Dialysis Patient Citizens

Improving Life Through Empowerment

Eliminating Commercial Coverage for End Stage Renal Disease Would Not Reduce Overall Health System Costs

The costs of dialysis are the costs of kidney disease. The best way to reduce these costs is upstream treatment of kidney disease. If insurers are not incentivized to avoid kidney failure and the accompanying complications (i.e., if they were allowed to dump the costs onto the Medicare program immediately) the incidence and costs of ESRD would grow, with those costs shifted onto taxpayers through public programs.

The American Kidney Fund is not an "illegitimate 'charitable' third party."

The American Kidney Fund (AKF) is a bona fide charity that has received a tax exemption from the IRS and its program has been authorized by a ruling from the HHS Inspector General. AKF received this authorization because it does not increase health care utilization and does not steer patients to particular providers.

Third party assistance does not "change the financial balance inherent in the relationship between payers and plan beneficiaries."

The payers have it exactly wrong: health insurance is "an agreement in which people share good fortune and bad," [i] with employment units constituting a naturally balanced risk pool. It is understood that the healthy will cross-subsidize the sick within the risk pool.

Longstanding federal policy—since 1981—promotes continuation of commercial coverage for ESRD.

The Social Security Act assures people whose kidneys fail that if they like their health plan they can keep it for at least for 30 months. This is often referred to as Medicare Secondary Payer (MSP) provision,[1] or 30-month "coordination period," and was clarified through the regulatory process as extending to exchange plans.[2]

Most consumers prefer private coverage over Medicare.

The option to maintain private health coverage is attractive to ESRD patients for several reasons.

First, DPC's Membership Surveys, conducted by the IPSOS international research firm, find that dialysis patients prefer private coverage.   We asked several questions from the Consumer Assessment of Health Plan Survey (CAHPS) to gauge relative satisfaction with their coverage. We found:

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[1] 42 USC 1395y

[2] 45 C.F.R. § 155, 156, and 157

- 77 percent of patients rate their private health insurance as the “best health insurance plan possible,” compared to 71 percent for Medicare.
- Medicare beneficiaries are more than twice as likely as private health plan members (13% versus 5%) to report having trouble getting health care that they wanted or needed.
- Medicare beneficiaries are more likely than private health plan members to report difficulties in getting the specific medication they need, difficulty getting someone on the phone to answer questions, and delays in receiving care or treatment.

Second, there is a significant financial advantage for dialysis patients to keep their private coverage. The Medicare program is extraordinarily popular with the American public, and we often hear advocates of universal health coverage call for “Medicare for All.” Those who are not familiar with the Medicare program may wonder, why would a dialysis patient prefer commercial coverage to Medicare?

The reason is Medicare’s structure, enacted in 1965 to mimic the indemnity-type health insurance that prevailed five decades ago. As a fee-for-service program, Medicare makes no insurer or provider organization accountable for patient outcomes, so no entity coordinates care to prevent avoidable complications. Further, Medicare retains a 1960s-era cost sharing structure with patients responsible for deductibles and co-insurance equal to about 20% of the cost of care. This is far less generous than employer or ACA health coverage, and most seniors buy Medigap supplemental coverage to ease this burden. In fact, the “Medicare for All” proposals put forward by Senator Bernie Sanders and the Center for American Progress do not retain Medicare’s cost sharing structure—they change it significantly by requiring little or no cost sharing.

According the Bureau of Labor Statistics, the average private health insurance plan has an actuarial value of 88.9 percent, significantly higher than Medicare’s 80 percent. Health maintenance organizations—which are not available to ESRD patients through Medicare—have an average actuarial value of 91.8 percent. We further note that Medicare Savings Program assistance is not as generous to low-income patients as are subsidies in the exchanges for patients with income between 100% and 200% of the poverty line. 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. Importantly, under the ACA, private health insurance plans have out-of-pocket maximums; fee-for-service Medicare does not. It is crucial for dialysis patients’ financial well-being that they retain equal access to private health insurance, especially in the many states that do not give under-65 patients access to Medigap supplemental coverage.

Finally, and most importantly, if a patient can lose coverage when his or her chronic kidney disease (CKD) progresses to end-stage renal disease (ESRD), an insurer has a perverse financial incentive not to take all possible measures to preserve the patient’s kidney functions. This is because CKD typically accompanies other co-morbidities, often making CKD patients more expensive than other enrollees. Some of the drugs that preserve a patient’s kidney function are quite expensive. While insurers complain about the high costs of dialysis care, many CKD patients have to hope that those costs are greater than the costs of organ-preserving treatments so that insurers' incentives align with their health needs and reflect the social costs of kidney failure. If an insurer could off-load those expenses onto the Medicare program it will root for the patient's kidneys to fail sooner rather than later.

Further, an insurer with no financial stake in a patient's well-being after onset of ESRD has no incentive to smoothly manage the transition from CKD to ESRD by obtaining a preemptive transplant if possible, creating a fistula for safe dialysis access, and educating the patient about kidney failure in advance so he doesn't "crash" into dialysis, resulting in infections and hospitalizations.

These perverse incentives are not present when plans must pay for renal dialysis for at least 30 months before Medicare becomes the primary insurer. And only a commercial insurer has both the incentive and the capability to properly prepare a CKD patient for ESRD. The "Optimal ESRD Start" program pioneered by Southern California Kaiser Permanente represents the most sophisticated effort to date to manage the CKD-ESRD transition. It is no exaggeration to say that most of the innovations in integrating kidney care have come through the efforts of private payers, and not from the Medicare program.

The rule the industry letter endorses has been struck down by a federal court and was withdrawn.

Industry urges revival of a CMS rule that would have allowed insurers to reject third-party payment on behalf of dialysis patients. That rule, however, was struck down by a federal court last April. The court found that the CMS rule was "arbitrary and capricious" because it did not consider the harm to dialysis patients that could result from insurers refusing to accept third-party payment. Specifically, the court found both that "HHS failed to consider the benefits of private qualified health plans and ignored the disadvantages of the Rule," and that "HHS failed to consider that the Rule would leave thousands of Medicare-ineligible ESRD patients without health insurance." The court further explained that eliminating third-party payment would be harmful to ESRD patients because

> Not all ESRD patients qualify for Medicare, and Medicare does not cover family members. Further, many health care providers do not accept Medicare. Therefore, some ESRD patients and their families could lose access to their health care providers or even lose insurance coverage altogether.

The court thus enjoined the rule, and thereafter the Department of Justice announced that the rule had been withdrawn.

The letter misrepresents the implications of private coverage for transplants.

Industry rehashes a discredited assertion adduced in response to CMS' 2016 Request for Information about "steering" of ESRD patients that suggested commercial coverage is a "barrier" to "timely access to a kidney transplant."

The source of the transplant canard was a comment letter CMS received from Teri Browne, a professor of social work who is a prominent advocate for reducing racial disparities in kidney transplantation and who has compiled considerable data on patients' journeys to transplants. If Dr. Browne's insights into transplant access based upon payer type arose from her data collection, she has not presented that data at an academic conference nor published it in a peer-reviewed journal. As we understand Prof. Browne's hypothesis (and she does not lay it out explicitly) the transition from commercial coverage to Medicare coverage at the time of transplant is somehow so difficult (she in fact uses no adjective to describe it) that transplant centers become frustrated and decline to place a patient on the transplant list. The principal problem, she says, is that AKF ceases making commercial premium payments after the transplant takes place, so patients must either pay the commercial premiums on their own or enroll in Medicare.

If a transplant center declined to list a patient for transplant because of a coverage transition, we do not think such a denial would be reasonable. Transplant centers are graded on the success of transplants (i.e., the avoidance of graft loss and mortality) and have a strong incentive to avoid patients who might be unable to purchase or adhere to their immunosuppressive drugs. There is considerable academic literature on factors affecting these outcomes and none of it identifies insurance type as a negative factor.

This is because the transition between commercial insurance coverage and Medicare coverage at the time of transplant is fairly seamless, as indicated in this article from the Medicare Rights Center, which operates a national Consumer Helpline that counsels 20,000 patients each year. https://www.medicareinteractive.org/get-answers/medicare-covered-services/medicare-and-end-stage-renal-disease-esrd/coverage-of-immunosuppressant-drugs-and-vitamins The Center advises ESRD patients that Medicare will cover immunosuppressive drugs so long as they are enrolled in Medicare Part A at the time of transplant; and that if they are not so enrolled, they have one year to enroll retroactively. We presume the Center has not encountered problems with these transitions because it weighed in with a response to CMS' Request for Information supporting ESRD patients' ability to choose between commercial coverage and Medicare.

Prof. Browne's most specific complaint about the coverage transition at the time of transplant is that a patient receiving premium assistance will be "stuck" paying premiums on his or her own when the AKF assistance ends, e.g., the patient would need to pay a Blue Shield premium of ~$318/month. Left unsaid by Prof. Browne is that if this patient had enrolled in Medicare at the time of kidney failure, he or she would have had to pay the Medicare Part B premium (currently $134 per month) and Medicare Part D premium (~$36 per month). The average ESRD patient waits 3.6 years for a transplant and is entitled to coverage in a commercial health plan for 30 months. We estimate that AKF assistance saves the average ESRD patient $5,100 in Medicare premiums, as well as coinsurance obligations in Medicare that usually exceed the out-of-pocket maximum in a commercial health plan. It is not clear to us how a patient could be worse off having to pay Medicare premiums beginning at the time of transplant than he or she would be paying these premiums beginning at the time of kidney failure.

We also wonder if Prof. Browne, whose clinical experience predates implementation of the ACA, fully understands that Medicare is no longer the only option for patients to obtain coverage for immunosuppressive drugs. During the time that Prof. Browne practiced social work in dialysis clinics, commercially insured patients had employer coverage that expired after 30 months, or earlier if the patient had COBRA. At that time, when insurers routinely denied coverage for preexisting conditions, and no subsidies were offered for individual coverage, a miscue in enrolling in Medicare could indeed threaten a patient's access to post-transplant care. Today, under the ACA, no ESRD patient can be denied coverage, and patients who are unable to pay for coverage receive Advance Premium Tax Credits. The scenario that Prof. Browne conjures up simply does not occur. Further, we know that transplant financial coordinators who have worked in those jobs over the past four years are well aware of the new insurance environment and would not decline to list a patient for transplant for the spurious reasons given in the Browne comment letter.

In fact, research shows that ESRD patients with private coverage are almost three times as likely to obtain a transplant as those on Medicare, and that privately-insured African-American ESRD patients are approximately 14 times as likely to obtain a transplant. Preventing such patients from accessing AKF funding would therefore reduce the likelihood that they would be able to obtain transplants.

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[i] Pauly MV, Zweifel P, Scheffler RM, Preker AS, Bassett M. Private Health Insurance In Developing Countries. Health Aff (Millwood). 2006; 25(2):369–79.