PEDRO R. PIERLUISI
PUERTO RICO

WASHINGTON OFFICE:
2410 RAYBURN HOUSE OFFICE BUILDING
(202) 225-2615 FAX: (202) 225-2154

SAN JUAN OFFICE:
157 AVENIDA DE LA CONSTITUCIÓN
ANTIGUO EDIFICIO DE MEDICINA TROPICAL
ALA DE ENFERMERÍA 2DO PISO
SAN JUAN, PUERTO RICO 00901
(787) 723-6333 FAX: (787) 729-7738

Congress of the United States
House of Representatives
Washington, DC 20515–5400

COMMITTEES:
JUDICIARY
NATURAL RESOURCES

May 11, 2015

The President
The White House
1600 Pennsylvania Avenue
Washington, DC 20500

Dear Mr. President:

I write to respectfully request that the White House convene an inter-agency meeting to discuss the Medicaid funding "cliff" that Puerto Rico is rapidly approaching and that it could reach as early as September 2017. Ideally, the meeting will be attended by myself, representatives of the Governor of Puerto Rico, and officials from the White House Domestic Policy Council, the Office of Management and Budget, the U.S. Department of Health and Human Services, and the U.S. Department of the Treasury. Following the meeting, I hope senior Administration officials will formulate a specific plan of action and conduct outreach to key Members of Congress, whom I have already begun to brief. I urge the Administration to include a legislative proposal in its Fiscal Year 2017 budget request to Congress that would address this issue, and then work for its enactment into law. Inaction would profoundly deepen the current health, migration and fiscal crisis in the U.S. territory. It would also be unacceptable from a moral and public policy perspective.

Background

The background of the problem is as follows. Puerto Rico has always been treated unequally under Medicaid, the health program for low-income individuals that was established in 1965 and that is funded in part by the federal government and in part by the state (or territory) government. In the 50 states and the District of Columbia, Medicaid is an individual entitlement. There is no limit on the amount of funding the federal government will provide so long as the state in question provides its share of matching funds. The federal contribution—known as an FMAP—can range from 50 percent in the wealthiest states to 83 percent in the poorest states.

By contrast, there is an annual "ceiling" on federal funding for Puerto Rico's Medicaid program, pursuant to 42 U.S.C. §1308.[1] When I took office in 2009, Puerto Rico was subject to a ceiling of about $280 million a year. Moreover, Puerto Rico's statutory FMAP was 50 percent—the

[1] See 42 U.S.C. §1308(a)(1) ("Notwithstanding any other provision of this chapter . . . the total amount certified by the Secretary of Health and Human Services . . . for payment to any territory for a fiscal year shall not exceed the ceiling amount for the territory for the fiscal year."). The ceiling amount for each territory has been increased at various points since 1965, and is adjusted annually for inflation.

same as the wealthiest states. Indeed, because of the annual ceiling, Puerto Rico's effective FMAP—that is, the actual federal contribution to the island's Medicaid program—was between 15 and 20 percent a year.[2] In other words, Puerto Rico was annually spending upwards of $1.4 billion in territory funds to provide health care services to about 1.2 million low-income beneficiaries, and receiving only $280 million from the federal government for this purpose.

To place this in context, it helps to examine three states of similar or smaller population sizes: Mississippi (73 percent FMAP), Oklahoma (64 percent FMAP), and Oregon (63 percent FMAP).

- There are approximately 781,000 Medicaid beneficiaries in Mississippi. In Fiscal Year 2014, Mississippi paid $1.3 billion in state funds and received $3.6 billion in federal funds.

- There are approximately 931,000 Medicaid beneficiaries in Oklahoma. In Fiscal Year 2014, Oklahoma paid $1.6 billion in state funds and received $3.0 billion in federal funds.

- There are approximately 751,000 Medicaid beneficiaries in Oregon. In Fiscal Year 2014, Oregon paid $1.8 billion in state funds and received $5.0 billion in federal funds.[3]

The contrast with Puerto Rico is stark. This disparate treatment helps explain why health outcomes are generally worse in Puerto Rico than in the states,[4] and why the territory has accrued large debt through borrowing.

ARRA and the ACA

Since 2009, Puerto Rico's treatment under Medicaid has improved substantially, but it is nowhere near state-like treatment and continues to be deeply inequitable. The first funding increase was a result of the *American Recovery and Reinvestment Act of 2009*, which increased Puerto Rico's federal cap by 30 percent—from about $280 million a year to about $364 million a year. That increase lasted from the first quarter of Fiscal Year 2009 through the third quarter of Fiscal Year 2011.

In 2010, Congress approved the *Patient Protection and Affordable Care Act* (ACA). The ACA perpetuated Puerto Rico's discriminatory treatment under federal health programs in key respects. For example, under the ACA's central provision, millions of individuals and families

---

[2] See CMS Presentation to House Committee on Ways and Means (July 2008).

[3] See State-by-State Total Medicaid Medical Assistance Expenditures, FY 2014, Congressional Research Service (prepared from CMS data). While the funding figures are from Fiscal Year 2014, the enrollment figures are from Fiscal Year 2012, the latest year for which such data is available.

[4] See, e.g., Marcella Nunez-Smith et al, "Quality of Care in the US Territories," JAMA Internal Medicine (Vol. 171, No. 17; Sept. 26, 2011) (concluding that, "[c]ompared with hospitals in the US states, hospitals in the US territories have significantly higher 30-day mortality rates and lower performance on every core process measure for patients discharged after [acute myocardial infarction, heart failure, or pneumonia]" and arguing that "[e]liminating the substantial quality gap in the US territories should be a national priority").

in the states and the District of Columbia can purchase insurance through an exchange operated either by the federal government or by a state government, with the federal government providing subsidies to those households with annual incomes below a certain level. However, Puerto Rico and the other territories were unable to establish a state-level exchange and are not eligible to participate in a federal exchange. In addition, under the ACA, the states and the District of Columbia are permitted to expand eligibility for Medicaid to certain population groups. If a state elects to expand eligibility for Medicaid, the federal government covers 100 percent of the cost of covering this newly-eligible population from 2014 to 2016, 95 percent of the cost in 2017, 94 percent of the cost in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond. While Puerto Rico and the other territories are authorized to expand eligibility for Medicaid to these new population groups, the territories are not eligible for the enhanced federal contribution to finance their care.

However, the ACA did one critically important thing for the territories. Specifically, the law provided a total of $7.3 billion in additional Medicaid funding for the five territories to share, with Puerto Rico receiving $6.3 billion of that amount. This funding, which is on top of the "ceiling" amount that Puerto Rico receives annually under 42 U.S.C. §1308, is available to be drawn down between the fourth quarter of Fiscal Year 2011 and the end of Fiscal Year 2019. In addition, Puerto Rico's FMAP was increased from 50 percent to 55 percent.

The upshot is that, instead of receiving about $300 million a year from the federal government, Puerto Rico now draws down about $1.1 billion to $1.3 billion annually.[5] This is a major funding increase, and we had to fight for every penny of it. But recall that Mississippi receives $3.6 billion in federal funds, Oklahoma receives $3.0 billion in federal funds, and Oregon receives $5.0 billion. They also continue to have far higher FMAPs than Puerto Rico.

It is critical to note that, because of this insufficient funding, the Puerto Rico Medicaid program—even post-ACA—has only been able to cover households with modified adjusted gross incomes that are less than 80 percent of the federal poverty level (FPL), with the precise percentage depending on the number of individuals in the household.[6] By contrast, post-ACA, every state and the District of Columbia cover children and pregnant women in households earning up to at least 133 percent of the FPL, and Medicaid "expansion states" cover non-elderly adults up to at least 133 percent of the FPL as well.

Moreover, the $7.3 billion in additional Medicaid funding that the territories received under the ACA expires at the end of the Fiscal Year 2019—the only coverage provision in the law that sunsets in this manner. That is the cliff. As of this writing, the Puerto Rico government has only $3.57 billion of its $6.3 billion in ACA funding remaining. At this spend-down rate, it is

[5] According to CMS, Puerto Rico drew down $1.15 billion in Fiscal Year 2013, $1.26 billion in Fiscal Year 2014, and is projected to drawn down $1.32 billion in Fiscal Year 2015. This is not much higher than the federal funding that one of the smallest and wealthiest states, Delaware, receives to cover only 225,000 beneficiaries.

[6] In 2014, for every U.S. jurisdiction other than Alaska and Hawaii, the FPL is $11,670 for an individual, $15,730 for a family of two, $19,790 for a family of three, and $23,850 for a family of four.

projected that Puerto Rico will deplete its pool of ACA funding in mid-2018. Recent inaction by CMS with respect to federal compensation for Puerto Rico's Medicare Advantage plans could result in the depletion date moving forward to September 2017. The cliff is coming, one way or the other; it is just a question of whether it will arrive in 2017, 2018 or 2019. If this pool of funding is not seamlessly replenished, Puerto Rico will go back to receiving Medicaid funds solely under the ceiling codified at 42 U.S.C. §1308—that is, less than $400 million a year.

I am confident that federal policymakers of both political parties understand the consequences of inaction for the U.S. citizens of Puerto Rico. I am also confident that policymakers understand how important it is to begin formulating a specific course of action now, rather than waiting until 2016 or 2017. The meeting I have requested is, I believe, a necessary first step in this process.

I thank you in advance for your attention to this critical matter.

Sincerely,

Pedro R. Pierluisi
Member of Congress

cc: Hon. Cecilia Muñoz, Director, Domestic Policy Council, the White House
Hon. Shaun Donovan, Director, Office of Management and Budget, the White House
Hon. Sylvia Matthews Burwell, Secretary, U.S. Department of Health and Human Services
Hon. Jack Lew, Secretary, U.S. Department of the Treasury
Hon. Andrew Slavitt, Acting Administrator, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
Hon. Vikki Wachino, Director, Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services
Hon. Stuart F. Delery, Co-Chair, The President's Task Force on Puerto Rico
Hon. Jerry Abramson, Co-Chair, The President's Task Force on Puerto Rico
Hon. Alejandro García Padilla, Governor of Puerto Rico
Hon. Ricardo A. Rivera Cardona, Executive Director, Puerto Rico Health Insurance Administration