



April 19, 2018

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

I am writing on behalf of Kidney Care Partners (KCP) in response to the recent letter sent to you and released by a small group of large health insurers, labor union representatives, and employers asking the Centers for Medicare & Medicaid Services (CMS) to re-issue regulations that would effectively prohibit individuals with kidney failure and who require dialysis from exercising their right to choose health coverage. The letter contains misleading and unfounded accusations and ignores the long-standing federal policy ensuring that dialysis patients have the same rights as other Americans. The effect of the recommendations in the letter would be the creation of a double-standard — one that allows wealthy individuals who can pay out-of-pocket premiums the right to obtain private health insurance, while prohibiting less affluent individuals from doing the same. We urge you not to allow insurers and unions to succeed in making patient charitable premium assistance programs the new pre-existing condition exclusion in America's health system.

KCP is the nation's only multi-stakeholder coalition representing patient advocates, physician organizations, health professional groups, dialysis providers, researchers, and manufacturers.

I. Individuals with Kidney Failure Have a Right to Choose Private Health Coverage

Since the inception of the End-Stage Renal Disease (ESRD) Medicare benefit, individuals with kidney failure who require life-sustaining dialysis have always had the right to retain their current health insurance policy.¹ The federal government has never forced these individuals to enroll in Medicare, which is precisely what the authors of the recent letter are asking you to do.

It should not be assumed that Medicare is always the right choice for every patient. Dialysis patients – most of whom no longer work – choose to retain their employer, COBRA, and other commercial coverage for several reasons. Private insurance often provides

¹42 U.S.C. § 1395y.

better, more robust coverage than government programs. Patients with family members who require coverage may choose to retain private coverage rather than duplicate cost-sharing requirements across two different plans. In about half of the states, patients who qualify for Medicare because of a diagnosis of ESRD may not be able to access Medigap plans and, therefore, wish to rely upon private insurance, which may have more favorable cost-sharing obligations or expanded coverage. Whatever the reason, individuals with kidney failure have the same right as all Americans to select the health plan that works best for them and their families. The 30-month Medicare Secondary Payer (MSP) statute already restricts this right and caps the duration for which any health plan must provide for coverage, it is worth noting that this is a substantial governmental subsidy for such plans. Most importantly, private insurance should not be the sole domain of wealthy and healthy Americans.

II. The Important Role of Charitable Assistance

Created in 1971 by a group of people who came together to pay for a neighbor's dialysis treatment, the non-profit American Kidney Fund (AKF) has played a crucial role in helping dialysis patients maintain access to health insurance coverage for nearly 50 years. AKF has continually sought to help patients retain their autonomy to select the health plan of their choice. As the Department of Health and Human Services (HHS) OIG concluded: "AKF is a bona fide, independent, publicly-funded, 501(c)(3) charitable organization whose charitable purposes include aiding ESRD patients and their families."

The AKF charity and ESRD program are unique in that the government established the Medicare entitlement in an era where access to commercial insurance was limited, intentionally extended the duration of the private sector's obligation from time to time (now only up to 30 months), and understood that the AKF charity would be funded by providers to assist low income individuals in accessing the coverage of their choice. These are the facts there has been no scheme to mislead or conceal them. The insurers themselves have produced no evidence of steering or misuse of charitable assistance. Their contention is that any individual that might need assistance is by default abusing the system and being "steered" into commercial coverage.

AKF has assisted patients in paying their health insurance premiums for over 20 years under the federally approved Health Insurance Premium Program (HIPP), which began in 1997, operating under guardrails provided by the Office of the Inspector General (OIG) at the U.S. Department of Health and Human Services. Since then, AKF has provided premium assistance for Medicare, Medigap, individual, and group health care coverage. In 2017, AKF helped over 74,000 people pay for all forms of public and private health insurance, and more than 60 percent of the charitable assistance was to help patients pay their premiums for Medicare Part B and Medigap. Another 25 percent was for employer-provided health plans, including COBRA. Only 12 percent of ESRD patients receiving assistance from AKF in 2017 were enrolled in a commercial plan, including just 4 percent who were in ACA Exchange plans.

Contrary to the misleading and unfounded accusations in the recent letter, the AKF process for awarding patients with year-long assistance grants is completely separate from any of the entities who provide donations, as the OIG has recognized in writing. This process relies upon the financial information provided by the patient. Individuals and organizations that provide funding to support the AKF have no influence over the AKF's decision of whether to provide charitable assistance to any particular patient or where that patient receives care. Indeed, many of the dialysis providers who refer patients to AKF do not contribute at all to HIPP.

AKF's patient-focused assistance allows those who are otherwise marginalized, particularly minority patients, to exercise their right to select a health plan that best meets their needs. There is—and should continue to be—a role for charitable assistance to needy patients. Health plans should not be permitted to discriminate against these patients merely because they rely upon a charity for assistance rather than an employer, family member, or other individual who can support them. It is unconscionable that health plans have singled out patients with kidney failure, especially since other patients with expensive chronic diseases, such as cancer or HIV/AIDS, are allowed to rely upon charitable assistance to remain in the health insurance plan of their choosing.

III. Health Plans Are Seeking Federal Approval for Discriminatory Behaviors

For years, the kidney care community has raised concerns about the practices of health insurers to restrict access to insurance in a manner that discriminates against dialysis patients. We have shared examples with CMS and the Department, highlighting how health plans have taken specific actions that require or incentivize individuals with kidney failure to drop their private coverage or make it secondary to Medicare and/or Medicaid before these individuals are required to do so. KCP members have documented the following activities undertaken by specific Exchange plan issuers with the intent of dropping individuals from coverage based on their health status:

- **Misleading patients:** Some plans mislead enrollees by suggesting that federal law requires individuals with ESRD to enroll in Medicare four months after having been diagnosed with ESRD.
- **Incentivizing patients to shift to Medicare:** Some plans will pay the Medicare coinsurance amounts or other cost-sharing obligations on behalf of the individuals if they shift their coverage to Medicare.
- **Increasing patients' coinsurance obligations:** Some plans increase individuals' coinsurance obligations by dropping the plans' payments to providers to rates at or slightly above the Medicare rates, placing individuals in the position of being

responsible for paying the remainder of the rates plans negotiated with providers.

These behaviors are discriminatory and seek to push patients off of their private coverage and into Medicare. These practices should be prohibited. We strongly encourage you to reject these activities and not re-issue regulations that have been enjoined by the federal courts or any other policy that would support discrimination against dialysis patients.

IV. Protect the Rights of Individuals Living with Kidney Failure

In 2016, when CMS originally published the Request for Information and subsequent Interim Final Rule that you have been asked to re-issue, KCP raised concerns that the language stated that the decisions by the Congress through the Medicare as Secondary Payer (MSP) provision, the Internal Revenue Service (IRS) through the tax credit and subsidies regulations, and even CMS, through previous Notice of Benefit and Payment Parameter regulations, should now apply to dialysis patients who are low-income. In each of these contexts, federal policy-makers have concluded that the unique status of dialysis patients as being eligible for Medicare does not eliminate their right to retain existing private coverage or even obtain new private coverage. While insurance plans may wish to eliminate their responsibility for these patients, patients have been very clear over the years that they support policies that promote patient choice in selecting their coverage options. This choice is essential to ensuring that patients can access the coverage that meets their medical and financial needs.

Eliminating this right to select their coverage would have an immediate negative impact on individuals with kidney failure. Medicare may not always be the right option for individuals and their families. Forcing them into a Medicare-only option could increase their financial burden, reduce their access to providers of choice (especially for their family members), cause disruption in their care management (especially for other chronic diseases they may be managing), and even reduce their chance for a transplant.

Medicare also may not be the best option for transplant patients because once a patient receives a transplant, he/she can no longer remain in Part A and retain Part B only for purposes of receiving immunosuppressive medications. In light of concerns about care coordination and maintaining provider relationships, there are clearly reasons why some patients with kidney failure would want to try to retain their private coverage for purposes of receiving a transplant and the follow-up care.

Additionally, patients with kidney failure are equally unique in that they are not subject to late enrollment penalties during the MSP 30-month period. Given the MSP statutory requirements, as well as the IRS and CMS decisions that clearly state that eligibility does not require enrollment, they are in a different place with regard to enrollment timing. In addition, the individual patient should have the ability based on

The Honorable Alex Azar

April 19, 2018

Page 5 of 5

accurate and complete information to decide whether he/she prefers commercial coverage versus Medicare. Health plans should not paternalistically make that decision for the patient.

Therefore, we also ask that you work with the Office of Civil Rights (OCR) and the Department of Labor to enforce antidiscrimination laws to protect dialysis patients, regardless of their economic status. KCP has strongly supported the antidiscrimination provisions in the Medicare Secondary Payer statute, as well as the Section 1557 requirements more recently implemented by the OCR and the Department of Labor requirements related to employer plans. Patient organizations have filed complaints with both OCR and the Department of Labor seeking to enforce the existing laws and to stop issuers from discriminating against individuals with kidney failure. We encourage CMS to work with these patient organizations to identify and stop discriminatory practices against individuals with kidney failure.

V. Conclusion

The letter's authors incorrectly label the actions of patients exercising their right to select a health plan that best meets their needs as inappropriate steering. Yet, as the federal judge who ruled against the publication of the regulations issued by the Obama Administration concluded, there was no evidence of any steering occurring or harm to patients. Make no mistake: The letter's authors are trying to avoid providing coverage to a small percentage of patients who are living with a serious chronic condition. The federal government should avoid enacting any policy that enables discriminatory behaviors and practices.

We would welcome the opportunity to work with you and the CMS teams on these and other issues affecting individuals with kidney disease and kidney failure.

Sincerely,

A handwritten signature in black ink, appearing to read "AR Nissenson, MD". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Allen R. Nissenson, MD
Chairman
Kidney Care Partners