To the participants of the Andrea Mitchell Center for the Study of Democracy:

I have prepared this work for the 2018 AMC Graduate Workshop Series. I am immensely grateful for you taking the time to read it. It discusses some arguments from my doctoral (J.S.D.) dissertation, Where are Health Care Losses Coming From and How Can They Be Controlled? A Legal and Political Analysis of the U.S. Health Care System, which includes studies of wasteful care and the rationing of health care costs. This paper analyzes the Puerto Rican health care system—which I found particularly distinctive—to determine when rationing policies can be painful and end up harming the system. In the process, I elaborate on the differences between the continental U.S. and Puerto Rican health care markets, concluding that following the policies of the former represents poor rationing and inequality in the access of health care.

I am grateful for the Kauffman Summer Fellowship and the Oscar M. Ruebhausen Fellowship, at Yale Law School, for supporting my research. Any and all comments will be greatly appreciated. As this is a preliminary and incomplete draft, please do not cite or distribute.

I very much look forward to the discussion.

Gratefully yours,

XB
THE PAINFUL RATIONING: AUSTERITY, INEQUALITY, AND HEALTH IN PUERTO RICO

Ximena Benavides*

ABSTRACT

Over the past ten years, Puerto Rico has been settled with a mounting public debt crisis, estimated to be $123 billion, borrowing over and over again to cover operating expenses, including health care. When Puerto Rico stopped paying its debt, in 2016, the U.S. Congress formed a financial board to deal with this crisis and to determine its future fiscal policies. Controlling public debt and reducing budget deficits, however, have been affecting people's social rights, depriving many access to health care, and prompting medical professionals to continue to leave the island.

Puerto Rico is currently struggling with how to effectively allocate the already scarce resources in a devastated health care system without depriving many access to health care. Puerto Rico is broke and continuously hit by natural disasters. It has a lower federal medical reimbursement cap rates than U.S. states, a limited number of medical professionals, as they continue to migrate away from the island, and poor infrastructure, as a result of a failed regionalized system and heavy disparities between private and public health care sectors. Since rationing is necessary, the question is not whether or not to ration but which rationing policies would be the most efficient to deal with this situation.

This paper focuses on austerity and inequality on the right to health in Puerto Rico as a result of rationing policies. Beginning with the story of a continuously reformed Puerto Rican

health care system, shaped by a colonial relationship between the island and the United States, the paper analyzes Puerto Rico's financing and delivery of health care, and the micro-allocation policies used to ration healthcare, policies implemented to respond to fiscal and natural disaster damages. While rationing can be beneficial, it can also prove to be painful when it results in disparities in access to health care or not delivering health care at all.

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TABLE OF CONTENTS

INTRODUCTION
I. THE HISTORY OF TRANSFORMATION
II. HEALTH CARE FINANCING AND DELIVERY IN PUERTO RICO
III. RATIONING HEALTH IN PUERTO RICO
   A. The Allocation Policy
   B. Medical Resource Allocation
CONCLUSION

INTRODUCTION

Since 2006, Puerto Rico has found itself in a deep recession, accumulating debt—estimated to be $123 billion—by borrowing to pay operating expenses, until 2016, when it ran out of cash and stopped paying its debt.¹ Unlike cities in the continental U.S., Puerto Rico cannot file for bankruptcy. In June of 2016, the U.S. Congress passed the Puerto Rico Oversight, Management, and Economic Stability Act (PROMESA), and formed a Financial Oversight and Management Board (the PROMESA Board) to deal with Puerto Rico’s crisis. The PROMESA Board’s plan includes an almost thirty-percent reduction in the island’s annual health care

budget. This aggressive austerity policy will severely impact more than half of the island’s population, who rely on government-provided health care. Puerto Rico’s government office expects that up to 400,000 people—almost 12% of the island’s population and 24% of the private health care insured population—will lose their coverage because they will not be able to afford it.

Reducing budget deficits have been negatively affecting people’s rights. The United Nations’ Human Rights Office of the High Commissioner explicitly addressed this issue: “economy should serve the people, not vice versa”.\(^2\) Further budget cuts will not aid economic recovery; instead, they will undermine the provision of essential public services, including health care.\(^3\)

The history of the Puerto Rican health care system is one of decentralization and fragmentation. In the years following the 1970s, the Puerto Rican health care system followed the structure in place in the continental United States, although both markets are markedly different. There already exists unequal access to health care on the island. While Puerto Ricans pay the same Medicaid tax as any other fiscal contributor in the U.S., they receive only half of the Medicaid federal funds, as if they were “half” a U.S. citizen when it comes to health care.

Austerity measures implemented in Puerto Rico have already caused higher unemployment—which reduces tax contributions; they have accelerated one of the highest migrations in history from the island to the mainland—which has significantly decreased the number of doctors on the island and, at the same time, left behind an increasingly aging population with higher chances of illnesses and a shorter fiscal contribution life span; and,

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\(^3\) Health care is not recognized in the U.S. as a human right, yet it is recognized internationally as such in those countries with health universal coverage.
finally, they have contributed to a severe economic contraction—which undermines people’s ability to afford health care copays or pay for private health care insurances. To make matters even worse, natural disasters in September of 2017 made the crisis of the allocation of the already scarce medical resources even greater.

This paper is not intended to advocate either for a privatized or government-based health care delivery system in Puerto Rico. Instead, it will focus on the upstream of health care: whether it is possible to overcome financial constraints in a U.S. territory in the long run, and assure Puerto Ricans access to health care. The allocation of scarce medical resources, and rationing, in particular, will be the object of analysis within the Puerto Rican health care crisis.

The paper consists of two parts. Part I describes the transformation of the Puerto Rican health care system into the current privatized system, with emphasis on La Reforma, a program that leads to the system in place now. Part II describes the struggles of financing and delivering health care in Puerto Rico. Finally, Part III is concerned with the rationing policies that affect the privatized Puerto Rican health care system.

I. The History of Transformation

Today’s Puerto Rican health care system is the result of U.S. neoliberal policies transferred to an active and dynamic social institution. Much of this “policy experiment” has been shaped by the colonial relationship between the U.S. and Puerto Rico. However, in order to understand the lessons of this legal transplantation, without tackling a political narrative, the colonial aspect will remain outside this paper.
Since the United States annexed Puerto Rico as a U.S. territory in 1898, the Puerto Rican health care system has been continuously under reform. Its evolution can be summarized in three main stages: colonialism, regionalization, and privatization.

During the U.S. colonial period, also called “war ward”, running from Puerto Rico’s invasion until the early 1950s, the public health care system was organized mainly by municipal governments responsible for basic healthcare. Ever since Puerto Rico was a Spanish colony, municipalities heavily influenced medical matters, and Spanish regulations controlled the medical profession with rigid credential requirements. Because of its colony status, the island’s population expected the government to provide free health care for the sick and poor. Soon after the U.S. intervention, the municipal system incorporated the Superior Board of Health, aimed at enforcing U.S. hygiene standards. This was the era of the “Americanization” of the Puerto Rican health care system: U.S. administrators misunderstood local conditions, while many patients and medical practitioners resisted colonial intervention—although initially supporting it as part of an anti-Spanish sentiment. Puerto Ricans, both physicians and residents, were viewed by the U.S. colonial government as “unable to administer their own affairs.” In turn, for Puerto Ricans, U.S. intervention created many dire health conditions, food shortages, and starvation.

Over the next three decades, federal legislation modified the health care system, adding to the inherited municipal system the creation of public clinics and insular facilities that were

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4 “War Ward” is the name that Bailey K. Ashford, a U.S. army medical officer, used to call the U.S. medical campaign during the U.S. colonial project in Puerto Rico. With the U.S. invasion, health became a military affair—the “U.S. colonial project”—where the U.S. was conceived as the benevolent physician and Puerto Rico the sick patient. See Bailey K. Ashford, A Soldier in Science: The Autobiography of Bailey K. Ashford. New York: William Morrow (1934).
5 Salvador Arana-Soto, Historia de la Medicina Puertorriqueña hasta el 1898. San Juan, PR. 1974.
7 Nicole E. Trujillo-Pagán, Health Beyond Prescription: A Post-Colonial History of Puerto Rican Medicine at the Turn of the Twentieth Century. University of Michigan, Department of Sociology, 2003. 128-139
8 Arana-Soto, supra note 5, ibid.
9 Ibid. 35.
financed and run by the colonial government.\textsuperscript{10} By the end of the 1940s, the U.S. allowed Puerto Ricans to elect their governor, ushering in a new health care era.

By midcentury, a more autonomous Puerto Rican government created a \textit{regional health care system}. Primary and preventive care were delivered at local health care centers in municipalities, whereas secondary and tertiary care were provided at regional hospitals. In turn, the U.S. central government created a regional office within the Department of Health to oversee the regional program and enforce policies and medical procedures.\textsuperscript{11}

The regional health care system rose under a new Constitution in Puerto Rico, that “formally” changed the island’s political status into an \textit{Estado Libre Asociado} (the “Commonwealth”), and removed Puerto Rico from the United Nation’s list of non-sovereign territories. During this era, the political agenda was directed by the local party \textit{Partido Popular Demócrata} (Popular Democratic Party), centered on an export-based economy, limited restrictions on foreign capital, and an extensive welfare state that provided healthcare. Nonetheless, since the political conditions fell short of decolonization, the Puerto Rican government was prevented from designing a health care system of its own. Federal law superseded Puerto Rican law, Puerto Rico had no vote in the U.S. Congress, and Puerto Ricans could not vote for U.S. President.

During the 1960s, U.S. Medicaid and Medicare public health care programs created (\textit{more}) disparities between Puerto Rico and U.S. states, and between Puerto Rico’s public and private sector, as well as contributed to the chronic underfunding of the public system by implementing federal funding caps. During the 1970s and 80s, the growth of a parallel private

\textsuperscript{10} In 1911, federal legislation created the Public Health Service. In 1912, the creation of the Institute of Tropical Medicine. In 1917, the Jones Act created a Department of Health, and made Puerto Ricans U.S. citizens “just in time to be drafted into World War I”. In 1933, the Public Health unit was created and by 1938 similar units were established in every municipality. \textit{See} Mulligan, \textit{supra} note 6, 36.

\textsuperscript{11} Mulligan, \textit{supra} note 6, 38-39.
insurance market and private health care infrastructure for the wealthy and middle class increased disparities between the private and public sectors, while duplicating health care costs.\textsuperscript{12}

The international community\textsuperscript{13} and the Puerto Rican government considered the regional system a hallmark of progress and development—even though it had some initial opposition from the Puerto Rican Medical Association, which called it a socialist program.\textsuperscript{14} Still, beginning in the 1990s, the regional system was eventually seen as outdated and inefficient. Although sympathetic to the regional system and in agreement with universal coverage, many academics called for health to be managed in a more business-like manner. They proposed the disintegration of the public and private health care system by enrolling the entire population in private health insurance plans, as a means to manage the risk created by increasing health costs—higher than inflation.\textsuperscript{15} This discourse inspired the marketization of the health care system in the 1990s.\textsuperscript{16}

In 1993, with an underfunded public health care, the health care system was \textit{privatized} by Law 72 and replaced by a managed care-based health care system (HMO) for the medically indigent called \textit{“La Reforma”} (The Reform), administered by private insurance companies. \textit{La Reforma} was aimed at eliminating the two-tier public-private system in place, controlling health costs, downsizing the health care bureaucracy and ensuring the delivery of high-quality health care regardless the of the ability to pay. However, it failed to control costs. The program turned to be much more expensive than the regional health system, placing a growing burden on the

\textsuperscript{12} José Nine Curt, La Salud en Puerto Rico, San Juan, Puerto Rico. 1972. 81.
\textsuperscript{14} \textit{Supra} note 6, 56-57.
\textsuperscript{15} In 1972, the Dean of the School of Public Health of the University of Puerto Rico, Dr. José Nine Curt, advocated in favor of reforming the regional system in order to maximize scarce resources.
\textsuperscript{16} \textit{Supra} note 6, 43.
mainland government budget. In 2005, Puerto Rico spent 26% of its gross national product on health care, compared to the 13% spent in the continental U.S. Since 1968, Medicaid spending in Puerto Rico was capped by the federal government. The imbalance between Puerto Rico and U.S. states with a high proportion of Medicaid beneficiaries was (and still is, as I will explain later) enormous. Only 12% of Puerto Rico’s health care spending is funded by the federal government.\textsuperscript{17} In contrast, in Mississippi and West Virginia (states with a similar amount of Medicaid beneficiaries as Puerto Rico, but only half of its population and not nearly as poor as Puerto Rico)\textsuperscript{18} over 70% of their health care expenditure is funded by the federal government.\textsuperscript{19} As a result, since the creation of the Medicare and Medicaid health programs, the Puerto Rican government has relied heavily on local taxes to cover health care costs—albeit high unemployment rates, a labor force migration to the continental U.S., and a staggering debt crisis.

\textit{La Reforma} also failed to make health care universal because it introduced stricter eligibility criteria and, as a result, created an uninsured population for the first time in Puerto Rico’s history.\textsuperscript{20} Before \textit{La Reforma}, only Medicare and Medicaid beneficiaries, government workers, and private sector workers had access to health insurance. With \textit{La Reforma}’s “\textit{tarjeta de Gobierno}” or “\textit{tarjeta de Rosselló}”, the poor no longer had to use a health system separate from the middle class and wealthy since they were incorporated into the private health care system. The newly insured, under \textit{La Reforma}, ultimately felt they were being integrated into a system that had formerly excluded them.\textsuperscript{21} This sentiment of inclusion made them believe that

\textsuperscript{17} In Puerto Rico, health care is funded 75% by local taxes, 12% by the federal government, 10% by municipalities, and 3% by CHIP (federal health insurance for children). \textit{See} Mulligan, supra note 6, 49.
\textsuperscript{18} U.S. National Bureau Census. Information as of 2010 (before a dramatic decrease in almost 30% of the Puerto Rican population), available at https://www.census.gov (accessed September 15, 2018). Mississippi and West Virginia each have less than 20% of their population below federal poverty line, while in Puerto Rico that number doubles.
\textsuperscript{19} \textit{See} supra note 17.
\textsuperscript{20} \textit{Id.}, 46-48.
\textsuperscript{21} \textit{Id.}, 51.
the quality of care was better in the private market, with private insurance, through a private company. However, the reform ignored or oversaw the enormous class division in place in Puerto Rico\textsuperscript{22}, and contributed to create greater disparities, especially between the professional classes and the poor. The elimination of the two-tiered system created prejudice against \textit{La Reforma} patients. Reforma patients were marked as such, and health care providers, as well as other patients, reacted negatively to their presence. From the point of view of the middle class, Reforma beneficiaries were overcrowding the private system. Medical professionals and health facilities (which included sold off public facilities) had the right to accept or not Reforma patients.\textsuperscript{23} In turn, an increased demand stemming from \textit{La Reforma} forced people to switch over to a new primary care physician no longer listed under \textit{La Reforma}. Hence, while \textit{La Reforma} was experienced as something the poor deserved, it was also a marker of class privilege.

Finally, medical education was transformed with the privatization of the health care system. Privatization of public hospitals eliminated many medical training opportunities because, the priority of many privatizers was not education, but service delivery. As a result, privatization disarticulated the connection and balance between training, treatment, and research. With the implementation of \textit{La Reforma}, the number of residents and interns decreased by 68\%.\textsuperscript{24} Many medical students left the island to find residency programs, because many were closed in the wake of \textit{La Reforma}, while doctors left the island in search of a higher quality of living.

\textit{La Reforma} is an irreversible phenomenon. It was an initiative of the statehood-supporting New Progressive Party (PNP), opposed by the Popular Democratic Party, who was behind the regional health care system. Privatization was a strategy tied to the political status of

\begin{itemize}
\item \textsuperscript{22} \textit{Id.}, 53.
\item \textsuperscript{23} \textit{Id.}, 54.
\item \textsuperscript{24} According to reports in the major daily newspaper \textit{El Nuevo Dia}. See Jessica M. Mulligan, \textit{Unmanageable Care: An Ethnography of Health Care Privatization in Puerto Rico}, New York University Press. 57.
\end{itemize}
the island. However, instead of creating a statehood status, it created further disparities between Puerto Rico and U.S. states, as well as in Puerto Rico. Because political choices highly impact long-run policy outcomes, as a result of an extraordinarily complex, limited policy process, after *La Reforma*’s passage, the government could not dismantle the program and take away insurance cards from the poor. Nonetheless, there are other ways to alter and improve the system in place.

**II. Health Care Financing and Delivery in Puerto Rico**

Puerto Rico differs from U.S. states in many respects. Based on the information from 2015 and 2016 shown in Table 1, Puerto Rico’s population represents only 1% of the total continental U.S. population. Almost half of the Puerto Rican population live in poverty (that is, at or below the federal poverty level - FPL), with a poverty rate three times higher than that of the rest of the U.S. The unemployment rate in Puerto Rico is more than twice as high as that in the mainland., with a substantial share of its labor force in the service industry (government-employment based). The latter consideration greatly determines the size of public health care coverage of the island’s population. Although Puerto Rico has a low rate of uninsured residents, over sixty percent of the total population rely on public insurance coverage in the form of Medicaid/CHIP and Medicare. One in two Puerto Ricans are enrolled in Medicaid program, a rate almost twice as high as that of the mainland U.S., which is not surprising considering their poverty rate.\(^{25}\) The median household income in Puerto Rico is only a third of the national average. In addition, the unemployment rate is high and the labor force population considerably smaller, which prevents Puerto Ricans from having a system based on employer-sponsored

\(^{25}\) Puerto Rico provides Medicaid coverage through a wider public health insurance program known as “*Mi Salud*” (My Health) that also includes CHIP, Medicare and some other Puerto Rico only funded coverage.
coverage, as found elsewhere in the mainland. The Puerto Rican health care system resembles a universal health care model, in the sense that the majority of the population relies on public insurance coverage. However, blind to this important fact, federal health care policies continue to treat Puerto Rico as if it were like a U.S. state, although the social and economic composition of the U.S. and Puerto Rico are decidedly, crucially different, leading to greater disparities. In turn, federal laws, based on these policies, create greater disparities.

With a higher income per capita, sixty percent of the health care coverage in the mainland is private, mostly employer-sponsored insurance or directly purchased, with only 20% of the population insured by Medicaid. Federal Medicaid mandatory eligibility rules are generally the same in Puerto Rico as in the U.S. However, the island is not required to follow U.S. federal poverty guidelines. This means that the income-eligibility levels for Puerto Rico’s Medicaid program are based on a local poverty level that is established by the Commonwealth and approved by the federal Center for Medicare and Medicaid Services (CMS).26

<table>
<thead>
<tr>
<th></th>
<th>Puerto Rico</th>
<th>50 States and DC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Population (2015)</strong></td>
<td>3,449,000</td>
<td>317,480,000</td>
</tr>
<tr>
<td><strong>Percent Change Since 2006</strong></td>
<td>-12%</td>
<td>+8%</td>
</tr>
<tr>
<td><strong>U.S. Born Citizens</strong></td>
<td>97%</td>
<td>86%</td>
</tr>
<tr>
<td><strong>Over Age 65</strong></td>
<td>18%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Below Federal Poverty Line (FPL)</strong></td>
<td>46%</td>
<td>15%</td>
</tr>
<tr>
<td><strong>Unemployment</strong></td>
<td>14%</td>
<td>5%</td>
</tr>
<tr>
<td><strong>Health Coverage (2015)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid/CHIP</td>
<td>48%</td>
<td>20%</td>
</tr>
<tr>
<td>Employer-Sponsored Insurance/Direct Purchase</td>
<td>35%</td>
<td>60%</td>
</tr>
<tr>
<td>Medicare or Military</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>6%</td>
<td>9%</td>
</tr>
<tr>
<td><strong>Economics Statistics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median Household Income (2016)</td>
<td>$20,078</td>
<td>$57,617</td>
</tr>
<tr>
<td><strong>Health Statistics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults Reporting Fair/Poor General Health (2016)</td>
<td>34%</td>
<td>18%</td>
</tr>
<tr>
<td>Adults Reporting Diabetes (2016)</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Adults Reporting Heart Attack or Heart Disease (2016)</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>Locally-Acquired Zika Virus Disease Cases (2016)</td>
<td>34,963</td>
<td>224</td>
</tr>
<tr>
<td>HIV Diagnosis Rate per 100,000 People (2015)</td>
<td>17.1</td>
<td>14.7</td>
</tr>
<tr>
<td>Infant Mortality Rate per 1,000 Live Births (2013)</td>
<td>7.1</td>
<td>6.0</td>
</tr>
</tbody>
</table>

Puerto Rico is not as racially diverse as the continental U.S., which makes certain health conditions predominate. Puerto Ricans have higher rates of diabetes, heart attacks CAD and HIV than people in the rest of the U.S., while the Zika virus is a national health emergency in Puerto Rico.28

Puerto Rico annually spends 26% of its gross national product on health care. In contrast, the United States spends only about 18%—already the highest share spent by a developed country.29 Seventy-five percent of Puerto Rico’s funding comes from local taxes, despite the natural struggles stemming from a financial crisis that has lasted over ten years, high unemployment rates and a massive migration of Puerto Ricans to the mainland.30 The delivery of health care in Puerto Rico is severely compromised by poor health infrastructure and a rapidly declining workforce. In 2015, approximately five hundred physicians moved away from the island, principally to the mainland, and left Puerto Rico with less than half the number of emergency physicians and other critical specialists.31 Economic conditions in the island make it hard to attract doctors.32 Moreover, after public hospitals were privatized in the 1990s, doctors had to leave the island to finish their medical training at residency programs abroad. As a result, Puerto Ricans have fewer physicians than ever before33 and long wait-times when accessing

28 On August 12, 2016, the US Department of Health and Human Services declared the Zika outbreak in Puerto Rico to be a public health emergency.
29 Mulligan, supra note 26, 49.
30 Id. See also supra note 24 and Table 1.
32 Physicians in Puerto Rico are paid a fixed fee of US$35 per consultation by insurance companies, before copays deductions, and taxes. Interview carried out in June 8, 2018 to Sally Priester, MD, Ashford Presbyterian Hospital (San Juan, Puerto Rico) and Director of the Puerto Rican Medical Association.
33 In 1990, Puerto Rico had 29 medical professionals available for its mentally disabled population (28% of Puerto Rican infants and children are mentally disabled). Today, there are only 3 medical professionals for an even larger population, as poverty and single-mother households have increased in number. Interview carried out in June 8,
health care. The Health Resources and Services Administration (HRSA) has deemed 72 of Puerto Rico’s 78 municipalities as medically underserved areas.\textsuperscript{34}

According to the Constitution, the U.S. Congress has the express power to make rules for U.S. territories and to treat them differently than states, as long as there is a “rational basis” for the differential treatment.\textsuperscript{35} Congress, the U.S. Supreme Court and the Federal government have repeatedly stated that Puerto Rico is a territory, and so falls under the Constitution’s Territory Clause.\textsuperscript{36} Some scholars, however, argue that Puerto Rico is no longer subject to the Territory Clause since the Commonwealth of Puerto Rico was established in 1952 and Puerto Rico became self-governing or, as the Puerto Rican Constitution states, a “Freely Associate State.”

Considering the income and poverty levels, and the health conditions of the Puerto Rican population, it seems clear that Puerto Ricans cannot afford health care as readily as those in the continental U.S. and, unfortunately, their demand for health care is greater. While there is in this case, a “rational basis” for differential treatment (e.g. greater reliance on public health care programs, higher rates of unemployment and population under the FPL, a severe financial crisis, different rates of illness) this Congress has not chosen to exploit these differences to overcome Puerto Ricans’ health care problems. Rather than combating deep inequalities by offering additional help, Congress is making them even more unequal in the name of “equal treatment”.

Unfortunately, federal laws regarding public health programs, like Medicaid and Medicare, result

\textsuperscript{34} Supra note 8.

\textsuperscript{35} Territory Clause of the U.S. Constitution (Article IV, Section 3, Clause 2): “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.” The President of the U.S. signs laws passed by Congress but cannot policy about territories. Territory residents cannot make their own rules or regulations except if allowed by Congress. The Supreme Court can interpret regulations for territories, but only Congress has the express power to make rules.


in even more differences between Puerto Ricans and U.S. citizens. Instead of improving health conditions and supporting the majority of the population who could not otherwise afford private health care for economic and political reasons, the U.S. government provides Puerto Ricans with special rules that undermine health and increase disparities.

The main “disparity” rule pertains to federal health care reimbursement. Medicaid is the public health care program that almost half of Puerto Ricans rely on to access to health care. It is funded by the states and the federal government, who pays a percentage (the Federal Medicaid Assistance Percentage—FMAP) of the program’s expenditures based on actual costs and needs of each U.S. state. Medicaid is a needs-based program designed to provide care for poor: children, adults, elderly, pregnant mothers, and disabled people. The beneficiaries of the program are not contributing federal government income tax, neither in Puerto Rico nor in any U.S. state. However, in contrast to any U.S. state, where FMAP can reach 83% (Table 2), Puerto Rico has a much lower FMAP, although its population’s needs are greater.

Although Puerto Ricans pay the same Medicaid tax as other fiscal contributors in the U.S., they receive only half of the Medicaid federal reimbursement funds, as if they were “half” U.S. citizens. Puerto Rico’s Medicaid financing differs from that of a U.S. state in two important ways. Firstly, federal funding for the Medicaid program in Puerto Rico is subject to a statutory cap (Table 2). Once each territory’s federal funds cap is exhausted, the territory no longer receives federal financial support for its Medicaid program during that fiscal year. Secondly, Puerto Rico’s federal match rate is fixed, unlike in the U.S., where the statutory formula is

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adjusted annually, based on the states’ relative per capita income.\textsuperscript{40} Of course, these are only two of many other differences.\textsuperscript{41} Natural disasters, quite common in the U.S. territories, permanently increase U.S. territories’ demand for public health care coverage and, along with it, the need to fund Medicaid federal matching share correlatively increases. In 2006, the Affordable Care Act (ACA) increased Puerto Rico’s Medicaid program funding through a $6.4 billion allotment and its federal match rate from 50\% to 55\%, yet insufficient.

\textbf{Table 2 - Medicaid in Puerto Rico, Compared to the 50 States and DC}\textsuperscript{42}

<table>
<thead>
<tr>
<th>Federal Medicaid Rules</th>
<th>Puerto Rico</th>
<th>50 States and DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Matching Rate</td>
<td>Fixed at 55%</td>
<td>Ranges from 50-83%, based on state’s per capita income</td>
</tr>
<tr>
<td>Federal Funding</td>
<td>Capped at $357.8 million in FY 2018</td>
<td>Uncapped</td>
</tr>
</tbody>
</table>

The issue in question is whether the Medicaid federal funding statute has a rational basis for differential treatment in health care between the states and U.S. territories. Previously, in \textit{Harris v. Rosario},\textsuperscript{43} the U.S. Supreme Court considered whether the Aid to Families with Dependent Children (AFDC) federal welfare legislation had a rational basis for treating Puerto


\textsuperscript{41} There are additional disparities originating from the financing of health care in U.S. territories. There are no Disproportionate Share Hospital (DSH) payments, used in U.S. states to provide hospitals that service a high share of Medicaid and uninsured patients with supplemental payments. Enrollment in Medicare Part B (for out-of-pocket health costs) is not automatic for Puerto Ricans—and, as a result, individuals fail to enroll and remain uncovered or are subject to late-enrollment penalties. In contrast to U.S. states, U.S. territories do not have Medicare Savings Programs (MSP) to assist low-income individuals with a part of their out-of-pocket expenses for Medicare—so many cannot afford Medicare Part B. Finally, there are no applicable low-income subsidies for residents in U.S. territories, only a fixed amount of funding for each territory to pay Medicare’s beneficiaries for drug prescriptions.


\textsuperscript{43} 446 U.S. 651 (1980).
Rico and other U.S. territories differently within the reimbursement plan, to provide financial support to needy families. The Court resolved that the statute was constitutional and did not violate the equal protection guarantee. The Court cited three rationales for differential treatment: Firstly, residents of Puerto Rico do not contribute to the U.S. Treasury, primarily because they do not pay federal income taxes. Secondly, treating Puerto Rico as a state would be costly. Finally, paying higher Social Security benefits to Puerto Ricans might disrupt the island’s economy. Justice Marshall dissented in Harris and questioned whether there was truly a rational basis for the discriminatory legislation directed at island residents. He argued it is not “rational to provide lower benefits to U.S. citizens who have the greatest need, and that a geographic area should not have the level of its antipoverty aid reduced simply because it has a weak economy.”

The Court decision ultimately followed previous decisions stemming from the Foraker Act, in 1900. By then, the Court had recognized that Puerto Rico was an unincorporated territory, which the government had no intention of converting into a state, and its residents were not entitled to all the privileges and protections otherwise afforded to states’ residents. As a result, residents of Puerto Rico could be denied full protection of the Constitution even after they were granted U.S. citizenship, which established a precedent for unequal treatment. In its recent due process rulings, the Court has avoided any pronouncement regarding the political status of the island.

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44 This rationale was drawn from an earlier case, Califano v. Torres, 435 U.S. I, 5 n.7 (1977), where the Court ruled that a complete exclusion of Puerto Rico from the Supplemental Security Income (SSI) program had a rational basis.
45 Harris at 1931 (Marshall, J., dissenting).
47 Although, the Court has held that due process rights against the Puerto Rican authorities are guaranteed by either the Fifth Amendment, with respect to actions of federal agents, or the Fourteenth Amendment, with respect to actions of state agents. See Examining Bd. v. Flores de Otero, 426 U.S. 572, 601 (1975); Calero-Toledo v. Pearson Yacht Leasing Co., 416 U.S. 663, 668-69 n.5 (1973).
For governors and representatives of U.S. territories before the U.S. Congress, the federal government believes U.S. territories cannot understand “Anglo” principles and, thus, should not have the same privileges, such as voting rights. The different levels of funding in Medicare and Medicaid are consequences of the colonial relationship that exists with the U.S., which is likely to lock Puerto Rico into a market model sharing the same problems as the mainland (growing inequality, health disparities, and rising health care spending), although differing in terms of poverty and the economic capability to access health care in a territory with almost two thirds of the population dependent of public health care programs. The regular struggles of the continental U.S. health care system are clearly exacerbated by Puerto Rico’s social and financial problems: higher poverty rates, debt crisis, underfunding, and a crisis in medical resources, including education, physicians and infrastructure. Puerto Rico has not gained the status of statehood, nor is it self-governing; instead, it retains attributes of an unincorporated dependency which, unfortunately, brings about a heavy burden for social rights as long as the U.S. Congress can unilaterally rule in favor of differential treatment with a detrimental but superficially rational basis.

III. RATIONING HEALTH IN PUERTO RICO

Imagine two scenarios. In the first, you are a patient who needs an organ transplant, and are on a waiting list for a kidney donor. Finally, after three months, there is one transplantable kidney, but also three potential recipients. Only one person will receive the transplantable

kidney, while the other two people will need to keep waiting—or die. In the second scenario, you need open-heart surgery, but hospitals in the region where you live only have a limited number of heart surgery beds per month.

Both scenarios are two fundamentally different forms of scarcity. When there is real scarcity—as in the first case of only one donor for three needy patients—medicine faces “tragic choices”\(^{50}\), but when medical resources are limited—such as the number of beds in a hospital for open-heart surgery—medicine faces “resource allocation choices.” Depending on how one allocates scarce resources, one may effectively address health care needs. However, with tragic choices, failure is highly likely no matter how hard one tries allocate the scarce resources at hand because there is no more than one allocation option.

Now, consider Puerto Rico during October 2017, right after Hurricanes Irma and Maria—the most catastrophic storm of Puerto Rico’s modern time—hit the island, on September 6 and September 20, respectively.\(^{51}\) Especially after Maria, Puerto Rican hospitals ran low on medicine and high on patients. Until March 2018, almost half of the facilities were still operating with generators or did not have power at all, thus some have been forced to limit hours of operation and services. The Kaiser Report published on March 16, 2018, six months after Maria, reflects the fact that Puerto Ricans still face incredible challenges and their lives are far from ordinary. According to the Report, the recovery efforts have been slow and insufficient, and it is very likely Puerto Rico will not recover, especially from Maria, for many years.\(^{52}\)

\(^{50}\) See Guido Calabresi & Philip Bobbit, Tragic Choices 21 (1978).


\(^{52}\) Supra note 4.
The natural disasters worsened the medical situation of the island by aggravating an existing crisis of allocation of scarce medical resources. Continual shortages can rapidly transform a “resource allocation choice” problem into a medical “tragic choice” problem. All societies ration medicine; however, not all rationing policies are safe policy tools.

There are two ways of allocating resources: macro-allocating and micro-allocating. The former refers to decisions regarding how resources are distributed to institutions or types of services (for example, how many surgeries a week a hospital can practice), whereas the latter refers to decisions regarding how resources are to be distributed to individuals (for example, who is to receive surgery).

For economists, both ways of allocation are forms of rationing; however, most policy analysts use “rationing” only with micro-allocation. For example, distributing the federal budget among public health care programs (such as Medicare, Medicaid, and CHIP) is a macro-allocation decision. At the micro-allocation level, in turn, the system decides whether patient A or patient B will receive a transplant, for example. Shortages of transplant organs trigger difficult choices on who, among eligible patients, will receive the transplant, and this will still mean rationing, in the sense of sharing scarce resources and trying to make equitable choices among individual patients.

Rationing, in the more restricted sense of micro-allocation, can be a problem when allocating means depriving someone of health care. Rationing will then become a “tragic

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54 In the literature that addresses problems of health care resources, Evans elaborates on the making of hard choices on health care distinguishing decisions about distribution at a macro-level (“allocation”) and at a micro-level (“rationing”). See Evans RW. Health care technology and the inevitability of resource allocation and rationing decisions. Part II. JAMA 1983, 249:2208-19. Evans’ categorization of macro and micro-allocation’ can be compared to Mechanic’s implicit and explicit rationing.
choice”, if by allocating scarce resources access to health care is denied to some individuals. This is precisely the type of rationing to be worried about. This kind of policy is surprising in countries like the U.S., which spends more than $3.2 trillion in health care annually—17.8 percent of the country’s gross domestic product (GDP)—the highest health care expenditure in the world, where still 7% of the population is uninsured. The U.S. can afford to spend that much on health care, but still people claim costs are out of proportion with respect to the quality of service and treatment they receive, not to mention the segment of the population without insurance.

In the following sections, I will discuss the resource allocation choice as a health care policy. In particular, whether it is a safe policy tool, with emphasis on the Puerto Rican health care system.

**A. The Allocation Policy**

Health care systems, whether driven by the market or government, allocate health care by **price**. The U.S. health care system is “(in)famous for rationing by price”. Even if medical services are affordable, public health insurance programs, like Medicaid, cut eligibility and limit the number of patient visits to a doctor or the reimbursed services, due to costs. Health insurance

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59. Kaiser Family Foundation. Health Insurance Coverage of the Total Population, 2016. [https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22,%22%7D](https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22,%22%7D)

coverage is overall limited to expenses. However, price is not the only way to draft allocational policies. It is also possible to apportion care services’ use equitably among individuals based on need. This “second tier of rationing” rations health care by age, disease, region, provider philanthropy, and equity. Most importantly, deliberate choices about the sharing of health care resources among individuals are made on grounds not only of individual, but also social needs.\(^6\)

This means of rationing represents a positive distribution of care in response to diverse eligibility criteria.\(^6\)

After Hurricane Maria, there were serious concerns about how health care providers would begin the essential recovery in places where diesel fuel was still scarce and communication almost nonexistent. Yet concerns went beyond merely restoring energy and communication from the power outage deemed “the largest blackout in American history.”\(^6\)

Puerto Rico’s health care system was already in financial crisis before the hurricane. The public debt that Puerto Rico had accumulated over the last ten years made things even more complicated. Before the hurricanes, Congress approved $296 million of additional Medicaid funding for Puerto Rico. At the same time, there was an outflow of the Puerto Rican labor force, meaning fewer tax contributions—local taxes finance 75% of Puerto Rico’s health care.\(^6\)

The hurricanes exacerbated pre-existing fiscal and health challenges. Because Puerto Rico is a U.S. territory and not a U.S. state, its safety net—which includes community health centers and health insurance programs like Medicaid and Medicare—receives less help from the

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federal government, and the local government has much less flexibility to step in during a crisis. With Puerto Rico’s finances controlled by “a congressionally appointed oversight board”, it cannot easily succeed in allocating more money toward these programs.

In October of 2017, the House of Republicans proposed directing one billion Medicaid dollars to Puerto Rico, as part of a five-year plan to fund the federal health insurance program for children (CHIP). That ties the system for 18 months with the current spending rates, but does not solve the shortage problem, which is likely to recur when the money runs out or another disaster strikes. Just before Hurricane Maria, Puerto Rico was already facing a Medicaid funding cliff, when the extra dollars provided to it through the ACA expired, at the end of 2017. It is a fact that U.S. territories—not only Puerto Rico—receive less federal Medicaid reimbursement than U.S. states, although they pay the same Medicaid taxes. So, technically, this policy is not a provision of “extra dollars.” On the other hand, it is also a fact that expanding the Medicaid budget is common when disasters occur. After 9/11, Hurricane Katrina, the Flint water crisis and the Zika outbreak, Medicaid provided care to people without insurance, who wouldn’t normally have qualified for the program.

The problem for Puerto Rico is not only its debt, but also that it is responsible for paying a more significant share of Medicaid costs than it would if it were a state. While in poor states the U.S. federal government reimburses close to seventy-six percent of the Medicaid costs (and

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67 Supra note 11.
68 Supra note 12. In recent years, Puerto Rico has used additional funds available by the Affordable Care Act (ACA). For example, in 2015 $1.52 billion federal dollars went to Puerto Rico’s Medicaid program, to cover almost 65% of Puerto Rico’s that year spending.
69 Supra note 12.
70 The poorest U.S. state is Mississippi, which gets reimbursement of 75.7% of Medicaid costs. See https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-
the lowest level of reimbursement is 50% in fourteen U.S. states), in Puerto Rico, compensation is set at fifty-five percent. If only Puerto Rico could be reimbursed using any U.S. state’s poverty formula,\textsuperscript{71} it would get eighty-two percent of its costs covered.\textsuperscript{72} Medicare is also reimbursed at lower rates.\textsuperscript{73}

In June of 2017, PROMESA proposed to reduce the fiscal budget, including undermining the provision of health care. With the already limited federal funding, how can U.S. Congress bring up the fearsome alternative of austerity, cutting out an already-slashed health care budget? Federal short-term funds will not fix the health care structural problems, and reducing the health care budget will profoundly worsen the health care crisis. Rationing transforms the health care upstream, as it particularly compromises the health regulatory, institutional, and economic upstream determinants. Therefore, austerity slashes not only health care points of delivery, but public health care coverage policies, and produces a violation of vulnerable patients’ rights.

Rationing is not only a response to a monetary issue and, hence, cannot be resolved just by prices (or by budgetary limitations). One of the world’s most commonly accepted means of rationing is the one that occurred during World War II; one of the most significant U.S. rationing experiences, and of great importance for policy. During World War II, there was neither a shortage of money nor a problem of an ability to pay, rather a problem of consumption. Still, having money to spend, there were not enough products to consume, such as sugar, meat, and gasoline. Rationing was “\textit{a national judgment that goods should be distributed according to multipliers}\textsuperscript{74} (last visit, March 8, 2017).

\textsuperscript{71} The Kaiser Family Foundation (KFF) has a full description of the formulas used to determine U.S. federal reimbursement in different states.

\textsuperscript{72} Estimation according to Medicaid and CHIP Payment and Access Commission, based on 2016 medicaid annual income for Puerto Ricans was $20,028 while in Mississippi—the poorest U.S. state—it was $41,754 and across the U.S. is $57,617.

\textsuperscript{73} Supra note 11.
collective standards of priority and fairness, rather than solely according to ability to pay.”74

Rationing was linked with equity, and the goal of distributing commodities equitably and according to need.

Rationing by need is an example of good rationing. One way of evaluating whether or not rationing is appropriate is in light of the facts of service availability. If scarce medical resources were allocated following clinical guidelines or medical practice parameters, assuming their fairness, then micro-allocational rules would result in rationing without pain.

B. Medical Resource Allocation

The United States spends more per capita on health care annually than any other country in the world, yet not all of its citizens have access to health care.75 A significant part of misspent medical care funds could have been used otherwise to reduce taxes, spend on social services, recalibrate the balance between health and social spending,76 or lower government expenditure. The government wants to expand coverage, but also to control costs. It faces the challenge of making access to affordable health care a reality; however, there is no real interest nor a strategy in cost containment of wasteful care as an end in itself.77 A misleading dilemma “cost versus care” underlies allocation rulemaking: either to accept high and rising medical care costs, or eventually ration them.

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75 The United States spends $8,713 per capita on health care annually. Norway had the second-highest health care budget, with expenditures at $5,699 per capita. This information comes from data released by the Organization for Economic Co-operation and Development (OECD) in “Health at a Glance 2015”.
76 Id., 48.
77 Theodore R. Marmor, Understanding Health Care Reform, 110.
The U.S. health care system is based on a fee-for-service payment model, where doctors have an incentive to maximize activity as they maximize their profits and incomes. This payment model was also imposed on the Puerto Rican health care system with *La Reforma*, by implementing “capitated primary care”. Every patient is assigned a primary care physician, who in turn receives a monthly payment (capitation) for each patient he or she manages. The goal of the capitated plan was to involve physicians in the preventive care of their patients and incentivize them to spend more time managing their patient population. However, every time the primary care physician referred patients to specialists or prescribed medication, there was money deducted from the capitation. Predictably, physicians preferred not doing referrals—meaning undertreatment or no treatment at all. The fewer the referrals and prescriptions, the higher the monthly fees were for physicians.\(^7^8\)

The U.S. fee-for-service model poses unnoticed, additional threats to the U.S. territories’ health care systems. The mainland model does not make physicians aware of wasteful care practices (inefficient, unnecessary medical services) nor the high probabilities of the denial of health care to individuals. For example, driven by a desire to increase their incomes, physicians could become “doctor-heroes” by performing heroic medical practices (v.g. services that would otherwise have been referred to a specialized medical professional). Ultimately, “doctor-heroes” frustrate treatments and disease prevention by undertreating. As a result, the still-in-place capitated payment model creates bad incentives—not to say greedy doctors—and painful rationing.

The Constitutional Territory Clause is not the only cause of disparities between Puerto Rico and other U.S. territories. The incentives allocated in a fee-for-service payment model worsen and contribute to the existing disparities in access to health care, and turn rationing

\(^7^8\) Mulligan, *supra* note 6, 54.
policies into painful rules. Limiting fiscal budgets and continuing to stand by while Puerto Rico increases its debt (as it has, over the past ten years) to fulfill health care needs, among others, will not do the Puerto Rican health care system any good. If 15 to 25% of what the U.S. spends now on medical care could be spent more efficiently, or not spent at all, then it would seem wrong to say that the health care system faces the dilemma “cost versus care” of reducing the quality of medical care or controlling its cost.

Under current conditions of non-universal health care, I will explore how the system can achieve a less painful rationing decision-making and appropriate resource allocation choices. To elaborate on some alternatives, I will address the dynamics, standards, and subjects for medical resource allocation.

**Who: Government or Market-Allocation?**

The U.S. rationing method has traditionally been handled through the market.\(^79\) Having a non-universal health care system is a way of rationing medicine: only those who pay for health care—either directly, by purchasing private health insurance, or indirectly, having employment health insurance—receive it. Robert Blank asserts, however, that rationing through the market brings “inequitable, haphazard” results, instead of a “comprehensive and fair [health care] system.”\(^80\) In an already unequal system—where not everyone has access to health care and having access to it is a privilege for those who can financially afford it—it could be seen that any additional rationing will bring forth more inequality. However, if health allocation policy objectives assert equity, thenrationing through market allocation should not necessarily draw additional disparities.

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\(^{80}\) Id., 80.
Equality will be achieved if health policies include both macro decisions, those concerning the total resources devoted to health care, and micro decisions, those concerning which individuals receive a specific medical service when the allocation of resources is insufficient to cover all necessary treatment of the same kind, at the same time. Equity-based decisions mean, for example, placing priority on “an equitable base of primary care for all citizens” before running an ambitious medical high-technology plan\textsuperscript{81}, or implementing a national medical savings account system with salary contributions covering a population with a meager unemployment rate. Singapore developed a health insurance system similar to the savings account system, in which public hospitals compete for patients benefiting from Medisave health insurance, which covers over 85% of the population. Patients, through the market, are rationing medical resources: their health care savings.

\textit{What: Standards Allocation}

Regardless of who establishes the resource allocation policy, either the government or the market, allocation standards apply. These standards determine what micro-allocational rules work and make scientific sense. Standards can be mostly professional (for example, what physicians consider is appropriate care service) or set by medical professional organizations.

Back in 1984, Aaron and Schwartz sparked off a debate on the application of rationing health care.\textsuperscript{82} Based on the U.K. National Health Service, they argued that care is valued and weighed against its costs—a cost-benefit analysis—and, hence, provision of care should be decided not merely by a beneficial judgment or medical standards, but by whether or not its benefits are higher than its costs. This statement is a misleading interpretation of rationing. It

\textsuperscript{81} Id., 124.
does not take the element of *equity* into account, which would have cared for and prioritized a just distribution and equal access to health care. Otherwise, a good medical practice would have been to deny service to patients because it would have been too costly. Therefore, the cost-benefit allocation tool hits on doctors who want to be both a fair allocator of limited health resources and a loyal advocate of their patients’ best interests.

*Painful rationing* is reducing the volume of services and denying health insurance reimbursement. It is a process of making choices based upon economic decision rules, such as cost-benefit analysis\(^{83}\) or risk stratification\(^{84}\). *Painless rationing*, in contrast, is eliminating wasteful care. Many medical treatments end up being considered wasteful care either because they are ineffective, medically unnecessary or positively harmful, ethically troubling, not cost-effective, or of uncertain effectiveness.\(^ {85}\) A study carried out by the American Medical Association in 2011 estimated that potential sources of health care waste totaled between 21 percent and 47 percent of total health expenditure that year.\(^ {86}\) These numbers are startling, taking into account that the U.S. health care expenditure, estimated by the National Health Expenditure Accounts (NHEA), was US$3.2 trillion in 2015, and that it was estimated to grow 4.9% in 2018.\(^ {87}\) The potential sources of wasteful spending include outright, but also non-outright criminal wasteful practices: pricing failure, misguided or inefficient government rules, health care delivery failures, over-treatment, health care coordination failures. Hence, substantial wasteful care exists that is not being observed or measured by the U.S. Department of Justice because it does not fall under fraud regulations.

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\(^{85}\) Marmor, *supra* note 77, 86-107.

\(^{86}\) Other potential sources of waste are failures on care delivery, failures of care coordination, over-treatment, administrative complexity, and pricing failures. The sum of the lowest available estimates of cost of waste for all these categories, including fraud and abuse, exceeds 20 percent of total health care expenditures (for all payers of private and public health programs). See Berwick and Hackbart, “Eliminating Waste,” 1514.

**Whom: Allocation Coverage**

Allocation coverage determines who receives care and who does not in a resource allocation choice scenario. Based on which merits do health policy officials select patients for medical treatments from a pool of eligible patients?

In 1989, the state of Oregon passed a bill—the “Brave Medical Experiment”\(^{88}\)—creating a subset of Medicaid’s beneficiaries with a new basic benefit package that excluded services deemed insufficiently cost-effective. The Oregon plan intended to provide all of its poor population the same health care benefits, instead of perpetuating the inequities that Medicaid eligibility criteria brought about between the insured and uninsured poor. The plan addressed the dilemma of health rationing: *whom* and *what*. While some observers consider rationing a (inevitable) set of arrangements that allocate costs and benefits in a society—social allocation, others understand it as reordering an existing allocation and making it more “rational” based on equity principles. But, another way of rationing is deliberately withholding goods or services from certain groups of the population on the grounds that the greater population cannot afford them due to emerging forces, like rising costs, technological innovation or consumer demands. The Oregon bill represents a rationing plan of this last type, based on the social and equity principles of the former ones.\(^{89}\) Medicaid “recipients are mostly unorganized [and] politically unsophisticated” and the program “tends to be a less salient source of revenue than is Medicare for most providers”.\(^{90}\) Both features make Medicaid a more attractive target for rationing, which

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\(^{89}\) Ibid., 30.

\(^{90}\) Ibid., 32.
is why many U.S. states fought severely against the ACA’s provision for expansion of Medicaid’s benefits.

In the case of Puerto Rico, allocation coverage pulls us back on a broader issue: rationing is treating some groups differently and denying equal protection. Treating equals differently negatively affects the quality of medical services. Treatment of breast cancer in U.S. territories and the continental U.S. is an example. A study run by a team of scholars at Yale School of Medicine compares female Medicare beneficiaries who were residents of U.S. territories and had surgical treatment for breast cancer between 2008-14 to those in the continental U.S., in terms of receipt of recommended breast cancer care and the timeliness of that care. The study found that territory residents were less likely to receive both biopsy and radiation therapy following breast-conserving surgery, and experienced significant delays in both surgical and radiation treatments. The study concluded that residence in a territory is associated with worse overall health care quality. The drivers of the disparities in breast cancer care were not solely geographic isolation (the study compares Hawaiian and Puerto Rican residents, who, although, living in a similar geographical territory, have markedly different socioeconomic status and available health care infrastructure, not showing significant disparities between Hawaiian residents and those of the continental U.S.), but the availability of treatment facilities and primary care providers.

Should Puerto Ricans continue to be treated differently than U.S. citizens when it comes to health care? Puerto Rico is different from the continental U.S. in many ways, but those differences were not taken into account constructively when the U.S. health care model was transplanted to Puerto Rico. As a result, the Puerto Rican health care system, as it is drafted now, places multiple disparities in the access to health care and quality of services between the U.S. and Puerto Rico.

CONCLUSION

Puerto Rico’s colonial relationship to the United States profoundly shapes the financing and delivery of health care in the island. The Puerto Rican health care system mirrors key federal health care delivery and financing policies, although its demographics, social conditions and economic situation show a population with different health care demands. Puerto Ricans struggle to access health care.

The U.S. Congress enlarges the already notorious differences between the island and the mainland. Fiscal and health challenges have been exacerbated over the years by differential treatment across many federal programs; however, the capped financing and limited federal match rate for Medicaid—the most popular public health insurance program, used by two thirds of the Puerto Rican population—stand out as critical contributors to both the fiscal crisis and a struggling health care system. In addition, the incentives allocated in a fee-for-service payment model worsen and contribute to the existing disparities in access to health care, and turn rationing rules into painful policies.

The U.S. Congress, where none of Puerto Rico’s representatives have the right to vote, decides the island’s health care spending. Recently, it has decided to reduce the federal health care budget based upon the Puerto Rican debt crisis. In turn, the Puerto Rican government tries to cover health care spending gaps with local income taxes; however, the island continues to have fewer tax contributors, as residents migrate to the mainland, a large group of the population is state-employed, and almost half of the population is poor. Limiting fiscal budgets and continuing to stand by while Puerto Rico increases its debt (as it has, over the past ten years) to fulfill health care needs, among others, will not do the Puerto Rican health care system any good.
Short-term financing tools in place to address “emergency” damages will not solve the underlying fiscal issues tied to the debt-burden that will be needed for longer-term stability, nor will it overcome the federal health spending shortages. Legislation to change the cap and match rate is needed to face longer-term issues. Improving economic balance is essential for efforts to stem the flow of out-migration and incentivize working people to remain or return to Puerto Rico. Recognizing that the island is different from the mainland and that the federal government has an affirmative obligation to remedy disparities, is mandatory.