

January 6, 2014

Hon. Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, D.C. 20201

Re: Coverage of Renal Dialysis in Exchange Plans

Dear Administrator Tavenner:

Dialysis Patient Citizens, America's largest patient-led organization representing dialysis patients, is comprised of more than 26,000 dialysis and pre-dialysis patients and their families. We seek to ensure the patient point of view is considered by policy makers.

We are writing to express our concerns about language we found in a spot-check of exchange plan documents that appears to permit disenrollment of patients when their kidneys fail. We ask that you investigate this matter and clarify the status of kidney patients who purchase health insurance plans in the federal and state exchanges.

As you know, consumer advocates must always be vigilant for signs that health insurers are engaging in risk selection. We examined health plan documents posted on the Rhode Island and Connecticut state insurance exchange websites to determine whether any plans were attempting to discourage patients with chronic kidney disease (CKD) from enrolling. As best we can tell, these are the only exchanges that make complete coverage documents available to "window shoppers" on their website.

What we found was that at least two insurers offering coverage indicated that their enrollees would no longer be eligible for coverage once they are "entitled to" or "eligible for" Medicare (please see attached exhibits.) While coverage expansion in the Affordable Care Act was not, of course, intended to supplement Medicare coverage for the elderly, end-stage renal disease (ESRD) patients can become entitled to Medicare coverage without regard to age. We do not believe it was Congress' intent that non-elderly Americans lose their exchange coverage due to the progression of an illness—indeed, 45 C.F.R § 156.125 specifies 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.

If a patient can lose coverage when his or her CKD progresses to 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, as with group health insurance, plans pay for renal dialysis for up to 30 months before Medicare becomes the primary insurer. We would further note that onset of kidney failure marks a critical period in which continuity of care is crucial.

We think that the ACA coverage expansion offers an opportunity for a natural experiment to determine whether exchange health plans can better coordinate care for non-elderly CKD and ESRD patients. While dialysis patients will always be grateful that Medicare benefits were extended to them in 1972, there are disadvantages to Medicare. First, there is no coordination of care in fee-for-service Medicare, and ESRD patients are not permitted to enroll in Medicare Part C plans. Second, the same geographic variations in expenditures that plague the Medicare program generally are also present in expenditures on ESRD patients, suggesting that there is overutilization in certain regions that could be alleviated by the managed care techniques practiced by exchange plans. Finally, 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, ACA guarantees that exchange health plans cover at least 87% of average medical expenses. This is not only more generous than Medicare, it is actually more generous than the average large employer-sponsored insurance plan. This assistance could be important for patients who experience the onset of serious illness well before they have accumulated pensions or retirement savings.

Finally, we are concerned that the health plans with the Medicare eligibility exclusions in their Subscriber Agreements will gain an unfair advantage over competing plans that do not use this exclusionary language. This would have the effect of penalizing insurers who do the right thing. We urge CMS to clarify that these exclusions are not permitted.

Thank you for your consideration of our comments and concerns. If you have any questions or would like additional information, please do not hesitate to contact me or our Government Affairs Director Jackson Williams (at 202-789-6931 or jwilliams@dialysispatients.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Hrant Jamgochian".

Hrant Jamgochian, J.D., LL.M.
Chief Executive Officer

- Not be receiving optional State supplementary payments (SSP)
 - Reside in the Service Area of the Exchange
5. Agree to pay for the cost of Premium that Anthem requires;
 6. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
 7. Not be incarcerated (except pending disposition of charges).
 8. Not be entitled to or enrolled in Medicare Parts A/B and or D;
 9. Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

- 1) Resides, intends to reside (including without a fixed address); or
- 2) is seeking employment (whether or not currently employed); or
- 3) has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1. If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2. If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the dependent meets a residency standard.

Eligible Dependents

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria and be:

- 1) The Subscriber's legal spouse.
- 2) The Subscriber's Domestic Partner - Domestic Partner or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
 - For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
 - A Domestic Partner's or a Domestic Partner's Child's Coverage ends on the date of dissolution of the Domestic Partnership.
 - To apply for coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the

2.0 ELIGIBILITY

You may purchase this *agreement* directly from us or from *HealthSource RI*.

If you purchased this *agreement* from us, this section of the *agreement* describes:

- who is eligible for coverage;
- when coverage begins;
- how to add or remove family *members*;
- when coverage ends; and
- continuation of coverage.

If purchased from *HealthSource RI*, eligibility determinations will be made by *HealthSource RI*. Please contact *HealthSource RI* at 1-855-683-6759 for questions about your eligibility.

2.1 Who is an Eligible Person

You: You are eligible to apply for coverage under this *agreement* if:

- you are not eligible for coverage under Medicare or Medicaid;
- you are not eligible for employer-sponsored group coverage or similar coverage, as long as the employer-sponsored coverage is of minimum value; ; AND
- you reside in Rhode Island.

Your Spouse: Your spouse is eligible to enroll for coverage under this *agreement* if you have selected family coverage. Only one of the following individuals may be enrolled at a given time:

- Your opposite sex spouse, according to the statutes of the state in which you were married, when your marriage was formed by obtaining a marriage license, having a marriage ceremony, and registering the marriage with the appropriate state or local official.
- Your common law spouse, according to the law of the state in which your marriage was formed (generally, common law spouses are of the opposite-sex). Your spouse by common law of the opposite gender is eligible to enroll for coverage under this *agreement*. To be eligible, you and your common law spouse must complete and sign our Affidavit of Common Law Marriage and send us the necessary proof. Please call us to obtain the Affidavit of Common Law Marriage.
- Your same-sex spouse, according to the laws of the state in which you were married, when your marriage was formed by obtaining a marriage license, having a marriage ceremony, and registering the marriage with the appropriate state or local official. Your same-sex spouse may be enrolled only if your marriage is recognized by the state in which you reside.