Oregon
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To: All Interested Stakeholders

From: Oregon Insurance Division

Re: Coverage of Kidney Dialysis and End Stage Renal Disease in Health Benefit Plans

The Oregon Insurance Division (OID) recently received stakeholder concerns regarding potentially discriminatory practices relating to kidney dialysis coverage and End Stage Renal Disease (ESRD). In response to the concerns, OID reached out to six insurers with Medicare-approved amount caps in their contract language on October 20, 2015, with a data call request. The data call asked insurers to provide an explanation of their benefit designs, to review letters received as part of recent public comment on the proposed 2017 Benchmark Plan, and to respond to a number of ESRD related questions highlighted below. OID has aggregated the responses received to date and included them below each question.

1.) **Does contract language found in your individual, small, or large group health benefit plan benefit for ESRD refer to Medicare benefits? If so, please furnish all variations of such contract language and identify which products have each variation.**
Responses: Four insurers indicated that benefits described in the 2015 member handbooks referenced Medicare eligibility as part of the ESRD benefits. One insurer indicated that contract language references allowed payments as a percentage of Medicare allowable amounts but did not reference Medicare benefits specifically.

2.) **How do your health plans administer the ESRD benefit?**
Responses: Two insurers provided specific answers to each question below. One of the two insurers indicated that benefits are administered in accordance with filed plan language which addresses benefit amounts for participating and non-participating providers. The other insurer indicated that the benefit was not operationalized in 2015 and has been removed for the 2016 plan year.

One insurer indicated that administrative difficulties prevented implementation of ESRD benefits but provided some information on how the benefit may have worked had it been available.

Finally, one insurer provided a breakdown of ESRD benefit changes occuring between 2015 and 2016. The insurer noted that in 2015 the individual market and group markets had different benefit applications. The individual market used a contract rate for in-network services and a percentage of billed charges for out-of-network services. The 2015 group market used a contract rate for in-network services and a percentage of Medicare-approved amount for out-of-network dialysis services consistent with other out-

of-network services. 2016 plan designs reimburse in-network benefits at the contract rate during a Medicare Waiting Period and pays based on a percentage of the Medicare-approved amount once members are eligible for Medicare.

a. **How does the benefit apply if the individual is not eligible for Medicare ESRD? E.g. what occurs if a person is not eligible for Medicare due to lack of work history or citizenship?**
Responses: One insurer uses a two-tiered benefit approach in the group market that applies the plan's deductible and out-of-pocket maximum for in-network and out-of-network providers during the first treatment period of three months. Following the first treatment period the deducible and out-of-pocket maximum is waived and the plan pays at 100% for both in and out-of-network providers. In the individual market the insurer applies the plan deductible and out-of-pocket maximum for both in-network and out-of-network provider's consistently for all services once the member is diagnosed with ESRD and receiving treatments.

One insurer indicates that in-network services are allowed at a contracted rate for all services and out-of-network services are allowed at a percentage of the billed charges for all services.

One insurer indicates that for the first three months the plan will reimburse in-network providers at the contracted rate subject to deductible and coinsurance. Out-of-network providers are reimbursed at a usual, reasonable customary rate, subject to the deductible and coinsurance. Beginning in the fourth month the plan will reimburse in-network and out-of-network providers at a percentage of the Medicare approved amount and deductible and coinsurance would not apply. For members covered under multiple non-Medicare plans coordination of benefit rules apply.

One insurer indicated that dialysis benefits are based on contracted rates for in-network providers. Out-of-network providers would be reimbursed at a rate consistent with allowable charges for all out-of-network benefits described in the contract. Benefits are consistent regardless of Medicare eligibility.

b. **How does the benefit apply if the individual is eligible for Medicare other than through ESRD but is not enrolled?**
Responses: One insurer responded that the benefit remains the same regardless of the reason for Medicare eligibility.

One insurer indicated that if a member is ineligible for Medicare the insurer applies the plan deductible and out-of-pocket maximum for both in-network and out-of-network providers.

Other insurers responded with explanations that mirror benefit coverages for members eligible for and enrolled in Medicare.

c. **How does the benefit apply if the individual is enrolled in Medicare other than through ESRD?**
Responses: All insurers indicate that the benefit remains the same regardless of

the reason for eligibility.

d. **Does the benefit depend on amounts Medicare actually pays as evidenced by EOBs?**
Responses: All insurers responded that they do not require submission of Medicare explanation of benefits to determine dialysis payment. One insurer indicated that Medicare Secondary Payer laws are followed.
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e. **Does the benefit depend on in-network vs. out-of-network provider status?**
Reponses: Two insurers reported a difference between in-network and out-of-network provider coverage.

One insurer indicated that during an initial benefit period provider networking is a factor in benefit reimbursement. However, following the initial benefit period the providers are paid at a rate equal to a percentage of the Medicare-approved amount.

Finally, one insurer indicated that benefit reimbursement is not dependent on in-network or out-of-network provider status.

f. **What is the average reimbursement rate for an in-network provider and an out-of-network provider?**
Responses: One insurer declined to include specific data indicating that provider contracting rates are confidential. However, the insurer did indicate that the reimbursement rate for out-of-network providers does not provide a complete picture of claims cost because some claims may be reimbursed based on a percent of the Medicare-approved amount while others may be based on a percent of the billed charges. The insurer did provide some basic figures indicating that in-network charges range from $1,045, for daily billing, to $69,898 for monthly billing. Out-of-network charges range between $1,477, when billed daily, to $88,275 when billed monthly.

Another insurer indicated their average in-network reimbursement rate is $1,500 per treatment and the average out-of-network rate is $2,650 per treatment. The insurer did note that the rates provided did not include amounts paid for pharmacy, physician services, or labs.

Finally, one insurer was unable to obtain specific provider reimbursement information prior to the due date of the data request. The insurer did cite research on dialysis costs indicating the average cost of a single dialysis session is $320 and that the cost was not equally shared among payers. Individuals and small insurers may pay an average of six times, but up to 15 times, the dialysis price of larger risk pools.

g. **Which providers are in-network for this benefit?**
Responses: Insurers listed the following providers as in-network: DaVita and subsidiaries; Fresenius and subsidiaries; U.S. Renal Care; Pacific Northwest Renal Services; and other local dialysis providers.

3.) **How does your health plan's ESRD benefits and administration of ESRD benefits comply with non-discrimination provisions found in state and federal regulations?**
Reponses: All responding insurers provided a general statement indicating compliance with all regulations prohibiting discrimination.

One insurer indicated that historical use of ESRD benefits and previous benefit approval by OID prompted the insurer to consider the benefit acceptable. Another insurer cited historical case law upholding Medicare-approved amount benefit designs and use of Medicare Secondary Payer regulations.

Finally, OID was provided detailed explanations of compliance with all regulations on discrimination listed below.

a. **45 CFR § 147.110 prohibits discrimination based on a health factor in the individual and group markets.**
Responses: Insurers stated that nothing in the benefit designs discriminated on a health factor with respect to eligibility for benefits. Members are eligible for the same benefit package regardless of health conditions.

b. **45 CFR § 156.125 which states that an insurer "does not provide Essential Health Benefits (EHB) if its benefit design, or implementation of the benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions."**
Responses: Insurers included an explanation that ESRD is the only condition expressly permitted by the Medicare Secondary Payer Act and insurers felt it was not a violation of EHB regulation to comply with the Medicare Secondary Payer Act.

c. **42 CFR 411.102, ESRD prohibitions and requirements applicable to group health plans.**
Responses: Insurers stated that this regulation was intended to implement the Medicare Secondary Payer Act which pre-dates the Affordable Care Act. Insures indicated that prior to the implementation of healthcare reforms they were permitted to exclude coverage for dialysis or implement pre-existing condition exclusions. In their responses, insurers explained that the regulation was intended to prevent employers from constructing pre-enrollment eligibility rules that diminished the value of employee healthcare coverages for individuals with ESRD compared to their coworkers. Additionally, insurers stated that benefits for dialysis start at the time treatment begins for all members regardless of ESRD diagnosis.

d. **Medicare Secondary Payer Rules.**
Responses: Insurers stated that the Medicare Secondary Payer regulations apply only to group coverage, workers compensation policies, automobile or liability insurance policies, and no fault insurance. Insurers indicated that use of the Medicare Secondary Payer regulations, when a commercial insurer pays more than the Medicare-approved amount, would prohibit providers from balance billing Medicare. Finally, responses stated that Medicare-approved amount

benefit designs are triggered by beginning dialysis treatment rather than a specific diagnosis and is therefore not in violation of the regulation.

e. **Section 2706 of the Affordable Care Act (ACA), which prohibits discrimination in health care providers.**
Responses: Insurers stated that the ESRD benefit does not discriminate based on providers acting within the scope of their license, and benefit language does not consider which provider or provider types provide dialysis treatment.

f. **Section 1557 of the ACA, and proposed rules issued September 3, 2015, prohibiting discrimination on the basis of, among other things, age or disability.**
Responses: Insurers stated that nothing in the benefit designs discriminate against an individual only because of disability. Additionally, insurers highlighted that all members have access to the same benefit under the same conditions regardless of diagnosis or disability.

g. **OAR 836-053-0431(2)(B), allowing insurers to deny enrollment to individuals entitled to Medicare Part A or Part B, if and only if, the individual is enrolled in such a plan.**
Reponses: Insurers stated that nothing in the language of their benefits violates the substance of the regulation and enrollment is not denied to any person entitled to Medicare Part B coverage who has not enrolled.

h. **ORS 743.752(1) and 743.754(1) prohibiting different policy or plan terms based on the actual or expected health status of the enrollee.**
Responses: Responders stated that under ORS 750.055 these statutes are not applicable to Health Care Service Contractors.

i. **ORS 746.015(2), prohibits discrimination based on disability.**
Responses Insurers responded stated nothing in the benefit design violates this statute. Also, insurers stated that the design was driven by actual and reasonably anticipated experience in the cost of dialysis treatment.

j. **ORS 746.035 and ORS 746.045, prohibiting policy inducements and rebates.**
Responses: Insurers stated that the statutes prohibit inducements and rebates not specified and expressed in the policy. Insurers indicated that their policies explain the benefit and any premium assistance that may be offered.

4.) **Does your plan pay for members' ESRD Medicare premiums?**
Reponses: Two insurers do not provide reimbursement of Medicare Part B premiums. One insurer reported past practice of paying Medicare Part B premiums that will be phased out at the end of the current policy year.

Two insurers provide reimbursement or payment of Medicare Part B premiums consistent with internal company policy. One of these insurers will also provide payment of Medicare Part A premiums.

a. **If so, please explain how this is administered.**
Responses: One insurer indicated the policy for Medicare premium payments is not finalized for 2016. The other insurer requires members to submit a quarterly reimbursement form and a Medicare statement showing the amount of premium.

b. **Are these payments consistent with OID's guidance on Individual Health Benefit Plan Premium Assistance Programs and Third-Party Assistance?**
Responses: Both insurers indicate Medicare Part B premium payment programs are consistent with OID's previous guidance on Individual Health Benefit Plan Premium Assistance Programs and Third-Party Assistance.

c. **Are these payments consistent with federal anti-kickback laws in 42 USC § 1320a-7b?**
Responses: Both insurers indicate compliance with federal anti-kickback laws.

5.) For contract years 2014 and 2015 please provide the following information (please keep the data separate for these two years):

	Number of members receiving dialysis	Number of members receiving dialysis with an ESRD diagnosis	Number of members known to have enrolled in Medicare due to ESRD diagnosis	Number of ESRD claims	ESRD claims paid
2014	395	349	155	11304	$54,663,907
2015 YTD (October 20, 2015)	369	337	102	8204	$23,856,001

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.