

**Office of Civil Rights Discrimination Complaint:  
Discriminatory Third-Party Premium Assistance Payment Policy in Idaho**

**May 19, 2016**

**I. Parties**

A. Complainant

Dialysis Patient Citizens  
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B. Respondent

Blue Cross of Idaho  
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800-274-4018

**II. Introduction**

A. Summary of Third-Party Payment Issue

Blue Cross of Idaho (“BCI”) enacted recent policy changes that jeopardize the ability of patients with kidney failure, also known as end-stage renal disease (“ESRD”), in Idaho to remain on their individual and small group health insurance plans sold on the Health Insurance Marketplace (“the Marketplace”).<sup>1</sup> For many years, BCI accepted third-party premium payments on behalf of enrollees. However, BCI recently ceased accepting direct or indirect third-party premium

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<sup>1</sup>While this complaint concerns BCI’s third-party premium payment policy, we think it is important to note that BCI and other insurers are also implementing another discriminatory policy against kidney failure patients. BCI is bifurcating coverage for dialysis into two treatment periods, one for the first three months after kidney failure where a patient is not eligible for Medicare, and one three months after the onset of kidney failure. Beginning with the fourth month of dialysis treatment, BCI and other insurers will only pay 100% or 125% of the Medicare allowed amount to providers. Many dialysis providers in Idaho are not be able to sustain their business on Medicare payments alone and are switching from BCI in-network providers to out-of-network providers. Currently, there is only one BCI in-network dialysis provider in Idaho, so patients receiving dialysis must either pay out-of-pocket for an out-of-network provider, travel (often long distances) to the singular in-network dialysis provider, or leave their BCI plan for Medicare. This policy discriminates against kidney failure patients on the basis of their disability to encourage these patients to disenroll from their private plans. See Audrey Dutton, *Idaho Kidney Patient Trapped Between Insurer, Dialysis Companies*, IDAHO STATE JOURNAL (March 30, 2016), <http://www.idahostatesman.com/news/business/health-care/article69155152.html>; Michael H. O’Donnell, *Kidney Institute Battles Blue Cross Rates*, IDAHO STATE JOURNAL (April 10, 2016), [http://www.idahostatejournal.com/members/kidney-institute-battles-blue-cross-rates/article\\_f2b44f4f-2b03-5331-9ea6-694ead97ce50.html](http://www.idahostatejournal.com/members/kidney-institute-battles-blue-cross-rates/article_f2b44f4f-2b03-5331-9ea6-694ead97ce50.html).

assistance payments by hospitals, health systems, or other health care providers and/or other commercial entities with a potential financial interest in the receipt of BCI payments, as well as foundations and other organizations related to these individuals and entities.<sup>2</sup> BCI's policy allows third-party premium payments from private, not-for-profit foundations such as Indian Tribes, tribal organizations, urban Indian organizations, state and federal government programs or grantees such as the Ryan White HIV/AIDS Program and other similar organizations or entities.<sup>3</sup> However, BCI has asserted that the American Kidney Fund ("AKF"), which provides third-party premium payments to insurers on behalf of low-income ESRD patients, is a not-for-profit organization related to hospitals, health systems or other health care providers, and BCI will not accept premium payments made on behalf of kidney failure patients under AKF's Health Insurance Premium Program ("HIPP").<sup>4</sup>

Dialysis Patient Citizens ("DPC") submits this complaint on behalf of the Idaho kidney failure patients that have come forward to DPC since January 2016 to report receipt of a notification letter that BCI no longer accepts HIPP payments. Approximately one-fifth of DPC's members receive HIPP payments. As a result of the notification letters, on February 22, 2016, AKF wrote a letter to the Director of the Idaho Department of Insurance ("the Director") to inform the Director of BCI's third-party payment policy and how the policy violates state non-discrimination laws.<sup>5</sup> On March 17, 2016, the Director drafted a response to AKF and declined to take action against BCI's policy.<sup>6</sup> The Director's refusal to take action against BCI's third-party payment policy that discriminates against individuals with disabilities, especially kidney failure patients, leaves DPC with no option but to submit this complaint to OCR in order to advocate for the rights of individuals with disabilities (*i.e.* kidney failure) to remain on their Marketplace plans.

## B. Examples of Patients Harmed By BCI's Third-Party Payment Policy

As examples of the patients affected by BCI's refusal to accept HIPP payments, we describe below the experience of Jessica Torrey and Miguel Rincon. Both of these individuals are kidney failure patients receiving dialysis and have been affected by BCI's policy within OCR's 180-day time limit for filing a complaint. In December 2015, Jessica received a notification letter that BCI discovered that her individual Marketplace qualified health plan ("QHP") premium had been paid by AKF. In February 2016, Miguel also received a notification letter that BCI would no longer accept HIPP payments made on his behalf. The notification letter sent to HIPP recipients states that BCI's member policy "prohibits the direct or indirect payment of premiums

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<sup>2</sup> Blue Cross of Idaho, Saver Policy (January 2016). This policy is on file with the complainant and can be shared upon request. *See also* Blue Cross of Idaho, *Provider Administrative Policy ("PAP") 115- Provider Payment of Member Premium*, March 2015, available at <https://providers.bcidaho.com/policies-and-procedures/pap/pap115.page>.

<sup>3</sup> Blue Cross of Idaho, Saver Policy (January 2016). This policy is on file with the complainant and can be shared upon request.

<sup>4</sup> Blue Cross of Idaho, Letter to Patient, February 17, 2016, attached as Exhibit A.

<sup>5</sup> Letter from Laverne A. Burton, President and CEO of American Kidney Fund to Dean Cameron, Director of the Idaho Department of Insurance, February 22, 2016. This letter is on file with the complainant and can be shared upon request.

<sup>6</sup> Letter from Dean L. Cameron, Director of the Idaho Department of Insurance to LaVarne Burton, President and CEO of the American Kidney Fund and Tonya L. Saffer, Senior Health Policy Director of the National Kidney Foundation, March 17, 2016. This letter is on file with the complainant and can be shared upon request.

for health insurance coverage by hospitals, health systems, or other health care providers and/or other commercial entities, including AKF and similar organizations.”<sup>7</sup> See Exhibit A for a sample of BCI’s patient notification letter.

BCI informed Jessica that as of January 1, 2016, BCI would no longer accept premium payments from AKF. BCI refused to accept the HIPP payment when Jessica tried to pay her premium in April 2016. Jessica was working prior to her kidney failure diagnosis, but she had to quit her job because she was unable to work due to the debilitating nature of her disease. Her sole income is through Social Security’s disability benefits and she is reliant on HIPP payments to pay her Marketplace plan premium.

Miguel Rincon, who was born in New Mexico and is of Mexican-American descent, works as an HVAC installer. Miguel is still employed after his kidney failure diagnosis, but has a limited income and does not receive insurance coverage through his employer. He chose his health plan after researching available options on the Marketplace. He is on the transplant waiting list and is concerned that the higher cost-sharing responsibilities in Medicare would imperil his ability to receive a new kidney. Without the HIPP payments, Jessica and Miguel will not be able to pay their premiums and they both could be terminated from their health plans. Jessica and Miguel are only two of the many kidney failure patients that received this notification from BCI and are affected by the policy change in this manner.

### C. All Health Insurers Have The Responsibility to Cover ESRD Benefits

Individual and group health insurance plans sold both on and off the Marketplace typically provide coverage for ESRD services for at least thirty-months. First, under Section 1302(a)(1)(B) of the Affordable Care Act (“ACA”), all non-grandfathered individual and small group plans sold on the Marketplace are required to cover the essential health benefits (“EHB”) package.<sup>8</sup> Furthermore, under the ACA, the Secretary must ensure that “the scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.”<sup>9</sup> Based on reports concerning the benefits typically covered by employers and input received from stakeholders, the Department of Health and Human Services (“HHS”) adopted a benchmark-based framework for defining EHBs, where

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<sup>7</sup> While we do not have the exact notification letters Jessica Torrey and Miguel Rincon received, we have copies of notification letters several other patients have received and they all contain the same language. *See* Blue Cross of Idaho, Letter to Patient, February 17, 2016 (Emphasis added) (Exhibit A).

<sup>8</sup> 42 U.S.C. § 18021(a)(1)(B). Grandfathered plans are those that were in existence on March 23, 2010 and have not made certain significant changes that reduce benefits or increase costs to consumers since the ACA’s enactment. *See* Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care, OCHIO-9991-IFC (June 17, 2010). The EHB package includes items and services in the following 10 statutory benefit categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care. *See* 42 U.S.C. § 18022(b).

<sup>9</sup> Section 1302(b)(2) of the ACA; 42 U.S.C. § 18022(b)(2). The statute required the Secretary of Labor to conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers and to provide a report on such survey to the Secretary of HHS to inform this determination. *Id.*

each state selects a benchmark plan or is assigned a default benchmark plan.<sup>10</sup> All Marketplace plans must provide benefits that are “substantially equal” to an EHB benefit plan.<sup>11</sup> Again, these benefit packages are modeled from the typical coverage provided by employer plans.

ESRD benefits are included in the typical employer plan and are therefore considered EHBs. For example, the Institute of Medicine’s (“IOM’s”) report to HHS on EHB criteria stated “if a requested medical service can reasonably be construed to fall within 1 of the 10 covered benefit categories and is not expressly excluded, then it should be considered eligible for coverage as long as it is judged medically necessary for a particular patient.”<sup>12</sup> ESRD services, such as dialysis services, fall within multiple EHB categories listed in the ACA, including ambulatory services, hospitalization, chronic disease management, and prescription drugs. ESRD services are not expressly excluded from any benefit categories and are essential for the survival of kidney failure patients. In addition, the IOM report cited a 2011 study that found 95% of all employer plans cover dialysis and kidney transplantation.<sup>13</sup> Congress also enacted a coordination period for ESRD benefits for individuals with employer-sponsored health insurance who also typically qualify for Medicare pursuant to ESRD status.<sup>14</sup> As a result, the vast majority of Marketplace plans cover ESRD services for at least 30 months.

Second, non-grandfathered, off-Marketplace plans must also cover the EHB package. Section 2707(a) of the Public Health Service Act (“PHSA”) extends the EHB package coverage requirement to non-grandfathered off-Marketplace plans in the individual and small group markets.<sup>15</sup> Therefore, these plans are subject to the same EHB requirements described above, and must provide benefits “substantially equal” to employer plans, which would include ESRD benefits for at least thirty-months. Whether a plan is sold on or off the Marketplace, current law contemplates extended ESRD coverage from private payers (*i.e.* the Medicare Secondary Payer law requires Medicare to be the secondary payer for the first thirty-months after an individual’s ESRD diagnosis, during which employer group coverage is considered the primary payer<sup>16</sup>).

#### D. Summary of How BCI’s Third-Party Payment Policy is Discriminatory

BCI’s third-party payment policy and related actions contravene recent CMS guidance and federal laws against discrimination on the basis of disability under the ACA and the Rehabilitation Act of 1973 and race under title VI of the Civil Rights Act of 1964. BCI’s policy disproportionately affects individuals with disabilities that are also low-income, such as many kidney failure patients,<sup>17</sup> because these individuals constitute the population that receives

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<sup>10</sup> See 45 C.F.R. § 156.100. The default benchmark plan is the largest plan by enrollment in the largest product by enrollment in the state’s small group market. *Id.* § 156.100(c).

<sup>11</sup> *Id.* § 156.115(a).

<sup>12</sup> Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Cost*, Washington, DC: The National Academies Press at 64 (2011), available at <http://www.nationalacademies.org/hmd/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx>.

<sup>13</sup> *Id.* at 171 (citing Mercer, *Health Care Reform: The Question of Essential Benefits. The Third Report in Mercer’s Ongoing Series of Topical Surveys on Health Reform* (2011)).

<sup>14</sup> See 42 U.S.C. § 1395y(b)(1)(C).

<sup>15</sup> *Id.* § 300gg-6(a).

<sup>16</sup> *Id.* § 1395y(b)(1)(C).

<sup>17</sup> The odds of kidney failure are almost 4 times higher among people with an annual household income of less than \$20,000 compared with those making more than \$75,000. Few participants (6.7%) lacked health insurance. See

premium assistance from not-for-profit organizations. BCI's policy also has a disparate impact on racial minorities, as African Americans and Hispanics are more likely to have kidney failure than other groups.<sup>18</sup> As many kidney failure patients cannot afford their premium payments,<sup>19</sup> BCI's third-party payment policy will cause these patients, such as Miguel, to lose access to private health insurance on the Marketplace and force them onto Medicare.

Forcing kidney failure patients to switch to Medicare has significant implications for these patients. BCI's Marketplace plans provide kidney failure patients with many advantages compared to Medicare coverage. For example, Marketplace plans can cover a significantly higher percentage of medical expenses for kidney failure patients than Medicare.<sup>20</sup> Marketplace plans also have out-of-pocket maximum limits, while Medicare does not. In addition, Marketplace plans can offer patients a broader provider network than Medicare and allow for continuity of care with current providers. For these reasons, it is crucial that BCI's third-party payment policy does not force kidney failure patients onto Medicare.

BCI's discriminatory third-party payment policy falls under the jurisdiction of the HHS Office of Civil Rights ("OCR") as it applies to Marketplace plans, which receive Federal financial assistance. Although the Director of the Idaho Department of Insurance declined to take action against BCI's policy, the Insurance Commissioners in New Mexico, Minnesota, and Oregon intervened to stop similar policies against third-party premiums from going into effect in those states. We also are aware of some health insurers requiring applicants and enrollees to submit attestation statements that they will not pay their premiums using funds received from any third-party.<sup>21</sup> We urge OCR to utilize its enforcement authority and enter into an agreement with BCI that requires BCI to cease its third-party payment policy that discriminates against individuals based on disability (*i.e.*, ESRD status) and race, and restricts kidney failure patients' access to private health insurance on the Marketplace. The ability of Jessica Torrey, Miguel Rincon, and other kidney failure patients affected by BCI's discriminatory third-party payment policy to stay on their Marketplace plans and receive the benefits of private insurance is dependent on OCR's enforcement actions.

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Natasha Persaud, *Kidney Disease Risk Linked to Household Income*, RENAL AND UROLOGY NEWS (Dec. 9, 2014), <http://www.renalandurologynews.com/end-stage-renal-disease/kidney-disease-risk-linked-household-income/article/387294/>. In addition, only 18.9% of dialysis patients ages 18 to 54 are employed. Nancy Kutner, Tess Bowles, Rebecca Zhang, Yijian Huang, and Stephen Pastan, *Dialysis Facility Characteristics and Variation in Employment Rates: A National Study*, CLIN. J. AM. SOC. NEPHROL. Jan. 2007, 111-116.

<sup>18</sup> University of California San Francisco, *The Kidney Project: Statistics*, <https://pharm.ucsf.edu/kidney/need/statistics> (last visited April 29, 2016).

<sup>19</sup> "Kidney failure treatment—hemodialysis, peritoneal dialysis and kidney transplantation—is costly, and most people need financial help." National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Disease, *Financial Health for Treatment of Kidney Failure*, <http://www.niddk.nih.gov/health-information/health-topics/kidney-disease/financial-help-for-treatment-of-kidney-failure/Pages/facts.aspx> (last updated March 2014).

<sup>20</sup> For persons earning between \$11,000 and \$23,000 a year, the ACA guarantees that exchange health plans cover at least 87% of average medical expenses. This is more generous than Medicare's coverage of 80% for the average enrollee. Dialysis Patient Citizens, *For Kidney Failure Patients Under 65: Is Medicare or an Exchange Plan the Better Insurance Option?*, <http://dialysispatients.org/articles/new-kidney-failure-patients-under-65-medicare-or-exchange-plan-better-insurance-option> (last visited May 4, 2016).

<sup>21</sup> While we are not aware of BCI requiring its applicants and enrollees to submit these attestation statements, we are including this information so that OCR is aware of other ways some insurers are discriminating against kidney failure patients. We request that OCR also investigate insurers that are requiring such attestation statements.

### III. Factual Background

#### A. The American Kidney Fund's Health Insurance Premium Program

The AKF is a bona fide, 501(c)(3) charitable and educational organization that provides financial support to patients with kidney failure in need and delivers programs that educate, build awareness, and drive advocacy on behalf of individuals with kidney failure. One-fifth of all kidney failure patients in the United States receive financial assistance from AKF, which is a testament to the debilitating nature of the disease both physically and financially.<sup>22</sup> AKF has financial assistance programs that assist financially eligible patients with the costs of medicine, transportation and durable medical equipment. The HIPP provides financial assistance to financially needy kidney failure patients for the costs of health insurance premiums for individual and small group Marketplace plans and other commercial plans, such as Part B Medicare, Medigap, employer group health plans ("EGHP") and COBRA.<sup>23</sup>

As the HIPP serves as a "last resort" of financial assistance for kidney failure patients who cannot afford their health insurance premiums, AKF has a stringent eligibility process for patients to receive premium assistance. Eligibility for participation in the HIPP requires a physician certification, a referral letter signed by a social worker or administrator at a dialysis provider, and an individual Patient Grant Application, which requests detailed financial information for the patient's household. Applicants must demonstrate that they cannot afford to pay the costs of health care coverage. Eligibility is restricted to patients who have no means of paying their premiums and would have to forgo coverage without assistance. All eligibility determinations are made by AKF employees who have no financial interest in the provision of health care based on their good faith assessment that the applicant is in financial need and eligible for assistance. Eligibility determinations do not take the identity of the referring facility or the amount of any provider's donation into consideration. Eligible patients receive premium assistance for one year and must reapply each year.

The HHS Office of Inspector General ("OIG") assessed whether donations by dialysis providers to the HIPP for Medicare Part B or Medigap premiums for financially needy Medicare beneficiaries with ESRD represents an approved program under the civil monetary penalties law in Section 231(h) of the Health Insurance and Portability and Accountability Act of 1996 ("HIPAA") in Advisory Opinion 97-1.<sup>24</sup> The OIG issued a favorable opinion and approved the HIPP because the contributions given by dialysis providers are not made to or on behalf of beneficiaries and the premium payments do not influence patients to receive services from particular providers. The OIG viewed the following as safeguards that ensure the providers' contributions are not made on behalf of their patients: dialysis providers will not track the amount AKF pays on behalf of patients utilizing their facilities to calculate future contributions, contributions are made without restrictions or conditions placed on the donation, and providers will not disclose the amount or method of calculating their contributions to other providers.

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<sup>22</sup> American Kidney Fund, *2013 Annual Report* at 1, [http://www.kidneyfund.org/assets/pdf/about-us/akf\\_2013\\_annual\\_report.pdf](http://www.kidneyfund.org/assets/pdf/about-us/akf_2013_annual_report.pdf).

<sup>23</sup> American Kidney Fund, *Financial Assistance- Information for Patients*, <http://www.kidneyfund.org/financial-assistance/information-for-patients> (last visited April 29, 2016).

<sup>24</sup> See HHS OIG Advisory Opinion 97-1, <http://oig.hhs.gov/fraud/docs/advisoryopinions/1997/kdp.pdf>.

Specifically, OIG found that “the interposition of AKF ... and its administration of HIPP provides sufficient insulation so that the premium payments should not be attributed to the Companies.”<sup>25</sup> In addition, the OIG found that the HIPP enhances patient freedom of choice in health care providers.<sup>26</sup>

## B. Description of Blue Cross of Idaho’s Third-Party Payment Policy

BCI’s third-party payment policy is described in its member contract. BCI applied its third-party payment policy in its notification letters to Jessica Torrey, Miguel Rincon, and other kidney failure patients that BCI will no longer accept premium payments from AKF.

BCI’s member contract states:

### II. PAYMENT OF PREMIUMS

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B. Blue Cross of Idaho prohibits the direct or indirect payment of premiums for health insurance coverage by hospitals, health systems or any other healthcare Providers and/or other commercial entity with a potential financial interest in receipt of Blue Cross of Idaho payments for patients under their care or anticipated to be under their care in the future. This prohibition includes any foundations or other related organization to the entities listed above. Private, not-for-profit foundations such as Indian tribes, tribal organizations, urban Indian organizations, state and federal government programs and grantees such as the Ryan White HIV/AIDS Program and other similar entities are not prohibited from paying premiums on behalf of individuals receiving medical treatment. Premiums submitted in violation of this provision will not be accepted and the Enrollee's Policy may be terminated for nonpayment.<sup>27</sup>

## IV. Discussion

### A. CMS Policy Does Not Prohibit AKF’s Third-Party Premium Payments

BCI’s third-party payment policy is based on a self-serving interpretation of CMS’s guidance on third-party premium payments for those enrolled in QHPs on the Marketplace. On November 4, 2013, CMS’s Center for Consumer Information and Oversight (“CCIIO”) issued a Frequently Asked Question (“FAQ”) applicable to QHPs that stated “hospitals, other health care providers, and other commercial entities” may be supporting premium payments for patients with QHPs in the Marketplace.<sup>28</sup> CMS expressed its concern that this practice would skew the insurance risk pool and encouraged insurers to reject these third-party payments.

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<sup>25</sup> *Id.* at 6 (Emphasis added).

<sup>26</sup> *Id.* at 7.

<sup>27</sup> Blue Cross of Idaho, Saver Policy (January 2016) (Emphasis added). This policy is on file with the complainant and can be shared upon request.

<sup>28</sup> Centers for Medicare and Medicaid, Center for Consumer Information and Oversight, *Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces* (Nov. 4, 2013), <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf>.

On February 7, 2014, CMS issued an additional FAQ to clarify its third-party payment policy. CMS stated that the November 4, 2013 FAQ “does not apply to payments for premiums ... made on behalf of QHP enrollees by Indian tribes, tribal organizations, urban Indian organizations, and state and federal government programs or grantees (such as Ryan White HIV/AIDS Program).”<sup>29</sup> CMS also stated that the November 4, 2013 FAQ does not apply to payments by private, not-for-profit foundations that are described above or “if they are made on behalf of QHP enrollees who satisfy defined criteria that are based on financial status and do not consider enrollees’ health status.”<sup>30</sup> In this situation, CMS expects the premiums would cover the entire policy year.<sup>31</sup>

On March 19, 2014, CMS issued an interim final rule requiring insurers to accept QHP premium plans from Ryan White HIV/AIDS programs; Indian tribes, tribal organizations, and urban Indian organizations; and state and federal government programs.<sup>32</sup> The interim final rule did not make any mention of payments from private, not-for-profit foundations. In addition, the HHS Notice of Benefit and Payment Parameters for 2017 final rule, published on March 8, 2016, deferred further commentary on the acceptance of third-party payments made by not-for-profit organizations to future rulemaking.<sup>33</sup> However, the final rule stated:

We refer stakeholders to our February 7, 2014, FAQ, which clarified that the concerns in our November 4, 2013 FAQ do not apply to payments from private, not-for-profit foundations if payments are made on behalf of QHP enrollees who satisfy defined criteria that are based on financial status and do not consider enrollees’ health status. In this situation, the FAQ stated that HHS would expect that the premiums and any cost sharing payments cover the entire policy year.”<sup>34</sup>

The FAQ from February 7, 2014 represents the current CMS guidance on third-party payments from private, not-for-profit organizations. Current CMS guidance allows insurance companies to accept HIPP payments. AKF is “a private, not-for-profit foundation” that makes payments “on behalf of QHP enrollees who satisfy defined criteria that are based on financial status.” As described above, to receive HIPP grant payments an individual must meet specific financial eligibility criteria and an AKF employee must determine that the individual is in financial need. To ascertain financial status, AKF requests detailed financial information on the individual’s entire household.

In addition, AKF’s eligibility determinations do not consider an individual’s health status. Although an individual must have a certain medical condition (*i.e.*, ESRD status) AKF does not take into account the individual’s health status within the medical condition when determining eligibility. In other words, AKF does not consider the seriousness of the patient’s condition or comorbidities when determining eligibility. Finally, the grant payments are made for the entire

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<sup>29</sup> Centers for Medicare and Medicaid, Center for Consumer Information and Oversight, *Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces* (Feb. 7, 2014), <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>

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> 79 Fed. Reg. 15,240-15,245 (Mar. 19, 2014); 45 C.F.R. § 156.1250.

<sup>33</sup> 81 Fed. Reg. 12,204, 12,320 (Mar. 8, 2016).

<sup>34</sup> *Id.*

policy year. Therefore, HIPP payments meet all of the required elements within CMS’s February 7, 2014 FAQ and are not prohibited per CMS policy.

## B. The ACA Prohibits Health Plans from Discriminating Against Individuals with Disabilities

### 1. Section 1557 of the ACA

Section 1557 prohibits federal health care programs, activities, and contracts of insurance from discriminating against individuals:

An individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29 [the Rehabilitation Act], be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).<sup>35</sup>

Section 1557 expressly includes “contracts of insurance” as health programs or activities that receive “Federal financial assistance.” Therefore, an insurance company that receives federally-subsidized payments, such as through the Marketplace, is covered by Section 1557. Section 1557 allows for an individual, class, or third party right of action for health insurance discrimination under Section 504 of the Rehabilitation Act and title VI of the Civil Rights Act of 1964. As we describe below, BCI’s third-party payment policy violates Section 1557 of the ACA by discriminating against individuals based on their disability and race and excluding kidney failure patients, such as Jessica Torrey and Miguel Rincon, from participation in the insurance plan.

BCI is also rejecting third-party premium payments on behalf of kidney failure patients for other types of coverage such as Part B Medicare, Medigap, EGHP, and COBRA that would fall under Section 1557 as “contracts of insurance” that receive “Federal financial assistance.” Although this complaint focuses on third-party premium payments for individual and group health plans on the Marketplace, BCI’s third-party payment policy also discriminates against kidney failure patients who receive assistance for their Part B Medicare, Medigap, EGHP, and COBRA premiums through Section 1557.

### 2. Other Non-Discrimination ACA Provisions

Aside from Section 1557, BCI’s third-party payment policy violates additional ACA non-discrimination provisions. First, under Section 1311(c)(1)(A) of the ACA, a QHP must “not employ marketing practices or benefit designs that have the effect of discouraging the enrollment

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<sup>35</sup> 42 U.S.C. 18116 (Emphasis added). Regulations implementing Section 1557 are effective July 18, 2016. *See* 81 Fed. Reg. 31,376 (May 18, 2016).

in such plan by individuals with significant health needs.”<sup>36</sup> BCI’s third-party payment policy is a benefit design that has the effect of discouraging enrollment in the plan by patients who have significant health needs, such as individuals with kidney failure.

Second, as described in the Introduction, Section 1302(b)(4) of the ACA requires all QHPs to offer a comprehensive package of items and services, known as EHBs. Health plans that provide EHBs must:

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category:

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life ...<sup>37</sup>

BCI’s policy of denying third-party payment with respect to kidney failure beneficiaries reflects a coverage decision or benefit design that discriminates against these individuals because of their disability (*i.e.*, ESRD status) by forcing these higher-cost, higher-risk beneficiaries to leave the plan. The policy also violates these non-discrimination protections in the ACA by failing to ensure that health benefits established as essential are not subject to denial against these individuals’ wishes on the basis of present disability.

### C. BCI’s Policy Violates Section 504 of the Rehabilitation Act of 1973

The Rehabilitation Act prohibits programs and services which receive federal funds from discriminating against individuals with disabilities. It applies to QHPs sold through the Marketplace:

No otherwise qualified individual with a disability ... shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.<sup>38</sup>

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<sup>36</sup> 45 C.F.R. § 156.225(b).

<sup>37</sup> 42 U.S.C. § 18022(b)(4)(Emphasis added).

<sup>38</sup> 29 U.S.C. § 794(a) (Emphasis added).

Under regulations implementing Section 504, an “individual with a disability” means any individual who has:

- (i) A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- (ii) A record of such an impairment; or
- (iii) Being regarded as having such an impairment as described in paragraph (i) of this section.<sup>39</sup>

Physical impairment means “any physiological disorder or condition ... affecting one or more body systems ... such as neurological, musculoskeletal, special sense organs, respiratory, cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, or endocrine ...”<sup>40</sup> “Major life activities” includes “the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.”<sup>41</sup>

Under the above definitions, kidney failure patients qualify as “individuals with a disability.” Kidney failure patients have a physical impairment affecting one body system, the renal system. Kidney failure also substantially limits the major life activities of these patients. The disease affects the operation of major bodily function, as the body has difficulty with removing excess fluid from the bloodstream, balancing electrolytes, and cleansing the blood of impurities. Therefore, individuals with kidney failure qualify as having a disability under the meaning of Section 504.

BCI’s third-party payment policy excludes the participation of individuals with disabilities in the insurance plan solely by reason of an individual’s disability. Not-for-profit third-party premium assistance programs, like the HIPP, provide support to individuals with disabilities such as Jessica Torrey who, because of the high cost of medically managing their disability and their inability to work, are also low-income. Without these premium assistance programs, these individuals with disabilities will not be able to pay their premiums and will be terminated from their insurance. In addition, there is no harm to the insurance company for accepting these third-party premiums. As described above, there is no federal law or guidance that prohibits these premium assistance programs and the insurance company will receive full payment for the premium from the third-party not-for-profit organization, as permitted by law. Therefore, a large number of individuals with disabilities will be excluded from participation in private health insurance plans that receive federal funds (*i.e.*, federal premium subsidies) through the Marketplace. BCI’s policy will particularly exclude individuals with kidney failure, as one-fifth of all kidney failure patients in the United States receive premium assistance from AKF.<sup>42</sup>

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<sup>39</sup> *Id.* § 705(20); 42 U.S.C. § 12102(1); 45 C.F.R. § 84.3(j)(1).

<sup>40</sup> 45 C.F.R. § 84.3(j)(2)(i).

<sup>41</sup> 42 U.S.C. § 12102(2)(B).

<sup>42</sup> American Kidney Fund, 2013 Annual Report at 1, [http://www.kidneyfund.org/assets/pdf/about-us/akf\\_2013\\_annual\\_report.pdf](http://www.kidneyfund.org/assets/pdf/about-us/akf_2013_annual_report.pdf).

D. BCI's Third-Party Payment Policy Violates Section 601 of Title VI of the Civil Rights Act of 1964 for any Beneficiary Protected under this Federal Law

Section 601 of Title VI prohibits discrimination on the basis of race, color, or national origin in programs and activities receiving Federal financial assistance. Specifically, Title VI states that:

[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.<sup>43</sup>

One theory for proving a Title VI violation is known as the “discriminatory effects” or “disparate impact” theory. Under the disparate impact theory, “a recipient, in violation of agency regulations, uses a neutral procedure or practice that has a disparate impact on protected individuals, and such practice lacks a substantial legitimate justification.”<sup>44</sup> First, the agency must determine whether the recipient utilized a “facially neutral practice” that has a disproportionate impact on a protected group.<sup>45</sup> If the *prima facie* case is met, the agency must determine whether the recipient has a substantial legitimate justification for the practice.<sup>46</sup> If the recipient has such a justification, then the agency analyzes whether there are equally effective alternative practices that would result in less disproportionality or whether the justification is a pretext for discrimination.<sup>47</sup>

Of the kidney failure patients that have come forward to DPC about BCI's third-party payment policy, many patients are racial minorities such as Miguel Rincon. BCI's third-party payment policy has a disparate impact on racial minorities, specifically African Americans and Hispanics, based on Section 1557 of the ACA and Section 504 of the Rehabilitation Act of 1973, discussed above. African Americans are more than 3.5 times more likely to have kidney failure than Caucasians and constitute over 31% of all patients receiving dialysis for kidney failure.<sup>48</sup> In addition, African Americans with incomes between \$20,000 and \$35,000 have more than double the risk of developing kidney disease compared to higher income African Americans, which is not seen among Caucasians.<sup>49</sup> Hispanics, such as Miguel, are also 1.5 times more likely to have kidney failure than Caucasians and in 2010, 10% of new kidney failure patients were Hispanic.<sup>50</sup>

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<sup>43</sup> 42 U.S.C. § 2000d.

<sup>44</sup> Department of Justice, *Title VI Legal Manual*, <https://www.justice.gov/crt/title-vi-legal-manual> (Sept. 1998).

<sup>45</sup> *Larry P. v. Riles*, 793 F.2d 969, 983 (9th Cir. 1984); *Elston v. Talladega County Board of Education*, 997 F.2d 1394 (11th Cir. 1993); *New York Urban League v. State of New York*, 71 F.3d 1031, 1036 (2nd Cir. 1995). *See also Alexander v. Choate*, 469 U.S. 287 (1985).

<sup>46</sup> *New York Urban League v. State of New York*, 71 F.3d 1031, 1036 (2nd Cir. 1995). *See also Alexander v. Choate*, 469 U.S. 287 (1985).

<sup>47</sup> *Larry P. v. Riles*, 793 F.2d 969, 983 (9th Cir. 1984). *See also McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973).

<sup>48</sup> University of California San Francisco, *The Kidney Project: Statistics*, <https://pharm.ucsf.edu/kidney/need/statistics> (last visited April 29, 2016); National Kidney Foundation, *Low Income Linked to Higher Levels of Kidney Disease in African Americans* (Nov. 5, 2012), <https://www.kidney.org/news/newsroom/nr/Low-Income-Linked-to-Higher-Levels-of-Kidney-Disease>.

<sup>49</sup> National Kidney Foundation, *Low Income Linked to Higher Levels of Kidney Disease in African Americans* (Nov. 5, 2012), <https://www.kidney.org/news/newsroom/nr/Low-Income-Linked-to-Higher-Levels-of-Kidney-Disease>.

<sup>50</sup> National Kidney Foundation, *Hispanics and Kidney Disease*, <https://www.kidney.org/atoz/content/hispanics-kd> (last visited May 5, 2016).

BCI's policy has a disparate impact on kidney failure patients based on their race. First, BCI's policy is "facially neutral" because it applies to all beneficiaries who receive payments from the HIPP regardless of race. However, as described above, the effects of prohibiting HIPP payments disproportionately affect African Americans and Hispanics. It is likely that African Americans and Hispanics disproportionately receive premium assistance from the HIPP and therefore will be disproportionately excluded from participation in the individual and group health plans on the Marketplace. Therefore, BCI's application of its third-party payment policy to HIPP grant payments will have a disparate impact on racial minorities (*i.e.* African Americans and Hispanics) such as Miguel.

BCI may argue that it has substantial legitimate justification for its policy based on CMS's November 4, 2013 or February 7, 2014 FAQ, but these FAQs do not prohibit HIPP payments. In fact, the February 7, 2014 FAQ supports the insurer's acceptance of HIPP payments. In addition, BCI would not be engaging in a charitable activity if it did not maintain its third-party payment policy. Without the policy, BCI would receive premium payments from the HIPP on behalf of qualifying enrollees in the normal course and enrollees would avail themselves to BCI's insurance coverage, just like every other enrollee. Thus, it would be difficult for BCI to show substantial legitimate justification for the policy. Therefore, BCI's third-party payment policy has a disparate impact on racial minorities and violates Section 601 of Title VI of the Civil Rights Act of 1964.

## **V. Relief Requested**

OCR has jurisdiction for ensuring compliance with the ACA non-discrimination laws, including Sections 1557, 1311, and 1302, Section 504 of the Rehabilitation Act of 1974, and title VI of the Civil Rights Act of 1964 as they apply to entities, programs, and services receiving Federal financial assistance.<sup>51</sup> Dialysis Patient Citizens requests that OCR require BCI to enter into an agreement that prohibits BCI from applying its third-party premium assistance policy to HIPP payments for individuals with ESRD on Marketplace plans as the policy is discriminatory based on disability and race. We also urge that the agreement prohibit BCI from applying this policy to premium assistance payments provided to individuals on Marketplace and other commercial plans, such as Part B Medicare, Medigap, EGHP, and COBRA, made by all not-for-profit organizations and foundations that meet CMS's criteria in its February 7, 2014 FAQ.

## **VI. Conclusion**

BCI's third-party payment policy prohibits not-for-profit organizations from assisting kidney failure patients with their premium payments for their individual and small group QHPs on the Marketplace. Most of the kidney failure patients affected by this policy, such as Jessica Torrey and Miguel Rincon, will not be able to afford their premiums as a result of their low-income status, and will be terminated from their health insurance. BCI's policy discriminates against individuals with disabilities solely because of their disability. The policy discourages enrollment

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<sup>51</sup> United States Department of Health and Human Services, Office of Civil Rights, *Laws and Regulations Enforced by OCR*, <http://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/laws/index.html> (last visited May 4, 2016).

of individuals with disabilities, including kidney failure patients, because these individuals are more likely to be unable to afford their premiums. BCI's policy also has a disparate impact on racial minorities, such as Miguel, as African Americans and Hispanics are more likely to have kidney failure than other groups. The policy forces these patients onto Medicare, which is not as generous to kidney failure patients as the coverage they can receive through individual and small group market private health plans. We implore OCR to ensure compliance with federal non-discrimination laws and prohibit BCI's and other health insurers' third-party payment policies that discriminate against individuals based on race and disability, particularly those with kidney failure.

Respectfully submitted,



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# Exhibit A



An Independent Licensee of the Blue-Cross and Blue Shield Association

February 17, 2016



Nampa, ID 83687

Group ID: [Redacted]  
Enrollee ID: [Redacted]

Dear [Redacted]

We recently performed an audit of our monthly premium payment records and discovered that your monthly health insurance premium has been paid by the American Kidney Foundation (AKF), a third-party organization.

The *Payment of Premiums* section of your Blue Cross of Idaho member policy prohibits the direct or indirect payment of premiums for health insurance coverage by hospitals, health systems or other healthcare providers and/or other commercial entities, including AKF and similar organizations. All premium payments received from AKF on your behalf for coverage in the month of February 2016 are in the process of being returned to them.

To give you time to make your payment, we are granting you a one-time extension to pay your February 2016 premium. You need to make your February 2016 premium payment no later than 5 p.m. on March 15, 2016. Your March 2016 premium payment is also due by its normal due date: March 1, 2016.

You can pay your premium in several ways; please see the back of this page for options. If you have already submitted your payment, including any outstanding balance, please disregard this invoice. If you have any questions, please call Blue Cross of Idaho Customer Service Department at 855-230-6862.

Your total monthly premium:	\$425.45
Your monthly financial subsidy (APTC):	<u>- \$ 0.00</u>
<b>Amount you owe each month:</b>	<b>\$425.45</b>

-----Please Detach the Coupon Below and Return With Payment-----

**TO PAY:**

Return a completed automatic bank withdrawal form (on the reverse of this page).

Or return the coupon with your payment for the amount due in the enclosed envelope.

**Payment**

**Amount Due**

\$78.84

**Enrollee Name**



**Enrollee ID Number**



Detach this coupon and mail your remittance to:

**Blue Cross of Idaho  
P.O. Box 6948  
Boise, ID 83707-0948**