to gradually adjust to the imposition of the market reforms and would be consistent with other actions the administration has taken to delay the effective dates of provisions where immediate application would not be technically feasible, such as the employer mandate, exchange quality, and employee choice provisions.

Congressional Actions

Should the administration decide that it lacks the statutory authority to adopt either of these alternatives, it may be necessary for Congress to provide relief for the territories. Both of the above remedies could also be accomplished by legislative means. In addition, Congress could take other steps to ensure that implementation of the market reforms in the territories does not result in adverse selection by leveling the playing field between the states and territories. This could be accomplished by revising the ACA's definition of "state" to mirror the definition in the PHSA, thereby including the territories, and by revising section 1323, which provides the limited funding for territories to fund exchange subsidies or Medicaid programs, to provide a level of subsidies that will help prevent adverse selection. While this approach would require additional federal funding at a time of strained budgets, it would also realize the ACA's goal of expanded coverage and enhanced consumer protections, while limiting the potential for market disruption in a way that the current interpretation of the law does not.

Territorial Actions

Like the states, the territories have the ability to take over primary responsibility for enforcement of provisions of the ACA, including the market reforms that were added to the PHSA. This will allow them to more effectively tailor implementation to the needs of their consumers and marketplaces. One

important option that the territories will have at their disposal to prevent adverse selection will be the creation of individual market open enrollment periods, whether or not they elect to establish exchanges. This option is specifically permitted by the final Market Rules regulations issued by HHS in February, 2013.¹¹ Puerto Rico has already adopted legislation establishing open enrollment periods for its individual market. This action will help control adverse selection and help mitigate exposure to unintended increases in premiums.

In the event that neither Congress nor the administration takes action to prevent adverse selection in territorial insurance markets, the territories themselves may need to step in to provide what stability they can to their insurance markets by adding the missing provisions of the ACA. These provisions include, most importantly, the individual mandate and exchanges with subsidies at a level that will be sufficient to ensure a balanced individual market risk pool that includes sufficient numbers of younger, healthier individuals to keep premiums from increasing dramatically. These provisions could be politically difficult, however, given the cost to the territories of funding subsidies and the divisiveness of the individual mandate in the states. Adding the level of needed exchange subsidies left unfunded by the ACA in the U.S. Virgin Islands would add \$226 million to a general fund budget of \$617 million, an increase of 37 percent.

In addition to adding a mandate and subsidies at the territorial level, territories could also implement a territorial reinsurance program that would subsidize coverage for individuals in the individual market with higher than average health costs. That program, however, would have to be funded with assessments on insurers in the territories' individual, small group and large group markets. Similarly, territories with exchanges could establish a territorial risk adjustment program to equalize risk between carriers, which would make payments to carriers with higher than average risk funded by assessments on carriers with lower than average actuarial risk. However, these mechanisms to mitigate risk have the potential to impose significant administrative and data collection burdens, especially when some of the territories have neither the means of collecting this kind of data nor the trained personnel to administer these mechanisms. While the territories are working to be compliant with the new health care reform, the fragmentary extension of ACA provisions to the territories could result in the weakening of health insurance coverage in the territories and the industries that provide that coverage, thus undermining the original intent of Affordable Care Act.

¹¹ 45 CFR 147.104(b)

Congress of the United States
Washington, DC 20515

September 17, 2013

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

The Honorable Sally Jewell
Secretary of the Interior
Department of the Interior
1849 C Street NW
Washington, DC 20240

Dear Secretary Sebelius and Secretary Jewell,

We write to request for a meeting of the Interagency Group of Insular Affairs (IGIA) to be convened for territorial government officials and appropriate federal entities to discuss concerns about the implementation of the Affordable Care Act (ACA) in the U.S. Territories.

As you know, many of the provision of the ACA are either not applicable or treat the territories differently than the rest of the nation. We are concerned about the effect of these differences on the health insurance markets in the territories, as are our local governments, health insurance providers, employers, and the public at large.

We appreciate the guidance that was issued to our governors by the Department of Health and Human Services on December 10, 2012 that outlined the application of certain portions of the ACA in each of the territories. This provided our local governments and health insurance companies with initial information on how the ACA will apply, but questions remain about the Act's ultimate effects.

For that reason, we believe that the direct dialogue provided by a meeting of the IGIA is needed at which territorial governments could convey their developing concerns and questions. This exchange could then enable both local and federal governments to make decisions that would most effectively advance the goals of health care reform.

We appreciate the leadership that your departments have already shown in addressing the many health care challenges in the territories. We hope that you will continue to work with each of the territorial governments to ensure that ACA implementation addresses our unique needs. We look forward to working with you to ensure the greatest possible benefit from the ACA for the people we represent.

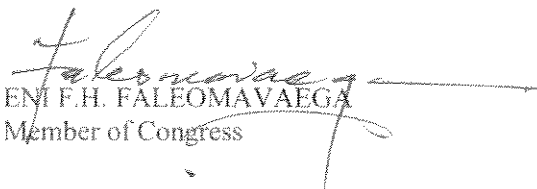
Sincerely,



MADELEINE Z. BORDALLO
Member of Congress



DONNA M. CHRISTENSEN
Member of Congress



ENI F.H. FALEOMAVAEGA
Member of Congress



GREGORIO KILILI CAMACHO SABLAN
Member of Congress