One size does not fit all for dialysis patients:

End-stage renal disease and the limitations of Medicare and Medicaid

End-stage renal disease (ESRD, or kidney failure) patients have complex health care needs. The two leading causes of kidney failure are diabetes and hypertension, so most kidney patients have additional comorbidities. Having health insurance options – including Qualified Health Plans (QHPs) – can lead to better health outcomes for ESRD patients, especially given some of the limitations in Medicare and Medicaid coverage.

Most ESRD patients are eligible for Medicare three months after beginning dialysis, and it is the primary health insurance program for them. But even with Medicare, dialysis patients can still face significant financial hardships.

Medicare pays 80% of covered charges; the other 20% is paid out-of-pocket by patients, or by private secondary insurance, such as Medigap or Medicaid. Medicare has no out-of-pocket limits.

Without secondary insurance, many dialysis patients on Medicare spend down until they have no assets and are forced to go on Medicaid. Insurers are only required to offer Medigap plans to ESRD patients under the age of 65 in 30 states, so Medigap is not an option for under-65 ESRD patients in 20 states.

Access to physicians can be difficult for Medicaid recipients. A 2014 report by Merritt Hawkins said only 45% of physicians in major metropolitan areas accepted Medicaid patients. Of those, only 55% were accepting new Medicaid patients.

Physicians who accept Medicaid can be hard to access and wait times for appointments are often long. An HHS OIG study found that 51% of providers listed in Medicaid MCO directories could not offer appointments to Medicaid patients. The Merritt Hawkins study found that in offices that could offer appointments, the average wait time to see a doctor was 18.5 days.

Some states cover only the federally mandated Medicaid benefits, which are very limited. Many states do not cover prosthetics, podiatry, physical therapy, optometry, etc., all of which can be essential services for ESRD patients.

Life-or-death choices:
Preserving the choice of private insurance for ESRD patients is essential

Dialysis patients have complex and unique medical needs. The issues they face with Medicaid coverage can be understood through the experiences of several patients who receive charitable assistance from the American Kidney Fund.

Patient A was ineligible for Medicare and had been on a state Medicaid plan that limited prescriptions to 10 per month, yet this patient needed 23 prescriptions each month. She was rationing prescriptions, self-determining which ones she would fill each month. Once she enrolled in a QHP, this patient was able to fill all 23 prescriptions.

Patient B had been on Medicaid for six years before kidney failure and dialysis, and had not seen a primary care physician (PCP) during that time. The patient lives in an area where no PCPs who accepted Medicaid were taking new patients. After enrolling in a QHP plan, the patient saw a PCP within a week.

Patient C has not been able to get a fistula placed because no vascular surgeons in her area accept Medicaid patients. Fistulas – created through a minor surgical procedure connecting an artery and a vein – are important because they are the safest and most effective way to administer dialysis treatment. A QHP was available to her, but she was not able to enroll due to the uncertainly around insurers accepting charitable premium payments for ESRD patients.

Patient D has not visited family out of state in years because Medicaid will not pay for dialysis out of state. Many QHPs are portable nationally for dialysis care, allowing ESRD patients to travel.

Patient E has not been able to get a prosthetic for an amputated limb because Medicaid has not approved it. Like Patient C, this patient also has access to a QHP but was not able to enroll due to uncertainty around insurers accepting charitable premium payments for ESRD patients.