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August 17, 2012

Ms. Donna Frescatore
Executive Director
New York Health Benefit Exchange
Executive Chamber
State Capitol
Albany, New York 12224

VIA ELECTRONIC SUBMISSION

Dear Ms. Frescatore:

DaVita Inc., the nation's leading provider of kidney disease services, congratulates you on your appointment as Executive Director of the New York Benefit Exchange, and appreciates the opportunity to follow up from the in-person meeting we had earlier this year (on March 9, 2012) to provide comments regarding New York's current process for determining its Essential Health Benefit (EHB) benchmark plan and related issues. The DaVita patient population includes more than 145,000 patients who have been diagnosed with end-stage renal disease (ESRD), a group representing approximately one-third of all Americans receiving dialysis services. Spanning 44 States and the District of Columbia, the DaVita network includes more than 1,800 locations. DaVita's nationwide network is staffed by 45,000 teammates (employees). In New York, DaVita provides dialysis treatment for approximately 4,000 individuals with kidney failure at our 40 centers across the State. Our comprehensive, in-center care team includes nephrologists, nephrology nurses, patient care technicians, pharmacists, clinical researchers, dieticians, social workers, and other highly-trained kidney care specialists.

Since our last meeting, I wanted to inform you that one of the issues of concern we spoke about pertaining to the health insurance exchange was resolved through regulations promulgated on March 13, 2012, by the U.S. Department of Health and Human Services, which clarified that the Medicare Secondary Payer provisions in section 1862 (b)(1) of the Social Security Act will apply to ESRD patients who are enrolled in qualified small group health plans in the health insurance exchanges. This is a critical protection that will ensure individuals with health insurance coverage through the exchange who subsequently develop kidney failure will be allowed to maintain that coverage for up to thirty months as is permitted under private health insurance plans outside of the exchange.

Background

ESRD, or kidney failure, is the last stage (stage five) of chronic kidney disease (CKD). This stage is reached when an individual's kidneys stop fully functioning and, therefore, cannot

sustain life. When one's kidneys fail that individual requires either a transplant or regular dialysis treatment; traditional in-center dialysis is generally performed at least three times a week for about four hours each session. Also of importance is the fact that, under federal law, individuals who are medically determined to have ESRD may apply for Medicare benefits.

The concerns expressed in this letter focus on the following three items: (1) choosing New York's EHB benchmark option, (2) clarifying prohibitions on qualified health plan (QHP) discrimination of patients with significant health needs, and (3) allowing individuals with ESRD to access exchange-subsidized coverage.

1. Choosing New York's EHB Benchmark Option

DaVita greatly appreciates the opportunity to comment on our preferred benchmark plan option. Of the ten benchmark plan options delineated by New York's Department of Health, all would be acceptable based on the explicit coverage of dialysis, adequate patient protections and other factors, with one exception. DaVita does not find to be acceptable the out-of-network policies contained within the Blue Cross Blue Shield (BCBS) Basic Federal Employee health plan. It is our experience that this plan has out-of-network benefits that are very restrictive for dialysis beneficiaries. Beneficiaries pay premiums to enjoy the freedom that comes with accessing the health care provider of their choice, be they in-network or out. This is especially true of individuals requiring dialysis a minimum of three times a week. New York's benchmark plan should ensure New Yorkers requiring dialysis have a viable option for out-of-network care and accordingly we strongly urge against the State of New York choosing the BCBS Basic Federal Employee plan.

2. Clarify Prohibitions on Qualified Health Plan Discrimination of Patients with Significant Health Needs

Proper benefit design is a critical aspect for consideration as Center for Consumer Information and Insurance Oversight (CCIIO) continues to promulgate regulations relating to EHBs. This is especially true in the case of individuals with significant health needs, like those with kidney failure. As noted above, patients with ESRD often require in-center dialysis at least three times per week for about four hours each session. Without the benefit of a kidney transplant, ESRD patients can require dialysis for the entirety of their lives. As such, without proper protections, health plans may be incentivized to design plans that encourage patients with significant health needs to drop their exchange insurance and move to other sources of coverage (such as Medicare in the case of individuals who are diagnosed with ESRD). Not only would this be a significant disruption for these individuals and their families, but if such patients "spend down" their assets sufficiently to pay the 20% coinsurance amount that Medicare does not cover, these individuals could become dually-eligible for Medicare and Medicaid, meaning New York's Medicaid budget would be negatively impacted.

As you know, the Affordable Care Act (ACA) and subsequent regulations prohibit Qualified Health Plan (QHP) benefit designs that have the effect of discouraging enrollment by higher-need individuals.[1] However, such discriminatory practices and the means to address such practices are not well-defined. EHB guidance released by CCIIO in December 2011 and additional guidance released in February 2012 raise concerns that upcoming EHB regulations, in

[1] § 1311(c)(1)(A) of the ACA; 45 CFR 156.225

fact, could explicitly allow plan designs that discourage enrollment by individuals with significant health needs.[2] For example, the February 2012 EHB FAQ specifically allows for scope and duration limits.[3] A March 2012 cost-sharing bulletin appears to allow for variations in cost-sharing on particular benefits or providers.[4] Although these bulletins note that such variations are subject to non-discrimination requirements, these requirements are not well-defined.

The December 2011 EHB bulletin indicated that CCIIO intends to propose that EHBs be defined by a benchmark plan selected by each state. **Under such a policy, we would respectfully request the New York Health Benefit Exchange urge CCIIO to satisfy the ACA's QHP benefit designs requirements by further clarifying that QHPs be prohibited from employing benefit designs for individuals with significant health needs that include limits on scope, duration, cost-sharing or network adequacy beyond those limits already included in a state's chosen benchmark plan.** This additional clarification to the ACA's QHP benefit design requirement should provide additional protection to vulnerable patient populations, protect New York's Medicaid budget from additional costs and ease the burden for New York's enforcement of the ACA's QHP benefit design requirements.

3. Allow Individuals with ESRD to Access Exchange-subsidized Coverage

Although not directly related to EHBs, we also would like to highlight here our strong preference that the Internal Revenue Service (IRS) ensures that ESRD patients have the right to choose between subsidized exchange coverage and Medicare coverage. As you know, the ACA provides new premium credits and cost-sharing subsidies for the purchase of individual coverage in an exchange, but disallows such assistance for individuals with other "minimum essential coverage," including Medicare Part A.[5] Allowing individuals to *choose* subsidized exchange coverage is critical because otherwise individuals with ESRD would be forced to leave an exchange simply because of their diagnosis. Unfortunately, in the exchange subsidy regulation published in the Federal Register on May 23, 2012[6], the IRS sets forth new regulations[7] which appear to disallow an individual with ESRD from choosing to not apply for Medicare benefits and, thereby, retain their subsidized exchange coverage. This is notwithstanding the fact that patients with ESRD must apply for Medicare benefits under the Medicare statute.[8]

Under the exchange subsidy regulation, it appears likely that, over time, a growing percentage of exchange members who are able to purchase affordable coverage through an exchange as a result of ACA subsidies will be disenfranchised from those subsidies once they develop ESRD. Such a dynamic also could negatively affect state Medicaid budgets. This is due to the fact that many ESRD patients without private coverage become dually eligible for both Medicare and Medicaid due to the high costs of coinsurance and other out-of-pocket expenses associated with their care. If patients cannot access their private plans, these patients will spend down their assets sooner

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[2] Center for Consumer Information and Insurance Oversight, Essential Health Benefits Bulletin, 16 December 2011.
[3] Center for Consumer Information and Insurance Oversight, Frequently Asked Questions on Essential Health Benefits Bulletin, 17 February 2012.
[4] Center for Consumer Information and Insurance Oversight, Actuarial Value and Cost-Sharing Reductions Bulletin, 24 February 2012.
[5] ACA § 36B(c)(2)(B)(i); IRC § 5000A(f)(1)(A)(i)
[6] 77 Fed. Reg. 30377 et seq. (May 23, 2012)
[7] 26 CFR 1.36B-2(c)(2)(ii) and 26 CFR 1.36B-2(c)(2)(vi)
[8] SSA § 226A(a)(3)

and enter state Medicaid programs prematurely. In New York, independent estimates show this could result in $129.8M in additional state and federal Medicaid spending over 7 years (2014-2021). Fortunately, the exchange subsidy regulation also notes that "the IRS and the Treasury Department expect to publish additional guidance…. clarifying when or if an individual becomes 'eligible for government-sponsored minimum essential coverage' when the eligibility for that coverage is a result of a particular illness or condition."[9] ***For all the reasons stated above, we respectfully request the New York Health Benefit Exchange urge the IRS to clarify in forthcoming guidance that those individuals with exchange-subsidized coverage who subsequently develop ESRD may remain eligible for exchange-subsidized coverage.***

I appreciate the opportunity to share my comments and recommendations with you.
Please do not hesitate to contact me at michael.such@davita.com or Richard Gallo, DaVita's Government Affairs Consultant in New York State, at rgallo@gallo-associates.com, if you would like to discuss these recommendations in detail or have any questions.

Sincerely,

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CC: Richard Gallo

[9] 77 FR 30379