Financial handbook for kidney transplant patients

Patient information

Corewell Health™

This booklet is designed to provide you with information needed to understand the costs associated with a kidney transplant.

You are always welcome to ask questions about anything that you don't understand.

Notes and questions

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Please keep in mind

The information contained in this booklet contains general information. Your individual experience may vary.

Introduction

Welcome to the Kidney Transplant Program at Corewell Health William Beaumont University Hospital. To determine eligibility for a kidney transplant, a comprehensive assessment will be done by the transplant team. This not only includes medical history, but psychosocial and financial history as well.

A kidney transplant candidate must have and maintain an appropriate level of transplant-specific insurance coverage before, during and after the transplant. This will help protect from unmanageable out-of-pocket expenses that may endanger the success of the transplant and/or cause serious financial hardship.

Some costs to consider:

- Transplant evaluation and testing.
- Transplant surgery.
- Hospital stay.
- Follow-up care after surgery.
- Laboratory testing and imaging (X-rays, MRIs, etc.).
- Medications.

The transplant financial representative will explain insurance benefits and assist with understanding financial costs associated with kidney transplantation.

Open communication with the transplant financial representative throughout the transplant process is essential. Changes to insurance coverage or loss of insurance coverage may affect the ability to receive a transplant until those issues are resolved.

If this should occur once on the transplant waiting list, it may be necessary to put a transplant candidate “on hold” (not eligible to receive organ offers) until a solution can be found. It may even be necessary to remove the candidate from the transplant waiting list if it is determined that a transplant would not be a safe option due to financial circumstances.

The ability to afford medical care and required prescriptions to prevent rejection after the kidney transplant is essential for success. The transplant financial representative and transplant social worker will assist with identifying financial resources, if needed.

As each individual case is different, this booklet is not meant to answer all financial questions but may help to clarify general health insurance benefits and transplant costs.

Financial considerations

Commercial health insurance, Medicare and Medicaid all provide coverage. The transplant candidate must know what medical coverage and resources they already have and exactly what is and what is not covered.

It is critical to know how much the individual's insurance company will pay for both the kidney transplant and for the medications after transplant.

It is unlikely that one single source will cover all costs related to transplant. Often it is necessary to draw on savings accounts, investments, federal and private assistance options and possibly fundraising.

Commercial insurance benefits

Commercial insurance is obtained through a work-sponsored policy or an individually-purchased policy. One should obtain a copy of the policy's benefit statement and gather the following information:

General benefits:

- What is the yearly deductible?
- Does insurance ever pay 100% of medical expenses?
- What is the maximum out-of-pocket? (This is the amount one must pay each year before insurance pays 100%.)
- What are the deductibles and insurance co-payments for hospital charges, doctor's visits and prescriptions?
- What is the lifetime-maximum benefit for this policy?
- Are referrals required for office visits, laboratory work or other procedures?

Prescription benefits:

- Are prescription medications covered?
- Is there a copay per prescription? At what percent?
- What is the copay for generic vs. brand name?
- Is the use of certain pharmacies required?
- Is there a mail-order option for prescriptions?
- If one must pay for medicines up front, how long does it take to get reimbursed?

Additional questions:

- Are pre-authorizations required for any services and/or medications?
- If a person is covered under two insurance policies, which policy is primary (which pays first)?
- Will insurance pay for travel expenses to and from Corewell Health William Beaumont University Hospital?

Most insurance companies will cover kidney transplantation, however, it is essential to check with the transplant candidate's insurance carrier to verify coverage.

Ask the insurance company about these benefits specific to transplant:

- Are there benefits for a kidney transplant at Corewell Health William Beaumont University Hospital?
- Does the policy require pre-authorization for a transplant?
- Are all diagnoses covered for kidney transplant?
- Is there a pre-existing condition that may exclude a person from coverage for transplant?
- Does insurance only pay for transplant at a specific transplant center?
  What is the copay if a person chooses to go out of network?
- Are organ procurement charges covered? Is there a limit?
- Are living donor expenses covered? At what percent?
- Is there a separate transplant lifetime-maximum benefit?
  - What is the maximum benefit?
  - If so, are prescription medications included in this maximum amount?
- Is there coverage for transportation and lodging? If so, how much?
- Is transplant case management a requirement? Who will manage care, and what is their role?
- Is there a time limit placed on the coverage for transplant related medications?

Ask the same questions of your secondary insurance if you have more than one policy.

If you do not clearly understand your benefits after reviewing your policy handbook and the above questions, consult your insurance company representative or your transplant financial representative.

Medicare

Medicare covers heart, lung, kidney, pancreas and liver organ transplants for adults.

For Medicare to cover any transplant services, the transplant candidate's transplant center must be Medicare certified. If a center is a non-approved Medicare facility or if Medicare certification is lost, the center cannot bill Medicare for payment of the transplant. If a transplant is done in a non-Medicare approved transplant center, it could affect the ability to have immunosuppressant (antirejection) medications paid under Medicare Part B. Corewell Health William Beaumont University Hospital is Medicare certified for adult kidney transplant services.

Certain requirements must be met to be eligible for Medicare coverage. People with certain medical conditions, such as end-stage renal disease (ESRD), are eligible to apply for Medicare. Other qualifying conditions are age and disability. If a person has Medicare solely because of ESRD, Medicare benefits may end 36 months after the month of the kidney transplant.

Hospital

When the primary insurer is Medicare, Medicare Part A covers hospital inpatient expenses. It will pay the hospital bill, less the amount of the inpatient deductible.

Physician

When the primary coverage is Medicare, Medicare Part B covers physician visits and outpatient expenses. Monthly premiums are required to obtain Medicare Part B.

Physician charges for the transplant hospitalization are paid at 80%.

Outpatient clinic visits, doctor's appointments, lab work and outpatient procedures are also paid at 80%.

The patient is responsible for an annual deductible and the 20% copay.

Medication

Patients transplanted at a Medicare approved transplant center and who have Medicare Part A at the time of transplant are eligible for Medicare Part B for immunosuppressant coverage.

When Medicare is the primary coverage, Medicare Part B will provide 80% payment for antirejection medications if Medicare entitlement is based on age, end-stage kidney disease or disability.

Medicare Part D prescription drug coverage is offered by private companies approved by Medicare. There are monthly premiums, deductibles and copays associated with the Medicare Part D plans. These out-of-pocket costs vary with the individual plans. Patient cost will also vary depending on which medications are prescribed and the plan selected. In certain cases, patients with limited income and resources may be eligible for assistance with paying for prescription drug costs.

When new to Medicare, enrollees may apply for Medicare prescription drug plans:

- Three months before and up to three months after first becoming eligible for Medicare (if eligible based on end-stage kidney disease).
- Three months before and up to three months after the 65th birthday (if eligible for Medicare based on age).
- Three months before and up to three months after the 25th month of cash disability benefits (if eligible for Medicare based on disability).

General enrollment for the Medicare prescription drug program may vary from year to year. Contact Medicare directly for the current year's open enrollment dates. The start period is January 1 of the new year.

A more detailed explanation of Medicare benefits is available in the government publication, "Medicare and YOU."

To call Medicare directly, dial 800-MEDICARE (800.633.4227).

It is important to note that Medicare Part A and Part B both have deductibles and/or co-payments. There is a monthly premium for Medicare Part B. Since the patient is responsible for all premiums, deductibles and copays, patients often purchase Medicare Supplemental Contracts, also called Medi-Gap policies. Generally, the supplemental policy follows Medicare guidelines and will pay the deductibles and co-payments which Medicare does not cover. Getting a Medicare supplement is an individual choice and the responsibility of the Medicare patient. Call Medicare for additional information.

Coordination of benefits

For people who are covered by two insurance policies, one insurance is primary and pays expenses first, and the other pays secondary.

Determination of Medicare's primary and secondary status

For people who have insurance in addition to Medicare, there are specific rules that determine which is primary and which is secondary. The chart below shows those with and without a Group Employee Health Plan (GEHP).

	CAPD	Hemodialysis	No dialysis
Medicare +GEHP	GEHP primary when CAPD (continuous ambulatory peritoneal dialysis) starts. Becomes secondary after the 31st month after the start of CAPD. (Medicare is then primary).	GEHP primary when hemodialysis starts. Becomes secondary after the 34th month after the start of hemodialysis. (Medicare is then primary).	GEHP primary at the time of transplant. Becomes secondary after the 31st month after transplant. (Medicare is then primary).
Medicare without GEHP	Medicare is primary at the effective date of coverage.	Medicare is primary at the effective date of coverage.	Medicare is primary at the effective date of coverage.

Medicaid

Patients with Medicaid will have either a straight fee for service coverage, or they can be assigned to a Medicaid health maintenance organization (HMO). Speak with the transplant financial representative about which Medicaid HMO plans are currently contracted with Corewell Health William Beaumont University Hospital for kidney transplant.

Hospital

Medicaid provides coverage for hospitalization, doctor's visits and lab work for kidney transplant patients.

Outpatient services

With approval, Medicaid will cover all medically necessary services to prepare a patient for a kidney transplant.

Physician

If Medicaid covers transplant, the policy will also cover any physician charges.

Medication

Medicaid will pay for prescription medications, including immunosuppressant (antirejection) medications. A co-payment may be required.

The pharmacist may be required to obtain prior authorization for selected medications.

Over-the-counter vitamins and supplements may not be covered under the plan.

Medicaid is re-evaluated every six months and is provided based on financial need and/or continuing disability. Therefore, one should not count on this coverage for long-term medications.

Coordination of benefits

For patients with both Medicare and Medicaid, Medicare will pay first and Medicaid will pick up deductibles and copays that Medicare did not fully cover.

If a person has both commercial insurance and Medicaid, the commercial insurer will pay first.

Pre-transplant evaluation and surgery

The cost of being evaluated for a kidney transplant includes physicians' fees, blood tests and other tests such as X-rays, ultrasounds and cardiac tests. These services are covered by most insurance carriers.

If there is a family member or friend who may be a potential living kidney donor, their testing to determine if they are a suitable match and healthy candidate would be billed under the kidney transplant candidate's insurance (or Medicare). Potential donors are not responsible for any medical bills incurred for their donor evaluation, surgery or follow-up after surgery (except for out-of-pocket expenses).

Inpatient stay

Inpatient costs include the transplant surgery, the average hospital stay, the kidney acquisition charge, medications and other miscellaneous charges incurred during the hospital stay.

Out-of-pocket expenses may include:

- Separate invoices for anesthesia services and professional fees.
- Private room fees. If a private room is requested, there is an additional charge per day.
- Family accommodations.
- Guest trays. Family may request to eat meals with the transplant recipient in their hospital room.

Post-transplant follow-up

Post-transplant costs include clinic visits, lab and radiology charges, medications and other related procedures.

Clinic visits

Some insurance companies require referrals for office visits.

The transplant recipient may be responsible for paying a percentage of office visit charges.

Ask your insurance carrier about your responsibility for your clinic visits.

Laboratory and radiology charges

Some insurance companies require authorizations for these services. Please contact the transplant financial representative to assist with authorizations prior to scheduled procedures.

Medications

Some insurance companies and prescription plans may pay for all medications. Other providers may have limited or partial coverage and may even dictate where prescriptions may be filled. Providers may have preferred pharmacies or mail-order programs.

Following transplant surgery, the transplant physician will prescribe several medications to prevent the body from rejecting the transplanted kidney. These medications are expensive, so it is important to begin planning for this expense prior to transplant surgery.

If Medicare is the primary insurance, Medicare will pay up to 80% of the costs of the antirejection medications for at least three years after transplant. If there is no secondary coverage that pays for the Medicare copays and deductibles, the remaining 20% is the patient's out-of-pocket responsibility.

After that three-year period, other prescription coverage should cover the cost of these medications (minus any copays and deductibles that may be required).

If you do not have additional prescription coverage, you will have to pay for these medications out-of-pocket.

Medicare coverage for antirejection medications may continue if the following qualifying factors are met:

- 65 years of age or older.
- The patient has a qualifying disability registered with Medicare.
- The patient has active Medicare Part A coverage at the time of transplant and has active Medicare Part B as primary coverage at the time medication is purchased.

Conclusion

It is important that you are familiar with your coverage under your individual insurance policy. All policies are different, so you cannot rely on word-of-mouth information. For example, your neighbor's coverage may be different from yours even though it is with the same company.

You must read your insurance policy information and follow-up with a call to your employer and/or insurance company to clarify any questions you may have. Write down the full name of the person with whom you speak.

Key points to remember:

- Find out as much as you can about your individual insurance policy.
- Bring your insurance cards with you to each visit.
- Plan early for how you will pay for expenses not covered by your health insurance.
- Do not change or cancel your health insurance without discussing it with the transplant financial representative.
- If you are enrolled in an HMO, secure referrals for the office visits, lab work or treatments before your appointment, as needed.
- Notify the transplant financial representative about any changes in your insurance, loss of insurance coverage or financial hardship.

Resources

There are agencies which provide funding to transplant patients in need. For those who need assistance, the transplant social worker or the transplant financial representative may assist with finding an agency that meets the patient's individual needs.

Some pharmaceutical companies offer programs to assist those who are unable to afford their medications. The transplant financial representative can assist with applying for these programs for those who qualify based on financial status.

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