KIDNEY CARE PARTNERS

January 15, 2016

Andrew Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces

Dear Acting Administrator Slavitt,

On behalf of Kidney Care Partners (KCP), I want to thank you for providing us with the opportunity to comment on the "Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces" (Draft LTI). KCP is an alliance of members of the kidney care community that serves as a forum for patient advocates, dialysis care professionals, providers, and manufacturers to advance policies that support the provision of high quality care for individuals with both chronic kidney disease (CKD) and End-Stage Renal Disease (ESRD).[1]

As the Draft LTI notes, many of the policies outlined in it relate to policies proposed in the "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017" Proposed Rule (NBPP Proposed Rule). Thus, our comments on the Draft LTI highlight the points that we made in our December comment letter on that proposed rule.

In addition, we are particularly pleased that the Draft LTI expressly states that ESRD patients who are under 65 years old are not required to enroll in Medicare.

> We remind issuers that individuals under age 65 with end stage renal disease (ESRD) are not required to sign up for or enroll in Medicare. Further, individuals who do not have Medicare Part A or Part B are eligible to enroll in individual market coverage, including a [Qualified Health Plan] QHP, if the individual meets the eligibility requirements for enrollment (i.e., criteria related to citizenship, lawful presence, incarceration, and residency).[2]

---

[1] *See* Appendix A for a list of the members.
[2] HHS, "Draft 2017 Letter to Issuers in the Federally-facilitated Marketplaces" 45-56 (December 2015).

As we have described in previous letters and in more detail below, several Marketplace plans have implemented plan designs or engaged in behaviors that communicate to these individuals that they must enroll in Medicare. We applaud CMS for clearly stating that these individuals retain the choice to select the insurance that best meets their needs. This statement is consistent with the promise of the Affordable Care Act (ACA) to end pre-existing condition discrimination, limitations on care, and coverage cancellations and President Obama's promise that "[i]f you like your health care plan, you keep your health care plan."[3]

Yet, Marketplace issuers have sometimes subtly and at other times not so subtly adopted policies that discriminate against enrollees with kidney disease when it progresses and the enrollees require dialysis. The problem is most notable in the case of plans refusing to accept third party payments from the not-for-profit public charity, the American Kidney Fund (AKF), and in the design of plan networks that dis-incentivize or otherwise make it difficult for enrollees to obtain the lifesaving treatments they require.

While we are sympathetic to the concerns issuers have expressed about the risk pool, it is not a valid reason for discriminating against individuals requiring dialysis treatments. CMS should work with issuers and address the risk pool problems through the risk adjustment, reinsurance, and risk corridors policies. These are distinct issues and should be addressed as such.

Thus, KCP asks that CMS strengthen the statement that individuals under 65 years old who developed ESRD have a right to enroll in Marketplace plans by:

(1) Requiring issuers to accept payments from not-for-profit charitable organizations that existed prior to the enactment of the ACA, have been reviewed favorably by the Office of Inspector General (OIG), provide at least one year of assistance to individual enrollees, and offer assistance for the purchase of any coverage option (*see* Chapter 2, § 13); and

(2) Providing federal oversight of issuers to ensure appropriate plan design and the adequacy of networks, instead of relying upon States, including establishing time and distance standards and minimum provider-covered person ratios, as well as ensuring continuity of care and reducing wait times (*see* Chapter 1, § 1; Chapter 2, § 3; Chapter 2, § 10).

[3]President Barak Obama statement at a town hall event in Grand Junction, Colorado (August 15, 2009) (cited in Lori Robertson, "Keep Your Health Insurance? Not Everyone," *FactCheck.org* (Aug. 18, 2009) (http://www.factcheck.org/2009/08/keep-your-insurance-not-everyone/)).

The ACA can only be effective if it lives up to the promises made by the President and provides all Americans regardless of their health condition with the ability to choose the health plan that is right for them. Prohibiting issuers from discriminating against enrollees who require dialysis treatments would likely increase their efforts to try to prevent or at least to slow the progression of kidney disease.

I. Chapter 2, § 13 Third Party Payment of Premiums and Cost-Sharing: CMS should require issuers to accept payments from not-for-profit charitable organizations that (1) existed prior to the enactment of the ACA; (2) have been reviewed favorably by the OIG; (3) provide assistance for at least one year; and (4) offer assistance for the purchase of any coverage option.

KCP is pleased that CMS announced in the NPBB Proposed Rule that it is considering "expand[ing] the list of entities for whom issuers are required to accept payments to include not-for-profit charitable organizations."[4] However, we were surprised that the same language did not appear in the Draft LTI and strongly urge CMS to require that issuers accept payments from not-for-profit charitable organizations that meet the following requirements.

(1) The not-for-profit organization existed prior to the enactment of the ACA;

(2) The OIG has reviewed the arrangement and determined that it presents no concerns through an Advisory Opinion;

(3) The organization provides at least one year of assistance to enrollees; and

(4) The organization offers assistance for the purchase of any coverage option (*e.g.,* qualified health plans, other private coverage, Medicare, Medicaid).

While we understand the need to minimize risk pool impacts, it is important to distinguish policies that support long-standing charitable organizations from policies related to establishing appropriate risk corridors. We encourage CMS to work with issuers to establish appropriate risk corridors, which we understand is beyond the scope of the Draft LTI. It is also important to note that even if a dialysis patient enrolls in a Marketplace plan, at the end of 33 months, he/she is automatically enrolled in Medicare under the Medicare Secondary Payer law.[5]

[4] 80 *Fed. Reg.* 75488, 75558 (Dec. 2, 2015).
[5] Social Security Act (SSA) § 1862.

This clarification is also necessary because some issuers are using the CMS guidance as a pretext for denying coverage to anyone who accepts direct or any form of assistance from a non-profit charitable organization. This includes some issuers interpreting CMS' current policy statements on third party payers as a basis for denying enrollment or cancelling coverage entirely for individuals with ESRD who accept premium assistance. We do not believe CMS intended for issuers to deny enrollment to lower income patients with ESRD under these circumstances. CMS should clarify its statements so issuers do not use the text to prohibit individuals from relying upon charitable organizations to assist directly with their premium and copayment obligations and so that the policy is consistent with the Public Health Services prohibition on discriminating against individuals participants and beneficiaries based on health status, medical condition, and other enumerated factors.[6]

A. AKF charitable support provides dialysis patients with critically important assistance.

AKF is a qualified public charity, founded in 1971, whose mission is to help people fight kidney disease and live healthier lives. One of AKF's core mission components is to help low-income dialysis patients in the United States access health care. It accomplishes this mission through its grant programs, including the Health Insurance Premium Program (HIPP), which was established in 1997. In reviewing this program, the OIG has concluded that AKF is a "bona fide 501(c)(3) charitable and educational organization."[7] The OIG also indicated that AKF reviews patient applications for HIPP assistance based upon "assessment of need and eligibility criteria." HIPP assistance is available to all individuals with kidney failure who rely on dialysis for survival. AKF's HIPP is not a "healthcare provider or commercial entity"[8] seeking to skew the risk pool, but rather a charity that seeks to assist eligible low-income people living with a chronic disease.

In the 18 years since AKF launched the HIPP program, AKF has provided premium support and cost-sharing assistance to Medicare beneficiaries so that they can maintain their Medigap policies, as well as their Medicare Part B, COBRA, and other commercial insurance. During these nearly two decades, there have been no questions or concerns raised about this assistance skewing the risk pool for these plans.

People living with kidney failure have come to rely upon AKF's HIPP. In 2014, AKF provided direct assistance to patients in all 50 states, the District of Columbia and every U.S. territory. As the OIG summarized in its Advisory Opinion:

---

[6] Public Health Service Act § 2702.
[7] OIG, Advisory Opinion 97-1.
[8] *See* 79 Fed. Reg. 15240, 15241 (March 19, 2014).

"AKF is a bona fide, independent, publicly-funded, 501(c)(3) charitable organization whose charitable purposes include aiding ESRD patients and their families."[9]

While we highlighted the story of Eric Dolby in our comment letter on the NBPP Proposed Rule, we believe it is worth reiterating here because it demonstrates the critical role AKF plays in patients' lives. Mr. Dolby was working as a nurse when he was diagnosed with hypertension in 2000. Six year later, his kidneys failed and he began dialysis. He was unable to continue to work as a traveling nurse. During this time, his financial resources were depleted. He found himself homeless and living at a truck stop in Houston, TX. After fighting with his pride, he let his social worker know that he was homeless. She referred him to AKF. Once the AKF received his application, they provided him with the financial resources that he needed to pay for healthcare costs. AKF was able to help him get the care that he needed by paying his health insurance premium. Once he had his health insurance covered, he was able to focus on getting back on his feet. Mr. Dolby's experience shows the important role that charitable assistance for dialysis patients plays in helping individuals overcome the hardships they experience.

B. Requiring issuers to accept payments from the AKF poses little to no risk of impacting the risk pool.

There is no evidence to support the conclusion that allowing AKF to continue to provide premium support and cost-sharing assistance to those enrolled in Marketplace plans, as it does today with other types of insurance programs, would inappropriately skew the risk pool. There are approximately 468,386 Americans who have been diagnosed with kidney failure receiving dialysis.[10] While the vast majority of these Americans rely upon dialysis, approximately 76 percent seek to enroll in Medicare when initially diagnosed with kidney failure.[11] Approximately 23.6 percent of individuals with kidney failure retain their employer-based group health insurance when they are initially diagnosed.[12] As patients remain on dialysis, this percentage is reduced. Dialysis facilities report that approximately 10 percent of prevalent patients access commercial insurance. Thus, if these historic trends remain steady a small percentage of this very small population would likely seek to remain in a Marketplace plan. Even if all of the individuals who do not seek Medicare enrollment were to seek coverage in the Marketplaces, they are dwarfed by the 17.6 million Americans[13] who have gained coverage through the ACA. Given these numbers, it is difficult to understand how such a small number of individuals could impact risk pools that are made up of thousands of individuals.

---

[9] OIG, *supra* note 12, at 6.
[10] United States Renal Data System, 2015 Annual Data Report (Vol. 2, Reference Table D.1).
[11] *Id.* (Vol 2, Reference Table C.3).
[12] *Id.*
[13] *See supra* note 2.

C. Guardrails should protect access and individual choice.

KCP understands the concerns that some issuers have expressed about the impact third party payments may have on their risk pools. For example, we agree that allowing individuals to obtain coverage before a major procedure only to have them drop coverage after the procedure is complete presents problems for issuers. But, these concerns should not lead to policies that are counter to the intent of the ACA, as articulated by the President, as well as the Secretary, to provide access and choice to affordable plans.

Thus, in addition to calling on CMS to require that issuers accept payments from not-for-profit charitable organizations, we support including guardrails that still provide dialysis patients with meaningful access and choice to private plans. Specifically, we recommend that CMS adopt the following guardrails.

(1) The not-for-profit organization existed prior to the enactment of the ACA. This criterion would guard against new entities that might try to establish themselves as non-profit foundations to avoid ACA requirements. The AKF has been providing assistance to dialysis patients since 1971, well before the enactment of the ACA.

(2) The OIG has reviewed the arrangement and determined that it presents no concerns through an Advisory Opinion. As you are aware, the OIG reviews arrangements to determine if they "constitute grounds for the imposition of a civil monetary penalty under Section 231(h) of the Health Insurance Portability and Accountability Act of 1996." This additional layer of review protects against inappropriate inducements to select a particular provider, practitioner, or supplier. The OIG in Advisory Opinion No. 97-1 reviewed the AKF arrangement and found that it "would not constitute grounds for the imposition of civil monetary penalties under Section 231(h) of HIPAA."

(3) The organization provides at least one year of assistance to enrollees. As noted above, we understand that some individuals enroll only to receive a particular procedure or service that is particularly expensive and then end their coverage. First, dialysis patients require regular, predictable treatments so this behavior is unlikely to occur. More importantly, the AKF provides a year of funding from the date of the initial grant for those individuals who meet its criteria.

(4) The organization offers assistance for the purchase of any coverage option (*e.g.,* qualified health plans, other private coverage, Medicare, Medicaid). Requiring the organization to provide payment assistance regardless of the type of plans (*e.g.,* qualified health plan, private coverage,

Medicare, Medicaid) ensures that enrollees are not incentivized to use only one type of coverage. There will be an even playing field that allows enrollees to select or maintain the coverage that best meets their needs and does not unnecessarily burden the Marketplaces in relation to other types of health plans.

KCP supports the clear statement in the Draft LTI that individuals under 65 years who develop ESRD have the right to select and remain in Marketplace plans. There are many reasons enrollees who need dialysis might prefer to remain in a private insurance plan offered through the Exchanges; they should have the same rights as other Americans to keep their insurance if they like it. Dialysis Patient Citizens (DPC) conducted a survey of patients using questions from the Consumer Assessment of Health Plan Survey (CAHPS) to gauge relative satisfaction with their coverage. DPC found that 77 percent of patients rate their private health insurance as the "best health insurance plan possible," compared to 71 percent for Medicare. They also found that Medicare beneficiaries have more difficulty getting the health care that they want or need than those enrolled in private plans. One reason for the difference in satisfaction is that Medicare requires higher cost sharing for chronically ill patients than some private insurance plans and Medigap policies are not available to those individuals who are under 65 years old in half of the United States. In addition, these under 65 years old patients may have families and enrolling in Medicare could negatively impact their family's insurance situation.

Dialysis patients are not unlike those individuals living with HIV/AIDS for whom CMS has required issuers to accept payments. Both patient populations have high medical needs. While the Ryan White Program was established by the Congress to assist HIV/AIDS patients to afford their insurance, AKF has been reviewed by the OIG and determined an appropriate model to do the same for dialysis patients. Given these parallels, CMS should treat AKF as it does Ryan White.

All Americans should have the right to access the coverage that best meets their needs. This right should not vanish because they are diagnosed with kidney failure and require dialysis treatments. The right also should not be reserved for those Americans who can afford their premiums/coinsurance or have wealthy family or friends who can help them. Those individuals who rely upon *bona fide* public not-for-profit charities should have these same choices. Therefore, we urge CMS in the final LTI letter to require issuers to accept payments from not-for-profit charitable organizations that (1) existed prior to the enactment of the ACA; (2) have been reviewed favorably by the OIG; (3) provide assistance for a year; and (4) offer assistance for the purchase of any coverage option.

II. CMS should provide federal oversight of issuers to ensure appropriate plan design and the adequacy of networks, instead of relying primarily upon the States, including establishing time and distance standards and minimum provider-covered person ratios, as well as ensuring continuity of care and reducing wait times.

KCP is also pleased that CMS proposes various ways to ensure the appropriateness of Marketplace plan designs and network adequacy. We strongly support the Agency's statement in the Draft LTI that "an issuer of a QHP that uses a provider network must 'maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.'"[14] It is important to specifically reference dialysis facilities and nephrologists as well. We also support "assess[ing] provider networks using a "reasonable access" standard in order to identify networks that fail to provide access without unreasonable delay."[15]

Dialysis patients have experienced various forms of discrimination by health plans over the years and it is critically important that CMS and other federal agencies provide clear standards to ensure appropriate access to quality care. Therefore, we ask that CMS provide federal oversight of issuers, rather than rely primarily on the States. We also support establishing time and distance standards, as well as minimum provider-covered person ratios. In addition, we agree that CMS should enact policies to ensure the continuity of care during provider transitions and reduce patient wait times.

A. Chapter 1, § 1: QHP Application and Certification Process; Chapter 2, § 10: EHB Discriminatory Benefit Design and QHP Discriminatory Benefit Design: The federal government, not States, is in the best position to assess plan design and network adequacy.

KCP strongly supports active monitoring of plan design and network adequacy. While having States engage in such monitoring is important, we reiterate the recommendation that we made to the Office for Civil Rights when commenting on the "Nondiscrimination in Health Programs and Activities" proposed rule. It is critically important that the federal government take a more proactive role in ensuring that Marketplaces do not discriminate against these individuals, which includes appropriate plan design and maintaining adequate networks. This engagement should occur both during the application and certification process

[14] Draft LTI at 22.
[15] *Id.* at 23.

(Chapter 1, § 10), as well as in addressing discriminatory benefit design (Chapter 2, § 10).

While KCP supports the proposal for CMS to perform an outlier analysis on QHP cost sharing as part of the QHP certification and application process, KCP remains concerned about the proposals that rely only upon actuarial analyses and health plan attestations during the QHP application and certification process, as well as deferring to States to police discriminatory benefit design. We appreciate the burden it may place on CMS, but believe it is important that the federal government retains the authority to provide the necessary oversight and require plan modifications to prohibit discrimination against vulnerable populations, including individuals with kidney failure requiring dialysis treatments.

The final rule implementing Essential Health Benefits (EHB) policies requires that coverage in individual and small group markets be "substantially equal" to the Benchmark.[16] While most plans comply with these requirements, the kidney care community has identified several instances in which plans are not providing substantially equivalent coverage. These plans target enrollees who develop kidney failure and require dialysis in an effort to push them toward enrollment in Medicare. In at least 20 States,[17] the benchmark plans indicate that if an individual is eligible for Medicare, he/she cannot enroll in a Marketplace plan, which is contrary to federal law. In 22 States,[18] the fact that an individual is eligible for Medicare results in a plans reducing coverage to the amount that it would pay if the individual were enrolled in Medicare, even if the individual has chosen <u>not</u> to enroll in Medicare. CMS has been very clear that issuers may not exclude dialysis patients from coverage, but much stronger federal enforcement of this requirement is needed.

If an individual enrolls in a plan, his/her problems frequently continue. One practice we have identified is limiting access to providers located significant distances from patients. An essential life-saving treatment, dialysis requires patients to be at a facility, unless they can rely upon home dialysis modalities, three times a week for three to four hours each treatment. Adding an hour or longer drive to this schedule is an unnecessary hardship when there are facilities closer to the enrollee's home. We have also seen plans limit nephrologists or other specialists who are essential to providing care to dialysis patients. Another problem has been that enrollees who are referred for transplant often find that there is no transplant hospital in the network, forcing them to incur additional costs.

---

[16]78 *Fed. Reg.* 12834 (Feb. 25, 2013).
[17]These States are: Arizona, Connecticut, Delaware, Florida, Georgia, Illinois, Kentucky, Maine, Michigan, Missouri, North Carolina, Nevada, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, and West Virginia.
[18]These States are: Alabama, Arizona, California, Colorado, Connecticut, Florida, Georgia, Indiana, Louisiana, Maryland, Maine, Michigan, Minnesota, Missouri, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and Wisconsin.

These practices – instituting long drive times and restricting access to necessary specialists and transplant hospitals, along with increasing the cost burden for enrollees requiring dialysis – discriminate against dialysis patients in violation of the intent of the ACA and other anti-discrimination laws. While we understand that ACA issuers may be struggling with risk, CMS should address these concerns through appropriate risk adjustment, reinsurance, and risk corridor policies rather than allowing discriminatory practices to stand.

Additionally, allowing plans to provide less than substantially equal coverage results in higher overall health care spending. Plans that push enrollees with kidney failure into Medicare after only three months are less likely to provide early disease prevention and maintenance, which are essential to improving patient outcomes and quality of life, as well as bending the cost curve.

Given that States too have an interest in maintaining their Exchanges, we believe it is critically important for the federal government to engage in active oversight to ensure network adequacy and prohibit discrimination against dialysis patients in particular. This engagement should be proactive and not rely only upon actuarial analyses or health plan attestations. When the Agency discovers that a plan is not meeting the requirements, it should enforce those requirements.

B. Prospective time and distance standards should be tailored to avoid negatively impacting patient outcomes and minimum provider-covered person ratios should be adopted.

KCP also supports the metrics for evaluating network adequacy identified in the Proposed Rule:

- Prospective time and distance standards at least as stringent as the FFE standard; and

- Prospective minimum provider-covered person ratios for the specialties with the highest utilization rate for its State.

As noted already, time and distance standards are important given the current practice of some issuers to use narrow networks to encourage enrollees requiring dialysis to leave their plans and enroll in Medicare. We believe that using the standards established in the Medicare Advantage program would be appropriate. Thus, we are concerned that the federal default time and distance standards for outpatient dialysis do not align with these requirements.

The Draft LTI proposes the following time and distance standards for outpatient dialysis.

Proposed 2017 Letter to Issuers Network Adequacy Standards for Dialysis					
Specialty	Maximum Time and Distance Standards (Minutes/Miles)				
	Large Metro	Metro	Micro	Rural	Counties with Extreme Access Considerations (CEAC)
Outpatient Dialysis	30/15	45/30	80/60	90/75	125/110

The current MA time and distance standards are much shorter. It is unclear why the Agency, in some instances, has proposed to increase the drive times and distances in the Draft LTI for a patient population that must receive treatment at least three times a week, every week.

2016 Medicare Advantage Network Adequacy Standards for Dialysis					
Specialty	Maximum Time and Distance Standards (Minutes/Miles)				
	Large Metro	Metro	Micro	Rural	Counties with Extreme Access Considerations (CEAC)
Outpatient Dialysis	20/10	45/30	65/50	55/50	100/90

Research evaluating the effect of self-reported one-way travel times for patients receiving hemodialysis has shown that longer travel times are associated with greater mortality risk and decreased health-related quality of life. Travel times can also affect adherence to treatment protocols, withdrawal from dialysis therapy, hospitalization, and transplantation. The study found an impact even when the drive time is as little as 15 minutes one-way.[19] Thus, it is critically important to make sure that time and distance standards are as short as possible to avoid negatively impacting patient care and outcomes.

Dialysis patients have also had difficulty accessing nephrologists and other specialists in network, so establishing minimum ratios would be helpful. When establishing these minimums, CMS should ensure access to dialysis facilities and nephrologists. Given the evolving nature of plans, we also encourage CMS to update

[19]LM Moist, JL Bragg-Gresham, RL Pisoni, *et al,* "Travel time to dialysis as a predictor of health-related quality of life, adherence, and mortality: The Dialysis Outcomes and Practice Patterns Study (DOPPS)," 51 Am J Kidney Dis 641-650 (2008).

the metrics as new practices that discourage enrollment of, or discriminate against, certain populations are identified.

C. CMS should require issuers, when a provider is terminated, to ensure continuity of care and appropriate patient transitions and add a wait time standard.

KCP strongly supports the proposal in the Draft LTI and NBPP Proposed Rule to require an issuer, in cases where a provider is terminated without cause, to allow an enrollee in active treatment to continue treatment until the treatment is complete or for 90 days. Continuity of care is a critical issue for dialysis patients. Being able to maintain access to their care team would allow for a smooth transition to other network providers, in the event their providers are terminated. Because these patients require monthly visits with their physicians, as well as dialysis three times a week, it is not easy for them to immediately change providers. A 90-day transition period would allow a dialysis patient time to consider his/her options and seek treatment from other providers if necessary.

Additionally, KCP supports adding a wait time standard across qualified health plans in the federal facilitated exchanges, as well as for State exchanges. Access to specialists is critically important to all chronically ill patients, especially those requiring dialysis. To provide adequate coverage for dialysis, which is an essential health benefit, plans must not only include the specialists necessary to care for such patients, but also a sufficient number of them in the network to ensure patients can schedule appointments with them in a timely manner. We urge CMS to tailor these standards to ensure that issuers are addressing the specific needs of the populations they are serving and cannot use long wait times as a tool to encourage individuals to disenroll from their plans.

III. Conclusion

KCP appreciates the opportunity to provide comments on the Draft LTI. We reiterate our support for the express statement that patients who are under 65 years old with ESRD are not required to enroll in Medicare. We urge CMS to promulgate policies that align with the intent of the ACA to provide access to affordable and high quality coverage. To meet these goals, practices that discriminate against certain types of enrollees, including dialysis patients, should be abolished.

To this end, KCP urges CMS to: (1) Require issuers to accept payments from not-for-profit charitable organizations that existed prior to the enactment of the ACA, have been reviewed favorably by the OIG, provide at least one year of assistance to individual enrollees, and offer assistance for the purchase of any coverage option; and (2) Provide federal oversight of issuers to ensure appropriate

plan design and the adequacy of networks, instead of relying upon States, including establishing time and distance standards and minimum provider-covered person ratios, as well as ensuring continuity of care and reducing wait times. We understand that issuers have concerns about the risk pool, but discrimination should not be allowed to continue for that reason. Instead, we support efforts to appropriately address risk adjustment, reinsurance, and risk corridors. These are distinct issues and should be addressed as such.

We look forward to working with you on these issues. Please do not hesitate to contact Kathy Lester at (202) 534-1773 or klester@lesterhealthlaw.com if you have any questions.

Sincerely,

Frank Maddux, M.D.
Chairman
Kidney Care Partners

Appendix A: KCP Members

AbbVie
Akebia Therapeutics, Inc.
American Kidney Fund
American Nephrology Nurses' Association
American Renal Associates, Inc.
American Society of Nephrology
American Society of Pediatric Nephrology
Amgen
AstraZeneca
Baxter Healthcare Corporation
Board of Nephrology Examiners and Technology
Centers for Dialysis Care
DaVita Healthcare Partners, Inc.
Dialysis Patient Citizens
Dialysis Clinic, Inc.
Fresenius Medical Care North America
Fresenius RTG
Greenfield Health Systems
Hospira a Pfizer Company
Keryx Biopharmaceuticals, Inc.
Kidney Care Council
National Kidney Foundation
National Renal Administrators Association
Nephrology Nursing Certification Commission
Northwest Kidney Centers
NxStage Medical
Renal Physicians Association
Renal Support Network
Rogosin Institute
Sanofi
Satellite Healthcare
U.S. Renal Care