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By U.S. Mail and Email

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RE: Complaint Regarding Unfair Business Practices and Charitable Trust Law Violations by the American Kidney Fund's Health Insurance Premium Program

Dear Senior Assistant Attorneys General Ibanez and Akers,

We write on behalf of our client, Service Employees International Union Healthcare Workers West (SEIU-UHW), to urge the Attorney General's office to investigate and take appropriate enforcement action to halt the California dialysis industry's illegal premium assistance scheme. Under this scheme, operated through the nonprofit American Kidney Fund's Health Insurance Premium Program, patients with End Stage Renal Disease ("ESRD") are steered away from Medi-Cal or Medicare in favor of individual commercial insurance policies sold on Affordable Care Act ("ACA") marketplaces, including Covered California. The Fund pays monthly premiums for ESRD patients, but, the evidence shows, only so long as they do not receive kidney transplants. Keeping ESRD patients on commercial insurance benefits the dialysis industry by allowing it to reap greater profits through charging commercial insurers exorbitant reimbursement rates. The steering scheme's sole purpose is to provide this boon for the dialysis industry; no legitimate purpose is served. In fact, the program operates in violation of federal guidance and to the detriment of ESRD patients throughout the state by causing them to be underinsured for their medical needs other than dialysis, and by threatening their insurance coverage for kidney transplants and post-transplant care.

As described in detail below, the evidence shows that the Premium Program violates California's Unfair Competition Law as well as charitable trust law, because the Program contravenes operative federal guidance and harms and endangers ESRD patients and health

insurance consumers. The Attorney General should therefore audit and investigate the Premium Program and take action to prevent further harm to vulnerable ESRD patients and to the public.

I. Background: The Kidney Fund's Premium Payment Scheme and Governing Federal Guidance

The Kidney Fund, a 501(c)(3) non-profit headquartered in Rockville, Maryland, is the vehicle for the dialysis industry's scheme to steer patients into commercial insurance rather than Medi-Cal or Medicare. The Kidney Fund is funded by contributions from the dialysis industry, with the two largest contributors providing approximately 80% of the Kidney Fund's revenue.[1] With these industry contributions, the Kidney Fund provides commercial insurance premium payments and other forms of financial assistance to an estimated 90,000 dialysis-dependent ESRD patients.[2] Funneling donations through the Premium Program to enroll patients into commercial insurance is a financial win for dialysis providers, because commercial insurers reimburse dialysis facilities at much higher rates than do Medicare or Medicaid, creating "a strong financial incentive for such providers to use premium payments to steer as many patients as possible to commercial plans."[3]

ESRD is a permanent and irreversible condition that can be treated only with costly regular dialysis treatments or with a kidney transplant. All patients with ESRD are eligible to enroll in Medicare (provided they qualify for Social Security benefits), as has been the case since the Social Security Act Amendments of 1972.[4] Since 1972, due to the spread of health conditions that lead to ESRD (such as diabetes and hypertension), the number of patients receiving treatment for the disease has risen dramatically, with the costs borne almost entirely by the federal government.[5] Commercial health insurance policies were constructed and negotiated with

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[1] DaVita and Fresenius, the two large dialysis care providers in the United States, each with annual revenue in the billions, have contributed nearly 80% of the Kidney Fund's approximately $250 million in annual revenue in recent years. *See* Katie Thomas and Reed Abelson, *Kidney Fund Seen Insisting on Donations, Contrary to Government Deal*, THE NEW YORK TIMES (December 25, 2016), https://www.nytimes.com/2016/12/25/business/kidney-fund-seen-insisting-on-donations-contrary-to-government-deal.html?_r=0, attached as Exhibit A; Nick Budnick, *Oregon Officials Grill Dialysis Companies and the American Kidney Fund About High Costs, Transplants*, THE OREGONIAN/OREGONLIVE (Jan. 4, 2012), http://www.oregonlive.com/health/index.ssf/2012/01/oregon_officials_grill_dialysi.html, attached as Ex. B. *See also* American Kidney Fund, Inc. Form 990 for 2015, attached as Ex. C; American Kidney Fund, Inc. Financial Statements for 2014 and 2015, attached as Ex. D, at p.19.

[2] Kidney Fund HIPP Guidelines August 2016 (http://www.kidneyfund.org/assets/pdf/financial-assistance/hipp-guidelines.pdf), attached as Ex. E, at pp. 4-5; *see also* Ex. C.

[3] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS") Interim Final Rule, Medicare Program, Conditions for Coverage for End-Stage Renal Disease Facilities—Third-Party Payment, 81 Fed. Reg. 90,211 (Dec. 14, 2016), attached as Ex. F.

[4] Social Security Amendments of 1972, Pub. L. No. 92-603, § 2991 (codified at 42 U.S.C. § 426-1).

[5] *See, e.g.*, Rudolph Daniels, *Legislation and the American Dialysis Industry: Some Considerations about Monopoly Power in Renal Care*, 50 THE AMERICAN JOURNAL OF ECONOMICS AND SOCIOLOGY 223, 223-

the knowledge that patients with ESRD would have Medicare coverage, such that the costs of ESRD care would not be felt throughout the commercial health care system in the form of higher premiums and deductibles for the average health care consumer.

In 1997, the Department of Health and Human Services, Office of the Inspector General issued an advisory opinion ("1997 OIG Opinion") that set forth a narrow, carefully delimited framework in which the Premium Program could operate in accordance with the anti-kickback provision of the Health Insurance Portability and Accountability Act ("HIPAA").[6] As the 1997 OIG Opinion notes, HIPAA section 231(h) provides for penalties against any person who "offers remuneration to any individual eligible for benefits under [Federal health care programs (including Medicare or Medicaid)] that such person knows or should know is likely to influence the individual to order or receive services from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, [by a Federal health care program]."[7]

The OIG explained in an advisory bulletin that the anti-kickback law's intent is to protect patients' quality of care; if providers could offer financial benefits in order to attract patients, they would have "an economic incentive to offset the additional costs attributable to the giveaway by providing unnecessary services or by substituting cheaper or lower quality services" (and larger providers would have an undue advantage over smaller ones).[8]

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242 (Apr. 1991) (detailing rise in patient care and costs in the first two decades following the 1972 Amendments); United States Renal Data System, Annual Data Report, vol. 2, ch. 11 (2015), at S278-S279, *available at* www.ajkd.org/article/S0272-6386(16)00114-1/pdf (from 2003 to 2013, Medicare-covered ESRD claims represented about three-quarters of all spending for ESRD patients in the United States).

[6] Office of the Inspector General, Advisory Opinion 97-1 (1997), *available at* https://oig.hhs.gov/fraud/docs/advisoryopinions/1997/kdp.pdf, attached as Ex. G. The CMS Interim Final Rule has been enjoined. Memorandum Opinion and Order, *Dialysis Patient Citizens, et al. v. Burwell*, Case No. 4:17-cv-16, 2017 WL 365271 (E.D. Tex., Jan. 25, 2017), ECF No. 36. The 1997 OIG Opinion therefore remains the operative guidance governing how the Kidney Fund's premium assistance scheme must function so as not to violate the federal anti-kickback statute (*see also* Ex. E (noting that "[s]ince 1997, AKF has operated the [Premium Program] with careful adherence to the guidelines set forth in AO 97.1")).

[7] Ex. G (bracketed and parenthetical language quoted as in 1997 OIG Opinion); 42 U.S.C. § 1320a-7b(b).

[8] Department of Health and Human Services, Office of the Inspector General, Special Advisory Bulletin, OFFERING GIFTS AND OTHER INDUCEMENTS TO BENEFICIARIES (August 2002), attached as Ex. H. The bulletin refers to the 1997 OIG Opinion as an example of terms according to which a third-party entity may provide remuneration to needy patients who are eligible for government insurance without violating the anti-kickback law, "so long as the independent entity makes an independent determination of need and the beneficiary's receipt of the remuneration does not depend, directly or indirectly, on the beneficiary's use of any particular provider." Ex. H, pp. 2, 7.

The OIG ruled that the Premium Program (which was slated for expansion at the time) would not constitute prohibited remuneration under HIPAA only if certain safeguards were met, including:

- Contributions to the Kidney Fund by dialysis providers must not amount to donations "made to or on behalf of an individual eligible for federal health care program benefits." To ensure that provider contributions to the Premium Program do not constitute prohibited donations made to or on behalf of patients eligible for federal program benefits, the Kidney Fund must maintain "absolute discretion" regarding the use of the contributions, and must not be subject to the providers' direct or indirect control;

- Eligibility for Premium Program assistance must be available to any financially needy ESRD patient, regardless of provider, not limited to patients of the contributing providers;

- Contributing providers will not track the amounts the Premium Program pays on behalf of patients receiving treatment at their facilities to calculate the amounts of their future donations, will not earmark donations for particular beneficiaries, will not collude in determining the amount of their contributions, and may change the amount of their contributions or discontinue contributions at any time; and

- The Premium Program would not be advertised to the public by the dialysis providers, and beneficiaries would be free to select any providers they choose, measures intended to prevent the Kidney Fund premium payment program from influencing patients' choice of providers in violation of HIPAA.

Ex. G (1997 OIG Opinion), at pp. 5-6.

Prior to the passage of the ACA in 2010, the Premium Program primarily served to provide premium assistance payments for Medicare Part B and Medigap health insurance, as well as some large group employer and COBRA health plans.[9] However, when the ACA prohibited denying commercial health insurance coverage on the basis of pre-existing health conditions, commercial insurance became available to ESRD patients who had previously been disqualified. As a result, the Kidney Fund began to use the Premium Program as a vehicle to steer ESRD patients into commercial insurance through the ACA individual market exchanges, with lucrative rewards for the dialysis industry.

[9] *See* Ex. G (noting that the Premium Program was intended to pay Medicare Part B and Medigap premiums).

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II. Legal Analysis

A. The Kidney Fund's Premium Program Is an Unlawful and Unfair Business Practice Because It Violates Federal Guidance and Operates to the Detriment of ESRD Patients and Consumers of Commercial Insurance.

In operating the Premium Program, the Kidney Fund flouts the terms of the 1997 OIG Opinion, and thus runs afoul of California's Unfair Competition Law ("UCL"), which prohibits "any unlawful, unfair or fraudulent business act or practice." Cal. Bus. & Prof. Code § 17200.

It has long been established that business practices that violate federal laws and regulations (as well as those that violate state law) constitute violations of the UCL. *See, e.g.*, *L.A. Memorial Coliseum Comm'n v. Insomniac, Inc.*, 233 Cal. App. 4th 803, 835-36 (2015) (authorizing suit under § 17200 for failure to pay payroll taxes as required by 26 U.S.C.§§ 3101 & 3102); *Southwest Marine, Inc. v. Triple A Machine Shop, Inc.*, 720 F. Supp. 805 (N.D. Cal. 1989) (authorizing § 17200 suit for violation of Navy procurement regulation and environmental laws); *Diaz v. Kay-Dix Ranch*, 9 Cal. App. 3d 588, 591 (1970).

A claim also arises under the UCL where a business practice is "unfair," even without a technical violation of the underlying law. *Cel-Tech Comm's, Inc. v. L.A. Cellular Tel. Co.*, 20 Cal. 4th 163, 180 (1999). Conduct that "violates the policy or spirit" of a law "because its effects are comparable to or the same as a violation of the law" is actionable under the UCL. *Id.* at 187.[10]

While the Kidney Fund purports to operate the Premium Program in compliance with the 1997 OIG Opinion, in practice we believe the evidence shows that the Premium Program violates every important provision of the federal guidance. Consequently, it also violates HIPAA's anti-kickback provision, by intentionally transferring remuneration (i.e., premium payments) to individuals who are eligible for Medicaid coverage in a way likely to influence which dialysis facilities provide treatment for large numbers of ESRD patients. 42 U.S.C. § 1320a-7b(b). In order to prevent the possibility of such prohibited influence, the 1997 OIG Opinion requires that the Kidney Fund may not use the Premium Program to distribute premium assistance on the basis of whether a given patient's dialysis provider has donated to the Kidney Fund, but instead must distribute funds to qualifying ESRD patients regardless of their

[10] The California courts cite several common formulations of what constitutes an "unfair" business practice in consumer cases. *See, e.g., Moran v. Prime Healthcare Mgmt., Inc.*, 3 Cal. App. 5th 1131, 1150 (2016) (discussing formulations of "unfairness" under the UCL). The Premium Program is an unfair business practice no matter what version of the standard is applied. It violates established public policy that is "tethered to" specific federal guidance setting forth the terms under which third-party premium programs may exist without violating federal anti-kickback law, and it causes substantial injury to consumers by endangering the health of ESRD patients and making healthcare more expensive for consumers of commercial insurance, without offering countervailing benefits that outweigh this harm.

providers.[11] Contrary to this requirement, we believe an investigation will confirm that the Premium Program directs grant money primarily to donating providers and discourages non-donating providers from referring their financially needy patients to the program, in violation of the federal guidance, the federal anti-kickback statute, and the underlying public policy objective of ensuring that patients who are eligible for federal insurance coverage are not influenced to receive treatment from particular providers.

Recent investigative reporting by *The New York Times* reveals that Kidney Fund assistance payments to patients are contingent upon providers' donations to the fund.[12] Interviews with social workers from various dialysis providers describe how the Kidney Fund kept them from applying for assistance on behalf of patients at non-donor clinics. As *The Times* explained, "Under an agreement with the federal government, the Kidney Fund must distribute the aid based on a patient's financial need. But the charity has resisted giving aid to patients at clinics that do not donate money to the fund … In multiple cases, the charity pushed back on workers at clinics that had not donated money, discouraging them from signing up their patients for assistance. Until recently, the Kidney Fund's guidelines even said clinics should not apply for aid on behalf of their patients if the company had not donated to the charity.[13]

The Times interviewed more than a dozen social workers, and found that they widely understood that the Kidney Fund's premium assistance is not available to patients whose dialysis provider does not make donations. In fact, *The Times* describes how the charity demanded in-kind donations for any patient covered through Kidney Fund premium assistance:

> An administrator at an independent clinic in a Midwestern city said he had helped a handful of patients maintain their coverage through the fund after they transferred to his clinic from a large chain. He declined to be identified because, he said, he did not want to anger DaVita and Fresenius, who sometimes send him patients.
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> Each time, he said, the charity's workers later demanded that the clinic make a donation that at a minimum covered the amount it had paid for the patient's premium. If he did not pay, he said he had been told, the patient risked losing the financial help from the charity for his insurance.[14]

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[11] Ex. G, at 4.
[12] Ex. A.
[13] Ex. I, Kidney Fund HIPP Guidelines (May 2014), at 5 ("All contributions are, of course voluntary …. Nonetheless, it should be obvious to all facilities that if each one does not contribute its fair share, the HIPP pool cannot continue to help all its patients who need assistance. If your company cannot make fair and equitable contributions, we respectfully request that your organization not refer patients to the HIPP program in order than we may preserve this important program ….").
[14] Ex. A.

The practices *The Times* describes constitute violations of the federal anti-kickback law, as they show that the Premium Program conditions assistance on whether an applicant's dialysis provider has donated to the Fund, in direct contravention of the strict requirements set forth in the 1997 OIG Opinion.[15]

Based on this evidence, and combined with additional evidence summarized in this letter that the Kidney Fund's practices are harming ESRD patients and consumers of commercial insurance (see Section II.C, below), we urge the Attorney General to take action to cease the Kidney Fund's violations of California's UCL.

B. The Kidney Fund Has No Legitimate Charitable Purpose, But Rather Exists to Provide Financial Benefits to For-Profit Dialysis Providers, at the Cost of Sacrificing Patients' Medical and Financial Wellbeing.

The Attorney General's supervisory authority over charitable trusts provides another basis for the office to investigate and take enforcement action against the Kidney Fund: Although it purports to be a nonprofit, the Kidney Fund serves no charitable purpose, but in fact operates to drive profits to the leading dialysis companies, and undermines patients' health.

In its 2015 IRS Form 990, the Kidney Fund described its charitable mission as follows: "We help people fight kidney disease and live healthier lives. We achieve our mission by providing financial support to patients in need, and by delivering programs that educate, build awareness, and drive advocacy, resulting in greater public understanding and ultimately the prevention of kidney disease."[16] Contrary to this commendable stated mission, however, the Kidney Fund operates not for the benefit of ESRD patients, but to advance the financial interests of the private dialysis industry.

As the leading treatise on California law explains, legitimate charitable or public purposes are "those deemed beneficial to the community … The purpose must be *public*, i.e., it must be of some social benefit."[17] Public purposes identified by the Restatement (Third) of

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[15] A spokesman for the OIG refused to tell *The Times* whether the agency is investigating the Kidney Fund for violations of the terms of the 1997 OIG Opinion. Ex. A. However, in January 2017, the Department of Justice issued subpoenas to the Kidney Fund, DaVita, and Fresenius, requiring them to produce information about the Premium Program. Katie Thomas and Reed Abelson, *Dialysis Chains Receive Subpoenas Related to Premium Assistance*, THE NEW YORK TIMES (Jan. 6, 2017), https://www.nytimes.com/2017/01/06/business/american-kidney-fund-fresenius-davita-subpoena.html?_r=0, attached as Ex. J.

[16] Ex. C.

[17] 13 Witkin, Summary of California Law: Trusts § 289 (10th ed. 2005) (emphasis in original). *See also Bob Jones University v. United States*, 461 U.S. 574, 622 (1983) ("In return for the favorable treatment accorded charitable gifts which imply some disadvantage to the community, the courts must find in the trust which is to be deemed 'charitable' some real advantages to the public which more than offset the

Trusts, § 28 (Am. Law Inst. 2003), include the following: (a) the relief of poverty, (b) the advancement of knowledge or education, (c) the advancement of religion, (d) the promotion of health, (e) governmental or municipal purposes, and (f) other purposes that are beneficial to the community. In addition, charities must operate according to a fundamental principle of the law of charitable trusts: that "the purpose of a charitable trust may not be illegal or violate established public policy." *Bob Jones Univ.*, 461 U.S. at 591 (citing *Perin v. Carey*, 24 How. 465, 501 (1861), holding that a public charitable use must be "consistent with local laws and public policy"); *see also* Restatement (Third) of Trusts, § 28 (Am. Law Inst. 2003); George G. Bogert & George T. Bogert, Law of Trust and Trustees § 378 (2d rev. ed. 1977); Restatement (Second) of Trusts § 377 cmt. c (Am. Law Inst. 1959); Austin Scott, The Law of Trusts § 377 (2d ed. 1956) and cases cited therein.

The true purpose of the Kidney Fund's steering scheme is to benefit private dialysis providers financially, by increasing the number of patients enrolled in commercial insurance, which in turn allows dialysis providers to collect more from these patients' insurers than they would if the patients had Medicaid or Medicare.[18] Channeling profits to for-profit dialysis providers is not a valid charitable purpose.

Further, the Fund does not benefit public health, as it claims, but endangers the health of individual ESRD patients who may lose coverage as a result of the Fund's risky practices or lose opportunities to receive life-saving transplants, while also raising costs for others in the insurance market. Such harm, too, provides a basis for Attorney General action against the Kidney Fund under charitable trust law. For example, the IRS has observed that paying additional money for referrals to hospitals "undermines a hospital's charitable purposes and may be questioned under a community benefit analysis or possibly private benefit or inurement."[19] Such referrals can "harm[ ] the community's health and society generally."[20] Therefore,

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disadvantages arising out of special privileges accorded charitable trusts.") (quoting G. Bogert & G. Bogert, The Law of Trusts and Trustees § 361, at 3 (rev. 2d ed. 1977)).

[18] *See, e.g.*, Ex. F, at 90,214-15, where CMS estimates, based on public comments, that a typical patient enrolled in commercial insurance would earn at least $100,000 more per year for a dialysis clinic than if that patient had government coverage, because commercial coverage reimburses providers at much higher rates. "This asymmetry creates a strong financial incentive for such providers to use premium payments to steer as many patients as possible to commercial plans." *Id.* at 90,215. Dialysis patients are "particularly vulnerable to harmful steering practices" because (a) their eligibility for Medicare coverage makes them "less profitable from the perspective of the facilities" due to lower Medicare reimbursement rates, but (b) the fact that they receive frequent, often lifelong treatment at dialysis facilities creates unique opportunities for providers to "influence of the coverage arrangements of patients under their care" in order to reap greater profits. *Id.*

[19] Jean Wright & Jay H. Rotz, "Illegality and Public Policy Considerations," 1994 IRS Exempt Organizations CPE Text, at pp. 15-16, attached as Ex. K.

[20] *Id.* at p. 16.

"payments to induce referrals may be inconsistent with exempt status even if they have not been declared illegal by a court."[21]

As an even stronger potential basis for finding a violation of charitable trust law, the evidence as outlined above in Section II.A also leads to the conclusion that the Premium Program is illegal under federal anti-kickback law, the Kidney Fund's governing federal guidance (the 1997 OIG Opinion), and the UCL. Under well-established law, illegality provides a basis for the Attorney General to take immediate action to prevent the Kidney Fund from continuing to misuse charitable funds.[22]

C. The Kidney Fund's Steering Scheme Results in Actual Harm to ESRD Patients and Healthcare Consumers at Large.

The Kidney Fund's profit-driven Premium Program not only violates the federal anti-kickback statute, unfair competition law and charitable trust law, but most troublingly, it is harmful to patients. As highlighted in the CMS Interim Final Rule, this harm has three facets: the steering scheme interferes with patients' ability to receive lifesaving kidney transplants, exposes them to unexpected health care costs, and disrupts their insurance coverage.[23]

1. The Premium Program Limits Patients' Access to Kidney Transplants.

Enrollment in the Premium Program may negatively impact a patient's decision and/or ability to receive a kidney transplant. The only treatment option available to ESRD patients other than regular dialysis treatments is kidney transplantation.[24] If transplantation is available, it is typically the recommended course of treatment, because patients who receive transplants are able to resume a normal life without the need for constant dialysis. Transplant patients have better health outcomes, decreased risk of death and improved quality of life.[25]

Patients undergo intensive health screening and evaluation by each transplant center to determine their transplant readiness, and only after they are approved by the transplant center are they added to the transplant waitlist. One factor in considering a patient's transplant readiness is that the transplant center must conclude that the patient will have access to continuous health coverage, because post-transplant healthcare is essential to maximize the chances for successful short-term recovery and long-term health. However, the Kidney Fund Premium Program

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[21] *Id.*
[22] *Id.* at p. 15; *see also* IRS General Counsel Memorandum 39862 (explaining that a violation of anti-fraud and anti-kickback laws by a hospital jeopardizes tax exempt status).
[23] Ex. F, at 90,215-17. As noted *supra*, note 7, following a legal challenge by dialysis providers and a corporate-backed advocacy group, the U.S. District Court for the Eastern District of Texas has issued a preliminary injunction blocking implementation of the regulation.
[24] Ex. F, at 90,212.
[25] *Id.* at 90,215.

provides assistance only for ESRD patients *currently receiving dialysis*.[26] The program will not continue to provide support to patients after a successful kidney transplant, even during necessary monitoring and follow-up care. This exceptionally cynical Kidney Fund policy on funding for transplant care reflects the priorities of a program designed not for patient care, but to promote the financial interests of dialysis facilities.

Patients who receive support from the Kidney Fund are, by definition, in need of financial assistance. In practice, because these patients are often unable to pay their commercial insurance premiums out-of-pocket when the Kidney Fund cuts off support, ESRD patients can be denied or delayed access to the transplant waitlist because they rely on Kidney Fund assistance to purchase ACA market plans.[27] In a letter to CMS in response to the Interim Final Rule, a transplant center employee describes how Premium Program assistance hinders ESRD patients' ability to access kidney transplants: "Many of these patients are having their transplant evaluations discontinued or delayed while they work to obtain appropriate and affordable insurance coverage …."[28]

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[26] Ex. I, Kidney Fund HIPP Guidelines (May 2014), at 6 ("Transplant patients are not eligible for HIPP.") More recently, Kidney Fund has revised its guidelines to replace this clear rule with ambiguous information about eligibility for transplant patients. The 2016 Guidelines state, "We continue assistance to qualified persons for their entire policy term, even if they change insurance, change health care provider or receive a kidney transplant" (Ex. E, p. 5), but also warn that "HIPP assistance is limited to those with ESRD and … there are potential limits in the HIPP funding pool. It is especially critical that HIPP enrollees who may be candidates for a kidney transplant understand this aspect of HIPP" (*id.* at 9). While the Guidelines have been edited in a manner that obfuscates the Kidney Fund's policies regarding assistance for patients who receive transplants, investigations into the Kidney Fund's activities indicate that they continue to cut off assistance when patients receive transplants. *See, e.g.*, Blue Shield of California, Comment Letter on Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans (Sept. 22, 2016), https://www.regulations.gov/document?D=CMS-2016-0145-0788, attached as Ex. L, and sources cited throughout this section.

[27] In the order enjoining the interim final rule, the District Court for the Eastern District of Texas held that an expedited rulemaking process was unwarranted, in part because, according to the court, the government had not produced an "example of a patient denied a kidney transplant because of charitable assistance." *Dialysis Patient Citizens*, 2017 WL 365271 at *4. Unfortunately, this reasoning ignores the inherent harm of delaying a patient's transplant while he or she grapples with the complicated process of establishing post-transplant coverage, as described in this section. *See, e.g.*, Teri Browne, Comment Letter on Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans (Sept. 22, 2016), https://www.regulations.gov/document?D=CMS-2016-0145-0822, attached as Exhibit M (comment from nephrology social worker describing problems being listed for transplants or with insurance coverage post-transplant as "the most alarming phenomenon" resulting from steering schemes such as the Kidney Fund's).

[28] Comment Letter on Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans (Sept. 22, 2016), https://www.regulations.gov/document?D=CMS-2016-0145-0761 (attached as Ex. N).

Based on our investigation, we are confident that the Attorney General will find that premium assistance through the Premium Program interferes with patients' ability to receive transplants, because of concerns about post-transplant coverage. We urge the Attorney General's office to act on its authority to end this alarming threat to public health.

2. ESRD Patients Enrolled in the Premium Program Face Added Costs and Problems Navigating the Terms of Their Coverage.

Another way the Premium Program harms patients is by exposing them to additional costs for health care services in the form of unexpected co-payments and deductibles. In addition, the program's lack of transparency makes it difficult for patients to comprehend the terms of their coverage and the potential disadvantages of commercial insurance.

ESRD patients have significant medical needs beyond dialysis treatment. As CMS stated in the interim final rule, for Medicare-enrolled ESRD patients, half or more of the cost of their coverage is for non-dialysis services, such as vascular care, inpatient hospital or skilled nursing facility care, prescription drugs, primary care and co-morbid conditions, and more.[29] As CMS also explained, for patients who are dually covered by Medicare and Medicaid, commercial insurance "exposes very-low income patients to thousands of dollars in out-of-pocket costs" they would not otherwise bear.[30] "Thus, it is very unlikely that it would be in such individual's financial interest to elect individual market coverage."[31] For patients eligible for "Original Medicare" (fee-for-service), CMS also identified financial drawbacks to commercial insurance, including the fact that commercial insurance often offers a more restrictive network of providers, resulting in potential higher costs for out-of-network services.[32]

Patients suffering from a severe illness such as ESRD are particularly unequipped to evaluate the potential additional costs they could incur by participating in the premium assistance program, or to handle coordination of coverage difficulties. As with the coverage disruption problems described below, these obstacles demonstrate that steering ESRD patients into commercial insurance benefits dialysis providers, not patients.

3. ESRD Patients Enrolled in the Premium Program Are at Risk of Coverage Disruptions That Endanger Their Health.

An additional harm wrought by the Premium Program is that it puts patients at risk of an unexpected mid-year disruption in health care coverage, which can be deadly for ESRD patients, who require uninterrupted dialysis treatments (or a transplant) to stay alive. As described above, disruptions in health coverage can obstruct a patient's access to kidney transplantation. However,

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[29] Ex. F, at 90,216-17.
[30] *Id.*
[31] *Id.*
[32] *Id.*

a more immediate concern is that the Kidney Fund's practices have begun causing insurers to reject payments from the Fund, which can result in a sudden loss of coverage for patients who can ill afford it.

Dialysis patients require constant care, typically including dialysis treatment sessions several times per week (and, because of their compromised overall health, many ESRD patients have crucial non-dialysis healthcare needs as well).[33] Their care cannot be interrupted even for a short time without disastrous health consequences or death.

Recently, CMS has urged private insurers to reject third-party premium payments because of concerns that allowing such payments would "skew the insurance risk pool and create an unlevel field" among ACA Marketplace plans, with an exception for premium payments from non-profit foundations who distribute funds for a full policy year and base assistance offers on patients' financial status only (without considering health status).[34] Based on this guidance and on the Kidney Fund's questionable criteria for awarding assistance, some insurers have recently begun refusing to accept payment from the Premium Program.[35]

The volatile relationship between the Kidney Fund and insurers puts ESRD patients at risk of suddenly losing coverage midyear, endangering their health and even their lives, and provides another basis for the Attorney General to investigate both charitable trust violations and unfair business practices by the Fund.[36]

4. Healthcare Consumers Are Also Harmed.

Finally, we urge the Attorney General to also investigate the harm the Kidney Foundation's steering scheme causes to California consumers in the form of rising costs and premiums in Covered California.

Due to their typical overall health conditions and their need for frequent and expensive treatment, ESRD patients are significantly more costly to insure than an average consumer of health insurance.[37] Routing these patients to commercial plans on the ACA exchanges means

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[33] Ex. F, at 90,217.
[34] Ex. O, CMS Nov. 4, 2013 and Feb. 7, 2014 Frequently Asked Questions regarding third party payments of marketplace health plan premiums.
[35] *See, e.g.*, Rebecca Zumoff, *Health Insurers Continue to Refuse Premium Payments from American Kidney Fund*, NEPHROLOGY NEWS AND ISSUES (May 10, 2017), *available at* http://www.nephrologynews.com/more-health-insurance-companies-refusing-premium-payments-from-american-kidney-fund/; Christopher Snowback, *Insurers Wary of Premium Help for Patients*, STAR TRIBUNE (July 30, 2016), *available at* http://www.startribune.com/insurers-wary-of-premium-help-for-patients/388618021/; Gary P. Taylor, JP Morgan Analyst's Report (August 18, 2016).
[36] Ex. F, at 90,217 (summarizing public comments concerning insurers' refusal to accept third-party premium payments and the consequences for patients of mid-year coverage disruption).
[37] Ex. L, at p. 4.

higher overall costs for these insurers, and therefore higher premiums for all consumers. Major insurer Blue Shield of California has estimated that it takes 3,800 healthy members enrolled for 12 months to make up for the costs of covering a single ESRD patient enrolled through the Kidney Fund exchanges.[38] Blue Shield also described how this third-party premium payment scheme has led directly to premium increases in their ACA exchange plans:

> Blue Shield has tracked at least $64 million in paid claims since the ACA took effect in 2014 that are related to fraudulent or abusive third-party payments. While the majority of this enrollment took place off-Exchange, it has a direct impact on our on-Exchange premiums because enrollees share the same risk pool. We estimate that every $10 million in claims drives up rates by one-half a percent.[39]

In late 2016, when this issue began to break publicly, a noted long-term Wall Street analyst attempted to quantify the impact on the healthcare exchanges and came up with a number that was over $1 billion.

The issue of growing costs in the ACA individual market has been of increasing concern to policymakers, and represents a major threat to the success of the individual market and accessible affordable health coverage for all. As a legal matter, harm to consumers caused by the Kidney Fund's practices provides a further basis for Attorney General investigation and action.

III. Conclusion

The California Attorney General has a critical role to play in enforcing the laws that protect California's health consumers, especially those that benefit some of the sickest members of our population. Through the Attorney General's authority to enforce of unfair competition law and charitable trust law, the Attorney General has the power to protect ESRD patients, to help make sure that ESRD patients can rely on stable, affordable, insurance coverage and treatment, and to keep insurance premiums and costs down for Californians in the private insurance market.

We urge that the Attorney General conduct a full audit and investigation into the Kidney Fund and its Premium Program, and take any action the Attorney General deems appropriate to address the misuse of this charity's funds and end its harmful practices. We would be glad to meet and discuss the information in this complaint and how we may be helpful to the Attorney General in further investigating these important issues.

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[38] *Id.*
[39] *Id.*

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jackson
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Sincerely,

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By _____
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_____
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cc: Deputy Attorney General Wendi Horwitz (by email to wendi.horwitz@doj.ca.gov)
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Enclosures