



March 15, 2016

Senator Joseph Crisco, Jr.,  
Representative Robert Megna  
300 Capitol Avenue  
Hartford, CT 06106

Submitted electronically to: [INStestimony@cga.ct.gov](mailto:INStestimony@cga.ct.gov)

**Re: Standards and Requirements for Health Carriers' Provider Networks**

Dear Senator Crisco, Representative Megna, and the Members of the Insurance and Real Estate Committee:

DaVita appreciates the opportunity to provide comments in response to Connecticut's review of standards and requirements for health insurance carrier's provider networks. 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 about 2,400 individuals with kidney failure throughout our 23 centers across Connecticut. 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.

### **IMPACT OF THE PROPOSED MERGER BETWEEN HEALTH INSURERS ANTHEM & CIGNA**

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 Connecticut patients particularly at risk, and would result in a market share for commercially insured patients exceeding 50% for the joint entity in 6 out of 8 counties in Connecticut.

### **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, Connecticut regulators and legislators should:

1. Implement regulatory and legislative measures to ensure meaningful healthcare network adequacy protections for Connecticut'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 & continuity of care for the chronically ill
  - Do not subject chronic condition patients to higher copays and out-of-pocket costs when receiving care from specialists/specialty facilities
2. Ensure regulators have resources to enforce network adequacy standards
- Require a % of merger cost savings go to funding network adequacy enforcement resources including:
    - Improved computer systems
    - Man-power
    - 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.<sup>1</sup>

It is for these reasons we commend Connecticut for its current network adequacy standards that require health insurance carriers to maintain a network of providers that is consistent with the National Committee for Quality Assurance's network adequacy requirements or URAC's provider network access and availability standards. The current URAC standards state that health plans must maintain a provider network that is sufficient in the number and types of providers and assure that all services can be accessed without unreasonable delay.

Raised Bill No. 433, "An Act Concerning Standards and Requirements for Health Carriers' Provider Networks and Contracts between Health Carriers and Participating Providers," strengthens Connecticut's provider network review process and prohibits discrimination against high-risk patient populations by health insurance carriers. Regarding evaluation of the adequacy of provider networks, the Bill states that "the Insurance Commissioner shall determine the sufficiency of a health carrier's network in accordance with the provisions of this subsection and may establish sufficiency by reference to any reasonable criteria, including, but not limited to, (i) the ratio of participating providers to covered persons by specialty, (ii) the ratio of primary care providers to covered persons, (iii) the geographic accessibility of participating providers, (iv) the geographic variation and dispersion of the state's population, (v) the wait times for appointments with participating providers, (vi) the hours of operation of participating providers, (vii) the ability of the network to meet the needs of covered persons that may include low-income

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<sup>1</sup> Maist, 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.



individuals, children and adults with serious, chronic or complex conditions or physical or mental disabilities or individuals with limited English proficiency, (viii) the availability of other health care delivery system options, such as telemedicine, telehealth, centers of excellence and mobile clinics, (ix) the volume of technological and specialty care services available to serve the needs of covered persons who require technologically advanced or specialty care services, (x) the extent to which participating health care providers are accepting new patients, (xi) the degree to which (I) participating health care providers are authorized to admit patients to hospitals participating in the network, and (II) hospital-based health care providers are participating providers, and (xii) the regionalization of specialty care.” We note with significant concern, however, that the Bill does not define maximum drive time and distance standards for provider networks. We note that this is inconsistent with current Medicare Advantage parameters as well as recommendations for network adequacy evaluation standards in the 2017 Letter to Issuers in the Federally-facilitated Marketplace (FFM).

We support additional quantitative standards in the Bill relating to maximum distance for outpatient dialysis similar to those used in the Medicare Advantage program. 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

As the Connecticut Legislature works to finalize provisions within the Bill, we urge the Legislature to consider the adoption of maximum distance standards for ESRD patients consistent with existing Medicare Advantage standards. Not only do we believe such standards will help to protect the vulnerable ESRD patient population in Connecticut, we believe that one standard across these markets would reduce confusion for beneficiaries and providers and be easier to administer for insurers and regulators.

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





DaVita appreciates the opportunity to share comments and recommendations with you regarding the Cigna/Anthem merger. Please do not hesitate to contact me at 612.916.0922 if you would like to discuss these recommendations in detail or have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Such".

Michael Such  
Senior Director, State Government Affairs  
DaVita HealthCare Partners

