Dialysis in the U.S.

A Broken Market Requires Thinking Outside The “Network” Box

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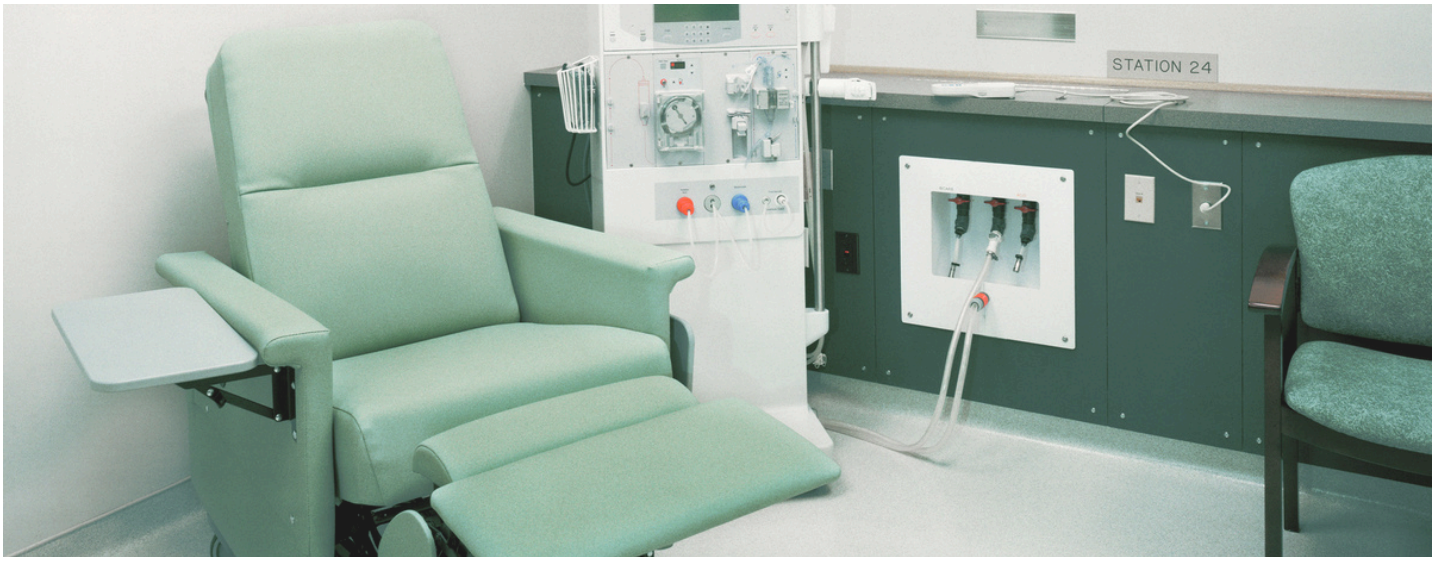
Out-of-Network vs. In-Network

Since the beginning of managed care, Americans have feared receiving care from doctors or hospitals who are “out-of-network” because that often means sky-high prices and more out-of-pocket costs. **But what happens when the opposite is true – when the “in-network” rate is unfair and higher than the “out-of-network” rate for the same exact service?** How does that happen? What should a plan or member do?

This is the situation faced by self-funded plans (employers, union-sponsored health plans, etc.) with members with end-stage renal disease (ESRD) or other kidney impairments that require in-center dialysis. In short, the dialysis market in the U.S. is fundamentally broken and perverts the tools and solutions, including networks, that work in other areas of American healthcare delivery.

“In short, the dialysis market in the U.S. is fundamentally broken.”



The Issue With Provider Networks

In an open, robust market, members of a self-funded plan can seek care from any one of multiple healthcare providers, paying a reasonable rate established by competition among the providers. As part of efforts to compete, providers almost always enter agreements with **Preferred Provider Organizations (PPOs)**, **Health Maintenance Organizations (HMOs)** or similar organizations. In turn, these organizations promote these providers by offering their services at lower prices than a purchaser (a plan or Third-Party Administrator) would be able to obtain if they bought services directly. This concept may sound complicated, but it's not. This is simply a set of contracts along which a provider offers a discounted rate to a **network organizer**, which in turn offers the provider's services at that discounted rate to purchasers of healthcare services. This arrangement is often referred to as a **"provider network"**.

This kind of arrangement can work well when there are enough providers and plans to create a robust competitive market that keeps provider rates at reasonable levels. **However, this is not the case for dialysis, which suffers from dysfunctional levels of concentration.** The market dysfunction that results from this two-sided consolidation means that the major cost control tool available to self-funded plans, namely a "network agreement", does not provide self-funded plans the same advantages in the dialysis market as it does in other areas of healthcare.

79% **On the plan demand/purchaser side Medicare covers 79% of all dialysis.**

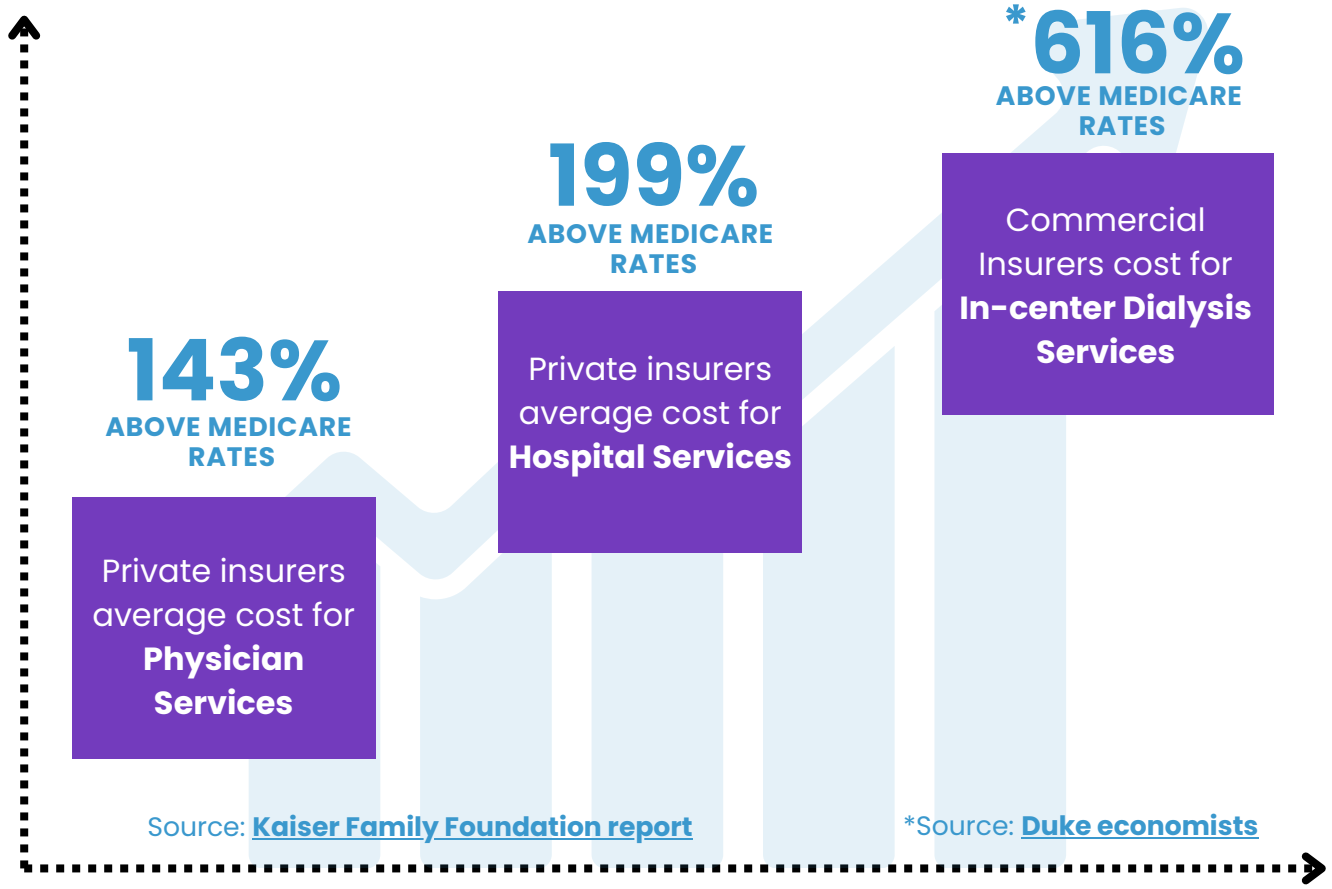
75% **On the provider/supply side TWO companies control more than 75% of the market.**

*Source: MedPAC

The Issue With Provider Networks

continued

As a result, dialysis expenses for self-funded plans are way out of line in comparison to other healthcare services in the U.S.



In-center dialysis regularly costs a self-funded plan

$200,000 *per year*

possibly up to

$500,000 *annually for a single member*

When you consider that there is typically a member on dialysis for every *2,500* adults insured by self-funded plans, it's easy to understand why renal care is almost always a top 10 expense for plans.

Carve-Out Plans

To bring dialysis costs into line with other healthcare services, self-funded plans have had to find other approaches than networks. One such approach is the creation of a “carve-out” benefit design just for dialysis benefits. **The use of a carve-out benefit design allows a self-funded plan the flexibility to establish reimbursement rates in a fair manner, without being held hostage by applying a network approach which is designed for a functioning market in the non-functioning dialysis market.**

Carve-out plans have advantages for self-funded plan sponsors (employers, municipalities, unions, tribes, etc.):

Lower Plan Costs

Reimbursement rates for dialysis services are established at levels more consistent with other medical services relative to government-established reimbursement rates. This saves hundreds of thousands of dollars each year per dialysis patient. Those savings can support other health benefits, keep premiums low, or can be used by employer sponsors to create jobs.

Greater Patient Choice

Under our dialysis carveout plan designs, patients can seek care from any dialysis provider and are not restricted to a certain pre-established network. Additionally, if a self-insured plan has members on dialysis and the plan makes the switch to such a carve program there is no change in dialysis provider, treatment continues as necessary, and there is no disruption to members or providers.

Carve-Out Plans *continued*

Advantages for self-funded plan members:

Lower Patient Costs

Under almost all our recommended dialysis carve-out plan designs, the self-funded plans waive all patient cost-sharing related to dialysis care. That means no deductibles, co-pays or co-insurance. For many members, that means savings of several thousands of dollars every year.

Increases Member Support

Under all of our carve-out designs, we partner with the plan to provide additional services to members suffering from Chronic Kidney Disease and End Stage Renal Disease including:

- Planning for members with late-stage CKD that are heading towards ESRD
- Assistance in registering for transplants
- Clinical education regarding treatment options, including modality (home dialysis vs. in-center, hemodialysis vs. peritoneal dialysis) and location
- Assistance enrolling in Medicare as allowed by the Medicare Secondary Payor regulations
- Care coordination across providers; health coaching and nutritional advice;
- Patient advocacy; and education for family members and caregivers.

Carve-Out Plans *continued*

Operationally, benefit carve-out plans follow a few basic steps:

01

Adjust Plan Documents

Plan sponsors amend their health plan documents to describe and document the methods under which dialysis benefits will be administered, separately from other types of benefits under the plan.

02

Establish Dialysis Reimbursement Rates

Plans work with experts like Renalogic to establish fair reimbursement rates for dialysis services.

03

Enroll/Update Members and Notify Providers

All members that are on dialysis are issued dialysis-specific insurance cards tied to the new dialysis-specific benefit plan. Members present their dialysis coverage card when receiving dialysis services. Providers are also notified that members receiving dialysis are now covered by a new dialysis-specific dialysis benefit.

04

Adjudicate Claims

After they provide dialysis services, providers bill the dialysis benefit administrator per the information on the dialysis benefit insurance card. Claims are processed in the same way and timeframe as other medical claims.

Self-Funded Plan Guidelines

Plans need to change their perspective and take a new approach to contain dialysis costs. *AND THEY NEED TO START ASAP.*

To investigate the advantages of such an alternative approach to better support CKD and ESRD members, self-funded plans should follow a few guidelines:

Work with an experienced, reputable company

There are numerous regulations from the Affordable Care Act to the Medicare Secondary Payer Act, to ERISA to HIPAA and the ADA that must guide the design of any carve-out benefit plans. Navigating the complexities of their various requirements takes knowledge and experience. Plans should avoid working with companies that do not have a long track record of specializing in this area.

Adhere carefully to all required regulations

While hugely beneficial to plans and members, dialysis carve-out plans must comply with the various regulations that apply, including the Medicare Secondary Payor Act's coordination of benefit period of 30 months.

Ensure plan reimbursement rates are fair to providers and are not arbitrarily established

In order to comply with ERISA and the MSP in particular, plan reimbursement rates must be based on methodologies that are not arbitrary and do not pose a risk of allowing unfairly low provider payments. This is a particular risk for plans using multiple of Medicare pricing methodologies, as there is no reasonable basis for choosing among possible multipliers. This creates a high risk of legal challenges and regulatory or judicial rejection of the methodology.

Self-Funded Plan Guidelines *continued*

Perform a data-driven savings analysis

Plans should work with their selected partner to analyze potential savings ahead of time. Having specific expectations of savings ensures that the plan, and all their hired partners, are all properly aligned.

Combine cost containment with care management

While reducing the cost of dialysis is possible, plans should also provide clinical support to help members avoid progressing to ESRD.

Get Started ASAP

Given the rising incidence of ESRD and the rising costs of dialysis, there is no need to wait until a plan renewal date. A mid-year plan adjustment can be easily implemented in a manner of weeks.

It's clear that the dialysis market in the U.S. is broken, but self-funded plans don't have to perpetuate the problem. They can use new, innovative approaches to lower costs and give members more support.

ALL THEY HAVE TO DO IS THINK OUTSIDE THE "NETWORK" BOX.

Schedule time with a product expert to learn more!

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