

## Insurance

### Introduction

Health insurance is critical for patients with chronic kidney disease. Patients will need intensive medical care and treatment throughout their lifetime and are at significant risk of dire consequences without adequate health insurance coverage. State by state, insurance opportunities will differ for patients with renal disease. What will be true across all states and communities is that young adults between the ages of 18 and 21 are among the most uninsured and underinsured in the United States. Social workers play an important role in assessing insurance problems and assisting patients and families in accessing the appropriate resources. Please use this section as a general guide with the understanding that each individual state will have different rules about eligibility and waiting periods, and may have different insurance options available for this population.

### Medicare

Patients with end stage renal disease (ESRD) have access to limited health insurance coverage through Medicare. Medicare is a federal program and ESRD patients are eligible by diagnosis. There is no income qualifier. Patients do need to be documented citizens with social security numbers. Patients need to have paid into the Medicare system through income tax for a sufficient number of quarters.

Peritoneal dialysis (PD) patients are eligible from the date of first PD treatment for the duration of time on dialysis. Hemodialysis (HD) patients are eligible starting 3 months following the first HD session for the duration of time on dialysis. Transplant patients will be eligible from the date of transplant for 36 calendar months.

Medicare will be the secondary payor for the first 30 months on dialysis and for all transplant coverage time unless the patient also has Medicaid coverage. For Medicaid patients, Medicare will be the primary payor for the duration of dual Medicaid/Medicare enrollment.

- *Medicare Part A:* All ESRD patients who enroll in Medicare will get Part A coverage at no cost. Part A covers inpatient costs associated with ESRD treatment as well as any other inpatient costs.
- *Medicare Part B:* Patients will need to sign up for Part B separately. Part B covers certain outpatient costs associated with ESRD treatment and certain medications (EPO, post-transplant immunosuppressant medications). Part B is free of cost for people on Medicaid. There is a tiered quarterly premium for those patients without Medicaid coverage.
- *Medicare Part D:* This is the new prescription drug plan for Medicare patients. There are multiple plans to choose from and plan availability will vary from state

to state. ESRD patients with Medicaid coverage must have a Part D plan. Patients will be auto-enrolled, but may opt to change Part D plans at any time. There are co-pays associated with Part D plans. Part D plans are also available for patients without secondary Medicaid coverage.

However, patients should be careful to assess out-of-pocket costs and to determine whether the Part D plan will interfere with coverage from an existing prescription drug benefit through private insurance. Patients without secondary Medicaid coverage will have co-pays, monthly premiums, and a coverage gap. In general, pediatric patients with private insurance do better without a Part D plan.

### **Medicaid**

State by state, Medicaid eligibility and coverage differs quite a bit. Medicaid is generally available for lower income individuals. Many states have multiple Medicaid programs that are available for individuals in different situations at different income levels. Programs typically determine eligibility based on age, income, citizenship, disability or state dependency.

Children will age out of their Medicaid program on their 19<sup>th</sup> birthday. Patients will need to reapply for a different Medicaid program or reapply for the same program as an independent adult.

### **Disability**

Supplemental Security Income (SSI) is available for low income children with disabilities. Patients need to qualify both medically and financially. Patients will qualify from a medical standpoint at some point during their progression to ESRD, at all times that they are receiving dialysis treatment, and for at least the first year post-transplant. Co-morbid diagnoses may extend eligibility periods beyond this timeframe.

SSI is beneficial in two important ways. First, there is a monthly cash benefit dependent upon family size and income. Second, patients receiving SSI are automatically eligible for Medicaid coverage.

Patients enrolled in Medicaid through SSI eligibility may need to reapply for Medicaid benefits if there is a change in SSI eligibility.

### **Group Coverage**

Group insurance coverage is offered to a particular group of people – typically through an employer or an organization. There is no government sponsorship and enrollment in the group determines eligibility for the coverage. Following are some examples of ways to get group insurance coverage:

- *Student Health Care:* Most colleges and universities offer student health insurance plans to part-time and full-time students. These plans are typically inexpensive, but also provide less extensive coverage.
- *Employer Health Care:* Many employers are able to offer group insurance plans to full-time employees and sometimes to part-time employees. These plans tend to be more comprehensive, but sometimes more expensive.
- *Consortium Health Care:* Some religious, fraternal, and business associations offer health insurance plans for members of the organization. Some national disability organizations offer health insurance options as well.

### **Individual Coverage**

It is possible to purchase individual coverage directly from commercial health plans. Individual coverage can be more costly than group coverage plans. There may also be more restrictions with regard to initial health screenings or waiting periods for pre-existing conditions.

### **COBRA Coverage**

COBRA stands for the Consolidated Omnibus Reconciliation Act. This is a federal law and will be applicable in all states. COBRA offers a way for individuals to extend insurance coverage for up to 36 months following the end of their eligibility in a group care plan. If a parent leaves a job that had employee health care benefits, the parent may use COBRA to pay the full cost of the plan for continued enrollment. If a child ages out of a parent's employer-based plan, the parent can use COBRA to pay the full cost of the plan for continued enrollment of their child.

You must notify the employer (or other enrollment group) within 60 days of the eligibility change in order to access COBRA benefits. COBRA has a maximum coverage period of 36 months. The full cost of a group plan may be quite expensive, but will typically be cheaper than purchasing an equivalent individual plan, and will eliminate waiting periods for pre-existing conditions.

### **Student Status**

Many group health care plans allow an extension of coverage for adult children who remain in school. The plan may determine the age of independence to be 18, but as long as the son or daughter remains a full time student in high school, college, or vocational school, the plan may allow them to remain fully enrolled in coverage through age 22-24. Some plans may even provide coverage for part time students.

### **Waiting Periods**

Many insurance plans include waiting periods for pre-existing conditions. This means that the health insurance plan will not cover any treatment related to a condition that existed prior to enrollment in that plan for a specified waiting period. Other care will be covered according to the health care plan.

Rules vary state to state. In many states, waiting periods are waived as long as the patient has had “equivalent” health care coverage previously and there is no gap in coverage. This allows people to change jobs and change insurance providers without concern for lack of coverage, as long as there is no day without coverage.

### **Lifetime Maximum Benefits**

Many health insurance plans have a lifetime maximum benefit. This means that the insurance company will not pay any more than \$1 million (for example) in total health care expenses for an individual. Pediatric ESRD patients are likely to hit that lifetime maximum benefit at some point in their treatment. Parents should be aware of their insurance policies. Some plans offer a renewable lifetime maximum. The dollar amount varies from plan to plan. Lifetime maximum benefits do not transfer with the patient, such that changing health care plans allows a patient to start over. Parents may need to advocate with employers to offer multiple health care plan options, allowing a change in plan to happen if the lifetime maximum benefit is exceeded.

### **Health Care Trusts**

There are a number of ways for parents to set up health care trusts for children with intensive medical needs. These trusts do not serve as insurance coverage, but offer a way for parents to save money for their children to use specifically for out-of-pocket health care expenses. Many states offer programs to help parents set up such accounts for disabled children. Any financial advisor can assist a parent in investigating these options.

### **Assistance for Out-of-Pocket Expenses**

Despite the many options highlighted above, it remains very difficult for many children and young adults to maintain adequate health care coverage. When patients are uninsured, please look to the following resources for assistance with out-of-pocket expenses:

- *Charity Care:* Most hospitals, especially pediatric facilities, offer charity care for uninsured individuals.

- *Drug Manufacturers:* Most prescription drug companies offer financial assistance for 1-3 month supplies of the medications they manufacture. There is often a lot of paperwork, and the supplies are usually limited to a short time.
- *Local and National Organizations:* The American Kidney Fund offers pharmacy assistance. Many local community organizations offer emergency fund assistance that can help with co-pays and other out-of-pocket expenses for health care.

### **Citizenship**

Many of the programs above will require proof of citizenship or applicable immigration status in order to qualify for coverage and assistance. Undocumented children have been excluded from health insurance coverage at astonishing rates over the last several years. The situation varies from state to state, with the southern border states having some of the most challenging barriers to care and treatment. Some states continue to provide partial to full coverage through state Medicaid programs. In other states, there is no payment option available.

Social workers play a vital role in these cases. Threat of jail or deportation creates significant barriers to open dialogue with patients and families. There are limited resources and options for patients and advocacy is a delicate issue.

### **Conclusion**

Given the high cost of medical care and the need for significant interventions that all chronic kidney disease patients face, it is critical that nephrology social workers attend to insurance issues in assessments and ongoing work with this patient population. While many hospital-based pediatric programs have ancillary staff that can provide assistance with insurance problems, it remains the role of the social worker to assess the insurance status and direct patients and families to existing resources as necessary.

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