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March 25, 2016

Honorable Dave Jones
Commissioner, California Department of Insurance
300 Capitol Mall, Suite 1600
Sacramento, CA 95814

Submitted electronically to: Kayte.Fisher@insurance.ca.gov

Re: CDI Public Meeting on the Cigna/Anthem Blue Cross Merger

Dear Commissioner Jones:

DaVita appreciates the opportunity to provide comments in response to California's review of the proposed Cigna/Anthem merger. The DaVita patient population includes more than 177,000 patients who have been diagnosed with kidney failure, also known as end-stage renal disease (ESRD), a group representing approximately one-third of all Americans receiving dialysis services. Spanning 43 States and the District of Columbia, the DaVita network includes more than 2,225 locations. DaVita's nationwide network is staffed by 63,000 teammates (employees). DaVita has the privilege of providing dialysis treatment for over 30,000 individuals with kidney failure throughout our 278 centers across California. 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

End Stage Renal Disease (ESRD), or kidney failure, is the last stage (stage five) of chronic kidney disease (CKD). This stage is reached when an individual's kidneys are functioning at ten to fifteen percent of their normal capacity or below and, therefore, cannot sustain life. Kidneys are vital organs that remove toxins from the blood and perform other functions that support the body, such as balancing fluid and electrolytes, and producing certain hormones. When kidneys fail, they cannot effectively

perform these functions, and renal replacement therapy, such as dialysis or a kidney transplant, is necessary to sustain life.

The most common type of dialysis is hemodialysis, which is predominantly performed in specialized outpatient facilities. Hemodialysis is a therapy that filters waste products, removes extra fluid, and balances electrolytes (sodium, potassium, bicarbonate, chloride, calcium, magnesium and phosphate), replacing the mechanical functions of the kidney. Traditional in-center hemodialysis is generally performed a minimum of three times a week for about four hours each session. Due to the significant impact of dialysis treatment on the body, the resulting fragility of those with the disease, and the amount of time involved in treatment, access to the renal replacement therapy modality that is right for the individual is of critical importance.

Individuals under 65 years of age who are medically determined to have ESRD are eligible to enroll in Medicare the third month after the month in which a regular course of renal dialysis is initiated. At the same time, Medicare Secondary Payer (MSP) provisions require group health plans provide 30 months of primary coverage, with the 30-month period beginning with the first month in which the individual is eligible for Medicare. Additionally, it should be noted that individuals with commercial coverage (EGHP, COBRA, individual via health exchange) who develop kidney failure are not required to enroll in Medicare despite their eligibility. Accordingly, many dialysis patients choose to remain on their commercial coverage for a variety of reasons, not the least of which is the fact they have paid premiums for that coverage.

IMPACT OF THE PROPOSED MERGER

Left un-checked, health insurance consolidation creates risks for the chronically-ill patients we care for, including loss of access and increased cost. Health insurers have begun to use a variety of tactics to exclude chronically ill patients from their plans including:

1. Cutting costs through narrowing networks, limiting patients' access to dialysis providers of choice and preventing patients from receiving dialysis treatments at nearby facilities
2. Imposing benefit designs that discriminate against members with kidney failure by eliminating access and/or increasing the out-of-pocket cost of dialysis treatment

3. Refusing to accept third party premium assistance payments from qualified charity organizations on behalf of members with kidney failure
4. Blocking applicants with kidney failure from enrolling based on eligibility for Medicare or Medicaid

These activities are occurring in a pre-merger environment; our concern in the kidney care community is that they will only be exacerbated once a larger merged entity is approved. Indeed, the proposed Cigna/Anthem merger puts California patients particularly at risk, and would result in market share exceeding 50% for the joint entity in 14 out of 58 counties in California.

PROPOSED SOLUTIONS TO PROTECT DIALYSIS PATIENTS

Divestitures alone will not protect patients from inadequate networks and discriminatory practices by health insurers. To protect patients, in addition to requiring divestitures in the most highly impacted markets, California regulators should:

1. Implement regulatory and legislative measures to ensure meaningful healthcare network adequacy protections for California's most vulnerable patients, including:
   - Quantitative (driving time/distance) standards for network adequacy applied at the county level (use Medicare Advantage standards as starting point)
   - Pre-approval of networks with meaningful penalties for misrepresentation
   - Proper notification to beneficiaries of provider terminations and continuity of care for the chronically ill
2. Ensure regulators have resources to enforce network adequacy standards
   - Require a percentage of merger cost savings go to funding network adequacy enforcement resources including:
     - Improved computer systems
     - Sufficient personnel
     - Improved plan comparison tools for patients

DETAILED NETWORK ADEQUACY STANDARDS

Individuals with kidney failure rely on life-sustaining dialysis treatment a minimum of three times per week. Inadequate networks, which force beneficiaries to drive long distances to and from treatment to access in-network providers, can discourage ESRD patients from health plan enrollment or incent an ESRD patient to enroll in Medicare earlier than desired. Peer-reviewed studies have shown that longer travel time for ESRD patients is associated significantly with greater mortality risk and decreased quality-of-life.[1]

It is for these reasons we commend California for its current network adequacy regulations requiring network specialists be certified, or eligible for certification, by the appropriate specialty board with sufficient capacity to accept covered persons within 60 minutes or 30 miles of a covered person's residence or workplace.

At the same time, we support strengthening the maximum drive time standards for outpatient dialysis to those used in the Medicare Advantage program. Existing Medicare Advantage standards are a good option and maintain consistency across insurance products the table below provides detailed maximum distances for specific geographic areas under Medicare Advantage for 2016.

2016 Medicare Advantage Network Adequacy Standards for Dialysis					
Specialty	Maximum Distance Standards (Miles)				
	Large Metro	Metro	Micro	Rural	Counties with Extreme Access Considerations (CEAC)
Outpatient Dialysis	10	30	50	50	90

Network adequacy standards must also have enforcement mechanisms in place to be successful. As stated earlier, CDI and other California regulatory bodies reviewing the proposed merger should require as a condition of approval a certain percentage of the estimated cost savings be used as an enforcement fund for the state of California.

[1] Moist, L. et al. (2008). Travel Time to Dialysis as a Predictor of Health-Related Quality of Life, Adherence, and Mortality: The Dialysis Outcomes and Practice Patterns Study (DOPPS), American Journal of Kidney Diseases, Vol. 51, No 4, pp. 641-650.

DaVita appreciates the opportunity to share comments and recommendations with you regarding the Cigna/Anthem merger. Please do not hesitate to contact me at 713.226.7544 if you would like to discuss these recommendations in detail or have any questions.

Sincerely,

Jeremy Van Haselen
Vice President, State Government Affairs
DaVita HealthCare Partners