



Administrator
Washington, DC 20201

JUL 16 2014

Commissioner Artemio B. Ilagan
Guam Dept. of Revenue & Taxation
Regulatory Division
PO Box 23607 GMF
Barrigada, Guam 96921

Dear Commissioner Ilagan:

The Department of Health and Human Services (HHS) appreciates the many opportunities we had over the past several months to discuss the implementation of the Affordable Care Act with officials of the territories. I am writing today to clarify an issue that you and other officials of the territories have raised on a number of occasions—the applicability of certain Affordable Care Act provisions to health insurance issuers in the territories. We are committed to ensuring robust markets so that consumers have ample choice of high quality, affordable health insurance products and appreciate the opportunity to work with you on this critical issue.

Currently, the Department uses the existing Public Health Service Act (PHS Act) definition of “state” for new PHS Act requirements and funding opportunities included in title I of the Affordable Care Act. Under this definition, the new market reforms in the PHS Act apply to the territories. We have been informed by representatives of the territories that this interpretation is undermining the stability of the territories’ health insurance markets.

After a careful review of this situation and the relevant statutory language, HHS has determined that the new provisions of the PHS Act enacted in title I are appropriately governed by the definition of “state” set forth in that title, and therefore that these new provisions do not apply to the territories. This means that the following Affordable Care Act requirements will not apply to individual or group health insurance issuers in the U.S. territories:¹ guaranteed availability (PHS

¹ Our analysis applies only to health insurance that is governed by the PHS Act. It does not affect the PHS Act requirements that were enacted in the Affordable Care Act and were incorporated into the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (Code) and apply to group health plans (whether insured or self-insured), because such applicability does not hinge on, or rely upon the term “state” as it is defined in either the PHS Act or in the Affordable Care Act. Similarly, it also does not affect the PHS Act requirements that were enacted in the Affordable Care Act and apply to non-federal governmental plans. As a practical matter, therefore, PHS Act, ERISA, and Code requirements applicable to group health plans continue to apply to such coverage and issuers selling policies to both private sector and public sector employers in the territories will want to make certain that their products comply with the relevant Affordable Care Act amendments to the PHS Act applicable to group health plans since their customers – the group health plans – are still subject to those provisions. Group health plans remain subject to those provisions of the PHS Act that were enacted in the Affordable Care Act, including, *inter alia*, the prohibition on lifetime and annual limits (PHS Act section 2711), the prohibition on rescissions (PHS Act section 2712), coverage of preventive health services (PHS Act section 2713), and the revised internal and external appeals process (PHS Act section 2719).


Act section 2702), community rating (PHS Act section 2701), single risk pool (Affordable Care Act section 1312(c)), rate review (PHS Act section 2794), medical loss ratio (PHS Act section 2718), and essential health benefits (PHS Act section 2707). Specifically, under this interpretation, the definition of “state” set forth in the PHS Act will apply only to PHS Act requirements in place prior to the enactment of the Affordable Care Act, or subsequently enacted in legislation that does not include a separate definition of “state” (as the Affordable Care Act does).

The Centers for Medicare & Medicaid Services (CMS) intends to issue regulations to affirm this interpretation and eliminate any text in the existing rules that is inconsistent with this interpretation (*e.g.*, the definition of “state” that includes territories set forth in the rate review regulations at 45 CFR 154.102). Pending the completion of such rulemaking, CMS will apply this interpretation and will not subject health insurance issuers in the territories to the Affordable Care Act requirements at issue.

Because this interpretation applies prospectively, territories will not have to pay back to the federal government any grants that have been spent by the territories as of the date of this letter, such as those provided for rate review (section 2794 of the PHS Act) and for consumer assistance (section 2793 of the PHS Act). However, all unspent grant funding must be returned to CMS, because the interpretation of the law making the territories eligible to expend such funds is no longer in place.²

I look forward to continuing to partner with the territories to assure that there is sufficient competition in their health insurance markets to provide its residents with a diverse selection of affordable health insurance plans. I hope you will continue to keep in touch about this and other issues of mutual concern.

Sincerely,



Marilyn Tavenner

² In addition, with respect to rate review grants, they would no longer be considered to have an “effective rate review program” since they would not be subject to PHS Act requirements enacted in the Affordable Care Act.