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Kim Rivera, Chief Legal Officer
Tel: (888) 484-7505
www.davita.com

September 2, 2015

VIA MAIL and EMAIL

Commissioner Laura Cali
Oregon Insurance Division
Director Patrick Allen
Oregon Department of Consumer and Business Services
PO Box 14480
Salem, OR 97309-0405
Laura.n.cali@state.or.us; dcbs.insmail@oregon.gov; dcbs.director@oregon.gov

RE: Discriminatory Plan Provisions for ESRD Coverage

Dear Commissioner Cali and Director Allen:

It has been brought to our attention that multiple insurers in Oregon are modifying their health benefit plan designs for individuals suffering from End Stage Renal Disease (ESRD) including Regence BlueCross BlueShield, Moda Health Plan, BridgeSpan Health, and Providence Health Plan. These modifications are being adopted and implemented in clear violation of federal and state laws and regulations. The result is plan provisions that unlawfully discriminate against members based on disease state and that mislead and deceive members with ESRD regarding the "benefits" of "required" Medicare enrollment.

Open enrollment in Oregon will commence shortly. To protect Oregonians it is imperative that you declare the ESRD-specific provisions in these insurers' plans, and any other plans with similar provisions that target, mislead or discriminate against members with ESRD, as non-compliant under Oregon law, unfair and deceptive trade practices, and injurious to members of the public. If these provisions are not withdrawn, you should exercise your authority under ORS §731.252 to issue a cease and desist order preventing the marketing and enforcement of these types of plan provisions.

As explained in detail below, the federal government gives individuals under the age of 65 who have ESRD and are on dialysis the option to enroll in Medicare. There are advantages and disadvantages to Medicare enrollment, which is why the federal government urges commercially insured individuals with ESRD to be cautious when considering the option of Medicare enrollment. However, these Oregon insurers are misrepresenting this option to members suffering from ESRD, telling members with ESRD that Medicare enrollment is affirmatively a benefit or even a legal requirement, without presenting any of the disadvantages of Medicare enrollment. To further entice their members with ESRD to enroll in Medicare, some plans are going so far as to reimburse the members' Medicare premiums; others penalize members who don't enroll in Medicare through treatment of out-of-pocket costs.

State and federal law prohibit discrimination by insurers based on disease state; these insurers are adopting and implementing provisions that discriminate against members with ESRD based solely on the fact they have ESRD. No sanctions are being imposed on plan members eligible for Medicare who forgo enrollment except for those suffering from ESRD; no members are being misled about the "advantages" of Medicare enrollment except those suffering from ESRD; no members are being enticed to enroll in Medicare through an offer to pay premiums except those with ESRD. State law prohibits insurers from using plans and plan materials that are untrue, deceptive, misleading or withhold material facts. These insurers' plan materials contain untrue, deceptive and misleading statements about Medicare enrollment requirements and benefits, while withholding important information about the consequences of Medicare enrollment. State law also prohibits the offer or promise of rebating premiums payable on an insurance policy, a provision violated by at least two Oregon insurers in their plans.

A. Individuals With ESRD Under 65 Have the Option to Apply for Medicare

1. Medicare Eligibility Under the Age of 65

Generally, individuals who are 65 years of age or older are eligible to apply for Medicare. Under limited circumstances, federal law extends Medicare eligibility to individuals under the age of the age of 65, including:

(i) Persons diagnosed with Amyotrophic Lateral Sclerosis (ALS);[1]
(ii) Persons diagnosed with ESRD who are on dialysis;[2] or,
(iii) Persons that have one of multiple specified medical conditions that qualified them to receive Social Security Disability Insurance.[3] There are many medical conditions that may qualify an individual for Medicare under this provision including hematological disorders such as sickle cell disease and aplastic anemia, immune system disorders such as lupus or scleroderma, endocrine disorders such as hypoglycemia or hyperglycemia, etc.

2. Medicare Coverage for ESRD-Related Dialysis

For commercially insured individuals with ESRD on dialysis who elect to enroll in Medicare Part B, there are three phases of coverage:

(i) An initial period of three months, during which the commercial plan continues to cover the member's dialysis;

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[1] *42 U.S.C.§1395p*
[2] *42 U.S.C. §426-1, §1395c*
[3] *42 U.S.C. 1395c*

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(ii) A coordination period lasting a maximum of 30 months, during which the commercial plan will provide primary coverage for dialysis and Part B will be secondary, covering any co-payments or balances;

(iii) At the end of the coordination period, Medicare Part B becomes the primary insurer of the individual and covers all Medicare-eligible out-patient medical services, including dialysis.

When an individual with ESRD under the age of 65 qualifies for Medicare, they may enroll in Part A (which generally covers in-patient services), Part B (which generally covers out-patient services, including dialysis), and Part D (which generally provides a drug benefit).[4] Importantly, once an individual under the age of 65 with ESRD elects to enroll in Medicare, they cannot dis-enroll: Medicare coverage will only terminate if the person is cured of ESRD by transplant or ceases dialysis.[5]

Individuals with ESRD under the age of 65 must separately enroll in each part of Medicare to be covered, and must pay separate premiums for Part B, Part D and sometimes for Part A. There are also deductible requirements for each part that must be met before Medicare will pay for covered services. The Part B premium is adjusted for income, and runs anywhere from $100-$336/month; the current Part B deductible is $147/year.

3. Voluntary Medicare Enrollment for ESRD Carries Adverse Consequences

For a commercially insured individual under the age of 65, treatment of ESRD through dialysis is generally recognized as a medically necessary service covered by their standard commercial insurance plans. Given that they have existing coverage, for these individuals enrollment in Medicare may be detrimental, exposing them to potential additional costs for premiums and deductibles and other potential negative consequences.

In addition to the additional premiums and deductibles, there may be material differences in Medicare coverage and the member's commercial insurance coverage. But the member won't experience those differences until the coordination period ends and Medicare becomes their primary insurer, when it is too late and federal law prohibits the member from dis-enrolling in Medicare. That is why the federal government emphasizes that for commercially insured individuals under the age of 65 with ESRD, enrollment in Medicare is optional and they must "think carefully" before electing to enroll in Medicare.[6]

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[4] *Medicare Part C, also known as Medicare Advantage, provides Medicare services through managed care. The overwhelming majority of Medicare Part C plans do not accept members with ESRD.*

[5] https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_8-28-14_v2.pdf, pages 9-10.

[6] *Id, page 9; https://www.medicare.gov/Pubs/pdf/10128.pdf, page 16.*

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B. Oregon Plan Designs

The recent plan modifications by Oregon insurers take several forms.

1. At least one Oregon insurer, Regence, modified its 2016 plan designs, purporting to add a "new ESRD benefit." In fact, the plan design modification is not new but merely restricts existing coverage for dialysis as a medically necessary service during the first two phases of coverage for dialysis treatment.

(i) For the initial period of three months, the commercial plan essentially retains the existing benefit, with the plan paying the allowable costs for dialysis; the member remains responsible for balances. Any amounts paid by the member count towards the plan's out-of-pocket maximum limit.

(ii) For the maximum 30 month coordination period, the commercial plan pays an amount based on the Medicare allowable payment. The major change in the benefit design is for members who elect not to enroll in Medicare Part B -- those members remain responsible for any balances owed but the member's payments will **not** count towards the plan's out-of-pocket maximum limit.

(iii) The plan materials are silent on the fact that after the coordination period, members who enrolled in Medicare Part B will automatically lose the commercial plan as primary coverage and move on to Medicare Part B for primary coverage of all out-patient medical services, and they will therefore lose certain other benefits only offered under their commercial plan.

BridgeSpan has a similar plan design for many of its Oregon plans, requiring members with ESRD who choose not to enroll in Medicare Part B to be responsible for any balances owed on dialysis services during the coordination period, but not allowing the member to count those payments toward plan out-of-pocket maximum limits. Like Regence, the BridgeSpan plans are silent on what happens after the coordination period.

2. Two Oregon insurers, Moda and Providence, have plans that misrepresent to their members that Medicare enrollment for individuals with ESRD is a requirement, not an elective option. Both insurers further incentivize Medicare enrollment by offering to pay Part B premiums on behalf of the member.

Moda advises commercial members with ESRD that they "*must be enrolled in Medicare Part B in order to receive the best benefit. While the Plan is primary for ESRD* (in other words, through the coordination period), *Moda Health will reimburse members for Medicare Part B premiums for a maximum of 30 months.*"[7]

[7] *Benefit Description Moda LG-OR-1-1-2015.*

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Providence advises commercial members with ESRD that the *"Medicare Secondary Payer statute requires"* Providence to identify members who are eligible for Medicare for ESRD, and further requires members to provide Providence with the effective date of their Medicare enrollment.[8]

Moda incentivizes members under the age of 65 with ESRD to enroll in Medicare Part B by representing that during the coordination period Moda *"will reimburse members for Part B premiums for a maximum of 30 months."* Similarly, Providence tells member it *"will cover"* Medicare Part B monthly premiums up to a lifetime maximum of $5500.

The Moda and Providence offers to cover or reimburse Medicare Part B premiums are likely based in part on an HHS-OIG Advisory Opinion regarding a health insurer's proposal to pay Part B premiums for commercially insured members with ESRD.[9] In that opinion, HHS-OIG stated that based on the facts presented it would not impose sanctions on the insurer for violating federal anti-kickback laws. But as explicitly stated by HHS-OIG, the opinion would not apply if the underlying facts differed from what was represented. The facts represented to HHS-OIG were that the insurer would only offer to pay the Medicare premium for members with ESRD if the member *"wishes to enroll in Medicare"* and that the plan would *"not pressure, require, or otherwise unduly influence or coerce Group Enrollees with ESRD to enroll in Medicare Part B."*[10]

Clearly the Moda and Providence plans present facts materially different from those presented to HHS-OIG; by the plain language of their plan materials Moda and Providence are attempting to pressure members into enrolling in Medicare. Further, the HHS-OIG opinion solely addressed the question of whether the insurer's payment of Medicare Part B premiums violated the federal anti-kickback laws or regulations; HHS-OIG specified it was not addressing whether the proposal violated any of the federal provisions that prohibit a health plan from discriminating against plan members based on their ESRD or need for dialysis.[11] The OIG also had no authority to consider, and thus did not consider, whether the proposal violated Oregon or any other state's laws protecting against discrimination, unfair/deceptive insurance marketing, or unlawful rebating of premiums.

C. Violations of Oregon Law

The modified plan designs described above discriminate against individuals with ESRD, imposing or modifying benefits based solely on the member's ESRD diagnosis, in violation of state law. The provisions are also misleading and deceptive, incentivizing members with ESRD to enroll in Medicare without full disclosure of the risks and consequences.

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[8] *Benefit Description, Outpatient Renal Dialysis, Providence Health Plans Large Group Plans, Small Group Plans and Individual Plans, SERFF filing id 130059632, 129918185, and 12997645.*

[9] *OIG Advisory Opinion 13-16, 11/7/2013, at http://oig.hhs.gov/fraud/docs/advisoryopinions/2013/AdvOpn13-16.pdf.*

[10] *Id at page 7.*

[11] *Id at page 8.*

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Oregon law prohibits discrimination by an insurer among individuals with health risks of essentially the same degree of hazard, including prohibiting insurers from imposing different terms or conditions on members based on health status, ORS §§743.752(1) and 743.754(1); ORS §743.731, §743.734 and §743.737; ORS §746.015; and OAR 836-853-0001 *et seq*. Oregon law is also replete with requirements that insurers be transparent with members; insurers cannot make untrue, deceptive or misleading statements or withhold material facts, ORS §§746.075 and 746.110; OAR 836-020-0225, OAR 836-053-0473, and OAR 836-053-0211. And Oregon insurers cannot transact the business of insurance in ways that are injurious to members of the public, ORS §§746.160, 746.240.
Violations include:

1. Specific provisions, such as those in the Regence and BridgesSpan plans, attempt to induce members to enroll in Medicare Part B by penalizing the members who don't enroll. If a member does not enroll in Medicare Part B, any expenditure for dialysis co-payments or balances during the coordination period will not count toward the member's out-of-pocket maximums. These provisions only apply to members with ESRD on dialysis; neither insurer imposes such a penalty on members with any other medical conditions, including one of the many other conditions that may qualify the member for Medicare such as ALS, sickle cell anemia or lupus -- out-of-pocket expenditures for medically necessary services for **all** other covered medical conditions do count towards the out-of-pocket maximums. These plan provisions are based solely on the members' medical status and discriminate in the benefits that each insurer provides to members with ESRD and the benefits provided all other members, in violation of state law.

2. ESRD coverage provisions such as the Regence plan materials for 2016 that represent that dialysis coverage for ESRD is a "new" benefit are false and misleading since dialysis was covered as a medically appropriate service for ESRD prior to the proposed modifications. The Regence 2016 plan design does not, as represented, add a new benefit, rather it modifies and restricts an existing benefit.

3. The Providence materials are written to mislead members with ESRD under the age of 65 into believing that Medicare enrollment is a legal requirement when it is not.

4. All of these insurers present Medicare Part B enrollment for members under the age of 65 with ESRD as a benefit to the member while omitting material facts regarding the risks of Medicare Part B enrollment, including: (i) enrollment in Medicare Part B is not mandatory and delaying enrollment will not impact Medicare eligibility; (ii) enrollment in Medicare Part B may necessitate enrollment in Medicare Parts A and D, otherwise Medicare coverage for kidney transplant, including hospitalization, or transplant anti-rejection drugs, may be forfeited; (iii) Medicare enrollment will trigger premium costs in Medicare Parts B and D, and possibly Part A; (iv) Medicare enrollment for members who have already had a transplant may result in lack of primary coverage for anti-rejection drugs; (v) there are often deductible requirements in Medicare Parts A, B or D for which the member may be personally responsible; and, (vi) that once enrolled in Medicare, they cannot change their mind and opt out of Medicare as long as they have ESRD.

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5. The Moda and Providence plans offer to pay Medicaid premiums only for members with ESRD, and thus unlawfully discriminate by treating members with ESRD differently from those suffering from one of the many other health conditions that may qualify them for Medicare coverage, such as ALS, sickle cell anemia, or lupus.

6. Provisions in the Moda and Providence plans, offering to pay Medicare Part B premiums for members suffering from ESRD, constitute prohibited rebates under ORS §746.045.

7. Provisions in the Moda and Providence plans, offering to pay Medicare Part B premiums for individuals suffering from ESRD, are misleading and omit material facts about the risks to the member of failing to also enroll in Parts A and D, as well as omit information about the premiums the member may owe if they do enroll in Parts A and D. The provisions are also silent on the fact that after the coordination period, when Medicare Part B becomes primary, the member will have full responsibility for all Medicare premiums, including Part B. The Moda plans represent that enrollment in Part B provides the "best benefit" for the member, when in fact under individual circumstances, remaining on the commercial insurance may well be the better option for the member.

8. All of the insurers' plan materials fail to inform members under the age of 65 with ESRD that if they enroll in Medicare Part B, Medicare coverage will be secondary to the commercial plan for no more than 33 months; no later than 33 months after Medicare enrollment, Medicare Part B will replace the commercial plan as the primary insurer for all out-patient services and the member may lose benefits they would otherwise have been entitled to if the commercial plan remained their primary coverage. Further, if the individual has been receiving out-patient services through a provider that is in network with its commercial plan but does not accept Medicare, the individual will have to find a new provider that accepts Medicare. This could be an especially important fact for members on the Moda plans, because Moda does not tell members the that Medicare part B will automatically become primary but instead represents that "*if the Plan is secondary to Medicare, Moda Health will not pay for any part of expenses incurred from providers who have opted out of Medicare participation.*"

Summary

Given the upcoming 2016 open enrollment period, it is imperative that you take immediate affirmative action to remove these unlawful plans from the Oregon market. As set out earlier, in order to protect Oregonians you should declare the provisions in these insurers' plans that target, mislead and discriminate against members who suffer from ESRD as non-compliant with Oregon law, unfair and deceptive trade practices, and injurious to members of the public. If these plan provisions are not withdrawn, the Director should exercise his authority pursuant to the provisions of ORS §731.252 and issue a cease and desist order to prevent the marketing and enforcement of these, and any similar, plan provisions.

DaVita looks forward to reviewing any responses to these concerns from the named insurers, and to working with the Insurance Division to quickly redress the issues raised in this letter. Discrimination

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against plan members with ESRD based on their medical condition is a violation of Oregon and federal law. DaVita would also welcome the opportunity to collaborate with the Insurance Division on guidance for Oregonians and Oregon insurers that makes clear that modifications of plan benefits targeting ESRD patients, including those tied to Medicare enrollment, are unlawful and will be enjoined as forms of illegal discrimination.

Sincerely,

Kim Rivera
Chief Legal Officer

KMR:kb
cc: Jeannette Holman, Senior Policy Analyst
jeannette.holman@oregon.gov

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