

# Medicare from A to D: What Every Nephrologist Needs to Know

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In 1972, the Congress of the United States put insurance coverage for ESRD under Medicare. Thus, most patients who required dialysis and transplantation in the United States were covered by this program, enabling widespread application of these treatments for kidney failure. The system of coverage is complex, and often patients and their physicians are confused about the regulations and intricacies of the system. The purpose of this article is to simplify Medicare from the perspective of a day-to-day financial counselor to patients in an active kidney transplant program. It is hoped that this article will leave the reader with three things: (1) A greater knowledge of Medicare's part in covering the expenses for ESRD treatment, (2) a grasp of what patients experience in negotiating the financial challenges of receiving dialysis or maintaining a kidney transplant, and (3) inspiration for advocacy on behalf of patients for a stronger Medicare program.

## Medicare: What Is It?

Medicare has been aptly described as the US version of single-payer universal health insurance (1), albeit restricted to approximately 13% of the population (2). According to the Centers for Medicare and Medicaid Services (CMS), fewer than half of Medicare beneficiaries believe that they know what Medicare covers; beneficiaries who are younger than 65 yr report the biggest gap in knowledge (3), and this is the largest segment of the Renal Medicare population (4).

In 1965, Congress created Medicare hospital (Part A) and medical (Part B) insurance for older Americans. In 1972, Medicare expanded to include people with permanent disabilities and those with ESRD (5). Although the program has many intricacies today as a result of changes enacted through the Medicare Modernization Act of 2003, Parts A and B are still the foundation on which all other Medicare benefits have been built.

## Who Can Enroll? Who Should Enroll?

To become entitled to Renal Medicare, a patient must meet two conditions: (1) Evidence of ESRD and current chronic treatment for it and (2) sufficient work history of his or her own or his or

her spouse or of a parent if he or she is a dependent child. The physician's signature on the CMS Medical Evidence Report, or 2728 form, is a binding attestation to the Social Security Administration (SSA) and the ESRD Network Coordinating Council that the first condition has been met.

With sufficient work credits, the patient applies to the SSA for benefits. Patients with ESRD are eligible for Medicare when they or their spouse or a parent on whom they are dependent is considered by SSA to be either "fully" or "currently" insured, as defined by the amount of money made in each year worked. To be fully insured, the patient must have at least one work credit for each year since 1950 (or since he or she turned 21, if that happened after 1950) up to the year dialysis was begun, the transplant took place, or he or she turned 62 (whichever came first); or if the patient was between the ages of 21 and 28 when ESRD hit, he or she must have at least six work credits to be eligible for Medicare benefits. To be currently insured, any patient must have earned at least 6 work credits in the past 3 yr and 3 mo. One can earn up to four work credits every year. In 2008, one earns one work credit for every \$1000 made income taxable by SSA, so to earn four work credits in 2008, one must earn \$4000 on which income taxes will be paid. The amount of money that one must make to earn a work credit goes up every year (6).

It is important to know that there is more flexibility in how credits are calculated for Renal Medicare than for Social Security Disability Insurance, the income replacement program for people with disabilities. Because the SSA handles the applications for both programs, patients often believe that one set of rules governs both and may not understand that they are eligible for Renal Medicare despite insufficient credits to qualify for Social Security Disability Insurance. According to a 2004 Government Accountability Office report, physicians can expect approximately 90% of patients to qualify for Renal Medicare.

Many patients are already members of an employer group health plan (EGHP) when they become eligible for Medicare. Is that first opportunity the best time to enroll? When a patient with an EGHP becomes eligible for Renal Medicare, a 30-month clock called the Coordination of Benefits (COB) period begins to tick. During this period, Medicare will be the patient's secondary coverage.

In almost all cases, because of the upward trend of shifting the expense of health care to employees in the form of higher

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out-of-pocket costs, the cost of the Part B premium is easily offset by Medicare's coverage. For a variety of reasons, patients may decide to forego Medicare enrollment until the end of the COB period, when Medicare becomes primary over the EGHP. By that date, patients should get their Medicare in place, because almost all EGHP reduce coverage to what their liability as a secondary payer would be.

The decision to enroll during the COB period must be weighed carefully. There is no end to the scenarios under which an EGHP can be lost or so altered as to be unaffordable to the patient. At this juncture in the process, patients benefit from collaboration between dialysis center and transplant center social workers and financial counselors. All providers should consider the long-term financial impact to the patient when options are being explored about insurance coverage.

## Medicare Parts A through D: When Coverage Begins, How It Helps, and What It Costs

Renal Medicare can be available as soon as the first month of treatment for chronic renal failure. Coverage ends 3 yr after transplantation for recipients who have a functioning allograft at that time and who are not eligible for Medicare coverage by virtue of age or permanent disability.

If the patient first succeeds at one of the home-based dialysis modalities, then Medicare entitlement is available retroactively to the first day of the month in which dialysis took place. In-center dialysis patients have a waiting period before entitlement becomes available on the first day of the fourth month of treatment. A kidney transplant either before initiation of dialysis or during the waiting period brings Renal Medicare entitlement retroactive to the first day of the month of transplantation.

### *Medicare Part A: Hospital Insurance*

When a patient enrolls, he or she becomes a Part A beneficiary. Part A helps to cover inpatient stays in hospitals and skilled nursing facilities, hospice care, and some home health care. Part A has no monthly premium, but there are costs and limits to using the coverage. If the admission meets medical necessity criteria, then a patient will owe the hospital at least the Part A deductible and, in the event of a very lengthy stay, daily copays. If 61 d after discharge the patient is readmitted, then he or she will owe the hospital another deductible and again face daily copays. Theoretically, a patient could face several such expenses in a calendar year. The Part A deductible is \$1024 in 2008, an increase of 13.3% over the past 3 yr.

### *Medicare Part B: Medical Insurance*

A patient can opt for Medicare Part B when he or she enrolls in Part A. Part B reimburses doctors' services, outpatient hospital care, and other medical services that Part A does not cover, such as outpatient dialysis and laboratory services. For kidney transplant recipients, Part B covers immunosuppression medications if Medicare helped to cover the transplant.

Using Part B coverage is different from Part A. First, the patient pays a monthly premium. In 2008, the Part B premium

is \$96.40 per month for most beneficiaries; this cost has climbed 40% in 3 yr. New in 2007 was the practice of indexing premiums to income, a sea change in Medicare policy. Approximately 4% of Part B members will pay higher monthly premiums, up to \$161.40 (7).

Part B also has an annual deductible of \$135 in 2008. This deductible also increases annually and is currently 30% higher than just 3 yr ago. For most covered services, Medicare pays providers 80% of its allowed charge. Because most laboratories are covered at 100% and Medicare caps what providers can charge for services and supplies, there is a built-in limit on a patient's share of cost for each covered service. Unlike most private health insurance plans, Medicare Part B has no annual out-of-pocket maximum. The patient is responsible for a share of every service covered at less than 100%, all year long, without relief. That is for 20% of Medicare's rate on relatively small charges, such as a routine office visit, as well as for 20% of enormous charges, such as dialysis treatment or antirejection drugs. The current Medicare allowed amount for the typical regimen of immunosuppression drugs prescribed by our kidney transplant program can leave as much as \$400 a month, or \$4800 a year, for a patient to pay out of pocket.

### *Medicare Part C: Medicare Advantage Plans*

Part C manages Medicare Advantage (MA) plans. MA plans, like their health maintenance organization precursors from the 1970s, are private health insurance plans that are contracted with Medicare to administer Medicare benefits. At a higher cost to the federal budget than original Medicare (8), they provide coverage to beneficiaries and generally offer some extra benefits. All MA plan members must continue to pay their Part B premium, as well as the MA premium. Premiums vary, and all MA plans require cost sharing by the member. MA plans are not supplemental insurance; neither can a beneficiary enroll in a Medicare supplement to get help with the out-of-pocket expenses of MA plans. Patients with ESRD are barred from enrolling in most MA plans.

### *Medicare Part D: Prescription Drug Insurance*

Part D, Medicare's prescription drug benefit, is also privately administered and includes both "stand alone" prescription drug plans (PDP) and MA plans with drug coverage (MA-PD). Benefits differ from plan to plan and from state to state. A December 2006 survey conducted by the Kaiser Family Foundation and the Harvard School of Public Health (9) found that only 35% of seniors understand that there are important differences between the plans, so dialysis and transplant financial counselors and social workers must know what to consider when helping a patient decide on a plan.

PDP must accept any applicant during legitimate enrollment periods. MA-PD choose who they will enroll. Although patients with ESRD are barred from joining most MA-PD plans, they can remain a plan member when ESRD develops after enrollment. Dialysis providers DaVita and Fresenius have partnered with CMS on a demonstration project to offer MA-PD to patients with ESRD. Currently available in several states, the plans may become more widely available in the next year.

Both PDP and MA-PD plans decide the price of their premiums, the drugs that they cover, and the cost to the beneficiary. Many plans have deductibles, and some cover generics during the infamous “doughnut hole,” or coverage gap period. Only residents of the state of Florida have access to a plan with some gap coverage for brand name drugs, forcing other beneficiaries throughout the United States back onto the charity of manufacturers’ Patient Assistant Programs. Plans must offer at least the standard benefit shown in Table 1 (10):

A December 2006 survey conducted by the Kaiser Family Foundation and the Harvard School of Public Health (9) revealed that an overwhelming majority of beneficiaries (72%), pharmacists (91%), and doctors (92%) have found the Medicare Part D benefit to be too complicated, but to date there have been no significant changes enacted to simplify this frustratingly complex program.

*B or D: Which Part Covers Which Drugs?*

Medicare coverage for immunosuppression has advanced slowly since ESRD entitlement was first established in 1972. The first legislation authorized standard Part A and B coverage only and came with the stipulation that entitlement would end 12 mo after a successful transplant; take-home immunosuppression drugs were not covered. By 1978, Renal entitlement was extended to 36 mo of posttransplantation care, but, still, outpatient immunosuppression was excluded from coverage. It was not until 1984 that Congress authorized 1 yr worth of posttransplantation outpatient immunosuppression as a Part B benefit, after a Medicare-covered kidney transplant, regardless of why or for how long the beneficiary was eligible for Medicare. Between 1993 and 1995, coverage grew until it offered 3 yr of posttransplantation immunosuppression, and that is where it remains today, unless a patient is entitled to age 65 or Disability Medicare at the 3-yr posttransplantation mark (11,12).

The advent of Part D gave birth to many myths, reflecting the confusion and worry that patients, doctors, transplant center staff, and pharmacies did and continue to experience. Medicare has a very simple rule regarding coverage for immunosuppression. If a patient had Medicare Part A at the time of transplantation *and* the transplant took place in a Medicare-approved

facility, Part B is the only Medicare program that will pay for his or her outpatient immunosuppression medications. The myths persist (Table 2).

Patients, doctors, pharmacies, and the plans themselves often misunderstand the immunosuppression benefit. More than 2 yr after CMS training for pharmacy and plan staff began, our center still routinely fields requests for prior authorizations for immunosuppression refills because the pharmacy billed the patient’s Part D prescription drug benefit rather than Part B. Until Congress decides otherwise, the rule of thumb is, regardless of whether a transplant recipient has original Medicare or an MA-PD plan, immunosuppression is paid as a Part B benefit if the patient was entitled to Medicare A on or retroactive to the date of the transplant.

**Why Beneficiaries Need Supplemental Insurance**

Medicare Parts A, B, C, and D are not enough coverage to protect most patients from serious financial difficulty. Few transplant programs will accept a Medicare beneficiary who has nothing but original Medicare and a PDP, largely because of the 20% co-insurance for immunosuppression. According to a 1997 Kaiser/Commonwealth Fund survey of Medicare beneficiaries (13), those who are “poor, the under-65 disabled, those in poor health, and those with ADL (activities of daily living) impairments reported problems paying their medical bills. One of four beneficiaries who are poor (27%) or in fair or poor health (24%) said that paying bills is very difficult or that doing so has exhausted all their savings. Among disabled beneficiaries, this rate increases to nearly one of three (30%).”

The Kaiser/Commonwealth Fund study estimated that 82% of Medicare beneficiaries have some form of supplemental coverage; however, 26% of Medicare’s under-65 population and 22% of its poor have no supplemental coverage at all (13). Supplements can be private plans such as Medigap policies or retiree health coverage. Most Medigap policies work very well for transplant recipients because they pay the 20% co-insurance for immunosuppression. Price and availability vary from state to state. Private supplements have a monthly premium and cover Medicare’s out-of-pocket costs to varying degrees, so patients may still pay for part of the cost of a covered service.

Table 1. Medicare Part D Standard Benefit 2007 and 2008

Parameter	Standard Benefit	
	2007	2008
Annual deductible	\$265	\$275
Initial coverage limit (beneficiary pays 25% of this amount)	\$2400 (25% = \$600 out-of-pocket)	\$2510 (25% = \$627.50 out-of-pocket)
Once in the donut hole, beneficiary pays the next...	\$2985	\$3147
Out-of-pocket threshold	\$3850 (\$265 + 600 + 2985)	\$4050 (\$275 + 627.50 + 3147.50)
Minimum cost sharing during catastrophic coverage	\$2.15 (generic) \$5.35 (brand name)	\$2.25 (generic) \$5.60 (brand name)

Table 2. Medicare Coverage for Immunosuppression: Myths and Realities

Myth	Reality
Medicare is moving immunosuppression coverage from Part B to Part D.	Immunosuppression remains a Part B benefit for recipients who have a Medicare-covered transplant.
Part D will pick up some or all of the 20% co-insurance for immunosuppression.	Parts B and D are separate programs that do not work together to share costs for any Medicare-covered drugs.
Pharmacies can bill immunosuppression to Part D if the patient does not have Part B or does not have a supplement to cover the 20% co-insurance	Although there are many verified reports of Part D plans covering immunosuppression in these instances, they do so in error for any patient who had a Medicare-covered transplant.
State Medicaid programs no longer pick up the 20% co-insurance for "dual eligibles" (those with Medicare and Medicaid).	Fee-for-service Medicaid or State Qualified Medicare Beneficiary programs remain responsible for Part B co-insurance for dual-eligible patients.

One major complaint about the MA plans is that beneficiaries routinely believe them to be supplements and so misunderstand their share of cost (14). There is growing evidence that aggressive and even deceptive marketing is to blame. In fact, in June 2007, after Congress began investigating the so-called Private Fee-For-Service MA plans, several agreed voluntarily to suspend marketing them until they could comply with CMS rules of fair play (15).

Publicly funded supplemental coverage can be Medicaid, a Medicare Savings Program (MSP), or special state-sponsored programs called State Pharmaceutical Assistance Programs (SPAP). Medicaid and MSP plans are available in all states, whereas SPAP are currently available only in 28 states (16). 25 states also have Kidney Disease Programs that offer various kinds of financial assistance to patients who have ESRD and meet income and asset test (17). A third kind of assistance for dialysis patients comes from the American Kidney Fund, whose web site cites having helped "nearly one-fifth of American dialysis patients" in 2006 (18). Many dialysis patients who are referred for transplantation participate in the American Kidney Fund's Health Insurance Premium Program, which pays Part B, Medigap, and COBRA premiums for needy dialysis patients. Health Insurance Premium Program assistance ends when a dialysis patient becomes a kidney transplant recipient. In Oregon, the combined monthly premiums for Part B plus a typical Medigap plan can amount to \$250 or more. A COBRA premium plus Part B may cost well over \$500 a month. The candidate's inability to shoulder these expenses immediately after transplantation is a common barrier to transplantation. No similar fund exists in the transplant community to provide the same level of relief.

The SSA offers a special Low-Income Subsidy to some Part D plan members. This "extra help" reduces or eliminates premiums and deductibles, lowers drug copays, and, most important, plugs the coverage gap found in almost all plans, ensuring year-round coverage without breaks for everyone who qualifies. The Kaiser Family Foundation's 2006 Fact Sheet on Part D

(19) reported that of the estimated 5.1 million other beneficiaries who could be receiving the subsidy, 54% had not applied as of July 2006. Many must reapply from year to year.

Typically, the lowest and highest income patients will have stable and adequate coverage for their ESRD treatment, the former being covered by public supplemental benefits and the latter having sufficient assets to shoulder the burden. Those in the middle pose the greatest concern. An August 2007 study published in *Transplantation* found that the average monthly out-of-pocket expenses for a kidney transplant recipient could range from \$203 to \$467 or more, with the most significant leap in expenses occurring in year 4 (20), when Medicare has ended for most.

### Once a Beneficiary, Always a Beneficiary?

The last improvement to coverage for immunosuppression came in 1999, when Congress authorized the "lifetime benefit." CMS's handbook *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* (21) explains, "Medicare will continue to pay for your immunosuppressive drugs with no time limit if you already had Medicare because of age or disability before you got ESRD, or became eligible for Medicare because of age or disability after getting a transplant that was paid for by Medicare, or paid for by private insurance that paid primary to your Medicare Part A coverage, in a Medicare-certified facility." The handbook also takes pains to point out twice that "if you have Medicare only because of kidney failure, your Medicare coverage will end 36 mo after the month of the (successful) transplant," so the patient must first be eligible for, then enrolled in, and paying the monthly premiums for Part B to have coverage for immunosuppression. In some programs, patients postpone active listing or living-donor surgery until the month of their 62nd birthday to be assured of uninterrupted lifetime help with the high cost of immunosuppression.

Part D prescription drug coverage terminates on the same day that eligibility for Medicare ends. As the handbook says, "Medicare won't pay for any services or items, including immunosuppressive drugs, for patients who are not entitled to

Medicare." Because Medicare D plans are sold by private companies, some patients see them as separate from Medicare and are surprised to find a large bill at the pharmacy the month after their Renal Medicare terminates. One must be entitled to either Part A or Part B to enroll in and keep a Part D plan.

### When Medicare Coverage Ends

Medicare coverage can end either as a result of nonpayment of premiums or the completion of the specified length of entitlement. Termination for nonpayment is a frustrating situation for transplant centers to help resolve because patients rarely tell us when they stop paying their premiums. It is not unusual for a chronically ill person with overwhelming medical expenses to confess to not opening envelopes that might bear bad news, such as a balance due. When Part B terminates prematurely, the immediate issue is the loss of immunosuppression coverage. Sometimes Part B can be restored retroactively to the date of termination but often times not. Most pharmaceutical manufacturers offer Patient Assistance Programs for times like these, but the assistance may come too late to fend off a bad transplant outcome.

When the patient's Medicare coverage terminates, what then? People who go back into the workforce will be protected from preexisting condition or wait period clauses in group plans only if they are within 63 d of their Medicare termination date when the new coverage begins—that is, if they can find a job with an affordable health care plan. According to the Kaiser Family Foundation, only 59% of workers had an employer group health plan in 2006, down from 63% in 2000 (22). According to the 2006 Health Confidence Survey (23), those still insured reported that the erosion of benefits has led to a decrease in saving for retirement and other savings and difficulty in paying for necessities and other bills. Three quarters of those surveyed said that they would prefer \$6700 in employment-based coverage to an additional \$6700 in taxable income.

For those with no EGHP, Veterans Administration, or Tricare coverage, options are limited to what a patient can afford and where he or she lives. Individual policies are available on the private market in some but not all states. Thirty-four states have "risk pool" insurance for those who are rejected by private plans for preexisting conditions. Premiums are costly and represent only a portion of the expense of using coverage. Some patients transition to drug manufacturer Patient Assistance Programs without an interruption to their medication regimen. Others fail at this over time, as a result of the complexity of program participation. In either case, both kinds of patients still lack coverage for medical care, which acts as a deterrent to proper follow-up, such as doctor's visits, laboratory work, biopsies, and, of course, any need for hospitalization. Nationwide, mounting requests for charitable care are straining health care providers at every level.

### The Future of Renal Medicare: A Vision

From 2008, we can look back on 35 yr of Medicare coverage for people with ESRD. When it began, Medicare expected to cover approximately 10,000 new patients with ESRD per year and max out at approximately 35,000 new incidents annually. In

1974, ESRD enrollment accounted for approximately 0.1% of all Medicare beneficiaries (12). In 2004, more than 104,000 patients began therapy for ESRD, and enrollment stood at approximately 1 percent of the total Medicare population. The prevalent rate of ESRD is growing approximately 2.0% per year, according to the US Renal Data System (24).

As it stands, Renal Medicare now provides lifetime coverage for patients who remain on dialysis. Transplant recipients who reach age 65 by the end of their Renal entitlement or who remain in the Social Security Disability program are also entitled to lifetime coverage for their medical care as well as their immunosuppression medications. There has never been successful legislation to extend the percentage of coverage for immunosuppression from 80 to 100%.

Some of Medicare's current limitations are a reflection of the "penny wise and pound foolish" operations of many public programs. Also, what the Medicare Modernization Act of 2003 is spending to support privatization could be used to reduce the patient's financial burden through expansion of MSP and other direct assistance to beneficiaries. Three changes to the current program would make all of the difference in the world to a patient's well-being.

First, eliminate the 3 yr posttransplantation limit on entitlement for Renal Medicare beneficiaries. Second, increase the immunosuppression benefit from 80 to 100% coverage. With these two steps, transplant recipients will have a guaranteed uninterrupted lifetime benefit for immunosuppression, and no patient need ever return to dialysis simply because of an inability to afford immunosuppression. Finally, eliminate privatization in Medicare D and redirect the savings into a drug benefit managed directly by the federal government, just like original Medicare.

Medicare will never be perfect. Nevertheless, we have 42 yr of experience on which to build, and the potential is vast for transforming Medicare from a health care payment system into the bedrock foundation of a universal health care delivery system in the United States. What better way to celebrate its Golden Jubilee in 2015 than to be able to say, "Medicare for all for life."

### Glossary of Abbreviations

**CMS**, Centers for Medicare and Medicaid.

**COB**, coordination of benefits period. A fixed period of 30 months when the patient first becomes eligible for Renal Medicare. If the patient has or joins an EGHP in this period, Medicare pays secondary after EGHP benefits. At month 31, Medicare becomes the primary payer for all covered services. The insurance industry uses the term 'COB' to describe the method by which two or more carriers or plans coordinate their respective benefits so the total benefit paid does not exceed 100% of the total allowable expenses incurred for a service.

**EGHP**, employer group health plan.

**LIS**, low-income subsidy for Medicare D. Also known as 'extra help.'

**MA**, Medicare Advantage plan. A health plan (like HMOs and PPOs) approved by Medicare and run by a private company.

**MA-PD**, Medicare Advantage plan that includes the Part D prescription drug benefit.

**MSP**, Medicare Savings Program. Federal/state partnership to help with premiums, deductibles, and coinsurance for needy beneficiaries. CMS uses this acronym for 'Medicare Secondary Payer' their method for determining whether Medicare or an EGHP is the primary payer for services.

**PAP**, patient assistance programs. Pharmaceutical manufacturers private charitable programs

**Part A**, Medicare hospital insurance.

**Part B**, Medicare medical insurance.

**Part C**, Medicare Advantage, also known as managed Medicare, or Medicare replacement. Private plan that administers Medicare Parts A and B benefits. May be a Health Maintenance Organization (HMO) Preferred Provider Organization (PPO) or Private Fee for Service contract (PFFS).

**Part D**, Medicare prescription drug insurance.

**PBM**, Pharmacy benefits management company.

**PDP**, Medicare 'stand alone' prescription drug plan, administered by a PBM.

**SPAP**, State Pharmaceutical Assistance Program, publicly funded help with cost of prescription drugs for the needy.

**SSA**, Social Security Administration.

**SSDI**, Social Security Disability Insurance.

## Disclosures

None.

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