Public vs. Private Dialysis Reimbursement Rates Create Incentives for Abuse:

Commercial: $300,000 per patient per year.
Medicare: $82,000 per patient per year.

Claims per Member are Significant

Market Segment	PAYOR	Total dialysis claims	Total payment issued
IFP	American Kidney Fund	144	$297,230.02
IFP	American Kidney Fund	141	$260,518.48
IFP	American Kidney Fund	142	$269,369.77
IFP	American Kidney Fund	145	$281,506.89
IFP	American Kidney Fund	134	$258,800.58

DaVita News

DaVita Provides Disclosures Regarding Charitable Premium Assistance

DENVER, Oct. 10, 2017 /PRNewswire/ -- DaVita Kidney Care, a division of DaVita Inc. (NYSE: DVA), a leading provider in kidney care services, today provided disclosures regarding charitable premium assistance.

Dialysis Patients and Charitable Premium Assistance
Dialysis patients across the US access charitable premium assistance in a government-designed system that has been in place for decades. The intentional support of the system includes the acceptance of provider funding in an explicit advisory opinion from the Centers for Medicare and Medicaid Services (CMS) Office of Inspector General (OIG).

Many of the beneficiaries of this assistance are unable to continue working full-time as a result of their severe condition. Charitable premium assistance enables these patients to afford continuity of health insurance coverage that they have had for years, at a time when they need it most. Assistance is based on financial need and available regardless of the type of insurance chosen by the patient, or the dialysis provider serving the patient. Across healthcare, charitable assistance is available to patients suffering from a variety of other high-cost, chronic diseases.

DaVita Patient Benefit
Currently less than 13% of DaVita's US dialysis patients – or about 25,000 patients – receive support from the American Kidney Fund (AKF). Of these,

- Approximately 1,800 patients receive charitable premium assistance for individual coverage, including both on- and off-Exchange plans. The majority of these patients came to DaVita with their plan already in place and simply seek to maintain coverage they had before they became ill. DaVita believes that more than half of these patients would utilize premium tax credits and cost-sharing reductions, or find other sources of funding, to maintain their coverage even if charitable premium assistance were no longer available to them. The loss of individual coverage for some or all of the remaining patients could, as previously disclosed, result in a reduction in expected annual operating income of $45-90M.
- 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. Even if charitable premium assistance were to become unavailable to these patients – which DaVita does not expect to happen – DaVita believes that some of these patients would find other ways to fund their insurance premium and retain their coverage.
- Nearly 80% of recipients, or approximately 19,000 patients, receive charitable premium assistance for government coverage, such as Medicare Part B and Medicare Supplemental Plans. Average reimbursement per treatment for these patients is at or below DaVita's average cost per treatment. Without charitable premium assistance, DaVita believes that many of these patients would be forced onto state Medicaid programs or be uninsured.

Risks and Mitigation
DaVita believes that charitable premium assistance will not be taken from dialysis patients, due to its benefit for patients and its importance to the entire dialysis system.

Charitable assistance has been a long-standing component of this system, and the share of patients receiving such assistance has been stable for many years. Charitable assistance is not only beneficial for individual patients who are able to retain coverage they could otherwise not afford, but also is in the interest of society overall, supporting continuity of coverage and access to care for the most vulnerable individuals.

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

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

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[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?").