



BATTLING A SILENT AND DEADLY EPIDEMIC

NEARLY 40 MILLION AMERICANS SUFFER FROM KIDNEY DISEASE, WHICH OFTEN GOES UNDETECTED FOR YEARS AND CAN LEAD TO COSTLY CLAIMS FOR SELF-INSURED PLANS. WHILE TWO LEADING PLAYERS HAVE BEEN CASTIGATED FOR CORNERING THE DIALYSIS MARKET AND SQUELCHING COMPETITION, EXPERTS SUGGEST EARLY DETECTION AND CARVE-OUTS TO IMPROVE OUTCOMES AND CONTAIN COSTS.

By Bruce Shutan

The high cost of kidney dialysis appears to be reaching a tipping point of frustration and finger pointing across political, social and economic landscapes, including the self-insured marketplace. Clinics specializing in these treatments have been demonized alongside big pharma and the BUCAHs, accused of placing profits ahead of patients. But they have lobbied hard to argue their worth.

In California, for instance, an aggressive TV advertising campaign convinced voters to reject a 2018 mid-term election ballot initiative that would have required dialysis clinics to refund patients and payers revenue above 115% of the cost of direct care and health improvements. Clinic operators argued that the measure would have nearly choked off access to life-saving treatment.

Kidney disease is known as a silent epidemic “because most people don’t know they have chronic kidney disease until it gets into late stages, where it becomes very difficult to reverse the progression,” according to Lisa Moody, president and CEO of Renalogic, whose methodology and services support different approaches for reimbursing on dialysis claims.



Rick Garrison

RISING TREATMENT COSTS

The overall cost of renal dialysis is rising about 10% to 15% a year, reports Rick Garrison, president of Specialty Care Management, whose specialty is managing renal disease and end-stage renal disease.

“We’re finding that the average renal dialysis case can be now anywhere between \$800,000 to \$1 million on the low side, which without appropriate measures put into action, can be a killer to a small to midsize firm or even a large employer group,” he says, adding to that list the health plan’s reinsurer.

“We actually had a case that was \$3 million annually down in Louisiana.”

When underwriting risk for stop-loss coverage for what appears to be a relatively healthy population, he says

there’s always a possibility that “lurking in the weeds can be that one case involving an employee who’s not showing any symptoms but may have diabetes or pre-diabetes or high blood pressure.”

The price-tag associated with kidney disease has indeed skyrocketed with virtually no end in sight. Roughly a dozen monthly in-center hemodialysis treatments cost \$50,000 or more, according to Sam Sletager, regional VP of sales at Zelis Healthcare, which helps payer clients manage the cost of kidney dialysis treatments. Many of his referrals now exceed \$80,000 per month with some well over \$100,000. The average billed charges per-treatment rate is \$6,000 to \$7,000, whereas he says it used to be around \$2,000 to \$3,000 less than 10 years ago.

HEALTH CARE’S NEW WHIPPING POST

The kidney dialysis sector has been demonized because “there just isn’t enough diversification, and that really holds true for kind of any area in healthcare,” Moody explains. There are only two main players, DaVita Inc. and Fresenius Medical Care. Critics consider them a duopoly whose crushing domination of the market has created an unfair playing field in nearly every region of the U.S. Moody says these firms fly under the antitrust radar.

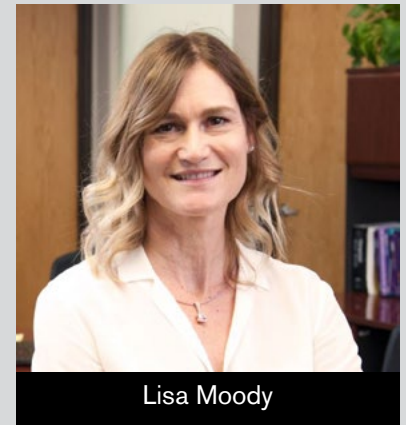
The fact is that there’s no focus on reducing the cost of kidney disease because these two companies, along with BUCAHs and PBMs that also play a role, are publicly traded and beholden to their shareholders, Moody laments.

Having cornered the market on dialysis, these providers aren’t inclined to do any direct contracting, she protests. “We’ve seen Blues contracts terminated because the providers just aren’t being reasonable about the rates that they negotiate with,” she says, noting there’s no blanket contract available to groups with a national company.

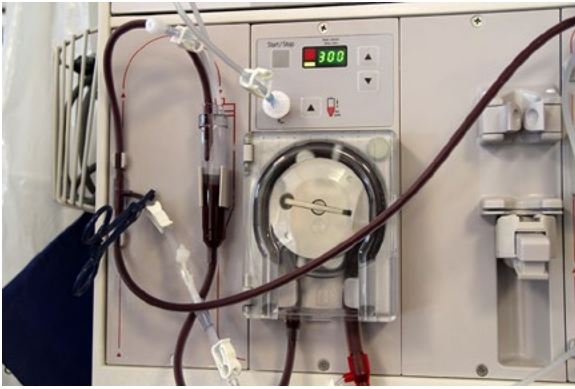
Both DaVita Inc. and Fresenius Medical Care declined an opportunity to respond to her comments.

Sletager believes that national and larger regional BUCAH networks also have proven to be obstacles to savings by not allowing employers to carve out services such as dialysis. Kidney dialysis has become a financial burden because many groups that leased smaller networks are now leasing BUCAH networks, he says.

“They’re based on contract language which many of them don’t even know they actually signed up for as part of the administrative agreement with their TPA,” he adds. “They’re bound to a PPO contract that doesn’t allow a carve-out, so they’re just stuck paying whatever the contract agreement is.”



Lisa Moody



The kidney disease management crisis isn't lost on the federal government, which is developing a new payment approach for treating nearly 40 million Americans with kidney disease. In addition, the Department of Health and Human Services has sought to make more kidneys available for transplant. That effort includes wearable and implantable artificial kidneys.

Moody cites advances in kidney transplantation, as well as use of artificial kidneys and wearable packs, as hopeful signs that innovation and technology will help mitigate costs and improve quality of life.

PREVENTIVE MEASURES

Meanwhile, the key to cost management is early identification of chronic kidney disease patients before they reach the end-stage renal disease and must go on dialysis, Sletager observes. He says most people who suffer from chronic kidney disease, which has never been a focus of the health care space, also have comorbid conditions such as hypertension, high blood pressure or cholesterol and diabetes.

Roughly 60% of patients with comorbidity factors end up developing chronic kidney disease in low stages without even knowing it, Moody reports. "They don't recognize, or are even informed by their PCPs, how their health and comorbid conditions are exacerbating their kidneys. That is just not something that gets focused on until it becomes too debilitating," she observes.

Her own husband of two years is a diabetic without other comorbid conditions that generally accompany that disease at age 41, so this issue obviously hits close to home. Without family support or health coaching to maintain a proper diet and exercise regimen, as well as stabilize blood sugars, Moody cautions that unmanaged diabetes will turn into kidney disease.

"It's critical to identify those patients that may not know they have this disease and educate them about why it's important to follow healthy behaviors and set goals for themselves to try to keep [chronic kidney disease] at bay," she suggests.

Moody's firm, formerly known as Dialysis Cost Containment, was founded in 2002 by her mother, Phyllis Langley, who noticed a serious gap in the marketplace with regard to managing kidney disease. When Moody came on board as an employee, her experience designing employee benefit plans and managing health care claims came in very handy. She took over the family business in 2008 when her mother retired and brought a proactive early intervention approach more upstream into the self-insured marketplace.





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The challenge is that there hasn't been "a huge focus on prevention" among self-funded groups, she notes, while the fully-insured model is more supportive of that approach. Much of what's done in terms of cost containment in the self-funded space is more about risk management, she adds, though noticing a shift toward prevention over the past two years.

That's somewhat understandable knowing that just one in 10,000 patients in any given employee population is on dialysis, Moody says. But self-insured employers risk bankruptcy from just one dialysis claim, she observes, which reinforces her argument to be proactive. Keeping end-stage renal disease at bay can save millions of dollars on a claim.

Another issue worth noting is patients who are discharged from the hospital because of a diabetic foot ulcer or other episodic event no longer receive care after they're discharged and the case manager is done getting them back on track, she adds.

HORROR STORIES

Sometimes the enemy is within the health care system and goes undetected. Mark Wilcox, CEO and founder of Wellness Partners, has noticed that as much as one-third of the cases his firm manages are actually caused by prescribed medicine "and the doctor is not even checking kidney function to see what the impact is."

But that phenomenon, which he describes as "shocking," is just one of several horror stories Wilcox has encountered from the trench warfare of kidney dialysis management. He recalls one such example from 2012



when, unable to stop the progression of kidney disease in a patient from one of his employer groups served by Blue Cross and Blue Shield of Nebraska (BCBSN), a direct contract was set up for full-treatment dialysis and care at about \$9,000 a month.

Those efforts lowered the carrier and employer's liability on that claim by about \$800,000, but it all went sideways when he learned that the Blues plan viewed it as a 15% reduction of income. In a meeting with the carrier's large group sales manager, as well as several service reps and IT staffers, Wilcox was chewed out for "diminishing the value and quality" of BCBSN and ordered to stop. The PPO operations and marketing people weren't told that the arrangement was approved by the carrier's underwriting department, he says. BCBSN later blacklisted his company to employer clients for engaging in what it considered illegal and immoral practices.

"What it comes down to is the carriers don't care whether a claim is paid by the reinsurance carrier or employer in the form of premiums," opines Wilcox, who says BCBSN pays about \$76,000 per month for dialysis. "Either way, it's revenue to the company."

A BCBSN spokeswoman notes that "we pay claims for medically necessary and appropriate care" consistent with an agreement the carrier signed with Wellness Partners. She adds that BCBSN "is a steward of our members' premium dollars."

CARVING OUT CLAIMS

By carving dialysis out of the PPO contract, Sletager notes that self-funded plans working with Zelis save an average of more than 90% on billed charges. Zelis provides dialysis language to its clients enabling them to carefully craft plan document language so that any reference-based price (RBP) chosen to maximize savings is usual, reasonable and customary. Put another way, the methodology used to reimburse providers cannot be arbitrary or capricious, he explains, referencing ERISA guidelines.

There are protections for patients on dialysis that prohibit balance billing by the providers if the member has the right Medicare coverage. Under Medicare's secondary payer rule, he notes that if the primary insurer's reimbursement is higher than what Medicare Part B would have paid as the primary insurance source, "then the provider is considered made whole and can't balance bill the patient."

Between ERISA and Medicare's Secondary Payer Act protections, and "based on the components of our reimbursement database," Sletager says, "we feel that our strategy is about as defensible as you can get."

While the RBP model can help self-insured groups negotiate reasonable rates, Moody says it's difficult applying it to the dialysis sector in the absence of a

competitive provider marketplace. As such, there's "limited ability to directly negotiate what is considered reasonable up front," she adds. The danger of using RBP specific to renal dialysis is that "the potential for balance billing is quite large by virtue of high dollar amounts for renal dialysis, Garrison cautions. "The exposure to the patient is only enhanced with reference-based pricing," he says.

Since the 1970s, anyone diagnosed with end-stage renal disease has been allowed to participate in Medicare, regardless of their age, Garrison points out. His firm helps self-funded entities allow patients access to such care and navigate their way through the federal program.



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“But there are many other ways to manage end-stage renal disease, and more so, it’s through preventive measures,” he explains. “When someone has kidney disease, it’s not a fait accompli that you’re going to have end-stage renal disease. There are many programs that can help either prevent or delay chronic kidney disease.”

Garrison suggests a multifold approach on the front end that includes case management, good plan design and wellness programs, as well as the use of appropriate analytics to better understand each patient population. Another critical step is to “set up a safety net on a prospective basis that would protect the plan from this type of exposure if it came up,” he adds, noting the importance of patient education. ■

Bruce Shutan is a Los Angeles freelance writer who has closely covered the employee benefits industry for more than 30 years.



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