



Congressman Pedro R. Pierluisi
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Good morning.

I want to thank Roberto Pando, the chairman of the Puerto Rico Health and Insurance Conference, for inviting me to speak. I also want to thank the Puerto Rico Chamber of Commerce, the Medicaid and Medicare Advantage Products Association, the University of Miami School of Business, and *El Nuevo Día* for sponsoring this event. I see many friends and familiar faces in the audience. If I paused to thank everyone in this room who has spent his or her professional life striving to improve the health care system in Puerto Rico, we would be here for a very long time. So, with your indulgence, I will just launch right into my remarks. But please know how much I appreciate all of you and the important work that you do.

I want to briefly outline my health care agenda in Congress, flagging for you the various issues I am working on. However, before I talk about the present and the future, let me speak a little about the past. Because to understand where we are trying to go, it helps to understand where we have been.

As everyone in this room knows all too well, Puerto Rico—because it is a territory and not a state—is treated unequally under Medicaid, the health program for low-income individuals that is funded in part by the federal government and in part by the state or territory government. Likewise, Puerto Rico is treated unequally under Medicare, the health program for elderly and certain disabled individuals that is funded entirely by the federal government. Finally, Puerto Rico is treated unequally under the *Affordable Care Act*, often called Obamacare, a landmark law that was approved in 2010, which creates new health programs, modifies existing health programs like Medicaid and Medicare, and otherwise makes many changes to our nation’s health care system.

The result of this unequal treatment should not come as a surprise to anybody: too many patients in Puerto Rico receive inadequate care, too many physicians and hospitals in Puerto Rico are not fairly compensated for their services, and too much of the financial burden associated with health care delivery is borne by the Puerto Rico government, rather than shared more equitably with the federal government, thereby harming the Puerto Rico government’s fiscal condition.

Let’s start with our Medicaid program, known as *Mi Salud*, which currently covers about 1.2 million people. In the 50 states and the District of Columbia, Medicaid is an individual entitlement. That means there is no limit on the amount of funding the federal government will provide so long as the state in question provides its share of matching funds. The federal contribution—known as an FMAP—ranges from 50 percent in wealthier states to about 80 percent in poorer states. For example: in a state with a 70 percent FMAP, of every one dollar

spent on services provided to a Medicaid beneficiary, the state must pay 30 cents in order to be able to access—that is, draw down—70 cents from the federal government.

By contrast, in Puerto Rico and the four other territories, there is an annual *cap* on federal funding for each jurisdiction's Medicaid program. In 2009, Puerto Rico was subject to a federal spending cap of less than \$300 million a year. To place this in context: Oklahoma, which has roughly the same population as Puerto Rico but is far wealthier, receives about \$3.5 billion in Medicaid funding from the federal government each year.

Prior to 2010, in addition to the severely low spending cap, Puerto Rico's FMAP was set by statute at 50 percent—the same as the wealthiest states. If Puerto Rico's FMAP were calculated the same way that FMAPs are calculated for the states, it would exceed 80 percent. Before 2010, because of the application of the spending cap, Puerto Rico's *actual* FMAP—that is, the true federal contribution to the island's Medicaid program—was less than 20 percent, which can only be described as a travesty from both a moral and a policy perspective.

During my tenure as a Member of Congress, federal funding for the *Mi Salud* program has been increased dramatically. The first significant increase was a result of the 2009 *American Recovery and Reinvestment Act*, which increased Puerto Rico's federal cap by 30 percent—from about \$270 million a year to about \$350 million a year.

Then, in 2010, Congress approved the *Affordable Care Act*. After a fierce, year-long struggle on the part of myself, then-Governor Luis Fortuño and many of you in this room, the final law

provided Puerto Rico with an additional \$6.3 billion in federal funding for *Mi Salud*, available to be drawn down between the fourth quarter of fiscal year 2011 and the end of fiscal year 2019. In addition, Puerto Rico's FMAP was increased from 50 percent to 55 percent. In sum, instead of receiving about \$300 million a year from the federal government, Puerto Rico now receives \$1.2 billion to \$1.3 billion annually. This is not equal treatment by any stretch—remember that Oklahoma receives about \$3.5 billion a year—but it is certainly a remarkable improvement. This funding has been used by the Puerto Rico government to improve services, to expand the number of individuals enrolled in *Mi Salud*, and to reduce the financial burden on the Puerto Rico government, all of which are very good things indeed.

However, there is a significant Medicaid-related challenge on the horizon that the federal government and the Puerto Rico government will need to address. The challenge is this: less than \$4 billion of the additional \$6.3 billion in federal funding that Puerto Rico received under the *Affordable Care Act* remains available, and this funding must be spent by September 30, 2019. Puerto Rico is spending down this pool of funding at such a rapid rate that it may be fully expended by the middle of 2018, if not earlier. On the one hand, this shows how badly the funding is needed. On the other hand, if Congress does not appropriate additional funding to replenish the pool before it runs out, Puerto Rico's annual Medicaid allotment from the federal government will revert to about \$400 million a year, a return to the wholly-unacceptable situation that existed prior to the *Affordable Care Act*. I am working hard to educate federal officials about this impending cliff, and about the need to take timely action. I am also working with CMS and ASES to determine if there are administrative steps that can be taken to slow the

rate at which we are spending our current pool of federal funding, so that it lasts as close to September 2019 as possible.

Let me turn now to the Medicare program. There are about 745,000 Medicare beneficiaries in Puerto Rico. About 560,000 individuals—or 75 percent—are on Medicare Advantage, while about 185,000—or 25 percent—are on traditional fee-for-service Medicare. This is the highest MA penetration rate in the country by far, so MA is extremely important in Puerto Rico—a real pillar of our health care system. I will return to the subject of MA in a moment.

Beneficiaries, hospitals and physicians in Puerto Rico are treated unequally under traditional Medicare in various respects. I should note that this unequal treatment also adversely affects the “per member per month” payments that MA plans on the island receive from the federal government, because federal funding for MA plans in a jurisdiction is linked to—and dependent upon—federal funding for traditional Medicare in that jurisdiction.

I want to mention the Medicare-related inequalities that I have been working to address. Because my time is limited, I will just provide a brief summary of each issue.

Let me start with Part A, which covers inpatient hospital services.

First, this week I re-introduced legislation to make Puerto Rico hospitals eligible to receive bonus payments under Medicare Part A for becoming users of electronic health records, which can improve patient care, reduce medical errors, and lower health care costs. Puerto Rico hospitals, unlike hospitals in the states, were excluded from this program when it was established in 2009. Last year, Republicans on the House Committee on Ways and Means released a comprehensive bill that contained the Committee's priorities related to hospital reform, and my bill to rectify Puerto Rico's unequal treatment under the electronic health record program was included in that package. In the wake of that important step forward, I have now re-filed the bill in the hope that it will again be included within a broader legislative package and enacted into law. It is estimated that my bill, if approved, could result in the federal government allocating approximately \$200 million in additional payments to island hospitals over the next decade.

Second, I will soon re-introduce legislation to eliminate another disparity in federal law that harms Puerto Rico hospitals. The federal government reimburses hospitals who admit Medicare patients under a system known as the Inpatient Prospective Payment System. The payment made to the hospital is intended to cover the operating and capital costs that a reasonably efficient hospital would incur in furnishing 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 Alaska, is paid the same base rate: about \$5,870. 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. This adversely affects patient care and the financial stability of Puerto Rico hospitals. The American Hospital Association has endorsed my legislation to eliminate this unprincipled disparity.

Let me turn now to Medicare Part B, which covers doctors' services and outpatient hospital services.

First, Puerto Rico is the only U.S. jurisdiction—state or territory—where individuals who become eligible for Part A are not automatically enrolled in Part B, but rather must opt *in* to receive Part B coverage. Individuals who do not enroll in Part B during a seven-month Initial Enrollment Period, which begins several months before they turn 65 and ends several months after they turn 65, are required to pay a late enrollment penalty. The penalty is significant and lasts for as long as that individual receives Medicare.

This system has operated to Puerto Rico's detriment. There are tens of thousands of seniors on the island who enrolled late in Part B, and each year they pay millions of dollars in late penalties to the federal government. There are also over 100,000 seniors in Puerto Rico who are enrolled in Part A but not Part B. When those individuals do seek to enroll in Part B in the future, they too will be required to pay lifetime late penalties.

I am working to address this issue on both the administrative and the legislative front. I persuaded the federal government to improve the written materials they make available to island seniors, so that they are better informed about the Part B enrollment period and the financial consequences of late enrollment. In addition, I have introduced legislation that would convert Puerto Rico from the nation's only *opt-in* jurisdiction to an *opt-out* jurisdiction—just like every other U.S. state and territory. My bill would also reduce the late penalties now being paid by

Puerto Rico seniors who enrolled late and would authorize a special enrollment period during which island seniors who do not have Part B could enroll on favorable terms.

Second, another Part B problem I am working to address involves the insufficient reimbursement payments that the federal government makes to Puerto Rico physicians who treat Medicare patients. The federal government calculates reimbursement rates for doctors through the use of a geographic pricing cost index, known as the GPCI system, which is designed to measure how much it costs to practice medicine in different parts of the countries. There are three separate GPICs: Malpractice, Physician Work, and Practice Expense. In the case of all three, the GPICs calculated for Puerto Rico are the lowest of any jurisdiction in the country. For several years, I have been working with CMS and the Puerto Rico College of Physicians and Surgeons to ensure that reimbursement rates for Puerto Rico physicians more accurately reflect the actual cost of practicing medicine in Puerto Rico. I have explained to federal officials that many doctors are leaving Puerto Rico and that this exodus owes, at least in part, to the inadequate payments they receive under the Medicare program. Because of these efforts, CMS has already made an important change to Puerto Rico's Malpractice GPCI, increasing it by 17 percent. Moreover, Congress has periodically enacted legislation to boost Puerto Rico's Physician Work GPCI, which would otherwise be significantly lower. Finally, I am fighting hard to increase Puerto Rico's Practice Expense GPCI, arguing that the way CMS calculates a physician's office rent—using residential rent as a proxy—does not work for Puerto Rico, which does not have a robust residential rental market. Dr. Mario Marazzi, the executive director of the Puerto Rico Institute of Statistics, has done some terrific work in this area, proposing an alternative formula that

would work far better for Puerto Rico than the current formula used by CMS. Rest assured that I will continue to wage this battle on behalf of our doctors.

Now let me turn to Medicare Part C—that is, Medicare Advantage. As noted, about 75 percent of all Medicare beneficiaries in Puerto Rico are enrolled in a MA plan. That is why it is so critical that these plans are fairly compensated by the federal government. Through our past efforts, we have informed CMS that the existing payment formula is unfair to MA plans in Puerto Rico in numerous respects, and the agency has responded by modifying the formula for Puerto Rico in important ways. However, much more work remains to be done, and I will be meeting later this month with the head of Medicare at CMS. My goal is to ensure that MA, a pillar of health care delivery in Puerto Rico, remains strong and stable over the long run for the benefit of the seniors who rely upon it.

Finally, let me briefly mention Part D, which covers prescription drugs. In the states, Medicare beneficiaries with an 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. By contrast, beneficiaries in Puerto Rico are not eligible for the low-income subsidy. Instead, the federal government provides the Puerto Rico government with a small block grant to supplement the territory's annual Medicaid cap. In 2014, Puerto Rico was eligible to receive about \$42 million. Based on Census Bureau statistics, it can be estimated that if the low-income subsidy were extended to Puerto Rico, as I have introduced legislation to do, about

60 percent of Puerto Rico's 745,000 Medicare beneficiaries could be eligible for federal assistance to help them afford prescription drugs. An estimate of the total amount of federal assistance that would flow to Puerto Rico as a result of the low-income subsidy is \$650 million a year, which is about 15 times the amount of federal funding that Puerto Rico is eligible to receive under the current block grant. I am not prone to hyperbole, but this disparity is clearly immoral, and leaves too many island seniors having to choose between filling their prescriptions and purchasing other basic necessities.

I will end here. Thank you for listening to me. And, again, thank you for all that you do for Puerto Rico.