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## Groups Outraged Dialysis Facilities Must Tell Issuers About Premium Assistance; Legal Action Eyed

Patient groups supporting people with end-stage renal disease (ESRD) are incensed over a CMS rule out Monday that they say goes beyond pushing for greater transparency and instead grants health plans the power to reject coverage for ESRD patients receiving assistance from third-party payers. At least one group, Dialysis Patient Citizens, is eyeing legal action and potential use of the Congressional Review Act to overturn the interim final rule, which goes into effect in 30 days.

Several non-profit entities either provide premium assistance or help patients to get premium assistance through other groups. One of the largest sources of funding comes from the American Kidney Fund (AKF), which has been offering ESRD patients financial assistance for years through a program approved by the HHS Office of Inspector General.

But issuers have said their costs for ESRD services have skyrocketed because some patients who would be eligible for Medicaid or Medicare, which covers all patients with ESRD regardless of age after a waiting period, have been steered into private plans. According to a CMS fact sheet on the rule, “a patient covered by a private issuers can bring in as much as four times higher than Medicare and Medicaid’s, adding up to a difference of \$100,000 to \$200,000 or more per patient per year. This easily dwarfs the several thousand dollar cost of providing premium assistance.”

CMS issued the IRF following an August request for information on the potential inappropriate steering of Medicare or Medicaid patients into private plans. According to the agency, the comments were compelling enough to warrant an immediate rule.

“In response to CMS’s request for information, dialysis facility social workers and others offered evidence that some dialysis facilities are aggressively steering vulnerable patients toward individual market coverage supported by premium assistance,” CMS says in the fact sheet. “CMS’s own data suggest that inappropriate steering of patients may be accelerating over time. Between 2014 and 2015, there were large increases in the number of ESRD patients enrolled in individual market coverage, particularly in some states,” the fact sheet adds.

CMS argues steering patients to private plans also harms consumers in various ways, including by exposing them to more financial responsibility, interfering with transplant readiness and potentially causing mid-year coverage disruptions.

The new rule requires Medicare-approved dialysis facilities to talk with patients about all available coverage options, including Medicare, Medicaid and private insurance.

**Additionally, and what galls the non-profit community, dialysis facilities are required to inform issuers that they will help with premium payments.** Facilities must also get assurance from the insurance plan that it will accept those payments for the duration of a plan year, and if no assurance is given, the facility cannot assist with premium payments.

Patient groups say the rule unfairly targets ESRD patients, and essentially creates a two-tiered system in which wealthier patients have access to the private coverage options, while low-income patients do not. Stakeholders also argue the rule allows issuers to discriminate based on health status, which is counter to the ACA.

“The administration is giving insurers the authority to discriminate against people based on their health status in ways that could force patients with complex medical needs off the coverage that gives them access to lifesaving care,” says Hrant Jamgochian, chief executive of Dialysis Patient Citizens, in a statement. “With this rule, CMS is telling dialysis patients that the patient protections afforded to everyone else do not apply to them.”

Kidney Care Partners (KCP), a coalition of patient advocates, kidney disease professionals, dialysis care providers, and manufacturers, says while it “recognizes and appreciates the need to ensure and maintain viability in the healthcare marketplace, we feel this rule simply goes too far and runs counter to the foundational principles of the ACA.”

“Dialysis patients are among the most medically fragile in our healthcare system, and they differ from other chronically ill patients,” KCP continues. “The kidney community is deeply troubled that payors are targeting high-cost patients with pre-existing conditions to move off of or away from their plans, which runs counter to the fundamental anti-discriminatory tenet of the ACA. Just like other Americans, those living with kidney failure have the right to select the insurance program that is right for them. A patient’s need for financial assistance should in no way disqualify him or her from any health insurance plan.”

“The message to low-income kidney failure patients is loud and clear: The Affordable Care Act is not for you,” LaVarne Burton, president and CEO of the American Kidney Fund, says in a statement.

“In sending such a message, CMS sets a dangerous precedent for people with any chronic condition who depend on charitable assistance to afford premiums. CMS’ stated goal in issuing the IFR is to create a more transparent process for

patient education and referral to nonprofits for charitable assistance for health insurance premiums. We wholeheartedly support that goal—but in reality, the IFR effectively removes kidney patients from the insurance decision-making process. It leaves to insurers the decision of whether to provide ACA coverage to low-income kidney patients who need charitable assistance to afford premiums,” she adds.

Steve Bruun, executive director of the Chronic Disease Coalition, says his group applauds efforts to provide for transparency and patient education about insurance options, but is “deeply troubled that CMS has failed to acknowledge or address the very real issues currently affecting patient protection and treatment, much less the additional problems this new rule could create.”

**At least one stakeholder is already looking at legal options.**

Dialysis Patient Citizens’ Jamgochian tells *Inside Health Policy* he believes the rule violates the Administrative Procedure Act (APA) because the agency failed to show good cause for skipping the comment and review period. CMS had plenty of time to go through the normal rulemaking process, he says. The rule stunned many people in the community because the White House Office of Management Budget website had indicated the rule was solely about disclosure. No one assumed that it would go so far as to ask insurers about the payments, he says.

Jamgochian was also disappointed because his group held several meetings with CMS to discuss how issuers have been refusing patients with premium assistance. Patient groups wanted CMS to issue regulations requiring plans to accept third-party payments. CMS already requires issuers to accept such payments from Ryan White/HIV programs, which led advocates to question why they are not getting the same treatment.

The Congressional Review Act, which allows Congress to overturn regulations, is another route to quash the rule. Jamgochian says the group has not yet started to lobby Congress. The CRA has been rarely used, but Jamgochian is hopeful lawmakers will use it this time around due the rule’s timing, his belief that it favors issuers, and its potential impact on patients.

The group also plans to reach out to the incoming administration, he says.

Prior to CMS’ rule, major dialysis companies DaVita and the American Renal Association had pledged to stop helping Medicaid-eligible patients receive private coverage until they saw more information from CMS.

Neither company responded to a query on the rule by press time. An analyst tracking the firms says that while companies had expected the rule would prohibit them from helping Medicaid-eligible patients get premium assistance, the rule’s application to all patients that could need assistance came as a surprise — and a negative for both companies.

This basically means “game over” for those activities, says the analyst.

The other major dialysis firm, Fresenius Medical Care North America, expressed concern over the rule. “We recognize the need to ensure the stability of the individual insurance marketplace, but we are concerned that CMS’ new rules could impair patients’ ability to benefit from charitable premium assistance,” Robert Sepucha, FMCNA’s senior vice president of corporate affairs, says in a statement. “Patients in need depend on this kind of charitable assistance to access life sustaining dialysis therapy. We will continue to work with stakeholders to ensure that all patients have access to high quality care, no matter their income status,” he adds. — *Amy Lotven*