Private Health Insurance Coverage: An Important Option for Dialysis Patients

Commercial health insurance is the foundation of health care coverage in America. An estimated 197 million Americans were covered by private insurance in 2013, the last year for which statistics are available. While dialysis patients will always be grateful that Medicare benefits were extended to them in 1972, most prefer to retain their private coverage for as long as possible.

There are several disadvantages to Medicare relative to commercial insurance. First, there is no coordination of care in fee-for-service Medicare, and ESRD patients are not permitted to enroll in Medicare Advantage managed care plans. Second, Medicare's 1965-vintage benefit structure, which pays about 80 percent of expenses, was designed for episodic acute care but leaves considerable out-of-pocket costs for those with chronic conditions like ESRD. Further, Medicare Savings Program assistance to financially vulnerable patients is severely limited.

The Social Security Act, and by extension, the Affordable Care Act, assures people whose kidneys fail that if they like their commercial health plan they can keep it for at least 30 months. Surveys of dialysis patients find that they do like their private insurance plans. In DPC's July 2015 survey of 650 patients we asked several questions from the Consumer Assessment of Health Plan Survey (CAHPS) to gauge relative satisfaction with their coverage. We found:

- 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.

According to 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. Thus, Medicare requires considerably higher cost sharing for chronically ill patients than commercial insurance. Most Medicare beneficiaries purchase supplemental insurance, known as Medigap, to help with cost sharing, but Medigap plans are not available to under-65 ESRD patients in half of the states.

Dialysis Patient Citizens supports the following policy positions related to Private Health Insurance:

ESRD Patients' Rights to Be Free From Discrimination Must Be Enforced. Federal regulations (C.F.R § 156.12) provide that a plan does not provide essential health benefits "if its benefit design, or the implementation of its 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."

Social Security Administration guidelines clearly state people that rely on renal replacement treatment to live qualify as disabled.

A health plan that disenrolls ESRD patients will gain an unfair advantage over competing plans that do not. This would have the effect of penalizing insurers who do the right thing and comply with the law. Further, actuarial values for ACA "metal" levels are determined taking into account the full panoply of illnesses and benefits covered by a benchmark plan, including ESRD. An insurer that shirks its obligations gains an unmerited windfall.

Maintain ESRD Patients' Access to Charity Funds. Recently, many insurance companies have instituted policies to prevent charitable organizations like the American Kidney Fund from making payments for a patient's insurance premiums. These charity payments allow patients whose kidney failure is preventing them from working to exercise their COBRA right to keep their employer-sponsored insurance. While DPC believes that these payments are protected by anti-discrimination laws and prior administrative rulings, we support legislative and executive action to clarify patients' rights to charitable benefits.

Extend the 30-month coordination period under Medicare Secondary Payer to 42 months. While every person with ESRD becomes eligible for Medicare coverage, under the Social Security Act, ESRD patients are entitled to keep their group health insurance for 30 months before enrolling in Medicare. 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, making CKD patients more expensive than other enrollees. An insurer can off-load those expenses onto the Medicare program if the patient's kidneys fail sooner rather than later. This perverse incentive is not present when plans pay for renal dialysis for at least 30 months before Medicare becomes the primary insurer.

The onset of kidney failure marks a critical period in which continuity of care is crucial. DPC supports the Chronic Kidney Disease Improvement in Research and Treatment Act (H.R. 1130/S. 598), which would extend the coordination period to 42 months.

Maintain ESRD Patients' Access to ACA Exchange Plans. Dialysis treatment is an "essential health benefit" (EHB) under state and federal law. The group health plans that are benchmarks for a state's EHB cover dialysis services, and their EHB benchmark designation extends the 30-month coverage mandate to the individual market.

Access to ACA Exchange plans is particularly important for low-income ESRD patients. Medicare Savings Program assistance is not as generous 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. Further, under the ACA, private health insurance plans have out-of-pocket maximums; fee-for-service Medicare does not.