



National
Kidney
Foundation™

May 10, 2018

Senator Ricardo Lara
Senate Committee on Appropriations
State Capitol
Sacramento, CA 95814

Re: SB 1156 Health care service plans: 3rd-party payments

Dear Senator Lara,

The National Kidney Foundation is very concerned about SB 1156, which would single out and limit people with end-stage renal disease's (ESRD) ability to receive charitable assistance to help pay for health insurance. The National Kidney Foundation is the largest, most comprehensive and longstanding, patient centric organization dedicated to the awareness, prevention and treatment of kidney disease in the US. While we do not provide premium assistance to help kidney patients pay for health insurance coverage nor do we counsel patients on the type of coverage they should choose, we do provide factual information and tools to help patients learn about their options and make informed decisions that best serve their unique needs. We also provide education and resources to kidney health care professionals about health insurance options for ESRD patients. Unless, significantly modified we believe SB 1156 will result in patients having fewer options for comprehensive, affordable health insurance, and in some cases face substantially increased health care costs.

SB 1156 should not single out ESRD patients and limit their ability to receive charitable assistance.

To determine Medicare eligibility for ESRD patients an application for Medicare would have to be submitted. Therefore Section 1 (c) (B), which requires an entity providing charitable premium

assistance to annually certify whether a recipient is eligible for Medicare would effectively be forcing all ESRD patients to apply for Medicare.

Passage of the Medicare ESRD program in 1972 was a lifesaving change in health policy for Americans with permanent kidney failure. Prior to the benefit most people with kidney failure died having never received dialysis treatment. For those who are eligible, Medicare continues to be the coverage that most ESRD patients choose today.

However, there are many reasons for which a patient may prefer private insurance coverage, including coverage offered through Covered California. Examples of these reasons are:

- the inability to obtain a Medigap policy
- lower costs of private coverage because of caps on out-of-pocket expenses for combined medical services and prescription drugs and the ability to benefit from family coverage and family caps
- access to practitioners that do not accept Medicare (including many mental health practitioners)
- access to benefits that are not covered by Medicare (vision, transportation, hearing aids, etc.)

For most patients with private group health plans, the group health plan remains their primary coverage for the first 30 months of Medicare eligibility due to Medicare Secondary Payer (MSP) rules. Once the 30-month Coordination of Benefits (COB) window closes, Medicare becomes primary and the group health plan secondary.¹ However, ESRD patients are not required to enroll in Medicare. Medicare benefits begin upon enrollment.²

The MSP policy for a guaranteed 30-month coordination of benefits period, where private insurance remains primary for ESRD patients, only applies to group health plans. For patients with individual health plans who enroll in Medicare, Medicare is primary the day their Medicare coverage begins.³ Some individual health plans do not pay out benefits secondary to Medicare. Prior to the Affordable Care Act (ACA), very few patients could even enroll in individual health plans if they had ESRD because of pre-existing condition exclusions. The Center for Medicare & Medicaid Services (CMS) has indicated that people who are under 65, not receiving disability benefits, and are enrolled in ACA compliant individual coverage may maintain that coverage.

¹ Medicare Secondary Payer Manual, Ch. 1, Section 10.1 (Rev. 87, 08-03-12)

² Sec. 226A of the Social Security Act; 42 U.S.C. 426-1; 42 C.F.R. § 406.13(c).

³<https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD.html>. For ESRD patients who enroll in Medicare, coverage generally starts after three months of receiving in-center hemodialysis. For home dialysis patients Medicare coverage starts during the first month they start dialysis and for transplant recipients Medicare coverage begins the date they are admitted to the hospital to receive a kidney transplant.

This option is available even if they are diagnosed with ESRD.⁴ In addition, kidney transplantation and dialysis are essential health benefits and the ACA risk adjustment model includes ESRD to help offset the added costs that health plans will have related to the care of ESRD patients. Selecting benchmark plans and providing risk adjustment payments are policy decisions that were designed to protect high cost patients with special needs from discrimination via denying benefits or attempting to exclude them from coverage as well as to help insurers balance their risk pools to be able to afford to serve high cost patients.

While Medicare may be the best option for many patients, others may face difficulty affording the health care services they need because California specifically excludes ESRD patients who are under age 65 from enrolling in Medigap coverage. This means that those Medicare beneficiaries who are not dually eligible for MediCal are subject to paying for all Medicare premiums and deductibles in addition to a 20% coinsurance for each dialysis treatment, out-patient office visit, testing, outpatient procedures, immunosuppressive medications, and non-ESRD related injectable medications. On average a dialysis patient can incur approximately \$7,000 or more annually in out-of-pocket expenses just on coinsurance alone for dialysis.⁵

In addition, Medicare does not cover benefits that patients may have under private insurance and Medicare Advantage plans are not available as an option for dialysis patients unless they were already enrolled in MA before progressing to ESRD, receiving retiree benefits under an MA plan and are grandfathered into that specific plan, or enrolled in a Special Needs Plan (SNP).

SB 1156 Should not create a process that delays payment of insurance premiums placing patients at risk of denied or terminated coverage.

Section 1 (c) (3)(A) states that an entity providing charitable assistance must notify the health plan and the Department of Insurance 60 days before a charitable premium payment is made. This could cause a delay of payment which may cause an insurer to terminate coverage or a gap in insurance coverage for the patient. This provision should remove the contingency of notification before a payment is made.

SB 1156 should not penalize patients and allow them to be exposed to catastrophic medical bills

Section 1 (d) penalizes the patient for any violations made by the third-party providing charitable assistance. By requiring that provider payments from the insurer are limited to the Medicare reimbursement rates in the face of a violation, patients are being put at risk of being billed charges for healthcare services that are more than that amount.

⁴ Frequently Asked Questions Regarding Medicare and the Marketplace August 1, 2014, updated April 28, 2016.

⁵ Methodology: Assumes Medicare reimbursement rate of \$230.39 per dialysis treatment (2016 final unadjusted base rate) and that the patient receives 156 treatments per year in an out-patient dialysis facility.

The National Kidney Foundation calls on the Senate to put the rights and interests of ESRD patients first. The Appropriations committee should oppose or further amend SB 1156 to address each of these concerns. ESRD patients should be able to choose among all insurance options available to Californians regardless of whether their financial situation requires them to receive charitable premium assistance.

Sincerely,



Chad Iseman
Region Vice President



Pier Merone
Executive Director, Serving the West