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Via Electronic Submission (www.regulations.gov)

June 3, 2013

Secretary Jacob J. Lew
Department of the Treasury
Internal Revenue Service
111 Constitution Avenue, NW
Washington, DC 20224

Re: Health Insurance Providers Fee, Notice of Proposed Rulemaking (IRS REG-118315-12)

Dear Secretary Lew:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the Internal Revenue Service's proposed rule to implement Section 9010 of the Patient Protection and Affordable Care Act (ACA), which imposes an annual Health Insurance Providers Fee on certain entities engaged in the business of providing health insurance for U.S. health risks. The AAMC represents all 141 accredited U.S. medical schools, nearly 400 major teaching hospitals and health systems, and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 82,000 medical students, and 110,000 resident physicians who deliver over one-fifth of all clinical care in the nation.

The AAMC recognizes the extraordinary efforts and coordination needed to implement the ACA's health insurance marketplace reform provisions. As the IRS implements the Health Insurance Providers Fee, AAMC encourages the Agency to carefully consider the long-term policy implications associated with reshaping the insurance market, and particularly the impact on graduate medical education (GME). AAMC will also comment on how educational institutions that provide students with access to health insurance should be treated under the rule.

Teaching hospitals are responsible for training the health care professionals necessary to meet our society's workforce needs. The Medicare program provides explicit support for GME through direct graduate medical education (DGME) payments, which compensate for a portion (the "Medicare share") of the direct costs of training residents, such as residents' stipends and benefits, teaching physicians' salaries, other direct costs, and related overhead expenses.

Medicare DGME payments currently total approximately \$3.2 billion. To assure continued Medicare beneficiary access to physician services, the AAMC strongly urges that this vital funding be preserved at a level consistent with its Congressionally mandated obligation.¹ The AAMC also encourages the agencies responsible for ACA implementation to consider how other payers might also contribute to the financing of GME.

ACA Section 9010 establishes aggregate amounts of revenue that are to be raised each year from certain covered entities.

The proposed rule explains how the fee would be calculated for each covered entity:²

- Covered entities (health insurance issuers except for self-insured employers, governmental entities and nonprofits) will have to report aggregate net premiums to the IRS.
- The IRS will make a preliminary calculation of the fee owed based on these reports and other sources of data that issuers are required to file.
- Then, the IRS will determine for each covered entity the ratio of 1) the net premiums written by the entity during the data year for health insurance for any U.S. health risk to 2) the aggregate net premiums for all covered entities for the data year.
- That ratio is multiplied by the applicable amount for the year, which is \$8 billion in 2014, \$11.3 billion in 2015-2016, \$13.9 billion for 2017, \$14.3 billion for 2018, and for 2019, and in subsequent years it is equal to the amount in the preceding year increased by the rate of premium growth for the preceding year.

Teaching hospitals play a unique and critical role as providers of highly specialized tertiary care and other special services/expertise often unavailable elsewhere in the community, while bearing the responsibility for training the next generation of physicians and other providers. As the ACA's marketplace reforms are implemented and the number of Americans with health insurance expands, it is critical that the nation also explores ways to expand support for GME. Only by expanding (and not reducing) GME support can we assure that the pipeline of providers keeps pace with growing coverage levels.

One way to do so is to set-aside a guaranteed level of funding from the proposed health insurance Providers Fee as an additional source for GME. Alternatively, the amount issuers compensate for GME through the rates they negotiate with hospitals could be subtracted from their aggregate income, which is used to determine the Providers Fee. AAMC would welcome

¹ When Medicare was established in 1965, Congress recognized that: "Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and others costs) should be born to an appropriate extent by the hospital insurance program." (House Report, Number 213, 89th Congress, 1st session 32 (1965) and Senate Report, Number 404 Pt. 1 89th Congress 1 Session 36 (1965)).

² *Health Insurance Providers Fee*, 78 Fed. Reg. 14034, 14035-14036 (Mar. 4, 2013).

the opportunity to work with the IRS during this implementation process to further develop incentives for insurance issuers to help cover the cost of training new doctors.

A precedent for this can be found in CMS' proposal that the federally facilitated exchange (FFE) user fee could be adjusted to reflect the cost of stand-alone contraceptive coverage provided to employees of religious nonprofits that object to contraceptive coverage and have self-insured group plans. Under the proposed approach Qualified Health Plan (QHP) issuers would be authorized to provide a stand-alone policy for free to employees and CMS would compensate such issuers by reducing their FFE user fees.³ The justification for this proposal to adjust user fees in this context was based on the contribution the health insurance issuer would be making to the ACA's goal of expanding access to affordable coverage, while furthering the governmental interests in promoting public health and protecting the ability of religious organizations to adhere to their beliefs.

Similarly, we believe there is a strong justification for the IRS to direct a stable and predictable portion of the Providers Fee to expand the support for physician training necessary to provide adequate access to care. This adjustment would facilitate expanded access in much the same way that the stand-alone contraceptive proposal would support important policy goals. At a time of looming physician shortages, it is important that the federal government consider how GME funding might be enhanced as the ACA's marketplace reforms go into effect and Exchanges become operational.

Educational Institutions and Student Health Insurance

AAMC appreciates that the IRS noted that educational institutions that provide students with access to health insurance would not be considered covered entities when they use premiums received from students to purchase health insurance from a separate unrelated issuer.⁴ The Association agrees with the IRS that in this context, the issuer is the covered entity, and that there are no circumstances under which this would not be the case. Given that self-insured employers are excluded from the definition of covered entity to the extent they self-insure their employees' health risks, even if a self-insured student health plan existed, it should similarly be excluded from the definition of covered entity. AAMC strongly believes the final rule should include the clarification that educational institutions are not covered entities for purposes of section 9010, thus allowing institutions of higher education to continue to purchase plans to serve the needs of their students.

Student Administrative Health Fee Arrangements

The Association also agrees with the IRS that if educational institutions periodically charge student administrative health fees to help cover the cost of student health clinical operations and care delivery, these arrangements do not constitute health insurance for purposes of section 9010. The Agency explains the differences well in the proposed rule by noting that these "arrangements are different from premiums and cost-sharing for group health plans and health

³ Coverage of Certain Preventive Services under the Affordable Care Act, 78 Fed. Reg. 8456, 8463 (Feb. 6, 2013).

⁴ 78 Fed. Reg. at 14037.

insurance coverage because all students pay the fee regardless of whether they have student health insurance.”⁵ AAMC encourages the IRS to include language making this distinction in the final rule.

Conclusion

The AAMC is very supportive of the IRS’ efforts to address the complex task of implementing the ACA’s health insurance market reforms. The Association is also well aware that it requires extensive coordination with the states, health insurance exchanges and private health plans to make new coverage options available in 2014. AAMC’s comments and proposals will ensure that health insurance issuers do not sacrifice their contribution to compensation for graduate medical education for the sake of initially providing lower premiums. Health insurance issuers should be incentivized to support graduate medical education as the insurance marketplace reforms take effect. AAMC would welcome the opportunity to work with the IRS to ensure that we can train the next generation of physicians to meet the country’s health care needs while continuing to provide critical health care services to all Americans.

The AAMC appreciates this opportunity to provide comments on this proposed rule. If you have questions, please contact me at ibaer@aamc.org or Senior Policy and Regulatory Specialist, Allison Cohen at acohen@aamc.org. We both can be reached at (202) 828-0490.

Sincerely,

/s/

Ivy Baer, J.D., M.P.H.
Senior Director and Regulatory Counsel
Health Care Affairs

cc: Allison Cohen, AAMC

⁵ 78 Fed. Reg. at 14038.