



September 27, 2012

Commissioner of Insurance
Attn: Adam Plain
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Carson City, NV 89706

Delivery via e-mail: aplain@doi.nv.gov

RE: Essential Health Benefits, State Health Insurance Exchange

Fresenius Medical Care North America ("FMCNA") appreciates the opportunity to provide comments on Nevada's selection of the Essential Health Benefits ("EHB") benchmark plan that will define the services that health plans will be required to cover beginning in 2014 pursuant to §1302 of the Affordable Care Act ("ACA"). Our comment relates specifically to the needs of individuals with kidney failure, also known as end stage renal disease ("ESRD").

Background on End Stage Renal Disease

Approximately 400,000 Americans are living with kidney failure. In Nevada, over 3,800 people have ESRD. Healthy kidneys remove excess fluid, minerals, and wastes from the body while producing hormones that keep bones strong and blood healthy. A diagnosis of ESRD means that the kidneys do not perform these functions sufficient to sustain life. Individuals with kidney failure have only two treatment options – transplantation and dialysis. If such treatment is delayed or not accessible, an individual with kidney failure will die within a few weeks.

A History of Public-Private Partnership

The United States Congress has long recognized the importance of ensuring that Americans of all ages have access to care for ESRD. In 1972 the Congress made a commitment to individuals with ESRD by providing Medicare coverage for those diagnosed with this disease, regardless of age. However, there is a waiting period for Medicare coverage, and individuals with kidney failure need treatment immediately.

Given the importance of insurance coverage to this complex and chronic patient population, we urge Nevada to maintain the federal commitment to Americans living with kidney failure by ensuring that coverage for ESRD is expressly included as an essential health benefit. While we appreciate the flexibility that is being provided to the States, it is critically important that Nevada residents in this life-threatening organ failure state have access to coverage for ESRD as an essential health benefit. Nevada residents who purchase coverage through the Exchange will have a clear indication that if they develop kidney failure there will be no gap in their coverage now, or in the future, as plans modify their benefit structures.

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The Importance of Providing Clarity

There is no question that coverage of ESRD meets the criteria set forth by the Institute of Medicine (IOM) in its recommendations to the Department of Health and Human Services.¹ Current treatment options for kidney failure, dialysis and transplantation, are the standard of care agreed upon by the medical community. They are safe, medically effective, lead to meaningful improvement in the quality of life, and are cost effective. Clarifying coverage for ESRD is critically important given the finding of the Department of Labor (DOL) that 73 percent of the plans it surveyed do not specifically list coverage of kidney dialysis.² This problem can be encapsulated by the statement in the DOL report: “Because kidney dialysis was mentioned in so few documents, information on the extent of coverage did not meet publication standards.”³ Similarly, 55 percent of these plans do not explicitly indicate coverage or exclusion for kidney transplants,⁴ even though the Bulletin states that organ transplants are generally covered by the benchmark plans.

In contrast, in March 2011, a survey of 779 employers was conducted by Mercer to assess essential health benefits of insurance plans. Because health plan coverage can vary significantly based on employer size, Mercer looked at the results for employers with fewer than 500 employees (157 respondents), 500–4,999 employees (401 respondents) and 5,000 or more employees (221 respondents). **Nearly all employers (95%) cover kidney dialysis and organ transplants.** There is little variation in the prevalence of this coverage by employer size. Only 8% of respondents covering dialysis placed any special limitations on this coverage in 2010. Of those, about a third either removed the limit or changed from a dollar limit to a visit limit in 2011 in response to the Affordable Care Act. The rest made no changes.

While the assumption is that coverage is ultimately provided, a lack of clarity could result in delays in treatments or substantial unnecessary out-of-pocket costs for Americans who may not be able to afford them. It would be inappropriate to risk coverage for ESRD by allowing States to choose how to interpret the silence of these plans.

FMCNA appreciates the opportunity to provide you with our recommendations regarding Nevada’s selection of the Essential Health Benefits benchmark plan that will define the services that health plans will be required to cover. We would welcome the opportunity to provide you and your team with additional information if that would be helpful. Please feel free to contact me.

Sincerely,



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¹See Institute of Medicine (IOM), *Essential Health Benefits: Balancing Coverage and Costs* (2011) (hereinafter “IOM Report”).

² *Id.* at 4-7; Department of Labor, “Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services” 18 (April 15, 2011) (hereinafter “DOL Report”);

³IOM Report, *supra*, note 1 at 4-7; DOL report, *supra* note 2 at 18.

⁴DOL Report, *supra* note 2 at 36; see also IOM Report, *supra* note 1, Appendix C (Table C-1).