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A Not So Special Rate: A Look at the Unequal Medicare Reimbursement Rates Between the United States and the Commonwealth of Puerto Rico

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A NOT SO SPECIAL RATE: A LOOK AT THE UNEQUAL MEDICARE REIMBURSEMENT RATES BETWEEN THE UNITED STATES AND THE COMMONWEALTH OF PUERTO RICO

MICHAEL L. TORRES*

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I. INTRODUCTION

The intended purpose of the Medicare system is to provide the elderly and disabled with adequate health care in order to create a healthier, more financially secure society.¹ As a Commonwealth of the United States, Puerto Rico is privy to the benefits of the Medicare program and is also subject to the regulations set out under the program.² As such, Puerto Rico contributes to the Medicare fund based on the same rates as all other Medicare participants, but Puerto Rico only gets reimbursed a portion of the benefits that the

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1. See 42 U.S.C. § 1395c (2000); PETER A. CORNING, *THE EVOLUTION OF MEDICARE . . . FROM IDEA TO LAW* 30–32 (1969).

2. See 42 U.S.C. § 1395ww(d)(9) (2000), amended by Pub. L. No. 108-173, 117 Stat 2066 (to be codified at 42 U.S.C. § 1395ww(d)(9)(E)); *Hosp. San Rafael, Inc. v. Sullivan*, 784 F. Supp. 927, 930 (D.P.R. 1991); Omnibus Budget Reconciliation Act of 1986, 42 C.F.R. §§ 412.200-.220 (2003).

states receive.³ Since 1987, Puerto Rico's hospitals have been subject to a special Medicare reimbursement rate based on just a portion of the national rate utilized by all other hospitals in the states.⁴ The special rate results in lower payment levels for the participating hospitals on the island, which in turn makes it more difficult for the elderly and disabled on the island to receive the medical care they need.⁵ Since the incorporation of the unequal rates, significant improvements have been developed; however, there is still much ground to make before Puerto Rico reaches the parity it seeks to obtain.⁶ This article will discuss the purpose and effect of the Medicare program and how the program is unequally applied to Puerto Rico.

Part II of this article will track the history and reasons behind the creation of the Medicare program. Part III will discuss the reforms that the system has undergone since its creation in 1965, and the social and economical impact it has had on the citizens of the United States. Part IV will discuss the Medicare program as applied to the Commonwealth of Puerto Rico, with a focus on the special reimbursement rate imposed on Puerto Rico. Part V will conclude with a brief analysis of the facts and how they support eliminating the unequal reimbursement rate.

II. THE LONG JOURNEY OF MEDICARE

In the United States, the concept that the government should contribute to the health care of its citizens started long before Lyndon B. Johnson signed Medicare into law.⁷ Early in the twentieth century, with the beginning of the Industrial Revolution, labor practices heightened the focus on welfare matters.⁸ Organizations such as the American Association for Labor Legislation ("AALL") began making a push toward health care legislation that protected workers.⁹ However, in the early 1900s health care issues were

3. See 42 C.F.R. §§ 412.200-.220; § 1395ww(d)(9); *Sullivan*, 784 F. Supp. at 930.

4. *Sullivan*, 784 F. Supp. at 930.

5. See *Congressional Committees Move to Increase Puerto Rico Medicare — Why. . . New Territories Staffers in Committees*, P.R. HERALD, June 13, 2003, at <http://www.puertorico-herald.org/issues/2003/vol7n24/WashUpdate0724-en.shtml> [hereinafter *Move to Increase Puerto Rico Medicare*]; Noticias, Aníbal Acevedo Vilá, Presidente Bush Convierte en Ley Reforma al Medicare: Significativo el Impacto Sobre Puerto Rico (Dec. 7, 2003) (copy on file with author) [hereinafter *Significativo el Impacto*].

6. See § 1395ww(d)(9); *Sullivan*, 784 F. Supp. at 930; *Move to Increase Puerto Rico Medicare*, *supra* note 5.

7. CORNING, *supra* note 1, at 120.

8. *Id.*

9. *Id.* at 6-7. The organization led a campaign requiring employers to insure their workers against industrial accidents and they created a Social Insurance Committee in order to spot issues and come up with solutions. *Id.* By 1915, the AALL managed to influence thirty

mainly handled within the states; this made it particularly difficult to implement any national welfare proposal since implementation had to be done on a state-by-state basis.¹⁰ In the early part of the twentieth century, Americans had the attitude that less government intervention was best for state issues such as health care.¹¹ Despite the majority philosophy, Theodore Roosevelt based his 1912 campaign on the “New Nationalism,” which contained ideas for a number of social welfare programs, including government health insurance.¹² Not surprisingly, Roosevelt was heavily criticized.¹³ The obvious lack of support brought the idea of government health insurance to an early halt and foreshadowed the difficulties to come.¹⁴

The United States was fond of private enterprise and independence, which acted as a large blockade to mandatory nation-wide health insurance.¹⁵ Furthermore, states were reluctant in adopting mandatory social welfare legislation fearing that such legislation would place them at a disadvantage on the national economic level.¹⁶ Despite the unfavorable positions presented on both the state and national level, implementation of a broad social welfare system would best be achieved on the federal level.¹⁷ The Great Depression of the 1930s created a vast sense of vulnerability amongst the United States citizens and provided an opportune moment to push for a nation-wide health care program.¹⁸

In 1932, Franklin Roosevelt, the newly elected president, came into office with change in mind.¹⁹ Roosevelt, through his “Fireside Chats” and proposed “New Deal,” provided great comfort to Americans during a time of economic struggle.²⁰ At this time, his inter-dependence ideas were widely accepted.²¹ The birth of the Social Security Act sprouted out of the many federal organizations and administrations established under the Roosevelt administration.²² In 1934, Roosevelt assembled the Committee on Economic

states to implement laws mandating employers to insure their workers against industrial accidents. *Id.*

10. CORNING, *supra* note 1, at 120.

11. *Id.* at 11–12.

12. *Id.*

13. *Id.* at 9, 11.

14. *See id.*

15. CORNING, *supra* note 1, at 11–12.

16. *Id.* at 12–13.

17. *Id.*

18. *Id.* at 29.

19. *Id.*

20. CORNING, *supra* note 1, at 29.

21. *Id.* at 30.

22. Michele Estrin Gilman, *Legal Accountability in an Era of Privatized Welfare*, 89 CAL. L. REV. 569, 585 (2001); CORNING, *supra* note 1, at 30. Among the many agencies

Security to investigate what issues were creating the most problems for economic security of individuals, to investigate all forms of social insurances, and to formulate possible solutions to the problem.²³ The results of the committee study were not definitive; however, health insurance and unemployment insurance were the leading concerns.²⁴ Roosevelt's strong push for nation-wide health care slowly died down as opposition grew from conservatives in Congress²⁵ and as pressure grew from the American Medical Association ("AMA").²⁶ The AMA represented the voice of American physicians who strongly opposed the idea of any national health care system because of fear that it would open the door to excessive government intrusion.²⁷ In spite of the AMA's strong opposition and Roosevelt's passiveness, the Social Security Act survived heavy scrutiny and was signed on August 14, 1935.²⁸ The signing of the Social Security Act was a tremendous accomplishment and paved the road for Medicare.²⁹

The outlook of the national health care system was particularly inconsistent throughout the 1930s and 1940s.³⁰ In the late 1930s a strong wave of pro-national health insurance arose, only to be dissolved by the preoccupation of the start of World War II and the death of President Roosevelt.³¹ In

established by the Roosevelt administration in an attempt to remedy the country's economic struggle were the: Civil Works Administration (CWA); Civilian Conservation Corps (CCC); Federal Emergency Relief Administration (FERA); National Recovery Administration (NRA); and Public Works Administration (PWA). CORNING, *supra* note 1, at 30.

23. William E. Forbath, *The New Deal Constitution in Exile*, 51 DUKE L.J. 165, 207 (2001); CORNING, *supra* note 1, at 30–31. The report was given a deadline of December 1, 1934, and the list of possible programs that would assist the economic state of the country ranged from accident insurance and unemployment insurance to retirement annuities and health insurance. CORNING, *supra* note 1, at 30–31.

24. CORNING, *supra* note 1, at 30–31.

25. Theodore R. Marmor & Gary J. McKissick, *Medicare's Future: Fact, Fiction and Folly*, 26 AM. J.L. & MED. 225, 227 (2000); CORNING, *supra* note 1, at 41.

26. Emily Friedman, *The Compromise and the Afterthought: Medicare and Medicaid After 30 Years*, 274 J. AM. MED. ASS'N 278, 279 (1995).

27. See CORNING, *supra* note 1, at 16.

28. *Id.* at 41.

29. See *id.* After the signing of the Social Security Act, the Social Security Board was created under section 702 of the Social Security Act. *Id.*

30. See *id.*

31. CORNING, *supra* note 1, at 51–52. The National Health Conference, held in July of 1938, created a lot of great publicity for a national health plan and placed pressure on the leading opposition (AMA) to take a public stance as to the health care issue in the country. *Id.* In February of 1939, the "Wagner Bill," featuring improvements to the Social Security program, was proposed. *Id.* The bill was unsuccessful due to the combination of AMA's strong campaigning against the bill and the President's inability to support the bill due to his preoccupation with the start of WWII. *Id.* Roosevelt's death in 1945 also posed as another gloomy

the 1940s Harry S. Truman was another pro-national health insurance president.³² He also made a push for health insurance but was interrupted with the rise of domestic anti-communism and an economic plummet.³³ By 1949, the polls indicated that favoritism toward government health plummeted to 51 percent and that private insurance coverage amongst the population more than doubled since 1946.³⁴

In an attempt to place a more appealing spin on an openly dissatisfying proposal, Merrill G. Murray, an official of the Social Security Administration, introduced an idea that originated during the Truman administration.³⁵ Murray suggested that “[g]overnment health insurance be limited (at least at first) to social security beneficiaries.”³⁶ Limiting government health insurance was appealing to the Social Security Administration.³⁷ The idea was particularly appealing because limiting the beneficiary class to the elderly citizens addressed an already existing objective, namely, to “protect against the greatest single cause of economic dependency in old age—the high cost of medical care.”³⁸ A 1950 census showed that the population of elderly people was growing rapidly and that two-thirds of them made less than \$1000 per year.³⁹ The numbers clearly exemplified the necessity elderly people had for health insurance.⁴⁰ Murray’s suggestion of limiting medical care to the elderly provided an attractive twist to an old issue.⁴¹

event for a national health care system. Friedman, *supra* note 26, at 279. However, Truman picked up where Roosevelt left off with the introduction of the “Fair Deal.” *Id.*

32. Daniel R. Berg, M.D., *A History of Health Care for the Indigent in St. Louis: 1904–2001*, 48 ST. LOUIS U. L.J. 191, 203 (2003).

33. CORNING, *supra* note 1, at 58.

34. *Id.* at 67; see also AMY E. RADICH, M.S. IV, A BRIEF HISTORY OF THE HEALTHCARE INDUSTRY IN AMERICA <http://www.ooanet.org/pdf/OUCOMManagedcare.pdf> (last visited Feb. 2, 2005). By 1950, about 60 percent of the population had at least hospitalization coverage through private insurance, which was more than double the amount in 1946, when only about 25 percent of the population had private coverage of any kind. CORNING, *supra* note 1, at 67.

35. CORNING, *supra* note 1, at 71. The idea of limiting government health insurance to social security beneficiaries was first suggested by Dr. Thomas Parran of the Public Health Service, in 1937. *Id.* The idea was never pursued and was forgotten until Murray suggested it again in 1944. *Id.*

36. *Id.*

37. *Id.* at 72.

38. CORNING, *supra*, note 1, at 72.

39. *Id.* Corning mentioned that “[t]he 1950 census showed that the aged population had grown from 3 million in 1900 to 12 million in 1950, or from 4 to 8 percent of the total population. Two-thirds of these people had income of less than \$1,000 annually, and only 1 in 8 had health insurance.” *Id.*

40. *Id.* at 72–73. Despite the necessity that the elderly had for health insurance, private insurance coverage was not always the answer. See *id.* The older generation presented a higher risk for the private insurance companies; thus, the private insurance companies would

The initial step of implementing universal medical care for the elderly began in 1950, when the federal government enacted a program that provided “direct payments to ‘medical vendors’ for the treatment of welfare clients, including the elderly.”⁴² The “medical vendors” program was a precursor to national health insurance; however, support for the highly debated topic declined in the early to mid-1950s.⁴³ The decline in popularity of national health insurance during the mid-1950s was mainly attributed to President Eisenhower’s administration and its support for private insurance coverage.⁴⁴

The national health insurance issue did not quiet down for long.⁴⁵ The activities in Congress soon rallied talks again.⁴⁶ By 1957, the government health insurance proposal received much needed support when the Labor Federations and the American Hospital Association (“AHA”) got involved.⁴⁷ Ironically, hospitals, unlike physicians, favored nationwide health insurance.⁴⁸ Because hospitals, much like the elderly, faced economic difficulties concerning health care expenses, it was no wonder that hospitals favored a government insurance system.⁴⁹ As usual, the AMA did not miss a beat in the government health insurance system debate, but this time the AMA was willing to compromise.⁵⁰ In an effort to address the obvious economic prob-

increase their premiums or choose not to cover them at all. CORNING, *supra* note 1, at 72–73; *see also* RADICH, *supra* note 34.

41. *See* CORNING, *supra* note 1, at 72–73.

42. *Id.* at 73.

43. *See id.* at 74–75.

44. Friedman, *supra* note 26, at 279.

45. *See* CORNING, *supra* note 1, at 74–76.

46. *Id.* Four events during the 1956 session of Congress helped rally the issue of government health insurance: 1) the enactment of a Military Medicare Program, which gave government health protection to dependents of servicemen; 2) an expansion of payments to medical vendors in order to provide more medical care for welfare clients; 3) the approval, by Congress, of a \$30,000 study focusing on problems of the aged (the study resulted in a Senate sub-committee that ultimately became a forum for national health care talks); and 4) the struggle to add totally and permanently disabled persons aged fifty and older to the list of social security cash beneficiaries. *Id.* Many physicians opposed this last measure because of fear that the government would be able to manipulate medical practice, even though the bill specifically required that physicians make the determinations themselves. *Id.*

47. *Id.* at 78.

48. Friedman, *supra* note 26, at 278–79.

49. CORNING, *supra* note 1, at 78. The burden on the hospitals was so heavy that “[m]any hospital officials viewed this growing problem as a threat to the very existence of the private hospital system.” *Id.*

50. *Id.* at 80.

lems faced by the elderly, the AMA advocated for doctors to cut medical fees for elderly people.⁵¹

Once again things settled down for a while in the late 1950s.⁵² There were a number of proposed bills and suggestions that were mostly unsuccessful.⁵³ Then came the “Mills Bill” of 1960, which provided the largest break in universal health care since the creation of the “medical vendors” payment plan in 1950.⁵⁴ With the cooperation of the AMA, Chairman Mills devised a plan that intended to expand the state run medical vendor program.⁵⁵ The expansion involved the creation of a new assistance category called “medical indigency,” which was intended for elderly citizens who needed assistance with their medical expenses but did not qualify for welfare benefits.⁵⁶ The “Mills Bill” presented a number of features that were appealing to both national health partisans and non-partisans.⁵⁷ In summary,

[The Bill] was more modest in cost and scope than either the Forand bill or the Republican “subsidy” plan; from a technical standpoint it was a logical first step; it was a “Democratic bill” in a Democratic Congress and was sponsored by the respected Ways and Means Committee chairman; and, not least, it had the backing of the AMA.⁵⁸

The Mills proposal (H.R. 12580) received immediate approval and swept right through the Ways and Means Committee, House Rules Committee, and the House of Representatives.⁵⁹ The proposal was modified and amended once it reached the Senate, but the “Mills Bill,” later re-named the “Kerr-Mills Bill,” was finally signed into law (Public Law 86–778) on Sep-

51. *Id.* The AMA preferred that physicians and hospitals address the issue on their own, rather than promoting government intervention. *Id.*

52. Friedman, *supra* note 26, at 279.

53. Will Mallon, *What is Medicare?*, CTR. FOR HISTORY GEO. MASON, July 21, 2003, at <http://www.historynewsnetwork.com/articles/1583.html>; see also CORNING, *supra* note 1, at 83–85. The “Flemming Bill,” which was proposed to assist states in subsidizing private health insurance premiums for low income elderly by providing federal grants, was just one proposal that arose and was quietly put to rest during the Eisenhower administration. CORNING, *supra* note 1, at 83. The “Forand Bill” was yet another casualty of the times. *Id.* at 83–85.

54. CORNING, *supra* note 1, at 83–85.

55. *Id.*

56. *Id.* at 85.

57. CORNING, *supra* note 1, at 85.

58. *Id.*

59. *Id.*

tember 13, 1960.⁶⁰ The “Kerr-Mills Bill” marked the first time that a prospective health insurance proposal obtained a floor vote in the United States Senate and was approved.⁶¹ Although government health insurance advocates were not fully satisfied with the bill, it served as a significant building block.⁶²

Despite the now newly enacted Kerr-Mills Act, the pressure for national health insurance for the elderly persisted.⁶³ Senator John F. Kennedy based his campaign for presidency on a pro-Medicare stance and won the election.⁶⁴ The beginning of President Kennedy’s term was preoccupied with a mild recession, but nonetheless, Kennedy eventually brought the focus back to his proposed Medicare plan.⁶⁵ The push for Medicare was propelled by the inadequacy of the Kerr-Mills Act.⁶⁶ Through the first eighteen months of the Act’s implementation, reports showed that only 88,000 elderly citizens, spread mainly throughout only four states, benefited from the Act.⁶⁷ The inability for the elderly to cover medical expenses began to weigh heavily on private insurance companies because medical treating facilities began to offset their losses by increasing costs of medical services across the board.⁶⁸ Furthermore, the elderly population continued to grow while the average cost for hospital care increased at a rate of 6.7 percent per year.⁶⁹

As a result of the disappointing numbers for the Kerr-Mills Act, the predominant number of Democrats both in the House and in the Senate, and Kennedy as President, the stage was set for Medicare to prevail.⁷⁰ However, the moment was cut short when President Kennedy was assassinated in

60. *Id.* at 85–86. The Democrats favored the government health insurance embodied in the bill, while the Republicans modified the bill with a “subsidy” plan. *Id.* at 86. Both suggestions were defeated and the differences between the parties were resolved in a Senate-House conference, which eventually led to the signing of the bill into law. CORNING, *supra* note 1, at 86.

61. *Id.* at 86–87.

62. See Donald R. Wolfensberger, *Federal Involvement in Healthcare: An Historic Perspective, An Introductory Essay for the Congress Project Seminar on Congress and Healthcare Policy*, Sept. 13, 2004, <http://wwics.si.edu/events/docs/hlthcare-essay.pdf>.

63. See CORNING, *supra* note 1, at 87.

64. *Id.*

65. *Id.* at 88–89.

66. HOUGHTON MIFFLIN COMPANY, MEDICARE, at http://college.hmco.com/history/readercomp/rcah/html/ah_058600_medicare.htm (last visited Feb. 2, 2005) [hereinafter MEDICARE].

67. CORNING, *supra* note 1, at 93–98.

68. *Id.* at 102–03. Only fifty percent of the elderly population was privately covered in 1963. *Id.*

69. *Id.* at 101–02. The elderly population grew from 12 million, or 8.1 percent of the total population, in 1950 to 17.5 million, or 9.4 percent of the total population, by 1963. *Id.*

70. See CORNING, *supra* note 1, at 104.

1963.⁷¹ Lyndon B. Johnson became President and immediately picked up where Kennedy left off.⁷² President Johnson managed to utilize the public sentiment to get many Kennedy endorsed bills to be passed, but the Medicare bill was not one of the successfully passed bills.⁷³

It was not until the introduction of the King-Anderson bill that Medicare made its final break-through.⁷⁴ Initially, the King-Anderson bill was denied by the Ways and Means Committee, but the bill managed to linger around long enough to obtain Senate approval.⁷⁵ The bill underwent a number of revisions and by spring of 1965, it was introduced on the House floor as the "Mills Bill" (H.R. 6675).⁷⁶ On April 8, 1965, the Mills Bill was approved by the House of Representatives.⁷⁷ It took four additional months of revisions, debates, and amendments before the final version of the bill was completed and approved by the House and the Senate.⁷⁸ On July 30, 1965, in Independence, Missouri, President Johnson signed Medicare into law and the United States finally had a national health care plan for its elderly.⁷⁹

III. THE MODERN MEDICARE PROGRAM IN THE UNITED STATES

A. *The Evolving Medicare Program*

The concept of Medicare began as a national health plan, which was to subsidize medical coverage for the elderly. By 1972, the program expanded to include coverage for disabled people and those patients with end-stage renal disease.⁸⁰ Medicare was an optimistic program, providing health care

71. THE WHITE HOUSE: LYNDON B. JOHNSON, at <http://www.whitehouse.gov/history/presidents/lj36.html> (last visited Feb. 4, 2005).

72. CORNING, *supra* note 1, at 106.

73. *Id.* at 106–07.

74. *See id.* at 107–09.

75. Wolfensberger, *supra* note 62, at 5–7. The King-Anderson bill actually failed twice. CORNING, *supra* note 1, at 108. However, on its second turn around, there were enough votes on the floor for the bill to attach to H.R. 11865 as an amendment, even without committee approval. *Id.*

76. CORNING, *supra* note 1, at 113. Chairman Mills finally sided with Medicare and took it upon himself to revise the King-Anderson bill into its final form, which was then renamed as the "Mills Bill" (not to be confused with the bill Chairman Mills introduced in 1960). *Id.* By the time the bill was approved by the Senate and the House in July of 1965, the bill underwent a total of 513 revisions or amendments. *Id.*

77. Wolfensberger, *supra* note 62, at 7.

78. CORNING, *supra* note 1, at 113–15.

79. *Id.* at 120.

80. Friedman, *supra* note 26, at 280.

security to those in need of assistance.⁸¹ However, it did not take long before the negative effects of the program started to shine through.⁸² Within the first couple months after the program began, there were significant increases in medical expenses across the nation.⁸³ The increase was attributable to the following: increased spending on services provided to beneficiaries, an unexpected increase in the number of Medicare beneficiaries,⁸⁴ and the hike in medical services charges.⁸⁵ Hospitals and physicians began to take advantage of the favorable payment system in place.⁸⁶ “Between the years of 1967 and 1971, the daily charges of American hospitals ‘increased at’ an average of thirteen percent per year.”⁸⁷

Creating reforms to impede the inflation of Medicare expenditure became a huge focus during the 1970s.⁸⁸ Congress attempted to freeze the rise in spending by developing a number of reform measures, such as: generating different reimbursement techniques, creating professional review organizations (to implement national cost controls over hospitals),⁸⁹ and creating a new administration called the Health Care Financing Administration (separating Medicare from Social Security).⁹⁰ One of the reimbursement techniques that temporarily froze the climbing increase in medical expenses during the 1970s was the concept of basing the reimbursement rates on a Medicare Economic Index (“MEI”).⁹¹ Despite the implementation of the MEI and other techniques, the national health expenditure continued to increase at a steadfast pace.⁹²

81. See 42 U.S.C. § 1395a (2000).

82. See Friedman, *supra* note 26, at 280–81.

83. *Physician Payments: Hearing on H.L. 12 Before the House Comm. on Ways and Means*, 107th Cong. (2002) (statement of Dan L. Crippen, Director, Congressional Budget Office) <http://www.waysandmeans.house.gov/legacy/health/107Cong/2-28-02/2-28crip.htm> [hereinafter *Physician Payments*].

84. Friedman, *supra* note 26, at 280.

85. *Physician Payments*, *supra* note 83.

86. Theodore R. Marmor & Gary J. McKissick, *Medicare's Future: Fact, Fiction, and Folly*, 26 AM. J.L. & MED. 225, 230 (2000). When hospitals were reimbursed their “reasonable costs” and physicians were reimbursed their “customary charge,” hospitals and physicians began to exploit the system. *Id.*

87. *Id.* at 231. The total expenditure for Medicare went up to \$7.9 billion in 1971 from \$4.6 billion in 1967. *Id.* During the spending increase, the total number of Medicare beneficiaries only rose by six percent. *Id.*

88. *Physician Payments*, *supra* note 83.

89. Friedman, *supra* note 26, at 280.

90. Marmor & McKissick, *supra* note 86, at 231–32.

91. *Physician Payments*, *supra* note 83.

92. Marmor & McKissick, *supra* note 86, at 232.

In the 1980s Congress decided to take a more aggressive stance by creating a completely new reimbursement rate.⁹³ The new plan was to incorporate a Prospective Payment System (“PPS”), which established a method of reimbursing hospitals on a fixed rate for each patient discharged no matter the costs incurred by the hospitals.⁹⁴ The PPS reimbursement rate continues to be utilized today.⁹⁵ The main incentive behind PPS was to promote cost efficiency by discouraging hospitals from spending unnecessary time and resources.⁹⁶ The reimbursement formula is composed of a three-pronged system.⁹⁷ First, the Secretary of the Department of Health and Human Services (the “Secretary”) must establish a predetermined national rate for all patient discharge costs,⁹⁸ which is done as follows:

PPS is based on a standardized amount that is multiplied by a weighing factor. 42 U.S.C. § 1395ww(d)(2)(G), (3)(D). The standardized amount is a base amount that equals the average Medicare allowable costs per discharge for all hospitals participating in the Medicare program in a base year, which is adjusted according to regional wage variations, indirect medical education costs, and hospital case mix. 42 U.S.C. § 1395ww(d)(2). The weighing factor is a multiplier based on the diagnosis related group (“DRG”) in which the discharged patient’s illness falls. The Secretary has created 470 DRGs, each with a weight derived from the relative cost to treat a patient in that DRG. 42 U.S.C. § 1395ww(d)(4).⁹⁹

Once the predetermined national rate for all patient discharges is determined, the next step is to determine the amount of reimbursement per Medicare patient discharge.¹⁰⁰ At this point, the Secretary must place each participating hospital in one of three geographical areas, which are categorized as “large urban,” “other urban,” or “rural.”¹⁰¹ The area in which a hospital is categorized will “determine the hospital’s ‘average standardized amount per discharge’ payment and the applicable area wage index, and are the organ-

93. *Id.* at 233.

94. *Alvarado Cmty. Hosp. v. Shalala*, 155 F.3d 1115, 1119 (9th Cir. 1998) (citing 42 U.S.C. § 1395ww(d)(1)).

95. *See* 42 U.S.C. § 1395ww (Supp. 2000).

96. *Alvarado Cmty. Hosp.*, 155 F.3d at 1119.

97. *See Coalition For Reclassification v. Sullivan*, No. 1:92CV242-B-O, 1992 WL 443455, at *1–2 (N.D. Miss. Jan. 25, 1992); *Alvarado Cmty. Hosp.*, 155 F.3d at 1119.

98. *Alvarado Cmty. Hosp.*, 155 F.3d at 1119.

99. *Id.*

100. *Coalition For Reclassification*, 1992 WL 443455, at *1.

101. *Id.*

izational basis for reimbursement under the [PPS].”¹⁰² Lastly, the system accounts for “outlier” cases, which are those cases that result in longer and more expensive treatments than are usually the case for the designated DRG.¹⁰³

The PPS reimbursement rate was first put into practice on October 1, 1983, and it took over four years before the system was applied to all hospitals.¹⁰⁴ The implementation of PPS considerably slowed down medical expenditures, but it did not provide for a permanent fix.¹⁰⁵ There have been some payment adjustment programs added to PPS since its inception.¹⁰⁶ One of the added programs was the Medicare Disproportionate Share (“DSH”) Payments.¹⁰⁷ It provides extra financial assistance to hospitals that treat a larger number of low-income patients.¹⁰⁸ Although there have been some

102. *Id.*

103. *Alvarado Cmty. Hosp.*, 155 F.3d at 1119. The outliers were calculated as follows: “Day outliers” occur when a patient’s length of stay (“LOS”), measured in days, exceeds the mean LOS for a particular DRG by a fixed number of days or standard deviations. 42 U.S.C. § 1395ww(d)(5)(A)(i). “Cost outliers” occur when the cost exceeds a fixed multiple of a particular DRG’s payment rate or when it exceeds the rate by a fixed dollar amount. 42 U.S.C. § 1395ww(d)(5)(A)(ii). The amount for additional payments for these cases “shall be determined by the Secretary and shall approximate the marginal cost of care” beyond the applicable cut-off point. 42 U.S.C. § 1395ww(d)(5)(A)(iii). Finally, the statute provides that [t]he total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharge in that year. 42 U.S.C. § 1395ww(d)(5)(A)(iv) (“Clause (iv)”) (emphasis added).

Id.

104. *Id.* (citing 42 U.S.C. § 1395(d)(1)(A)(i)). During the years that the PPS was being incorporated nationwide, the Secretary performed a two-portion reimbursement method that consisted of a “hospital specific portion” and a “federal rate.” *Id.* The court in *Alvarado Community Hospital* explained it as follows:

The “hospital specific portion” was calculated under the prior system, based on the hospital’s actual costs. 42 U.S.C. § 1395ww(d)(1)(A), (C). The other portion, the “federal rate,” was determined under PPS. The hospital specific portion of the reimbursements was 75% in FY 1984, 50% in FY 1985, 45% in 1986, and 25% in 1987, while the federal rate increased correspondingly. 42 U.S.C. § 1395ww(d)(1)(C). Thereafter, all reimbursements were calculated under PPS.

Id. (citation omitted).

105. Marmor & McKissick, *supra* note 86, at 233.

106. See Association of American Medical Colleges, *Medicare Disproportionate Share (DSH) Payments*, at <http://www.aamc.org/advocacy/library/teachhosp/hosp0003.htm> (last visited Feb. 2, 2005) [hereinafter *DSH Payments*].

107. *Id.*

108. *Id.* “Low income Medicare patients tend to be sicker and more costly to treat than other Medicare patients with the same diagnosis.” *Id.*

additions and proposed reforms to PPS, it has gone largely untouched and continues to be the reimbursement rate used today.¹⁰⁹

B. *The Social and Economical Effects of Medicare in the United States*

The citizens of the United States have had, and continue to have, serious concerns about their medical health care coverage because having health care coverage means having a bit of economic security.¹¹⁰ The poor and the elderly have historically been, and continue to be, the groups that would benefit the most from a national health coverage plan. Hence, the creation of programs that assist the neediest people first would be the most logical approach.¹¹¹ Medicare was one of those programs.¹¹² The program has provided, and continues to provide, millions of beneficiaries with the medical coverage they need and a taste of the economic security they seek.¹¹³

According to the statistics provided by the Health Care Financing Administration (“HCFA”), Medicare has helped keep millions out of poverty “[b]y [simply] reducing the amount of money the elderly had to pay for health care.”¹¹⁴ The statistics showed that before Medicare was implemented, an average of one in every three senior citizens was living at or below poverty level.¹¹⁵ Senior citizens who were living off of social security were forced to pay for over fifty-three percent of their health care costs out of pocket, which generally consumed about twenty-four percent of their social security checks per month.¹¹⁶ In 1997, HCFA statistics showed that on average, the elderly were paying for only eighteen percent of their medical expenses out of pocket and that the amount of senior citizens living at or below poverty level dropped to one in every ten.¹¹⁷

In addition to the financial assistance provided to the elderly, Medicare has also improved the quality of life and life expectancy amongst Americans

109. See 42 U.S.C. § 1395ww.

110. See CORNING, *supra* note 1; International Association of Machinists and Aerospace Workers, *Social Security/Medicare*, at <http://www.iamaw.org/politics.asp?n=2&c=857> (last visited Feb. 2, 2005) [hereinafter IAMAW].

111. See CORNING, *supra* note 1; Friedman, *supra* note 26, at 280. Statistically, the poor get sicker more often and stay sicker longer than the rich. See *DSH Payments*, *supra* note 106.

112. See Friedman, *supra* note 26, at 280.

113. See *id.*

114. *Id.*; see HEALTH CARE FINANCING ADMINISTRATION, *MEDICARE: A PROFILE 33 (2000)* <http://www.cms.hhs.gov/statistics/35chartbk.pdf> [hereinafter PROFILE OF MEDICARE BENEFICIARIES].

115. PROFILE OF MEDICARE BENEFICIARIES, *supra* note 114, at 33.

116. *Id.* at 33–34.

117. *Id.* at 33.

in general.¹¹⁸ The survey conducted by HCFA in 1999 showed that there has been a dramatic increase in access to medical care and medical coverage amongst Americans since the inception of Medicare in 1965.¹¹⁹ The improved health care system has led to a twenty percent increase in the life expectancy of the average sixty-five year old American.¹²⁰ Lastly, Medicare has improved access to medical care for minority and disabled Americans.¹²¹ In order for hospitals and physicians to participate in the program, the government implemented a non-discrimination policy as a condition to obtain the federal funds provided from Medicare.¹²²

Despite all the positive contributions Medicare has imparted thus far, there continues to be serious issues about the inadequate funding given to health care.¹²³ The cost of medical health care continually rises on a yearly basis due to the constant improvements in medical technology and its infrastructure, which also results in an increase in Medicare expenditures.¹²⁴ Even with estimated benefit payments that exceed \$234,970,769,877, as reported in the fiscal year of 2001,¹²⁵ there continues to be a need for more funding because too many Americans are still going without adequate health care services.¹²⁶

118. *Id.*

119. *Id.* The numbers provided by HCFA, in their 2000 profile, were as follows: “[h]ospital discharges averaged 190 per 1,000 elderly in 1964 and 350 per 1,000 by 1973; the proportion of elderly using physician services jumped from 68 to 76 percent between 1963 and 1970. [In 1999], more than 94 percent of elderly beneficiaries receive a health care service paid for by Medicare.” PROFILE OF MEDICARE BENEFICIARIES, *supra* note 114, at 33.

120. *Id.*

121. *Id.* at 34.

122. 42 U.S.C. § 608(d) (2000); *see also* PROFILE OF MEDICARE BENEFICIARIES, *supra* note 114, at 34.

123. *See* Friedman, *supra* note 26, at 280; IAMA, *supra* note 110; Reed Abelson, *Hospitals Say They're Penalized by Medicare for Improving Care*, N.Y. TIMES, Dec. 5, 2003, at A1.

124. RANDALL HAUGHT ET AL., FINANCIAL IMPACT OF IMPROVED MEDICARE REIMBURSEMENT FOR RURAL HOSPITALS 1-2 (2003), <http://www.nrharural.org/blasts/Lewin-Reach.pdf>.

125. CENTERS FOR MEDICARE & MEDICAID SERVICES, MEDICARE ESTIMATED BENEFIT PAYMENTS BY STATE FISCAL YEAR 2001 <http://www.cms.hhs.gov/researchers/pubs/datacomp-ndium/2003/03pg71.pdf> (last visited Feb. 2, 2005).

126. *See* David Demko, *Empty Wallet New Cause of Elder Death*, SENIOR WORLD ONLINE, at <http://www.seniorworld.com/articles/a20000330192223.html> (last modified Mar. 30, 2000); Patricia Barry, *Chasing Drugs: Many Readers Take Drastic Steps to Get Prescription Medicine*, AARP BULLETIN ONLINE, Oct. 2003, at http://www.aarp.org/bulletin/prescription/Articles/a2003-09-29-chasing_drugs.html.

There are hospitals that are taking significant financial losses each year simply because they do not receive adequate reimbursements from the Medicare program.¹²⁷ Low reimbursement rates impact more than just hospitals; they also affect the social and economic status of the United States.¹²⁸ Generally, the elderly and the poor are most affected by reductions in government programs because they are in the most need for such assistance.¹²⁹ However, low Medicare reimbursement rates also affect the middle and upper classes due to medical providers' "balance billing" techniques, also known as "cost shifting."¹³⁰ "Cost shifting" is the method in which hospitals make up for their financial losses.¹³¹ The costs that hospitals incur from treating the poor who are not adequately covered by Medicare reimbursements or other such programs are passed onto the rest of the nation through cost increases.¹³² Furthermore, the financial dilemmas that many elderly Americans are facing today, create the very same nationwide insecurities that were suppose to be overcome with the creation of Medicare.¹³³ Clearly, the Medicare program has provided some financial relief to an extremely needy health care system, but the system is still in terrible need of more financial support.

IV. MEDICARE AS APPLIED TO PUERTO RICO

A. *Puerto Rico and Its Integration into the Program*

Puerto Rico was originally a Spanish colony from the year 1493 until 1898, the year the Spanish-American War ended and Spain was forced to surrender the island by virtue of defeat.¹³⁴ The island was officially ceded to

127. See Abelson, *supra* note 123; Press Release, Schumer Unveils Plan to Reverse Impact of Medicare Cuts that Began on October 1 (Oct. 22, 2002), at http://schumer.senate.gov/SchumerWebsite/pressroom/press_releases/PR01264.html [hereinafter *Schumer Unveils Plan*].

128. See HAUGHT, *supra* note 124, at 1–2; Abelson, *supra* note 123; CORNING, *supra* note 1, at 78, 102; Friedman, *supra* note 26, at 280; Marmor & McKissick, *supra* note 86, at 231.

129. See IAMAW, *supra* note 110.

130. *Physicians Payments*, *supra* note 83. See also CORNING, *supra* note 1, at 78, 102; FRIEDMAN, *supra* note 26, at 280.

131. FRIEDMAN, *supra* note 26, at 280.

132. *Id.*

133. See IAMAW, *supra* note 110; CORNING, *supra* note 1, at 28–33; Demko, *supra* note 126; Barry, *supra* note 126.

134. Puerto Rico Industrial Development Company of the Commonwealth of Puerto Rico, *The Commonwealth Relationship*, at http://www.pridco.com/english/overview/2.2pr_overview_commonwealth.html (last visited Feb. 4, 2005) [hereinafter *The Commonwealth Relationship*].

the United States in the Treaty of Paris in 1898.¹³⁵ By 1900, the United States Congress passed the Foraker Act, which set up a United States government system in Puerto Rico with a United States governor, an upper legislative chamber, an elected house of delegates, and “Congress was given the right to review all legislation.”¹³⁶

The island slowly obtained more and more autonomy as the years passed.¹³⁷ For instance, the people of Puerto Rico were granted United States citizenship in 1917 under the Jones Act, and by 1948, the governor of Puerto Rico was no longer appointed by the United States President; the Puerto Rican people were given the right to have a popular election in order to elect their own governor.¹³⁸ Finally, the island was proclaimed a Commonwealth in 1952 through operation of Law 600 of 1952, which continues to be its status today.¹³⁹ As a Commonwealth of the United States, the island operates under both its own laws and Constitution and the laws and Constitution of the United States.¹⁴⁰ The Commonwealth is not allowed to vote in the general elections,¹⁴¹ nor does it have a vote in Congress.¹⁴² However, its people are allowed to vote in the presidential primaries, have a non-voting seat in the United States House of Representatives, and are represented in Congress by an elected Resident Commissioner.¹⁴³

The residents of Puerto Rico are subject to many United States laws.¹⁴⁴ As participants in the United States Medicare System, the residents of Puerto Rico are particularly subject to the Medicare legislation set out by Congress.¹⁴⁵ The residents of Puerto Rico contribute to the Medicare fund and in return, they are entitled to benefits.¹⁴⁶ Prior to 1983, Medicare reimburse-

135. COLUMBIA ENCYCLOPEDIA, ENCYCLOPEDIA .COM, PUERTO RICO, at http://www.encyclopedia.com/html/section/puertori_history.asp (last visited Feb. 4, 2005).

136. *Id.*

137. *The Commonwealth Relationship*, *supra* note 134; COLUMBIA ENCYCLOPEDIA, *supra* note 135.

138. COLUMBIA ENCYCLOPEDIA, *supra* note 135.

139. *Commonwealth Relationship*, *supra* note 134.

140. *Id.*

141. *Id.*

142. Jamin Raskin, *A Right-to-Vote Amendment for the U.S. Constitution: Confronting America's Structural Democracy Deficit*, 3 ELECTION L.J. 559, 565 (2004).

143. *Commonwealth Relationship*, *supra* note 134.

144. *Id.*

145. *See Hosp. San Rafael, Inc. v. Sullivan*, 784 F. Supp. 927, 930 (D.P.R. 1991).

146. INTERNAL REVENUE SERVICE, TEMA 903 - IMPUESTOS PATRONALES (FEDERALES) EN PUERTO RICO, at <http://www.irs.gov/taxtopics/tc903.html> [hereinafter TEMA 903]. Puerto Rico and the rest of the United States are taxed 6.2% of their first eighty-seven thousand dollars earned in a year in order to fund social security and 1.45% of their entire yearly wages in order to fund Medicare. *Id.*

ments to all qualified participants were based on the same cost-based system, where the health care providers were reimbursed based on their actual costs.¹⁴⁷ However, since the implementation of PPS in 1983, the reimbursement rates for Puerto Rico qualified Medicare providers has been much lower than the rates given to the providers located in the states.¹⁴⁸

The integration of PPS, among the mainland states, began in 1983 and it took four years before the system was fully implemented across all Medicare participating hospitals.¹⁴⁹ The Omnibus Budget Reconciliation Act of 1986 (“OBRA”) initiated PPS in Puerto Rico, but it was not actually implemented until September of 1987.¹⁵⁰ PPS was made applicable to Puerto Rico in a different manner than it was applied in the mainland states.¹⁵¹ OBRA presented a seven-step process that was to be applied in order to determine the PPS rate for Puerto Rican Medicare providers.¹⁵² The system was adequately summarized in *Hospital San Rafael v. Sullivan*¹⁵³ as follows:

(1) *Determination of Target Amounts*

The Secretary first determines the “target amount” for each participating Puerto Rico Hospital. 42 U.S.C. § 1395ww(b)(3)(A). The target amount represents the actual costs borne by each hospital in a base year. The use of these target amounts as the basis for determining PPS rates is meant to insure that payment under PPS will closely approximate the actual economic experiences of Puerto Rico hospitals.

(2) *Updating the Target Amounts*

The target amounts are then updated for inflation to mid-fiscal year 1988 levels by prorating the applicable percentage increase for fiscal year 1988. See 42 U.S.C. § 1395ww(b)(3)(B).

(3) *Standardizing the Target Amounts*

After arriving at updated target amounts . . . the Secretary [is] to remove distorting effects stemming from several sources, in-

147. *Sullivan*, 784 F. Supp. at 929 (D.P.R. 1991) (referencing Title XVIII of the Social Security Act, 79 Stat. 291, amended by, 42 U.S.C. § 1395 *et seq.*).

148. See *id.* at 929–32.

149. *Id.* at 930.

150. *Id.*

151. *Id.*

152. *Sullivan*, 784 F. Supp. at 930–32.

153. *Id.* at 927.

cluding variations in area wage levels. 42 U.S.C. §§ 1395ww(d)(2)(C)(ii), 1395ww(d)(9)(B)(ii); *See generally* 52 Fed. Reg. 33,034, 33,066 (Sept. 1, 1987) . . .

(4) *Determination of the Discharge-Weighted Average*

Following the standardizing of the target amounts, the Secretary determines the average standardized amount per discharge in urban and rural settings for Puerto Rico. 42 U.S.C. § 1395ww(d)(9)(B)(iii). These amounts are arrived at by first determining the total labor-related and nonlabor-related standardized costs for urban and rural areas of Puerto Rico. This is reached by adding the target amounts for each hospital in each area. The four total costs are divided by the total number of discharges in urban and rural areas, respectively. This process yields four standardized average amounts per discharge: two for labor and nonlabor costs in Puerto Rico's urban areas; and two for labor and nonlabor costs in Puerto Rico's rural areas. *See* 52 Fed. Reg. at 33,062, 33,070, Table 1c.

(5) *Adjustment for Outlier Payments*

The Secretary is . . . to adjust the average standardized amounts to account for [outlier] payments by estimating the degree to which outlier payments will be made in each urban and rural area. The average standardized amounts are then reduced proportionally.

(6) *Adjustment for Differences in Area Wage Levels*

The Secretary reemploys the wage index to adjust the average urban and rural standardized amounts, arrived at in steps one through five, to account for variations in area wage levels. 42 U.S.C. § 1395ww(d)(9)(B)(vi). This is done by multiplying the labor-related portion of the average standardized amounts by the "appropriate wage index for the area in which the hospital is located." 52 Fed. Reg. at 33,065. The use of the wage index here differs from the use of the wage index to adjust for variations in area wages discussed in the context of step three Here, the discharge-weighted average standardized amounts are multiplied by the appropriate wage index.

(7) *Determination of Payment Rates Per DRG*

The final step in determining PPS rates for Puerto Rico hospitals involves the addition of the average adjusted standardized

labor-related amount for urban areas, arrived at in step six, to the nonlabor-related average standardized amount for urban areas. The average standardized amounts for rural areas are similarly added. The total adjusted average standardized urban amount per discharge is then multiplied by the predetermined weighting factor corresponding to a particular DRG. This product determines the payment rate for that ailment rendered at a hospital in either an urban or rural area. Since Congress has specified that the overall PPS payment rate for Puerto Rico providers is to consist of a blend of seventy-five percent of a Puerto Rico adjusted rate and twenty-five percent of the national rate, 42 U.S.C. §§ 1395ww(d)(9)(A); 42 C.F.R. section 412.204, seventy-five percent of this figure is added to twenty-five percent of the national rate for the same DRG to reach the overall amount to be paid to the Puerto Rico hospital.¹⁵⁴

Since *Sullivan*, the reimbursement rate has undergone some reform in regards to how it applies to Puerto Rico.¹⁵⁵ Originally, the PPS payment rate for Puerto Rico consisted of a blend of seventy-five percent based on the Puerto Rico adjusted rate and twenty-five percent based on the national adjusted rate.¹⁵⁶ From the inception of PPS, the people of Puerto Rico would have preferred a reimbursement rate solely based on national rates, just like the one applied to the mainland states, but unfortunately, that was not the case.¹⁵⁷ The special PPS rate resulted in lower federal funds being supplied to Puerto Rico, which was appealing to many because it helped keep Medicare costs down.¹⁵⁸ The Commonwealth also had to contend with the fact that it did not have any voting representation in Congress, which made it

154. *Id.* (internal footnotes omitted). The court went on to explain how wages were also taken into consideration in order to better standardize the target amounts:

To effect this standardization for the cost variation at issue in this action—differences in area wage levels—the Secretary first divides the target amounts into labor and nonlabor components derived from the national hospital market basket. This division is necessary since wages correspond only to the labor-related costs of a hospital. The labor component is 74.39% of each hospital's updated target amount. 52 Fed. Reg. at 33,044. In order to remove the effect of disparate wages, this labor component is divided by a wage index for the geographic area in which each hospital is located. This yields a standardized target amount taking into account variations in area wage levels.

Sullivan, 784 F. Supp. at 930–31. The hospital market basket is a price index compiled from prices of various categories of goods and services purchased by hospitals across the nation, including Puerto Rico. *Id.* at 930 n.4.

155. See *Move to Increase Puerto Rico Medicare*, *supra* note 5.

156. See *Sullivan*, 784 F. Supp. at 932; *Move to Increase Puerto Rico Medicare*, *supra* note 5.

157. *Move to Increase Puerto Rico Medicare*, *supra* note 5.

158. *Id.*

virtually impossible for the Commonwealth to obtain the reimbursement rate its people wanted.¹⁵⁹ Ultimately, the implementation of the special formula was justified at the time by the fact that costs in Puerto Rico were drastically lower than the rest of the nation; thus, this resulted in the need to provide the island with more financial backing was not pressing.¹⁶⁰

By 1997, due to a strong lobbying effort from the Resident Commissioner of Puerto Rico, assistance from democratic representatives in Congress, and a strong push from the Clinton Administration, the Puerto Rico reimbursement rate was amended.¹⁶¹ The newly amended rate was now based on fifty percent of the Puerto Rico adjusted rate and fifty percent of the national rate.¹⁶² The rate change made an immediate and apparent contribution within the first year of its implementation, when it provided the island hospitals an additional \$44 million in health care assistance.¹⁶³ The Clinton Administration attempted to achieve another amendment to the reimbursement rate in 2000 by proposing that the rate be based on seventy-five percent of the national adjustment rate and only twenty-five percent on the Puerto Rico rate.¹⁶⁴ This proposal was heavily opposed in Congress and was ultimately denied.¹⁶⁵

The “fifty-fifty” reimbursement rate remained in place until its amendment under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“Modernization Act”).¹⁶⁶ Initially presented under the Medicare Puerto Rico Hospital Payment Parity Act of 2003 (“the Parity Act”), the proposed amendment presented itself as a second chance at changing the Puerto Rico rate from “fifty-fifty” to seventy-five percent national adjustment rates and twenty-five percent Puerto Rico rates.¹⁶⁷ On December 8, 2003, the amendment was included within the newly approved Moderniza-

159. *Id.*

160. *Id.*

161. *Id.* Leading the lobby for equality in the reimbursement rates was then-Resident Commissioner of Puerto Rico, Carlos Romero-Barcelo and then-Governor of Puerto Rico, Pedro Rossello. *Move to Increase Puerto Rico Medicare*, *supra* note 5. Other politicians and organizations that provided much needed support was then-House Hispanic Caucus Chair Xavier Becerra (D-CA), Senator Bob Graham (D-FL), the Puerto Rican Hospital Association, the New York Hospital Association, and Puerto Rico’s Association’s Lobbyists. *Id.*

162. *Id.*

163. *Id.* The additional funding range estimated at the time anticipated an increase in funds from \$50 million to \$75 million a year. *Id.*

164. *Move to Increase Puerto Rico Medicare*, *supra* note 5.

165. *Id.*

166. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 504, 117 Stat. 2066, 2292-93 (2003).

167. Medicare Puerto Rico Hospital Payment Parity Act of 2003, S. 653, 108th Cong. § 2 (2003).

tion Act signed by President George W. Bush.¹⁶⁸ Although the amendment went against President Bush's objective of luring "people away from a reliance on Medicare to private insurance plans to reduce costs," a compromise was reached and the amendment went forward.¹⁶⁹

The amendment to the Modernization Act proposes a gradual change toward the new percentages. Starting April 1, 2004, through October 1, 2004, "the applicable Puerto Rico percentage [will be] 37.5 percent and the applicable federal percentage [will be] 62.5 percent."¹⁷⁰ The percentages will then take final form starting and continuing on from October 1, 2004, at the rate of twenty-five percent based on the applicable Puerto Rico percentage, and seventy-five percent based on the federal percentage.¹⁷¹ The Resident Commissioner of Puerto Rico, Anibal Acevedo Vila, anticipates that the amended rates will provide the health care system in Puerto Rico with an average of \$300 million per year over the next decade.¹⁷² Vila also claims that the amendment will provide prescription drug coverage for an additional 250,000 Medicare enrollees on the island that were presently not receiving any such coverage.¹⁷³ The amendment has significantly advanced Puerto Rico's pursuit toward equalizing the reimbursement rates, but there is still much room for progress.¹⁷⁴

B. *A Closer Look at the Special Reimbursement Rate*

Currently, and in years prior, Puerto Ricans have been subject to the same Social Security and Medicare taxes as any other U.S. citizen.¹⁷⁵ In order to fund Social Security, the first \$87,000 made each year, by all employ-

168. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 504; *Move to Increase Puerto Rico Medicare*, *supra* note 5.

169. *Move to Increase Puerto Rico Medicare*, *supra* note 5. President Bush attempted to lure people away from Medicare by creating outpatient prescription drug benefits that would provide incentives for people to move toward more of a private insurance plan basis. *Id.* Ultimately, the compromise was that the new "legislation would provide equal prescription drug subsidies under both Medicare and private insurance plans." *Id.*

170. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 504, 117 Stat. 2066, 2292-93 (2003).

171. *Id.*

172. Significativo el Impacto, *supra* note 5.

173. *Id.*

174. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 504; Significativo el Impacto, *supra* note 5.

175. TEMA 903, *supra* note 146; see also SOCIAL SECURITY ONLINE, SOCIAL SECURITY & MEDICARE TAX RATES, at <http://www.ssa.gov/OACT/ProgData/taxRates.html> (last visited Feb. 3, 2005).

ees in the United States and in Puerto Rico, are subject to a 6.2 percent tax.¹⁷⁶ Likewise, Medicare is funded by imposing a 1.45 percent tax on all income made by employees in a year.¹⁷⁷ Despite being subject to the same Medicare and Social Security taxes, participating hospitals on the island are subject to special reimbursement rates, which result in lesser payment levels.¹⁷⁸ According to Centers for Medicare & Medicaid Services, 560,725 Puerto Ricans were enrolled in the Medicare program in 2002,¹⁷⁹ and the Medicare participating hospitals on the island received an average reimbursement of \$2842 per patient, while the participating hospitals within the fifty states received an average reimbursement of \$3780 per patient.¹⁸⁰

Providing adequate medical care is already an extremely difficult task without the added disadvantage of smaller reimbursement rates.¹⁸¹ For instance, United States hospitals continue to face serious funding issues despite the fact that they receive reimbursements based on the more favorable national rate.¹⁸² As previously discussed, state hospitals claim that the threat of the slightest reduction in reimbursement rates would cause a loss of millions of dollars in funding and would lead to hospitals taking even more losses each time they treat a patient.¹⁸³ There are also numerous stories about elderly people in the United States dying more frequently from the inability to afford adequate health care than from old age itself.¹⁸⁴ All these events are taking place in the richest country in the world, where according to the United States Census Bureau calculations of 2000, the median family income in the United States was \$50,046.¹⁸⁵ Puerto Rico, on the other hand, had a

176. TEMA 903, *supra* note 146.

177. *Id.*

178. See Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 504, § 1886(d)(9), 117 Stat. 2066, 2292-93 (2003); *Hosp. San Rafael, Inc. v. Sullivan*, 784 F. Supp. 927, 930-32 (D.P.R. 1991); *Move to Increase Puerto Rico Medicare*, *supra* note 5.

179. CENTERS FOR MEDICARE & MEDICAID SERVICES, MEDICARE ENROLLMENT BY STATE 2002, <http://www.cms.hhs.gov/researchers/pubs/datacompendium/2003/03pg74.pdf> (Nov. 2003).

180. CENTERS FOR MEDICARE & MEDICAID SERVICES, MEDICARE HOME HEALTH AGENCY UTILIZATION BY STATE CALENDAR YEAR 2002, <http://www.cms.hhs.gov/statistics/feeforservice/HHAUtil02.pdf> (last visited Feb. 4, 2005).

181. See generally Barry, *supra* note 126; Schumer Unveils Plan, *supra* note 127; Demko, *supra* note 126.

182. See generally Schumer Unveils Plan, *supra* note 127; Demko, *supra* note 126.

183. See Schumer Unveils Plan, *supra* note 127; Barry, *supra* note 126.

184. Demko, *supra* note 126.

185. *Id.*; U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2003 826, <http://www.census.gov/prod/2004pubs/03statab/outlying.pdf> (last visited Feb. 4, 2005) [hereinafter STATISTICAL ABSTRACT].

median family income of \$16,543 in 2000,¹⁸⁶ which means that in addition to coping with the constant increases in medical technology and costs, the island's hospitals also deal with the added financial pressures of treating low-income patients.¹⁸⁷ Despite all these factors, Puerto Rico is still reimbursed at a lower rate than the fifty states.¹⁸⁸

The reimbursement rates given to Puerto Rico have been judicially challenged in the past.¹⁸⁹ In *Sullivan*, a number of Puerto Rican hospitals raised a direct challenge to the implementation of PPS for Medicare rates for hospitals in Puerto Rico.¹⁹⁰ In their complaint, the plaintiffs alleged that the wage index was determined arbitrarily, the reliance on the national hospital market basket to calculate the wage index was contrary to law because the data is not exclusively based on Puerto Rico numbers, and that the "Puerto Rico PPS statute violates the Equal Protection clause of the United States Constitution because it results in a lower level of payment to Puerto Rico hospitals, which are owned, operated, and staffed predominately by Hispanic persons."¹⁹¹ The court rejected each of the plaintiffs' challenges.¹⁹² Under the wage index claim, the plaintiffs argued that the Commonwealth hospitals, which are not subject to minimum wage regulations, and federal hospitals, whose pay scales are higher than the national norm, equally distort wage indices; hence, both should be excluded from the wage index calculation.¹⁹³

According to the Secretary of the Department of Health and Human Services (the "Secretary"), the federal hospitals were excluded from the calculations because they did not participate in the Medicare program, while the Commonwealth hospitals were included because they generally did participate in the program.¹⁹⁴ The court stated that their job was not to determine the reasonableness of the calculations, but rather they were to look at the explanation of the methodology to determine if the calculations were arbitrary or capricious.¹⁹⁵ They then concluded that the calculations were not arbitrary or capricious because the methodology used was logically related to

186. STATISTICAL ABSTRACT, *supra* note 185, at 827.

187. *See DSH Payments*, *supra* note 106.

188. *See Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, Pub. L. No. 108-173, § 504, 117 Stat. 2006, 2292-93 (2003).

189. *See Hosp. San Rafael, Inc. v. Sullivan*, 784 F. Supp. 927 (D.P.R. 1991); *Harris v. Rosario*, 446 U.S. 651 (1980).

190. *Sullivan*, 784 F. Supp. at 929.

191. *Id.* at 932-33.

192. *Id.* at 940.

193. *Id.* at 934-35.

194. *Id.* at 935.

195. *Sullivan*, 784 F. Supp. at 936.

the means used and the purpose achieved.¹⁹⁶ Next, the court rejected the argument that the use of the national market basket was contrary to law.¹⁹⁷ The plaintiffs argued that the statute requires that “a Puerto Rico adjusted DRG prospective payment rate” be established in order to determine the applicable wage index; thus, the use of separate labor and non-labor rates specific to Puerto Rico must be used.¹⁹⁸ It was conceded that the Puerto Rico labor costs were lower than the national labor costs and that such a factor does alter the results.¹⁹⁹ However, the court held that incorporating the percentage difference would be so trifling that it did not warrant interfering with the methodology currently in place.²⁰⁰

Lastly, the plaintiffs argued that Congress violated the Equal Protection clause of the United States Constitution when it created a method to determine Puerto Rico’s PPS rates that was different than that utilized by the rest of the nation.²⁰¹ In denying the equal protection claim, the court first reasoned that entitlement to Medicare reimbursements is not a fundamental right guaranteed by the Constitution.²⁰² However, creating a burden on a suspect class, such as Hispanics, deserves strict scrutiny.²⁰³ The court ultimately decided that the statute did not appear to be racially based and that the plaintiffs’ claim that the different methodology result in less reimbursement payments to Puerto Rico, lacked factual support.²⁰⁴ The court further supported their denial of the equal protection claim by holding that the Territory Clause of the Constitution gave Congress “the power to treat Puerto Rico differently from States if there is a rational basis for doing so.”²⁰⁵ The Court, making reference to the Supreme Court decision of *Harris v. Rosario*,²⁰⁶ then laid out the rational basis factors that justified Congress’ actions in treating Puerto Rico differently when allotting funds:

- (1) Puerto Ricans do not contribute to the federal treasury; (2) high costs of treating Puerto Rico as a state for purposes of the statute; (3) the possibility that greater benefits might disrupt the economy of Puerto Rico. *Rosario*, 446 U.S. at 652, 100 S.Ct. at 1930. These

196. *Id.*

197. *Id.* at 937.

198. *Id.* at 936 (quoting 42 U.S.C. § 1395ww(d)(9)(B) (2004)).

199. *Id.* at 937.

200. *Sullivan*, 784 F. Supp. at 937.

201. *Id.* at 939.

202. *Id.*

203. *Id.*

204. *Id.* at 939–40.

205. *Sullivan*, 784 F. Supp. at 940.

206. 446 U.S. 651 (1980).

factors, as well as the unique economic circumstances attributable to Puerto Rico, support Congress' decision to prescribe a separate PPS rate for Puerto Rico.²⁰⁷

The arguments made by the Secretary, and the reasons provided by the *Sullivan* court for its ruling, were contradictory to the facts and lacked adequate support.²⁰⁸ In *Sullivan*, the Secretary made it a point to account for all Medicare participants equally, which is why all participating Commonwealth hospitals, even those without minimum wage regulations, were included in the national market basket to calculate applicable wage indices.²⁰⁹ Apparently, the parity that exists when calculating overall PPS rates does not apply when it comes time to make actual PPS payments.²¹⁰ At the beginning of the PPS process, Puerto Rico is treated like any other Medicare participant.²¹¹ "Puerto Ricans are expected to pay" the same tax rate to fund the Medicare program, and no special treatments are rendered while the majority of the PPS rate is being determined; that is, until it is time to actually distribute payments.²¹² At the point of distribution, a Puerto Rico specific rate is blended in with the national rate in order to determine the Puerto Rico payment, which ultimately results in lower levels of payments for Puerto Rico hospitals.²¹³

In justifying the special treatment, the court in *Sullivan*, citing to the Constitution and *Rosario*, stated that Congress has the power to treat Puerto Rico differently from the states, under the Territory Clause, so long as there is a rational basis for doing so.²¹⁴ The exact wording under the Territory Clause is as follows: "The Congress shall have Power to dispose of and make all needful Rules and Regulations respecting the Territory or other Property belonging to the United States; and nothing in this Constitution shall be so construed as to Prejudice any Claims of the United States, or of any particular State."²¹⁵ On its face the clause does not contain any wording that allows Congress to "treat Puerto Rico differently from States if there is a

207. *Sullivan*, 784 F. Supp. at 940.

208. *See id.*

209. *Id.* at 935.

210. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 504, 117 Stat. 2066, 2292-93 (2003); *see also* Hosp. San Rafael, Inc. v. Sullivan, 784 F. Supp. 927, 935 (D.P.R. 1991).

211. *See* 42 U.S.C. § 1395ww (2000); TEMA 903, *supra* note 146.

212. *See* TEMA 903, *supra* note 146.

213. 42 U.S.C. § 1395ww(d)(9)(E) (2000 & Supp. 2004).

214. *Sullivan*, 784 F. Supp. at 940 (citing U.S. CONST. art. IV, § 3; *Harris v. Rosario*, 446 U.S. 651, 651-52 (1980) (Marshall, J. dissenting), *reh'g denied*, 448 U.S. 912 (1980)).

215. U.S. CONST. art. IV, § 3.

rational basis for doing so.”²¹⁶ Furthermore, the dissenting opinion in *Rosario* accurately pointed out that the majority did not cite any authority for the proposition, and that the statement made by the majority was overbroad and unsupported.²¹⁷ The dissenting opinion went on to say that the United States must be careful as to how differently it treats Puerto Rico because Puerto Ricans are United States citizens who are entitled to many constitutional rights, such as the Due Process and Equal Protection clauses of the Fifth and Fourteenth Amendments.²¹⁸

The rational basis factors provided by the *Sullivan* court, in support of the statute enacted by Congress, also lacked support.²¹⁹ First, the rationale that Puerto Rico does not contribute to the Federal Treasury was not applicable with regards to the Medicare program in Puerto Rico, because Puerto Rico contributes to the Medicare fund in the same manner as all other Medicare participants.²²⁰ Likewise, treating Puerto Rico as a state when it comes to the PPS payments is no more costly than when it is treated as a state for Medicare taxing purposes.²²¹ Puerto Rico contributes to the Medicare program at the same tax rate as all other states;²²² hence, it should be reimbursed in the same manner as all other states. Next, the rationale that greater benefits might disrupt the Puerto Rican economy was viewed as having “troubling overtones” by the dissent in *Rosario*, and it appears to have the same defect in *Sullivan*.²²³ The dissent in *Rosario* stated that the rationale suggests that programs designed to help the poor should be scarcely applied in areas where the need is greater because such aid will disrupt the poverty levels in those areas.²²⁴ Moreover, the dissenting opinion stated that the theory suggests that those areas of the country that are the most economically sound would receive the most funding because that is where the aid will cause the least amount of disruption.²²⁵ The anticipated economic effects and so called “unique economic circumstances attributable to Puerto Rico,” that supposedly justify the special Puerto Rico PPS rate, are irrational and lack any evidence to support said rationales.²²⁶

216. *Sullivan*, 784 F. Supp. at 940.

217. *Rosario*, 446 U.S. at 653.

218. *Id.*

219. *Sullivan*, 784 F. Supp. at 940.

220. TEMA 903, *supra* note 146.

221. *Id.*

222. *Id.*

223. *Rosario*, 446 U.S. at 655; *see also Sullivan*, 784 F. Supp. at 940.

224. *Rosario*, 446 U.S. at 655–56.

225. *Id.* at 656.

226. *See id.* at 652–56; *Sullivan*, 784 F. Supp. at 940.

V. CONCLUSION

Puerto Rico is not a state, thus treating it with full statehood privileges may not be justified.²²⁷ Yet, there are compelling reasons for providing equality in the administration of a government program such as Medicare. Puerto Rico, as well as the United States, will benefit from a healthier Puerto Rico.²²⁸ Puerto Ricans are United States citizens, therefore, the well-being of Puerto Rico residents would improve the well-being and economic status of United States citizens overall.²²⁹ Furthermore, Puerto Ricans should also be entitled to the full benefits of the program, since they are subject to the same contribution rates that all other participants are mandated to pay.²³⁰ Anything less than equal treatment under such circumstances is unjustifiable.

In the Emily Friedman article, *The Compromise and the Afterthought: Medicare and Medicaid After 30 Years*, she quotes, "It is both a flaw and a strength of human nature that one tends to forget the circumstances that surrounded the need for and that shaped certain decisions and actions."²³¹ In the instant case, it is a flaw for the United States to forget the circumstances that led us to the formation of Medicare.²³² The program was designed to provide the needy, predominantly the elderly, with adequate health care so as to avoid the economic insecurities that loom over an unhealthy society.²³³ Today, in a time where the improvements in medical technology and medications are increasingly costly, the need for medical funding assistance contin-

227. See *Rosario*, 446 U.S. at 652; *Sullivan*, 784 F. Supp. at 940; *The Commonwealth Relationship*, *supra* note 134.

228. See *Rosario*, 446 U.S. at 653; THE COUNCIL OF STATE GOVERNMENTS EASTERN REGIONAL CONFERENCE, PROMOTING FEDERAL ECONOMIC INCENTIVES FOR PUERTO RICO (2002), at <http://www.csgeast.org/page.asp?id=2002puertoricores> [hereinafter PROMOTING FEDERAL ECONOMIC INCENTIVES]. The United States benefits from a prosperous Puerto Rico because Puerto Rico is the tenth largest trading partner of the United States. *Id.* Puerto Rico purchases over \$16 billion worth of goods from the United States every year, which results in over 180,000 jobs. *Id.* Furthermore, a prosperous Puerto Rico also creates more jobs on the island, thus resulting in "less welfare in Puerto Rico, which leads to more Social Security, Medicare and federal payroll taxes for the United States." *Id.* For instance, in 2001 Puerto Rico contributed \$20.90 billion in Medicare taxable earnings and \$19.14 billion in Social Security taxable earnings. SOCIAL SECURITY ADMINISTRATION, STATE STATISTICS, DECEMBER 2002-PUERTO RICO (2002), at http://www.ssa.gov/policy/docs/quickfacts/state_stats/pr.html [hereinafter STATE STATISTICS].

229. See *Rosario*, 446 U.S. at 653.

230. TEMA 903, *supra* note 146.

231. Friedman, *supra* note 26, at 280.

232. See generally CORNING, *supra* note 1.

233. See generally 42 U.S.C. § 1395c (2000); CORNING, *supra* note 1.

ues to grow.²³⁴ Puerto Rico is no exception to the trend.²³⁵ As an island with approximately half of its population living below the poverty line, Puerto Ricans are prime candidates for a national health care program such as Medicare and all the benefits it has to offer.²³⁶ Currently Puerto Rico is receiving assistance, and its situation has gotten progressively better.²³⁷ This does not necessarily mean that the system currently in place is adequate.²³⁸ In order for Puerto Rico to achieve the parity it deserves, the Medicare program will need to undergo further reform with a focus on achieving equality on the issue of reimbursement once and for all.

234. HAUGHT ET AL., *supra* note 124, at 1–2. *See also* Demko, *supra* note 126; Barry, *supra* note 126.

235. *See Move to Increase Puerto Rico Medicare, supra* note 5; Significativo el Impacto, *supra* note 5.

236. PROMOTING FEDERAL ECONOMIC INCENTIVES, *supra* note 228.

237. *See* 42 U.S.C. § 1395ww(d)(9) (2000 & Supp. 2004); Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 504, 117 Stat. 2066, 2292-93 (2003).

238. *See Move to Increase Puerto Rico Medicare, supra* note 5; Significativo el Impacto, *supra* note 5.