CONGRESSWOMAN JENNIFFER GONZÁLEZ-COLÓN

PUERTO RICO - AT LARGE

COMMITTEE ON ENERGY & COMMERCE

Remarks

Last week, this Committee took a big step towards correcting the effects of decades of disparate treatment regarding healthcare programs in the territories by allocating critically needed resources to our Medicaid program and ensure its sustainability while a more permanent legislative solution is developed.

Pending before this Committee are 3 additional bills that I have introduced, which seek to correct this disparate treatment in federal healthcare programs in Puerto Rico and which are also critically necessary to meet the healthcare needs of our vulnerable populations:

H.R. 813, the PUERTO RICO INTEGRITY IN MEDICARE ADVANTAGE ACT

H.R. 2172, A BILL TO REMOVE THE MATCHING REQUIREMENT FOR MEDICARE PART D DRUGS

HR 2310, the FAIRNESS IN MEDICARE PART B ENROLLMENT ACT

I respectfully request from this Committee that it take these bills under advisement and act favorably for the benefit of those Americans living in Puerto Rico, who have been left behind by our healthcare system.

<u>Background</u>

According to an analysis undertaken by the Office of the Assistant Secretary for Planning and Evaluation of the U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES,[1] Americans living at the bottom of the income distribution often struggle to meet their basic needs on very limited incomes, even with the added assistance of government programs. Among the key findings are the following:

- Low-income individuals are especially sensitive to even nominal increases in medical out-of-pocket costs, and modest copayments can have the effect of reducing access to necessary medical care.

- Medical fees, premiums, and copayments could contribute to the financial burden on poor adults who need to visit medical providers.

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[1] Analysis conducted by Lauren Frohlich, Kendall Swenson, Sharon Wolf, Suzanne Macartney, and Susan Hauan. Available at https://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty.

- The problem is even more pronounced for families living in the deepest levels of poverty, who effectively have no money available to cover out-of-pocket medical expenses including copays for medical visits.

Americans living in poverty have significantly constrained budgets that severely limit their ability to pay out-of-pocket health care costs; those in deep poverty have literally no available income after they pay for their most basic necessities each month, necessities which do not include health care, child care, or transportation. People in poverty tend to be less healthy than those with higher incomes and therefore need more medical care. But people in poverty are often unable to afford even nominal premiums and copayments, and research shows that they may forgo necessary medical treatment as a result of required cost-sharing.

Research shows that increases in cost-sharing in the form of copayments can discourage individuals with low income from accessing necessary medical care, which can have negative health consequences. An analysis of the Oregon Health Plan redesign implemented between 2003 and 2005 found that increased out-of-pocket costs such as mandatory copayments are associated with unmet health care needs, reduced use of care, and financial strain for already vulnerable populations.[2] A study of Utah's Medicaid program found that $2 copayments for physician services resulted in Medicaid patients seeing doctors less often.[3] The national RAND Health Insurance Experiment found that low-income individuals reduce their use of effective care by as much as 44 percent after being subject to copayments.[4] The study also found that copayments lead to poorer health outcomes among low-income adults and children due to a reduction in the use of care, including worse blood pressure and vision and higher rates of anemia.[5]

Puerto Rico's current population provides a prime example of these findings. With a median annual income of approximately $19,500, close to half of Puerto Rico's residents live below the poverty level and depend upon the public health system for their medical care.

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2 Wright, Bill J. *et al*, 2010. HEALTH AFFAIRS. "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out."

3 Ku, Leighton *et al*., 2004. Center on Budget and Policy Priorities. THE EFFECTS OF COPAYMENTS ON THE USE OF MEDICAL SERVICES AND PRESCRIPTION DRUGS IN UTAH'S MEDICAID PROGRAM.

4 Newhouse, Joseph, 1996. FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT, Cambridge: Harvard University Press; Ku, Leighton. Center on Budget and Policy Priorities, 2003. CHARGING THE POOR MORE FOR HEALTH CARE: COST-SHARING IN MEDICAID. Effective care refers to services the researchers judged to be clinically effective in improving health outcomes.

5 *Id*.

	Puerto Rico	50 States & DC
Population Change (2010-2018)	-14%	+6%
<65 years	20%	15%
Poverty Index	45%	13%
Median Income	$19,343 (⇩5.5%)	$60,336 (⇧2.6%)
Medicaid/CHIP	40%	20%
Unemployment	8.5%	3.8%
Adults reporting poor health status	34%	18%
Adults with diabetes	13.7%	9.5%
Child Mortality (per 1,000)	7.1	5.9
HIV Diagnosis (per 100,000)	17.8	14.7

Resident of Puerto Rico are ineligible for Supplemental Security Income merely because of where they live.[6] They are also ineligible to receive assistance in the payment of their Medicare Part B and Part D premiums. Thus, residents of Puerto Rico bear a heavier burden of healthcare costs than do those similarly situated residents of the States and the District of Columbia.

In order to ameliorate this situation while the Congress acts to come up with a permanent solution, I have filed the following bills which are currently pending before this Committee:

H.R. 813, the Puerto Rico Integrity in Medicare Advantage Act (PRIMA)
to amend title XVIII of the Social Security Act to provide for temporary stabilization of Medicare Advantage payments following Hurricane Maria.

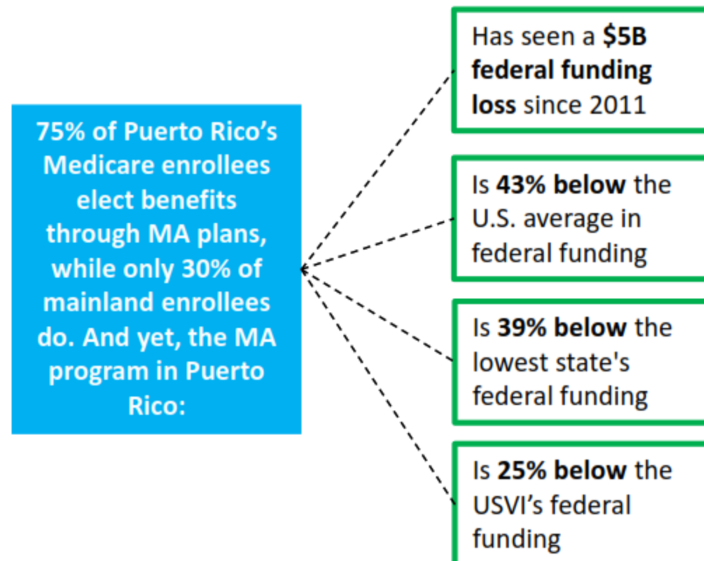
Puerto Rico depends upon Medicaid to cover a large low-income population; but we also depend upon Medicare Advantage to provide most funding to the Puerto

[6] *See* H.R. 947, Supplemental Security Income Equality Act to extend the supplemental security income program to Puerto Rico, the United States Virgin Islands, Guam, and American Samoa, and for other purposes. Available at https://www.congress.gov/bill/116th-congress/house-bill/947/titles?r=20&s=1. For a discussion of the effects of the inapplicability of SSI to residents of Puerto Rico, please see the *amicus brief* filed in *United States of America v. Vaello Madero*, Civil no. 19-1390, before the U.S. District Court for the District of Puerto Rico (Nov. 7, 2018, docket 78).

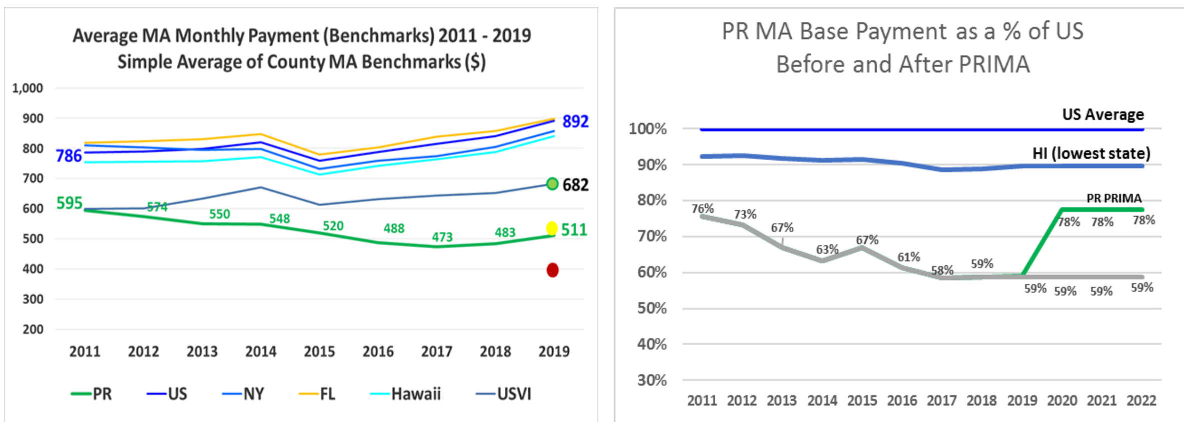
Rico healthcare system. Medicare Advantage accounts for nearly 50% of all health care funding to patients and providers in Puerto Rico.

Unlike the mainland, the vast majority (90%) of Medicare beneficiaries with Medicare Part A and Part B in Puerto Rico and almost all dual (97%) eligible beneficiaries receive their care through local Medicare Advantage (MA) Plans. Puerto Rico depends upon Medicare Advantage to cover its large senior population, with the 8th largest Medicare Advantage-covered population in the nation.

Like so many other federal health care programs, Medicare Advantage institutionalizes disparities by giving the territories second-tier funding. Medicare Advantage accounts for nearly half of all health care expenses in Puerto Rico. However, due to local particularities, the congressional Medicare Advantage rate-setting formula has caused Medicare Advantage rates to be severely underestimated for Puerto Rico, paying only 57% of the U.S. mainland average.

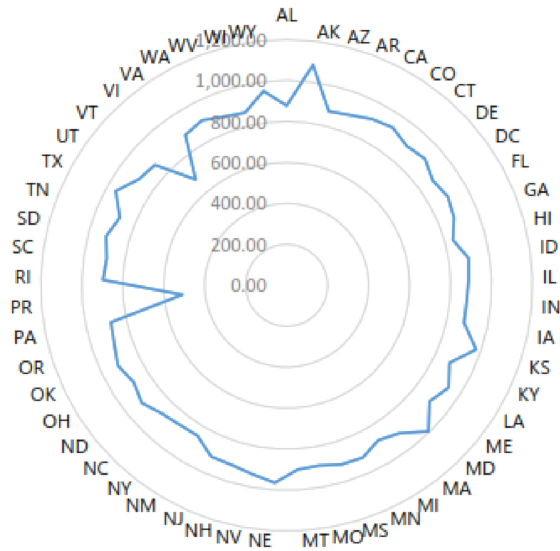


Medicare Advantage rates in Puerto Rico are shockingly low. In 2011, Puerto Rico Medicare Advantage rates were 24% lower than the national average. Medicare Advantage rates in Puerto Rico have fallen for 7 years to a level that is now 43% below the national average. When federal health care funding to Puerto Rico decreases, fewer resources and support pass through to patients and providers. Adding an economic crisis and the catastrophic devastation of Hurricane Maria has resulted in a health care system with sub-standard infrastructure and provider migration to the mainland.



The funding formula (found at 42 U.S.C. 1395w-23) works against MA plans in Puerto Rico due to Congress' decision in 2010 to set reimbursement based upon a healthcare cost basket, which, when accounting for grossly underestimated costs and artificially low salaries of physicians on the Island, resulted in rates far below the rest of the United States. This, in turn, set off a death spiral, where physician reimbursements were lowered to account for lower rates per member per month, which in turn drove MA rates lower still, and so on. ***Today, CMS reimburses Puerto Rico plans approximately $1 billion less than it did it 2011 – contrary to the trend across every state in the nation.***

Medicare Advantage Monthly Capitation Rates for 2019



Puerto Rico Medicare Advantage has been in freefall since the hurricanes. The story of how the hurricanes impacted the Island is well known. What is not common knowledge, however, is the impact the hurricanes had on the patients and providers under the Medicare Advantage program. The hurricanes unmasked and further exacerbated a longstanding problem of unequitable and chronic underfunding, which caused an accelerated exodus of patients and providers. Due

to the hurricanes' direct impact and the HHS Emergency Declaration, hundreds of thousands of residents of Puerto Rico left (temporarily, if not permanently) for the mainland (principally FL, NY, TX, NJ, and CT). Thus, physicians, who were already suffering from low salaries, suddenly had fewer patients to treat, and the Medicare Advantage organizations (due to the Emergency Declaration) had to pay for more expensive "out-of-network" care at U.S. mainland rates, even though the CMS Medicare Advantage payment was at the Puerto Rico rate. As a result, hundreds of physicians have left, the Island's Medicare infrastructure has been destabilized, and the potential Medicare Advantage success story has been put at risk, putting care for all residents of Puerto Rico in jeopardy. PRIMA breaks this death spiral in Medicare funding to PR by setting a floor to federal payments. Puerto Rico would still have the lowest levels of Medicare Advantage rates in the Nation, but we could begin to reverse the disparities, fully recover from the hurricanes, and fund the health care system Puerto Rico deserves.

PRIMA seeks to correct and stabilize the Medicare Advantage payment downward spiral. The current reimbursement formula is not working. The hurricanes have accelerated the decline in Medicare coverage and of healthcare in Puerto Rico. A solution is needed, and needed now, to remedy this challenge if the Island's healthcare system is to stabilize. The PRIMA Act would achieve these goals by doing the following:

- Revising Medicare Advantage payments for three years by establishing a 0.70 Adjusted General Average (AGA) floor to any county in the nation that exceeds this benchmark will help stabilize the free-falling MA base payment rate for Puerto Rico.

- PRIMA will support healthcare providers in Puerto Rico. Under existing law, Medicare plans are required to spend at least of 85% of funding on care (increasing provider reimbursement or expanding program benefits for beneficiaries) and may use the remaining 15% to cover administrative expenses. PRIMA requires that at least half of the additional funding (above and beyond the 85% MLR rule) for Puerto Rico be devoted to increase provider payments, incentivizing physicians to stay.

- Supporting Medicare Advantage's coordinated care platform, performance-based and quality standards that provide care to the the most fragile and needy Dual population in the island, which serves as the backbone of the healthcare system in Puerto Rico.

CBO has informally scored PRIMA as budget neutral.

H.R. 2172, A BILL TO REMOVE THE MATCHING REQUIREMENT FOR MEDICARE PART D DRUGS

Medicare Part D is a voluntary outpatient prescription drug benefit for people with Medicare, provided through private plans approved by the federal government. Beneficiaries can choose to enroll in either a stand-alone prescription drug plan (PDP) to supplement traditional Medicare or a Medicare Advantage prescription drug plan (MA-PD), mainly HMOs and PPOs, that cover all Medicare benefits including drugs. In 2018, more than 43 million of the 60 million people with Medicare are enrolled in Part D plans.

Beneficiaries with low incomes and modest assets are eligible for assistance with Part D plan premiums and cost sharing. Through the Part D Low-Income Subsidy (LIS) program, additional premium and cost-sharing assistance is available for Part D enrollees with low incomes (less than 150% of poverty, or $18,210 for individuals/$24,690 for married couples in 2018) and modest assets (less than $14,100 for individuals/$28,150 for couples in 2018). ***While this assistance is available for Medicare beneficiaries in the States and in the District of Columbia, Medicare beneficiaries who reside in the territories are not eligible for the LIS.***

In lieu of the LIS, the Social Security Act provides a fixed amount of funding to each territory to provide Medicaid coverage of prescription drugs for low-income Medicare beneficiaries. Before accessing the federal funds, each territory government is required to contribute, or "match", funds toward the payment of the Medicare Part D covered drugs. In the case of Puerto Rico, FMAP has been set by statute at 55%.

The territories (to varying degrees) have struggled to comply with the matching requirement and thus are not able to access the federal funding. ***Between Fiscal Year 2010 and Fiscal Year 2016, Puerto Rico has been able to draw down only about 51 percent of its available federal funding for prescription drugs for low-income Medicare beneficiaries.***

H.R. 2172 amends title XIX of the Social Security Act to remove the matching requirement before a territory can access and draw down the territory's federal funds for Medicare Part D drugs. This bill is consistent with the recommendations made by the Congressional Task Force on Economic Growth in Puerto Rico.

Although a score has not yet been obtained, given that Puerto Rico's FY2020 allotment for Medicaid coverage of prescription drugs for low-income Medicare beneficiaries is approximately $59million, covering the 45% share currently required of the territorial government would be insignificant.

H.R. 2310, the FAIRNESS IN MEDICARE PART B ENROLLMENT ACT

to amend title XVIII of the Social Security Act to eliminate late enrollment penalties under part B of the Medicare program for individuals residing in Puerto Rico if such individuals enroll within 5 years of becoming entitled to benefits under part A of such program.

Medicare Part B provides coverage for physicians' services, outpatient hospital services, durable medical equipment, outpatient dialysis, and other medical services. Residents of every state and territory *other than Puerto Rico* who are receiving Social Security benefits are automatically enrolled in both Part A and Part B, with coverage beginning the first day of the month they turn 65.

Under federal law, when residents of Puerto Rico turn 65 and start receiving Social Security benefits, they are automatically enrolled in Part A, but not automatically enrolled in Part B. Instead, beneficiaries in Puerto Rico are required to take the affirmative step of enrolling in Part B during their seven-month initial enrollment period. If they fail to enroll, they are subject to a lifetime late-enrollment penalty of 10% for each 12-month period they were eligible but failed to enroll.

The lack of an automatic Part B enrollment process in Puerto Rico has resulted in a disproportionate number of Medicare beneficiaries in Puerto Rico paying the lifetime late-enrollment penalty. According to CMS, ***there are currently 38,343 Medicare beneficiaries in Puerto Rico who are paying lifetime penalties of $20,383,705.00 a year for enrolling late in Part B.*** According to CMS, there are 108,678 individuals in Puerto Rico who are currently enrolled in Part A only, not Part B. Many of those individuals, if they do elect to enroll in Part B, will be subject to a lifetime late-enrollment penalty.

Data from the U.S. Census indicates that 40% of residents of Puerto Rico who are 60 years and over live below the poverty level.[7] Given that the U.S. Census determined the Poverty Threshold for 2017 for individuals 65 and over at $11,756,[8] the annual Part B premium of $1,626.00—or at least 15% of their monthly income—might be too costly for a large number of residents to pay.[9]

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[7] U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates. Available at https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF.

[8]] U.S. Census Bureau, Poverty Thresholds for 2017 by Size of Family and Number of Related Children Under 18 Years. Available at https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html.

[9] Residents of Puerto Rico are ineligible to receive assistance for paying their Medicare premiums through the four different Medicare Savings Programs (the QUALIFIED MEDICARE BENEFICIARY PROGRAM, the SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PROGRAM, the QUALIFYING INDIVIDUAL PROGRAM, and the QUALIFIED DISABLED AND WORKING INDIVIDUAL PROGRAM).

> Thus, rather than propose the automatic enrollment in Part B of eligible Medicare beneficiaries in Puerto Rico, this bill maintains the automatic opt-out enrollment, but extends the period for Medicare beneficiaries in Puerto Rico to enroll in Medicare Part B to a total of five years. This extended period will allow beneficiaries to learn that, unlike the rest of the United States, they were not automatically enrolled in Part B and to determine if they can financially afford the cost of the Program.
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> Although a score has not yet been obtained, the financial impact of this legislation upon the federal budget should be negligible.

This Committee has acted swiftly to ensure continuing access to healthcare for Puerto Rico's Medicaid population. However, adequate Medicaid funding is only one part of the problem that this Committee must seek to correct. I ask the Committee's continued assistance in this endeavor.

I thank you for your time and for your availability.