



# Council of Nephrology Social Workers

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## **Affordable Care Act: What Nephrology Social Workers Need to Know**

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## **WEBINAR FOLLOW-UP Q&A**

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**Q: If a person does choose to keep their marketplace coverage and also enroll in Medicare, how would that work? If there is no coordination of coverage, which would cover what? Would marketplace coverage be considered secondary payer? I'm still confused about this aspect...**

**A:** Medicare does not have a coordination of benefits period with individual health insurance plans only with group health plans. Marketplace plans offer individual coverage so each plan may have different language as to how and when they will pay secondary to Medicare. Some individual plans may not pay secondary at all. In those cases it is unlikely to be beneficial for a patient to keep a Marketplace plan and enroll in Medicare. Patients should check their policies carefully to see what how their Marketplace plan will work with Medicare before making a decision. In addition, if the patient enrolls in Medicare they can no longer receive tax credits and subsidies to offset their premium and out-of-pocket costs, which may make the plan unaffordable for them.

One difference to this is that the Marketplace also sells health insurance plans to small businesses through the State Health Insurance Options Program (SHOP). Any plan sold through the SHOP is considered a group health plan and will follow the same Medicare coordination of benefits that apply to employer group health plans today.

**Q: Can an ESRD patient who is already enrolled in Medicare purchase a plan in the Marketplace and use it as supplemental coverage.**

**A:** According the Federal Marketplace website, Healthcare.gov it is illegal for anyone to sell a Marketplace plan to a current Medicare beneficiary. So unfortunately, the marketplace will not help patients obtain affordable secondary coverage.

**Q: Are Medicare supplements available to cover the 20% for dialysis and transplant patients if they switch from marketplace to Medicare?**

**A:** In 28 states there are Medigap plans available for dialysis and transplant patients to purchase. The federal government does not require that these plans be offered to ESRD patients so these decisions are made on a state by state basis. The states offering coverage are: Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Washington, and Wisconsin. However, in some states there are different laws related to timing of enrollment so it will be important for patients to understand those requirements when considering enrollment in Medicare.

**Q: I had a dialysis patient from Montana call and report that their Medigap plan dropped them due to ACA. The patient is well under 65, so is now Medicare only. I referred the patient to the state's SHIP program and renal social worker, but am wondering if this is going to be an issue for other patients - particularly in states where there is no Medicaid expansion and/or Medigap plans for under age 65.**

**A:** Montana actually does not offer Medigap plans to those under 65, but they did expand their Pre-existing Condition Insurance Pool (PCIP), also known as a high-risk pool, to offer secondary coverage to ESRD patients. However, many states will end their PCIPs January 1, 2014 because the Affordable Care Act no longer allows insurers to deny people coverage for pre-existing conditions or charge differential premiums based on health status, so in most cases these programs are no longer necessary. For ESRD patients getting secondary coverage through a state PCIP, this will pose a problem if the state doesn't offer affordable Medigap plans to ESRD patients under 65. It's definitely worth a call to your states health insurance commissioner to raise the concern because ESRD patients with Medicare legally cannot be sold Marketplace plans. NKF as well as the Center for Medicare Advocacy are following this issue closely. We are also gathering information on additional states that are discontinuing PCIP and had Medicare patients enrolled in secondary coverage.

**Q: If a patient on dialysis loses their Medicare due to nonpayment of premiums, will they be able to go to the Marketplace until they are able re-enroll in Medicare during open enrollment?**

**A:** There does not appear to be guidance on this answer. However, if someone doesn't pay CHIP, Medicaid, or their employer group health premiums they are not able to enroll in Marketplace coverage. Presumably the same would apply to Medicare, but it's unclear.

**Q: How is COBRA impacted by the Affordable Care Act?**

**A:** COBRA is not directly impacted by the Affordable Care Act, but those not enrolled in Medicare who want to get private insurance after they lost their job can compare Marketplace plans to their COBRA policy to see if more affordable options are available in the Marketplace compared to maintaining their full premiums for their employer group health plan. However, they should also compare plan benefits to make sure the services and provider networks they need are covered before switching plans.

**Q: Can you clarify what you said about Native Americans enrollment?**

**A:** There are some exemptions to the penalty for not obtaining health insurance. One of those exemptions is if you are a member of a federally recognized tribe or eligible for services through an Indian Health Services provider. The other exemptions include:

- Those uninsured for less than 3 months of the year
- The lowest-priced coverage available would cost more than 8% of your household income
- Those that don't have to file a tax return because their income is below the federal poverty level
- Members of a recognized health care sharing ministry
- Members of a recognized religious sect with religious objections to insurance, including Social Security and Medicare
- Those incarcerated, and not awaiting the disposition of charges against them
- Those not lawfully present in the U.S.

**Q: In the case scenarios wouldn't the transplant patient's coinsurance be 30% if they have a Silver Level plan?**

**A:** While a Silver level plan means that insurers have to pay 70% of the health care costs for an enrollee (excluding the premium) the plan can still organize the enrollee's share of the costs by using a mix of different deductible, coinsurance and copayment amounts so not every healthcare service will have a coinsurance of 30% tied to it.

In addition, subsidies are available at different income levels, which would increase the actuarial value (the percent of health care services the plan has to pay) of the plan, decrease the enrollee's cost-sharing, and lower the enrollee's out-of-pocket max. Here's a chart that breaks down the government financial assistance available for Marketplace plans. Please note subsidies to lower out-of-pocket costs are only available for Silver level plans (premium assistance can be applied to bronze, silver, gold, and platinum plans).

Income	Premiums Limited to % of Income (through tax credits)	% of total Health Care Costs not covered by the plan (limited by government subsidies for incomes <250% FPL)	Out-of-Pocket Maximums Individual/Family
<133% FPL	2.0%	6%	\$2,250/\$4,500
133 - 150% FPL	3.0 - 4.0%	6%	\$2,250/\$4,500
150 - 200% FPL	4.0 - 6.3%	13%	\$2,250/\$4,500
200 - 250% FPL	6.3 - 8.05%	27%	\$5,200/\$10,400
250 - 300% FPL	8.05 - 9.5%	30%	\$6,350/\$12,700
300 - 400% FPL	9.5 %	30%	\$6,350/\$12,700

**Q: In what year does the Medicare Part D coverage gap end completely?**

**A:** 2020, that's the year that patient cost sharing is 25%, which is equal to what it is now before the coverage gap is reached.

**Q: What happens to catastrophic coverage when the Medicare Part D donut hole closes. Is the tradeoff that those who reach catastrophic coverage continue to pay the same amount for their prescriptions rather than the 5% they do now?**

**A:** Catastrophic coverage remains intact. So there will still be a catastrophic threshold that patient and plan expenditures have to meet before patients cost-sharing is limited to 5%.