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Submitted electronically via www.regulations.gov.

March 7, 2017

Patrick Conway, MD
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS 9929-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Patient Protection and Affordable Care Act; Market Stabilization Proposed Rule (CMS-9929-P)

Dear Acting Administrator Conway:

The Association of American Medical Colleges (the AAMC or Association) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's or Agency's) proposed rule entitled, "Patient Protection and Affordable Care Act; Market Stabilization," 82 *Fed. Reg.* 10980 (February 17, 2017).

The Association of American Medical Colleges is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 147 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 160,000 faculty members, 83,000 medical students, and 115,000 resident physicians. Together, these institutions and individuals are the American academic medicine community.

The AAMC appreciates CMS's efforts to improve the availability of affordable health insurance coverage in the individual and small group markets. We agree that consumers must have access to high-quality, high-value healthcare providers, and addressing ways to make health insurance more affordable is one way to achieve this goal. However, the AAMC is concerned that the proposed changes aimed at strengthening the individual market – specifically, relaxing the regulations surrounding network adequacy and essential community providers for qualified health plans (QHPs) – may actually limit consumer choice and restrict access to providers and, in addition, leave providers who treat these patients either underpaid or not paid at all.

CMS Should Play a Key Role in Ensuring that All States Provide Network Adequacy

Beginning with the 2018 plan year, CMS proposes to change its approach to monitoring the network adequacy of plans seeking certification as QHPs. CMS proposes to rely on state reviews for network adequacy in states in which a federally facilitated exchange is operating and where the state has a sufficient network adequacy review process. CMS states it will require QHPs to maintain the "reasonable access standard" [1] for network adequacy, by relying on states with "the authority and means to assess issuer network adequacy" to determine whether or not a network meets the criteria for adequacy. For those states without the ability to conduct network adequacy reviews, CMS will rely "on an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity."[2] These proposed changes would supersede the time and distance criteria currently required for QHP certification.[3]

In an effort to lower costs, insurers are eliminating currently offered QHPs that have robust networks of doctors and hospitals and are replacing them with plans with narrow provider networks that limit patients to a select number of providers and decrease access to hospitals that provide specialized care. However, consumers enrolled in commercial insurance offered by their employers tend to continue to have access to plans with robust networks of doctors and hospitals. Limiting provider choice can be particularly detrimental for certain patient groups that already suffer from disproportionate levels of disease and death. In order to make inroads on improving the health and well-being of individuals, meaningful partnerships with local communities are paramount. That includes providing access to high-quality care for patients by ensuring that robust provider networks are offered by issuers in the individual and small group marketplaces. The AAMC is concerned that allowing states to determine the standards for QHP network adequacy as proposed has the potential to exclude teaching hospitals and faculty physicians from exchange plans. This exclusion would be based on these providers being deemed "high cost," without accounting for the value added by the other missions and societal benefits academic medical centers provide.

While representing just 5 percent of the nation's hospitals, America's teaching hospitals provide 35 percent of total hospital charity care in this country. Many of these institutions are safety net providers that care for vulnerable, underserved populations who often cannot seek treatment elsewhere. They are also the hospitals that maintain the vast majority of the country's critical standby units, including trauma centers, burn units, and neonatal and pediatric ICUs, that provide cutting edge treatments to medically complex patients. Compared to other hospitals, major teaching hospitals care for patients that are sicker, poorer, and more likely to be disabled. Teaching hospitals are committed to missions of providing critical services, serving vulnerable populations and educating the next generation of physicians. However, these missions carry heavy expenses that are often under reimbursed by payers with these costs being absorbed by the hospitals themselves.

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[1] 45 CFR 156.230(a)(2)
[2] 82 Fed. Reg. 32 (February 17, 2017)
[3] 2018 Letter to Issuers in the Federally-facilitated Marketplaces (December 16, 2016)

We strongly recommend that CMS continue to include the criteria for time and distance when determining whether an issuer is meeting the network adequacy requirements. Continuity of care is of particular importance in rural areas that struggle with physician shortages and is often compromised due to the lack of accessible providers. Compounding this problem, is the distance patients must travel in order to seek care from specialists who are usually located at academic medical centers. Allowing insurers to exclude from their networks physicians and institutions solely on the basis that the valuable care they provide is perceived as too costly will only exacerbate the problems of access and lack of care continuity.

The AAMC believes that it is essential that QHP network standards do not undermine the goal of exchanges by allowing networks to be constructed in a manner that discourages access, and thus enrollment, of those with unique or high cost conditions, as a means to lower premiums. Failing to ensure network adequacy often means that major teaching hospitals are excluded from the networks of QHPs due to cost. While excluding a "high-cost" hospital from an issuer's network can work in favor of the issuer, it puts vulnerable patients who may rely on services that only are available at certain hospitals at risk of not receiving the care that is needed.

CMS Should Not Reduce the Standard for Demonstrating a Sufficient Number and Geographic Distribution of Essential Community Providers

CMS is proposing that QHP issuers will be able to satisfy the regulatory standard for certification and recertification for the 2018 plan year if the issuer contracts with "at least 20 percent of available essential community providers (ECPs) in each plan's service area to participate in the plan's provider network."[4] In CMS' view, this decrease from the current 30 percent ECP requirement necessary for certification is expected to "substantially lessen" the regulatory burden on issuers. Moreover, CMS states there will be cost savings as a result of loosening issuer requirements for network size. The AAMC urges CMS to keep the current 30 percent ECP requirement in order to ensure that patients have sufficient access to providers in their communities. While lessening regulatory burden is a laudatory goal, it should not come at the expense of patients seeking care who will experience increased travel and wait times as a result of the decrease in available providers.

The AAMC remains concerned that this reduction in required ECPs will negatively impact vulnerable populations that rely on academic medical centers for their care. Major teaching hospitals and physician faculty practices serve a disproportionately large volume of underserved, low-income individuals, provide access to essential health services for disadvantaged groups, and are often the last resort for treatment for many. Academic medical centers serve as the backbone of many communities' health care infrastructure. However, in past years, QHP plan issuers have been allowed to exclude these institutions from their networks putting pressure on

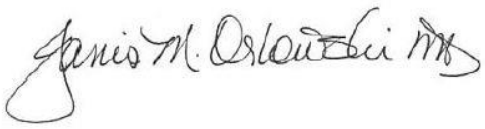
[4] 82 Fed. Reg. 10990-10991

patients to sever ties with providers with whom they have established doctor-patient relationships or incur financially burdensome cost sharing in order to maintain continuity of care.

Conclusion

Thank you for the opportunity to present our views. We would be happy to work with CMS on any of the issues discussed above or other topics that involve the academic health center community. If you have questions regarding our comments, please feel free to contact Mary Mullaney at 202.909.2084 or mmullaney@aamc.org.

Sincerely,



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Chief, Health Care Officer, AAMC

cc: Ivy Baer, J.D., M.P.H, AAMC
Mary Mullaney, M.P.H., AMMC