CMS Interim Final Rule Protects Insurers at Patients’ Expense

Statement from LaVarne A. Burton, President and Chief Executive Officer, American Kidney Fund

Rockville, Maryland (PRWEB) December 13, 2016 -- The following statement was issued by LaVarne A. Burton, president and chief executive officer of the American Kidney Fund:

"On Monday, the Centers for Medicare and Medicaid Services (CMS) issued an Interim Final Rule (IFR) that protects health insurance companies at the expense of patients. The message to low-income kidney failure patients is loud and clear: the Affordable Care Act is not for you. 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.

For nearly three years, CMS has refused to act on the mounting evidence that we have presented to the agency: insurance companies increasingly are refusing to insure people who depend on nonprofit assistance to obtain the coverage for the care that they need. This CMS inaction has led to insurance companies steering kidney failure patients away from ACA plans, and has limited patient choice. With Monday’s IFR, CMS has effectively endorsed this type of behavior on the part of insurers, alleging adverse impacts to patients without providing a single documented example of a patient's health being adversely impacted.

In early 2014, CMS chose to protect people living with HIV/AIDS by requiring insurers to accept premium assistance payments from the Ryan White HIV/AIDS program, but the agency has failed to provide a similar protection for kidney patients. Indeed, CMS has now done the opposite, paving the way for insurers to deny coverage to the population we serve. The IFR puts back into effect discrimination against patients with a pre-existing condition. That is wrong.

We maintain that it should always be the patient’s choice to select the health insurance plan that is best suited to his or her individual circumstances, and that this decision should not be influenced by profit motives on the part of health care providers. Choice of insurance should also not be influenced by profit motives on the part of insurers, and this is where CMS gets it wrong.

The American Kidney Fund has been the safety net for low-income dialysis patients for 45 years, and we have assisted patients in paying their health insurance premiums for 20 years under our federally approved Health Insurance Premium Program. The majority of people we help come to us for assistance with Medicare Part B and Medigap premiums. A small minority seek our help for ACA plans. Part of the IFR does align with actions AKF has recently taken to ensure patient autonomy and informed choice when applying for financial assistance through our program. In recent meetings with CMS, we laid out these plans in detail and expressed our strong desire to work with the agency to protect patient choice. But the only real choice in the IFR is left to insurance companies. Under this rule, they alone will determine whether or not to accept a kidney patient who receives
charitable financial assistance to pay for premiums.

The rule gets the facts wrong, as well. It presents a specious argument that 7,000 kidney patients in ACA plans skew a risk pool of more than 12 million people. The rule maintains, unbelievably, that private insurance somehow makes it more difficult for ESRD patients to get transplants, when the opposite is true. Without premium assistance from AKF, many people would not be able to go through the transplant process. Most incredibly, the rule fails to point out that mid-year disruption in coverage—a real problem for patients—is caused entirely by insurers who elect to terminate coverage for patients who receive charitable assistance.

CMS should have taken this opportunity to provide a strong protection to people who have reviewed all of their insurance options and have selected an ACA plan, but need charitable assistance to afford it. Instead, the IFR leaves it entirely to the discretion of insurers who have a strong financial incentive to drop these patients from their rolls or refuse to insure them, even though, as quoted in the rule, “regulations at 45 CFR 147.104 and 156.805 prohibit issuers from discriminating against or employing marketing practices that discriminate against individuals with significant health care needs.” If the Affordable Care Act was designed to provide protections for patients against insurer abuses, this IFR strips away those protections for kidney patients.

CMS needs to acknowledge that insurers have financial incentives to deny coverage for expensive patients with pre-existing conditions. For nearly three years, we have repeatedly provided to CMS information about insurance company practices that are resulting in kidney patients losing coverage. The independent Medicare Rights Center laid out in its recent comment letter to CMS that there are circumstances where individual coverage is in a patient’s best interest. Denying such coverage can be harmful to patients. Many kidney patients also submitted comments detailing why an ACA plan was the better choice for them. CMS apparently ignored these comments despite repeated efforts from many organizations to provide a comprehensive view of the patient perspective.

We are deeply concerned that dropping from ACA plans those kidney patients who need charitable assistance is merely the opening salvo in insurers’ efforts to exclude kidney patients from other types of policies, as well as to exclude low-income patients with other chronic illnesses from coverage. We have already seen some insurers refusing charitable premium payments from AKF for Medigap plans—a move that can cause great financial harm to patients.

We believe that CMS should protect ESRD patients in the same way that it protected low-income HIV/AIDS patients in 2014 when insurers tried to exclude them from Marketplace coverage by refusing payments from the Ryan White AIDS Program.

We further believe that a patient’s need for financial assistance should in no way disqualify him or her from any health insurance plan.

This action by CMS threatens to turn back the clock to a time when patients with pre-existing conditions could not get private health care coverage. We urge CMS to halt this one-sided effort to help insurance companies at the expense of kidney patients.

We will never stop fighting for the rights of kidney patients. We will continue working with regulators and lawmakers at the state and federal levels to ensure that patients can access the health insurance plan of their choice, even if they need help paying for it."
About the American Kidney Fund
As the nation’s leading nonprofit working on behalf of the 31 million Americans with kidney disease, the American Kidney Fund is dedicated to ensuring that every kidney patient has access to health care, and that every person at risk for kidney disease is empowered to prevent it. AKF provides a complete spectrum of programs and services: prevention outreach, top-rated health educational resources, and direct financial assistance enabling 1 in 5 U.S. dialysis patients to access lifesaving medical care, including dialysis and transplantation. For more information, please visit KidneyFund.org, or connect with us on Facebook, Twitter and Instagram.
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