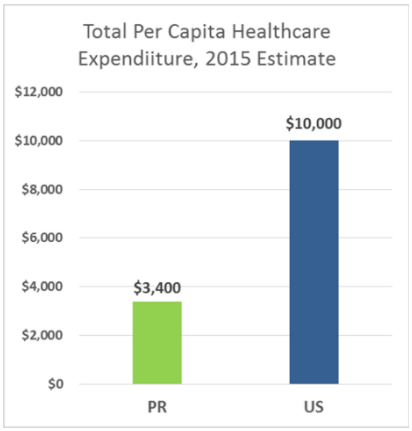
September 29th, 2015

Senate Committee on Finance
Attn. Editorial and Document Section
Rm. SD-219
Dirksen Senate Office Bldg.
Washington, DC 20510-6200b

Written statement for the record in relation to the hearing:
Financial and Economic Challenges in Puerto Rico
United States Senate Committee on Finance
Tuesday, September 29, 2015, 10:00 AM

Presented by:
Puerto Rico Healthcare Community Leaders
P.O. Box 009023547
San Juan PR 00902-3547

Dear Members of the US Senate Finance Committee:



In present times, a discussion about *financial and economic challenges in Puerto Rico* would be gravely incomplete without a careful assessment of the social and economic implications of the growing disparities and underfunding in the healthcare segment of the island. The case of Puerto Rico represents today a unique, and concerning, scenario within the US healthcare economy. At the very macro level, total healthcare expenses per capita are approximately $3,400 in Puerto Rico, compared to the national average projection of $10,000 or more for 2015.[1] Not only Puerto Rico is very distant from US average funding levels for healthcare, but also has significantly less resources for healthcare than many countries with diverse healthcare systems like Canada, France, Germany, and the UK, which are also known to spend significantly less than the US average.[2] Many of these well studied and recognized healthcare systems spend $5,000-$6,000 per capita, placing Puerto Rico's expenditure levels at a distinct disadvantage for many perspectives, especially considering that core inputs like prescription drugs, equipment, electric power and others are acquired within the US market, and mostly at above average prices. Moreover, the partial and uneven implementation of the Medicare and Medicaid programs for 5 decades has been a core element impacting the resulting imbalances that we see today. The situation of relative underfunding and increasing disparities within the same US healthcare economy, and the same Federal programs, has sustained itself only by inevitably depressing professional compensation, stalling capital and information technology investments, and by increasing barriers to appropriate access to care for the low income population.

[1] http://www.forbes.com/sites/danmunro/2015/01/04/u-s-healthcare-spending-on-track-to-hit-10000-per-person-thi -year/
Estimates for Puerto Rico are based on the financial statements of health plans in the island reported to the National Association of Insurance Commissioners (NAIC). CMS reports for Medicare FFS, and reports of the Government of Puerto Rico Office of Management and Budget.
[2] [2] World Health Organization (WHO) http://apps.who.int/gho/data/node.main.78?lang=en

While there may be different theories about why this is the current scenario, our call for urgent action is borne out of the following facts:

1. **There is a problem with the economy of Federal healthcare programs in Puerto Rico**, and over 740,000 Medicare beneficiaries and 1,600,000 Medicaid beneficiaries are directly impacted with less benefits, much higher out of pocket costs, and less disposable income than any similarly situated individual elsewhere in the US.

2. **The problem is inevitably tied to decades of partial and uneven implementation of Federal healthcare programs.** Medicare and Medicaid for Puerto Rico are impacted by particularly disparate treatment in the statute, while the implementation of "one-size-fits-all" regulation and calculations for the programs has not accounted for basic differences in statutory benefits, eligibility, and the socio-economic situation of Puerto Rico. The effect of unadjusted program implementation in the face of statutory differences for so many years has exacerbated disparities, produced harmful unintended consequences, and pushed Puerto Rico farther to the bottom with regards to healthcare funding.

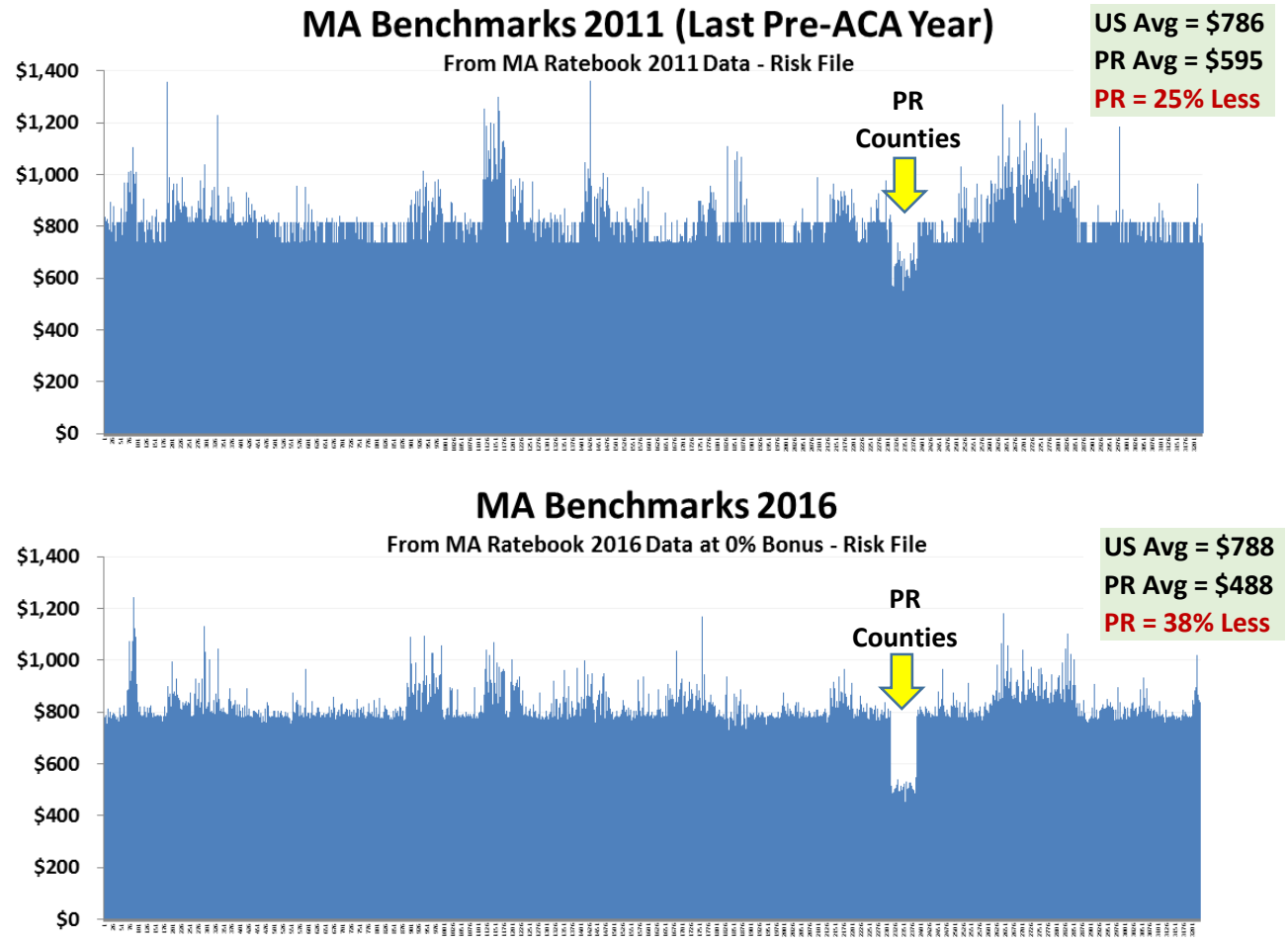
3. **There are immediate solutions available** – With US citizens in Puerto Rico paying the same Medicare Tax and the same Part B premium as any other citizen in the country, we believe there are legitimate "NO-Bailout" solutions that directly impact the capacity of programs in Puerto Rico to provide appropriate access to quality care, and contribute to the strengthening of the economy in general, while also maintaining in Puerto Rico the most cost-efficient Medicare and Medicaid programs in the nation. Moreover, historic cuts and migration to the mainland could inevitably lead to higher costs for the Federal government as beneficiaries would immediately participate in much higher-cost versions of the Medicare and Medicaid programs.

Growing Disparities with Federal Healthcare Programs

Due to historic deficiencies in the Medicare FFS reimbursement, Medicare managed care was not viable and non-existent for beneficiaries in Puerto Rico before 2001. Changes and protections to the lowest cost areas defined in the Benefits Improvement and Protections Act (BIPA, 2000), and the Medicare Modernization Act (MMA, 2003) provided the first real opportunity for the availably of coordinated care and plan choice. Subsequently, in the first decade of the century, Medicare Advantage (MA) became the preferred choice of beneficiaries in Puerto Rico, especially for the dual eligible and the low income beneficiaries. Today, Puerto Rico has the largest integrated Medicare-Medicaid program in the nation serving over 270,000 dual beneficiaries, and the MA program serves more than 570,000 beneficiaries in total. Most significantly, even before the Affordable Care Act (ACA) cuts began, the MA program in Puerto Rico had the lowest benchmark in the nation, 25% lower than the US average and 21% lower than Hawaii. The MA program in Puerto Rico was doing a lot more, for a lot less.

Unfortunately, the ACA has provoked the highest Medicare funding cuts in history for citizens and providers residing in the island. Since 2011, MA benchmarks have decreased 18%, and payment levels are estimated to be $1 billion less in 2015. Puerto Rico's MA base rates are now 38% lower than the US average, and 34% lower than the lowest state (HI). The aggregate funding reduction so far has reached over $3 billion less in MA. These reductions have already generated tangible cuts in benefits, provider compensation and provider networks. Most importantly, the reductions have put at risk the viability of the program for dual eligible, Medicare Platino, and have basically eliminated crucial help in benefits for non-dual, BUT low income, beneficiaries that are also excluded by statute from the Part D Low Income Subsidy Program (LIS). With regards to duals, the local Government has estimated that it would need at least $600-$800 million more from the local general fund to maintain a Medicaid program for the dual eligible without MA.

Chart 1 - Illustration of the MA Benchmarks at 0% Bonus for Every County in the US
(Only Northern Marianas, American Samoa, and Guam are not included)

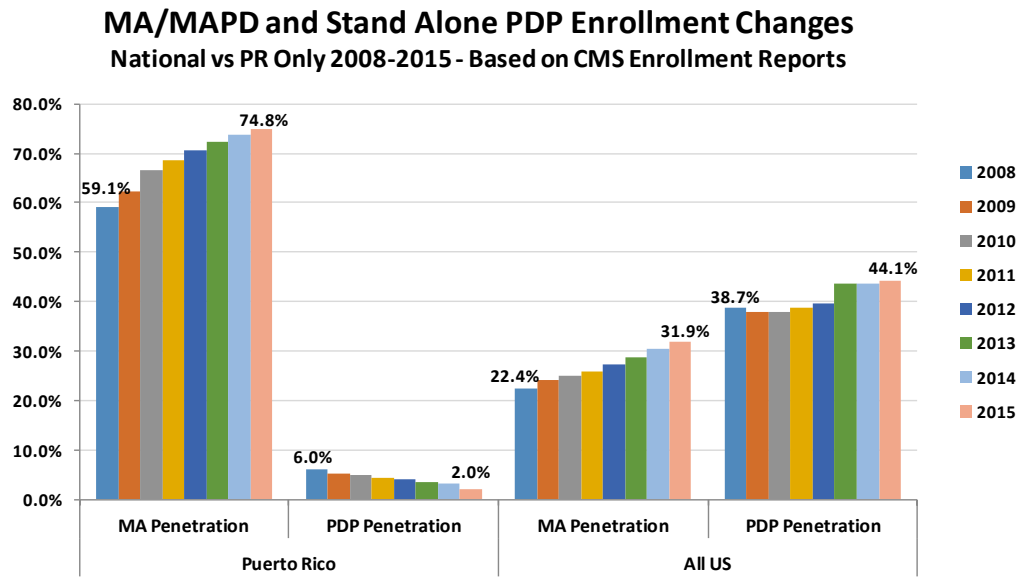


Aggravating Disparities for the Low Income in MA and Part D

After the enactment of the MMA (2003), the MA program increasingly became the vital platform for the dual eligible population and the low income non-dual population to get appropriate access to care. MA penetration is 75% of all Medicare, serving basically 9 out of every 10 beneficiaries with Parts A & B, while the national average penetration is 32%. Moreover, Stand Alone PDP enrollment is dramatically revealing, going down from 6% to 2% in Puerto Rico from 2008 to 2015, while at the national level the amount of beneficiaries buying a stand-alone part D plan has increased from 39% to 44% (See Chart 2). The disadvantageous socio-economic status of Medicare beneficiaries in the island evidently impacts their decision to use MA as their most, and for most the only, secure access to Medicare benefits. Without a viable MA program that helps with the gaps in Part D, access to prescription drugs for beneficiaries in Puerto Rico would be unaffordable for the majority of the population. In regards to hospital coverage, another example of anomalies alleviated by MA, is the fact that the regular Medicaid program in Puerto Rico does not pay for the Part A deductible to hospitals. We estimate that over $70 million in uncompensated care is saved yearly by the first-dollar hospital coverage under the MA-based Medicare Platino program for the dual eligible in Puerto Rico.[3]

[3] Estimate based on assuming 230 admissions per dual beneficiary, for 270,000 beneficiaries in Medicare Platino D-SNPs. The Part A deductible for 2015 is $1,260.

Chart 2 – MA/MAPD and PDP Enrollment in PR compared to National Perspective



The recent national-level discussions about the need for socio-economic status (SES) adjustments for risk scores and STAR (quality) rating methodologies have underscored two key barriers for Puerto Rico with regards to the appropriate implementation and funding for the MA and part D programs: (1) 50% of MA beneficiaries are dual eligible, and (2) the fact that Part D has much less benefits in Puerto Rico (without the Part D LIS) compared to Part D benefits for citizens residing in the sates and Washington DC. Important studies have examined and concluded that plans that serve higher proportion of low income beneficiaries are disadvantaged in the current STARs methodology, and have proposed policy amendments accordingly (Innovalon 2013, National Quality Forum 2014, Holtz-Eakin 2015).[4] However, while neither Congress nor CMS has acted to implement any conforming policies, the poorest beneficiaries have lost millions in benefits given continuing deficiencies in risk scores, and Lower-MA Rebate, NO-Bonus scores in the STARs program. For 2014 and 2015, over 60% of MA beneficiaries were at 4.0 STARs or more (5% Bonus), while there were none (0%) in Puerto Rico.

Furthermore, the alarming increasing disparity in Medicare Advantage has exacerbated the impact of the exclusion of the Part D LIS for beneficiaries in Puerto Rico since the MMA (2003). It is estimated that from 100,000-150,000 beneficiaries residing in Puerto Rico have income between 87% FPL and 150% FPL, and would be eligible to get help from Medicaid and/or from the Part D LIS if they resided elsewhere in the states. The partial Part D benefits for the low income beneficiaries aggravates the scenario with regards to quality measures. We have repeatedly presented this problem in Congress and to CMS, but responses have been null.[5] Holtz-Eakin (2015) concluded that plans with high LIS lost over $470 million to pay for benefits due to missing the cut-off for bonus payment by less than half-star. With most plans in Puerto Rico at 3.0 or 3.5 STARs, we estimate that the lost funds for benefits (due to unattained MA rebate percentage and/or MA bonus) was at least $200-$250 million in 2015, and an amount close to $200 million in 2014.

[4] ***Inovalon*** (October 2013); ***National Quality Forum*** (August 2014); Holtz-Eakin, Ryan; July 2015 http://americanactionforum.org/research/medicare-advantage-stars-are-the-grades-fair

[5] The Obama 2008 healthcare proposals for PR explicitly included the elimination of the Part D LIS exclusion, but no meaningful action has been taken so far. The President's Task Force on Puerto Rico recognized this problem in March 2011 and later the HHS Report to the Task Force from April 2013 confirmed the problem. HR3966 was introduced in 2014 by Resident Commissioner Pierlusi to address the LIS exclusion. The Community of PR presented a response with more details to the CMS RFI on November 2014.

Effect on Low Income Citizens Financial Circumstance and on Consumption for the Economy

There is no question that the MA cuts, the exclusion of the Part D LIS, and the lost resources under the related to the uneven implementation of the STARS rating program, have severely impacted the disposable income of citizens, with an effect on Puerto Rico economy in general. It should be noted, for example, that - different from all other similarly situated citizens - dual beneficiaries in the island do not get help to pay the monthly Part B premium, which is deducted from their Social Security checks. Starting in 2006, the MA program for duals provided consistent plan alternatives that effectively increased the social security payments for the poorest citizens by providing a credit to the Part B premium. Pre-ACA plan offerings mostly offered $25 or higher in monthly credits. By 2016, the average Part B credit has gone down probably around $25pmpm. Using this assumption, 270,000 beneficiaries are each losing $300 from their pockets in 2016, and over $80 million as a group. Moreover, although a detailed analysis has not been not been finalized, it is fair to estimate that MA beneficiaries in Puerto Rico are losing $50-$60pmpm from their pockets due to the ACA reductions. This means $600-$720 per beneficiary and $340 to $400 million in the aggregate, lost as disposable income most likely to be consumed in the local economy to cover other basic needs. With average Social Security payments that are 2/3 of the national average, and the exclusion from Supplemental Security Income (SSI), we can make two very logical and relevant conclusions (see Table 1):

1. MA cuts have a relatively higher impact on the disposable income in Puerto Rico given the lower level of poverty and exclusion of Part D benefits and other safety-net programs;

2. MA cuts will directly reduce consumption in the local economy given that circumstances almost assure the healthcare help frees income for basic needs. This is the lowest income population in the nation, paying a higher than average cost of living (COLI, Jan-Mar 2015).

From the national perspective, on the other hand, there is also increasing discussion and analysis about how expansions in healthcare coverage is generating increased consumption and supporting economic growth (WSJ Sept 2014).[6]

Table 1 - Comparison of the Typical Low Income Beneficiary Situation in PR vs Other Jurisdictions[7],[8]

Puerto Rico Perspective	National Perspective
• **99.1%** Hispanic / Latino	• **7.3%** Hispanic / Latino
• **$12,000** Average Social Security Income	• **$19,000** Average Social Security Income
• **30%** with retirement income	• **48%** with retirement income
• **53%** have education less than a high school diploma	• **20%** have education less than a high school diploma
• **$0** Supplemental Security Income (SSI)	• **$8,841** Average Supplemental Security Income (SSI)
• **115.4 Cost of Living Index (COLI);** San Juan area Ranked #35 in highest cost of living compared to 296 US metropolitan statistical areas (Jan-Mar 2015)	• **100.0 Cost of Living Index (COLI)** for Jan-Mar 2015

[6] http://blogs.wsj.com/economics/2014/09/11/health-care-revenue-rebound-could-boost-u-s-economic-growth/

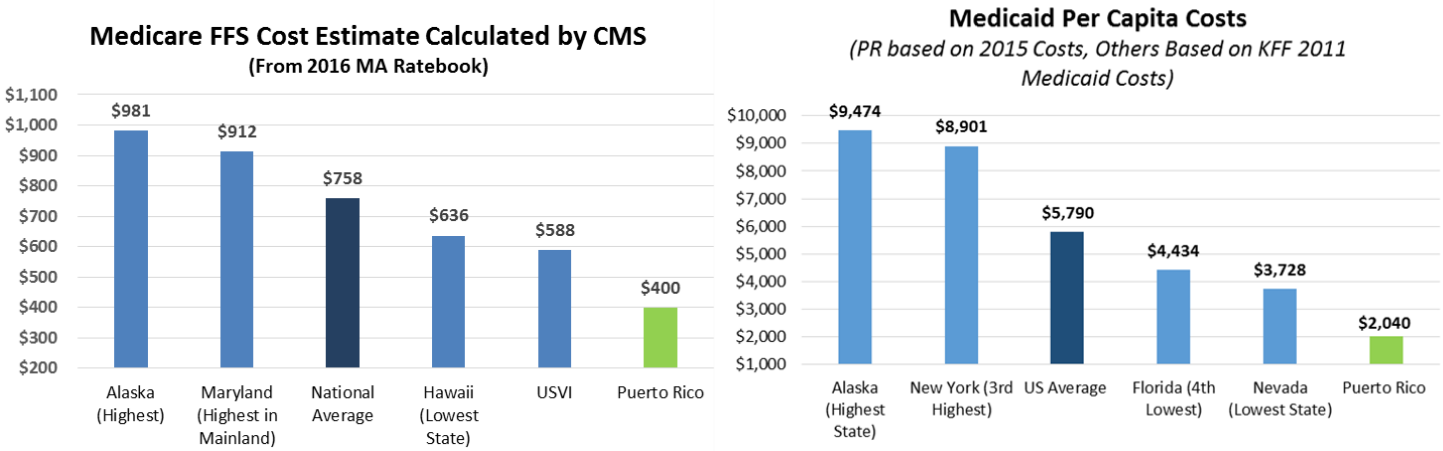
[7] Selected figures from - US Census Bureau, American Fact Finder, 2011-2013 American Community Survey 3-Year Estimates; http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

[8] Cost of Living Index (COLI) of the *Council For Community and Economic Research* http://www.estadisticas.gobierno.pr/iepr/LinkClick.aspx?fileticket=SEqx6Sl8Ugo%3d&tabid=384

Traditional Medicare never worked in Puerto Rico as in Other Jurisdictions

The increasing crisis in the beneficiary-chosen MA program in Puerto Rico brings back historic disparities and underfunding in the Medicare FFS program. For decades, Part A payments have been distinctly lower for hospitals in the island because of a discounted formula defined by law, and due to regulatory implementation that further reduced payments. An example of the later is the significant reduction in DSH payments for PR given CMS has not used a proxy for the "Medicare SSI days" in the formula, even when this program is also excluded for the Territories by law. This makes the SSI days an unrealistic indicator of the low income population in Puerto Rico, and has reduced hundreds of millions of dollars in payments to Medicare hospitals in the island, which is contrary to the intent of Congress in relation to DSH. Under Part B, other examples of issues include the potential underestimation of the geographic practice cost indexes (GPCIs). The survey used by CMS for estimating office rent costs is disproportionally biased due to the use of 2-bedroom apartment rent which are subsidized in a greater proportion in Puerto Rico.[9] In general, based on data reported by CMS as 2016 estimates, Medicare FFS payment estimates for PR are 47% lower than the US average, also an outlier at the bottom among all jurisdictions (See Chart 3). Statutory, regulatory and context differences over 50 years have shaped a Medicare FFS program that is not reliable and not realistic as an accessible and appropriate coverage option for most beneficiaries in Puerto Rico. The program in the island is not what the ACA assumed as the good standard, like it may be elsewhere. In Puerto Rico, it is simply not a reliable source of what Medicare Parts A & B are supposed to be for eligible beneficiaries.

Chart 3 – Medicare FFS and Medicaid Expense in PR vs Other Jurisdictions



Medicaid has also been Extremely Different

The Medicaid program in Puerto Rico has also developed under statutorily defined limitations for several decades. After being limited by a statutory cap on benefits since the early 80s that maintained the effective Federal matching percentage below 20%, the ACA approved a defined grant for the period of 2011-2019, which totaled $6.3 billion in additional Medicaid funds, and increased the FMAP to 55%.[10] The applicable FMAP under the regular formula would be 83%. As a temporary measure, the new allocation has been crucial to maintain the healthcare of the poorest, while it has also helped to keep the government finances afloat. Nonetheless, it should be noted that the Medicaid program premiums in Puerto Rico are still 65%

[9] Report about the *Public Housing Prevalence Bias in the Office Rent component of the GPCIs*; PR Institute of Statistics, July 2015. http://www.estadisticas.pr.gov/iepr/LinkClick.aspx?fileticket=ZdH5lxNObgs%3d&tabid=165

[10] This includes the $925 million initially allocated for an option to start a local health insurance marketplace. Government studies concluded that the marketplace was not viable with this fixed amount and decided to use the funds in Medicaid.

lower than the US average (See Chart 3, above). Moreover, there is certainly increasing concern about the upcoming scenario when the ACA funds run out. The program currently depends on the current annual level of Federal funds to support the coverage for over 1.6 million citizens. As we emphasize herein below, the "Medicaid Cliff" presents a situation for the local government finances that could put at risk the access to health for hundreds of thousands of beneficiaries and/or increase the local government's deficit by another $1 billion or more.

The Health Insurance Providers Fee - A new Incongruence with the ACA

Finally, the uneven applicability of Sec 9010 – health insurance provider's fee ("HIT") – to the Territories is severely impacting the situation of healthcare under all segments: Medicare, Medicaid and Commercial. Our community has presented several legal analysis to HHS and to the US Treasury in relation to our understanding that the inapplicability of many ACA provisions tied to new expenditures supported by the tax, is also basis for the inapplicability of Sec. 9010. As recent as July 2014, HHS re-interpreted its initial policy on the implementation of several Title I provisions of the ACA to deem them inapplicable to Territories. Basically, plans, citizens and governments of the Territories are being required to pay the price for a product that they are not getting. Puerto Rico is excluded from key provisions like the individual and the employer mandates, the individual and small group subsidies, and the Federal funding for the Medicaid expansion. As reviewed by Federal Courts in recent ACA litigation, we understand the ACA is meant to be a coherent package of provisions, not a list of independent and unrelated rights and obligations. We contend that not re-assessing the applicability of the HIT is incongruent with the intent of the ACA, as validated by courts in different circumstances. The HIT is costing the PR health system about $150 million in 2015 and would increase to annual payments of approximately $250 million in the next few years.

General Economic Impact

As part of our efforts to present the urgent situation of Medicare and Medicaid in Puerto Rico, we prepared estimates of the current shortfall in Federal resources for these programs, assuming a defined parameter of would could be an appropriate level of funding. The appropriate levels are mostly based on the list of policy proposals approved by the Puerto Rico Healthcare Crisis Coalition, which we include as the last section of this document. We can submit more detail or discuss the estimates with the Committee as requested.

Based on our analysis, the estimated Federal healthcare (Medicare and Medicaid) shortfall is approximately $1.9 billion in 2015.[11] If we consider the exclusion of Supplemental Security Income (SSI) as well, the shortfall is $3.6 billion. Unless urgent action is taken by Congress and by CMS, the projected worse case may occur in 2018-2019 and would be a shortfall of $3.6 billion (not including SSI), with no ACA funds for Medicaid and after the potential additional incremental cuts to MA and FFS Medicare based on factors currently legislated or still unaddressed by regulation. At the current level, the shortfall for healthcare programs have an economic impact of approximately $3.8 billion in a year, considering direct loss and a multiplier (x2) for indirect impacts. Healthcare is mostly a local economic activity, generating immediate impact on jobs, disposable income of beneficiaries and providers, and local government tax revenue. In addition, the direct impact to citizens and the economy is supported by the new minimum Medical Loss Ratio (MLR) requirements, and the fact that currently direct medical services expenses for the combined Medicare and Medicaid programs in PR is at around 90%. All these factors closely link any shortfall or enhancement in healthcare program funding to local economic performance, to benefits, and to provider compensation.

[11] Uses current MA and Mi Salud membership and premiums. The MA shortfall is based on the minimum MA rate proposed in the Schumer bill and the Medicaid shortfall is based on the use of 83% Federal matching percentage instead of the cap and the 55% limit that applies today. No projections of increased trends or increases to provider payment levels are added.

With respect to the combined impact of local expenses and lost tax revenues, the estimate of the healthcare shortfall impact on the PR Government's budget is currently $1.1 billion a year (using 2015). If we estimate the impact considering a $3.6 billion shortfall after the additional ACA grant for Medicaid runs out, it means $720 million less in tax revenue, and an expense to the Puerto Rico Government's budget of $1.9 billion. A $2.6 billion total. The net increase to government expenses compared to 2015 would be $1.4 billion in order to maintain the current Medicaid program and eligible population if there are no legislative and administrative fixes to Medicare Advantage and Medicaid urgently.[12]

The relation between economic performance, government finances and Medicaid expenditures is increasingly being studied across the nation. HHS recently published a summary of recent literature specifically describing impacts in the finances of low income citizens, impacts on uncompensated care, and impact on the states Gross Domestic Product (GDP).[13] Most of the work has also been reviewed by the Kaiser Family Foundation, which concluded that state case studies show savings to the local government expenses and revenue gains in relation to increased Medicaid expenditures.[14]

Healthcare Economic Impact

The healthcare segment in Puerto Rico represents approximately 11% of the Gross Domestic Product (GDP) and supports directly from 60,000 to 80,000 jobs. At the current underfunding levels, legitimate fixes to Medicare and Medicaid would not only stop the growing crisis in healthcare, but also immediately generate jobs, increases in disposable income of the poor, increases in tax revenues and reductions in local Government expenses on healthcare. Healthcare expenses are too low for Puerto Rico as a community that is part of the US healthcare economy and part of the US healthcare programs, as decided for many decades by Congress and the Federal Government. It should be noted that, the cost of living in Puerto Rico is on average significantly higher than in the mainland. This has recently been validated when Puerto Rico was included the Cost of Living Index (COLI) of the Council for Community and Economic Research[15] (C2ER) which has shown consistently that PR is over 15% costlier than other jurisdictions for the composite index.

Contrastingly, significantly lower compensation in healthcare is part of the context for historic levels of migration to the US mainland. The Puerto Rico Institute of Statistics just reported that in 2014 about 84,000 citizens moved to the mainland, resulting in a net migration of 64,000. This level of migration is the highest recorded in history, and is even higher compared to the exodus of Puerto Ricans to the mainland in the 1950s.[16] More specifically, data from the American Community Survey and the PR Community Survey suggests a net migration of 12% of the physicians in Puerto Rico moving to the US mainland between 2005-2013. The latest figures suggest that over 200 physicians are migrating from the island annually.

Moreover, with over 4.5 million Puerto Ricans residing in the mainland, the decision for many Medicare and Medicaid to move to Florida, New York or Texas, is much easier. At the macro level, the scoring of policy adjustments for Puerto Rico, has to include the increased Federal expenses related to migration. For example, if a beneficiary moves from Puerto Rico to Florida, the Federal government:

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[12] Considers $800 million increase to cover regular Medicaid and a $600 million increase to cover for dual eligible beneficiaries if Medicare Platino is not viable under the MA platform.

[13] Economic Impact of the Medicaid Expansion. Office of the Assistant Secretary for Planning and Evaluation. Department of Health and Human Services. March 23, 2015. http://aspe.hhs.gov/pdf-document/economic-impact-medicaid-expansion

[14] Dorn, S, et al. (March 2015). Kaiser Family Foundation and Urban Institute (March 2015). The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States. Kaiser Family Foundation. Accessed at: http://kff.org/medicaid/issue-brief/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states/

[15] See: http://www.c2er.org/.

[16] http://www.estadisticas.gobierno.pr/iepr/LinkClick.aspx?fileticket=KmY2LP3VLPw%3d&tabid=39&mid=590

- Will pay 65% more for Medicare Advantage beneficiaries, plus the LIS as applicable;
- Will pay 100% more for a beneficiary in FFS Medicare;
- Will pay 115% more for a beneficiary in Medicaid.

Saving healthcare programs in Puerto Rico saves money to the Federal government.

Conclusion:

Congressional and Administrative Action for Healthcare Funding is part of the Solution for PR

We ran out of time. Healthcare in Puerto Rico can't wait. Benefit reductions to the poorest, increasing migration, and impacts on the economy and the government's financial crisis are already real. Moreover, Federal action would actually save money to the Federal government.

We respectfully request the US Senators and staff of the Senate Committee on Finance to carefully consider the following basic points:

1. There are legitimate fixes to Federal healthcare programs funding that can be part of the immediate support to our economy and government finances, while NOT being a Federal bailout. Given the cuts in MA that continue to increase, the net result of the ACA for beneficiaries in the island is a net loss in funding even before 2019.

2. Continuing administrative and legislative inaction in relation to the imbalances of the Medicare and Medicaid programs in Puerto Rico will worsen the crisis in government finances and the PR economy given significant incremental cuts anticipated in 2016, 2017 and 2018.

3. Not acting on healthcare in Puerto Rico can cost the Federal government more, given that the fixes proposed will still leave the island at the lowest level of healthcare expenditure in all the nation. Any beneficiary that moves from Puerto Rico to the mainland will automatically mean higher Federal expenses of 50% or more.

4. Fixing Medicare Advantage, Part D and Medicaid for Puerto Rico will have direct impact on beneficiaries' disposable income, on the economy through increased consumption, on local government expenditures and on tax revenues. Efforts to invest time and funding on other types of economic development projects are currently hindered by the continuing crisis in healthcare.

5. The incongruences and funding disparities in the island are a result of decades of partial and uneven implementation of the Medicare and Medicaid programs, which has influenced the structure and economics of the PR healthcare system in general. In particular, we stress the importance of corrections in the Medicare program, for which citizens in Puerto Rico pay the same Medicare Tax and the same part B premium as residents anywhere else.

6. The MA program in Puerto Rico has reported higher improvement measures in the Part C and part D STAR rating system compared to the national average. CMS has noted significant improvement in quality even at the lowest levels of cost. This means that fixes for MA and Part D will work on a highly monitored, measured, and performance improving platform. Actually, the most cost-effective healthcare platform in the entire US.

7. **Common Ground:** Amidst all the complexities and positions about the economic situation of Puerto Rico, policy proposals for Federal healthcare programs have revealed common ground across political parties and segments both in Puerto Rico and in the US. We strongly urge you to support the proposals listed by the Coalition (See last page).

List of Legislative and Administrative Policy Proposals approved by the PR Healthcare Crisis Coalition
Sept 15, 2015

Legislative Proposals Needed for PR

1. **Urgent minimum protection for Beneficiaries in Medicare Advantage with Part D (MAPD), Including Duals** – (A) Establish a minimum MA benchmark rate for Territories at 20% lower than the national average Medicare FFS per-capita costs, or at an amount equal to the lowest MA benchmark county among the States and the District of Columbia, whichever is the lowest; and (B) Eliminate the exclusion of the Part D Low Income Subsidy (LIS) for beneficiaries residing in Territories. This would provide part D funding to cover essential benefits for all dual eligible and citizens with incomes below 150% FPL.

2. **Parity for Beneficiaries in the Medicaid Program** – (A) Eliminate the total dollar cap on Federal funding, and (B) the Federal Medical Assistance Percentage (FMAP) limit of 55% for citizens residing in Puerto Rico that eligible to Medicaid under the program standards for the rest of the nation.

3. **Eliminate Disparities in Traditional Medicare –** In the Part A Inpatient Prospective Payment System (IPPS) Formula, use the regular national costs formula for 100% of the standard operating costs and capital cost components of the DRG base rates for inpatient services. Establish a new wage index floor to avoid increasing disparity.

4. **Medicaid DSH** - Extend Medicaid Disproportionate Share Hospital (DSH) payments for Hospitals in Puerto Rico.

5. **Medicare HITECH** Funds for hospitals in PR.

6. **Medicare Part B** auto-enrollment and waiver of late enrollment penalty.

Administrative Adjustments Needed for PR

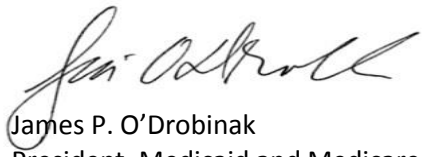
1. **Inapplicability of Health Insurance Tax ("HIT")** – The US Treasury and HHS have the authority to deem Sec 9010 of the ACA inapplicable to the Territories to avoid the current incongruence in the implementation of inter-related provisions of the law.

2. **Part A - Use of alternative to SSI Days** - Establish an alternate indicator of "Medicare SSI Days" in the Part A formulas to calculate payment using mainly the "dual days".

3. **Adjust MA and Part D risk scores and STAR ratings based on Socio-economic Status (SES)** to account for increased challenges for plans that serve a high proportion of dual eligible beneficiaries (similar to national policy proposal) and the additional distinction of the lack Part D LIS benefits for citizens residing in the territories.

4. **Appropriate Part B Physician Fees** – Make corrections to the Practice Expense GPCI (current is 0.705).

Respectfully,



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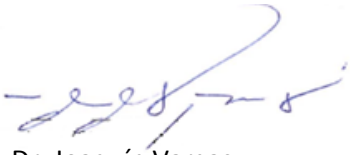

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