October 3, 2011

The Honorable Patty Murray
Russell Senate Office Building, Room: 448
1st and C Streets, N.E.
Washington, DC 20510

The Honorable Jeb Hensarling
Cannon House Office Building, Room: 129
1st and Independence Ave., S.E.
Washington, DC 20515

Dear Senator Patty Murray and Representative Jeb Hensarling:

As kidney disease and dialysis patient advocacy organizations, one of our most critical missions is to protect patients' access to care. We stand ready to assist you in your efforts to reduce the deficit by highlighting measures that both protect beneficiaries with kidney failure while producing long-term, meaningful Medicare savings.

When individuals experience kidney failure, or end stage renal disease (ESRD), they require regular dialysis treatments, typically three times a week for 4 hours at a time, or a kidney transplant to survive. In 1972, Congress recognized the importance of life-saving dialysis treatment and guaranteed Medicare coverage for patients with ESRD, regardless of age. This life-sustaining benefit has enabled hundreds of thousands of Americans to carry out their lives while coping with kidney failure. Thanks to this special disease-based entitlement, Medicare covers approximately 80 percent of the dialysis population and, of those, 40 percent are dually eligible for both Medicare and Medicaid. Thus, reductions in Medicare spending have a proportionally larger impact on patients with kidney disease and their providers than they have on most other categories of Medicare beneficiaries.

Starting in January of this year, the Medicare ESRSD program underwent a dramatic restructuring with the implementation of a new prospective payment system (PPS). The statute that created the PPS required a two percent reduction in overall payment to dialysis providers beginning in 2011 and the inauguration of Medicare's first Quality Incentive Program (QIP), which links additional payment reductions to certain quality measures specific to ESRD, starting in 2012. Given the considerable reductions already imposed on dialysis care, we urge you to refrain from imposing additional payment reductions that would further erode the funding for treatment of beneficiaries on dialysis. We are concerned that additional reductions this early in the implementation of the new dialysis reimbursement system could have a negative impact on patient access to care. The Medicare Payment Advisory Commission (MedPAC) has consistently reported low margins for dialysis providers and additional reimbursement reductions could result in the closure of dialysis clinics and reduced access to care for ESRD patients.

However, we recognize the importance of reducing the nation's deficit, and we want to take this opportunity to highlight policy proposals that would help preserve health care coverage and access for this population, while saving billions in Medicare spending.

First, we recommend the Joint Select Committee on Deficit Reduction ensure parity between coverage inside and outside of the new health insurance exchanges, specifically as it pertains to application of the Medicare Secondary Payer (MSP) law. Under current MSP law, Medicare is the secondary payer for individuals with group health coverage who develop ESRD. After the first 30 months of this entitlement, Medicare becomes the primary payer for these patients. Unless it is clarified that MSP law applies to plans available through the exchanges, patients will automatically lose their opportunity to obtain coverage through the health insurance exchanges once they are diagnosed with ESRD. At the same time, Medicare will become the primary payer of coverage for the patients, resulting in an increase in Medicare expenditures. We want to ensure that individuals who develop kidney failure do not lose their private coverage and shift automatically to Medicare. From the patient's perspective, an abrupt shift in coverage could limit access to

benefits and increase out-of-pocket expenses. By ensuring consistent application of MSP in the new exchanges, the Joint Select Committee on Deficit Reduction can help to reduce the economic burden of the ESRD program on Medicare and ensure parity between the mechanisms of coverage inside and outside of the exchanges.

Additionally, we urge the Joint Select Committee on Deficit Reduction to ensure that individuals who satisfy income requirements and who develop ESRD are able to qualify for premium credits and cost-sharing subsidies that will help them afford health insurance through an exchange, even though their kidney failure makes them eligible to enroll in Medicare. If an individual is eligible to enroll in Medicare, but has not filed an application for benefits, he/she is not "eligible for coverage" (and therefore not entitled to Medicare Part A benefits) and should be permitted to receive exchange subsidies. Ensuring access to these subsidies will make private coverage attainable for more Americans, further reducing the number of persons with kidney disease who rely on Medicare for health coverage.

By creating consistent policy for people with kidney failure inside and outside health insurance exchanges, the Medicare program could save billions.[1] As a result, we are pleased that this proposal is currently being reviewed by the Congressional Budget Office. These commonsense, cost-effective policies will ensure equal treatment and access to choice for Americans who develop kidney failure, while working to improve our country's long-term economic outlook.

We urge you to make these policy proposals part of your important work on the Joint Select Committee on Deficit Reduction.

Thank you for your continued leadership on these important issues facing our nation.

Sincerely,

American Kidney Fund

Dialysis Patient Citizens

National Kidney Foundation

Renal Support Network

cc: The Honorable Max Baucus
The Honorable Xavier Becerra
The Honorable Dave Camp
The Honorable James Clyburn
The Honorable John Kerry
The Honorable Jon Kyl
The Honorable Rob Portman
The Honorable Patrick Toomey
The Honorable Fred Upton
The Honorable Chris Van Hollen

[1] "Assessing the Budgetary Implications of Policies Designed to Maximize Private Insurance Coverage of End Stage Renal Disease Patients," The Moran Company, March 2011, page 2.