White Paper:

The Exorbitant Cost of End-Stage Renal Disease ("ESRD"):

Causes, Cost Containment, and Stop-Loss Carve-Out Strategies

November 1, 2016

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Cost Containment

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Overview

In its "Top Ten Catastrophic Claims Conditions" report, Sun Life Financial U.S. identified Chronic/End-Stage Renal Disease ("ESRD") as its 3rd costliest medical condition, with the value of stop-loss claims reimbursement totaling $156.6M over a four-year period. DialysisPPO engaged Windsor Strategy Partners to perform an actuarial analysis of the cost of stop-loss premiums for self-funded health plans. Plans can expect to pay $11.37 PEPM in stop-loss premiums, assuming a $50,000 specific deductible - a significant fixed cost for self-funded health plans. This White Paper examines the causes of the high cost of ESRD along with cost containment and stop-loss carve-out strategies.

Disease Overview & Treatment Options

ESRD is the stage of advanced kidney impairment that requires continued dialysis treatments or a kidney transplant to sustain life. Dialysis is the removal of toxins, fluids and salt from the blood of ESRD patients by artificial means. There are approximately 600,000 ESRD patients in the U.S.

The dialysis services industry provides two treatment modalities for patients who suffer from ESRD – hemodialysis and peritoneal dialysis. Hemodialysis, the most common form of treatment utilized for approximately 90% of all patients, is not a cure but a blood-filtering process that prolongs life - patients must undergo dialysis for the rest of their lives. Without dialysis treatment or a kidney transplant, ESRD is a terminal disease. Diabetes and high blood pressure are the top two causes of kidney disease, with diabetes alone accounting for over a third of all new cases.

The hemodialysis process involves passing a patient's blood through a machine and various chemical solutions to remove toxins, fluids, and chemicals. The treatment process lasts three to five hours and patients require treatment three times per week. An alternative to hemodialysis is peritoneal dialysis, which spreads chemicals through the patient's abdomen. Kidney transplantation, the only current cure for ESRD, is becoming more effective but is limited by the availability of suitable donor kidneys. Less than 5 percent of patients receive a kidney transplant.

Cost Drivers – Unique Medicare Entitlement & Concentrated Provider Market

The reimbursement environment for renal dialysis services is unlike any other in U.S. healthcare for two reasons. Firstly, ESRD is the only Medical diagnosis that entitles a patient to Medicare — regardless of their age. Secondly, over the course of the past fifteen years, consolidation amongst dialysis providers has resulted in two large organizations treating approximately 75% of all U.S. dialysis patients. The confluence has created a cost environment that is exceptionally challenging for health plans.

Persons with ESRD have a unique entitlement into the Medicare program, regardless of age. For example, a person 45 years of age will become entitled to Medicare coverage so long as they have met some basic, minimal employment requirements. Congress put this coverage in place in 1972 as a backstop to ensure that patients without group health insurance had access to care to cover the high costs of this life threatening disease – those with group coverage require the group to be the primary payer (and Medicare the secondary payer) for a period of 30-33 months, depending on treatment modality.

Dialysis providers lose money on 75% of their patients. Self-funded plans pay extraordinary amounts to compensate.

Because Medicare becomes the primary payer for ESRD patients after (typically) 33 months of treatment, approximately 75% of a dialysis facility's census is comprised of Medicare patients. The provider community has stated that the Medicare payment rates are not sufficient to cover their average cost of providing a dialysis treatment. When you lose money on 75% of your volume, you have to make extraordinary profits on the remaining minority.

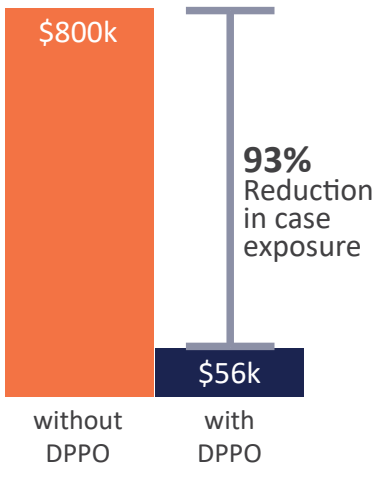
On average, our clients are charged 2,100% of the Medicare allowable amount for the same services. The average monthly charges for each ESRD patient is $67,000 across our client-base. It is not unusual for monthly dialysis charges to exceed $85,000.

Cost Containment & Carve-Out Options

Self-funded health plans purchase stop-loss insurance to mitigate their exposure to catastrophic claims. ESRD claims clearly fall into this category, as evidenced by the Sun Life report. Stop-loss carriers, well aware of the high cost of these claims, analyze and price the risk to self-funded plans such that, on average, the carrier will have profitably rated the risk / premium. DialysisPPO engaged Windsor Strategy Partners to perform an actuarial analysis of this cost across the full spectrum of specific deductible levels and age groupings, and determined that self-funded plans can expect to pay $11.37 PEPM in stop-loss premiums, assuming a $50,000 specific deductible, which is a significant fixed cost to health plans - assuming an environment where a potential ESRD claimant will experience claims of $800,000 per year. This doesn't have to be the case.

As noted above in the Cost Drivers section, the unique Medicare entitlement due to ESRD has created a pricing environment whereby providers attempt to bill and collect extraordinary profits before patients transition to having Medicare be the primary payer of claims. The silver lining to this Medicare entitlement is that while a self-funded plan must be the primary payer for the first 33 months of treatment (and Medicare secondary), the patient can enroll in Medicare after just three months. This is significant, because patients with Medicare as a secondary insurance cannot be balance-billed above and beyond the Medicare allowable amount. Plans can limit their dialysis reimbursement level without exposing the patient (the Plan's employee or dependent) to balance-billing, effectively eliminating the provider's attempt to gain outsized profits to the tune of $800,000 per claimant per year.

Revisiting the Windsor analysis, a 500-life self-funded plan that has not implemented a dialysis cost containment program will pay about $34,000 in premiums ($11.37 PEPM * 250 employees, assuming a 50/50 employee / dependent coverage mix) to insure against the risk of experiencing an expensive $800,000 claim. However, under our patented dialysis cost containment program, the $800,000 case exposure is significantly reduced to a national average of approximately $56,000. Now, paying $34,000 in premiums + their $50,000 specific deductible, or $84,000, to insure against a potential $56,000 impact makes no financial sense.



A well informed self-funded plan will immediately implement a dialysis cost containment program via a mid-year amendment to their Plan Document – there is no need to wait until renewal to enact such a program – and obtain a premium credit on their stop-loss policy reflecting the diminished risk. A variation on this concept is to completely remove coverage for dialysis claims from the stop-loss

contract's specific deductible (but not their aggregate deductible), and effectively self-insure these claims. This makes sense if the policy credit offered is insufficient vis-à-vis the new, low $56,000 (national average) risk.

Another alternative that has been offered by stop-loss insurers is a stand-alone dialysis carve-out policy. The self-funded plan keeps its current stop-loss policy, and adds this additional carve-out policy, along with a dialysis cost containment program that is amended into the Plan Document by the insurer's cost management partner. Unlike in the variation discussed above where dialysis is carved-out and essentially self-insured by the plan, these additional carve-out policies typically exclude – paradoxically – active dialysis cases. Those stay under the legacy stop-loss policy, and are cost-contained as a result of the amendment to the plan reducing the cost down to the $56,000 (national average) risk. Also excluded are plan members that are clinically progressing towards needing dialysis in the near term – namely, those diagnosed with Stages 3/4/5 of Chronic Kidney Disease ("CKD"). Like the active ESRD/dialysis cases, if these persons progress to needing dialysis, they are cost-contained as a result of the amendment to the plan reducing the cost down to the $56,000 (national average) risk.

As a result, coverage under a stand-alone dialysis carve-out policy is only for persons in the early stages of CKD (Stages 1 & 2), and new members to the plan subsequent to the policy effective date that have ESRD and require dialysis. For example, a new employee joins the company and begins coverage under the self-funded plan, and his/her spouse has ESRD.

These policies typically cost in the range of $20 - $30 PEPM; let's analyze the economics using the mid-range figure of $25 PEPM, along with our example 500 employee self-funded plan: $25 PEPM * 250 employees (assuming a 50/50 employee / dependent coverage mix) equates to $75,000.

We know that the implementation of the dialysis cost containment program amended into the Plan Document has already reduced the risk to $56,000 (national average), so for a policy to make sense, the plan would have to experience more than 1 new ESRD/dialysis case from a very small population - new ESRD/dialysis cases entering the plan via new employment and persons with CKD Stages1/2 that will likely not progress towards the expensive services needed by ESRD/dialysis members for 4-7 years, well beyond the timeframe of a typical stop-loss policy.

Significant reduction to the cost of a potential ESRD claim

Implementation of a dialysis cost containment program into the Plan Document of the self-funded plan is essential. Doing so significantly reduces the cost of a potential ESRD claim, thereby lowering the risk that was originally priced into the plan's stop-loss policy before such a program. Plans have a number of options to restructure their policy and premium cost, and should consider the cost / benefit of each within this reduced risk environment in establishing their new coverage.