DEPARTMENT OF CONSUMER & BUSINESS SERVICES

INSURANCE DIVISION

M E M O R A N D U M

November 4, 2015

To: All Interested Parties

From: The Oregon Insurance Division

Subject: Access to kidney dialysis benefits, use of Medicare-approved amount caps, and use of Medicare eligibility to determine benefit and coverage eligibility in the Oregon commercial health benefit plan market

Purpose

This memorandum addresses issues related to Medicare eligibility due to End Stage Renal Disease (ESRD) and Medicare-approved amount caps on kidney dialysis coverage. Coverage of kidney dialysis, regardless of cause, is an essential health benefit (EHB) and a covered service in health benefit plans in Oregon. The Oregon Insurance Division (the Division) understands the importance of access to dialysis benefits to maintain the health of consumers and the significant costs associated with dialysis care. The purpose of this memorandum is to address concerns raised by dialysis providers and consumers regarding choice of coverage; access to health benefit plans; use of Medicare-approved amount caps; and coverage restrictions based on Medicare eligibility or entitlement. Included with this memorandum is a compilation of comments received on ESRD coverage issues and the aggregated results of the recent insurer data call on coverage of dialysis.

Concerns

Generally, the use of Medicare-approved amount caps has been a recorded Oregon practice since 2012 however, some research indicates the practice dates back to the 1990s. Prior to the enactment of PPACA, consumers with ESRD relied on Medicare coverage to provide access to lifesaving dialysis treatment. Since 2014, consumers have also had access to the commercial health benefit plan market while maintaining entitlement for Medicare coverage if diagnosed with ESRD.

The Division has recently been made aware of concerns regarding the use of Medicare-approved amount caps and Medicare eligibility and entitlement requirements employed by some insurers. Public comments were solicited during a public meeting on October 23, 2015 and via email through October 27, 2015. Concerns expressed by consumers, insurers, and providers on this issue include choice of coverage, discrimination, provider access, continuity of care, balance billing, provider contracting disputes, the increasing cost of dialysis, and accuracy of information

about Medicare benefits. These issues may negatively impact the insurance market, the cost of insurance, and the health and wellbeing of consumers.

The Division has additional concerns regarding: (1) insurers requiring Medicare enrollment, terminating commercial coverage, and denying new enrollees based on Medicare eligibility or entitlement; (2) inaccurate information about commercial health coverage and Medicare eligibility for members with ESRD and coverage options for their families; (3) insurers unfairly reducing coverage of dialysis benefits based on Medicare eligibility or entitlement; and (4) policies and practices that jeopardize benefits or consumer's healthcare costs. Insurers requiring Medicare enrollment, reducing in-network benefit coverage, or terminating membership based on eligibility or entitlement for Medicare, potentially violate non-discrimination provisions found in state and federal regulations.[1] The Division will take action when appropriate to protect Oregon citizens from harmful enrollment, eligibility, and benefit construction practices.

Criteria

All health benefit plan insurers are required to comply with applicable EHB provisions and guaranteed availability and renewability requirements. Consistent with other benefits insurers are prohibited from discriminating based on health factors. Additionally:

- Insurers may not require enrollment in Medicare, regardless of member entitlement or eligibility. However, insurers may provide general information about access to Medicare coverage for members approaching age 65 or recently diagnosed with a disabling condition that may prompt Medicare eligibility (examples: ESRD or ALS).
    - Insurers providing information to members regarding Medicare benefits must ensure the information provided is factual. Insurer communication about Medicare benefits cannot appear to require enrollment in Medicare or suggest a consumer's coverage may terminate under their commercial insurance plan. Any information provided is subject to review by the Division. Insurers shall provide DCBS contact information to enrollees who receive information about Medicare coverage.
- Insurers may not terminate or non-renew members due to Medicare eligibility or entitlement.[2] However, insurers may use Medicare Secondary Payer regulations to coordinate coverage for members actively enrolled in Medicare.
- Insurers may use case management, consistent with other chronic conditions, to provide coordinated care efforts to members receiving kidney dialysis regardless of cause.
- In-network dialysis benefits may not be reduced or eliminated due to Medicare eligibility or entitlement. However, consumers have a choice to use out-of-network providers consistent with other benefits. Coverage of out-of-network services may be provided at a reduced coverage level, with increased member cost share, consistent with other benefits. Members actively enrolled in both Medicare and commercial plans may have access to additional dialysis providers and coordination of benefits.

[1] For example 45 CFR § 146.121 prohibits discrimination based on health factors.
[2] Guaranteed renewability 45 CFR § 148.122.

Next steps
The Division will continue to monitor access and coverage issues facing individuals receiving dialysis and investigate consumer complaints. Division staff will also work with insurers to adjust policy and certificate language to ensure benefit clarity.

If you have questions regarding this information please contact Tashia Sample by email at tashia.m.sample@oregon.gov or by phone at 503-947-7210.