National Kidney Foundation™

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January 26, 2016

Via Electronic Submission

Mr. Mike Kreidler
Commissioner
Washington State Office of the Insurance Commissioner
P.O. Box 40255
Olympia, WA 98504-0255

Re: Discriminatory plan designs for end-stage renal disease patients

Dear Commissioner Kreidler,

It has been brought to our attention that several insurance carriers have developed discriminatory polices based on an individual's status as having End-Stage Renal Disease (ESRD). The National Kidney Foundation (NKF) is concerned that these health plans operating in the state of Washington are misleading and discriminating against patients with ESRD. NKF is America's largest and oldest health organization dedicated to the awareness, prevention, and treatment of kidney disease for hundreds of thousands of healthcare professionals, millions of patients and their families, and tens of millions of people at risk. NKF has local division and affiliate offices serving our constituents throughout the U.S., including a Northern California and Pacific Northwest Division serving the approximately 3,522 dialysis patients residing in Washington.

Some insurers are going so far as to offer to pay for their member's Medicare premiums to promote enrollment in Medicare and/or penalize members who do not enroll by using non-negotiated payments rates for dialysis providers and subjecting patients to balance billing – costs, which will not apply to the patient's out-of-pocket maximum. For example, in some plans, the outpatient dialysis benefit for members with ESRD is reduced after the first treatment period from standard commercial rates to a limit capped at 125% of the Medicare reimbursement level, leaving the patient responsible for the remaining provider charges.

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While individuals are eligible to enroll in Medicare due to ESRD, regardless of age, they are not required to do so. In August, the Centers for Medicare & Medicaid Services clarified this right for ESRD patients in its frequently asked questions document, which can be found at http://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Overview1.html. For group health plans, the Social Security Act, Medicare Secondary Provisions allows ESRD patients to keep their private health insurance and requires the private plan to pay primary for at least for 30 months. ESRD patients do not have to enroll in Medicare during this time frame and instead can enroll in Medicare after 30 months to avoid having to pay Medicare premiums during a time when the patient is unlikely to receive any additional benefit from Medicare coverage. For individual marketplace plans, ESRD patients who enroll in Medicare will lose tax credits and subsidies and Medicare can become primary to individual plans after three months, which limits most, if not all, of the benefit patients would have under the marketplace plan.

There are many reasons patients may wish to keep their private insurance and forgo Medicare enrollment. Some of these reasons include lower copays/coinsurance versus the typical 20% under Medicare Part B, limits on out-of-pocket costs not offered under Medicare, potentially having to switch healthcare providers, desire to maintain coverage of all family members under one plan, and coverage of additional benefits not covered by Medicare.

Plans are misleading patients by touting the payment of Medicare premiums as a benefit and stating that patients must enroll in Medicare as soon as possible. These plans are not disclosing any potential downside or tradeoffs patients may have to make should they enroll in Medicare. In addition plans that cap the reimbursement rate to dialysis facilities for ESRD patients and leave patients at risk of being billed the remainder of provider charges may effectively be forcing patients to enroll in Medicare. NKF respectfully requests your division to prohibit these actions and to broadly clarify that plans may not implement benefit designs that single out ESRD patients.

Sincerely,

Tonya L. Saffer, MPH
Senior Health Policy Director