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Private insurers keep dialysis clinics humming

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Click here to see a Flash presentation that includes a video, photos and interactive information about dialysis and kidney transplantation.

New patients with private insurance supply lifeblood to the $65 billion-a-year dialysis industry.

Fresenius Medical Care, the world's largest dialysis provider, made more than $800 million last year — even though it reported losing money on those patients who receive federal Medicare benefits.

Its top competitor, DaVita, meanwhile, made $374 million last year, and said nearly all its profits came from people who have private insurance.

"We need to identify new patients and, certainly, new patients with insurance," said LeAnne Zumwalt, DaVita's vice president. "That's what allows us to treat all patients. This private subsidy really allows the whole model to work."

A Pittsburgh Tribune-Review investigation found that doctors at dialysis clinics failed to inform thousands of patients about kidney transplantation. That failure could shorten lives and cost taxpayers millions of dollars a year.

Kidney transplantation adds an average of 10 years to a patient's life, and giving that patient a new kidney costs the federal Medicare program $50,000 less per patient each year than conventional dialysis.

The payment system regulated by Medicare creates a perverse incentive for providers: For-profit companies constantly need new patients with private insurance. Those people subsidize the cost of treating the elderly, the poor and those who need long-term care, and they account for much of the companies' profits.

OVERNIGHT LIABILITIES

About 35 percent of DaVita's dialysis revenue comes from patients with private insurance, while payments from those commercial payors generate nearly all of the company's profit, the company stated in a February filing with the U.S. Securities and Exchange Commission.

The response of Fresenius has been to look for ways to be more efficient and to "use commercial insurance payments to help sustain the overhead needed to care for Medicare and Medicaid patients," said Terry Morris, vice president of investor relations and corporate communications.

About two-thirds of Fresenius' business comes from the United States, where it spends about $289 per treatment but receives about $250 from Medicare. The agency takes over payments for almost every patient who has been on dialysis longer than 33 months.

That reimbursement schedule transforms patients with private insurance from being profit-drivers to liabilities overnight, as the government takes over their care.

The timing of Medicare payments for dialysis coincides with the median wait-time of 36 months that patients spend on dialysis before a transplant, according to data collected by the United Network for Organ Sharing, a federal contractor that collects transplant data.

Some doctors say the payment system creates unhealthy incentives for providers to focus on filling their clinics when they should be primarily concerned with making sure patients receive information about transplantation as soon as possible.

The companies "want their dialysis units filled,"said Dr. Bruce Kaplan, chief of nephrology and medical director of the Abdominal Transplant Program at The University of Arizona's medical center. "Obviously, that's how they make their money. They do have a vested interest in not having patients transplanted."

Officials with Fresenius, DaVita and other companies said they inform patients about transplantation and other options before they even start dialysis treatments if possible. A medical director for DaVita said he rejects any suggestion that the company would withhold information to earn a profit.

MONEY TALKS

Frontline caregivers "don't know whether you have Medicare or private insurance, nor should they know that," Zumwalt said. New Medicare rules, which took effect in October, require clinics to inform every patient about all of their options, including transplantation, said Dr. Barry Straube, the agency's chief medical officer and director of its Office of Clinical Standards and Quality.

That does not necessarily mean, however, that kidney doctors will refer patients for a transplant evaluation, said Dr. Tom Parker III, a Dallas-based nephrologist who co-chaired a summit on dialysis failures this spring at Harvard Medical School. Nephrologists do not have a financial incentive to provide detailed information to every patient, he said.

"It's not happening," he said. "And the response of the nephrologist is, 'There's no reimbursement for me to do this. Why should I do this? It's not my responsibility.' "

Instead, like the clinics, the kidney doctors who decide which patients to refer for transplant evaluation often have a financial incentive to put a patient on dialysis, some experts said. The doctors are hired by the clinics to serve as medical directors and, while the clinic cannot force them to bring their patients along, the patients typically follow their doctor.

"The pressure on the medical director to keep the dialysis facility full and to have patients in the dialysis facility rather than sending them home and rather than having them get a transplant is occult but significant," Parker said.

The only alternative to having nephrologists determine which patients to refer for a transplant evaluation, however, is to have them refer everyone, said Dr. Ben Hippen, a transplant nephrologist at the Carolinas Medical Center in Charlotte. Transplant surgeons have their own incentives to perform surgeries, he said.

"I've had dark nights of soul searching about whether there's a vast reluctance against transplantation for reasons of financial self-interest on the part of nephrologists," Hippen said. "If there is, I haven't seen it."

Because of the inherent pressures, the decision might not be a cognizant one, Kaplan said.

"My bias is that there is a delay in referring because, as in other things in life, when there's a monetary incentive not to do it, you can rationalize reasons why you're not doing it," Kaplan said. "You don't say it's for the money but when you stand to gain monetarily, it becomes awfully easy to rationalize why you're not doing it."

SUCCESSFUL TRANSPLANT LESS COSTLY

For payers — whether it's federal taxpayers through Medicare or private insurance companies — transplantation costs more at first but pays for itself within months through lower postsurgical costs, experts said.

When Medicare picks up the cost, it spends more than $17.8 billion a year on dialysis alone — accounting for 5 percent of its total $355 billion budget in 2006, according to the U.S. Renal Data System, a federal contractor that collects dialysis information. Government projections predict Medicare's hospital insurance fund will be broke by 2017.

The federal program spends about $70,000 a year for each patient on dialysis, versus $17,000 a year on someone who receives a successful kidney transplant, data show. The year in which the person receives the organ is the most expensive, at $106,000, although the savings are realized in two years.

Private insurers might pay even more for dialysis. Each treatment can cost $1,000 or more, totaling more than $13,000 a month, said Chris Pricco, chief operating officer in the complex medical conditions division at OptumHealth, a Minnesota health care consulting company.

At that rate, transplantation could cost less than ongoing dialysis in as little six months, he said.

"There is no doubt based on an economic analysis, giving someone a kidney within about three years is a tremendously cost-effective thing to do," said Dr. Bryan Becker, a transplant nephrologist at the University of Wisconsin-Madison and the president of the National Kidney Foundation.

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