Congressional Research Service
Informing the legislative debate since 1914

Puerto Rico and Health Care Finance: Frequently Asked Questions

Annie L. Mach, Coordinator
Analyst in Health Care Financing

November 18, 2015

Congressional Research Service
7-5700
www.crs.gov
R44275

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

Puerto Rico's financial circumstances, including uncertainty about its ability to service its large public debt, have drawn attention in recent months. As Congress examines Puerto Rico's finances, questions have arisen about how federal health care programs (Medicare, Medicaid, and the State Children's Health Insurance Program [CHIP]) and private health insurance requirements apply to Puerto Rico. Is Puerto Rico treated like a state, or is it treated differently?

This report provides answers to frequently asked questions (FAQs) about Puerto Rico's health care system. The FAQs are divided into the following sections:

- Demographic and Economic Overview
- Medicare
    - Part A
    - Part B
    - Part C, Medicare Advantage
    - Part D
- Medicaid
- CHIP
- Private Health Insurance

The FAQs illustrate that in some circumstances, health programs in Puerto Rico differ from programs in the 50 states and the District of Columbia (DC) in ways that are advantageous to Puerto Rico. In other cases, different treatment results in less generous assistance for Puerto Rico. In still other circumstances, Puerto Rico is treated the same as the states but is still at a financial disadvantage because of different economic circumstances. As such, these FAQs should be viewed as a discussion of the complexity of health care financing as it relates to Puerto Rico under current law.

This report does not provide a comprehensive overview of how federal health care programs and requirements apply in Puerto Rico. Instead, the report answers questions about health care financing that have arisen in light of Puerto Rico's financial circumstances. This report will be updated as additional relevant questions and answers arise.

Contents

Demographic and Economic Overview 1
What Is the Population of Puerto Rico? 2
What Explains the Recent Decline in Puerto Rico's Population? 2
What Is the Size of Puerto Rico's Economy? 3
What Is the State of Puerto Rico's Economy? 3
What Is the Median Household Income in Puerto Rico? 4
How Does Household Income in Puerto Rico Compare to Household Income in the 50 States and DC? 5
What Is the Poverty Rate in Puerto Rico? 6
How Does the Poverty Rate in Puerto Rico Compare to the Poverty Rate in the 50 States and DC? 6
How Many People Are Employed and Unemployed in Puerto Rico? 7
Medicare 8
Medicare Part A 8
How Do Medicare Part A Provider Payment Methods Differ Between Puerto Rico and the 50 States and DC? 9
How Does Medicare Part A Acute-Care Hospital Inpatient Reimbursement Differ Between Puerto Rico and the 50 States and DC? 9
Are Hospitals in Puerto Rico Eligible for Medicare Disproportionate Share Hospital Payments? 10
Medicare Part B 11
How Does the Medicare Part B Enrollment Process in the 50 States and DC Compare with the Process in Puerto Rico? 12
Are Medicare Physician Payments Different in Puerto Rico Than in the 50 States and DC? 13
Part C, Medicare Advantage 13
How Many Medicare Beneficiaries in Puerto Rico Are Enrolled in MA? How Does This Compare to MA Enrollment in the 50 States and DC? 14
How Are Private Plans Paid Under MA? 14
In General, How Has the Payment/Benchmark Methodology Changed Over Time? 14
How Do the Changes in Medicare Advantage Payment/Benchmark Methodology Differ Between Puerto Rico and the 50 States and DC? 16
Medicare Part D 17
Do the 50 States and DC Help Finance Medicare Part D? 18
In General, How Do the Part D Low-Income Subsidies Work? 18
What Proportion of Part D Program Spending is Used for Low-Income Subsidies? 19
Are Beneficiaries in Puerto Rico Eligible for Low-Income Subsidies? 19
Medicaid 19
Does Puerto Rico Have a Medicaid Program? 20
Are the Federal Medicaid Rules for the Territories Different Than for the 50 States and DC? 20
Who Is Eligible for Medicaid in Puerto Rico? 21
Does Puerto Rico's Medicaid Coverage Include All the Mandatory Medicaid Benefits? 23

What Service-Delivery Model Does Puerto Rico Use for Its Medicaid Program? 23
What Federal Medicaid Matching Rate Does Puerto Rico Receive? 24
How Much Federal Medicaid Funding Does Puerto Rico Receive? 24
Did the ACA Provide Additional Medicaid Funding for Puerto Rico? 26
Does Puerto Rico Receive Medicaid Funding in Lieu of Medicare Part D Low-Income Subsidies? 26
State Children's Health Insurance Program 27
Does Puerto Rico Provide CHIP Coverage? 27
How Much Federal CHIP Funding Does Puerto Rico Receive? 27
Private Health Insurance 28
How Many Individuals Have Private Health Insurance in Puerto Rico? 28
Do Private Plans Offered in Puerto Rico Have to Comply with ACA Market Reforms? 28
Does Puerto Rico Have an ACA Health Insurance Exchange? 31
Are the ACA's Premium Tax Credits and Cost-Sharing Subsidies Available in Puerto Rico? 31
Are the ACA's Small Business Tax Credits Available in Puerto Rico? 31
Does the ACA Employer Mandate Apply to Businesses in Puerto Rico? 32
Does the ACA Individual Mandate Apply in Puerto Rico? 32

Figures

Figure 1. Annual Population Estimates for Puerto Rico, 2010-2014 2
Figure 2. Annual GDP Growth (%) for Puerto Rico, 1993-2013 4
Figure 3. Distribution of Household Income for Puerto Rico, 2014 5
Figure 4. Employed and Unemployed Workers, Puerto Rico 7
Figure 5. Unemployment Rate, Puerto Rico 8
Figure 6. Medicare Disproportionate Patient Percentage (DPP) 10
Figure 7. Medicaid Income Eligibility as a Percentage of FPL in Puerto Rico Versus Federal Mandatory Levels for the States and the District of Columbia 22
Figure 8. Puerto Rico's Federal Medicaid Funding, FY2014 25

Tables

Table 1. Major Differences in the Federal Rules for Medicaid in States and the District of Columbia Versus the Territories 20
Table 2. Sections of the Public Health Service (PHS) Act as Added by the Patient Protection and Affordable Care Act (ACA) 29

Contacts

Author Contact Information 33
Key Policy Staff 33

Puerto Rico's financial circumstances, including uncertainty about its ability to service its large public debt, have drawn attention in recent months.[1] As Congress examines Puerto Rico's finances, questions have arisen about how federal health care programs (Medicare, Medicaid, and the State Children's Health Insurance Program [CHIP]) and private health insurance reforms apply to Puerto Rico. Is Puerto Rico treated like a state, or is it treated differently?[2]

This report provides answers to frequently asked questions (FAQs) about how federal health care programs and requirements are implemented in Puerto Rico, including eligibility, coverage, program requirements, and payment rules. In some circumstances, health programs in Puerto Rico differ from programs in the 50 states and the District of Columbia (DC) in ways that are advantageous to Puerto Rico. For example, in some instances Puerto Rico's programs have a more generous payment formula or more flexibility in administration. In other cases, different treatment results in less generous assistance for Puerto Rico. In still other circumstances, Puerto Rico is treated the same as the states but is still at a financial disadvantage because of different economic circumstances. As such, these questions and answers should be viewed as a discussion of the complexity of health care financing as it relates to Puerto Rico under current law.

This FAQ begins with a brief background on the demographics and economics of Puerto Rico. It then examines Puerto Rico's treatment under Medicare, Medicaid, and CHIP and concludes with a look at how federal requirements for private health insurance apply to Puerto Rico. This report will be updated as additional relevant questions and answers arise.

U.S. Territories

In this report, references to *U.S. territories* (or *territories*) include, in addition to Puerto Rico, American Samoa, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands. Although Puerto Rico is the focus of this report, in some cases general information about U.S. territories is provided for context. For more detailed information about a specific territory other than Puerto Rico, please contact one of the analysts listed in the Key Policy Staff table at the end of the report.

Demographic and Economic Overview

This section addresses questions about Puerto Rico's population and key economic features. These questions provide context for the federal health care program rules applied to Puerto Rico and their implications. Data used to answer these questions are drawn from several sources, and methodological differences should be borne in mind when interpreting the information. Although in many cases 2014 is the most recent data year for which data are available, some statistics represent outcomes in 2013 (e.g., national economic data) and 2015 (e.g., labor force data).

[1] For more background information on Puerto Rico and, in particular, the fiscal issues, see CRS Report R44095, *Puerto Rico's Current Fiscal Challenges*, by D. Andrew Austin, and CRS In Focus IF10241, *Puerto Rico: Political Status and Background*, by R. Sam Garrett.

[2] This paper focuses on health care finance and the extent to which Puerto Rico is treated the same or differently relative to the 50 states and the District of Columbia (DC). Other Congressional Research Service (CRS) analyses examine various aspects of Puerto Rico's general financial circumstances and possible policy options for Congress. For example, see CRS Legal Sidebar WSLG1289, *Fiscal Distress in Puerto Rico: Two Legislative Approaches*, by Carol A. Pettit.

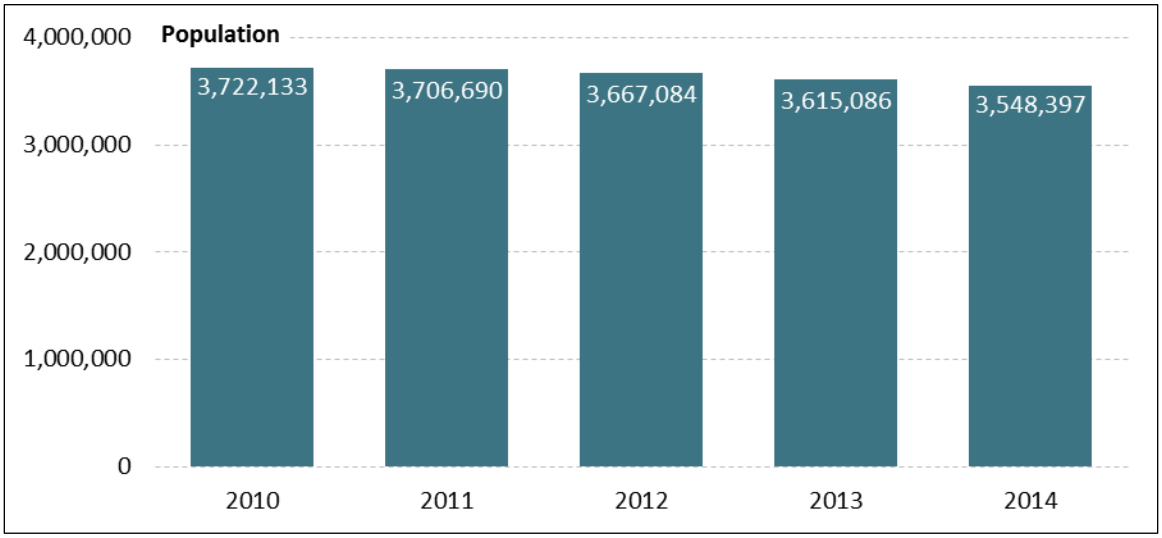
What Is the Population of Puerto Rico?

According to the U.S. Census Bureau, Puerto Rico's resident population was approximately 3.55 million in 2014.[3] Puerto Rico's population was slightly smaller than that of Connecticut (3.60 million) and Oklahoma (3.88 million) but slightly larger than that of Iowa (3.11 million) and Mississippi (2.99 million).

What Explains the Recent Decline in Puerto Rico's Population?

Figure 1 presents annual population estimates for 2010-2014 and shows a steady decline over this period. Jaison R. Abel and Richard Dietz of the New York Federal Reserve Bank examine potential driving factors and consequences of the recent drop in population in Puerto Rico.[4] Their analysis identifies a declining birth rate and a rising death rate, both of which put downward pressure on population growth. Out-migration, however, appears to be the primary driving factor for the recent population decline. Abel and Dietz estimate that the *natural population increase*—the difference between the birth rate and the death rate—contributed 0.3 percentage points to population growth in 2013, while net migration accounted for -1.3 percentage points (by their estimate, the annual population growth rate was -1% in 2013). The study finds that out-migrants are disproportionately young and less educated when compared to the overall population.[5] The demographic makeup of persons leaving Puerto Rico has contributed to an aging population but has not reduced the share of the population that is college-educated.

Figure 1. Annual Population Estimates for Puerto Rico, 2010-2014



Source: U.S. Census Bureau, Puerto Rico Community Survey, 2014, One-Year Estimates, Table CP05 "Comparative Demographic Estimates," at https://www.census.gov/programs-surveys/acs/.

[3] U.S. Census Bureau, Puerto Rico Community Survey and American Community Survey, 2014, One-Year Estimates, at https://www.census.gov/programs-surveys/acs/.

[4] Jaison R. Abel and Richard Dietz, "The Causes and Consequences of Puerto Rico's Declining Population," Federal Reserve Bank of New York, *Current Issues in Economics and Finance*, vol. 20, no. 4 (2014), at http://www.newyorkfed.org/research/current_issues/ci20-4.html.

[5] Relative to the overall population, greater shares of out-migrants were in the 16-30 year age group and were high school graduates with no higher education.

What Is the Size of Puerto Rico's Economy?

Puerto Rico's gross domestic product (GDP) was $103.1 billion in 2013; in the same year, its gross national product (GNP)—which measures income earned by *residents*—was $70.7 billion.[6] The difference between GDP and GNP indicates that a sizeable portion of Puerto Rico's GDP accrued to nonresidents and reflects the large presence of U.S. multinational firms operating in Puerto Rico. Manufacturing accounted for 46.5% of GDP in 2013, followed by finance, insurance, and real estate (20.4%) and by services (12.6%).[7]

What Is the State of Puerto Rico's Economy?

Puerto Rico has been in an economic downturn since 2006.

Figure 2 plots the percentage change in GDP from 1993 to 2013 and shows negative growth over the 2006-2013 period. Close linkages with the U.S. economy—which experienced its own recession from 2007 to 2009—and the 2006 expiration of certain tax benefits for U.S. businesses operating in Puerto Rico are thought to have contributed significantly to recent economic trends.[8] Weak economic performance and other factors also have led to serious fiscal challenges in Puerto Rico, and the territory is deeply in debt.[9] According to a New York Federal Reserve Bank analysis, Puerto Rico's outstanding public debt was $72.8 billion in March 2014, a figure similar to its GNP in 2013.[10]

[6] Government Development Bank of Puerto Rico, Economic Analysis Division, "Puerto Rico Economic Fact Sheet," December 2014, at http://www.gdb-pur.com/economy/fact-sheet.html.

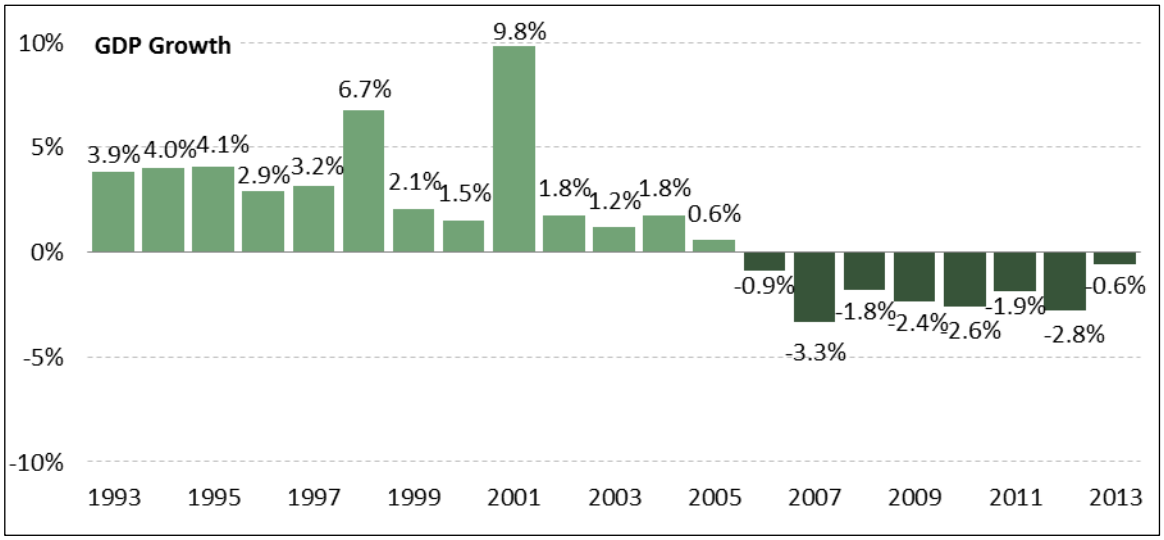
[7] The remaining share of gross domestic product (GDP) comprised government (8%), trade (7.7%), transportation and other public utilities (2.6%), construction and mining (1.3%), and agriculture (0.7%). Ibid.

[8] Federal Reserve Bank of New York, *Report on the Competitiveness of Puerto Rico's Economy*, 2012, at http://newyorkfed.org/regional/puertorico/.

[9] For a discussion of Puerto Rico's fiscal challenges, see CRS Report R44095, *Puerto Rico's Current Fiscal Challenges*, by D. Andrew Austin.

[10] Federal Reserve Bank of New York, *An Update on the Competitiveness of Puerto Rico's Economy*, 2014, p. 16, at http://newyorkfed.org/outreach-and-education/puerto-rico/2014/report-main.html. Debt estimates reported by the New York Federal Reserve Bank differ substantially from those published by the Government Development Bank of Puerto Rico, which reported debt levels of nearly $65 billion for June 2013 and $67.3 billion (preliminary numbers) for June 2014. CRS was not able to determine the source of the discrepancy. Government Development Bank of Puerto Rico, *Statistical Appendix of the Economic Report for the Governor and Legislative Assembly*, Table 29: Gross Public Debt of Puerto Rico, at http://www.gdb-pur.com/economy/statistical-appendix.html.

Figure 2. Annual GDP Growth (%) for Puerto Rico, 1993-2013



Source: World Bank, World Development Indicators Database, at http://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG/countries/PR.

Notes: GDP = gross domestic product. Gross national product (GNP) growth has not been uniformly negative over 2006-2013. The Federal Reserve Bank of New York reports that GNP grew by 0.9% in fiscal year (FY) 2012 and by 0.3% in FY2013. See Federal Reserve Bank of New York, *An Update on the Competitiveness of Puerto Rico's Economy*, 2014, p. 3, at http://newyorkfed.org/outreach-and-education/puerto-rico/2014/report-main.html.

What Is the Median Household Income in Puerto Rico?

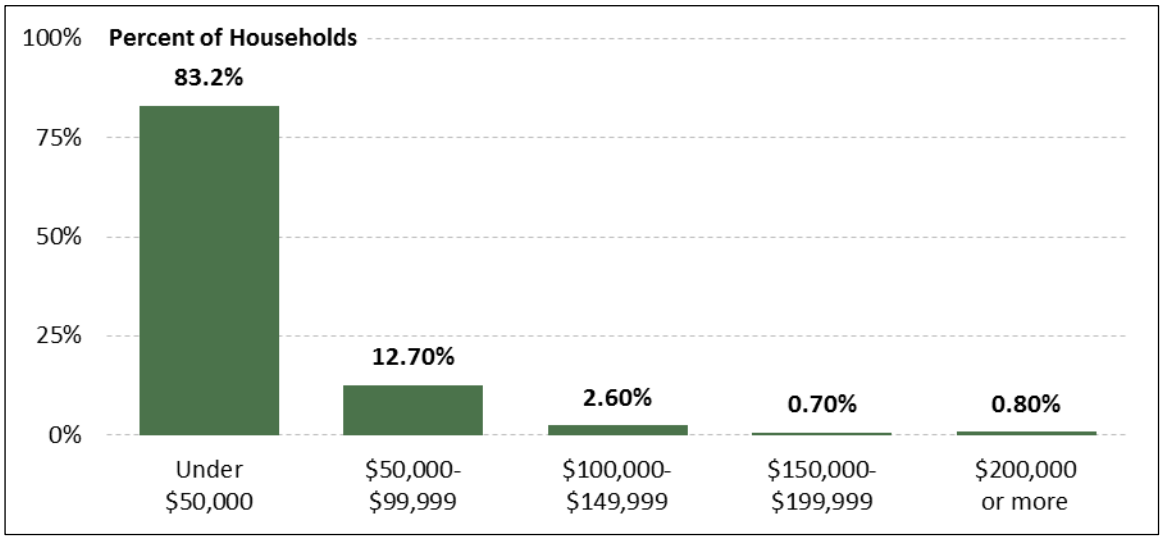
Median household income in Puerto Rico was $18,928 in 2014. **Figure 3** provides a snapshot of the household-income distribution in that year and shows that a sizable majority of households in Puerto Rico reported incomes under $50,000. Relatively few households (0.8%) reported incomes over $200,000.

A potentially sizeable informal economy in Puerto Rico is an important consideration when interpreting household-income statistics.[11] If households underreport income from informal-sector work, particularly when responding to a government-sponsored survey (such as those conducted

[11] Although there is no commonly agreed-upon definition of the informal economy, the term generally refers to unregulated economic activity. For example, persons in unregistered self-employment activities (e.g., a street salesperson), certain transactions by persons otherwise engaged in formal-sector work (e.g., unreported cash payments made to a licensed physician), or illegal economic transactions (e.g., the sale of illegal drugs) all would be considered part of the informal economy under most definitions. Given the inherent difficulties in measuring these activities, particularly illicit activities, estimates of the size of the informal economy in Puerto Rico are scarce. Nonetheless, the existence of an informal economy and its significance to the island are recognized by the public, policymakers, and scholars. See, for example, Luciana Lopez, "Desperate for taxes, Puerto Rico tries to get grip on underground economy," *Reuters*, April 9, 2014, at http://www.reuters.com/article/2014/04/09/us-usa-puertorico-economy-insight-idUSBREA380BS20140409. María Enchautegui remarks that prevalent informal economic activity in Puerto Rico "was part of the motivation for establishing a sales tax in 2006." María Enchautegui, *A Work Tax Credit that Supports Puerto Rico's Working Families*, Urban Institute, December 12, 2014, at http://www.urban.org/research/publication/work-tax-credit-supports-puerto-ricos-working-families/view/full_report. For an overview of the informal economy and its measurement, see Dan Andrews, Aida Caldera Sanchez, and Asa Johansson, *Towards a Better Understanding of the Informal Economy*, Organization for Economic Cooperation and Development, Economics Department working papers No. 873, Paris, May 30, 2011, at http://www.oecd.org/eco/workingpapers.

by the U.S. Census Bureau), income statistics may not fully capture income from all market sources.

Figure 3. Distribution of Household Income for Puerto Rico, 2014



Source: U.S. Census Bureau, Puerto Rico Community Survey, 2014, One-Year Estimates, at https://www.census.gov/programs-surveys/acs/.

Notes: Household income is the sum of household members' pretax cash income from several sources in the previous 12 months. It excludes in-kind public assistance and capital-gains income. For more information, see U.S. Census Bureau, *American Community Survey and Puerto Rico Community Survey 2014 Subject Definitions*, at http://www2.census.gov/programs-surveys/acs/methodology/design_and_methodology/acs_design_methodology_ch06_2014.pdf.

How Does Household Income in Puerto Rico Compare to Household Income in the 50 States and DC?

In 2014, median household income in Puerto Rico ($18,928) was lower than median household income in any U.S. state. Among the 50 states and DC, Mississippi had the lowest median household income at $39,680 in 2014.[12]

Information on local prices is needed to assess the extent to which income differences between Puerto Rico and the states and DC reflect true differences in purchasing power. Put simply, if prices are lower in Puerto Rico than in the states, then $1 in Puerto Rico has greater purchasing power (i.e., can buy more goods and services) than the same $1 in the states. The U.S. Bureau of Economic Analysis (BEA) measures spatial price differences within the United States, and its estimates reveal considerable price variation across the 50 states and DC.[13] For example, in 2013, average price levels for consumption goods and services in DC were 7.7% higher than the national price average, whereas prices in Mississippi were 13.2% below the national price average. Puerto Rico was not included in the BEA analysis. It was, however, included in

[12] U.S. Census Bureau, American Community Survey and Puerto Rico Community Survey, 2014, One-Year Estimates, "S.1901: Income in the Past 12-months," at https://www.census.gov/programs-surveys/acs/.

[13] See Commerce Department, Bureau of Economic Analysis, Regional Data: Regional Price Parities (All Items), published July 1, 2015, at http://www.bea.gov.

exploratory research on state prices conducted by BEA in 2007, which suggested that Puerto Rico ranked last (i.e., had the lowest prices) among all states.[14]

What Is the Poverty Rate in Puerto Rico?

In 2014, 46.2% of the population in Puerto Rico had family income below the federal poverty threshold, representing approximately 1.62 million people.[15] Children (under the age of 18) had a higher poverty rate (58.4%) than persons aged 18 to 64 (43.5%) or persons aged 65 and older (40.4%).

A potentially large informal economy has implications for poverty statistics in Puerto Rico.[16] If individuals omit informal-sector earnings when reporting their incomes in official surveys, family income may be undercounted, which may result in an overestimate of families with incomes below the official poverty threshold. That is, some families identified as being in poverty may have incomes that are *above* the federal poverty threshold when income from both formal- and informal-sector work is considered.

How Does the Poverty Rate in Puerto Rico Compare to the Poverty Rate in the 50 States and DC?

In 2014, the poverty rate in Puerto Rico (46.2%) was higher than the U.S. national rate and higher than the poverty rate in any U.S. state.[17] State poverty rates ranged from 9.2% (New Hampshire) to 21.5% (Mississippi) in that year.

Relative price differences between Puerto Rico and the 50 states and DC are an important consideration when making poverty-rate comparisons. Poverty status is determined by comparing family income to a dollar threshold that varies only by family size and composition; federal poverty thresholds are not adjusted for local prices.[18] For example, the federal poverty threshold

---

[14] It should be stressed that although this study was conducted by a U.S. Bureau of Economic Analysis (BEA) analyst, it does not represent official BEA statistics or positions. Bettina H. Aten, *Estimates of State Price Levels for Consumption Goods and Services: A First Brush*, Commerce Department, BEA, November 2, 2007, at http://www.bea.gov/papers/pdf/estimates_of_state_price_levels_oct2007.pdf.

[15] Poverty status is not determined for a small segment of the population (approximately 1%). Excluded from poverty statistics are individuals living in institutions, military group quarters, and college dormitories, and unrelated individuals under 15 years of age. For more information on how poverty status is estimated in the American Community Survey and the Puerto Rico Community Survey, see U.S. Census Bureau, *American Community Survey and Puerto Rico Community Survey 2014 Subject Definitions*, at https://www.census.gov/programs-surveys/acs/. Poverty statistics for 2014 are from Census Bureau, American Community Survey and Puerto Rico Community Survey, 2014, One-Year Estimates, "S.1701: Poverty Status in the Past 12-months," at https://www.census.gov/programs-surveys/acs/.

[16] See footnote 11 for information on the informal economy.

[17] The official U.S. poverty rate for 2014 (14.8%) is derived from income and household-composition data collected by the Census Bureau through the Current Population Survey, Annual Social and Economic Supplements (CPS-ASEC). The CPS-ASEC does not collect data from households in Puerto Rico; consequently, there is no poverty rate statistic for Puerto Rico that is directly comparable to the official U.S. rate. However, conceptually similar poverty-rate estimates are available for Puerto Rico, the U.S. states, and the United States (as a whole) based on data collected by the Census Bureau through the Puerto Rico Community Survey and the American Community Survey; these statistics are reported in the text of this report. Estimates based on American Community Survey data reveal that 15.5% of individuals in the United States have incomes below the federal poverty threshold.

[18] According to a Government Accountability Office (GAO) report, Puerto Rico uses a local poverty measure to determine income eligibility for Medicaid. GAO, *Puerto Rico: Information on How Statehood Would Potentially Affect Selected Federal Programs and Revenue Sources*, GAO-14-31, March 2014, p. 74, at http://www.gao.gov/assets/670/ (continued...)

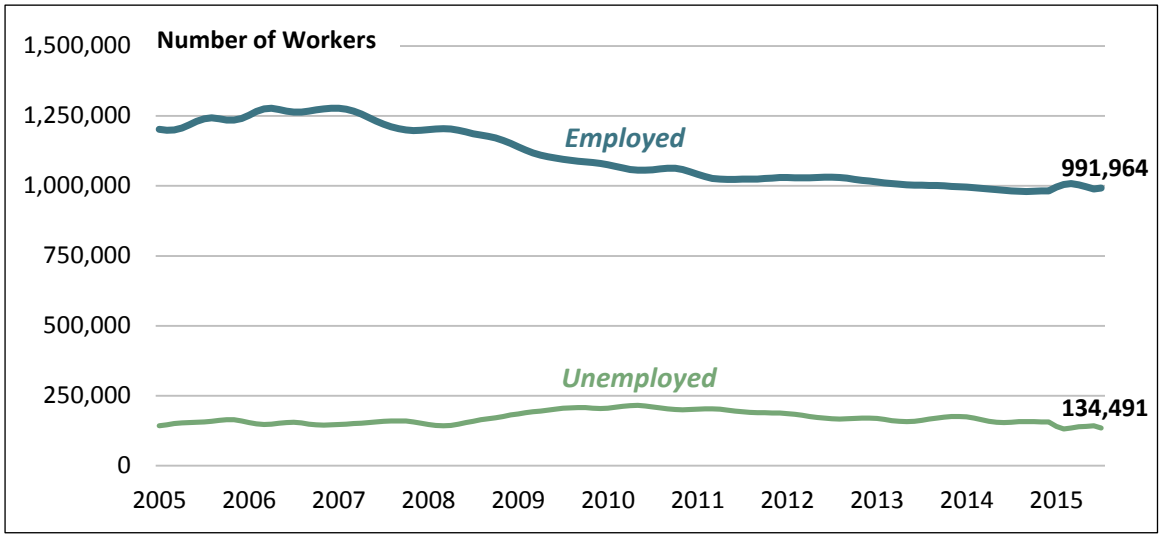
for a two-adult, two-child family in 2014 was $24,008.[19] This means that a two-adult, two-child family with an annual family income of $24,000 in 2014 would be considered to be living in poverty in both Puerto Rico and the states. However, if prices are lower in Puerto Rico than in the states, then a family with this income living in Puerto Rico would have greater purchasing power (i.e., could buy more goods and services) than the same family living in the states.

How Many People Are Employed and Unemployed in Puerto Rico?

The Bureau of Labor Statistics estimates that nearly 1 million individuals were employed and just over 130,000 individuals were unemployed in Puerto Rico in July 2015.[20] **Figure 4** plots the number of employed and unemployed workers from January 2005 to July 2015 and shows that employment fell by more than 200,000 workers over this period.

Figure 4. Employed and Unemployed Workers, Puerto Rico

(January 2005-July 2015)



Source: Bureau of Labor Statistics, "Local Area Unemployment Statistics Program," at http://www.bls.gov/lau.

The unemployment rate was 11.9% in July 2015. Although this figure was considerably higher than the U.S. national unemployment rate in that month, it was significantly below recent unemployment-rate peaks in Puerto Rico of 16.5% in March-April 2011 and 16.9% in April-May 2010 (**Figure 5**).

The potentially large informal sector in Puerto Rico has implications for official employment statistics if households report only formal sector-employment when surveyed.[21] In 2004, María Enchautegui and Richard Freeman undertook a small-sample pilot study of informal-sector

(...continued)

661334.pdf.

[19] U.S. Census Bureau, "Poverty Thresholds for 2014 by Size of Family and Number of Related Children Under 18 Years," at https://www.census.gov/hhes/www/poverty/data/threshld/.

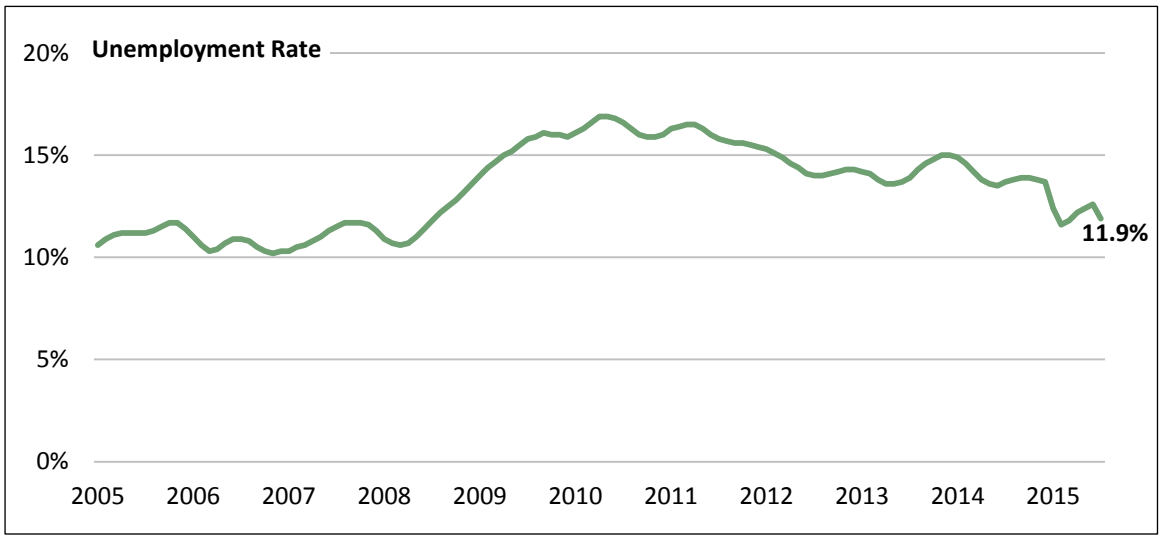
[20] Bureau of Labor Statistics, "Local Area Unemployment Statistics Program," at http://www.bls.gov/lau/. Employment and unemployment is measured for persons aged 16 and older in the civilian, noninstitutionalized population.

[21] See footnote 11 for information on the informal economy.

employment in an effort to better understand men's low labor force participation in Puerto Rico.[22] The results of their exploratory study suggest that "a better counting of informal workers would increase the employment rate for men aged 18-64 [who are] not attending school."

Figure 5. Unemployment Rate, Puerto Rico

(January 2005-July 2015)



Source: Bureau of Labor Statistics, "Local Area Unemployment Statistics Program," at http://www.bls.gov/lau/.

Medicare

Medicare is a federal program that pays for covered health care services of qualified beneficiaries. It was established in 1965 under Title XVIII of the Social Security Act (SSA) to provide health insurance to individuals aged 65 and older, and it has been expanded over the years to include permanently disabled individuals under the age of 65. Today, Medicare consists of four distinct parts: Part A (Hospital Insurance), Part B (Supplementary Medical Insurance), Part C (Medicare Advantage), and Part D (outpatient prescription drug coverage). In FY2014, the Medicare program provided health care benefits to nearly 54 million seniors and certain individuals with disabilities at a cost of roughly $606 billion to the federal government.[23]

Medicare Part A

Most persons aged 65 or older in the United States (including Puerto Rico and other U.S. territories) are automatically entitled to premium-free Part A because they or their spouse paid Medicare payroll taxes for at least 40 quarters (10 years) on earnings covered by either the Social Security or the Railroad Retirement system. Persons in the United States (including Puerto Rico and other U.S. territories) under the age of 65 who receive cash disability benefits from Social Security or the Railroad Retirement system for at least 24 months also are entitled to Part A.

[22] María Enchautegui and Richard B. Freeman, *Why Don't More Puerto Rican Men Work? The Rich Uncle (Sam) Hypothesis*, National Bureau of Economic Analysis, Working Paper 11751, November 2005, p. 31, at http://www.nber.org/papers/w11751.

[23] Congressional Budget Office, *Congressional Budget Office's March 2015 Medicare Baseline*¸ March 9, 2015.

(Because there is a five-month waiting period for cash payments, the Medicare waiting period is effectively 29 months.) The 24-month waiting period is waived for persons with amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease). Additionally, individuals in the United States (including Puerto Rico and other U.S. territories) under the age of 65 with end-stage renal disease (ESRD) who receive dialysis on a regular basis or a kidney transplant generally are eligible for Medicare. Medicare Part A provides coverage for inpatient hospital, skilled nursing facility (SNF), home health, and hospice benefits.

How Do Medicare Part A Provider Payment Methods Differ Between Puerto Rico and the 50 States and DC?

Under Part A, Congress requires specific Medicare payment methods to reimburse providers for covered benefits. For example, unique prospective payment systems (PPSs)—reimbursement methods that use predetermined rates that are often based on a patient's diagnosis and expected health care needs—provide reimbursement for SNF care, home health care, and hospice care. Unless otherwise excluded by statute, providers of inpatient hospital services are also reimbursed under different PPSs: inpatient prospective payment system (IPPS), long-term care hospital (LTCH) PPS, inpatient rehabilitation facility (IRF) PPS, and inpatient psychiatric facility (IPF) PPS. With the exception of Medicare reimbursement for inpatient hospital care in an acute-care hospital, Medicare payment methods for Part A providers (e.g., SNFs, IPFs) in Puerto Rico are not different than Medicare payment methods to Part A providers in the 50 states and DC.

How Does Medicare Part A Acute-Care Hospital Inpatient Reimbursement Differ Between Puerto Rico and the 50 States and DC?

For inpatient hospital care in an acute-care hospital, hospitals in Puerto Rico are reimbursed under a modified IPPS. Puerto Rico's IPPS and the IPPS for hospitals in the 50 states and DC differ in the *operating base rate*—the dollar value that captures the labor and supply costs of hospitals within the IPPS formula—and the *capital base rate*—a dollar value that captures the depreciation, interest, and property-related costs of hospitals within the IPPS formula. Puerto Rico's IPPS base rates are constructed from 75% of the national average costs of hospitals in the 50 states and DC and 25% of the average costs of hospitals in Puerto Rico.[24] Most IPPS hospitals in the 50 states and DC receive base rates that are 100% of the national average costs of hospitals in the states and DC, unless a hospital qualifies for a special base rate, such as a sole community hospital or a Medicare-dependent hospital.

While IPPS hospitals in Puerto Rico receive a modified base rate, such hospitals are eligible for IPPS add-on payments that hospitals in the 50 states and DC also receive, such as disproportionate share (DSH) payments and graduate medical education payments. However, certain special adjustments are not available to Puerto Rican hospitals, such as special base rates for sole community hospitals or Medicare-dependent hospitals. Puerto Rican hospitals also are not eligible for a low-volume adjustment that can be available to other IPPS hospitals that meet certain requirements. Additionally, some quality-related programs specific to IPPS hospitals do

[24] For FY016, the operating base rate constructed from the average costs of hospitals in the 50 states and DC (for a hospital that is a meaningful user of electronic health records) is $5,271. The operating base rate constructed from the average costs of Puerto Rican hospitals is $2,609. Therefore, the blended inpatient prospective payment system (IPPS) operating base rate for Puerto Rican hospitals is $4,606. Similarly, for FY016, the capital base rate constructed from the average costs of hospitals in the 50 states and DC is $439. The capital base rate constructed from the average costs of Puerto Rican hospitals is $213. Therefore, the blended IPPS capital rate for Puerto Rican hospitals is $383.

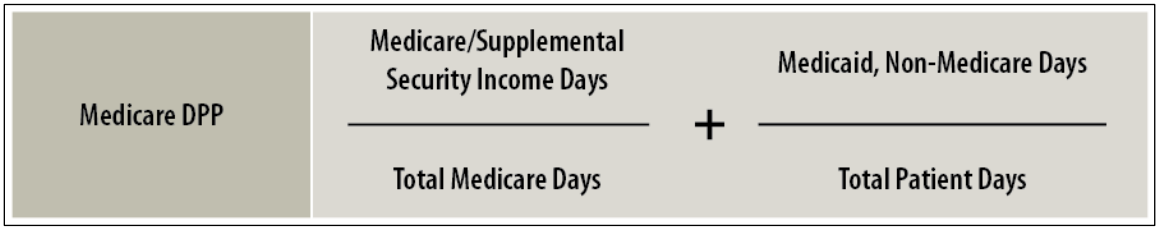
not include IPPS hospitals in Puerto Rico, such as the Hospital-Acquired Condition Reduction Program, the Hospital Readmissions Reduction Program, and the Hospital Value-Based Purchasing Program.

Finally, IPPS hospitals in Puerto Rico are not eligible for the Medicare Electronic Health Record (EHR) Incentive Program, which began in FY2011. The program has been paying incentives to IPPS hospitals in the 50 states and DC that demonstrate meaningful use of certified EHR technology. Medicare EHR incentive payments end in FY2016. Eligible hospitals that are not meaningful EHR users are subject to an annual payment adjustment (penalty) beginning in FY2015.

Are Hospitals in Puerto Rico Eligible for Medicare Disproportionate Share Hospital Payments?

Yes. In general, eligible IPPS hospitals—including hospitals in Puerto Rico—that treat a certain share of low-income patients can receive additional DSH payments to offset the financial effects of treating such patients.[25] Prior to the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), DSH payments were provided by a statutory formula that increased the IPPS reimbursement amount based on the disproportionate patient percentage (DPP). The DPP is based on a hospital's share of low-income patients, defined as the share of Medicare inpatient days for beneficiaries receiving Supplementary Security Income (SSI) benefits out of total Medicare inpatient days plus the share of Medicaid inpatient days out of the hospital's total inpatient days. **Figure 6** provides an illustration of the DPP. DSH payment adjustments may be made if a hospital's DPP exceeds the necessary DPP threshold.[26]

Figure 6. Medicare Disproportionate Patient Percentage (DPP)



Source: Medicare Learning Network, *Medicare Disproportionate Share Hospital*, Centers for Medicare & Medicaid Services, ICN 006741, August 2014, at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Disproportionate_Share_Hospital.pdf.

Note: Patient days in a hospital include only those days attributable to units or wards of the hospital providing acute-care services generally payable under the inpatient prospective payment system.

In a 2007 report to Congress, the Medicare Payment Advisory Commission (MedPAC) estimated that current DSH funding exceeded its empirically justified rate.[27] A provision in the ACA modified DSH funding that otherwise would have been provided in FY2014 and following fiscal

[25] IPPS hospitals that are ineligible for disproportionate share hospital payments include certain sole community hospitals and hospitals participating in the Rural Community Hospital Demonstration.

[26] Disproportionate patient percentage (DPP) thresholds vary based on a hospital's urban or rural classification and bed size. Further, disproportionate share hospital (DSH) payment adjustments are capped at 12% for urban hospitals with fewer than 100 beds and rural hospitals (that are not rural referral centers) with fewer than 500 beds.

[27] Medicare Payment Advisory Commission (MedPAC), "Hospital Inpatient and Outpatient Services," *Report to Congress: Medicare Payment Policy*, March 2007, p. 77, at http://www.medpac.gov/documents/reports/Mar07_Ch02a.pdf?sfvrsn=0.

years as empirically justified DSH payments and additional payments that reflect uncompensated care. The ACA modification specified that empirically justified DSH payments would be distributed based on the traditional DPP (see **Figure 6**) and necessary thresholds but reduced payment adjustments by 75%. The remaining 75% of DSH payments that otherwise would have been provided prior to this modification would be distributed as uncompensated-care payments, but these payments would be reduced over time by changes in the rate of individuals without health insurance in the United States.[28]

Uncompensated-care payments are provided each fiscal year based on each hospital's share of uncompensated care out of the total amount of uncompensated care of *all* hospitals that receive DSH (including in Puerto Rico). In contrast to the DSH payment adjustment, which is a percentage increase to the IPPS payment, uncompensated-care payments are calculated as an aggregate dollar amount and distributed to each hospital through the IPPS payment. Each hospital's aggregate dollar amount of uncompensated-care payment is distributed on a per Medicare discharge basis. The ACA requires the Secretary of the Department of Health and Human Services (HHS) to determine the amount of uncompensated care based on the most appropriate data available. Currently, the Secretary uses each hospital's share of Medicare SSI inpatient days and Medicaid inpatient days as a proxy for uncompensated care.

Individuals residing in Puerto Rico are ineligible for SSI benefits. Rather, Puerto Rico provides assistance under Title XVI of the SSA—Assistance to the Aged, Blind, and Disabled. Because Medicare SSI inpatient days are used both in the DSH payment-adjustment formula and for distributing uncompensated-care payments, advocates have argued that the DSH payment-adjustment formula disadvantages hospitals in Puerto Rico.[29]

However, the ACA changes to Medicare DSH payments, specifically the methodology for distributing uncompensated-care payments, have greatly increased Medicare payments to IPPS hospitals in Puerto Rico relative to their prior levels. In FY2014, the Centers for Medicare & Medicaid Services (CMS) estimated that ACA changes to DSH payments would increase total DSH payments from $8 million to $82 million in Puerto Rico, which would increase total Medicare IPPS payments to hospitals in Puerto Rico by 41.8%.[30] Total DSH payments to hospitals in Puerto Rico, in addition to DSH payments to hospitals in the 50 states and DC, would decline in future years if the rate of individuals without health insurance in the United States were to decline.

Medicare Part B

Beneficiaries entitled to Medicare Part A have the option of enrolling in Part B, which provides coverage for physicians' services, outpatient hospital services, durable medical equipment, outpatient dialysis, and other medical services. Beneficiaries who choose to receive coverage through a Medicare Advantage plan (Part C) must enroll in both Medicare Parts A and B.

[28] Should the percentage of individuals without health insurance in the United States fall to 0%, uncompensated-care payments would not be provided under the statutory formula.

[29] Puerto Rico Health Care Crisis Commission, "Puerto Rico Healthcare Crisis Coalition Commends Resident Commissioner Pierluisi for Introducing Comprehensive Bill to Fix Island's Healthcare Disparities,' press release, June 23, 2015, at http://puertoricohealthcarecrisis.com/2015/06/03/puerto-rico-healthcare-crisis-coalition-commends-resident-commissioner-pierluisi-for-introducing-comprehensive-bill-to-fix-islands-healthcare-disparities/.

[30] Centers for Medicare & Medicaid Services (CMS), "Medicare Program; Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status," 78 *Federal Register* 50623, August 19, 2013.

How Does the Medicare Part B Enrollment Process in the 50 States and DC Compare with the Process in Puerto Rico?

An automatic-enrollment process applies to residents of the 50 states and DC,[31] but it does not apply to residents of Puerto Rico.

Residents of the states and DC who are receiving Social Security benefits are automatically enrolled in both Parts A and B of Medicare, and coverage begins the first day of the month they turn 65. However, because beneficiaries must pay a premium for Part B coverage, they have the option of turning this coverage down.[32] Disabled persons who have received cash payments for 24 months under the Social Security disability programs also automatically receive a Medicare card and are enrolled in Part B unless they specifically decline such coverage.

Those individuals who are not automatically enrolled in Medicare, for example because they have not yet filed for Social Security benefits, need to file an application for Medicare with the Social Security Administration during their initial enrollment period. This period is seven months long and begins three months before the month in which the individual first turns 65. Beneficiaries who do not sign up for Part B during their initial enrollment period, or who drop it and then sign up again later, may have to pay a late-enrollment penalty for as long as they are enrolled in Part B.[33] Monthly premiums for Part B may go up 10% for each full 12-month period that one could have had Part B but did not sign up for it.

Certain low-income beneficiaries may qualify for premium assistance from Medicaid through a Medicare Savings Program (MSP).[34] Beneficiaries in an MSP are not subject to late-enrollment penalties regardless of when they signed up for Medicare. About one in five Medicare beneficiaries currently receives Part B premium subsidies.

Residents of Puerto Rico who receive Social Security benefits are automatically enrolled in Part A when they turn 65; however, they are not also automatically enrolled in Medicare Part B.[35] Rather, they need to sign up for Part B during their initial enrollment period or possibly be subject to a penalty.

The automatic-enrollment process as well as the Puerto Rico exception is in statute, specifically Section 1837(f) of the SSA.[36] The rationale for excluding residents of Puerto Rico from automatic enrollment in Part B is that most residents are also eligible for Puerto Rico's state Medicaid program, which already covers most of the same benefits as Part B.[37] Further, Puerto Rico does

[31] The automatic-enrollment process also applies to residents of U.S. territories, other than Puerto Rico.

[32] Additional information on Part B enrollment and premiums may be found in CRS Report R40082, *Medicare: Part B Premiums*, by Patricia A. Davis,

[33] These beneficiaries also would need to wait until the next *general enrollment period* to sign up. The general enrollment period lasts for three months from January 1 to March 31 of each year, with coverage beginning on July 1 of that year.

[34] See Medicare.gov, "Medicare Savings Programs," at http://www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html and Medicare Publication, "Get Help with Your Medicare Costs," at https://www.medicare.gov/Pubs/pdf/10126.pdf.

[35] See Social Security Administration, "Medicare in Puerto Rico," at http://www.socialsecurity.gov/pubs/EN-05-10521.pdf.

[36] Added by the 1972 Social Security Amendments (P.L. 92-603).

[37] According to S. Rept. 92-1230, "(t)he committee has modified the House provision to exclude residents of Puerto Rico and foreign countries from the automatic enrollment provisions since it would usually be to their disadvantage to enroll. Many residents of Puerto Rico are eligible for comprehensive care under its Medicaid program, which generally eliminates the need for supplementary medical insurance."

not have an MSP to assist low-income Medicare beneficiaries with their Part B premium payments. Therefore, automatically enrolling low-income individuals into a program that carries a premium could subject them to costs that they cannot afford.

There is concern that the lack of an automatic Part B enrollment process in Puerto Rico has resulted in a disproportionate number of Puerto Rican Medicare beneficiaries paying the late-enrollment penalties. In 2010, 4.2% (27,851) of Medicare beneficiaries in Puerto Rico paid Part B penalties totaling over $4.2 million.[38] By comparison, about 1.4% of all Medicare Part B enrollees currently pay this penalty.[39] Because Puerto Rico does not have an MSP program, low-income beneficiaries subject to this penalty may be responsible for paying the full penalty amount in addition to their premiums.

Are Medicare Physician Payments Different in Puerto Rico Than in the 50 States and DC?

Currently, Medicare payments for the services of physicians and certain non-physician practitioners are made on the basis of a fee schedule in the 50 states, DC and Puerto Rico. The Medicare physician fee schedule (MPFS) assigns relative value units to each of the approximately 7,500 service codes that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative value for a service compares the relative work involved in performing one service with the work involved in providing other physicians' services.

The relative values are adjusted for geographic variation in input costs by geographic practice cost indexes (GPCIs). The GPCIs adjust geographically for three factors to reflect differences in the cost of resources needed to produce physician services: physician work, practice expense, and medical malpractice insurance. The GPCIs reflect how each area compares to the national average in a "market basket" of goods related to the production of physician services. A value of 1.00 represents the average across all areas (including Puerto Rico). The geographically adjusted relative values are then converted into a dollar payment amount by a conversion factor.

There are currently 89 Medicare payment localities for purposes of MPFS payment. Puerto Rico is its own locality, and its GPCI is partly constructed from Puerto Rico's production of physician services. Puerto Rico's GPCIs for 2015 are 1.00 for physician work,[40] 0.705 for practice expense, and 0.293 for malpractice insurance.[41]

Part C, Medicare Advantage

Medicare Advantage (Part C, or MA) is an alternative way for Medicare beneficiaries to receive covered benefits. Under MA, private health plans are paid a per person monthly amount to provide all Medicare-covered benefits (except hospice) to beneficiaries who enroll in their plan. The plan is at risk if costs for its enrollees exceed program payments as well as beneficiary cost

[38] Medicare Part B Enrollment in Puerto Rico for the President's Task Force on Puerto Rico's Status, April 2013.

[39] In May 2015, 75% of beneficiaries in Puerto Rico were enrolled in a Medicare Advantage (MA) plan, compared with 32% of beneficiaries in the 50 states and DC. As noted, enrollment in MA requires enrollment in both Medicare Parts A and B.

[40] A series of bills set a temporary floor value of 1.00 on the physician work index for all payment localities beginning January 2004 and continuing through December 31, 2016.

[41] See CMS, 2015 Final Rule Addendum E, "Geographic Practice Cost Indices," at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2015-PFS-FR-Addenda.zip.

sharing and premiums; conversely, plans generally can retain savings if aggregate enrollee costs are less than program payments and cost sharing.

How Many Medicare Beneficiaries in Puerto Rico Are Enrolled in MA? How Does This Compare to MA Enrollment in the 50 States and DC?

In May 2015, 75% of Puerto Rican beneficiaries were enrolled in an MA plan, compared with 32% of beneficiaries in the 50 states and DC. More than half of Puerto Rican enrollees are in a special type of MA plan called a Special Needs Plan (SNP). SNPs are coordinated-care plans targeted at MA-eligible individuals who are institutionalized, as defined by the HHS Secretary, are eligible for both Medicare and Medicaid (i.e., dual-eligible beneficiaries),[42] or have a severe or disabling chronic condition and would benefit from enrollment in a specialized MA plan. Almost half of Puerto Rican SNP enrollees are in plans targeted at dual-eligible individuals (approximately 275,000 enrollees).

How Are Private Plans Paid Under MA?

The Secretary of HHS determines a plan's capitated monthly payment by comparing its *bid* to a *benchmark*. A bid is the plan's estimated cost of providing Medicare-covered services (excluding hospice but including medical services, administration, and profit). A benchmark is the maximum amount the federal government will pay for providing those services in the plan's service area. If a plan's bid is less than the benchmark, its payment equals its bid plus a rebate. The rebate must be returned to enrollees in the form of additional benefits, reduced cost sharing, reduced Part B or Part D premiums, or some combination of these options. If a plan's bid is equal to or above the benchmark, its payment equals the benchmark amount and each enrollee in that plan will pay an additional premium equal to the amount by which the bid exceeds the benchmark. Payments are risk adjusted to take into account the demographic and health history of the enrollees.

In General, How Has the Payment/Benchmark Methodology Changed Over Time?

The benchmark methodology has changed to reflect Congress's shifting priorities, from a policy of encouraging greater private plan participation to a policy of payment neutrality between private plans and original Medicare.

Prior to 1997, private plans were paid 95% of the Medicare per capita fee-for-service (FFS) spending in each county. Per capita spending varied across the country, as did payments to private plans. Plans primarily chose to serve areas where Medicare spending was high or areas that had a long history of managed-care participation. The plans often offered generous supplemental benefits, such as prescription drug coverage and low cost sharing.

The Balanced Budget Act of 1997 (BBA97; P.L. 105-33) created the Medicare+Choice (M+C) program and a formula for determining plan payments. The formula was designed to (1) slow the growth of payments in high-expenditure areas, (2) raise payments to a minimum, or *floor rate,* in

[42] Dual-eligible individuals are low-income seniors and individuals with disabilities who are eligible for both Medicare and Medicaid. The two main categories of dual-eligible individuals are full dual-eligible individuals and partial dual-eligible individuals. Full dual-eligible individuals receive full benefits from Medicare, and Medicaid provides them with full benefits in addition to financial assistance with their Medicare premiums and cost sharing. Partial dual-eligible individuals receive full benefits from Medicare and financial assistance from Medicaid for Medicare premiums and cost sharing.

areas with low per capita FFS spending, and (3) blend local rates toward a national average over time, all subject to a budget-neutrality provision. The portion of the formula that created the floor rate was designed to encourage participation in areas that previously had not been served. Subsequently, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA; P.L. 106-554) created a second floor rate, sometimes referred to as the *urban floor rate*, which applied to counties within metropolitan statistical areas (MSAs) with a population of more than 250,000 people within the 50 states and DC.

Private plan participation expanded slightly after BBA97 but then experienced a period of retraction that lasted through 2003. The goal of controlling spending by slowing the growth of payments in higher spending areas may have dampened the interest of private plans to develop new markets and add plan options, although the reasons for the reduction in plan interest may have been more complex. Regulatory burden, difficulty establishing provider networks, and—at least in the late 1990s—market competition all could have played a role as well.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; P.L. 108-173) replaced the M+C program with the Medicare Advantage program and added an optional outpatient prescription drug benefit (Part D). The MMA again changed how plans were paid. It instituted the payment method based on bids and benchmarks described above (see "How Are Private Plans Paid Under MA?") and established the previous payment rates under the M+C program as the beginning benchmarks for the MA program. Each county benchmark was increased yearly by the growth in overall Medicare spending; however, in certain years designated by the HHS Secretary as *rebasing years*, the benchmark was the greater of either (1) the previous year's benchmark increased by the growth in overall spending or (2) projected per capita FFS spending in that county. This methodology increased benchmarks.

Plan participation and enrollment expanded. For the first time starting in 2006, all beneficiaries had access to at least one MA plan. However, because the benchmarks were set at amounts above per capita spending in original Medicare in many parts of the country, estimated spending to provide covered benefits to MA enrollees exceeded what would have been spent had those beneficiaries remained in original Medicare. In 2010, benchmarks for all MA plans exceeded estimated FFS spending by 17% and payments to MA plans exceeded estimated FFS spending by 13%.[43]

Whereas changes to private plan payment methodology between 1997 and 2010 reflected policies designed to increase participation, another set of changes made as part of the ACA sought to establish neutrality between payments to plans and expenditures under original Medicare. The ACA changed the benchmark calculation, bringing it closer to or below the value of FFS spending. Under the ACA, county benchmarks are set at a percentage of FFS spending in each county.[44] The percentage multiplied by per capita FFS spending in each county is either 95%,

[43] MedPac, *Report to the Congress: Medicare Payment Policy*, March 2010, p. 266. The estimates of benchmarks and payments as a percentage of original Medicare spending were calculated by MedPac assuming that Congress allowed Medicare payment reductions to physicians under the sustainable growth rate methodology to be enacted (the statistics presented in the text above), but they also were calculated assuming that Congress would not allow the physician payment reductions to go into place. Under this second assumption, MA benchmarks in 2010 were 112% of estimated per capita fee-for-service (FFS) spending and MA payments were 109% of estimated per capita FFS spending.

[44] The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) also requires benchmarks to be adjusted based on plan quality. This adjustment applies the same way for plans serving Puerto Rico and the 50 states. As such, it is not discussed in detail in this report. For more information about the quality adjustment to benchmarks, see CRS Report R43921, *Medicare Advantage—Proposed Benchmark Update and Other Adjustments for CY2016: In Brief*, by Paulette C. Morgan.

100%, 107.5%, or 115%, with higher percentages applied to counties with the lowest FFS spending. In other words, the 25% of counties with the lowest FFS spending will receive the highest percentage (115%) of per capita FFS as their MA benchmark. The 25% of counties in the 50 states and DC with the highest FFS spending will receive the lowest percentage (95%) of per capita FFS. The transition to the new methodology will take place over two, four, or six years, with a longer transition period for counties expected to have larger benchmark decreases.

As of 2015, 27% of counties are still transitioning to the ACA benchmark calculation methodology. Benchmarks for all MA plans exceeded estimated FFS spending by 7%, and payments to MA plans exceeded estimated FFS spending by 2%.[45]

How Do the Changes in Medicare Advantage Payment/Benchmark Methodology Differ Between Puerto Rico and the 50 States and DC?

Since 1997, three provisions have set or calculated the payment (or benchmark) for Puerto Rico differently relative to the 50 states and DC. These provisions were in BBA97, BIPA, and the ACA.

First, under the BBA97 methodology, the minimum payment (or floor rate) was set at $367 in 1998 in the 50 states and DC; for areas outside of the states and DC (including Puerto Rico and the other territories), the payment was limited to 150% of the annual per capita payment rate in effect in 1997 (which was 95% of average per capita FFS spending in the county, with adjustments). The county payment rates in Puerto Rico in 1997 ranged from $149 to $259 per person per month, with an enrollee-weighted average of $201 per person per month. The payment rates in Puerto Rico for 1998 reflected the change specified by BBA97 and ranged from $223 to $367 per person per month, with an enrollee-weighted average payment of $302 per person per month. The floor calculation for Puerto Rico under BBA97 represented a payment increase for 1998, but given that per capita FFS spending in Puerto Rico was low, the new payments for Puerto Rico were often less than payments in the 50 states and DC.

The BIPA payment provision also was different for Puerto Rico (and the other territories). That legislation established the second minimum, or floor payment, rate for urban areas, as described above. The urban floor rate for qualifying counties in the 50 states and DC was set in statute at $525 for 2001. Outside of the states and DC, a county that otherwise would qualify as an urban floor based on its MSA status received a 2001 payment rate that did not exceed 120% of its payment in 2000. The county payment rates in Puerto Rico in 2000 ranged from $243 to $401 per person per month, with an enrollee-weighted average of $329. The urban floor calculation for Puerto Rico under BIPA again represented an increase relative to rates prior to BIPA, but it was lower than the $525 level specified for the 50 states and DC.

Until the ACA, all other payment provisions applied to Puerto Rico in the same manner as in the 50 states, including the provisions for updating county-level payments (and later benchmarks). Just as average benchmarks rose above the level of per capita FFS spending in the 50 states and DC (118% of per capita FFS spending), so too did benchmarks rise in Puerto Rico. In 2009, all but one benchmark in Puerto Rico was set at the statutory floor rate, which at that time was 180% of estimated FFS spending in the county.[46]

[45] MedPac, *Report to the Congress: Medicare Payment Policy*, March 2015, p. 325.

[46] MedPac, *Report to Congress: Improving Incentives in the Medicare Program*, June 2009, pp. 172 and 179, at http://www.medpac.gov/documents/reports/Jun09_EntireReport.pdf?sfvrsn=0.

The third payment provision to MA plans that was specifically different for Puerto Rico (and all territories) was in the ACA. Under the benchmark-calculation provisions—in which benchmarks are set at a percentage of FFS—Puerto Rico is not included in the original calculation of the county quartiles.[47] The 50 states and DC are separated into low, medium-low, medium-high, and high per capita FFS expenditure counties, where 25% of all counties are in each of the four groups. Once the level of per capita spending that distinguishes each of the four groups is determined, Puerto Rican counties are allotted to the appropriate group based on their per capita FFS spending. In 2015, all Puerto Rican counties are in the lowest spending quartile group. This methodology does not so much benefit Puerto Rico as allow more counties in the 50 states to occupy that lowest spending quartile where the benchmarks are set at the highest percentage of FFS spending.

The transition to the ACA methodology represents a decrease in MA benchmarks in Puerto Rico.[48] Under current law, Puerto Rican counties will transition from benchmarks as high as 180% of FFS spending to benchmarks set at 115% of FFS spending.[49]

Medicare Part D

The MMA established a voluntary, outpatient prescription drug benefit under Medicare Part D, effective January 1, 2006. Part D provides coverage through private prescription drug plans (PDPs) that offer only drug coverage or through Medicare Advantage prescription drug (MA-PDs) plans that offer coverage as part of broader, managed-care plans. Medicare provides an average subsidy of about 74.5% of the cost of a standard benefits package through direct subsidies for all enrollees and reinsurance for individuals with high drug costs.[50]

A key element of Part D is enhanced coverage for low-income individuals. Persons with incomes up to 150% of the federal poverty level (FPL) and assets below set limits are eligible for extra assistance with Part D premiums and cost sharing.

---

[47] Social Security Act §1853(n)(2)(C)(ii).

[48] MedPac was asked to examine the methodology for determining per capita FFS spending prior to the passage of the ACA. It indicated that the low Part B take-up rate in Puerto Rico drew into question the reliability and stability of the per capita FFS spending estimates. MedPac, *Report to Congress: Improving Incentives in the Medicare Program*, June 2009, p. 179, at http://www.medpac.gov/documents/reports/Jun09_EntireReport.pdf?sfvrsn=0. For benchmarks in 2012, CMS changed the method of calculating per capita FFS for Puerto Rico to restrict its analysis to only the portion of beneficiaries in FFS Medicare who were enrolled in both Parts A and B (rather than Parts A and/or Part B). This change increased MA benchmarks in Puerto Rico for 2012 by an additional 0.4%. CMS, *Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, April 2011, p. 29, at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2012.pdf.

[49] Various statutorily required adjustments to both the MA benchmarks and the risk-adjustment mechanism could result in further reductions (or increases) to the payments that all plans actually receive (beyond the change in the benchmark methodology specified in the ACA). In addition, adjustments to the benchmarks and to the risk-adjustment mechanism may be undertaken at the HHS Secretary's discretion. These adjustments are made to increase the accuracy of the benchmarks or risk-adjustment methodology, and they may result in increases or decreases to plan payments. As such, the reduction in the benchmarks for counties in Puerto Rico may not be the only reduction that plans serving Puerto Rico may face. For a discussion of some of these other adjustments, see CRS Report R43921, *Medicare Advantage—Proposed Benchmark Update and Other Adjustments for CY2016: In Brief*, by Paulette C. Morgan.

[50] MedPAC, "Part D Payment System," Rev. October 2014, at http://www.medpac.gov/documents/payment-basics/part-d-payment-system-14.pdf?sfvrsn=0.

Do the 50 States and DC Help Finance Medicare Part D?

Yes. The 50 states and DC make annual payments, known as the *phased-down state contribution* (or *clawback* payment) to help cover the cost of Part D benefits for low-income enrollees. Prior to the implementation of Part D, dual-eligible individuals received drug benefits through Medicaid, with the 50 states and DC financing a share of this coverage. The MMA shifted prescription drug coverage for dual-eligible individuals to Part D and required the 50 states and DC to continue paying a portion of the cost. In 2013, state contributions amounted to $8.8 billion.[51]

In General, How Do the Part D Low-Income Subsidies Work?

Dual-eligible beneficiaries who qualify for Medicaid based on income and assets are automatically deemed eligible for Part D low-income subsidies (LIS). Additionally, individuals who receive premium and/or cost-sharing assistance from Medicaid through the Medicare Savings Program (MSP),[52] plus those eligible for Supplemental Security Income (SSI) cash assistance, are automatically deemed eligible for LIS. This group includes all eligible persons with (1) incomes below 135% of FPL, or $15,889.50 for an individual and $21,505.50 for a couple in 2015,[53] and (2) resources below $8,780 for an individual and $13,930 for a couple in 2015. The limits are increased annually by the percentage increase in the Consumer Price Index for All Urban Consumers (CPI-U).

Individuals with limited incomes and resources who do not automatically qualify may apply for LIS and have their eligibility determined by either the Social Security Administration or their state Medicaid agency. This group includes all other persons who (1) are enrolled in a PDP or MA-PD plan; (2) have incomes below 150% of FPL, $17,655 for an individual and $23,595 for a couple in 2015; and (3) have assets below $13,640 for an individual and $27,250 for a couple in 2015[54] (increased in future years by the percentage increase in the CPI-U).

LIS cost sharing varies based on income and assets.[55] Beneficiaries eligible for the full Part D subsidy have no annual deductible and minimal cost sharing. In addition, beneficiaries who

---

[51] The Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds*, July 28, 2014, Table III.D1.

[52] The Medicare Savings Program includes the Qualified Medicare Beneficiary (QMB) program, Specified Low-Income Medicare Beneficiary (SLMB) program, and Qualifying Individual (QI) program. These programs help Medicare beneficiaries of modest means pay all or some of Medicare's cost-sharing amounts (i.e., premiums, deductibles, and co-payments). To qualify, an individual must be eligible for Medicare and must meet certain income limits, which change annually.

[53] See Social Security Administration, Program Operations Manual System (POMS), "HI 03001.020 Eligibility for Extra Help (Prescription Drug Low-Income Subsidy)," at https://secure.ssa.gov/poms.nsf/lnx/0603001020#c3; and Social Security Administration, Program Operations Manual System (POMS), "HI 03001.005 Medicare Part D Extra Help (Low-Income Subsidy or LIS)," at https://secure.ssa.gov/poms.nsf/lnx/0603001005.

[54] Social Security Administration, Program Operations Manual System (POMS), "HI 03030.025, Resource Limits for Subsidy Eligibility," at https://secure.ssa.gov/poms.nsf/lnx/0603030025.

[55] Cost sharing is linked to a Part D standard benefit. Under the standard benefit, an enrollee first pays a deductible ($320 in 2015). After the deductible has been met, the beneficiary is responsible for 25% of the cost of prescription drugs (with the plan covering the remaining 75%) up to the initial coverage limit ($2,960 in 2015). After the initial coverage threshold has been reached, a beneficiary enters the coverage gap, or "doughnut hole," and is responsible for a larger share of prescription drugs costs until he or she reaches the catastrophic threshold, which is about $7,061.76 in total drug costs in 2015. Most Part D plans modify this standard benefit by using different cost-sharing requirements, such as altering the size of deductibles or co-payments. All Part D plans must be at least actuarially equivalent to the standard benefit.

qualify for a full subsidy do not pay monthly premiums if they enroll in lower-cost plans that offer basic Part D coverage and charge premiums equal to, or below, a regional benchmark.[56] Partial subsidy-eligible individuals have higher cost sharing and receive premium assistance based on an income sliding scale.

What Proportion of Part D Program Spending is Used for Low-Income Subsidies?

Low-income Part D enrollees tend to be in worse health and to have higher prescription-drug expenditures than non-LIS enrollees. According to a recent MedPAC analysis, in 2013, combined spending for the LIS, direct subsidy, and individual reinsurance for LIS enrollees was about two-thirds of total Part D government spending.[57]

Are Beneficiaries in Puerto Rico Eligible for Low-Income Subsidies?

Residents of the territories are not eligible for LIS. In lieu of LIS, the MMA included a provision providing Medicaid funding to the territories to provide Medicaid coverage of prescription drugs for low-income Medicare beneficiaries. This funding is provided through Section 1935(e) of the SSA, and it is sometimes referred to as the enhanced allotment program (EAP). The question below in the Medicaid section entitled "Does Puerto Rico Receive Medicaid Funding in Lieu of Medicare Part D Low-Income Subsidies?" provides more information about the federal guidelines.

CRS reviewed hearing transcripts, committee reports, proposed and final regulations, and other administrative documents to ascertain the reason for excluding the residents of the territories from eligibility for LIS but was unable to find any explanation.

Medicaid

Medicaid is a joint federal-state program that finances the delivery of primary and acute medical services, as well as long-term services and supports (LTSS), for a diverse low-income population, including children, pregnant women, adults, individuals with disabilities, and people aged 65 and older.[58] In FY2014, Medicaid is estimated to have provided health care services to 63 million individuals[59] at a total cost of $494 billion, with the federal government paying $299 billion (about 61%) of that total.[60]

To participate in Medicaid, the federal government requires states and DC to cover certain mandatory populations and benefits, but it allows states and DC to cover optional populations and services. This flexibility results in variability across Medicaid programs.

---

[56] See CRS Report R40611, *Medicare Part D Prescription Drug Benefit*, by Suzanne M. Kirchhoff and Patricia A. Davis. The benchmark is set annually.

[57] MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2015, p. 149, at http://medpac.gov/documents/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0.

[58] For more information about the Medicaid program, see CRS Report R43357, *Medicaid: An Overview*, coordinated by Alison Mitchell.

[59] This enrollment figure is measured according to *average monthly enrollment*, which differs from *ever-enrolled* counts that measure the number of people covered by Medicaid for any period of time during the year. Congressional Budget Office, *Detail of Spending and Enrollment for Medicaid – CBO's March 2015 Baseline*, March 9, 2015.

[60] CMS, CMS-64 data as of March 30, 2015.

Historically, Medicaid eligibility generally has been limited to certain low-income populations, such as children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities. However, the ACA included the ACA Medicaid expansion provision, which extends Medicaid eligibility to individuals under the age of 65 with income up to 133% of FPL,[61] at state option.[62]

Does Puerto Rico Have a Medicaid Program?

Yes, Puerto Rico operates a Medicaid program. Participation in Medicaid is voluntary, although all states, DC, and the territories choose to participate. In July 2014, Puerto Rico's Medicaid program had 1.4 million enrollees.[63] In FY2014, Puerto Rico's Medicaid program had total expenditures of $1.8 billion, with the federal government paying $1.1 billion of that amount.[64]

Are the Federal Medicaid Rules for the Territories Different Than for the 50 States and DC?

Yes. The territories operate Medicaid programs under rules that differ from those applicable to the 50 states and DC. **Table 1** identifies the major differences between the Medicaid programs in the states and DC versus the territories.

Table 1. Major Differences in the Federal Rules for Medicaid in States and the District of Columbia Versus the Territories

	States and the District of Columbia (DC)	Territories
Eligibility	Medicaid requires states to cover certain mandatory eligibility groups and allows states to cover optional eligibility groups.	Same requirements as the states and DC.[a]
Benefits	The Medicaid statute identifies the services states must cover as well as those that may be covered at the states' option.	Same requirements as the states and DC.[a]
Federal Matching Rate	Varies according to states' per capita income and can range from 50% to 83%.[b]	Fixed at 55%.[c]
Federal Funding	Open-ended.	Capped.

Source: Congressional Research Service (CRS).

a. American Samoa and the Commonwealth of the Northern Mariana Islands operate their Medicaid programs under the Section 1902(j) waiver authority, which is named after the section of the Social Security Act (SSA) under which authority is granted to waive certain Medicaid program rules. Under a Section 1902(j) waiver,

[61] The income limit is effectively 138% of the federal poverty level (FPL) after adjusting for a 5% income disregard applicable if individuals are at the highest income limits for coverage.

[62] For more information about the ACA Medicaid expansion, see CRS Report R43564, *The ACA Medicaid Expansion*, by Alison Mitchell.

[63] Data retrieved from Commonwealth of Puerto Rico website (https://data.pr.gov/category/Salud) on June 2, 2015.

[64] CMS, CMS-64 data as of March 30, 2015.

the only Medicaid requirements that may not be waived include (1) the federal matching rate; (2) the capped Medicaid allotments; and (3) that payment may not be made for services not described in Section 1905(a) of SSA.

b. DC's federal matching rate (FMAP) rate has been set in statute at 70% since 1998 for the purposes of Title XIX and XXI of SSA.

c. The ACA increased the FMAP rate for all the territories from 50% to 55% beginning on July 1, 2011.

Most of the eligibility and benefit requirements for the 50 states and DC apply to the territories, but none of the territories cover all the mandatory eligibility groups and benefits. Two territories (i.e., American Samoa and the Commonwealth of the Northern Mariana Islands) operate their Medicaid programs under the Section 1902(j) authority, named after the section of SSA that states that the HHS Secretary may waive or modify any Medicaid requirement, with a couple of exceptions. The other three territories are supposed to abide by most of the same Medicaid requirements as the 50 states and DC. However, it has been documented that these territories do not cover all of the federally mandated coverage groups or benefits.[65]

The five territories all have the same federal medical assistance percentage (FMAP) rate (i.e., federal matching rate) of 55%, whereas the FMAP for the 50 states and DC varies by state according to each state's per capita income and can range from 50% to 83%.[66] Prior to the ACA, the FMAP rate for all territories was set at 50%. The ACA increased the FMAP rate for all the territories from 50% to 55% beginning on July 1, 2011.

Federal Medicaid funding to the states and DC is open-ended, but the Medicaid programs in the territories are subject to annual federal spending caps (i.e., allotments). In FY2015, the Medicaid allotments to the territories totaled $378.3 million. Prior to the ACA, all five territories typically exhausted their federal Medicaid funding prior to the end of the fiscal year. For this reason, the ACA provided $6.3 billion in additional Medicaid federal funding to the territories available between July 1, 2011, and September 30, 2019.[67]

Who Is Eligible for Medicaid in Puerto Rico?

Since January 1, 2014, Puerto Rico has had an approved Medicaid state plan to provide Medicaid coverage to residents with income up to at least 133% of the Puerto Rican poverty line, which is 50% of FPL for a family of three.[68] **Figure 7** shows Puerto Rico's Medicaid income-eligibility levels for the various populations compared with the federal mandatory levels for the 50 states and DC.[69]

[65] GAO, *U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding*, GAO-06-75, October 2005.

[66] In FY2015, the FMAP rate ranges from 50% (13 states) to 74% (Mississippi). For more information about the FMAP rate, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016*, by Alison Mitchell.

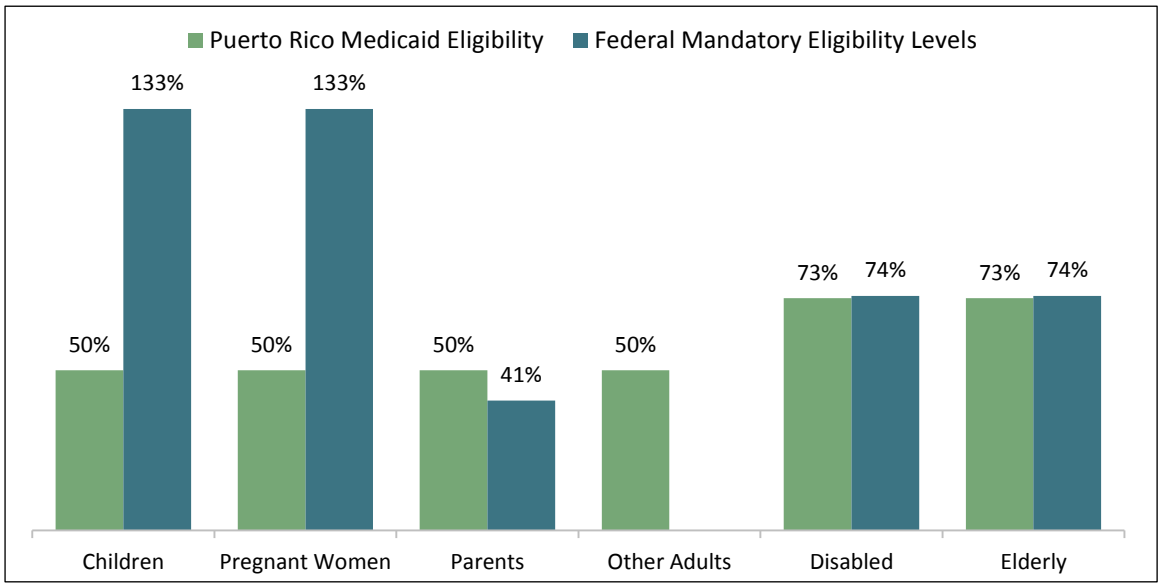
[67] In addition to the ACA Medicaid funding, none of the territories elected to establish health insurance exchanges, and they are all entitled to their share of the $1.0 billion initially allocated to the territories for providing premium and cost-sharing assistance through the exchanges to increase their existing Medicaid funding caps.

[68] The income-eligibility levels for Puerto Rico's Medicaid program are based on a local poverty level established by Puerto Rico and approved by CMS instead of the FPL. For a family of three, the Puerto Rican poverty line was 38% of FPL in 2014.

[69] The federal mandatory Medicaid eligibility levels are what states are required to cover in order to participate in the Medicaid program. However, states are able to provide coverage at higher income levels, and many states do.

Figure 7. Medicaid Income Eligibility as a Percentage of FPL in Puerto Rico Versus Federal Mandatory Levels for the States and the District of Columbia

(2015)



Source: Communication with the Centers for Medicare & Medicaid Services from June 16, 2015.

Notes: For comparative purposes, this figure shows the Puerto Rican Medicaid income-eligibility levels in terms of the federal poverty level (FPL) for a family of three.

States are required to provide Medicaid coverage for parents (and their dependent children), at a minimum, at their 1996 eligibility levels for the Aid to Families with Dependent Children, which is the cash assistance program for needy families that preceded the Temporary Assistance for Needy Families block grant. This mandatory level varies by state, and the figure shows the average of the states' mandatory eligibility levels.

Puerto Rico's Medicaid income-eligibility levels are significantly lower than the federal mandatory Medicaid eligibility levels for children and pregnant women,[70] but Puerto Rico's eligibility for parents is slightly higher than the mandatory level. Puerto Rico provides Medicaid coverage to individuals with disabilities and the elderly at roughly the federal mandatory Medicaid income level. It also provides Medicaid coverage to other adults (i.e., able-bodied, non-elderly adults), and the states are not required to provide Medicaid coverage to this population. However, 30 states and DC do provide coverage to other adults with income up to at least 133% of FPL through the ACA Medicaid expansion.[71]

A higher proportion of Puerto Rico's residents are covered by Medicaid relative to the 50 states and DC. In 2012, 46% of Puerto Rican residents reported having Medicaid coverage, whereas 18% of people in the 50 states and DC reported Medicaid coverage.[72] As mentioned earlier, since 2012, 30 states and DC have implemented the ACA Medicaid expansion, which should have increased the proportion of people in the states that have Medicaid coverage.

[70] Children under the age of 19 with family income above 133% of the Puerto Rican poverty line are eligible for the State Children's Health Insurance Program (CHIP) coverage up to 266% of the Puerto Rican poverty line.

[71] Wisconsin also provides Medicaid coverage to other adults up to 100% of FPL.

[72] This estimate is based on data from the American Community Survey and the Puerto Rico Community Survey. (Maria Portela and Benjamin D. Sommers, "On the Outskirts of National Health Reform: A Comparative Assessment of Health Insurance and Access to Care in Puerto Rico and the United States," *The Milbank Quarterly*, 2015 forthcoming.)

Does Puerto Rico's Medicaid Coverage Include All the Mandatory Medicaid Benefits?

No. Puerto Rico does not provide all of the mandatory Medicaid benefits, even though the federal requirements for Puerto Rico's Medicaid benefit coverage are mostly the same as the requirements for the 50 states and DC.

There has not been a comprehensive analysis of the benefits provided through Puerto Rico's Medicaid program, but at least two reports identify several mandatory Medicaid benefits that have not been provided in Puerto Rico.[73] Specifically, nursing facility and home health services, which are mandatory services for Medicaid coverage, have not been provided in Puerto Rico.[74] In addition, children covered by Puerto Rico's Medicaid program received limited benefits from the early and periodic screening, diagnostic, and treatment (EPSDT) [75] services.[76]

What Service-Delivery Model Does Puerto Rico Use for Its Medicaid Program?

Puerto Rico exclusively uses managed care to provide Medicaid coverage.

In general, benefits are made available to Medicaid enrollees via two service-delivery systems: *fee-for-service* (FFS) or *managed care*. Under the FFS delivery system, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under the managed-care delivery system, Medicaid enrollees get most or all of their services through an organization under contract with the state. States traditionally have used the FFS service-delivery model for Medicaid, but since the 1990s, the share of Medicaid enrollees covered by the managed-care model has increased dramatically. In FY2011, about 72% of Medicaid enrollees were covered by some form of managed care, and all but four states (Alaska, Idaho, New Hampshire, and Wyoming) used managed-care coverage to some extent.[77]

Puerto Rico provides Medicaid coverage through a program called Mi Salud[78] that provides acute and primary services through a managed-care delivery model. Behavioral health services are provided through a separate behavioral health managed care organization.[79] Since 2006, dual-

---

[73] GAO, *Puerto Rico: Information on How Statehood Would Potentially Affect Selected Federal Programs and Revenue Sources*, GAO-14-31, March 2014; President's Task Force on Puerto Rico's Status, *Report by the President's Task Force on Puerto Rico's Status*, March 2011.

[74] According to CMS, Puerto Rico lacks the infrastructure of nursing home facilities. (GAO, *Puerto Rico: Information on How Statehood Would Potentially Affect Selected Federal Programs and Revenue Sources*, GAO-14-31, March 2014).

[75] Early and periodic screening, diagnostic, and treatment (EPSDT) services are mandatory for children (defined as under the age of 21 for this benefit). Under EPSDT, states are required to provide comprehensive services and furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines.

[76] President's Task Force on Puerto Rico's Status, *Report by the President's Task Force on Puerto Rico's Status*, March 2011.

[77] Data from Maine, Tennessee, and Vermont were excluded due to spending anomalies and reporting differences. All three of these states use managed care in their Medicaid programs. (Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP*, June 2014.)

[78] Mi Salud is an umbrella program for Puerto Rico's Medicaid, CHIP, some Medicare, and some Puerto Rico-only funded coverage.

[79] CMS, *Managed Care in Puerto Rico*, August 2014.

eligible individuals have had the option to participate in Medicare Platino, an MA program that provides Medicare acute and primary care and Medicaid wraparound services,[80] which together offer coverage equivalent to Mi Salud.[81]

What Federal Medicaid Matching Rate Does Puerto Rico Receive?

Puerto Rico has a few Medicaid matching rates. For most Medicaid expenditures, Puerto Rico's FMAP rate (or federal Medicaid matching rate) is 55%, which is the statutorily set rate that all the territories receive.[82] For 2014 and 2015, Puerto Rico is receiving an additional 2.2 percentage point increase to its FMAP rate that is applied to coverage for individuals who are not "newly eligible" individuals through the ACA Medicaid expansion.[83]

In addition, Puerto Rico receives the *expansion state* FMAP rate for the services provided to the individuals in the new eligibility group for the ACA Medicaid expansion.[84] The expansion state FMAP rate for Puerto Rico was 78% in 2014.

How Much Federal Medicaid Funding Does Puerto Rico Receive?

Puerto Rico received almost $1.2 billion in federal Medicaid funding for FY2014. This federal funding was provided through several different sources: annual allotment, ACA Medicaid funding, electronic health records (EHR) funding, the SSA Section 1935(e) funding,[85] and some administrative funding for the Medicaid Management Information System (MMIS).

[80] In general, when other sources of insurance/payment are available (including Medicare), Medicaid wraps around that coverage (i.e., additional coverage for services covered under Medicaid but not under the other source of coverage).

[81] CMS, *Managed Care in Puerto Rico*, August 2014.

[82] If Puerto Rico were to receive an FMAP rate according to the formula based on per capita income that is used for the 50 states, Puerto Rico likely would receive an FMAP rate of 83%, which is the maximum rate allowed under statute. (GAO, *Puerto Rico: Information on How Statehood Would Potentially Affect Selected Federal Programs and Revenue Sources*, GAO-14-31, March 2014.)

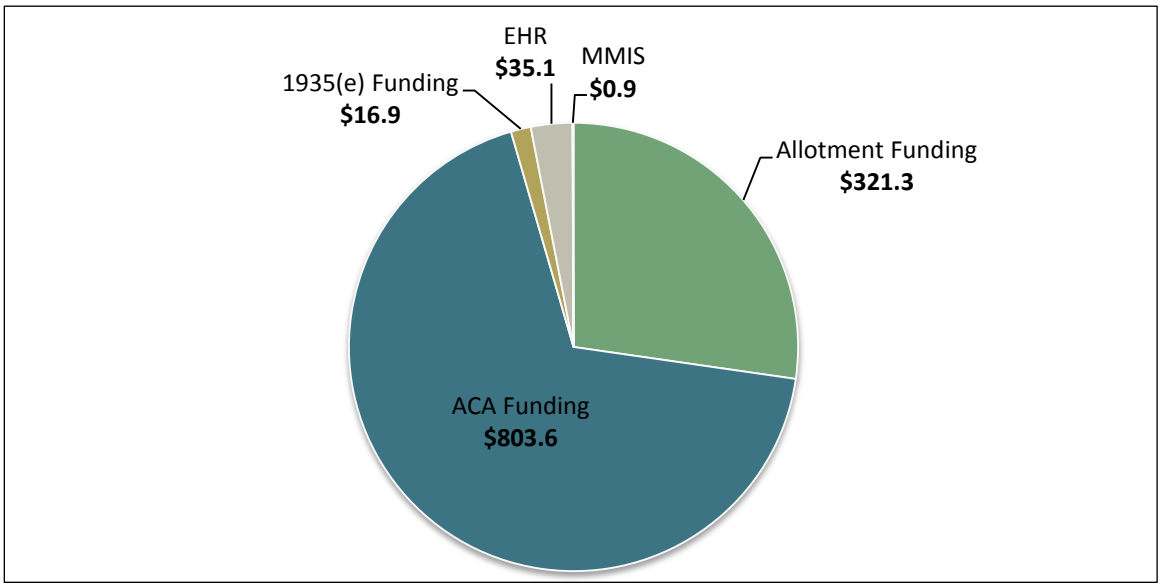
[83] This is the additional FMAP increase for certain expansion states established in the ACA. (§1905(z) of the Social Security Act.) For more information about the additional FMAP increase for certain states, see CRS Report R43564, *The ACA Medicaid Expansion*, by Alison Mitchell.

[84] The expansion state FMAP rate is available for individuals in expansion states who were eligible for Medicaid on March 23, 2010, and are in the new eligibility group for non-elderly adults at or below 133% of FPL. This definition of expansion state was established prior to the Supreme Court decision that made the ACA Medicaid expansion optional for states. In this context, expansion state refers to states that had already implemented (or partially implemented) the ACA Medicaid expansion at the time the ACA was enacted. Specifically, expansion states are defined as those that, as of March 23, 2010 (the ACA's enactment date), provided health benefits coverage meeting certain criteria statewide to parents with dependent children and adults without dependent children up to at least 100% of FPL. For more information about the expansion state FMAP rate, see CRS Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2016*, by Alison Mitchell.

[85] See, below, "Does Puerto Rico Receive Medicaid Funding in Lieu of Medicare Part D Low-Income Subsidies?"

Figure 8. Puerto Rico's Federal Medicaid Funding, FY2014

($ in millions)



Source: Communication with the Centers for Medicare & Medicaid Services from July 24, 2015.

Notes: ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended). EHR = Electronic Health Record. MMIS = Medicaid Management Information System.

The Medicaid programs in the territories are subject to annual federal spending caps (i.e., allotments).[86] In FY2014, Puerto Rico's Medicaid allotment was $321 million, and Puerto Rico used this entire amount. After the annual allotment funds were exhausted, Puerto Rico used $803 million of the available ACA Medicaid funding. (See "Did the ACA Provide Additional Medicaid Funding for Puerto Rico?" for more information.)

Puerto Rico has access to other sources of federal Medicaid funds in addition to its capped funding for specific activities. For instance, Puerto Rico is eligible for Medicaid Electronic Health Record (EHR) Incentive Program payments to encourage providers to use EHR technology and federal Medicaid funding for the design and operation of the Medicaid Management Information System, which is the Medicaid claims-processing and information-retrieval system. In addition, Puerto Rico receives 1935(e) funding in lieu of its residents being eligible for low-income subsidies (LIS) under Medicare Part D. (See "Does Puerto Rico Receive Medicaid Funding in Lieu of Medicare Part D Low-Income Subsidies?" for additional information.)

[86] These Medicaid caps increase annually according to the change in the Consumer Price Index for All Urban Consumers (CPI-U). Once the cap is reached, the territories assume the full cost of Medicaid services or, in some instances, may suspend services or cease payments to providers until the next fiscal year.

Did the ACA Provide Additional Medicaid Funding for Puerto Rico?

Puerto Rico received an additional $6.4 billion in funding through the ACA.

The ACA provided $6.3 billion in additional Medicaid federal funding to the territories available between July 1, 2011, and September 30, 2019. This funding was provided to the territories because prior to the ACA, all five territories typically exhausted their federal Medicaid funding prior to the end of the fiscal year.

Puerto Rico's share of the ACA Medicaid funding is $5.5 billion. In FY2014, Puerto Rico used $803 million of this funding, and the ACA Medicaid funding comprised 71% of the federal Medicaid funding to Puerto Rico in FY2014. From FY2011 through FY2014, Puerto Rico used 42% of the allotted ACA Medicaid funding, which leaves Puerto Rico with almost $3.2 billion of the funding to use in FY2015 through FY2019.

In addition to the ACA Medicaid funding, Puerto Rico received an increase to existing Medicaid funding caps of $0.9 billion. This funding initially was supposed to be used to provide premium and cost-sharing assistance through the exchanges. However, Puerto Rico did not elect to establish a health insurance exchange and therefore is able to use this funding to increase its Medicaid funding caps in 2014 through 2019. Puerto Rico can use this funding once it exhausts the $5.5 billion in ACA Medicaid funding.

Does Puerto Rico Receive Medicaid Funding in Lieu of Medicare Part D Low-Income Subsidies?

Yes. Puerto Rico (like the other territories) is eligible for federal Section 1935(e) funding, which is Medicaid funding provided to the territories in lieu of residents of the territories being eligible for low-income subsidies (LIS) under Medicare Part D. It is sometimes referred to as the enhanced allotment program (EAP).

Each of the territories is able to submit a plan to the HHS Secretary for providing prescription drug coverage under Medicaid for low-income Medicare beneficiaries (i.e., individuals with income less than 150% of FPL). Territories with approved plans receive a share of additional federal funds through Medicaid. This funding is provided through Section 1935(e) of SSA. Puerto Rico has been eligible for federal Section 1935(e) funding since the funding became available on January 1, 2006.

Puerto Rico is required to match the Section 1935(e) funding at its regular FMAP rate (i.e., 55%). This means for every dollar Puerto Rico spends on providing Medicaid coverage for prescription drugs to low-income Medicare beneficiaries, Puerto Rico draws down $0.55 from its allotted Section 1935(e) funding. However, Puerto Rico can draw down federal Section 1935(e) funding only up to its annual limit. In FY2014, Puerto Rico received a Section 1935(e) allotment (i.e., maximum amount of federal funds available for this purpose) of $42 million, but Puerto Rico used only $17 million of these funds.[87]

[87] Communication with CMS on July 24, 2015.

State Children's Health Insurance Program

The State Children's Health Insurance Program (CHIP) is a means-tested program that provides health coverage to targeted low-income children and pregnant women in families that have annual income above Medicaid-eligibility levels but have no health insurance.[88] For CHIP, the federal rules for the territories are the same as the rules for the 50 states and DC.

Under CHIP, the federal government sets basic requirements, but states have the flexibility to design their own versions of CHIP within the federal government's basic framework. As a result, there is significant variation across CHIP programs. The federal government reimburses states for a portion of every dollar they spend on CHIP, up to state-specific annual limits called allotments.

States may design their CHIP programs in three ways: as a CHIP Medicaid expansion, as a separate CHIP program, or through a combination approach in which the state operates a CHIP Medicaid expansion and one or more separate CHIP programs concurrently. CHIP benefit coverage and cost-sharing rules depend on program design.

Does Puerto Rico Provide CHIP Coverage?

Puerto Rico provides CHIP coverage to children with family incomes up to roughly 266% of the Puerto Rican poverty line,[89] which is 100% of the FPL for a family of three.[90] Puerto Rico operates its CHIP program as a CHIP Medicaid expansion, which means CHIP coverage is the same as Medicaid but financed under CHIP rather than Medicaid. In July 2014, Puerto Rico's CHIP program had 99,340 enrollees.[91]

How Much Federal CHIP Funding Does Puerto Rico Receive?

In FY2014, Puerto Rico's CHIP program had total expenditures of $214.9 million, with the federal government paying $149.5 million of that amount.[92] Puerto Rico's CHIP allotment for FY2014 was $141.0 million. Puerto Rico's federal CHIP expenditures were higher than its FY2014 allotment amount because Puerto Rico was eligible for CHIP redistribution funds (i.e., one of the shortfall funding sources available under CHIP) after exhausting its allotment funds.[93] Puerto Rico also received CHIP redistribution funds in FY2012 and FY2013, and Puerto Rico is the only state or territory to receive CHIP redistribution funds since the funding became available in FY2009.

---

[88] For more information about CHIP, see CRS Report R43627, *State Children's Health Insurance Program: An Overview*, by Evelyne P. Baumrucker and Alison Mitchell.

[89] The income-eligibility levels for Puerto Rico's Medicaid program are based on a local poverty level established by Puerto Rico and approved by CMS instead of the FPL. For a family of three, the Puerto Rican poverty line was 38% of the FPL in 2014.

[90] In the 50 states and DC, children in families with income less than 133% of FPL are required to be covered by Medicaid. However, some children aged 6 through 18 with family incomes between 100% and 133% of FPL are financed by CHIP.

[91] Data retrieved from Commonwealth of Puerto Rico website (https://data.pr.gov/category/Salud) on June 2, 2015.

[92] CMS, CMS-64 data as of March 30, 2015.

[93] After two years, any unused state CHIP allotment funds are redistributed to shortfall states. For more information about CHIP redistribution funds, see CRS Report R43949, *Federal Financing for the State Children's Health Insurance Program (CHIP)*, by Alison Mitchell.

Private Health Insurance

Private insurance includes both employer-sponsored (group) coverage and individual market (non-group) coverage.[94] The ACA includes many different provisions that affect the private health insurance market. All of the provisions apply to the 50 states and DC, but their application to Puerto Rico varies. The applicability of many ACA provisions to Puerto Rico is not explicitly stated in statute. In the absence of explicit applications, HHS has provided some guidance on the topic.

How Many Individuals Have Private Health Insurance in Puerto Rico?

Private insurance is not as pervasive in Puerto Rico as it is in the 50 states and DC; in particular, enrollment in group coverage is not as common. In 2014, approximately 38.3% of individuals living in Puerto Rico had private insurance.[95] About 27.6% of individuals had group coverage, and 10.9% had non-group coverage. In comparison, in the 50 states and DC in 2014, approximately 66.4% of the population received coverage through private insurance. About 54.2% of the population had group coverage, and 12.8% had non-group coverage.

Do Private Plans Offered in Puerto Rico Have to Comply with ACA Market Reforms?

The ACA includes a number of provisions, collectively referred to as market reforms, that apply to group and non-group health insurance plans; impose requirements on sponsors of coverage (such as employers); and establish a federal floor with respect to access to coverage, premiums, benefits, cost sharing, and consumer protections. For example, nearly all private health insurance plans must extend dependent coverage to children under the age of 26, and some private health insurance plans have to cover a defined set of benefits called the essential health benefits.[96]

HHS determined the applicability of the market reforms to Puerto Rico in 2010 and then revisited and changed its determination in 2014.[97] According to the revised determination, the market reforms included in Title I of the ACA as amendments to the Public Health Service (PHS) Act are governed by the definition of state included in Title I of the ACA, which does not include the territories (i.e., Puerto Rico). As such, HHS takes the position that the market reforms do not apply to non-group and group health insurance issuers in the territories. However, HHS indicates

[94] See CRS Report RL32237, *Health Insurance: A Primer*, by Bernadette Fernandez and Namrata K. Uberoi.

[95] This statistic and all subsequent statistics in the paragraph are from the U.S. Census Bureau's 2014 American Community Survey (ACS).

[96] For more information about the ACA market reforms, see CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

[97] The market reforms are included in Title I of the ACA as amendments to Title XXVII of the Public Health Service (PHS) Act. The ACA definition of state that applies to Title I does not include the territories; in contrast, the relevant definition of state in the PHS Act includes the territories. In July 2010, the Department of Health and Human Services (HHS) resolved the ambiguity of which definition of state applies for purposes of the market reforms by determining that the territories are included in the definition of state. Under this position, the market reforms applied to the territories the same way they applied to the states, which means they applied to Puerto Rico. This is the determination that was revisited in 2014.

its analysis applies only to health insurance governed by the PHS Act and that the market reforms could still apply to group health plans:

> 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.[98]

This position also is described in a preamble to a proposed rule.[99] In the preamble, HHS lists the sections of the PHS Act (as added by Title I of the ACA) with which non-group and group health-insurance issuers in the territories do not have to comply. In the preamble HHS reiterates that its position applies only to health insurance governed by the PHS Act and indicates that, as a practical matter, any market reforms applicable to group health plans still apply. **Table 2** shows the market reforms that *do not apply* to non-group and group health insurance issuers in Puerto Rico but may still apply to group health plans in Puerto Rico.

Table 2. Sections of the Public Health Service (PHS) Act as Added by the Patient Protection and Affordable Care Act (ACA)

PHS Act Section	Brief Description
§2701	Rating Restrictions: Applicable plans can only adjust premiums based on certain ACA-specified factors.
§2702	Guaranteed Issue: Applicable plans are required to accept every applicant for health coverage (as long as the applicant agrees to the terms and conditions of the insurance offer).
§2703	Guaranteed Renewability: Applicable plans must renew individual coverage at the option of the policyholder or group coverage at the option of the plan sponsor.
§2704	Coverage of Preexisting Health Conditions: Applicable plans are prohibited from excluding coverage for preexisting health conditions for all individuals.
§2705	Nondiscrimination Based on Health Status: Applicable plans are prohibited from basing eligibility for coverage on health status-related factors.
§2706	Nondiscrimination Regarding Health Care Providers: Applicable plans are not allowed to discriminate, with respect to participation under the plan, against health care providers acting within the scope of their license or certification.
§2707	Comprehensive Health Insurance Coverage: Applicable plans must cover the essential health benefits (EHB); are prohibited from imposing out-of-pocket limits that exceed specified limits; and must meet one of four levels of generosity based on actuarial value (categorized as metal tiers—bronze, silver, gold, or platinum).

[98] Ibid.

[99] 79 *Federal Register* 70673, November 26, 2014.

PHS Act Section	Brief Description
§2708	Waiting Period Limitation: Applicable plans cannot establish a waiting period greater than 90 days.
§2709	Nondiscrimination Regarding Clinical Trial Participation: Applicable plans cannot prohibit enrollees from participating in approved clinical trials.
§2711	Prohibition on Lifetime and Annual Limits: Applicable plans are prohibited from imposing lifetime limits and annual limits on the dollar value of the EHB.
§2712	Prohibition on Rescissions: Applicable plans are prohibited from rescinding coverage except in cases of fraud or intentional misrepresentation.
§2713	Coverage of Preventive Health Services with No Cost Sharing: Applicable plans are required to provide coverage for preventive health services without cost sharing.
§2714	Extension of Dependent Coverage: Applicable plans that offer dependent coverage must make that coverage available to children under the age of 26.
§2715	Summary of Benefits and Coverage: Applicable plans must provide to individuals a summary of benefits and coverage that meets the requirements specified by the Secretary of the Department of Health and Human Services (HHS).
§2716	Prohibition of Discrimination Based on Salary: Applicable plans are prohibited from establishing eligibility criteria for full-time employees based on salary.
§2717	Reporting Requirements Regarding Quality of Care: Applicable plans must annually submit reports to the HHS Secretary and enrollees that address plan quality.
§2718	Medical Loss Ratio (MLR) Requirement: Applicable plans are required to spend a certain amount of premium revenue on medical claims or otherwise provide rebates to policyholders.
§2719	Standardized Appeals Process: Applicable plans must implement an effective appeals process for coverage determinations and claims.
§2719A	Patient Protections: Applicable plans must comply with requirements related to choice of health care professionals and benefits for emergency services.
§2794	Rate Review: Applicable plans must submit a justification for an "unreasonable" rate increase to the HHS Secretary and the relevant state prior to implementation of the increase.[a]

Source: CRS analysis of the ACA and its implementing regulations.

Notes: This table shows the ACA market reforms that *do not apply* to non-group and group health insurance issuers in Puerto Rico but may still apply to group health plans in Puerto Rico. For more information about the market reforms, see CRS Report R42069, *Private Health Insurance Market Reforms in the Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

a. §2794 allows states to apply for federal grants to be used to establish new or enhance existing health insurance rate-review programs. Under the previous position of HHS (i.e., that the market reforms applied to the territories), the territories also were allowed to apply for the federal grants. However, the territories are not eligible for the grants under the current position of HHS. HHS is not requiring the territories to pay back any grants received and spent, but the territories are required to return any unspent grant funding. For more details, see Letters from Marilyn Tavenner, CMS Administrator, to U.S. Territories, July 16, 2014.

Does Puerto Rico Have an ACA Health Insurance Exchange?

No, Puerto Rico has not established an ACA health insurance exchange.[100] Under Section 1323 of the ACA, Puerto Rico, as well as other territories, could elect to establish an exchange but was not required to do so. Such an election was required to be made by October 1, 2013.

Territories, including Puerto Rico, electing to establish exchanges could receive federal funding. The funds had to be used for premium and cost-sharing assistance for individuals who enroll in the exchange. Section 1323 provides $1 billion to be available for this purpose beginning in 2014 and ending in 2019. The ACA directs the HHS Secretary to allocate $925 million to Puerto Rico and divide the remaining $75 million among American Samoa, Guam, the Northern Mariana Islands, and the Virgin Islands.[101]

If a territory did not establish an exchange, Section 1323 provides that the territory is entitled to an increase in Medicaid funds. Since Puerto Rico did not establish an exchange, it is entitled to the increased Medicaid funds. (See "Did the ACA Provide Additional Medicaid Funding for Puerto Rico?" for additional information.)

Are the ACA's Premium Tax Credits and Cost-Sharing Subsidies Available in Puerto Rico?

Under the ACA, individuals who purchase coverage through an exchange may be eligible for premium tax credits and cost-sharing subsidies.[102] This assistance is directed at lower-income individuals to help with the cost of purchasing and using health insurance coverage.

Puerto Rico did not establish an exchange, so the ACA's premium tax credits and cost-sharing subsidies are not available.

As noted above, if Puerto Rico had established an exchange, it could have received federal funds to be used for premium and cost-sharing assistance for individuals who enroll in the exchange. Puerto Rico would have had flexibility in how to provide such premium and cost-sharing assistance, subject to a Section 1323 agreement with HHS.

Are the ACA's Small Business Tax Credits Available in Puerto Rico?

Small businesses purchasing coverage through a Small Business Health Option Program (SHOP) exchange may be eligible for a small business health insurance tax credit.[103] The credit is intended to help make small-group coverage more affordable for certain small businesses.

Puerto Rico has not established an exchange (including a SHOP exchange), so the small business tax credits are not available. If Puerto Rico had established an exchange, Puerto Rican businesses

[100] For general information about health insurance exchanges, see CRS Report R44065, *Overview of Health Insurance Exchanges*, coordinated by Namrata K. Uberoi.

[101] HHS described how the $75 million would be allocated in a letter sent to territory governors on December 10, 2012. According to the letter, American Samoa would receive about $16.5 million, Guam would receive about $24.4 million, the Northern Mariana Islands would receive about $9.1 million, and the Virgin Islands would receive about $24.9 million.

[102] 26 U.S.C. §36B and 42 U.S.C. §18071.

[103] 26 U.S.C. §45R.

are treated as foreign businesses for U.S. tax purposes, which means they are taxed only on their U.S. source income. Foreign businesses may claim the general business credit (of which the small business health insurance tax credit is part) against their U.S. tax liability, if they have any.

Does the ACA Employer Mandate Apply to Businesses in Puerto Rico?

Under the ACA, certain large employers are subject to a shared-responsibility provision.[104] This provision does not explicitly mandate that a large employer offer health insurance to its employees; instead, it has the potential to impose penalties on large employers that do not provide affordable and adequate coverage to their full-time employees and their employees' dependents.

As HHS has observed, certain tax provisions, including the employer mandate, generally do not apply in Puerto Rico and the other territories. [105] Furthermore, because Puerto Rico is a non-mirror territory,[106] there is no requirement that Puerto Rico implement a provision comparable to the employer mandate under its own tax code.

Does the ACA Individual Mandate Apply in Puerto Rico?

As of January 1, 2014, the ACA requires most individuals to maintain health insurance coverage or otherwise pay a penalty. Some individuals are exempt from this individual mandate and the penalty.[107]

The individual mandate generally does not apply to Puerto Rico because statute provides that bona fide residents of the territories are treated as having coverage that complies with the individual mandate.[108] Furthermore, because Puerto Rico is a non-mirror territory,[109] there is no requirement that Puerto Rico implement a provision comparable to the individual mandate under its own tax laws.

[104] 26 U.S.C. §4980H.

[105] Letter from Kathleen Sebelius, HHS Secretary, to Governors of U.S. Territories, December 10, 2012.

[106] HHS has observed that application of the ACA tax provisions depends, in part, on whether the territory is required to use the Internal Revenue Code (IRC) as its territorial income-tax laws (this is commonly referred to as having a mirror code). Territories that must have tax codes that are identical to the federal IRC are referred to as mirror territories. Territories that are not required to use the IRC, referred to as non-mirror territories, have significant flexibility in implementing their own income-tax laws and can choose whether to adopt provisions comparable to those in the IRC. Puerto Rico is a non-mirror territory.

[107] 26 U.S.C. §5000A.

[108] 26 U.S.C. §5000A(f)(4)(B). A bona fide resident of Puerto Rico must be present in Puerto Rico for at least 183 days in the taxable year, must not have a tax home outside Puerto Rico during the taxable year, and must not have a closer connection to the United States or a foreign country during such year. 26 U.S.C. §937.

[109] See footnote 106 for an explanation of non-mirror territory.

Author Contact Information

Annie L. Mach, Coordinator
Analyst in Health Care Financing
amach@crs.loc.gov, 7-7825

Patricia A. Davis
Specialist in Health Care Financing
pdavis@crs.loc.gov, 7-7362

Sarah A. Donovan
Analyst in Labor Policy
sdonovan@crs.loc.gov, 7-2247

Jim Hahn
Specialist in Health Care Financing
jhahn@crs.loc.gov, 7-4914

Suzanne M. Kirchhoff
Analyst in Health Care Financing
skirchhoff@crs.loc.gov, 7-0658

Alison Mitchell
Analyst in Health Care Financing
amitchell@crs.loc.gov, 7-0152

Paulette C. Morgan
Specialist in Health Care Financing
pcmorgan@crs.loc.gov, 7-7317

Scott R. Talaga
Analyst in Health Care Financing
stalaga@crs.loc.gov, 7-5956

Key Policy Staff

Area of Expertise	Name	Phone	Email
Demographic & Economic Information	Sarah Donovan	7-2247	sdonovan@crs.loc.gov
Medicare Financing	Patricia Davis	7-7362	pdavis@crs.loc.gov
Medicare Physician Payments	Jim Hahn	7-4914	jhahn@crs.loc.gov
Medicare Part A	Scott Talaga	7-5956	stalaga@crs.loc.gov
Medicare Advantage (Part C)	Paulette Morgan	7-7317	pcmorgan@crs.loc.gov
Medicare Part D	Sue Kirchhoff	7-0658	skirchhoff@crs.loc.gov
Medicaid & CHIP	Alison Mitchell	7-0152	amitchell@crs.loc.gov
Private Health Insurance	Annie Mach	7-7825	amach@crs.loc.gov