End-Stage Renal Disease (ESRD) and Medicare – Frequently Asked Questions

1. What is End-Stage Renal Disease?

Someone with End-Stage Renal Disease (ESRD) has irreversible kidney damage. Kidneys are the organs that filter an individual's blood. An individual with ESRD needs treatment, so that waste does not build up in their blood and make them sick. Treatments for ESRD include dialysis and kidney transplant. Dialysis is a process that uses mechanical means to remove waste from an individual's blood since their kidneys cannot perform that function.

2. What is ESRD Medicare?

Medicare for those with End-Stage Renal Disease (ESRD Medicare) provides an individual with health coverage if they have permanent kidney failure that requires dialysis or a kidney transplant. ESRD Medicare covers a range of services that treat kidney failure. In addition, someone with ESRD Medicare will have coverage for all the usual services and items covered by Medicare.

3. What ESRD treatments does ESRD Medicare cover?

Medicare covers the following care related to ESRD:

- Kidney transplants
- Hospital inpatient dialysis
- Outpatient dialysis from a Medicare-certified hospital or free-standing dialysis facility
- Home dialysis training (also called self-dialysis) from a dialysis facility
    - Training for a beneficiary and caregivers who will provide home dialysis
    - Home dialysis equipment and supplies
    - Medications related to treatment (medication is only covered when overseen by a doctor)
- Immunosuppressant drugs after a kidney transplant as long as the beneficiary had Medicare Part A at the time of the transplant

Medicare covers most services associated with ESRD treatment with standard Original Medicare cost-sharing. This means that Original Medicare pays some of the cost of the services, and the beneficiary pays the rest. The beneficiary's costs for ESRD care also depend on the treatment plan (see questions 17, 18, 19, and 20).

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4. Does ESRD Medicare only cover treatments related to ESRD?
No. ESRD Medicare provides coverage for all the usual services and items covered by Medicare, in addition to the range of services to treat kidney failure. For example, ESRD Medicare covers visits with primary care providers and specialists, durable medical equipment, inpatient hospital stays unrelated to ESRD, and other services. For more information about Medicare-covered services, call 1-800-MEDICARE or visit www.medicare.gov.

5. How does one become eligible for ESRD Medicare?
To be eligible for ESRD Medicare, an individual must be under 65 and diagnosed with ESRD by a doctor. Additionally, they must have enough work history to qualify for Social Security Disability Insurance (SSDI) or Social Security retirement benefits, or enough railroad work history to qualify for Railroad Retirement benefits or railroad disability annuity. An individual can also qualify through the work history of a spouse or parent. An individual can contact the Social Security Administration (SSA) at 800-772-1213 to learn if they have enough work history to qualify for ESRD Medicare.

6. Can a child be eligible for ESRD Medicare?
Children with ESRD can qualify for ESRD Medicare if one of their parents has worked and paid taxes for a sufficient period of time. A child is eligible for ESRD Medicare if one of their parents:

- Has earned at least six credits of work history within the last three years by working and paying federal payroll taxes
- Or, is eligible for or receiving Social Security or Railroad Retirement benefits

Additionally, a child must either need regular dialysis because their kidneys no longer work or have had a kidney transplant. Someone is considered a child if they are:

- Unmarried and age 21 or younger
- Age 22 to 25 (and receive some support from their parents)
- Or, an adult dependent child (a child determined disabled before age 22)

Coverage of ESRD treatment for children works the same as it does for adults. For more information or to enroll a child in ESRD Medicare, contact the Social Security Administration (SSA) at 800-772-1213.

7. How can one enroll in ESRD Medicare?

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To enroll in ESRD Medicare, an individual can contact their local Social Security office. (Even if they qualify based on prior railroad work, Social Security is responsible for handling their ESRD Medicare enrollment.) An individual's provider and/or dialysis center should send documentation to Social Security verifying that this individual has ESRD and stating their treatment needs. If someone is unable to enroll on their own due to illness, a family member or other designated party can enroll for them.

8. When does ESRD Medicare coverage begin?

When ESRD Medicare begins depends on an individual's treatment plan:

- If an individual starts a **home dialysis training program**, sometimes called self-dialysis, they are eligible for Medicare starting the first day of the first month of the home dialysis program. They must start the program before the third month of dialysis. Additionally, their doctor must state that they expect this individual can complete the program and will continue home dialysis after the program ends.
- If an individual receives **dialysis at an inpatient or outpatient dialysis facility**, they are eligible for Medicare starting the first day of the fourth month they receive dialysis. For example, if someone begins receiving dialysis on May 10, their ESRD Medicare can start on August 1.
- If an individual is going to receive a **kidney transplant**, they are eligible for Medicare starting the month they are admitted to a Medicare-approved hospital for the transplant, or for health services they need before getting the transplant.
    - A beneficiary must receive the transplant within two months following the beginning of their coverage. If the transplant is delayed, Medicare coverage begins two months before the month of the transplant.

9. What happens if someone with ESRD Medicare becomes eligible for Medicare due to age or disability?

If a beneficiary has ESRD Medicare before becoming eligible for Medicare due to age or disability, they should enroll in Medicare again in addition to their ESRD Medicare. This is because ESRD Medicare can end under certain circumstances (see question 20), and enrolling in age or disability Medicare ensures that a beneficiary has coverage to meet their health care needs.

10. What if someone has Medicare due to age or disability and then develops ESRD?

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If a beneficiary has Medicare due to age or disability before developing ESRD, they do not have to enroll in ESRD Medicare. However, there are circumstances when they may want to enroll in ESRD Medicare:

- **The beneficiary needs an earlier Medicare start date.** ESRD Medicare can be retroactive up to one year.
- **The beneficiary wants to eliminate a Part B late enrollment penalty (LEP).** If a beneficiary declined Part B during their Initial Enrollment Period (IEP), they may have an LEP. Enrolling in ESRD Medicare waives the Part B LEP.
- **The beneficiary wants to shorten the 24-month waiting period for Medicare due to disability.** In general, individuals must collect Social Security Disability Insurance (SSDI) for 24 months before they are eligible for Medicare. If an individual become eligible for ESRD Medicare, they can enroll in Medicare before the disability waiting period ends.

11. When and how does ESRD Medicare coverage end?

If a beneficiary is only eligible for Medicare because they have ESRD and their condition improves, their Medicare coverage may end. ESRD Medicare coverage will end if:

- **Dialysis is no longer needed.** Medicare coverage will end 12 months after the month of the last dialysis treatment.
- **The kidney transplant was successful.** A transplant is considered successful if it lasts for 36 months without rejection. If the transplant was successful, Medicare coverage will end 36 months after the month of the transplant.

If the beneficiary has Medicare due to age or disability, their Medicare coverage will continue regardless of their ESRD Medicare status.

12. Can ESRD Medicare coverage ever resume once it has ended?

ESRD Medicare coverage can resume if, within 12 months of stopping dialysis, the beneficiary starts dialysis again or has a transplant. Coverage also continues if, within 36 months of having a transplant, the beneficiary starts dialysis or has another transplant.

If a beneficiary becomes eligible for ESRD Medicare again after their previous coverage ends, they can start receiving ESRD Medicare without a waiting period. Their Medicare coverage will either resume the first of the month that they start dialysis again or the first of the month they have a kidney transplant. There is also a separate 30-month coordination period each time a beneficiary becomes eligible for ESRD Medicare.

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13. If someone has group health plan (GHP) coverage, do they have to enroll in ESRD Medicare?

If an individual has job-based insurance, retiree coverage, or COBRA when they become eligible for ESRD Medicare, they do not have to enroll in Medicare right away. The group health plan will remain primary for 30 months, beginning the month the beneficiary first becomes eligible for ESRD Medicare. This is called the 30-month coordination period. During the 30-month coordination period:

- An individual does not have to sign up for ESRD Medicare immediately if they have GHP coverage
- The GHP coverage must pay first, and ESRD Medicare may pay second for health care costs
- If an individual does not have other insurance, ESRD Medicare will pay primary as soon as they enroll

The 30-month coordination period begins when eligibility for ESRD Medicare begins, even if the individual hasn't signed up for ESRD Medicare yet.

After the 30-month coordination period ends, Medicare automatically becomes the primary insurance, and should pay first on health care claims. Once the coordination period ends, the GHP coverage may act as a secondary payer and cover Medicare cost-sharing. An individual who is eligible for ESRD Medicare should enroll in Medicare before their 30-month coordination period ends so that they have primary insurance (see question 14).

It is important to note that the 30-month coordination period applies to people with ESRD Medicare only. If a beneficiary has Medicare due to age or disability before developing an ESRD diagnosis, the normal rules for Medicare's coordination with other insurances apply.

14. When should someone with a group health plan (GHP) enroll in ESRD Medicare?

When someone chooses to enroll in ESRD Medicare during the 30-month coordination period depends on their health care needs and insurance benefits. It is important to remember that:

- A beneficiary can enroll in ESRD Medicare at any time during the 30-month coordination period
- And, they should make sure to enroll before the coordination period ends to avoid experiencing gaps in coverage (see question 15)

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Individuals may want to enroll in ESRD Medicare even though their GHP pays primary during the 30-month coordination period. ESRD care is typically expensive, and Medicare may the GHP's deductibles, coinsurance, or other cost-sharing amounts. Paying for Medicare may help a beneficiary reduce their out-of-pocket costs. However, if their GHP coverage has low cost-sharing, they may not need Medicare coverage. An individual can talk to their insurer and consider the costs they are facing when considering when to enroll in ESRD Medicare.

It is also important to note that if an individual receives a kidney transplant and wants Part B to cover their immunosuppressant drug costs, they must have Part A at the time of the transplant (see question 20 for more about coverage of immunosuppressant drugs).

Also note that if a beneficiary has COBRA first and then enrolls in ESRD Medicare, their employer can choose to end their COBRA coverage—though not all employers end COBRA after an employee enrolls in ESRD Medicare. Beneficiaries should speak to their employer before making enrollment decisions. If an individual has ESRD Medicare first and then qualifies for COBRA, the employer must offer them COBRA coverage. In either case, COBRA coverage is primary during the 30-month coordination period and secondary after.

15. What happens if an individual with GHP coverage does not enroll in Medicare before the end of their 30-month coordination period?

If an individual does not have Medicare when the coordination period ends, they may not have adequate coverage. After the 30-month coordination period ends, the GHP coverage is only responsible for paying after Medicare pays. The GHP may choose to pay very little or not at all if the beneficiary is not enrolled in Medicare. This means the beneficiary would pay significantly more out of pocket for their health care. A beneficiary should make sure to enroll in Medicare Part A and Part B before the end of their 30-month coordination period.

16. Can a beneficiary delay ESRD Medicare enrollment?

If someone chooses to delay ESRD Medicare enrollment, they should turn down both Part A and Part B. This is because if a beneficiary enrolls in Part A and delays Part B, they lose the right to enroll at any time. Instead, they will have to wait to enroll in Part B until the General Enrollment Period (GEP), January 1 through March 31 of each year, and will likely face gaps in coverage and a late enrollment penalty.

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17. What are the costs of receiving an inpatient transplant or inpatient dialysis with ESRD Medicare?

Part A covers the cost of an inpatient kidney transplant or dialysis at a Medicare-approved facility after the Part A deductible ($1,676 in 2025) has been met. If the length of the hospital stay exceeds 60 days during the benefit period, the beneficiary owes a daily hospital coinsurance for days 61-90 ($419/day in 2025).

Part B covers doctors' fees, including fees for transplant surgeons. Beneficiaries will typically pay a 20% coinsurance as long as the provider accepts Medicare assignment.

Medicare also pays for costs related to the kidney donor's hospital stay and their follow-up care—without charging the beneficiary or the kidney donor any cost-sharing. The beneficiary receiving the kidney should not be asked to pay for their donor's care.

If a beneficiary has a Medicare Advantage Plan, they should contact their plan for more information about inpatient transplant and dialysis costs.

18. What are the costs of receiving outpatient dialysis with ESRD Medicare?

Part B covers dialysis overseen in a Medicare-approved outpatient dialysis facility. After meeting the Part B deductible ($257 in 2025), the beneficiary will typically pay a 20% coinsurance for the cost of each session, which includes equipment, supplies, lab tests, and most dialysis medications. Doctors' fees for certain services and items, such as intravenous iron therapy, are billed separately from the dialysis charges.

Note: ESRD Medicare does not cover surgery or services that are required to prepare a person for dialysis before their Medicare eligibility begins. For example, Medicare will not pay for the surgery needed to create an access point for a dialysis machine.

If a beneficiary has a Medicare Advantage Plan, they should contact their plan for more information about outpatient dialysis costs.

19. What are the costs of receiving home dialysis with ESRD Medicare?

Part B pays certified home dialysis facilities a set fee that includes the cost of training the beneficiary to administer dialysis themselves. The fee also covers supplies, lab tests, most dialysis

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medications, and home dialysis equipment. After meeting the Part B deductible ($257 in 2025), the beneficiary will typically pay a 20% coinsurance.

If a beneficiary has a Medicare Advantage Plan, they should contact their plan for more information about home dialysis costs.

20. How does ESRD Medicare cover immunosuppressant drugs?
After getting a kidney transplant, an individual will need to take immunosuppressant drugs for the rest of their life to prevent their body from rejecting the donor organ. Medicare covers these drugs differently depending on the circumstances.

Time-limited Part B coverage
If the kidney transplant is in a Medicare-approved facility, Medicare Part B will cover the immunosuppressant drugs for 36 months* after the beneficiary departs the hospital if the beneficiary:

- Had Part A at the time of the transplant
    - If an individual did not have Medicare when they had a transplant, they can enroll retroactively in Part A within a year of the transplant
- Has Medicare Part B when getting the prescription filled
- And, is only eligible for ESRD Medicare
    - If the kidney transplant was successful, Medicare coverage will end 36 months after the month of the transplant

Part B coverage for the rest of a beneficiary's life
If a beneficiary receives a kidney transplant in a Medicare-approved facility, Part B will cover their immunosuppressants for the rest of their life if they:

- Had Part A at the time of the transplant
- Have Medicare Part B when getting their prescription filled
- And, qualify for Medicare based on age or disability

Part B-ID coverage
If ESRD Medicare benefits end 36 months after an individual's transplant, they may qualify for Part B-ID coverage of immunosuppressants if the individual:

- Qualifies for Part B coverage of immunosuppressants prior to losing ESRD Medicare

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- Does not have Medicaid or other public or private health insurance that covers immunosuppressants

Part B-ID coverage may not be the best choice if any other insurance is available. Part B-ID only covers immunosuppressant drugs and does not include coverage for any other Part B benefits or services. It also does not allow an individual access to Part A.

Part D coverage

If a beneficiary does not have Part A when they receive a transplant, their immunosuppressants will be covered by Part D after the transplant. Part D coverage for this type of drug typically means higher costs and additional restrictions, such as having to go to specific in-network pharmacies for drugs.

All Part D formularies must include immunosuppressant drugs. Step therapy (when a plan requires a beneficiary to try a different or less expensive drug first) is not allowed once the beneficiary is stabilized on their immunosuppressant drug. However, prior authorization can apply. This means the plan may need to verify that Part B will not cover the drugs before providing coverage. Be sure to look for plans that have the fewest coverage restrictions and that have the beneficiary's pharmacies in the preferred network.

Group health plan (GHP) coverage

For those with a GHP (job-based, retiree, or COBRA coverage), the plan should cover the immunosuppressants during the 30-month coordination period (see question 14). Medicare is secondary during this period. After 30 months, Medicare will become the primary insurance, and Part D should cover the immunosuppressants if the beneficiary did not have Part A at the time of their transplant.

Vitamins for dialysis patients

Those receiving dialysis typically need to take various vitamins after each session to replenish the vitamins in their blood. Medicare usually does not cover vitamin supplements, but some Part D plans may offer enhanced coverage that includes vitamins. Enhanced Part D plans are typically more expensive. Individuals should check the plan's formulary before joining to see if their vitamins are covered.

21. Can someone with ESRD enroll in a Medicare Advantage Plan?

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People with End-Stage Renal Disease (ESRD) can enroll in Medicare Advantage Plans. Medicare Advantage Plans must cover the same services as Original Medicare but may have different costs and restrictions. However, Medicare Advantage Plans cannot set cost-sharing for either outpatient dialysis or immunosuppressant drugs higher than would be the beneficiary responsibility under Original Medicare. It is important to consider provider networks and costs when evaluating Medicare Advantage Plans.

Provider networks

Each type of Medicare Advantage Plan has different network rules. A network is a group of doctors, hospitals, and medical facilities that work with a plan to provide services. A beneficiary's costs are typically lowest when in-network providers and facilities are used. Before enrolling in a Medicare Advantage Plan, a beneficiary should make sure their providers, including their dialysis facility, are in network. An individual can ask their current providers which plans they accept. While some plans offer coverage outside their network, costs and restrictions are often higher.

Costs

When comparing Medicare Advantage Plans, find out the costs of the services needed, such as dialysis and immunosuppressants. Medicare Advantage Plans have annual maximum out-of-pocket limits on Part A and Part B care ($9,350 in 2025). These limits can help protect a beneficiary if they have high health care costs. When comparing Medicare Advantage Plans, it may be helpful for the beneficiary to calculate if they are likely to reach the maximum out-of-pocket limit during the year. This is because after the limit is reached, the beneficiary does not pay anything for in-network covered inpatient or outpatient services for the rest of the year.

22. Can someone with ESRD Medicare enroll in a Medigap?

Maybe. Whether or not someone with ESRD Medicare can enroll in a Medigap depends on the state they live in. Medigap policies are supplemental insurance policies that offer standardized benefit to work with Original Medicare. Medigap policies pay part or all of certain remaining costs after Original Medicare pays first. Medigaps may cover deductibles, coinsurance, and copayments. Federal law does not require Medigap insurers to sell Medigap policies to people with ESRD Medicare who are under age 65. This means that an individual under 65 who has ESRD Medicare may not be able to purchase any Medigap policy until they turn 65.

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Each state has its own rules about purchasing Medigap policies, in addition to the federal guidelines. To learn more about a state's rules, contact that state's State Health Insurance Assistance Program (SHIP) by calling 877-839-2675 or visiting www.shiptacenter.org.

23. What if someone with ESRD Medicare needs help paying for Medicare costs?

Those with ESRD Medicare are also eligible for programs that help pay Medicare costs.

- **Medicare Savings Programs (MSP)**: If a beneficiary has a low monthly income, they may qualify for an MSP, a program that helps pay Medicare costs. Beneficiaries can find out if they are eligible for an MSP in their state by contacting their State Health Insurance Assistance Program (SHIP) by calling 877-839-2675 or visiting www.shiptacenter.org.
- **Extra Help:** Also known as the Part D Low-Income Subsidy (LIS), this federal program helps individuals with low incomes pay for costs of Medicare prescription drug coverage. If a beneficiary is enrolled in Medicaid, an MSP, or receives Supplemental Security Income (SSI), they should get Extra Help automatically. Individuals can apply for the Extra Help program online through the Social Security Administration (SSA) at www.ssa.gov.
- **Medicaid:** Individuals with low monthly income and few assets may be eligible for coverage through Medicaid. Medicaid can pay for Medicare costs, like copayments and deductibles, and for health care not covered by Medicare, such as dental care and transportation to medical appointments. For more information, individuals can contact their local Medicaid office to ask about eligibility requirements.

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