Summary of Legislative Provisions Establishing Medicaid Parity in
Puerto Rico and the Territories

Background

Medicaid, the health program for low-income individuals established in 1965, 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 provides its share of matching funds. The federal contribution—known as an FMAP—can range from 50 percent of all Medicaid expenditures in the wealthiest states to 83 percent in the poorest states.

By contrast, there is a "ceiling" or "cap" on the total amount of funding that the federal government annually provides to support the Medicaid program in each U.S. territory, pursuant to Section 1108 of the Social Security Act (42 U.S.C. §1308). In Fiscal Year 2008, the Section 1108 statutory caps were extraordinarily low:

- Puerto Rico: $260.4 million
- USVI: $13.0 million
- Guam: $12.76 million
- CNMI: $4.76 million
- American Samoa: $8.62 million

In addition, the FMAP for each territory was set by statute at 50 percent, the same as the wealthiest states. Because of the annual statutory cap, Puerto Rico's effective FMAP—the actual federal contribution to the island's Medicaid program—was between 15 and 20 percent a year. Puerto Rico was spending upwards of $1.4 billion in territory funds to provide health care services to about 1.2 million low-income beneficiaries, and receiving less than $300 million from the federal government for this purpose.

To place that in context, in FY 2014:

- Mississippi had a 73 percent FMAP and received $3.6 billion in federal funds.
- Oklahoma had a 64 percent FMAP and received $3.0 billion in federal funds.
- Oregon had a 63 percent FMAP and received $5.0 billion in federal funds.
- Starting in 2009, federal law was amended to substantially improve the treatment of the territories under Medicaid, but this treatment—especially in the case of Puerto Rico—remains deeply inequitable.

The first funding increase was a result of the 2009 American Recovery and Reinvestment Act, which temporarily raised each territory's annual ceiling by 30 percent. That increase lasted from the first quarter of Fiscal Year 2009 (October 1, 2008) through the third quarter of Fiscal Year 2011 (June 30, 2011).

In 2010, Congress enacted the Affordable Care Act (ACA). The territories were excluded from major provisions of the bill, but were provided $7.3 billion in additional Medicaid funding. In addition, each territory's FMAP was modestly increased from 50 percent to 55 percent.

Of the $7.3 billion, each territory received the following:

- Puerto Rico: $6.40 billion
- USVI: $298.75 million
- Guam: $292.78 million
- CNMI: $109.26 million
- American Samoa: $197.82 million

This funding, which is on top of the ceiling amount that each territory receives annually under Section 1108 of the Social Security Act, is available to be drawn down between the fourth quarter of Fiscal Year 2011 (July 1, 2011) and the end of Fiscal Year 2019 (September 30, 2019).

The result is that each territory annually receives the following in federal Medicaid funds, including funding under the Children's Health Insurance Program (CHIP) and the Enhanced Allotment Program (which applies in the territories in lieu of the Medicare Part D low-income subsidies and helps low-income seniors purchase prescription drugs):

- Puerto Rico: $1.1 to $1.3 billion
- USVI: $75 to $78 million
- Guam: $53 to $59 million
- CNMI: $20 to $21 million
- American Samoa: $34 to $38 million

However, 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. This has been called the Medicaid funding "cliff." As of this writing, the Puerto Rico government has only $3.57 billion of its $6.3 billion in ACA funding remaining. It is projected that the ACA funding for Puerto Rico will be depleted by mid-2018 or even late 2017. If this pool of funding is not seamlessly replenished, each territory will go back to receiving Medicaid funds solely under Section 1108 of the Social Security Act—which, for Puerto Rico, means annual federal funding of less than $400 million a year.

The ACA perpetuated Puerto Rico's discriminatory treatment under Medicaid in another respect. The states and the District of Columbia are permitted to expand eligibility for Medicaid to certain population groups (in general, non-elderly adults with incomes up to 133 percent of the federal poverty level). If a state elects to expand eligibility for Medicaid to individuals within these groups, 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 the 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.

Summary of Legislative Provisions Derived from HR 2635, Improving the Treatment of the U.S. Territories under Federal Health Programs Act of 2015

- Section 101 to Section 104 of the legislation would establish new federal rules to govern the Medicaid programs in the U.S. territories and would avert the Medicaid federal funding "cliff" that each territory will automatically reach on September 30, 2019 and that at least one territory, Puerto Rico, will likely reach in 2018 or even 2017. The new rules would provide the territories with state-like treatment, but only within certain well-defined parameters related to income eligibility levels.

- Specifically, each territory's Medicaid program could cover individuals whose family income is equal to or less than 100 percent of the federal poverty level, and receive state-like federal financing for that purpose. In the states and the District of Columbia, the applicable income eligibility level is generally 133 percent of the federal poverty level, and many states cover individuals whose family income exceeds 133 percent. Under the legislation, each territory government must cover individuals earning up to 100 percent of the federal poverty level who fall within the "mandatory" population categories (such as children up to age 18 and pregnant women) and may cover individuals earning up to 100 percent of the federal poverty level who fall within the "newly eligible" population categories established by the ACA (in general, non-elderly adults). As long as a territory government covers individuals whose household income is within these limits, the federal government will fund the territory's Medicaid program as if it were a state Medicaid program. However, if a territory wants to cover individuals earning more than 100 percent of the federal poverty level, it will generally be required to use territory dollars, not federal dollars.

- "State-like" treatment means:

    - The "ceiling" or "cap" on the amount of annual funding that the federal government provides to support the Medicaid program in each territory, pursuant to Section 1108 of the Social Security Act (42 U.S.C. §1308), would be eliminated.
    - The federal government's share of total Medicaid expenditures (FMAP) would be calculated for each territory according to the territory's per capita income relative to U.S. per capita income, just like the FMAP is calculated for each state. Under current law, each territory's FMAP is set by statute at 55 percent. Under the bill, and given current economic conditions in the territories, each territory's FMAP would likely be around 80 percent. A territory, like a state, would receive an "enhanced" FMAP (at least 90 percent) if the territory elects to cover individuals in the "newly eligible" population categories established by the ACA.

- The effective date of these provisions would be October 1, 2016, the first day of Fiscal Year 2017. The five territories received a total of $7.3 billion in the ACA to add to their

Section 1108 Medicaid caps through Fiscal Year 2019, with Puerto Rico receiving $6.4 billion of that amount. If any territory has not used its share of this additional Medicaid funding as of October 1, 2016, the unused funding would revert to the federal treasury and would be used to offset the cost to the federal government of the legislation's new Medicaid provisions.

- The policy rationale behind the Medicaid provisions in the legislation is that, as long as the territories are covering individuals whose incomes are at or below the federal poverty level, the federal government should treat the territories no different than the states in terms of financing each territory's Medicaid program. This is state-like treatment, but with an important limiting principle that will control the cost to the federal government.

- Section 105 would extend the Medicaid DSH program to the territories. Since 1993, the federal Medicaid statute requires the states and the District of Columbia to make disproportionate share hospital (DSH) payments to hospitals treating large numbers of low-income patients. This provision is intended to recognize the disadvantaged financial situation of those hospitals because low-income patients are more likely to be uninsured or enrolled in Medicaid. Hospitals often do not receive payment for services rendered to uninsured patients, and payments made to providers under Medicaid are generally lower than the rates paid by Medicare and private insurance. The federal government reimburses each state for a portion of the state's Medicaid DSH expenditures based on that state's FMAP. Each state receives an annual DSH allotment, which is the maximum amount of federal matching funds that each state is permitted to claim for Medicaid DSH payments. In Fiscal Year 2014, federal DSH allotments totaled $11.7 billion. While there are some federal requirements that states must follow in defining DSH hospitals and calculating DSH payments to hospitals, states tend to have significant flexibility.

- However, Medicaid DSH allotments are not provided to the five territory governments, because Section 1923(f)(9) of the Social Security Act defines "State" as the 50 states and the District of Columbia. Section 105 would correct this exclusion and provide $150 million in annual DSH allotments for the five territories to share. Of that amount, funding would be distributed among the territories based on the number of low-income and uninsured individuals residing in each territory as periodically estimated by the Secretary of the Department of Health and Human Services. Puerto Rico would receive about $130 million annually. To place this in context, Mississippi receives about $160 million annually and Florida receives about $215 million annually.

- Section 105 is designed to be enacted alongside Sections 101-104, or alongside any other legislation that provides the territories with fair FMAPs. Otherwise, Puerto Rico might not be able to make meaningful use of its Medicaid DSH payments because the local matching rate would be too high.