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The state of renal failure in the United States in 2018

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End Stage Renal Disease impacts the lives of 703,243 American patients (including transplants) as well as their families and costs United States taxpayers approximately $33.9 billion in Medicare expenditures per year and continues to rise each year as a result of diabetes, hypertension, and the aging population. The program was well intentioned and actually a good start treating the disease although cost projections were grossly underestimated. In 1972, the United States, under President Nixon, a bill was signed that would provide care to patients suffering from chronic kidney disease and it was to be the initial model for a nationalized health care system. In hindsight, it was a poor plan with a rationale that didn't make economic or serve as a long-term example of providing a universal base for a health care system. CMS, serving as the catchment for payment for patients, isn't involved, for patients under the age of 65, in the treatment or prevention until a patient has total renal failure. The structure of the payment system is one whereby patients under the age of 65 pay for treatment through third-party commercial insurance companies. These insurance companies typically reimburse dialysis companies at a significantly higher rate than Medicare or Medicaid leading to a higher cost for those that provide employer insurance and a higher weighted average of revenue for dialysis companies than if Medicare were the sole reimbursement provider. Without employer insurance, a gap in payment would exist until the patient moved over to Medicare insurance after a 33-month waiting period. The landscape of America's health care system is presently financially in-flux with the repeal of the Affordable Care Act mandate for the requirement for health insurance. At this point it is unclear what the actual financial impact on providers that can be calculated based on this change in law although it's likely not favorable due to some commercial insurance patients not purchasing coverage and using the emergency room for treatment. This burden is a cost shift to those holding insurance to cover patients without and was one of the reasons behind the mandate. The future of dialysis has always been a discussion of financial stability in the United States within dialysis providers. Medicare does reimburse below the cost of care for ESRD and have implemented a capitated system with a "pay for performance" model in an attempt to reduce expenditures through the abolition of the previous "a la cart" delivery of medicine. This has resulted in a significant cost shift to commercial third-party payers that may have seen some comfort with the mandate. However, with the abolishment of the mandate, will these insurance companies further erode the reimbursement for dialysis. With the federal budget in question and rumors cuts to entitlement programs, Medicare it is probable that the agency won't change course and maintain the present system. Dialysis providers and hospitals. Dialysis has always been an industry in transition. Some new therapies, such as the use of home hemodialysis, has never really gained traction despite impressive technological advances, but carrying a higher cost of service. Peritoneal dialysis has also remained a stagnant therapy but with relatively low and steady margins despite not requiring the infrastructure of a clinic. Providers, have instead been focusing towards utilizing their outpatient dialysis units to leverage utilization reflecting higher earnings margins than the more-costly peritoneal dialysis and home hemo therapies. In review, dialysis providers, insurance companies, Medicare and Medicaid, all have an economic stake in dialysis. Patients are the only stakeholder that do not have a voice at the table. This is an unfortunate consequence of the health care environment in the United States. Newer therapies, for the correct patient, can yield positive economic results. Studies have reflected that home hemo dialysis, for example

result in patients feeling better and not dropping out of the workforce as a result of their dialysis. Patients that are treated in-center typically cannot work and become an economic burden on the country. For HHD patients that remain active, they contribute to the economy via taxes and a higher level of spending. To evaluate and fix a healthcare field, sometimes the mold must be broken. In the case of the entire system, there are multiple models that work internationally with some drawbacks. Of course, this is presently not politically feasible in the United States under the current administration that's focus has been to dismantle the Affordable Care Act and have voiced potential budget cuts to Medicare and Social Security while preserving or increasing military spending. For the dialysis industry, the short-term outlook is likely to remain the same with challenges brought on by reimbursement, such as staffing training, development, and retention as well as encouraging young physicians to enter nephrology. Incentives for investment in equipment and infrastructure will continue to present difficult decisions for the medical device community, drug providers, and dialysis companies. In the long-term, dialysis will continue to have access to treatment, but possibly with fewer options. Any fiscal changes via Washington will depend on policy makers that have an interest in the entire health care system.

Biography

John D Sullivan is an expert in health care policy, finance, and asset valuation. Prior to joining Boston University, he worked for Fresenius Medical Care, completing the acquisitions of over one hundred health care companies with an estimated value of over $5 billion. In 2008, Sullivan co-founded Reliant Renal Care with private equity funding. He has provided strategic guidance for many of the largest health care organizations in the United States. Sullivan presently teaches mergers and acquisitions, corporate finance, investments, and financial markets and institutions.

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