Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of	)	
	)	
Promoting Telehealth in Rural America	)	WC Docket No. 17-310

REPLY COMMENTS OF GENERAL COMMUNICATION, INC.

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SUMMARY

The comments submitted in response to the Federal Communications Commission's ("FCC" or "Commission") Notice of Proposed Rulemaking to reform the Rural Healthcare Program ("RHC Program") overwhelmingly support an update of the $400 million annual program cap to reflect not just inflation, but also increased demand for telehealth services. Telehealth is essential to the delivery of health care in rural America.

With respect to rules governing support calculations in the Telecom Program, the Commission should update its rules to reflect its light-touch approach to Ethernet rates. As with Ethernet broadband data services more generally, prices for broadband service under the Telecom Program should be determined by the market, not by cost-based rate-setting or funding caps. The cap on terrestrial Ethernet rates proposed by Alaska Communications ("ACS"), based on satellite service rates, is premised on flawed assumptions and, moreover, is unnecessary in light of the existing cost-effectiveness requirement.

In addition, the Commission should balance its concerns regarding healthcare providers' purchasing discipline with their lack of financial resources—especially for providers funded through the Indian Health Service—in two ways: first, by adopting GCI's proposal for a modest and limited increase in healthcare providers' contributions; and second, by moving to a system of equal dollar reductions where necessary to meet the budgetary cap.

Finally, the Commission should prioritize funding for healthcare providers based on the rurality of the area they serve, rather than on the economic need of their patients. A benchmark system, by which "outlier" proposals are subjected to enhanced review or capped outright, would be both unfair and statutorily impermissible. The Telecom Program is not only vital to the provision of healthcare in rural areas—it is also mandated by statute. The Commission should

do everything possible to ensure that the program successfully and effectively helps the people it was designed to serve.

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I. INTRODUCTION

On behalf of itself and its affiliates, General Communication, Inc. ("GCI") submits this reply in response to the comments filed regarding the Federal Communications Commission's ("FCC" or "Commission") Notice of Proposed Rulemaking regarding the Rural Healthcare Program ("RHC Program").[1] Commenters—including GCI—agree that the RHC Program, and especially the Telecom Program, is vitally important to the provision of healthcare in rural areas.[2] Commenters also generally agree that the RHC Program cap should be raised, and many,

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[1] *Promoting Telehealth in Rural America*, Notice of Proposed Rulemaking and Order, FCC 17-164, 83 Fed. Reg. 303 (2018) ("Notice").

[2] *See, e.g.*, Comments of ADS Advanced Data Servs., Inc. at 1, WC Docket No. 17-310 (filed Feb. 2, 2018) ("ADS Comments") (noting that a funding shortfall is "disastrous" for healthcare providers); Comments of AK Child & Family at 1-2, WC Docket No. 17-310 (filed Feb. 2, 2018) ("AK Child & Family Comments") (describing the positive impact telehealth has had on its ability to provide necessary healthcare); Comments of Alaska Native Health Board at 4, WC Docket No.17-310 (filed Feb. 2, 2018) ("ANHB Comments") (stating that "connectivity is mission crucial to Alaska [Tribal Health Organizations] delivering health care to some of our country's most remote communities"); Comments of Alaska State Hospital & Nursing Home Ass'n at 1-2, WC Docket No. 17-310 (filed Feb. 2, 2018) ("ASHNHA Comments") (asserting that telemedicine "has allowed us to dramatically improve access to and quality of care, accelerate diagnosis and treatment, avoid unnecessary costs such as medivacs, and expand local treatment options"); Comments of Nat'l Rural Health Ass'n at 1-2, WC Docket No. 17-310 (filed Feb. 2, 2018) (stating that broadband is a necessary component of rural health care and that "[r]obust health IT systems are essential for narrowing the access gap in rural America"); Comments of NTCA – The Rural

including GCI, agree that the cap should be deliberately updated to reflect advances in telehealth technology and increased demand for bandwidth, and not just limited to an increase to account for inflation.[3] Across the board, there is a general consensus that the RHC Program performs an essential role in health care delivery for rural areas that lack the health care resources of urban areas, and, as such, warrants a budget increase going forward.

Beyond this broad agreement, however, several commenters espouse positions regarding rate regulation, healthcare providers' contributions, and prioritization of limited funds that would

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Broadband Ass'n at 2-5, WC Docket No. 17-310 (filed Feb. 2, 2018) (describing how telehealth "serve[s] critical healthcare needs in rural America"); Comments of Yukon-Kuskokwim Health Corp. at 1, WC Docket No. 17-310 (filed Feb. 2, 2018) (stating that, for its own patients, the telemedicine services made possible by the RHC Program "often make the difference between life and death").

Notably, one commenter not only disagrees but argues that the Telecom Program should be wholly eliminated. *See* Comments of Kellogg & Sovereign Consulting, LLC at 15, WC Docket No. 17-310 (filed Feb. 2, 2018) ("Kellogg Comments"). GCI addresses this contention *infra*.

[3] *See, e.g.*, ADS Comments at 1-2 (asserting that the cap should be raised to account for inflation as well as the increasing number of eligible beneficiaries and advances in technology); Comments of ADTRAN, Inc. at 3-4, WC Docket No. 17-310 (filed Feb. 2, 2018) (noting that the $400M cap "is a somewhat arbitrary number selected back in 1997 as a 'best guess' on needs" and that, in revising the cap, the Commission should consider advances in telehealth and telemedicine); AK Child & Family Comments at 1 (stating the cap should be increased to reflect inflation, technological advances, and increased demand due to HIPAA and changes in standards of care); ASHNHA Comments at 1 (asserting that the budget should be raised to reflect inflation, "increases in the level of support available" from the RHC Program, and "increased technology and telecommunications demands"); Comments of Nat'l Org. of State Offices of Rural Health at 2, WC Docket No. 17-310 (filed Feb. 2, 2018) (recommending an increase "that realistically reflects inflation, changes in technology and expansions of eligibility"); Comments of Schools, Health & Libraries Broadband Coal. at 4-6, WC Docket No. 17-310 (filed Feb. 2, 2018) ("SHLB Coalition Comments") (asserting that the cap should be increased due to "changes in health care delivery and technology," the "closure crisis for rural hospitals," the addition of Skilled Nursing Facilities to the list of eligible entities, and federal mandates on health providers).

undermine the Commission's current policy framework for Ethernet services and that are inequitable and at odds with the statute. GCI addresses each of these in turn.

II. THE COMMISSION SHOULD RELY ON THE MARKET TO SET REASONABLE RATES FOR RURAL HEALTHCARE PROVIDERS.

A. Capping Terrestrial Rates Based On Satellite Rates Is Irrational When Services Are Not Functionally Equivalent To the End User.

Alaska Communications ("ACS") asks the Commission to "exercise better oversight of the rates charged for middle-mile capability" in rural Alaska,[4] complaining that the current rules allow service providers to "overcharge for terrestrial middle-mile services."[5] To remedy this alleged problem, ACS urges the Commission to cap RHC Program funding at "the lower of the satellite rate or the terrestrial rate, if functionally equivalent services are available."[6]

In the first instance, ACS' proposed cap is a blunt tool that seeks to accomplish the same objective as the existing cost-effectiveness requirement, but in a cruder way that fails to account for all the relevant technological variables. The existing cost-effectiveness rule requires a healthcare provider to select the lowest-cost service only after considering all other aspects of each service, including their features, quality of transmission, and reliability.[7]

ACS' proposal treads the same ground by purporting to impose a cap only where the services offered by satellite and terrestrial technologies are functionally equivalent. Thus, to the

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4 Comments of Alaska Communications at 16, WC Docket No. 17-310 (filed Feb. 2, 2018) ("ACS Comments").

5 *Id.*

6 *Id.*

7 47 C.F.R. § 54.603(b)(4).

extent these services are functionally *different* from the user's perspective,[8] the proposed cap would not be applicable and would serve no purpose. Under well-established Commission precedent, services are functionally equivalent if they are "the same" for a healthcare provider's purposes, "with cost considerations being the sole determining criterion."[9] Thus, where a healthcare provider's defining requirements are such that either satellite or terrestrial service would suffice, the cost-effectiveness rule already requires the healthcare provider to select the service that costs less. The proposed cap would serve no additional purpose.

In addition to serving no new function, ACS' proposed cap fails because it erroneously assumes that a healthcare provider can be provisioned with identical quantities of satellite and terrestrial services, such that the total price should be the same. Even setting aside differences in service quality—which could render the services not functionally equivalent—a greater quantity of satellite service may be needed, for example, to provide back-up service that is necessary for an unprotected satellite, but would not be necessary for a ringed terrestrial service (which has its own inherent redundancy). In these cases, the terrestrial service can be more cost-effective, even with a higher price per megabit throughput.

ACS' proposal is further flawed because it treats satellite and terrestrial services the same with respect to all telehealth applications. This ignores physical reality. One limitation on current generation satellite service, particularly as it applies to many telehealth applications, is satellite service's high latency. Latency, "the time it takes for a signal to get from one place to

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8 *See Competitive Telecomms. Ass'n v. FCC*, 998 F.2d 1058, 1061 (D.C. Cir. 1993) (functional equivalence depends on customer perception); *MCI Telecomms. Corp. v. FCC*, 917 F.2d 30, 39 (D.C. Cir. 1990) (same).

9 *Competitive Telecomms. Ass'n*, 998 F.2d at 1061. The main inquiry in a functional equivalence determination is whether a customer views the services as performing the same functions. *Id.*; *see also MCI Telecomms. Corp.*, 917 F.2d at 39.

another," is often a problem with satellite service due to the orbital height of the satellites.[10] A high-latency satellite service and a low-latency terrestrial service are not necessarily functionally equivalent.

For the reasons discussed above, contrary to ACS' proposal, satellite rates cannot reasonably be used to limit the rates charged for a higher-quality terrestrial service. Importantly, however, if that higher-quality terrestrial service is priced at or below satellite rates, it can and should be deemed to be reasonable. This is essentially what the existing rule already accomplishes: terrestrial rates cap satellite rates, but not vice versa.

B. As the Commission Has Found, Rate Regulation of Ethernet Services Is Unnecessary and Threatens Rural Network Deployment.

In addition, any effort to impose rate regulation on rural broadband services, via price caps or otherwise, is misguided and inconsistent with the Commission's historic reliance on market pricing. As GCI noted in its initial Comments,[11] the Commission has entirely forborne regulation of rates for packet-based services, choosing instead to rely on the market.[12] In its *BDS Order*, the Commission concluded that, "even if the record demonstrated insufficiently robust competition, proposals to apply price cap regulation to packet-based services were complex and not easily administrable and did not reflect the fact that costs to serve individual customers vary."[13] In Alaska, moreover, there *is* a competitive market. The Requests For Proposal

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10 David Meyer, *Here's What You Need to Know About SpaceX's Satellite Broadband Plans*, FORTUNE, Feb. 22, 2018, http://fortune.com/2018/02/22/spacex-starlink-satellite-broadband.

11 *See* GCI Comments at 28-29.

12 *See Business Data Services in an Internet Protocol Environment, et al.*, Report and Order, FCC 17-43, 32 FCC Rcd. 3459, 3464 ¶ 7 n. 24, 3499 ¶ 87 (2017) ("BDS Order") (finding that "packet-based services are best not subjected to tariffing and price cap regulation, even in the absence of a nearby competitor").

13 *Id.* at 3499 ¶ 87.

("RFPs") issued by healthcare providers under the RHC Program often attract multiple bidders, including ACS, Leonardo DRS, AT&T, and GCI. Furthermore, new competitors—such as Quintillion (a terrestrial and undersea fiber provider) and various satellite providers, including SpaceX, OneWeb, Space Norway, and Telesat[14]—have recently, or will soon, enter the market. These new entrants have and will continue to supplement and enhance the competition that already exists.

The logic applied by the Commission to Ethernet rates in its *BDS Order* applies equally to rural rates for the same services. Regulating rates based on price caps or cost studies would ignore this logic and turn the Commission's expanding policy of deregulation on its head. There is no sound basis for the Commission to impose cost-based rate regulation on Ethernet services (much less impose a price cap-like structure on such services) when sold to healthcare providers, while allowing these rates to be naturally disciplined by the existing—and, in this case, competitive—market when sold to commercial customers.

In addition, as GCI noted in its initial Comments,[15] economics cannot not yield a single cost-based rate due to the problem of allocating common costs, which would be the overwhelming majority of network costs. Any attempt by the Commission to impose cost-based

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[14] Press Release, Federal Communications Commission, Chairman Pai Statement on SpaceX Satellite Broadband Application (Feb. 14, 2018), *available at* https://transition.fcc.gov/Daily_Releases/Daily_Business/2018/db0214/DOC-349224A1.pdf (announcing proposal to approve SpaceX's application and noting recent approved requests by OneWeb, Space Norway, and Telesat for large, non-geostationary satellite orbit, fixed-satellite service systems to expand broadband services in remote and rural areas.) Although current generation satellite service faces limitations that make functional equivalence with regard to many telehealth applications a challenge, the advent of next-generation satellite service, using satellites in *non*-geosynchronous orbits, may well assuage that disparity. It is also important to recognize that once these next generation satellites are launched, significant investment will have been irreversibly sunk.

[15] *See* GCI Comments at 32-36.

rate regulation would not only be inconsistent with the *BDS Order*, but would ultimately fail to yield economically-meaningful results and would risk suppressing rural network deployment. As the Commission has observed, when regulators set rates, there is a risk of error, and setting rates too low compromises network deployment.[16]

III. GCI'S PROPOSAL TO INCREASE HEALTHCARE PROVIDER PAYMENTS BALANCES THE COMMISSION'S AND HEALTHCARE PROVIDERS' CONCERNS.

The Alaska Native Health Board ("ANHB"), along with some of its members,[17] states that it "cannot support GCI's proposal to, in the event of a [budget] shortfall, require highly rural [healthcare providers] to pay a minimum amount that increases each year over five years."[18] Tribal healthcare providers in Alaska "cannot absorb these costs," it argues, "and do not need any extra incentive or 'skin in the game'" because they are "already working diligently to ensure efficient use of all program resources in order to maximize patient care."[19] Moreover, the ANHB argues, "the GCI proposal is not a modest increase in the costs paid by [healthcare providers]" and would "increase the costs for many rural [healthcare providers] in Alaska by 500% over 5 years, equivalent to paying 5 times the urban rate."[20]

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16 *See* BDS Order at 3462 ¶ 4-5, 3499-500 ¶ 87.

17 These members filed comments virtually identical to those filed by the ANHB. *See* Comments of Alaska Native Tribal Health Consortium, WC Docket No. 17-310 (filed Feb. 1, 2018); Comments of Council on Athabascan Tribal Gov'ts, WC Docket No. 17-310 (filed Feb. 1, 2018); Comments of Bristol Bay Area Health Corp., WC Docket No. 17-310 (filed Feb. 2, 2018); Comments of Maniilaq Ass'n, WC Docket No. 17-310 (filed Feb. 2, 2018); Comments of Norton Sound Health Corp., WC Docket No. 17-310 (filed Feb. 1, 2018). For the sake of simplicity, this Reply Comment will cite only to the comments filed by the ANHB.

18 ANHB Comments at 7.

19 *Id.*

20 *Id.*

GCI recognizes that rural healthcare providers, especially those funded by the Indian Health Service, cannot be expected simply to produce more funds in a short period. That is the fundamental flaw in the current pro rata reduction system, which has led to two years of successive waivers permitting carriers to waive Alaskan rural healthcare providers' payment of the shortfall amounts.[21] But those waivers are not a long-term solution. Accordingly, GCI has sought to develop a phased-in proposal that modestly increases the proportion of charges paid by the rural healthcare provider, but does so in a manner that permits budgetary planning with funding agencies.

GCI's proposal thus is a carefully balanced contribution to a more comprehensive solution to the RHC Program's monetary woes. The proposed increase to healthcare providers' payments is in direct response to the Commission's expressed concern that healthcare providers are not subject to sufficient purchasing discipline.[22] This proposal is designed to balance this concern with the financial reality faced by many rural healthcare providers. Under GCI's proposal, healthcare providers' contributions would initially be raised only to the greater of the urban rate or 1 percent of the rural rate. These contributions could theoretically increase to a maximum of 5 percent of the rural rate. Because of the included "circuit breaker" mechanism, however, any further increases to these minimum contributions would be suspended if the cap is not exceeded. Moreover, under this proposal, healthcare providers' contributions would increase

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[21] *See Rural Health Care Support Mechanism*, Order, FCC 17-84, 32 FCC Rcd. 5463, 5464-65 ¶¶ 5, 8 (2017) ("Alaska Waiver"); Notice at 37-38 ¶ 109.

[22] *See, e.g.*, Notice at 27-28 ¶ 83.

beyond 1 percent only if absolutely necessary to introduce further fiscal discipline.[23] Thus, if rural healthcare providers are already "working diligently to ensure efficient use of all program resources in order to maximize patient care,"[24] additional fiscal discipline will not be necessary, and healthcare providers' contributions should not be increased. GCI joins the ANHB and its member organizations in hoping that the RHC Program can be reformed and structured in a way that allows for full funding for all rural healthcare providers and eliminates the need for incremental increases to healthcare providers' contributions.

The Commission could also help alleviate ANHB's concerns by switching from the current system of equal percentage reductions to a system of equal dollar reductions—when reductions are necessary to meet the budgetary cap—as well as by adopting a system of funding priority. The application of the percentage reduction approach in the RHC Program is unique and leads to unduly harsh and burdensome impacts on the healthcare providers facing the most need. In the E-rate program, by contrast, the percentage reduction is not applied across the whole program, but only within a given priority tier. However, as GCI recommended in its initial Comments, a far better and more equitable approach would be, within a given priority level, to reduce all support by an equal dollar amount, as is done in the High Cost Loop Support Mechanism.[25] This avoids placing the greatest total dollar burden on the healthcare providers with the most need.

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[23] *See* GCI Comments at 45-46 (suggesting an incremental increase if necessary to introduce further fiscal discipline, but noting that the Commission should not pursue this path unless and until doing so becomes necessary).

[24] ANHB Comments at 7.

[25] GCI Comments at 41-42.

IV. THE COMMISSION SHOULD PRIORITIZE FUNDING BASED ON RURALITY RATHER THAN ECONOMIC NEED OR BENCHMARKS.

In its Notice, the Commission asked whether the RHC Program should "take into consideration the economic need of the population served by the healthcare provider when prioritizing disbursements."[26] As GCI explained in its initial Comments,[27] and as other commenters agree,[28] prioritization based on economic need is not appropriate in Alaska.

One consultant, however, suggests that the RHC Program prioritize funding using a combination of rurality and a "federal standardized measure of need, such as Medicaid."[29] A prioritization scheme based on Medicaid or federal welfare would not work for the same reason a prioritization scheme based on economic need generally would not work: in rural Alaska, wealth cannot buy healthcare. All rural Alaskan residents, regardless of their economic resources, rely heavily on telemedicine. Moreover, prioritizing RHC Program funding based on the number of

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[26] Notice at 14-15 ¶ 33.

[27] *See* GCI Comments at 49 ("When patients are located in remote areas accessible only by air, financial resources can only take them so far; even if a patient can pay for a medivac to Anchorage, an airlift will always be slower than a broadband connection. All residents of rural areas, regardless of income, are equally deserving of medical treatment. When the availability of quality healthcare turns on the availability of a telehealth communications network—as it does in rural Alaska—economic need is not an appropriate basis for disbursement prioritization.").

[28] *See, e.g.*, Comments of Alaska Primary Care Ass'n, WC Docket No. 17-310, at 2 (filed Feb. 2, 2018) (asserting that prioritization should be based on rurality and, only if a second factor is necessary, health professional shortages); SHLB Coalition Comments at 3 (asserting that prioritization should be based only on rurality).

[29] Kellogg Comments at 7. Oddly, Kellogg also argues that "a prioritization based on economic need . . . would be too subjective and not possible to implement." *Id.* at 8. In any event, for the reasons explained above, economic need should not be a consideration in any prioritization scheme.

Medicaid or welfare recipients in a given state would skew support away from sparsely-populated states like Alaska, thereby undermining the entire purpose of the RHC Program.[30]

The Commission also proposed establishing benchmarks to identify outlier funding requests. Under this proposal, outlier requests would either be subjected to enhanced review or capped at the benchmark.[31] One commenter agrees with the Commission's proposal, suggesting that establishing a benchmark would "provide greater transparency for RHC Program participants and clearer guidance to USAC."[32] Even if a benchmark system did establish clear boundaries, however, the cost of that clarity would be far too high. Any hypothetical benefit would be enjoyed only at the expense of the healthcare providers the RHC Program was designed to assist.

As GCI explained in its initial Comments, the Commission's benchmark proposal would have an unfair, untenable impact on "outlier" providers, including virtually all providers in Alaska. Moreover, the benchmark proposal is incompatible with section 254(h)(1)(A), as it imposes an external limitation on the calculation of rates that is impermissible in light of the statute's mandate that carriers receive credit for the difference between the *actual rates* paid by rural healthcare providers and the *actual rates* paid by other, non-healthcare rural customers.[33] The Commission's benchmark proposal is also at odds with the *BDS Order*, which expressly finds benchmark pricing "unnecessary" and notes that it could inhibit infrastructure investment.[34]

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30 *See* GCI Comments at 3 (discussing the purpose of section 254(h)(1)(A) and the RHC Program).

31 Notice at 17-21 ¶¶ 42-69.

32 Kellogg Comments at 11.

33 GCI Comments at 36-37.

34 BDS Order at 3499 ¶ 87; GCI Comments at 30.

Multiple commenters agree with GCI. The ANHB, for example, notes that "Alaska has extremely high costs for connectivity . . . Alaska is not an 'outlier,' but is rather simply Alaska."[35] If the Commission implements a benchmark model, the ANHB states, "Alaska will suffer disproportionately because its costs are much higher to begin with and remote Alaska communities rely on connectivity to an even greater extent than even other rural locations in the United States."[36] GCI wholeheartedly agrees, and other commenters echo these concerns.[37] The Commission's benchmark proposal is neither viable nor fair.

V. THE COMMISSION CANNOT PHASE OUT THE TELECOM PROGRAM.

Finally, GCI shares the viewpoint, expressed by several other commenters, that a failure to fully fund the Telecom Program is contrary to the statute.[38] One commenter suggests "[p]hasing out" the Telecom Program, arguing that it creates an undue administrative burden.[39] This suggestion does not merit a moment's consideration. The Telecom Program—or, at the very least, a program performing its exact function—is mandated by statute. Section 254(h)(1)(A) entitles rural healthcare providers to receive "telecommunications services which

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35 ANHB Comments at 7.

36 *Id.*

37 *See, e.g.*, Comments of Am. Hosp. Ass'n at 15-16, WC Docket No. 17-310 (filed Feb. 2, 2018) (urging the Commission to "proceed cautiously before establishing benchmarks"); Comments of Southcentral Found. at 5, WC Docket No. 17-310 (filed Jan. 31, 2018) ("Southcentral Comments") (stating that "service in Alaska is unique" and that "setting some arbitrary benchmark for requests that we will likely exceed is not reasonable or acceptable").

38 *See* GCI Comments at 39-40; *see, e.g.*, ANHB Comments at 3; SHLB Coalition Comments at ii, 6; Southcentral Comments at 4; *see also, e.g.*, ADS Comments at 1 (arguing that the Telecom Program should not be capped); Comments of New England Telehealth Consortium at 6, WC Docket No. 17-310 (filed Feb. 2, 2018) (arguing that the Telecom Program should be separated from the HCF and that the cap should be reserved solely for the HCF).

39 Kellogg Comments at 15.

are necessary for the provision of health care services . . . at rates that are reasonably comparable to rates charged for similar services in urban areas in that State."[40] The statute further entitles service providers to receive universal service credit for the difference between the (urban) rates paid by rural healthcare providers and rates paid by other rural customers.[41] In drafting and passing this legislation, Congress evinced a clear intent to subsidize the provision of telecommunications service to rural healthcare providers. Any administrative burden is irrelevant; unless the Commission establishes a separate program to perform this statutory mandate, the Telecom Program cannot be eliminated.

[40] 47 U.S.C. § 254(h)(1)(A).

[41] *Id.*

VI. CONCLUSION

GCI encourages the Commission to undertake a full reevaluation of the budget cap. In addition, in establishing a scheme for prioritizing funding disbursements, the Commission should consider only a healthcare provider's level of rurality and avoid unfairly targeting high-demand funding requests through the implementation of a "benchmark" system. Finally, the Commission should allow rates to be determined solely by the market.

Respectfully submitted,

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