

Detailed Summary of H.R. ____
Improving the Treatment of the U.S. Territories Under Federal Health Programs Act of 2015

Title I: Medicaid

Section 101 to Section 104: Provides More Equitable Medicaid Funding to the Territories and Avoids Upcoming Medicaid Funding Cliff

- Section 101 to Section 104 of the bill would establish new federal rules to govern the Medicaid programs in the U.S. territories and would avert the Medicaid federal funding “cliff” that each territory will automatically reach on September 30, 2019 and that at least one territory, Puerto Rico, will likely reach in 2018 or even 2017. The new rules would provide the territories with state-like treatment, but only within certain well-defined parameters related to income eligibility levels.
- Specifically, each territory’s Medicaid program could cover individuals whose family income is equal to or less than 100 percent of the federal poverty level, and receive state-like federal financing for that purpose. In the states and the District of Columbia, the applicable income eligibility level is generally 133 percent of the federal poverty level, and many states cover individuals whose family income exceeds 133 percent. Under the bill, each territory government must cover individuals earning up to 100 percent of the federal poverty level who fall within the “mandatory” population categories (such as children up to age 18 and pregnant women) and may cover individuals earning up to 100 percent of the federal poverty level who fall within the “newly eligible” population categories established by the *Affordable Care Act* (in general, non-elderly adults). As long as a territory government covers individuals whose household income is within these limits, the federal government will fund the territory’s Medicaid program as if it were a state Medicaid program. However, if a territory wants to cover individuals earning more than 100 percent of the federal poverty level, it will generally be required to use territory dollars, not federal dollars.
- “State-like” treatment means:
 - The “ceiling” or “cap” on the amount of annual funding that the federal government provides to support the Medicaid program in each territory, pursuant to Section 1108 of the Social Security Act (42 U.S.C. §1308), would be eliminated.
 - The federal government’s share of total Medicaid expenditures (FMAP) would be calculated for each territory according to the territory’s per capita income relative to U.S. per capita income, just like the FMAP is calculated for each state. Under current law, each territory’s FMAP is set by statute at 55 percent. Under the bill, and given current economic conditions in the territories, each territory’s FMAP would likely be around 80 percent. A territory, like a state, would receive an “enhanced” FMAP (at least 90 percent) if the territory elects to cover individuals in the “newly eligible” population categories established by the *Affordable Care Act*.

- The effective date of these provisions would be October 1, 2016, the first day of Fiscal Year 2017. The five territories received a total of \$7.3 billion in the *Affordable Care Act* to add to their Section 1108 Medicaid caps through Fiscal Year 2019, with Puerto Rico receiving \$6.4 billion of that amount. If any territory has not used its share of this additional Medicaid funding as of October 1, 2016, the unused funding would revert to the federal treasury and would be used to offset the cost to the federal government of the bill's new Medicaid provisions.
- The policy rationale behind the Medicaid provisions in the bill is that, as long as the territories are covering individuals whose incomes are at or below the federal poverty level, the federal government should treat the territories no different than the states in terms of financing each territory's Medicaid program. This is state-like treatment, but with an important limiting principle that will control the cost to the federal government.

Background to Medicaid Provisions (Sections 101-104)

- Medicaid, the health program for low-income individuals established in 1965, is funded in part by the federal government and in part by the state (or territory) government. In the 50 states and the District of Columbia, Medicaid is an individual entitlement. There is no limit on the amount of funding the federal government will provide so long as the state provides its share of matching funds. The federal contribution—known as an FMAP—can range from 50 percent of all Medicaid expenditures in the wealthiest states to 83 percent in the poorest states.
- By contrast, there is a “ceiling” or “cap” on the total amount of funding that the federal government annually provides to support the Medicaid program in each U.S. territory, pursuant to Section 1108 of the Social Security Act (42 U.S.C. §1308). In Fiscal Year 2008, the Section 1108 statutory caps were extraordinarily low:
 - Puerto Rico: \$260.4 million
 - USVI: \$13.0 million
 - Guam: \$12.76 million
 - CNMI: \$4.76 million
 - American Samoa: \$8.62 million
- In addition, the FMAP for each territory was set by statute at 50 percent, the same as the wealthiest states. Because of the annual statutory cap, Puerto Rico's effective FMAP—the actual federal contribution to the island's Medicaid program—was between 15 and 20 percent a year. Puerto Rico was spending upwards of \$1.4 billion in territory funds to provide health care services to about 1.2 million low-income beneficiaries, and receiving less than \$300 million from the federal government for this purpose.

- To place that in context, in FY 2014:
 - Mississippi had a 73 percent FMAP and received \$3.6 billion in federal funds.
 - Oklahoma had a 64 percent FMAP and received \$3.0 billion in federal funds.
 - Oregon had a 63 percent FMAP and received \$5.0 billion in federal funds.
- Starting in 2009, federal law was amended to substantially improve the treatment of the territories under Medicaid, but this treatment—especially in the case of Puerto Rico—remains deeply inequitable.
- The first funding increase was a result of the 2009 *American Recovery and Reinvestment Act*, which temporarily raised each territory’s annual ceiling by 30 percent. That increase lasted from the first quarter of Fiscal Year 2009 (October 1, 2008) through the third quarter of Fiscal Year 2011 (June 30, 2011).
- In 2010, Congress enacted the *Patient Protection and Affordable Care Act (ACA)*. The territories were excluded from major provisions of the bill, but were provided \$7.3 billion in additional Medicaid funding. In addition, each territory’s FMAP was modestly increased from 50 percent to 55 percent.
- Of the \$7.3 billion, each territory received the following:
 - Puerto Rico: \$6.40 billion
 - USVI: \$298.75 million
 - Guam: \$292.78 million
 - CNMI: \$109.26 million
 - American Samoa: \$197.82 million
- This funding, which is on top of the ceiling amount that each territory receives annually under Section 1108 of the Social Security Act, is available to be drawn down between the fourth quarter of Fiscal Year 2011 (July 1, 2011) and the end of Fiscal Year 2019 (September 30, 2019).
- The result is that each territory annually receives the following in federal Medicaid funds, including funding under the Children’s Health Insurance Program (CHIP) and the Enhanced Allotment Program (which applies in the territories in lieu of the Medicare Part D low-income subsidies and helps low-income seniors purchase prescription drugs):
 - Puerto Rico: \$1.1 to \$1.3 billion
 - USVI: \$75 to \$78 million
 - Guam: \$53 to \$59 million
 - CNMI: \$20 to \$21 million
 - American Samoa: \$34 to \$38 million

- However, the \$7.3 billion in additional Medicaid funding that the territories received under the ACA expires at the end of the Fiscal Year 2019—the only coverage provision in the law that sunsets in this manner. This has been called the Medicaid funding “cliff.” As of this writing, the Puerto Rico government has only \$3.57 billion of its \$6.3 billion in ACA funding remaining. It is projected that the ACA funding for Puerto Rico will be depleted by mid-2018 or even late 2017. If this pool of funding is not seamlessly replenished, each territory will go back to receiving Medicaid funds solely under Section 1108 of the Social Security Act—which, for Puerto Rico, means annual federal funding of less than \$400 million a year.
- The ACA perpetuated Puerto Rico’s discriminatory treatment under Medicaid in another respect. The states and the District of Columbia are permitted to expand eligibility for Medicaid to certain population groups (in general, non-elderly adults with incomes up to 133 percent of the federal poverty level). If a state elects to expand eligibility for Medicaid to individuals within these groups, the federal government covers 100 percent of the cost of covering this newly-eligible population from 2014 to 2016, 95 percent of the cost in 2017, 94 percent of the cost in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond. While the territories are authorized to expand eligibility for Medicaid to these new population groups, the territories are not eligible for the enhanced federal contribution to finance their care.

Section 105: Extends Medicaid DSH Payments to Hospitals in the Territories

- This section would extend the Medicaid DSH program to the territories. Since 1993, the federal Medicaid statute requires the states and the District of Columbia to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients. This provision is intended to recognize the disadvantaged financial situation of those hospitals because low-income patients are more likely to be uninsured or enrolled in Medicaid. Hospitals often do not receive payment for services rendered to uninsured patients, and payments made to providers under Medicaid are generally lower than the rates paid by Medicare and private insurance. The federal government reimburses each state for a portion of the state’s Medicaid DSH expenditures based on that state’s FMAP. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds that each state is permitted to claim for Medicaid DSH payments. In Fiscal Year 2014, federal DSH allotments totaled \$11.7 billion. While there are some federal requirements that states must follow in defining DSH hospitals and calculating DSH payments to hospitals, states tend to have significant flexibility.
- However, Medicaid DSH allotments are not provided to the five territory governments, because Section 1923(f)(9) of the Social Security Act defines “State” as the 50 states and the District of Columbia. Section 105 would correct this exclusion and provide \$150 million in annual DSH allotments for the five territories to share. Of that amount, funding would be distributed among the territories based on the number of low-income and uninsured

individuals residing in each territory as periodically estimated by the Secretary of the Department of Health and Human Services. Puerto Rico would receive about \$130 million annually. To place this in context, Mississippi receives about \$160 million annually and Florida receives about \$215 million annually.

- Section 105 is designed to be enacted alongside Sections 101-104, or alongside any other bill that provides the territories with fair FMAPs. Otherwise, Puerto Rico might not be able to make meaningful use of its Medicaid DSH payments because the local matching rate would be too high.

Title II: Medicare

Subtitle A: Medicare Part A (Inpatient Hospital Care)

- **Section 201:** This section incorporates the language of H.R. 1417, the *Puerto Rico Hospital Medicare Reimbursement Equity Act of 2015*, introduced by Rep. Pierluisi on March 18, 2015. The federal government reimburses hospitals who admit Medicare patients under the Inpatient Prospective Payment System (IPPS). Puerto Rico hospitals, like hospitals in the states and unlike hospitals in the other territories, are paid under the IPPS. The payment made to the hospital is intended to cover the operating and capital costs that a reasonably efficient hospital would incur in providing care. Each hospital is paid a base rate, which can then be adjusted upwards based on a variety of factors. Every hospital in the states, whether in New York City or rural Montana, is paid the same base rate: about \$5,870 per discharged patient. In Puerto Rico, however, hospitals are paid a base rate that is slightly over \$5,000—about 14 percent lower than the base rate for stateside hospitals. That is because, instead of receiving a base payment based on 100 percent of the national operating and capital costs associated with running a hospital, Puerto Rico hospitals receive a base payment based on 75 percent of the federal base payment amount and 25 percent of a lower Puerto Rico-specific rate. Section 201 would provide Puerto Rico hospitals with the same base rate as stateside hospitals. Hospitals in the other territories are not affected by this provision because they are not included in the IPPS.
- **Section 202:** This section incorporates the language of H.R. 1225, the *Puerto Rico Hospital HITECH Amendments Act of 2015*, introduced by Rep. Pierluisi on March 3, 2015. The HITECH Act, enacted as part of the 2009 *American Recovery and Reinvestment Act*, authorizes bonus payments under Medicare and Medicaid for doctors and hospitals that become “meaningful users” of electronic health records. Under the Medicare program, physicians and hospitals receive bonus payments if they adopt electronic health records, and are penalized if they fail to adopt electronic health records by a certain date. The HITECH Act omitted Puerto Rico hospitals from the Medicare program. This exclusion is illogical and may have been inadvertent, since the HITECH Act makes Puerto Rico physicians eligible for bonus payments under both Medicare and Medicaid, and makes Puerto Rico hospitals eligible for bonus payments under Medicaid. Section 202 would make Puerto Rico hospitals eligible for bonus payments starting in Fiscal Year 2016. Consistent with the way stateside hospitals are treated under the law, Puerto Rico hospitals that become meaningful users of electronic health records starting in either 2016, 2017 or 2018 would receive bonus

payments for four consecutive years, hospitals that become meaningful users in 2019 would receive bonus payments for three consecutive years, and hospitals that become meaningful users in 2020 would receive bonus payments for two consecutive years. Penalties for Puerto Rico hospitals that do not convert to electronic health records would begin to be assessed in 2022. Hospitals in the other territories are not affected by this provision because they are not included in the IPPS through which HITECH payments are made.

- **Section 203:** This section would ensure that Puerto Rico hospitals receive fair Medicare disproportionate share hospital (DSH) payments. This section involves *Medicare* DSH, whereas Section 105 involves *Medicaid* DSH, which is a separate and different program. Since the 1980s, the federal government—through the Medicare DSH program—has provided additional financial support directly to hospitals that treat a high percentage of the most vulnerable population groups—Medicaid beneficiaries, low-income Medicare beneficiaries, and the uninsured. Prior to the ACA, the formula that the federal government used to calculate Medicare DSH payments to hospitals consisted of several factors, including a factor called “Medicare SSI days.” This factor measured the number of times a hospital treated a patient who has Medicare Part A *and* who receives benefits under the federal Supplemental Security Income (SSI) program. This formula operated to Puerto Rico’s disadvantage because Congress has not extended the SSI program to the territory. The ACA modified the formula used to distribute Medicare DSH payments, and the new formula substantially improves the treatment of Puerto Rico hospitals. However, the new formula still uses the “Medicare SSI days” factor in two places, and thus continues to disadvantage Puerto Rico. Section 203 would provide an alternative Medicare DSH payment formula for Puerto Rico hospitals that utilizes a proxy for SSI, so that a hospital would get credit for a Medicare SSI day when the patient in question has Medicare Part A and either (1) receives benefits under SSI, (2) receives benefits under the Aid to the Aged, Blind and Disabled (AABD) program that applies in Puerto Rico in lieu of SSI, *or* (3) is a “dual eligible” enrolled in both Medicare and Medicaid. Hospitals in the other territories are not affected by this provision because they are not included in the IPPS through which Medicare DSH payments are made.

Subtitle B: Medicare Part B (Doctor Care and Outpatient Hospital Care)

- **Section 211:** This section incorporates the language of H.R. 1418 and S. 1453, the *Puerto Rico Medicare Part B Equity Act of 2015*, introduced by Rep. Pierluisi on March 18, 2015 and by Sen. Charles Schumer on May 21, 2015. Most individuals become eligible to enroll in Medicare Part A when they turn 65 years old. In every state and territory except Puerto Rico, individuals enrolled in Part A are automatically enrolled in Part B, which requires the payment of a monthly premium. Individuals can opt out of Part B if they do not want it. In Puerto Rico, individuals enrolled in Part A are not automatically enrolled in Part B, but rather must opt *in* to receive this coverage. The law requires individuals to elect Part B coverage within a seven-month initial enrollment period or pay a late enrollment penalty to the federal government. The penalty is substantial—a 10 percent increase in the monthly Part B premium for every year of delayed enrollment—and lasts as long as the individual is enrolled in Medicare. Because of the opt-in requirement and inadequate beneficiary education, there are tens of thousands of individuals in Puerto Rico who are already paying a lifetime penalty

for enrolling late in Part B. Each year, they pay millions of dollars in late fees to the federal government. There are also more than 100,000 residents of Puerto Rico enrolled in Part A but not Part B. If these individuals do eventually enroll in Part B, as most will, the seven-month window will have closed and they, too, will be required to pay a lifetime penalty. Section 211 would amend federal law so that, going forward, Medicare beneficiaries in Puerto Rico are treated like their counterparts in every other jurisdiction: that is, they will be automatically enrolled in Part B with the option to opt out of coverage. And, to ease the burden on those who already enrolled late in Part B, this section would reduce by 85 percent the monthly penalty they are required to pay. Finally, to address those beneficiaries who are enrolled in Part A but not Part B—and who will pay a late penalty if they do enroll—this section would authorize a special enrollment period during which those individuals could enroll in Part B and pay a monthly penalty that is 85 percent less than the penalty they would be subject to under current law.

- **Section 212:** This section would ensure that Puerto Rico doctors who serve traditional, fee-for-service Medicare patients are more fairly treated under the Practice Expense Geographic Practice Cost Index (GPCI) payment formula. Lack of fair treatment under the GPCI system is an important factor behind the well-documented exodus of Puerto Rico physicians to the U.S. mainland. The Medicare program compensates doctors pursuant to the Physician Fee Schedule (PFS). Three separate Relative Value Units (RVUs) are associated with the calculation of a physician payment under the PFS. The Physician Work RVU reflects the relative time and intensity associated with providing a Medicare service. The Practice Expense RVU reflects the costs of maintaining a practice (such as renting office space, buying supplies and equipment, and paying staff). The Malpractice RVU reflects the cost of malpractice insurance. GPCIs are adjustments that are applied to each of the three RVUs in order to account for geographic variations in the costs of practicing medicine in different areas within the country. Using U.S. Census Bureau data, the Centers for Medicare and Medicaid Services (CMS) has calculated for Puerto Rico the lowest Work GPCI, Practice Expense GPCI, and Malpractice GPCIs of any payment locality in the United States, including the other territories. The Practice Expense GPCI calculated for Puerto Rico is particularly problematic, and there is strong evidence to suggest that the current formula—particularly its reliance on residential rent data as a proxy for commercial rent data—unduly disadvantages Puerto Rico, and results in payments to physicians that do not adequately capture the actual cost of practicing medicine in the territory. For Calendar Year 2015, Puerto Rico’s Practice Expense GPCI is 0.705, whereas the state with the lowest Practice Expense GPCI is West Virginia at 0.836—a huge gap. Section 212 would establish a Practice GPCI floor for Puerto Rico of 0.800, similar to the 1.0 Practice Expense GPCI floor that Congress has already established for the “frontier states” of Montana, Nevada, North Dakota, South Dakota, and Wyoming; and the 1.0 Work GPCI floor that Congress has established for payment localities, including Puerto Rico, which would otherwise fall below 1.0.

Subtitle C: Medicare Part C (Medicare Advantage)

- **Section 221:** This section would ensure that Medicare Advantage (MA) plans in Puerto Rico receive more adequate per-member, per-month payments from the federal government by

establishing a floor on such payments. This provision would be a supplement to, and not a substitute for, current efforts by Rep. Pierluisi, other Members of Congress and community stakeholders to convince the Centers for Medicare and Medicaid Services (CMS) to take immediate administrative action to improve payments for MA plans in Puerto Rico. There are approximately 745,000 Medicare beneficiaries in Puerto Rico and 560,000—75 percent—are enrolled in an MA plan, the highest penetration in the United States by far. A plan’s per-member, per-month payment from the federal government is determined by comparing the plan’s “bid” to its “benchmark,” which is the maximum amount the federal government will pay for providing Medicare-covered services in the plan’s service area. Thus, the benchmark has a significant effect on payments to MA plans, because the benchmark is used in conjunction with the bid to determine those payments. Separate benchmarks are calculated for each county (or, in the case of Puerto Rico, each municipality) in the United States. The ACA changed the way in which a benchmark is calculated for a county, bringing it closer to the amount that the federal government pays on average to provide services to individuals enrolled in traditional, fee-for-service Medicare in that county (“per capita FFS spending”). Specifically, county benchmarks are set at a percentage of per capita FFS spending in each county—either 95 percent, 100 percent, 107.5 percent, or 115 percent, with higher percentages applied in counties (like those in Puerto Rico) with the lowest FFS spending. In other words, the “base benchmark amount” (per capita FFS spending) is multiplied by the applicable percentage to produce a final “blended benchmark amount” for each county. Because Puerto Rico is treated unequally in various respects under fee-for-service Medicare, there are strong and well-substantiated concerns that the ACA-established formula used to calculate per-member, per-month payments to MA plans is resulting in inadequate payments to plans in Puerto Rico. Every county (municipality) in Puerto Rico has a far lower blended benchmark amount than any county in the 50 states or the District of Columbia, which is making it difficult for these plans to continue providing high-quality and affordable services to Medicare beneficiaries in the territory. Section 221 would establish a reasonable floor on payments to MA plans in Puerto Rico by ensuring that the blended benchmark amount for any county (municipality) in Puerto Rico is no less than 80 percent of the national average of per capita FFS spending.

Subtitle D: Medicare Prescription Drug Coverage

- **Section 231:** This section would ensure that the territories can fully use, rather than forfeit to the federal government, the annual Enhanced Allotment Program (EAP) funding that the territories receive in lieu of the Medicare Part D low-income subsidy (LIS). Part D covers prescription drugs. It is voluntary, requiring a monthly premium. If a beneficiary is enrolled in traditional Medicare, the beneficiary can purchase standalone Part D coverage through a private drug plan. If the beneficiary is enrolled in a Medicare Advantage (MA) plan, the beneficiary pays a monthly Part D premium to that plan. In the 50 states and the District of Columbia, Medicare beneficiaries with annual income below 150 percent of the federal poverty level are eligible to receive a low-income subsidy from the federal government, which reduces or eliminates their monthly premium and other out-of-pocket costs associated with Part D. The subsidy is paid directly by the federal government to the beneficiary’s plan, whether it is a standalone drug plan or an MA plan. However, beneficiaries in Puerto Rico and the other territories are not eligible for the low-income subsidy. Instead, the federal

government provides each territory government with an “enhanced allotment”—known as an EAP—to supplement the territory’s annual *Medicaid* cap under Section 1108 of the Social Security Act. Under the EAP formula, the Puerto Rico government is eligible to receive about \$44 million a year, a paltry amount compared to the \$400-\$600 million that low-income seniors in the territory would receive directly if they had access to LIS. (Under EAP, the USVI receives about \$1.1 million annually; Guam about \$817,000; the CNMI about \$114,000; and American Samoa about \$270,000.) Moreover, the federal government has interpreted federal law as requiring each territory government to pay a 45 percent local match in order to draw down EAP funds, just as the territory governments must do to access all other federal Medicaid funding because they have a 55 percent FMAP. Evidently, the Puerto Rico government annually returns about half of its \$44 million in annual EAP funding to the federal government because it struggles to meet the local match, even though the funding is badly needed. Section 231 would remove the local matching requirement, which arguably was not intended to apply in the first place, and would provide the territory governments with additional flexibility in deciding how to use this limited funding in order to help low-income seniors purchase prescription drugs.

- **Section 232:** This section would place a deadline on the U.S. Department of Health and Human Services (HHS) to submit to Congress a report describing how each territory is using its EAP funding—a report that was required by the 2003 federal law that established the Part D program. HHS, to date, has not submitted this required report to Congress. The bill would require the report to be submitted by February 1, 2018. Ideally, this timeframe would enable HHS to describe how assistance was used during the period in which the territories were required to match EAP funds and the two fiscal years—2016 and 2017—under which the territories would have significantly improved access to, and flexibility in spending, these funds as a result of enactment of Section 231 of this bill. As part of this report, HHS will also be required to make recommendations to Congress about ways to improve federal assistance to help low-income seniors in each territory purchase prescription drugs, whether through increased EAP funding or inclusion in LIS.

Title III: Miscellaneous

- **Section 301:** This section would modify the health insurance tax (HIT) imposed by Section 9010 of the ACA as it applies to health insurance companies in the territories, reducing the tax by 50 percent for insurance companies in the territories and using the 50 percent that is paid by insurance companies in the territories to help the territory governments meet their local matching requirements under Medicaid and/or provide financial assistance to low-income seniors under the Enhanced Allotment Program (EAP) so these seniors can afford prescription drugs. Section 9010 of the ACA imposes an annual fee on health insurance providers, with the first fees due in 2014. Application of the Section 9010 fee to insurance companies in the territories is inappropriate, since the purpose of the fee is to help offset the cost to the federal government of the provisions in the ACA that require increased federal outlays. But the territories are treated worse than the 50 states and the District of Columbia under nearly every important provision in the law, including each of its key spending provisions. If the territories are not entitled to receive all—or even most—of the benefits of the ACA, it is unprincipled to subject insurers in the territories to the burdens of the law,

such as the Section 9010 fee, that are designed solely to offset the cost of spending provisions that apply in the states and D.C. but do not generally apply in the territories. Thus, Section 301 would cut the fee by 50 percent. (In Puerto Rico, insurers are estimated to owe \$158 million in 2015 under Section 9010; this provision would reduce that amount to \$79 million.) The 50 percent of the fee that would be collected would be made available to the respective territory governments to help them meet their local Medicaid matching rate or to supplement the EAP funding they receive from the federal government to help low-income seniors afford prescription drugs.

- **Section 302:** This section incorporates the language of H.R. 1570, the *Medicaid and CHIP Territory Transparency and Information Act*, introduced by Rep. Gus Bilirakis (R-FL) on March 24, 2015, with the five territory delegates as original cosponsors. The Centers for Medicare and Medicaid Services (CMS) maintains a website called Medicaid.gov. This website includes a drop-down menu where a visitor can obtain specific and detailed information about the Medicaid and CHIP programs in operation in each of the 50 states and the District of Columbia. For nearly a year, Rep. Pierluisi has been urging CMS to provide equivalent information about the Medicaid programs in Puerto Rico and the other territories. CMS has repeatedly pledged to do so, but has not yet fulfilled this pledge. Section 302 would mandate by law that CMS publish, and periodically update, this important information for each of the territories.
- **Section 303:** This section would require the U.S. Department of Health and Human Services (HHS) to submit a report to Congress regarding the adverse impact resulting from the exclusion of the territories from the Health Benefit Exchanges established by the ACA for the purpose of making health insurance more affordable and accessible for individuals and small businesses.