

April 16, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Azar:

We are writing to request that the Department of Health and Human Services (HHS) take immediate action to address recent disclosures confirming inappropriate steering of individuals with End Stage Renal Disease (ESRD) who are eligible for Medicare or Medicaid into commercial coverage. Working together, our organizations or their members finance, provide and advocate for health care benefits for more than a hundred million Americans across the country. The undersigned groups share the goal of ensuring that our members and employees receive high-value care while keeping premiums affordable and sustainable. These recent disclosures have raised serious concerns and threaten to interfere in our collective ability to provide affordable health coverage.

In agency actions, CMS has recognized steering by dialysis providers as a problem that could cause significant harm to individuals with ESRD and to the individual market as a whole.ⁱ Recent financial reports have further confirmed that certain providers are steering a high volume of enrollees into the individual commercial markets for financial gain.ⁱⁱ As demonstrated by evidence collected during an earlier rulemaking related to the Exchanges, dialysis providers are paying premiums through a financially interested third party – the American Kidney Fund – for ESRD patients in order to steer them away from Medicaid and Medicare and into commercial Exchange plans so that they can profit from the higher reimbursement rates paid by these issuers.ⁱⁱⁱ This gaming of the Affordable Care Act's guaranteed issue rules generates significant profit for dialysis providers engaged in these schemes. J.P. Morgan estimated that the return on "charitable" donations by dialysis providers to the American Kidney Fund likely exceeds 500 percent.^{iv} Similarly, an August 2016 analysis written by J.P. Morgan reported that 6,400 Qualified Health Plans purchased through the AKF HIPP program drove an estimated \$1.7 billion in adverse selection.^v

Moreover, the same financial reports cited above reveal a previously unknown scale of steering of high-cost ESRD patients into the employer market. One financial report reveals that this steering into the employer market generates \$450 million a year in operating income for a single dialysis provider.^{vi} These disclosures show that illegitimate "charitable" third parties are urging individuals to elect COBRA coverage rather than consider other options in order to maintain the generous provider reimbursements offered by employer plans. These third parties may then either make COBRA premium payments on behalf of the beneficiary or "reimburse" the beneficiary for some portion of the costs of the premiums. This results in increased cost due to skewing of the employer plan's risk pool – ultimately increasing premiums for all plan beneficiaries.

This practice raises overall health system costs and results in significant increases in premiums for the entire commercial population, not just those with ESRD needs. It is also potentially harmful to patient care and poses a barrier to both appropriate coordination of care for people with ESRD and timely access to a kidney transplant, particularly for low income patients. The abuse of third party

payments undermines the system for everyone, including good actors who are sincerely invested in ensuring patients have access to the right care and coverage. For this reason, while rules governing third-party payments should enable legitimate organizations who are acting in good faith to provide consumer support, we strongly urge that CMS re-issue its rule on steering in the individual market and prohibit third-party payments made directly or indirectly by a financially-interested party. Policymakers should also consider actions to protect the employer market from inappropriate steering.

Decisions about which health insurance plan to enroll in, or where to obtain medical care, should always center on the best interests of the patient – not on the highest reimbursement for providers. As CMS demonstrated in its earlier rulemaking, for certain specific conditions, perhaps most notably ESRD, individuals eligible for, and/or receiving, Medicare and Medicaid benefits may enjoy more comprehensive coverage. In response to concerns raised by CMS and others about the impact on enrollees, premium payments are increasingly made through pre-paid debit cards to avoid any transparency to health plans or employers and further attempt to game the system putting corporate profit before consumer needs and the efficiency of the health care system overall.^{vii}

Our organizations are committed to preserving the commercial market, and just as steering of additional risk can threaten the sustainability of marketplaces and premium affordability, the practice also poses a threat to employer plans' risk pools. What may appear to be innocent assistance to a patient, may in fact be an effort to change that individual's coverage and caregiving in a way that benefits the third party or others, and not the patient. When third parties with conflicts of interest and who gain financially intervene in the provision of health insurance benefits in a manner that changes the financial balance inherent in the relationship between payers and plan beneficiaries, to the detriment of the health care system, the results can be adverse for the individual being assisted, for other plan beneficiaries, and for the sustainability of commercial health plans as a whole.

We urge you to scrutinize these recent disclosures and to work collaboratively with us to ensure our employees and members receive the most appropriate coverage to which they are entitled.

Sincerely,

America's Health Insurance Plans
Blue Cross Blue Shield Association
Corporate Health Care Coalition
ERISA Industry Committee
Families USA
National Alliance of Healthcare Purchaser Coalitions
National Association of Health Underwriters
National Association of Wholesaler-Distributors
National Partnership for Women & Families
National Retail Federation
Outdoor Amusement Business Association, Inc.
Pacific Business Group on Health
Service Employees International Union
Society of Professional Benefit Administrators
The Auto Care Association

Cc: Randy Pate, Deputy Administrator & Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services

Preston Rutledge, Assistant Secretary
Employee Benefits Security Administration,
Department of Labor

ⁱ Conditions for Coverage for End-Stage Renal Facilities: Third Party Payment Rule, December 14, 2016.

ⁱⁱ DaVita Provides Disclosures Regarding Charitable Premium Assistance, October 10, 2017. (“Approximately 1,800 patients receive charitable premium assistance for individual coverage, including both on- and off-Exchange plans. ... Approximately 4,000 patients receive charitable premium assistance for commercial group coverage, i.e., employer group plans and COBRA plans, to maintain continuity of coverage from prior to the ESRD diagnosis. These patients account for a total of approximately \$450M of DaVita’s expected annual operating income.”); American Renal Associates, Third Quarter 2017 Financial Results, November 14, 2017 (disclosing 131 patients transitioned into individual market coverage, and 456 moved into employer coverage).

ⁱⁱⁱ The American Kidney Fund is registered as an independent charitable 501(c)(3), even though it generates a 500%-700% rate of return for its primary donor.

^{iv} J.P. Morgan, North America Equity Research, “DaVita Inc.,” October 9, 2017.

^v J.P. Morgan, North America Equity, “DaVita Healthcare Partners: DVA Commercial Mix at Risk, Sensitivity is Material,” August 18, 2016.

^{vi} DaVita Provides Disclosures Regarding Charitable Premium Assistance, October 10, 2017.

^{vii} DaVita Q3 Earnings Call Transcript, November 5, 2017 (Question from JPMorgan Securities: “Instead, [health plans are] now seeing a lot of these patients paying with a prepaid debit card, and in fact that those cards are going to the dialysis center care of patients and dialysis administrative personnel are helping these patients pay those premiums. And I guess my question is, given your view that this is an acceptable and sustainable part of the ecosystem, why is it necessary for the AKF to potentially hide the origin of that funding? And is there any business risk to DaVita in essentially being complicit in circumventing these plans’ terms and conditions of coverage if they decided not to accept those payments?”).