



**Association of
American Medical Colleges**
655 K Street, NW, Suite 100, Washington, DC 20001-2399
T 202 828 0400
aamc.org

December 21, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-1850
RE: CMS-9936-NC

Submitted at www.regulations.gov

Dear Administrator Verma:

The Association of American Medical Colleges (AAMC of “the Association”) welcomes the opportunity to comment on guidance, State Relief and Empowerment Waivers, 83 Fed Reg, 53575 (October 24, 2018). Although the Federal Register notice provides for a 60-day comment period, it also indicates that the guidance is applicable beginning October 22, 2018. The AAMC supports the development of new waiver concepts and appreciates that CMS is trying to provide states with flexibility. **For the reasons described below, the AAMC strongly urges CMS to consider all comments submitted and to revise and re-issue the guidance to address suggestions concerns raised by stakeholders.**

The AAMC 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 are all 152 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 more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

Our member institutions, and the physicians, residents, students and other health care professionals who work there are committed to serving the health care needs of vulnerable populations. Although members of the AAMC’s Council of Teaching Hospitals and Health systems are just 5% of all US nonfederal short term general hospitals, they provide 31% of all charity care, and have 25% of all Medicaid hospitalizations.

Overview of Section 1332 Waivers

Section 1332 of the Affordable Care Act (ACA) authorizes the Departments of Health and Human Services and Treasury to waive certain ACA provisions for states that want to offer alternative approaches to offering coverage in the individual and small group health insurance markets. All waivers must comply with certain “guardrails” that are specified in the statute.¹ If the waiver is granted and the state reduces the amount that the federal government must spend on premium tax credits, then the savings

¹ 42 U.S.C. § 18001 (2010)

are passed through to the state to fund its waiver program. By statute, the waivers must meet four guardrails:

- Coverage must be at least as comprehensive as the coverage offered through Exchanges;
- There must be coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the required under the ACA;
- Coverage must be provided to at least a comparable number of residents as those who would have been covered under the ACA; *and* (emphasis added)
- The waiver must not increase the federal deficit.

Section 1332 waivers also must be authorized by state legislation.

Impact of Changes to the Guidance

The October 2018 guidance makes significant changes to the waiver requirements by substantially reinterpreting the guardrails. CMS characterizes these changes as a way to increase state flexibility. However, the 2015 guidance did not prevent states from obtaining 1332 waivers; eight states received waivers, the majority for state-based reinsurance programs.

CMS states that “the new guidance maintains the same strong-protections for people with pre-existing conditions as the law currently provides absent a 1332 waiver. To be clear, the waiver concepts presented here do not open any flexibility for states to undermine these protections.”² The AAMC strongly disagrees. The guidance makes substantial changes to the guardrails which we believe will leave many Americans with less comprehensive coverage, including loss of coverage for pre-existing conditions, than is provided by the ACA. The AAMC strongly believes that Americans should be afforded health care that meets the requirements of the ACA, including the availability of minimum essential health benefits and protection against being denied insurance, or having insurance underwritten, because of pre-existing conditions. This guidance does not meet these requirements.

Under the guidance, the comprehensiveness and affordability guardrails will be evaluated together. The test as to whether coverage is comprehensive and affordable will be that the coverage is “*available* to a comparable number of otherwise qualified residents as would have had such coverage available absent the waiver.” (p. 53578; emphasis added). The focus of comprehensiveness and affordability of coverage will be on the type of coverage that is made available to residents, not on the coverage that residents actually have, so that as long as a state has some policies in the marketplace that are comparable to what is required by the ACA the test will be met, even if fewer people are covered by such policies. The guidance also will allow Association Health Plans (AHPs) and Short-Term Limited Duration Insurance Plans (STLDIs) to be considered as insurance plans, although these plans do not provide minimum essential health benefits and are able to exclude individuals with pre-existing conditions, or to use underwriting. The effect of these change is that states will no longer need to ensure that coverage qualifies as “minimum essential coverage” as defined by the ACA but may have waivers approved provided that they provide some access to comprehensive and affordable coverage, even if fewer people actually have such coverage. Ensuring that coverage includes the minimum essential benefits protects individuals from unexpected gaps in coverage for standard or catastrophic medical events and should be considered as the minimal acceptable insurance.

² Section 1332 State Relief and Empowerment Waiver Concepts, Discussion Paper, page 5, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF>

To determine if the coverage is provided to at least a comparable number of residents as those who would have been covered under the ACA CMS will do an assessment in aggregate over all populations. No longer will an assessment of the waiver effects on vulnerable populations be required. The assessment also will be done over the entire term of the waiver, rather than on a year-by-year basis.

The guidance also relaxes the requirement that states must either enact a law or revise an existing law to implement the waiver. Instead, states will be able to use existing legislation that provides statutory authority to implement or enforce ACA provisions and can be combined with state regulation or executive order.

The requirement that the waiver not increase the federal deficit is not changed substantially.

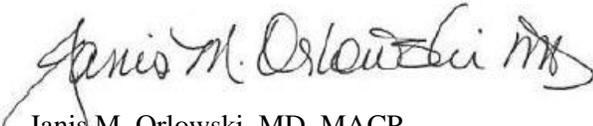
The AAMC believes that the 2015 guidance more accurately reflects the intent of 1332 waivers and that CMS should revise the 2018 guidance to more closely resemble the earlier guidance.

Conclusion

When individuals have less coverage, they may find that preventive care is no longer part of their insurance plan, and thus not receive that care. After an accident or unexpected major illness, they may find that their medical expenses are not covered by their insurance. Vulnerable populations may find less coverage or higher out-of-pocket costs. This will mean that when these individuals seek care the teaching hospitals and physicians who treat them will likely receive less payment, and in many instances there may be no payment for the services, thus placing further financial strains on these institutions. The waivers allowed by section 1332 of the Affordable Care Act sought to avoid such dire consequences while allowing states an opportunity to innovate. The new guidance does not comport with the requirements of the statute. **Therefore, the AAMC urges CMS to not proceed with the changes in this guidance.**

If you have questions or need additional information please contact Ivy Baer, Senior Director, ibaer@aamc.org or 202-828-0499.

Sincerely,



Janis M. Orlowski, MD, MACP
Chief, Health Care Affairs

Cc: Ivy Baer, AAMC