America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite Five Hundred
Washington, DC 20004

March 20, 2019

Senator Laurie Monnes Anderson
Senate District 25
900 Court St. NE
S-211
Salem, Oregon 97301

Re: SB 900 – Third Party Payments (SUPPORT)

Dear Senator Monnes Anderson:

I write today on behalf of America's Health Insurance Plans (AHIP) to express our support for SB 900, legislation that requires greater transparency and robust consumer protections regarding third-party payments of premiums for patients of outpatient dialysis treatment facilities, to ensure that individuals are enrolled in coverage that best meets their needs.

AHIP is the national association whose members provide insurance coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

Third-party payments (TPPs) are payments made for consumers by outside entities, such as health care providers and facilities, pharmaceutical companies, or foundations. These payments can help patients pay their health care premiums, but many of the organizations making these payments stand to benefit financially through greater reimbursement by steering patients away from public program and into commercial coverage on the individual market. These payments may leave patients financially exposed and without access to care once payments are no longer being made and may lead to higher premiums for all consumers in the individual market.

The abuse of third-party payments undermines the system for everyone, including good actors who are sincerely invested in ensuring patients have access to the right care and coverage. Guardrails are critical to ensure that payments made by third-party entities are truly in the best interests of the patient, are not motivated by financial gain for the provider, and do not result in market destabilization.

We believe that SB 900 achieves these goals and establishes appropriate standards for the use of third-party payments, including requiring third-party payments to continue for a full year, providing disclosure of its payments to health plans and insurers, and prohibiting the steering of patients towards specific coverage options that benefit the third-party payer.

Third-party payments can harm consumers and threaten affordability for everyone.

TPPs raise overall health system costs and result in significant increases in premiums for the entire commercial population. Concerns about third-party payments have led to their general prohibition in public programs, with only clearly-specified exceptions. The federal anti-kickback statute prohibits third-party payments in the Medicare and Medicaid programs because of inherent conflicts of interest that often arise between the provider's financial interest and the best interest of the patient.

The practice of entities making third-party payments steering Medicare- and Medicaid-eligible beneficiaries into the individual market can increase the number of older and less healthy individuals in the individual market risk pool. When the risk pool is skewed and medical expenses exceed premium payment, costs go up for everyone. Although health plans undertake a number of activities to control the individuals' medical expenses (e.g., care management, value-based provider arrangements), steering a vulnerable, high-cost population to the individual market presents affordability concerns, and could lead to the destabilization of the individual market. An August 2016 analysis from J.P. Morgan reported that 6,400 qualified health plans purchased through the American Kidney Fund's program drove an estimated $1.7 billion in adverse selection.[1] It is critical that patients be enrolled in the coverage best designed to meet their needs to ensure a stable, sustainable individual market.

While TPPs can help some patients for certain periods of time, many third-party payers stand to benefit from higher reimbursement rates that ultimately raise premiums for the approximately 220,000 Oregonians enrolled in the individual market. J.P. Morgan estimated that the return on "charitable" donations by dialysis providers to the American Kidney Fund likely exceeds 500 percent.[2] We support appropriate reimbursement rates of financially interested providers that promote affordability across the entire health care system, particularly for those providers who refuse to contract with health plans and insurers.

Third-party payments pose particular harm for dialysis patients.

In response to a December 2016 request for information, HHS received comments from a range of stakeholders and concluded that enrolling end state renal disease (ESRD) patients in individual market coverage is in the financial best interest of dialysis facilities and has the potential to harm patients.[3]

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[1] J.P. Morgan. North America Equity, "DaVita Healthcare Partners: DVA Commercial Mix at Risk, Sensitivity is Material," August 18, 2016.
[2] J.P. Morgan, North America Equity Research, "DaVita Inc.," October 9, 2017.
[3] *Medicare Program; Conditions for Coverage for End-Stage Renal Disease Facilities-Third Party Payment*. 81 FR 90211. December 14, 2016. Available at https://www.govinfo.gov/app/details/FR-2016-12-14/2016-30016.

Specifically, HHS identified three types of harm that third-party payment arrangements create for ESRD patients:

- They negatively impact a patient's priority for a kidney transplant, placing the patient's health and well-being at risk;
- They could expose the patient to significant additional out-of-pocket costs for unrelated health care services that would have been covered at a much lower cost had the individual been enrolled in coverage through Medicare or Medicaid; and
- They place the patient at risk for mid-year disruptions in coverage, particularly if the third party stops making premium and cost-sharing payments once initial treatment is received, which could result in serious or life-threatening interruptions in access to care.

Health plans are committed to providing comprehensive coverage and access to high-quality care, including for those with chronic or complex health conditions.

SB 900 does not prohibit third-party payments but provides critical guardrails so that TPPs truly serve patients' interests, are not motivated by financial gain, and do not threaten Oregon's private, competitive, stable individual market. Consumers must fully understand the benefits – and limitations – of TPPs before making the decision to enroll. AHIP supports the author's commitment to eliminating the practice of third-party entities inappropriately steering patients to commercial health plans, improving transparency, and reducing the unintended harmful health-related and financial consequences of TPPs.

Patients should be given every opportunity to make informed decisions without undue influence from third parties.

Patients should be encouraged to apply for Medicaid, Medicare, or Exchange plans before seeking assistance from third parties. Existing public programs such as no-cost Medicaid may better suit patients' financial and health care needs, and many consumers may be eligible for significant financial aid through the Exchange that will lower their monthly premiums and/or copays and deductibles. Patients should have access to all relevant information before enrolling in TPPs, and we support the requirement that third-party entities inform patients of all available health coverage options and agree not to "steer, direct, or advise the insured into or away from a specific coverage program option or health coverage."

SB 900 gives consumers peace-of-mind by requiring TPPs for a full plan year.

TPPs are potentially harmful to patient care and pose a barrier to appropriate coordination of care. Patients are vulnerable to financial exposure or disruptions in care if payments stop in the middle of treatment. CMS guidance from 2014 supports the expectation that private, not-for-

profit foundations cover premium and any cost-sharing payments for the entire policy year.[4] This ensures consumers can focus on their health, knowing there will be no disruptions to their coverage or financial benefit. Without this protection, consumers would be left wondering how to afford their premiums if TPPs suddenly stop in the middle of a plan year.

Our members unequivocally support policies that will help patients access the care that they need, while ensuring that health coverage remains affordable for all. For those reasons, we support SB 900.

Please do not hesitate to contact me at sberry@ahip.org or 202.778.3200 should you have any questions.

Sincerely,

Stephanie Berry
Regional Director, State Affairs

CC: Representative Andrea Salinas
Representative Rachel Prusak
Senate Committee on Health Care

[4] *Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces*. Centers for Medicare & Medicaid Services. February 7, 2014. Available at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-payments-of-premiums-for-qualified-health-plans-in-the-marketplaces-2-7-14.pdf.