United States Government Accountability Office

GAO

Report to Congressional Requesters

October 2005

U.S. INSULAR AREAS

Multiple Factors Affect Federal Health Care Funding

GAO-06-75

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Highlights

Highlights of GAO-06-75, a report to congressional requesters

Why GAO Did This Study

Five insular areas of the United States—American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands—benefit from federal health care financing and grant programs that help fund health care services to their over 4 million residents. However, notable differences exist in how the programs are funded or operate in the insular areas, such as statutory limits on federal Medicaid funding to the insular areas that do not apply in the states. To help understand these differences, GAO was asked to identify (1) the key sources of federal health care funding in the insular areas, (2) differences between insular areas and the states in the methods used to allocate these funds, and (3) differences in spending levels per individual between insular areas and the states.

In commenting on a draft of this report, American Samoa, CNMI, and Puerto Rico suggested the need for additional information on certain issues, such as implications of statutory limits on federal Medicaid spending and a more comprehensive analysis of local circumstances that affect the availability and costs of health care services.

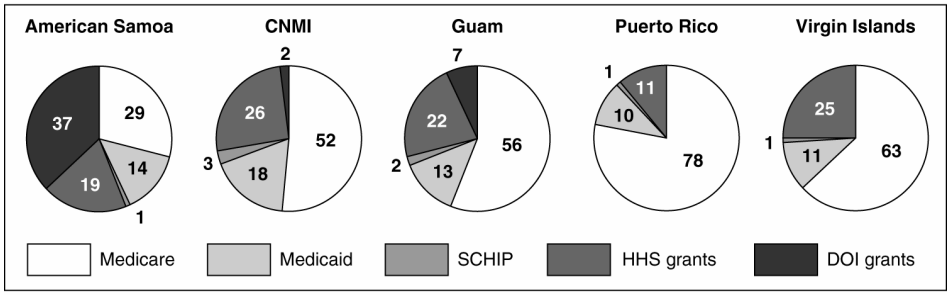
www.gao.gov/cgi-bin/getrpt?GAO-06-75.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or allenk@gao.gov.

What GAO Found

Multiple federal programs fund health care services in the insular areas. Federal health care financing programs—Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP)—represented nearly 90 percent of the $2.2 billion in health care funding to these areas in fiscal year 2003, with Medicare alone representing over three-quarters of total funding. The Departments of Health and Human Services (HHS) and the Interior (DOI) also provide grants to the insular areas. Significant variation exists among the insular areas in terms of the distribution of funds by these sources, largely due to the number of Medicare beneficiaries in each area.

Key Federal Health Care Funding Sources to Five Insular Areas, by Percentage, Fiscal Year 2003



Source: GAO analysis of funding data from Medicare, Medicaid, SCHIP, grants from three HHS agencies, and DOI.

The methods used to allocate these federal funds to insular areas often differ from methods used in the states. For example, Medicare pays hospitals in most insular areas based on their costs rather than the prospective payment system used for most hospitals in the states. Similarly, federal funding for Medicaid and SCHIP is subject to statutory limits that do not apply to states, including minimum federal contributions and a cap on federal Medicaid payments. In addition, certain HHS grants use different rules to determine insular areas' funding.

Differences in allocation methods as well as other factors contribute to lower spending levels per individual in the insular areas compared to the states. For example, Medicare spending per beneficiary in the insular areas was less than half the amount it was in the states, due in part to differences in payment policies and to beneficiaries' lower utilization of services. In addition, the statutory limits on federal Medicaid funding in these areas contributed to lower federal Medicaid per capita payments in the five insular areas compared to the national average. However, in light of limits on federal funding, the insular areas are not held accountable for covering all Medicaid benefit requirements, such as nursing facility services that represent nearly one-third of Medicaid expenditures in the states. Insular areas benefit from certain HHS grant allocation formulas that result in higher per capita payments to them than the states, on average.

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United States Government Accountability Office
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Congressional Requesters

The five largest insular areas of the United States—American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands—and their more than 4 million residents have a unique relationship with the federal government.[1] With the exception of American Samoa, those born in the insular areas are U.S. citizens; however, insular area residents are not afforded all of the rights of citizens residing in the 50 states.[2,3] Although numerous federal health care financing and social programs—including Medicare, the federal health care program for the elderly and disabled, and Medicaid, the joint federal-state program that finances health care for certain low-income individuals—have been extended to insular area residents to varying degrees, notable differences exist in how these programs are funded or operate in the insular areas compared to the states. For example, the insular areas are subject to statutory limits on federal Medicaid funding that do not apply to the states. To help understand these differences, you asked us to identify (1) the key sources of federal health care funding in the insular areas, (2) the extent to which the methods used to allocate these sources of health funds differ from the methods used in the states, and (3) how spending levels per individual from these key sources differ between insular areas and the states.

To identify key sources of health care funding to the insular areas, we reviewed the Census Bureau's *Consolidated Federal Funds Report* and interviewed officials at the Departments of Health and Human Services (HHS) and the Interior (DOI) as well as officials from each of the five insular areas. For the key sources identified, we obtained comprehensive

[1]These five insular areas are the subject of this report. Nine smaller insular areas of the United States, which are not included in the scope of this report, are Navassa Island in the Caribbean Sea, and Baker Island, Howland Island, Kingman Reef, Jarvis Island, Johnston Atoll, Midway Atoll, Palmyra Atoll, and Wake Island in the Pacific Ocean.

[2]Throughout this report, the term states refers to the 50 states and the District of Columbia.

[3]Those born in American Samoa are considered to be American nationals of the United States. An American national is either a citizen or someone who "owes permanent allegiance to the United States." 8 U.S.C. § 1101(a)(21), (22) (2000). While American nationals are not entitled to all the benefits for which only citizens qualify, they are not aliens and therefore cannot be expelled or deported.

health expenditure data for federal fiscal years 1999 through 2003 from the respective agencies. To assess the reliability of HHS and DOI data, we discussed data quality control procedures and reviewed relevant documentation with officials. We determined the data were sufficiently reliable for the purposes of this report.

To determine the extent to which methods used to allocate funds to the insular areas differ from those used in the states, we reviewed federal laws and guidance on this funding and interviewed agency and insular area officials. To determine the extent to which spending levels per individual from these key sources differ between insular areas and the states, we examined trends in program expenditures between states and insular areas. To assess the reliability of the program expenditure data, we reviewed relevant documentation, interviewed agency officials about the data, and conducted electronic data testing. We determined that the program expenditure data were sufficiently reliable for the purposes of this report. We conducted our work from October 2004 through September 2005 in accordance with generally accepted government auditing standards. (For additional information on our methodology, see app. I.)

Results in Brief

Multiple federal programs, such as federal health care financing programs and various HHS and DOI grant programs, fund health care services in the insular areas. In fiscal year 2003, funding from these sources to the five insular areas totaled $2.2 billion. Medicare was the single largest source of health care funding, representing over three-quarters of total funding. When funding from the other federal health care financing programs—Medicaid and the State Children's Health Insurance Program (SCHIP)—is added to the Medicare total, the federal health care financing programs represented nearly 9 of every 10 federal dollars spent in the five insular areas. However, because Puerto Rico represents over 90 percent of the total insular area population, the aggregate spending numbers mask the often significant variation that exists in the sources of funding among the insular areas. Specifically, while the proportion of federal spending by source in Puerto Rico largely mirrored the aggregate numbers, health care grant funding represented a much larger proportion of health care funding in the other four insular areas, largely due to their comparatively smaller Medicare populations. For example, grant funding represented about 56 percent of total funding in American Samoa in fiscal year 2003 but only 11 percent of total funding in Puerto Rico. In addition, the extent to which the insular areas relied on grant funding often fluctuated significantly from year to year. For example, from fiscal years 1999 through 2001, DOI

funding to CNMI grew from 2 to 26 percent of total health care funding and fell back to 2 percent in 2003.

Notable differences exist in methods used to allocate federal health care funds in the insular areas compared to the states, and these differences are often statutory in nature. For example, while most hospitals in the states and Puerto Rico are paid under Medicare's inpatient prospective payment system (PPS),[4] hospitals in the other insular areas are not included in the PPS statutory provision and are instead paid based on their costs. Similarly, under the new Medicare prescription drug benefit, to be implemented in January 2006, certain low-income beneficiaries in the insular areas will not receive direct subsidies to help pay for their premiums, deductibles, and copayments that are available to certain beneficiaries in the states. Instead, CMS will provide each insular area with an allotment, which they will then use to administer the program to low-income beneficiaries based on a locally developed plan. In addition, federal funding for the Medicaid and SCHIP programs in the insular areas is subject to statutory limits that do not apply to states. For example, the statutory formula used to calculate the federal share of a state's Medicaid expenditures, which results in a higher federal share of Medicaid expenditures in poorer states, does not apply to the insular areas. In contrast, the federal contribution to the insular areas is set by statute at the minimum rate available to states, although nearly all of the insular areas have a lower median household income than the poorest state. In addition, unlike the states, where there are no caps on the federal share of Medicaid funding as long as the state contributes its share of program expenditures, federal Medicaid funding in the insular areas is subject to an annual statutory cap. Although similar methods are used to allocate some HHS grants to states and insular areas, other grants use separate rules to determine funding amounts in the insular areas.

Multiple factors, including differences in funding allocation methods, compliance with program requirements, and beneficiaries' use of program services, all contribute to differences in program spending per individual in insular areas compared to the states. For example, Medicare spending per beneficiary in the insular areas is less than half the amount it is in the states, due in part to differences in methods used to pay for certain

[4]Since 1984, Medicare payments to most hospitals have been based on PPS instead of on their allowable incurred costs, which was the previous practice. Under PPS, each hospital receives a standard rate for each discharge related to a specific diagnosis, which is adjusted based on local costs and the delivery setting.

services and beneficiaries' utilization of services. In addition, the statutory limits on federal Medicaid funding in the insular areas—particularly the minimum federal matching contribution and funding cap—contribute to federal Medicaid spending per capita levels in the insular areas that are significantly lower than in the states. However, insular areas are not required to meet all Medicaid eligibility requirements, and in light of limits on federal funding, CMS does not hold these areas accountable for covering all Medicaid benefit requirements, which may help explain lower per capita spending. For example, none of the insular areas provides full coverage for nursing facility services, which represented nearly one-third of Medicaid expenditures in the states in fiscal year 2003. In contrast, HHS grant funding per capita is higher in the insular areas than in the states due in part to allocation formulas that result in higher payments to them as well as to states with smaller populations.

We received written comments on a draft of this report from DOI, American Samoa, CNMI, and Puerto Rico, and technical comments from HHS and Puerto Rico. DOI acknowledged that improving health care in the insular areas is a priority for both the agency and the insular areas and commented that the report identifies areas of disparity that may be reviewed for improvement. The three insular areas expressed concern that the report did not sufficiently address certain issues, such as implications of statutory limits on federal Medicaid spending and a more comprehensive analysis of local circumstances that affect the availability and costs of health care services. Where appropriate, we revised the report to include information about local circumstances that may affect the provision or cost of health care services. However, a more comprehensive analysis of insular areas' local contribution to total health care funding or their health care infrastructures was beyond the scope of this report.

Background

Five insular areas—American Samoa, Guam, CNMI in the Pacific Ocean, and the Commonwealth of Puerto Rico and the Virgin Islands in the Caribbean Sea—represent the largest insular areas of the United States. More than 4 million U.S. citizens and nationals live in these insular areas under the sovereignty of the United States. These areas vary in terms of how they came under the sovereignty of the United States and also in terms of their demographics, such as median age and education levels. However, all of these insular areas participate in three major federal health care financing programs—Medicare, Medicaid, and SCHIP—and are eligible for a variety of federal health grant programs.

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