CHAPTER 9
CONSUMER HEALTH PROTECTION ACT

AG OPINION: Portions of this Chapter [Articles 1-5] are unenforceable because of violations of federal law (ERISA). See AG Opinion GHPDA #86-1021.

ARTICLE 1
GENERAL PROVISIONS

§ 9101. Legislative Intent.

The Legislature hereby finds and declares that the cost of health care now exceeds the ability to pay for the average resident of Guam. Expanded insurance protection has been seriously retarded by uncontrolled inflation in health care costs.

Factors responsible for the inflationary spiral in health costs include failure to place primary emphasis on personal disease prevention, and personal maintenance of health and ambulatory health care. To improve this situation, it is necessary to strengthen the planning of operating health services, guarantee quality and accessibility of appropriate health care at all times and require the accountability of the provider to make available that care plus development of standards of quality sufficient to adequately protect patients.

To assure that citizens of the Territory will be able to obtain as well as afford necessary health services on an equitable basis, compulsory prepaid health and sickness coverage, accomplished through payroll deduction made by employers and employees, is effective on the passage of this Chapter, and operative on the first day of the first calendar year after the

rates and benefits proposed by the Commission have been approved by the Legislature.

SOURCE: GC § 9990.

§ 9102. Definitions.

(a) *Prepaid Health Plan* means a plan which offers a specified scope of benefits to an enrolled population for a predetermined prepaid annual rate.

(b) *Health Maintenance Organization* means any organization of providers of personal health services with a proven capacity to provide preventive and health maintenance services to a given population of enrolled consumers in a Prepaid Health Plan. Providers shall guarantee that quality services be available and accessible twenty-four (24) hours a day, seven (7) days a week. The definition of health maintenance organization under this Subdivision shall include, but not be limited to, "medical care foundations," group practice prepayment organizations and health consumer organizations. Medical care foundation means any non-profit foundation whose physician membership is capable and guarantees to provide comprehensive health services to patients enrolled in a Prepaid Health Plan. Health consumer organization means any incorporated organization of citizens whose primary motive for organizing is to create a system of financing and arranging for the delivery of personal health services under circumstances which require sensitivity to the consumer's desires in this field. A group practice prepayment organization means a formal, organized group of doctors and other providers in a group practice center with centralized management peer review, and a formal structure and organization.

(c) *Fiscal Intermediary* means any private insurance company which performs fiscal and administrative functions for any organization or provider of health care, or on behalf of consumers through a contract for health benefits.

(d) *Peer Review-Medical Audit* means an organized system for regular review of professional performance in or out of the hospital by a committee of peers. Such review is designed to judge the medical justification for case management to assure its quality.

(e) *Utilization Review* means an organized review by peers designed to control or eliminate unnecessary admissions to hospitals, and unwarranted length of stays in hospitals.

(f) *Provider Profiles* means computer-assisted files of the performance of a provider over an extended period of time.

(g) *Provider* means any licensed individual or organization engaged in the providing of personal health service to the public.

(h) *Health Commission* means that body under which this legislation assumes powers and responsibility for activities related to providing personal health care to the public.

(i) *Approved Hospital* means a licensed hospital which meets the standards of performance as developed by the Health Commission to assure quality of care, safety of the patient and such other criteria as the Commission deems necessary.

(j) *Health Facility* means any licensed facility whose primary function is to deliver personal health service to the public. This includes, but is not limited to, out-patient clinics, hospitals, clinics, nursing homes, home care organizations and intermediate care facilities.

(k) *Prepaid Capitation* means an annual fixed premium per person paid in advance for a specified set of comprehensive health benefits.

(l) *Benefit Period* means the period of time during which an enrolled person is covered under a Prepaid Health Plan.

(m) *Allied Health Professional* means any professional person involved in the provision of skilled health service both directly or indirectly in support of physicians and health institutions engaged in the delivery of health care services.

(n) *Out of Area Emergency Services* means medical treatment for any sudden or unexpected illness, or the medical treatment of an injury or injuries. Such illnesses or injuries shall be those requiring medical services at a location outside the area of the patient's own health maintenance organization, and requiring the medical services of another provider of health care services, so as to not compromise the quality of care or safety of the patient by delaying treatment. This shall include any emergency services provided to an enrollee while off-island.

(o) *Enrollee* means a person who has enrolled as a beneficiary of a health benefit plan.

SOURCE: GC § 9990.1.

ARTICLE 2
ADMINISTRATION

§ 9201. Administration: Health Commission Created.

The Health Commission is hereby created and is the regulatory body which shall set policy and determine regulations which relate to the operation of personal health service of all kinds. The Health Commission shall consist of seven (7) members, appointed by the Governor with the advice and consent of the Legislature, four (4) members of the initial commission to be appointed for one (1) year, three (3) members to be appointed for two-year terms. The Commission shall choose from its membership, a chairman. The Director of Public Health and Social Services shall be the Chief Administrative Officer and shall carry out the decisions, policies and regulations of the Commission.

(a) Compensation of Members. Members of the Commission shall be paid at the rate of Fifty Dollars ($50) per day for each day on which the Commission meets, such compensation not to exceed One Hundred Dollars ($100) per month.

SOURCE: GC § 9990.2, as amended by P.L. 15-148.

§ 9202. Same: Contracts Executed After This Act.

Notwithstanding any other provisions of law, no contract for provision of health care services executed after the operative date of this Chapter between individuals and fiscal intermediaries or groups of any type and fiscal intermediaries, may be issued or renewed without approval of the Commission and in compliance with the standards as set forth in Subchapter 3, but all such existing benefit coverage shall remain in full force and effect until its date of expiration, provided that such time period does not exceed a date four (4) years from the effective date of this Chapter, except that existing programs may be renewed if, the Commission has not been established and has not developed "standards" as required.

SOURCE: GC § 9990.3.

ARTICLE 3
STANDARDS OF PARTICIPATION

§ 9301. Standards of Participation: Application of Act.

The provisions of this Chapter shall apply to health maintenance organizations, as defined in Subdivision (b) of § 9102, engaged in the delivery of health care services under this Chapter.

SOURCE: GC § 9990.4.

§ 9302. Same: Annual Report and Monthly Lists.

Each health maintenance organization shall be required to report annually to the Commission on the cost of operation, the use of services, the current description of the location of physicians, allied health professional and health facilities and the number of persons to whom service is rendered. Full fiscal disclosure by any and all providers of service shall be a condition of participation under this Chapter.

Each health maintenance organization shall be required to furnish complete lists monthly to the Commission or to the agency designated by the Commission of those persons eligible to receive benefits under Title XVIII or XIX of the Social Security Act. This information is to be used solely for the purpose of receiving such Federal reimbursement funds, and in no way is to be used to discriminate against the persons or the quality of health care to which they are entitled. All information obtained pursuant to this Section shall be confidential.

SOURCE: GC § 9990.5.

§ 9303. Same: Laboratory Services.

Laboratory services provided under the provisions of this Chapter are to be provided only in the laboratories which are approved by the Commission or the agency it so designates, in conformance with law.

SOURCE: GC § 9990.6.

§ 9304. Same: Certification.

Health maintenance organizations shall be certified by the Commission, and shall at least meet the conditions of participation under Federal law.

SOURCE: GC § 9990.7.

§ 9305. Same: Availability of Services.

Health maintenance organizations shall make those services readily available at reasonable times to all enrollees.

SOURCE: GC § 9990.8.

§ 9306. Same: Liability for Fees.

Health maintenance organizations shall be liable for payment at the prevailing and customary fees for reasonable services as recognized by the Commission, and in conformity with law, for all out-of-area emergency services as defined in Subdivision (n) of § 9102 rendered by another provider which are required under the scope of benefits pursuant to this Chapter. Payment pursuant to this Section shall cover such emergency treatment as may be reasonable and necessary until the enrollee can be transferred to the provider group in which he is enrolled. The provider group in which the patient is enrolled must be notified within twenty-four (24) hours of the initiation of emergency treatment or hospitalization if on Guam and within seventy-two (72) hours if off-island.

SOURCE: GC § 9990.9.

§ 9307. Same: Employment of Health Professionals.

Health maintenance organizations shall employ those health professionals who are qualified and licensed under the law to perform specific acts of medical care for which they are qualified and licensed. Health maintenance organizations shall require continuing education for all professional personnel engaged in the delivery of health care service. Such

continuing education shall be that which is recommended by the particular professional organization of which the professional is a member.

SOURCE: GC § 9990.10.

§ 9308. Same: Ratio of Physicians and Health Professionals.

The ratio of physicians and other allied health professionals to enrollees in health maintenance organizations shall be set pursuant to regulations adopted by the Commission, subject to adjustment as deemed appropriate by the Commission.

SOURCE: GC § 9990.11.

§ 9309. Same: Standards of Care.

Health maintenance organizations shall furnish services in such a manner as to provide available and continuous care, quality care and provision of services shall include ready referral of patients to such services at such times as may be medically appropriate. Such supervision and coordination shall be done in such a manner as to provide coordinated family care for enrolled families.

SOURCE: GC § 9990.12.

§ 9310. Same: Open Enrollment.

Health maintenance organizations shall hold periods of open enrollment when consumers who so desire may enroll, unless a health maintenance organization can demonstrate to the satisfaction of the Commission that it is operating at maximum enrollment capacity.

SOURCE: GC § 9990.13.

§ 9311. Same: Booklet.

Health maintenance organizations shall provide a printed booklet that is available to all consumers who demonstrate an interest. The booklet shall contain a description of the available facilities, the days and hours that medical services are available, public and emergency transportation, a listing of all health professionals employed or performing services on behalf of the organization, and any such additional information necessary to assist the consumer in making a rational, reasonable choice of providers.

SOURCE: GC § 9990.14.

§ 9312. Same: Enrollee Grievance Procedure.

Health maintenance organizations shall establish an enrollee grievance procedure which shall be in conformity with such procedures as defined and authorized by the Commission.

SOURCE: GC § 9990.15.

§ 9313. Same: Peer Review.

Health maintenance organizations shall be subject to formalized peer review as established by the Commission.

SOURCE: GC § 9990.16.

§ 9314. Same: Grounds for Disenrollment.

Health maintenance organizations shall not disenroll any enrollee against his wishes without cause as determined by the Commission, either through public hearings or by regulation. All eligible persons who become enrollees, shall remain enrolled in the health maintenance organization of their choice for a benefit period of one (1) year, with the following exceptions:

(a) An enrollee who changes his residence; or

(b) The health maintenance organization is terminated; or

(c) The enrollee declares his intent to disenroll through the grievance procedure established by the Commission; or

(d) The enrollee declares his intent to voluntarily change HMO's at a time other than the end of the benefit period, he shall pay a premium; and

(e) An enrollee if he is unwilling or unable to follow the advice of his physician.

SOURCE: GC § 9990.17.

§ 9315. Same: Enrollee Advisory Board.

Health maintenance organizations, to the extent feasible, shall organize an Advisory Board of Enrollees for the purpose of advising the health maintenance organization on matters of primary interest to the consumer.

SOURCE: GC § 9990.18.

§ 9316. Same: Emergency Services.

Health maintenance organizations shall provide all care including emergency medical services to their enrollees either directly or by

contracting for such services in such locations as are readily available to the enrollees. Such emergency services shall include, but not be limited to:

(a) Hospital intensive and coronary care in the hospital;

(b) A team consisting of physicians, nurses and other allied health professionals on duty as necessary to provide 24-hour service;

(c) Equipment, facilities for electrocardiogram, transfusion, inhalation therapy, X-ray and laboratory;

(d) Adequate doctor personnel and an enrollment not to exceed one thousand five hundred (1,500) enrollees per full-time doctor;

(e) Ambulatory care facilities of not less than one thousand (1000) square feet per one hundred (100) enrollees.

SOURCE: GC § 9990.19.

ARTICLE 4
BENEFITS

§ 9401. Benefits: Personal Health Services.

(a) The full range of personal health services is covered to include prevention, screening, annual health assessment, diagnosis and treatment of illness, both in and out of hospitals, extended care, medical rehabilitation, medically justified nursing home care and care provided in an organized home care program.

(b) A nominal charge for prescription drugs for the treatment of all illnesses.

(c) No payments shall be made for custodial or residential care. Payments may be made for medical and nursing services performed in custodial or residential living arrangements.

(d) Enrollees of any health maintenance organization may seek medical services outside their health maintenance organization, or services in addition to the scope of benefits set forth in this Chapter; provided, however, that such enrollees shall be strictly and solely liable for any such services requested and received. Such enrollee liability shall include but is

not limited to those benefits specifically excluded in this Chapter pursuant to Article 4, and such extra medical care is not reimbursable under approved prepaid plans.

(e) All charges resulting from an emergency while an enrollee is off-island shall be reimbursable to the enrollee or their closest living heir.

(f) The Commission shall establish the benefits and limits of liability to be provided by this personal health service program.

SOURCE: GC § 9990.20.

§ 9402. Same: Mandatory Benefits and Optional Services.

(a) Mandatory benefits under this Chapter applying to Prepaid Health Plans, shall include:

(1) Out-patient services which are covered as follows: physicians; hospital out-patient; optometric; acupuncture; podiatric; physical therapy; and audiology, insofar as these can be encompassed by Federal participation under an approved plan;

(2) Hospital in-patient care;

(3) Nursing home care (when available in Guam), including physician services and prescription drugs;

(4) Purchase of prescription drugs prescribed by a physician for the treatment of all medical conditions at a nominal charge;

(5) Hospital out-patient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs and equipment required for dialysis;

(6) Out-patient laboratory and out-patient x-ray services;

(7) Blood and blood derivatives;

(8) Dental services;

(9) Preventive services (physical examinations, well baby care, immunizations and injections);

(10) Basic dental services (examination, prophylaxis, x-rays, routine fillings and extractions, emergency treatment);

(11) Emergency care on and off-island (including ambulance);

(12) Durable medical equipment and medical supplies;

(13) Other diagnostic screening or preventive services.

(b) Optional Services shall include:

(1) Eyeglasses;

(2) Comprehensive dental care (dentures, crown and bridgework, root canal, etc.);

(3) Home health care;

(4) Prosthetic devices and hearing aids;

(5) Out-patient services including chiropractic, psychology, occupational therapy, speech therapy.

(c) For providers who are not Prepaid Health Plans, the benefits of Subdivision (a)(6) shall apply, but such benefits shall be subject to the following limitations:

(1) Nursing home care shall be limited to one hundred twenty (120) days per benefit period;

(2) Prescription drugs shall be excluded, except those required for long-term treatment of chronic disease;

(3) Cosmetic surgery shall be excluded unless approved by psychiatric consultation or vocational rehabilitation agency and related employment.

(d) Services to be provided by the government of Guam through the Department of Public Health and Social Services, shall include:

(1) Speech, occupational and audiology therapy;

(2) Rehabilitative services;

(3) Psychiatric care; and

(4) Long-term treatment of infectious disease.

SOURCE: GC § 9990.21.

ARTICLE 5
CONSUMER HEALTH PROTECTION PREMIUM

§ 9501. Consumer Health Protection Premium: Definitions.

(1) Employer means any individual or body of persons, corporate or unincorporated, public or private, the government of Guam or subject to the laws of Guam, making payment of wages to employees for services performed within Guam or the person having control of the payment of such wages, whether or not the person having control of the payment of such wages is subject to the jurisdiction of the laws of Guam.

(2) Wages means all remuneration (other than fees paid to a public official) for services performed by an employee for his employer, including all remuneration paid to a nonresident employee for services, performed in Guam and, the cash value of all remuneration paid in any medium other than cash; except that such term shall not include remuneration paid for services, the total value of which does not exceed Fifty Dollars ($50) per week, or for active services as a member of the Armed Forces of the United States; or for agricultural labor (as defined in §3131(g) of the Internal Revenue Code of 1954); or for domestic service in a private home; for services performed by a duly ordained, commissioned or licensed minister of the church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order; or for services performed by an individual under the age of eighteen (18) in the delivery or sale of newspaper; or in the form of group-term life insurance on the life of an employee.

(3) Employee means a resident of the territory of Guam.

(4) Payroll Period means a period for which a payment of wages is ordinarily made to the employee by his employer.

(5) Business Income in the case of an individual, means gross income minus the deductions authorized as business expenses on Form 1040 Internal Revenue Service, minus rental income; dividend income gains or losses from the sale or exchange of an individual's capital assets; royalties; alimony and separate maintenance payments; income from an interest in an estate or trust; and income from annuities, life insurance and endowment contract and pensions.

SOURCE: GC § 9990.22.

§ 9502. Same: Employee Premium.

There shall be imposed for each taxable year upon the wages paid every employee, subject to the Consumers Health Protection Act a fixed consumers health protection premium, based on one-half of reasonable cost of care as determined by the Commission for the employee, and a fixed premium based on the reasonable cost care for his dependents who are not otherwise covered by a health protection plan.

SOURCE: GC § 9990.23.

§ 9503. Same: Employer Premium.

There shall be imposed for each taxable year upon the wages paid by every employer to employees, subject to the Consumers Health Protection Act a fixed consumer health protection premium, based on one-half of the reasonable cost of care as determined by the Commission for each employee.

SOURCE: GC § 9990.24.

§ 9504. Same: Individual Premium.

There shall be imposed for each taxable year upon the business income of every individual, subject to the Consumer Health Protection Act, from which the consumer health protection premium is not deducted and withheld, a fixed consumer health protection premium based on the reasonable cost of care, to be determined by the Commission.

Individuals not employed or covered under Medicaid or Medicare, shall pay twenty-five per cent (25%) of a fixed consumer health protection premium based on the reasonable cost of care to be determined by the Commission. The government of Guam will pay the balance of seventy-five per cent (75%) of such fixed premium from appropriations for such purpose.

SOURCE: GC § 9990.25.

§ 9505. Same: Federal Legislation.

The provisions of this Chapter shall continue to be operative, and shall be merged or rearranged in accordance with any Federal legislation that provides similar or equivalent benefits, if and when such Federal legislation is enacted. Fiscal arrangements pursuant to such enacted Federal law shall be accomplished by the Commission in accordance with law.

SOURCE: GC § 9990.26.

§ 9506. Amendments.

No provision of this Chapter and no amendment to the Government Code made by this Chapter, shall affect or alter any contractual or other nonstatutory obligation of an employer to provide health services to his present and former employees and their dependents or to any such persons, or the amount of any obligation for payment (including any amount payable by an employer for insurance premiums or into a fund to provide for any such payment) toward all or any part of the cost of such services. And, such employer-employee negotiated funds as currently exist may be used to meet the obligation of premiums on behalf of the employee.

SOURCE: GC § 9990.27.

ARTICLE 6
MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN

NOTE: Article 6 was repealed by P.L. 22-130:1; however, the same subject matter is found in Article 4 of Chapter 3 of this Title.

ARTICLE 7
MATERNAL AND CHILD HEALTH SERVICES

NOTE: Article 7 was repealed by P.L. 22-130:1; however the same subject matter is found in Article 5 of Chapter 3 of this Title.

ARTICLE 8
SERVICES FOR CRIPPLED CHILDREN

NOTE: Article 8 was repealed by P.L. 22-130:1; however the same subject matter is found in Article 6 of Chapter 3 of this Title.

ARTICLE 9
HEALTH CARE PROMPT PAYMENT ACT OF 2000

NOTE: This Article was enacted in its entirety by P.L. 25-189:3. Compiler has renamed this Article the "Health Care. . . Act" to differentiate it from the other Prompt Payment Act in Title 5 GCA, which deals with payments by the Government of Guam.

§ 9901. Definitions.

For the purpose of this Chapter, the following words and phrases have the meanings assigned to them, respectively, except where the context otherwise requires:

(a) '*Claim*' means any claim, bill, or request for payment for all or any portion of healthcare services provided by a healthcare provider, or services submitted by an individual pursuant to a contract or agreement with a payer entity.a patient or Health Care Provider that is eligible for reimbursement.

(b) '*Clean Claim*' means a claim, or portion thereof, that may be processed without a reasonable request for additional information from the provider of service or from a third party, but does not include any claim under investigation for fraud or abuse or claims under review for medical necessity. In no event may a claim be contested or denied for the lack of information that has no factual impact upon the Health Plan Administrator's ability to adjudicate the claim.

(c) '*Contest*,' 'contesting' or 'contested' means the circumstances under which a payer entity was not provided with, or did not have reasonable access to, sufficient pertinent information needed to determine payment liability or basis for payment of the claims.

(d) *'Deny,' 'denying*' or '*denied'* means the assertion by a Health Plan Administrator that it has no, or partial, liability to pay a claim based upon eligibility of the patient, coverage of a service, medical necessity of a service, liability of another payer or other grounds.

(e) '*Health Plan Administrator*' means insurance companies, health plan providers, all companies defined as third party payers, including, but not limited to, health maintenance organizations, medical service organizations, governmental organizations, worker's compensation organization, or other legal entities providing or applying to provide third party payment or health insurance or payment for healthcare services that are organized and operating under the laws of Guam.

(f) *'Health Care Provider'* means any health care facility, hospital, clinic, laboratory, nursing home, home health agency, pharmacy, physician, dentist, nurse, acupuncturist, chiropractor, or any other practitioner or organized entity certified or licensed to provide health care services on Guam.

§ 9902. Prompt Payment for Health Care and Health Insurance Benefits.

(a) This Section applies to Health Plan Administrators, as defined by this Chapter, organized and operating under the laws of Guam.

(b) Health Plan Administrators shall reimburse a Clean Claim, or any portion thereof, submitted by a patient or Health Care Provider, that is eligible for payment and not contested or denied not more than 45 calendar days after receiving the Clean Claim filed in writing.

(c) If a claim is contested or denied, or requires more time for review by the Health Plan Administrator, the Health Plan Administrator shall notify the Health Care Provider in writing not more than thirty (30) calendar days after receiving a claim filed for payment. The notice shall identify the contested or denied portion of the claim and the specific reason for contesting or denying the claim, and may request additional information. Requests for information on a contested or denied claim, or portion thereof, shall be reasonable and relevant to the determination of why the claim is being contested or denied. In no event may a claim be contested or denied for the lack of information that has no factual impact upon the Health Plan Administrator's ability to adjudicate the claim.

(d) If information received pursuant to a request for additional information is satisfactory to warrant paying the Clean Claim, the Clean Claim shall be paid not more than 45 calendar days after receiving the additional information in writing.

(e) The payment of a Clean Claim under this Section shall be effective upon the date of postmark of the mailing.

(f) Health Care Providers shall be responsible for obtaining proof in writing that a specific claim was delivered to a Health Plan Administrator on a specific date for determining the time periods for the purposes of prompt payment.

(g) Notwithstanding any provisions to the contrary, interest shall be allowed to accrue at a rate of 12% per annum as damages for money owed

by a Health Plan Administrator for payment of a Clean Claim, or portion thereof, that exceeds the applicable reimbursement time limitations under this Section, including applicable costs for collecting past due payments as provided in § 9905 of this Article, as follows:

(1) for an uncontested Clean Claim:

(i) filed in writing, interest from the first calendar day after the 45-day period in § 9902(b); or

(2) for a contested claim, or portion thereof, filed in writing:

(i) for which notice was provided under § 9902(c), interest from the first calendar day forty-five (45) days after the date the additional information is received; or

(ii) for which notice was not provided, but not within the time specified under § 9902(c), interest from the first calendar day after the claim is received.

(h) Each Health Care Provider shall notify the Health Plan Administrator and patient in writing of all claims for which they intend to charge interest. Any interest that accrues as a result of the delayed payment of a Clean Claim, or any portion thereof, in accordance with the provisions of this Act shall be automatically added by the Health Plan Administrator to the amount of the unpaid Clean Claims due the Health Care Provider.

(i) Interest shall only apply to the principal portion of the claim.

(j) The provisions of this Section shall not apply to the payment or reimbursement of any claim, or portion thereof, involving a Coordination of Benefits between multiple payers of a claim.

§ 9903. Timely Filing of Accurate Claims.

(a) This Section applies to Health Care Providers, as defined by this Act, duly certified, licensed, or organized and operating under the laws of Guam.

(b) All claims submitted for reimbursement must be submitted on a UB-92, HCFA 1500, ADA claim, or other billing document generally accepted by Health Plan Administrators. Claims may be submitted electronically if such a transmittal arrangement has been agreed to by the Health Plan Administrator.

(c) Health Care Providers shall be responsible for the accuracy of all claims filed. Duplicate claims, unbundled claims, or fee-for-service claims

billed in a capitated arrangement, may not be submitted and cannot be considered for prompt payment in accordance with the provisions of this Act.

(d) Should a Health Care Provider fail to submit a response to a reasonable request for additional information on a contested or disputed claim, within 45 days from the date of request for such additional information, no interest shall accrue to the claim or portion thereof eligible for payment. For purposes of this Subsection, should a Health Care Provider be a hospital, then such a hospital provider shall be allowed to submit a response to a reasonable request for additional information on a contested or disputed claim within 90 days from the date of request for such additional information.

(e) In order for a Health Care Provider to receive interest for the late payment of a claim as provided in § 9902, a claim for health services rendered must be submitted within 45 days from the date the health service was provided.

(f) With the exception of those claims that involve the coordination of benefits, all claims for payment must be submitted by the Health Care Provider within 90 days from the date that health services were rendered. Any claim not submitted by the Health Care Provider within 90 days from the date that health services were rendered shall not be the financial responsibility of either the Health Plan Administrator or the patient.

§ 9904. Billing of Patients Allowed.

(a) No patient receiving care from a Health Care Provider, may be billed for the same Clean claim, or portion thereof, submitted for payment to a Health Plan Administrator, unless the provider has elected to terminate that person's efforts to collect interest penalties as provided for in § 9902(g) of this Act, or a period of 90 days has lapsed from the date of submission of a Clean Claim for payment. This provision shall not apply to any Clean Claim or portion of a Clean Claim that is due and payable by the patient as a benefit limitation, deductible, co-payment, non-covered benefit, patient share, or personal comfort or convenience item.

(b) A Health Care Provider may not charge more than (12%) interest per annum to any patient as a penalty for their failure to make prompt payment of a Clean Claim, or portion thereof, for which the patient is responsible for paying.

(c) A Health Care Provider may not charge both the Health Plan Administrator and the patient interest penalties for the same Clean Claim, or portion thereof, submitted for payment to either party.

§ 9905. Damages.

In any action or proceeding for violation of the requirements of this Act, the Health Plan Administrator or the Health Care Provider shall be entitled to recover all costs of litigation or arbitration,including reasonable attorneys' fees or arbitration costs, incurred in the successful prosecution of the action or proceeding.

§ 9906. Cumulative Remedies.

The provisions of this Act are not exclusive. The remedies provided herein are in addition to any other remedy or procedure provided by any other law or at common law.

§ 9907. Effective Dates.

The provisions of this Article shall not apply to any claim filed prior to the date of enactment. The Article shall take effect 60 days from the date of enactment into law, with the exception of the Government of Guam's Medically Indigent Program (*MIP*) whose effective date for implementation of the provisions of this Article shall be March 1, 2001.

NOTE: This Article was enacted on January 18, 2001, so the effective date for all but the MIP Program is March 19, 2001. The Compiler has changed the word "Act" to "Article" to conform with the codification of P.L. 25-189 in this Article.

§ 9908. Existing Contracts to Prevail.

The provisions of this Article shall not supercede any contract in force between a Health Plan Administrator and a Health Care Provider as of the effective date of the Act.
