



900 7th Street, NW
Suite 680
Washington, DC 20001
Tel: 202.789.6910 Fax 202-789-6930
www.davita.com

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Scott Kipper, Commissioner
Division of Insurance, Department of Business and Industry
1818 E. College Parkway, Suite 103
Carson City, NV 89706

VIA ELECTRONIC SUBMISSION

Dear Commissioner Kipper:

DaVita appreciates the opportunity to provide comments regarding Nevada'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. In addition to the 332 teammates in our Brentwood business office, DaVita has the privilege of providing dialysis treatment for over 1,689 individuals with kidney failure throughout our 19 centers across Nevada. 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.

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 Nevada'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 Nevada's EHB Benchmark Option

DaVita greatly appreciates the opportunity to comment on our preferred benchmark plan option. Of the benchmark plan options delineated by Nevada's Division of Insurance, 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 Nevada Hometown 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. Nevada's benchmark plan should

ensure Nevadans requiring dialysis have a viable option for out of network care and accordingly we strongly urge against the State of Nevada choosing the Nevada Hometown Health 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 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 Nevada’s Medicaid budget would be negatively impacted.

As you know, the ACA and subsequent regulations prohibit 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 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 Nevada Division of Insurance 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 Nevada’s Medicaid budget from additional costs and ease the burden for Nevada’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 highlight here our strong preference that the Internal Revenue Service (IRS) ensure 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

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

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.

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, 2012⁶, the IRS sets forth new regulations⁷ 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 and enter state Medicaid programs prematurely. In Nevada, independent estimates show this could result in \$13M 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 Nevada Division of Insurance 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 jeremy.vanhaselen@davita.com if you would like to discuss these recommendations in detail or have any questions.

Sincerely,



Jeremy Van Haselen
Vice President, State Government Affairs
DaVita

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)

⁹ 77 FR 30379