December 19, 2016

From: Puerto Rico Healthcare Community

To: Hon. Sylvia Mathews Burwell, Secretary of the US Department of Health and Human Services

CC:
Hon. Orrin Hatch, Chairman, Congressional Taskforce on Puerto Rico
Hon. Tom Price, Nominated Secretary of the US Department of Health and Human Services
Hon. Dr. Ricardo Rosselló Nevárez, Governor Elect of Puerto Rico
Hon. Jennifer González, Resident Commissioner Elect of Puerto Rico
Hon. Alejandro García Padilla, Governor of Puerto Rico
Hon. Pedro Pierluisi, Resident Commissioner of Puerto Rico
Mr. Andrew Slavitt, CMS Administrator
Mr. Sean Cavanaugh, Director of the Center for Medicare
Mr. Tim Gronniger, CMS Deputy Chief of Staff
Mr. Andrew Bremberg, HHS Transition Team
Mrs. Seema Verma, Nominated CMS Administrator
Mrs. Jackie Cornell, Regional Director for Region II, US Department of Health and Human Services
Dr. Rafael Rodríguez Mercado, Nominated Secretary of Health, Government of Puerto Rico
Mr. José Carrión, Chairman, Puerto Rico Fiscal Oversight Board

Urgent Healthcare Challenges in Puerto Rico
Action Needed for the 2018 Advance Notice For Medicare Advantage Rates

Even though HHS and CMS have taken steps in the right direction, the federal funding shortfall is still too large, and the Medicare Advantage (MA) funding continues to shrink, to the detriment of the island's healthcare system. HHS and CMS can take action to implement additional adjustments to overcome the underfunding of the healthcare system for 2018.

Executive Summary

Problem

Medicare fee-for-service (FFS) program expenditures are not an accurate basis for Medicare Advantage (MA) rate-setting in Puerto Rico under the formula in the Affordable Care Act (ACA). A history of differential statutory treatment for Medicare and Medicaid programs and payments, coupled with a unique economic, cultural, and socio-economic context, has impaired the development of a healthcare economy in Puerto Rico as compared to elsewhere in the US.

The Medicare FFS program data that Congress considered as a *standard* for the ACA MA payment formula does not work in Puerto Rico. The resulting anomaly is that Puerto Rico's average MA benchmark is now 43% below the US average, 38% below the average in the lowest state (HI) and 26% lower than the USVI (just 9 miles away from Puerto Rico).[1] MA serves over 570,000 Medicare beneficiaries in Puerto Rico, but

[1] In 2011, when nationwide adjustments began under the ACA, Puerto Rico's average MA benchmark was only 25% lower than the US average, 24% below HI's average and 7% higher than the USVI average.

has suffered benchmark reductions of over 20% since 2011, while the US average benchmark has increased by 4% in the same period. This reduction is the main cause of the current financial challenges, which have in turn accelerated the outward migration of healthcare professionals. Pending Congressional resolution, additional administrative fixes are critical to mitigate increasing adverse impacts to benefits, access to care, and provider migration.

Action Proposed: Establish an MA Benchmark Proxy

- **Proposal 1 -** The **CY2018 Advance Notice and Draft Call Letter** to be released on **February 1st, 2017** will be decisive for the immediate future of the healthcare system in Puerto Rico. While the Puerto Rico healthcare community appreciates the close communication and recent adjustments implemented by HHS and CMS, the funding disparity is still significantly large, and increasing.

  To resolve the resulting deadlock, we respectfully ask CMS to establish an **MA Benchmark Proxy** for Puerto Rico that would address the increasing evidence of anomalies in the FFS program and data that are routed in historic statutory differences compared with other jurisdictions (See ***Attachment 1***, FFS Data study from The Moran Company). CMS could establish this proxy using its wide discretion to best estimate the average per capita cost for MA benchmarks. Consistent with other proxy adjustments in Medicare policy, CMS could establish the proxy using the MA benchmarks defined for USVI. This level of payments would still be 17% lower than the average in the state with the lowest MA payments. The minimum MLR rules (85%), the formal CMS bid process and market competition assure the use of resources for benefits and provider payments.

Alternative Technical Adjustments to existing MA Benchmark

In the alternative, and only as a path toward a more permanent solution, we would propose the following set of actions:

- **Alternative Proposal 2(A) – Zero-Claim Members:** CMS should maintain an adjustment to the FFS population denominator to account for the anomalous proportion of zero-claim beneficiaries in the Medicare FFS population residing in Puerto Rico. The adjustment should follow a similar methodology as used for 2017 MA rates.
- **Alternative Proposal 2(B) – Dual Bias in Benchmark:** Define adjustments at the MA benchmark level to reflect the minimal and biased representation of dual eligible beneficiaries in the FFS population. The difference in dual proportion in MA vs FFS Medicare in Puerto Rico is so large that risk scores alone cannot fix the large discrepancy that exists between the two populations without an adjustment at the base rates (MA benchmarks).
- **Alternative Proposal 2(C) – No Rebasing reductions:** Considering the new analysis and evidence of particularities in FFS for Puerto Rico, CMS should avoid additional reductions originated from the rebasing of cost calculations. This would be independent of updates for repricing and other adjustments.

Other Critical Proposals Needed (regardless of the outcome of Proposal 1 or its alternatives)

- **Proposal 3 – MA ESRD Benchmark:** Establish a minimum level of payments for the ESRD MA Benchmark, which has been reduced by more than 40% since 2012. Puerto Rico has a unique situation with ESRD. The self-generating cost-payment cycle of the FFS payment system perpetuates an unrealistic compensation level in traditional Medicare, causing undue reductions in the resources for 3,500 ESRD patients in MA. We propose the use of the US average MA

benchmark or the USVI MA Benchmark for ESRD as a temporary proxy to avoid additional undue harm in CY2018.

- **Proposal 4 – Part B Premium Support as Core Benefit for Duals:** In line with the policy to define Part A and B deductibles and cost-sharing as part of the A/B Bid, CMS should consider Part B member premium reductions for full benefit duals as part of the core A/B benefit in Puerto Rico. Medicare Savings Programs (MSPs) and Part B Buy-in programs are not available given the history of the statutorily fragmented and capped Medicaid program funding in Puerto Rico. Similarly situated beneficiaries residing in states get the Part B premium paid under Part B Buy-in programs and this helps to alleviate the benefit differential.
- **Proposal 5 – STARs Methodologies:** CMS should maintain the current STARs adjustments for Puerto Rico considering the statutory exclusion of Part D LIS benefits. In addition, CMS should propose additional adjustments related to the uniqueness of the system (*Getting Appointments Quickly)*, and the high proportion of dual eligible beneficiaries (*Members Choosing to Leave the Plan*).

More details about the background and the proposals enumerated are presented in the sections that follow. Please note that, in line with the regular rate setting process, it is critical that in the case of Puerto Rico, CMS incorporates the latest changes in the Part A Uncompensated Care and IPPS formulas and in the Part B Geographic Practice Cost Indexes (GPCIs).

Finally, we reiterate that inadequate MA funding in Puerto Rico directly impacts benefits and provider compensation, and consequently, beneficiaries' health and access to care. The deteriorating economics of the island's healthcare system have been aggravated by the accelerating migration of professionals. This deepening funding disparity in MA increasingly burdens a system that is trying to manage higher prices of inputs and a higher cost of living than the US average.

It has been evidenced that **Puerto Rico has a higher cost of living than the US average**. In contrast, many of the anomalies that keep payments as a low outlier relate to relative cost indexes and geographic factors that pull payment levels to a distant bottom. In 2015, the *Puerto Rico Institute of Statistics* was able to formally insert Puerto Rico in a national cost of living survey that confirmed the higher costs for most of the inputs needed for healthcare.[2] The spiral towards the bottom in Medicare payments has been possible only by artificially lowering labor costs, while other costs like prescription drugs and utilities continue to increase. This flawed payment structure is the key reason for the increasing migration of our health professionals, which some estimate at 2,000-3,000 departures in the past six years, around 20% of the estimated active physicians in Puerto Rico. In parallel, as per reports from the *Puerto Rico Office of the Insurance Commissioner*, margins for managed care organizations have been notably low, and even negative in the past years.

The proposals presented for the CY2018 Advance Notice, and detailed in the sections below, are intended to break the downward spiral of the Medicare Advantage program in Puerto Rico.

We thank you again for the steps taken so far to overcome the island's financial challenges in the healthcare system. Thank you as well for your attention and anticipated action in the Advance Notice CY2018,

[2] http://www.estadisticas.gobierno.pr/iepr/Publicaciones/Proyectosespeciales/ICV.aspx

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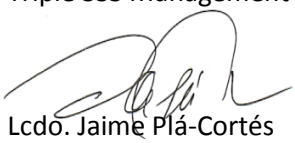

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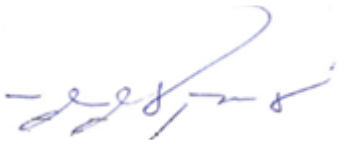

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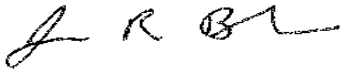

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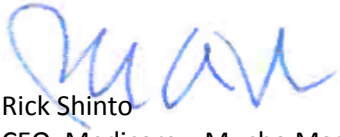

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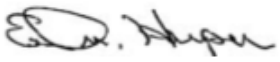

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About Signatories:

Medicaid and Medicare Advantage Products Association (MMAPA)
MMAPA is a non-profit association composed of the leading Medicaid and Medicare Advantage organizations in Puerto Rico: First Medical, Humana, MCS, MMM/PMC, Molina Healthcare and Triple-S. Over 75% of all Medicare eligible in Puerto Rico choose Medicare Advantage for their healthcare needs and 45% of the island's residents participate in the Medicaid program.

Puerto Rico Hospital Association (AHPR by its Spanish acronym)
The Puerto Hospital Association was founded in 1942 and it is affiliated to the American Hospital Association. PRHA is a non-profit association composed of 67 public and private hospitals in the island, as well as other health institutions such as: Ambulatory Care Centers, Treatments and Diagnostics Centers, and distinguished members of the healthcare sector.

Puerto Rico Healthcare Crisis Coalition (PRHCC)
The PRHCC is a group of concerned patient advocates, doctors, hospitals, managed care organizations, activists, labor unions and business leaders that have joined forces to call on the Federal Government to end the appalling injustice in funding of healthcare in Puerto Rico. The Coalition believe that restoring equitable healthcare funding is essential to redress the blatant discrimination against the more than 3.4 million U.S. citizens, who live in Puerto Rico and pay equal Medicare taxes as U.S. mainland residents.

Puerto Rico Chamber of Commerce (PRCC)
The Puerto Rico Chamber of Commerce is the island's principal multisector organization advocating on behalf of the private sector. PRCC is the "Voice and Action" of Puerto Rico's private sector and one of seven State Chambers "Accredited by the U.S. Chamber of Commerce." The PRCC is a private, non-profit organization comprised of individuals, professional organizations, entrepreneurs, and private employers representing small, medium, and large businesses from all economic sectors of Puerto Rico.

Puerto Rico IPA Association
The Puerto Rico IPA Association is non-profit association that serves more than 800,000 patients currently under its membership. The association is composed of the primary care groups, who collectively serve through the government health insurance plan for the past 20 years.

Primary Health Association of Puerto Rico (ASPPR by its Spanish acronym)
The ASPPR is a non-profit associations that represents, influences and empowers the 330 Centers' prevention and primary health network. The ASPPR promotes quality standards through technical assistance, training and support to its network, in order to improve health services in the island.

Puerto Rico College of Healthcare Services Administrators (CASS by its Spanish acronym)
CASS is a non-profit organization that brings together professionals in the administration of healthcare services. CASS was created by law No. 2 of February 23, 1990.

Puerto Rico Community Pharmacies Association (AFCPR by its Spanish acronym)
The AFCPR is a non-profit organizations that was established in 1952 to educate its members and improve the pharmaceutical services to patients and advocate for the wellbeing of the local community pharmacies. The AFCPR has more than 700 member community pharmacies around the island. They collectively serve more than 85% of the government Medicare and Medicaid beneficiaries through the government health insurance plan.

Entrepreneurs for Puerto Rico
The organization of Entrepreneurs for Puerto Rico is a non-profit organization that was founded in 2013 to group various local product and service companies from a wide range of commercial sectors in the island. They represent more than $6 billion in retail sales and more than 1,000 commercial establishments.

Subsequent Sections with Additional Information:

A. Background

B. Proposals

- **Proposal 1** - FFS Data Study and Findings Support the use of an MA Benchmark Proxy

Alternative Technical Adjustments to MA Benchmark

- **Alternative Proposal 2(A)** – Zero-Claim Members Anomaly
- **Alternative Proposal 2(B)** – Dual bias in MA benchmark adjustment
- **Alternative Proposal 2(C)** – Considering unique scenario, avoid reductions from rebasing

Other Critical Proposals

- **Proposal 3** – Unique & harmful situation of the ESRD MA Benchmark in Puerto Rico
- **Proposal 4** - Treat Part B reductions in Platino D-SNPs as part of the A/B bid
- **Proposal 5** - Maintain Current STARs Adjustments, And make two enhancements

C. Final Remarks

D. Attachment

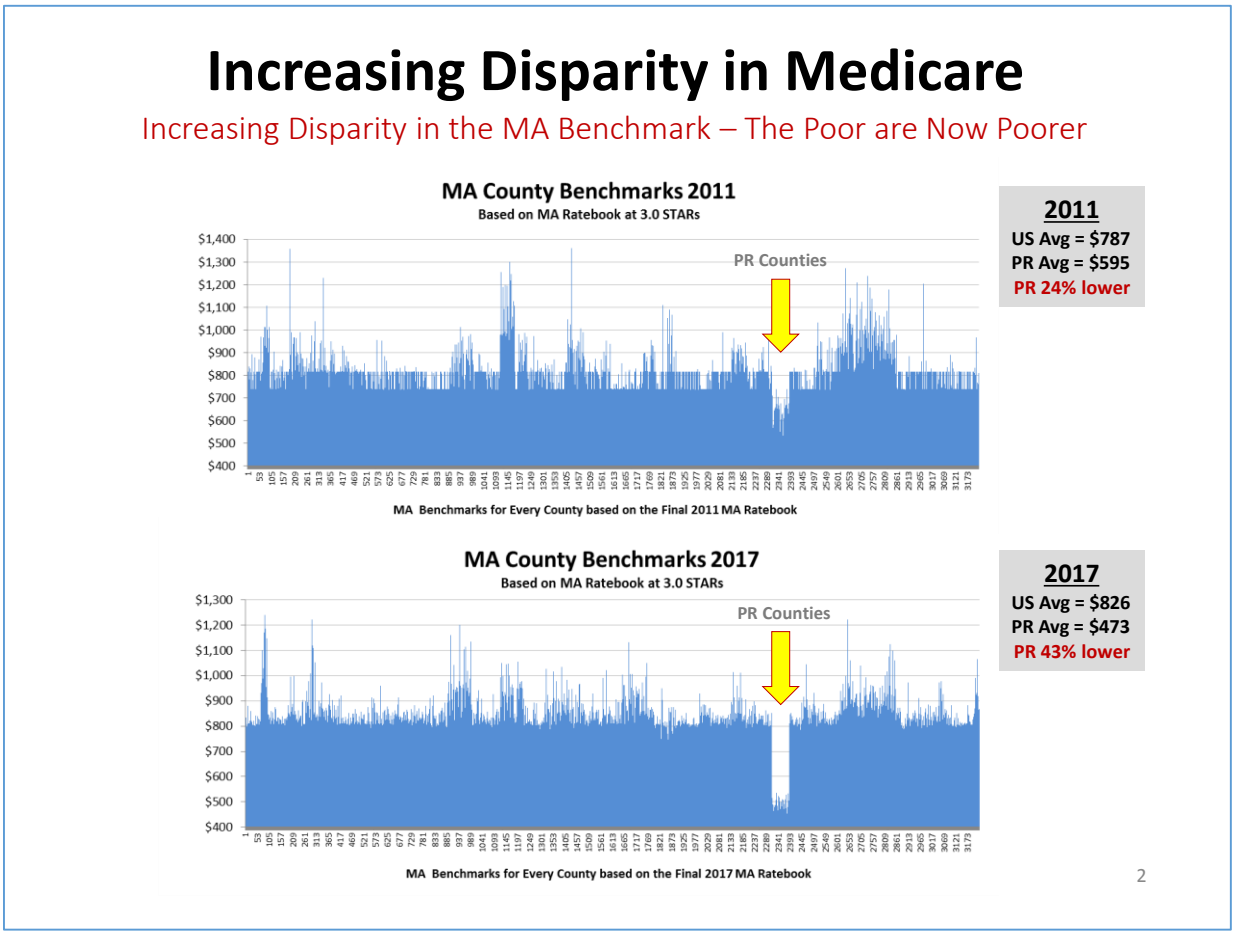
Analysis of Puerto Rico Fee-For-Service Medicare Experience: Implications for Setting Medicare Advantage Benchmarks. The Moran Company.
December, 2016

A. Background

The Puerto Rico healthcare community has been formally working with HHS, CMS and Congressional officials to address and seek solutions to the reductions in Medicare Advantage since 2012. During the last cycle of the Medicare payment rules, important steps were taken to mitigate the increasing disparity in funding for beneficiaries in Puerto Rico. Our community is grateful for the adjustments made to Part A payments, Part B payments, to FFS cost estimates for MA and to STARs methodologies. Yet, the changes are far from resolving the current challenges and the increasing disparity for beneficiaries in Puerto Rico, and we urge HHS and CMS to continue on the path and act on the proposals we enumerate as part of this letter.

For 2017, MA benchmarks are:

- **<u>43% lower</u> than the national average, compared to <u>24% lower in 2011</u>.**
- **<u>38% lower</u> than Hawaii, the lowest MA benchmark state, compared to <u>21% lower in 2011</u>.**
- **<u>Reduced by 20%</u> compared to the average benchmark for Puerto Rico counties in 2011.**



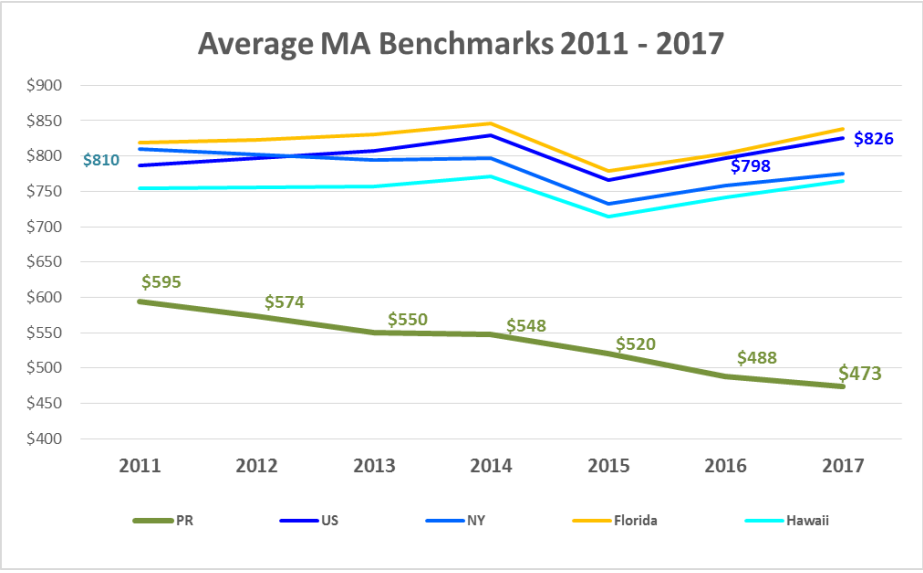
We are appreciative of the attention and efforts of HHS and CMS so far, but it is clear that this scenario is unsustainable. It is imperative to recognize the acceleration in the migration of healthcare professionals, and citizens in general, from Puerto Rico to the states. It is estimated that one physician or more leaves every day, with overall net migration at historic highs, accumulating to close to 300,000 US citizens in the past five years. This is close to 10% of the population and physicians are leaving at a faster rate. Simultaneously, MA funding reductions have been the primary factor in the deterioration of Puerto Rico

health care for the past six years, with an estimated loss of close to $4 billion in aggregate and currently $1 billion per year.

As seen in sections below, there has been substantial new analysis about the FFS data used to set MA benchmarks for Puerto Rico, with important observations about existing anomalies. The most fundamental anomaly for Puerto Rico is the MA benchmark level itself. Historic cultural, social, economic and unique statutory treatment has not allowed the healthcare economy of Puerto Rico to develop as in the rest of the US. Unfortunately, current geographic factors, and resulting data issues, have tended to increase the gap between the poorest jurisdictions and the national average, instead of decreasing it.

In parallel, the big myth that was refuted in the past year is that Puerto Rico is cheaper than the states. It is, in fact, significantly more expensive. The *Puerto Rico Institute of Statistics* was able to formally insert the island in the Cost of Living Index (COLI) of the Center for Community and Economic Research. The program compares costs of over 300 metropolitan areas across the US. Based on 2015 data, Puerto Rico is 13% more expensive that the average metropolitan area within states, with basic items like groceries at 24% costlier, and utilities 72% costlier than the average.[3] Contrastingly, healthcare services are 46% "cheaper", which reveals the critical incongruence of our situation. Healthcare inputs like utilities, prescription drugs, equipment, etc., cost more in Puerto Rico. To fund Medicare services, the factor that has been correspondingly reduced is professional labor. Labor and infrastructure have been depressed and underdeveloped in relation to the healthcare economy in order to adapt to the funding disparities. In general, the doctors, nurses, and professionals that are unwilling to accept the lowest price for their work are simply moving to the states.

In Puerto Rico, the MA program evolved in the 2000s as an organized system of choice, competition, and performance based payments. It now serves approximately 75% of all Medicare beneficiaries, and nine of every 10 beneficiaries with Medicare Parts A & B. It is also the reason why we have an integrated Medicare + Medicaid duals program (known as Medicare Platino), which allows the rest of the Medicaid program to survive. However, there is a point of diminished funding that is unsustainable and that impacts beneficiaries and providers.



[3] Source: Cost of Living Index, Center for Community and Economic Research, 2015Q3

We are requesting that HHS and CMS re-assess pending administrative fixes, and propose them as part of the CY2018 Advance Notice for MA & Part D. Apart from the overall funding shortfall, there are critical technical adjustments that CMS can make, to mitigate recent cuts, and avoid deteriorating care not only for more than 700,000 Medicare beneficiaries, but for all the 3.5 million citizens residing on the island.

B. Proposals

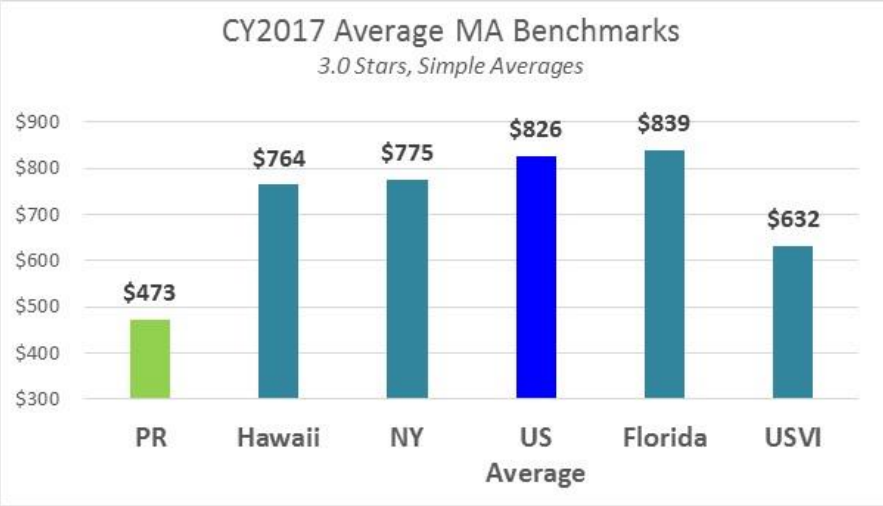
Proposal 1 - FFS study and findings support the use of an MA benchmark alternate proxy

The Moran Company has been working on an analysis of the FFS data from Puerto Rico for the past year. After several exchanges of information and reports with CMS, The Moran Company finalized its report. (***Attachment 1***).

As anticipated, the report validated concerns in relation to the use of the data from the FFS program, as a valid estimate of the costs for Medicare A and B benefits in Puerto Rico. In general, not only do the FFS data represent only approximately 10% of the Medicare A & B population in the island, but the findings confirmed that the Puerto Rico FFS population is a group of beneficiaries that self-selected themselves out of MA, with particular and significant differences in character and utilization patterns. For example, while over 50% of the MA beneficiaries are dual eligible, duals account for only 10% of the FFS data. Also, FFS member months have decreased 27% over five years, with a much higher rate of switching to MA compared to the US. The FFS population utilization experience is not representative of the larger MA population and exhibits selection bias. Utilization of services is also distinctly higher in MA, and FFS beneficiaries show consistently much higher rates of zero-claims (no use of Medicare services over significant periods of time), ranging up to three times higher than the national average.

We understand that the general scenario discussed in ***Section A*** above, and the work during the past year on the analysis of the FFS data, merits the consideration of an alternate proxy for the MA benchmark in Puerto Rico, while a different methodology is defined by Congress. It is evident that the FFS program that Congress considered as a standard for MA rate setting is rapidly eroding in Puerto Rico and no longer fits the assumptions underlying its use for MA benchmarks in the mainland US.

Puerto Rico has a different statutory history compared to any other jurisdiction, and the Traditional Medicare FFS program is simply not the same. In line with the policy rationale followed by CMS for other Medicare Part A or Part B rate issues in Pacific or the Caribbean Territories, one option is to set an MA benchmark proxy at the level of the US Virgin Islands. The ACA mandated minimum MLR of 85%, combined with the bid process administered by CMS, and market competition, would assure that the benchmark increase flows appropriately to benefits and provider payments. This approach may break the spiral towards the bottom in order for Puerto Rico to operate a version of the Medicare program similar to the one that exists everywhere else.



Proposal: Define an MA benchmark proxy, tied to similar geographic areas. The use of an MA benchmark proxy would not be an unprecedented policy adjustment. In fact, it would provide more consistency in the definition of Medicare payment policies for the Territories, while also keeping Puerto Rico as the lowest cost Medicare Advantage program in the nation. CMS could use its authority under Section 1876(a)(4) of the Social Security Act to estimate average adjusted per capita cost for Puerto Rico, based on actual experience "in a similar [geographic] area," as well as "appropriate adjustments to assure actuarial equivalence." At $632, the MA benchmark would be **17% lower than Hawaii, the state with the lowest average MA benchmark**.

Alternative Proposal 2(A) - Zero-claim members' anomaly

In the Final Notice and MA Benchmark Rates for 2017 for Puerto Rico, CMS included an adjustment to account for the anomaly in the Parts A and B FFS beneficiaries' data showing many more beneficiaries exhibiting no claims related encounters or expenses than in the 50 states & District of Columbia. This disparity identified in the Medicare FFS data for Puerto Rico includes a proportion of approximately **26%** of the FFS beneficiaries reporting zero claims, compared to a national average of under **8%** in a given year for those beneficiaries enrolled in Medicare Parts A and B.

In addition to creating a simple math problem of a much higher proportion of enrolled FFS months without any utilization in the denominator, thus depressing the typical MA benchmarking calculation, there is a selection bias for those remaining in the FFS population. This selection bias of who remains in FFS versus who opts into an MA plan is distorting the FFS data in a unique manner that is leading to a significant underestimation of FFS costs relative to other jurisdictions. ***In recognition of the zero-claim FFS beneficiary anomaly in Puerto Rico, CMS should continue to adjust the denominator in the calculation of the local FFS costs for counties in Puerto Rico to account for a level of zero-claim beneficiary months equivalent to the national average in FFS until such a time as a permanent, overall benchmark solution is devised.***

Alternative Proposal 2(B) - Duals bias in MA benchmark adjustment

Approximately 270,000 beneficiaries, almost 50% of the total MA beneficiaries in Puerto Rico, are dual eligible. These beneficiaries have selected the integrated MA, Part D and Medicaid program (Medicare Platino) voluntarily since 2006. However, as presented in **Table 13** of The Moran Company report (***Appendix 1***), in 2014 there were only 5,837 beneficiaries Medicare FFS with Parts A & B. This means that **98%** of all the Medicare A & B population are served by the MA program, and **only 2%** are in Traditional Medicare FFS.

The very low and eroding number of dually eligible beneficiaries in the PR FFS data suggests that this portion of the data used to set MA benchmarks is particularly distorted by selection bias, and reliance on different data in Puerto Rico is needed from that used in the mainland US. The Moran Company report shows a significant number of dually eligible Puerto Rico beneficiary residents with Medicaid obtained in U.S. states that may not be used in setting the benchmarks. Those beneficiaries have vastly higher PMPM cost compared to PR residents with Medicaid obtained in Puerto Rico. Other data elements are also distorted due to differences in data sources and high rates of zero claims. The FFS duals represent a particular case of selection bias in using their data to set MA benchmarks for the vast majority of dually eligible beneficiaries in MA plans. Risk adjustment by itself cannot correct for this selection bias.

In addition, the difference in how the dual eligible beneficiaries are managed in Puerto Rico presents a unique challenge to the development of accurate benchmarks for the overall Medicare population. In particular, two aspects could likely result in the overall benchmark underestimating the true cost of providing Medicare services for Puerto Rico beneficiaries:

- Since the Platino program basically provides full cost share buy-down for Part A/B and D services and no other government programs are available to provide similar coverage, the Dual population remaining in Medicare fee for services (less than 7,500 as of 2014) likely faces significant financial and/or accessibility issues. The distinct accessibility issues may be causing dual members not enrolled in Platino plans to not seek needed medical care, or use a significantly different model to access care through Mi Salud.

- The dual population represents 50% of MA enrollment, but 10% of the remaining FFS population. This discrepancy significantly leverages the impact of misestimating the dual eligible population. For example, a 10% change in the dual population cost results

in approximately 1.2% impact on the overall fee for service cost, but 5.5% impact for the equivalent Medicare Advantage dual distribution[1].

Please note that we do not have the sufficient data available to evaluate the possible impact of the dual issues identified. The dual population for the 5% sample and 100% CMS Statistical Analytical File (SAF) appears to identify dual members flagged in other stateside Medicaid buy-in programs, as the Puerto Rico Medicaid program does not provide such coverage. This population represents about 2% of the fee for service population (approximately 1,600 members out of approximately 74,000 in 2014).The dual population's normalized cost is more than double the cost for the non-dual Puerto Rico population, likely indicating that the actual cost for dual members once they are engaged in other health care assistance programs is significantly higher than for those duals that remain in Puerto Rico without access to the Platino program.

Obviously the low enrollment level for the dual population results in concerns regarding the level of credibility assigned to the results, but the magnitude of the difference is significant enough to warrant additional investigation based on the completed data set. The table below summarizes the per member per month (PMPM) cost for the Non-Institutionalized, Non ESRD, Non-Hospice Dual and Non-Dual Puerto Rico FFS claim cost for the 5% and 100% CMS data for calendar year 2014. In addition to evaluating additional details regarding the Medicaid Buy in population, we recommend a similar analysis be completed for all fee for service dual populations at the service level to validate all beneficiaries' base claim costs reflect a reasonable distribution of cost across all service types, in particular professional and non-emergency Part B services.

Table 1: Puerto Rico Non-Institutional, Non ESRD, Non-Hospice Dual and Non-Dual FFS claim

	Dual	Non-Dual	Dual vs Non-Dual Ratio
5% Data (Part A + B)			
Member Months	946	41,151	
Allowed PMPM	$695.22	$406.20	1.71
Net Paid PMPM	$570.09	$326.44	1.75
100% Data*			
Member Months	19,615	742,815	
Allowed PMPM	$683.03	$228.71	2.99
Net Paid PMPM	$589.16	$192.36	3.06

*Claim types include Inpatient Facility, Outpatient Facility, Home Health Agency, Hospice and SNF

[1] Impact based on average non-normalized ratio of 1.35 for national PMPM cost of Non-Institutionalized, Non ESRD Duals vs Non Duals.

Proposal: CMS should make adjustments to the FFS cost data for Puerto Rico to reflect the unique particularities of the dual eligible population and data. **(1)** An adjustment should be made in Part

[1] Impact based on average non-normalized ratio of 1.35 for national PMPM cost of Non-Institutionalized, Non ESRD Duals vs Non Duals.

B related expenses for the duals in FFS, based on the average proportion of Part A and B costs for duals in Medicare FFS nationally, to avoid an unintended underestimation of the Part B costs for a dual beneficiary. **(2)** In addition, an adjustment should be implemented to reflect dual beneficiary costs in the PR FFS data at the weight of at least the US average proportion of duals in Medicare FFS.

Alternative Proposal 2(C) - Considering unique scenario, Avoid reductions in case of rebasing

Considering the new analysis and evidence of particularities in FFS for Puerto Rico, CMS should avoid additional reductions originated from the rebasing of cost calculations. This would be independent of updates for repricing and other adjustments.

Proposal 3 - Unique & harmful situation of the ESRD MA benchmark in Puerto Rico

Medicare Advantage ESRD rates for Puerto Rico continue to be severely depressed and place a significant administrative burden on plans that serve ESRD membership, which are effectively subsidized at a loss. When comparing ''non-mainland'' or ''island'' states/territories' rates, we note that the Puerto Rico rates are at an absolute bottom:

State	2017 Dialysis Rate after $5.25 user fee
US Average	**$7,023.24**
Hawaii	$6,741.47
Northern Mariana	$5,889.92
USVI	$5,841.74
American Samoa	$5,045.56
Guam	$4,988.83
Puerto Rico	**$4,201.31**

As noted in the 2017 Rate Announcement, CMS "will continue to determine the 2017 ESRD dialysis rates by state as we specified in the Advance Notice." The 2017 Advance Notice states: "Statewide dialysis-only ESRD rates are determined by applying a historical average geographic adjustment to a projected FFS dialysis-only ESRD USPCC. We will use a 5-year average of State data to determine the average geographic adjustment, similar to the method used to determine the geographic adjustments for non-ESRD rates."

The 2017 Dialysis only FFS USPCC (US Per Capita Cost) is **$7,023.24**. For a glimpse at the magnitude of the problem, note that the Puerto Rico Dialysis Rate is currently at **59.82%** of the National FFS USPCC. Furthermore, the average geographic adjustment (2017 AGA Factor) for regular non-ESRD FFS rates for Puerto Rico is **0.50555**, whereas the unweighted national county average is 0.96835

[4]or **52.21%**. Time and again, using various indices and comparison methodologies, the anomaly as pertains to ESRD treatment in both Traditional Medicare and Medicare Advantage is apparent. This has undoubtedly triggered much of the discussion and several of the comments submitted by the Puerto Rico community as part of the more recent CY2016/CY2017 ESRD PPS final rule-making process, which we include henceforth for expediency:

> "Specifically, we solicited comment on the useful suggestions that were submitted in last year's final rule (80 FR 69007) and reiterated above. The comments and our responses to the comments for the proposal and solicitation are set forth below. Comment: An LDO that operates 27 ESRD facilities in Puerto Rico pointed out that the continued gradual reduction in the wage index floor has impaired operations in Puerto Rico since all areas of the island have been subject to the floor due to low wage index values. This commenter appreciates CMS' recommendation to apply a wage index of .40 to areas with a wage index below the floor for CY 2017, but believes the Agency must do more. Until CMS is able to adjust the wage index used to calculate ESRD facility reimbursements and fully take into account the totality of circumstances challenging facilities operating in Puerto Rico, they recommend that the wage index floor be re-instituted at a level that will avoid a negative impact on dialysis facilities. They recommend that CMS consider using the wage index for Guam or the Virgin Islands as they are similar to Puerto Rico in their island and U.S. territory status. The commenter believed CMS' policy to utilize the same wage index as Guam for the Northern Marianas and American Samoa could serve as a precedent for doing the same thing for Puerto Rico. The commenter does not believe maintaining a wage index of 0.40 for CY 2017 in Puerto Rico is adequate to offset the poor economic conditions to which patients and dialysis facilities are exposed. An organization of community stakeholders agreed, suggesting that CMS apply ESRD wage indexes in Puerto Rico that are consistent with other territories through the use of a temporary proxy. This group is requesting urgent administrative action from CMS. They are requesting that CMS: (1) Re-establish a fair and meaningful wage index floor given factual uncertainties and the demonstrated anomalies with the wage index for Puerto Rico; (2) Establish a temporary alternative wage index for Puerto Rico, given the observed disadvantage and the inconsistencies with the indexes used for other Territories; and (3) Ensure the corresponding adjustment in MA benchmarks for ESRD to secure the appropriate support to the Medicare program that serves 90 percent of all the Medicare A & B beneficiaries in Puerto Rico. However, an industry organization expressed support for our current methodology for determining the wage indices and the continued application of the wage index floor of 0.4000. **Response**: For the commenters that asked us to take an administrative action to establish a temporary alternative wage index value for Puerto Rico until we are able to correct the anomalies, we unfortunately, are unable to do so for several reasons. First, we did not propose an alternative to the wage indices for Puerto Rico based on reported hospital wage data. Rather, we presented various alternatives and requested public comment on

[4] Source: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/calculationdata2017.zip

those alternatives. We would need to have proposed changes to the Puerto Rico wage index in order to finalize a change in their wage index. With regard to the corresponding adjustment in MA benchmarks for ESRD to secure the appropriate support to the Medicare program, we note that this comment is beyond the scope of the proposed rule. One of the commenters who addressed the proposed wage index alternatives expressed an interest in basing the wage indices for Puerto Rico CBSAs on the wage values applied to other U.S. Territories and another commenter suggested applying the wage value for the U.S. Virgin Islands. The only other recommendation was maintenance of the current floor of 0.4000 with no comment on the alternatives in the proposed rule. When we developed the wage indices for the Pacific Rim territories in the CY 2014 ESRD PPS final rule (78 FR 40845), we applied the methodologies we use to calculate wage index values for ESRD facilities that are located in urban and rural areas where there is no hospital data. Those policies were finalized in the CY 2011 and CY 2012 ESRD PPS final rules (75 FR 49116 through 49117 and 76 FR 70239 through 70241, respectively). For urban areas with no hospital data, we compute the average wage index value of all urban areas within the State and use that value as the wage index. For rural areas with no hospital data, we compute the wage index using the average wage index values from all contiguous CBSAs to represent a reasonable proxy for that rural area. As we explained in the CY 2014 ESRD PPS final rule (78 FR 72172 through 72173), in the case of American Samoa and the Northern Mariana Islands, we determined that Guam represented a reasonable proxy because the islands are located within the Pacific Rim and share a common status as United States Territories. In addition, the Northern Marianas and American Samoa are rural areas with no hospital data. Therefore, we used the established methodology to compute an appropriate wage index using the average wage index values from contiguous CBSAs, to represent a reasonable proxy. While the islands of the Pacific Rim are not actually contiguous, we determined that Guam is a reasonable proxy for American Samoa and the Northern Marianas. The primary difference between how we handled the wage index for the Pacific Rim islands and the situation in Puerto Rico is that we were able to rely upon existing policy for determining a wage index for areas with no hospital data for the Pacific Rim islands. We have hospital data upon which to base wage index values for Puerto Rico CBSAs, so our policy for CBSAs without wage index data does not apply to Puerto Rico, despite the fact that its, wage index data results in very low wage index values compared to other Territories and mainland CBSAs. This is a complex policy issue that cannot be resolved for CY 2017. We intend to continue analysis in this area so that we can address this issue in a future rulemaking. **Final Rule Action**: After considering the public comments we received regarding the wage index, we are finalizing the CY 2017 ESRD PPS wage indices based on the latest hospital wage data as proposed. In addition, we are maintaining a wage index floor of 0.4000."

The specific request in the rule that is pertinent for the Medicare Advantage program in Puerto Rico was for CMS to:

> "(3) Ensure the corresponding adjustment in MA benchmarks for ESRD to secure the appropriate support to the Medicare program that serves 90 percent of all the Medicare A & B beneficiaries in Puerto Rico".

The response in the Final Rule:

> "With regard to the corresponding adjustment in MA benchmarks for ESRD to secure the appropriate support to the Medicare program, we note that this comment is beyond the scope of the proposed rule."

We agree that it is beyond the scope of the PPS rule-making process, but feel compelled to highlight the direct correlation with the MA rate setting process and include the request herein so it is properly addressed as part of the CY 2018 MA Advance Notice.

We stress that the ESRD rate anomaly is analogous to and runs concurrent with the Physician Fee Schedule process and adjustments that are still pending for CY2018. From the CY 2017 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B (Final Rule CMS-1654-F)[5]:

> "As noted above, currently Puerto Rico is the only territory for which we calculate GPCIs using the territory-specific information relative to data from the U.S. States. For several years stakeholders in Puerto Rico have raised concerns regarding the applicability of the proxy data in Puerto Rico relative to their applicability in the U.S. states. We believe that these concerns may be consistent across island territories, but lack of available, appropriate data has made it difficult to quantify such variation in costs. For example, some stakeholders previously indicated that shipping and transportation expenses increase the cost of acquiring medical equipment and supplies in islands and territories relative to the mainland. While we have previously attempted to locate data sources specific to geographic variation in such shipping costs, we found no comprehensive national data source for this information (we refer readers to 78 FR 74387 through 74388 for the detailed discussion of this issue). Therefore, we have not been able to quantify variation in costs specific to island territories in the calculation of the GPCIs. For all the island territories other than Puerto Rico, the lack of comprehensive data about unique costs for island territories has had minimal impact on GPCIs because we have used either the Hawaii GPCIs (for the Pacific territories) or used the unadjusted national averages (for the Virgin Islands). In an effort to provide greater consistency in the calculation of GPCIs given the lack of comprehensive data regarding the validity of applying the proxy data used in the States in accurately accounting for variability of costs for these island territories, we proposed to treat the Caribbean Island territories (the Virgin Islands and Puerto Rico) in a consistent manner. We proposed to do so by assigning the national average of 1.0 to each GPCI index for both Puerto Rico and the Virgin Islands."

[5] Source: https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/html/2016-26668.htm

"The following is a summary of the comments we received regarding the proposed update to the methodology for calculating GPCIs in the U.S. territories. Comment: Several commenters expressed support for CMS' proposal to assign the national average of 1.0 to each GPCI in Puerto Rico, stating that the physicians in Puerto Rico who treat patients enrolled in fee-for-service Medicare will be reimbursed in a manner that more closely aligns with the manner in which physicians in the other U.S. territories are reimbursed, and better reflects the cost of practicing medicine in Puerto Rico. Other commenters supporting the proposal also suggested that there has been a need for revision of Medicare payment in Puerto Rico, and that the territories of the U.S. have not been treated similarly even though the territories are much alike. Another commenter stated that the existing fee schedule for Puerto Rico does not correlate with the cost of caring for patients, and that the proposed policy is long overdue. Some commenters also stated that increasing the GPCI's for Puerto Rico is an important and necessary first step in trying to salvage Puerto Rico's deteriorated health system. Response: We thank the commenters for their support."

"**Comment**: We received several comments that are outside of the scope of the Physician Fee Schedule, requesting that CMS explore every option to determine whether a one-time correction can be made to the Medicare Advantage (MA) regulatory cycle so that the per-person monthly payment to Puerto Rico MA Plans in CY 2017 will reflect the increase to the fee-for-service spending in the territory as a result of the proposed GPCI increase. Some commenters stated that it is imperative that CMS see that the increased physician fees reach the actual providers and are not diverted away from patient care by third parties such as Medicare Advantage Organizations. Some commenters requested that CMS clarify that the new GPCIs will be incorporated into the MA benchmarks in CY 2018. **Response**: We appreciate the concerns raised by the commenters. Consistent with the statute, we published the final CY 2017 Rate Announcement for Medicare Advantage on April 4, 2016. Medicare Advantage actuarial bids and benefit packages for 2017 have been approved by CMS and sponsors have begun marketing plan to beneficiaries. Thus, a change in to CY 2017 benchmark would be disruptive to beneficiaries. In future years, including CY 2018, we will follow our normal process for calculating rates. This process incorporates historical Fee for Service expenditures, which would include any updates to Fee for Service payment rates, such as an adjustment to the Puerto Rico GPCI. CMS will not be making any adjustments to CY 2017 Medicare Advantage rates as a result of this final rule. Finally, we note that according to the statute, we are prohibited from interfering or directing the contracting between Medicare Advantage Organizations (MAOs) and contracted providers. As such, we are not permitted to dictate to MAOs how any increase in payment rates can be spent, including on provider rates. **Comment**: One commenter suggested that if the MA benchmark cannot be adjusted for CY 2017 that CMS should postpone the applicability of the GPCI change in Puerto Rico until CY 2018 when such an effect is also reflected in the MA benchmarks. **Response**: We do not agree that the proposal to update to the methodology for calculating GPCIs in the U.S. territories, which will provide greater

consistency in the calculation of GPCIs for these areas, should be delayed based on when the MA benchmarks will reflect the increases as a result of this policy. After consideration of the public comments received regarding our proposal to treat the Caribbean Island territories (the Virgin Islands and Puerto Rico) in a consistent manner, by assigning the national average of 1.0 to each GPCI index for both Puerto Rico and the Virgin Islands, we are finalizing as proposed."

There is support to treat Caribbean Island territories (the Virgin Islands and Puerto Rico) in a consistent manner for Physician Fee Schedule rate-setting, as observed in the fact that for 2017 a national average of 1.0 was assigned to each GPCI index for both Puerto Rico and the Virgin Islands. We propose a similar approach for ESRD rate-setting in Medicare Advantage. This can take any one of several forms, for example:

(1) Apply the 2012 Puerto Rico MA ESRD Rates as a proxy for CY 2018 while a more permanent solution is evaluated.
(2) Use the 2018 ESRD MA Benchmark for USVI as a proxy for Puerto Rico, given similar conditions as island-Territories.
(3) Apply the USVI average geographic adjustment (AGA factor) to the projected 2018 FFS dialysis-only ESRD USPCC and adjust for a higher risk profile (ESRD Dialysis only Risk Scores) in Puerto Rico when compared to the Virgin Islands[6]:

Dialysis Risk Scores Tab:

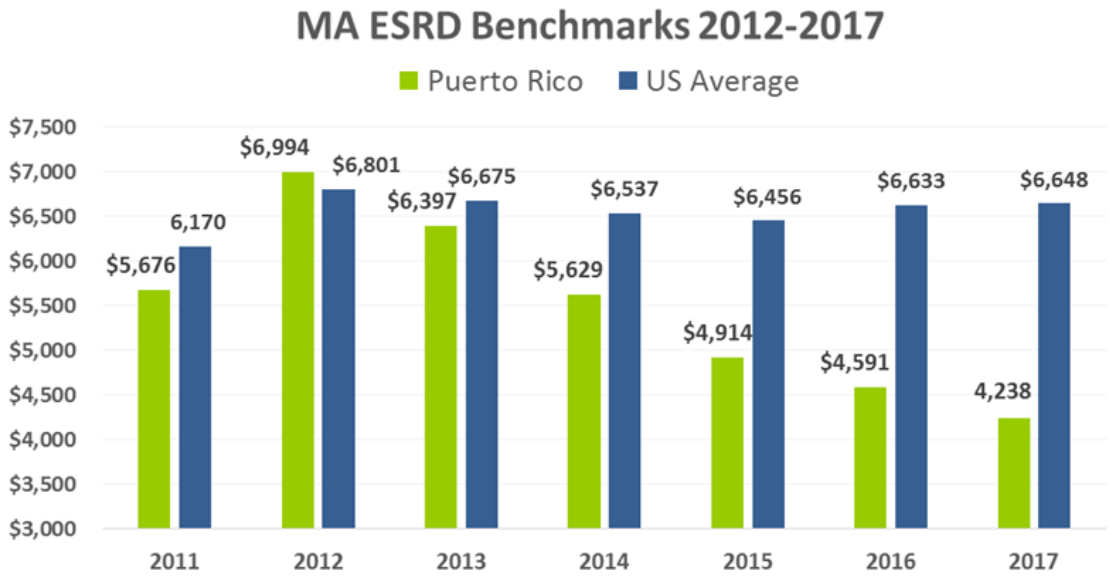
state code	state	2010	2011	2012	2013	2014
National Average (raw)		0.948	0.957	0.972	0.974	0.981
40	Puerto Rico	1.004696	0.956017	0.947760	0.941702	0.929538
48	Virgin Islands	0.804637	0.826041	0.832007	0.849689	0.877732

As we have stated in many comment letters to CMS during the past years, Puerto Rico has a Medicare Advantage penetration of 90% of total Medicare beneficiaries with Parts A & B on the island. With 570,000 total MA beneficiaries, the ESRD population in MA is significant, even when ESRD patients in FFS are excluded from eligibility. **The recent study from The Moran Company found that there are approximately 3,500 ESRD beneficiaries in the MA plans of Puerto Rico. Moreover, the data in the Puerto Rico CMS File only included 60 ESRD patients in FFS Medicare with reported risk score data**. Meanwhile, as seen in **Chart 1**, the MA benchmark for ESRD has been reduced by 39% since 2012. Based on the estimated population (3,500), this means that in 2017 health plans in Puerto Rico will have to provide care for the same number of ESRD patients with approximately **$160 million less** in MA funding compared to the funding available in 2012.[7]

[6] *Source:* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/calculationdata2017.zip
[7] A difference of $2,800 in the monthly MA ESRD Benchmark (CY2012 vs CY2017), an average 1.4 risk score, and a total of 3,500 ESRD beneficiaries are considered for this estimate.

This is a direct result of the continuing use of FFS cost estimates which, based on what we know at the moment, could be based only on the utilization of 60 beneficiaries in Medicare FFS.

Based on the new empirical analysis available, we reiterate our request for urgent administrative action. This is yet another opportunity for CMS to use its authority to make legitimate policy corrections and adjustments to portions of the Medicare payments to Puerto Rico, and save access to care at the lowest cost.



Proposal 4 - Treat the benefit to help pay for Part B premium in D-SNPs as part of the A/B bid

In line with the policy to define Part A and B deductibles and cost-sharing as part of the A/B Bid, CMS should consider Part B member premium reductions as part of the core A/B benefit in Puerto Rico. Medicare Savings Programs (MSPs) and Part B Buy-in programs are not available in the island given the history of the statutorily fragmented and capped Medicaid program on the island.

Similarly situated beneficiaries residing in states get the Part B premium paid under Part B Buy-in programs. Therefore, they can join D-SNP plans without the need to pay for the Part B member premium. As a core benefit for full duals, the Part B member premium should be covered without taking away the percentage applied to supplemental benefits under the MA rebates. The Part B member premium support is usually not a supplemental benefit for full benefit duals. But since the Medicare and Medicaid program and funding are different in Puerto Rico, support from the MA program is the only way to help duals with their Part B member premium.

Proposal 5 - Maintain current STARs adjustments, and make two additional enhancements

The following are our community comments regarding Star Ratings in advance of the draft 2018 Call Letter.

<u>Reduction in the weights of Part D Medication Adherence Measures but use of values for calculation of the improvement factor</u>

Because of the lack of the Part D low income subsidy in Puerto Rico, we continue to support the reduction in the weights of the three Part D Medication Adherence measures to zero for the calculation of the overall and summary Star Ratings for contracts operating solely in Puerto Rico. In addition, we appreciate the ability to use the values/associated weights of the three adherence measures for the calculation of the improvement factor, as we continuously strive to improve our performance by implementing medication adherence outreach and targeted programs that are visibly improving the beneficiary experience in Puerto Rico.

Maintaining LIS proxy for CAI calculation for contracts serving beneficiaries in Puerto Rico

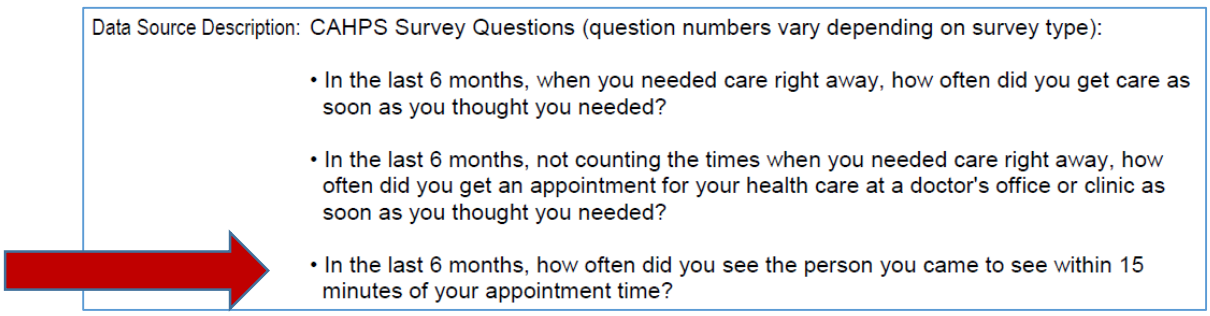
As noted in Attachment O of the Medicare 2017 Part C & D Star Rating Technical Notes, "*Puerto Rico has a unique health care market with a large percentage of low-income individuals in both Medicare and Medicaid. Since the percentage of LIS/DE is a critical element in the categorization of contracts to identify the contract's CAI, an additional adjustment is done for contracts that solely serve the population of beneficiaries in Puerto Rico to address the lack of LIS. The additional analysis for the adjustment results in a modified percentage of LIS/DE beneficiaries that is subsequently used to categorize the contract in its final adjustment category for the CAI.*"

We request CMS' continued support of this LIS proxy, since it is the only adjustment available to account for the high percentage of low-income individuals in Puerto Rico and the particular challenges this represents for all MA Carriers on the Island. We request CMS revisit the reasonableness of the CAI Calculation for Puerto Rico. Although the current calculation assists Puerto Rico contracts in a positive direction, the CAI/LIS-driven analysis should result in Puerto Rico being not only categorized among the highest levels of poverty, but at the absolute highest decile level of poverty, since Puerto Rico per capita income is factually much lower than the lowest-income state.

Alternate scoring methodology for C21 Getting Appointments Quickly for Puerto Rico Contracts

Even after the new socio-economic status adjustments (SES) previously noted, Stars Measure C21 does not reflect the local realities of the healthcare system and the culture specific to Puerto Rico. Three CAHPS survey questions make up this measure. Notably, the 3rd question uses a 15-minute wait as a standard for specialists' appointments, which is not realistic in the case of Puerto Rico. As was done with the medication adherence measures, C21 should be adjusted accordingly.

CY 2017 Technical Notes, Page 43



Data Source Description: CAHPS Survey Questions (question numbers vary depending on survey type):

- In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
- In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

In Puerto Rico, patients, doctors, and support personnel are accustomed to slightly longer waiting times given the reality of our delivery system. A reasonable, high-quality waiting time for Puerto Rico is probably 30-60 minutes, not 15. Moreover, and most significantly, the current healthcare challenges have accelerated the migration of the population and of health professionals to the U.S. mainland. Data from the "*Travelers Survey*" performed by the Puerto Rico Institute of Statistics (PRIS) has reported that Puerto Rico may be losing one doctor a day.[8] The problem is particularly worrisome in the case of physician specialists. In general, using the most recent figures available (transportation statistics) the PRIS has projected that net outmigration from Puerto Rico in the past year could be as high as 100,000. This net outmigration of physicians has been exacerbated more recently, and places undue strain to see as many patients as possible in order to address the demand on ever-dwindling healthcare resources.

Upon examination of each Puerto Rico H-Contract's particular CAHPS scores, the results for the 3rd question, which explicitly uses this 15-minute standard, will be dramatically different than the result for the initial 2 questions. This 3rd question could be weighted at zero when calculating the average score for C21. Therefore, with regards to measure C21, a possible methodology change for Puerto Rico contracts would be to exclude the 3rd question results from the calculation of the score, following a policy that is similar as the one implemented for the medication adherence measures for Puerto Rico contracts. CMS would then calculate the score of C21 based on the other two questions. Conversely, the national average score for this question could be used as a reasonable proxy. This would reduce the unintended negative consequences of applying one-size-fits-all standards to a significantly different healthcare system, both from a cultural and socio-economic standpoint, while we continue to make inroads to raise the performance level of the Puerto Rico healthcare system as a whole.

Stars Measures C27 and D05 – Members Choosing to Leave the Plan – SNP Adjustment

We have previously requested a modification to Stars Measures C27/D05 in order to account for a higher prevalence of D-SNP beneficiaries in Puerto Rico contracts. Dual beneficiaries represent half of the eligible members in Puerto Rico, and since D-SNPs participate in a year-round annual SEP, a higher proportion of the D-SNP population continuously switch plans, looking for alternatives to better serve their needs throughout the year. Although this makes for a vibrant and dynamic market, the statistical clustering method consistently places Puerto Rico contracts (which have a significantly higher proportion of D-SNPs) at a disadvantage vis-à-vis plans at the national level with a much lower proportion of said beneficiaries. The goal of this adjustment is to not unfairly penalize contracts that work under very different market conditions. We propose two alternatives: (1) adding an additional exclusion to Measures C27/D05, i.e. removing D-SNP Members from the final numerator, or (2) applying an adjuster to Measures C27/D05 similar to the CAI adjustment methodology proposed for the Overall Star Rating. The objective is to ensure

[8] *Puerto Rico is Losing a Doctor Day*, http://money.cnn.com/2016/04/13/investing/puerto-rico-debt-medicare/index.html. *See also - SOS: Puerto Rico is Losing Doctors, leaving Patients Stranded; National Public Radio;* http://www.npr.org/sections/health-shots/2016/03/12/469974138/sos-puerto-rico-is-losing-doctors-leaving-patients-stranded?utm_source=npr_newsletter&utm_medium=email&utm_content=20160919&utm_campaign=npr_email_a_friend&utm_term=storyshare

a more reasonable place in the normal distribution curve for this measure with respect to all other plans at the national level.

C. Final remarks

It has been evidenced that <u>Puerto Rico has a higher cost of living than the U.S. average</u>. In contrast, many of the anomalies that keep federal payments to Puerto Rico as an outlier at the bottom tie back to relative cost indexes and geographic factors that pull payment levels to a distant bottom. The *Puerto Rico Institute of Statistics* was able in 2015 to formally insert Puerto Rico in a national cost of living survey that confirmed higher costs for most of the inputs needed for healthcare.[9] The spiral towards the bottom in Medicare payments has led to artificially lowering or depressing labor costs to balance other costs like prescription drugs and utilities that continue to increase. This is in turn the major factor impacting the migration of our health professionals, which some estimate could be reaching 2,000-3,000 in the past six years, around 20% of the estimated active physicians on Puerto Rico.

Another critical misconception occurs in the assessment of the MA program financial situation in Puerto Rico. Some have questioned the financial impact of the cuts arguing that health plans in Puerto Rico reflect higher than usual profit margins in MA. The reality is the opposite. Puerto Rico is doing a lot more with a lot less. As per reports from the *Puerto Rico Office of the Insurance Commissioner*, margins for managed care organizations have been notably low and even negative in the past years.

An assessment of MA health plans' performance influenced by the uniqueness of the D-SNP bids for Puerto Rico is not a reflection of how the program really works in Puerto Rico. Therefore, such scenario should not be a limitation to CMS' adjustments in the efforts to calculate the most appropriate estimate of **<u>Medicare FFS costs</u>** in a locality. The fact that Puerto Rico plans can cover the current Medicare A/B benefits costs in our depressed system not mean the current state of benefit levels, access, provider payments, and the system in general, is adequate. Health professionals would remain in Puerto Rico if that were the case.

<u>From the Puerto Rico Office of the Insurance Commissioner, Annual Report 2015</u> [10]

The following are some of the most important ratios for this sector of the insurance industry:

Ratios	2015	2014	2013	2012	2011
Medical Loss Ratio	87.2%	87.2%	86.0%	86.5%	87.4%
Combined Ratio	99.6%	98.5%	98.7%	97.2%	97.6%
Profit Margin Ratio	0.01%	-1.5%	1.2%	2.5%	1.9%

[9] http://www.estadisticas.gobierno.pr/iepr/Publicaciones/Proyectosespeciales/ICV.aspx
[10] http://ocs.gobierno.pr/enocspr/index.php/nuestra-oficina/informe-anual, Page 22.

A comparison between the results of the ratios for Puerto Rico and the average for the insurance industry in the United States shows that the medical loss ratio for the local industry was 87.2%, while the United States average was 85.4%, a difference of 1.8%. The combined ratio of the industry in Puerto Rico was 99.6%, while the United States average was 98.5%, a difference of 1.1%. Finally, the profit margin ratio for the domestic industry was 0.01% compared with the United States average of 0.9%, that is to say, 0.89% below the latter.

D. Attachment

Analysis of Puerto Rico Fee-For-Service Medicare Experience: Implications for Setting Medicare Advantage Benchmarks. The Moran Company.
December, 2016