

# From the desk of William Rogers, MD

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## ESRD and Medicare

I guess I am probably a bit older than my average reader. I graduated from medical school in 1981. Thankfully, I never practiced in a time when patients died because they could not afford to be hooked up to a dialysis machine 3 times a week. Only a decade before I became a doctor this very thing was happening.

### **The Dawn of Dialysis**

The basic chemical derangement of renal failure was understood 200 years ago. The name translates from the Latin as “urine in the blood.” While doctors understood the chemistry and physiology, treatment was impossible until 1945, when a 67-year old woman hospitalized in the Netherlands with acute renal failure was dialyzed by Dr. Willem Kolff using a primitive dialysis machine. The machine circulated the patient’s blood through tubes of cellophane suspended in a bath of dialysate. The patient survived (unlike the 16 patients he treated before her), her native kidneys recovered, and she lived to see her 73rd birthday.

### **Dialysis: An Ethical Slam Dunk**

During the next decade more efficient dialysis membranes were developed, anticoagulation with heparin was refined, and better approaches to vascular access were developed. Dialysis became a practical option at tertiary medical centers for the treatment of temporary renal failure. In 1952, Major Paul Teschan brought a Kolff-Brigham kidney to a MASH unit in Korea and treated 31 soldiers with acute renal failure due to battlefield injuries.

For the patient with acute renal failure, dialysis was an ethical slam dunk. The disease was

generally self-limiting, and the patients were often young and otherwise healthy. This expensive, dangerous treatment truly was a bridge to full recovery and, therefore, the risk and expense were easy to justify. The ethical dilemma concerned the treatment of patients with chronic renal failure. In 1945, 16 of 17 patients died despite or perhaps due to the primitive dialysis available at the time. Dialysis to sustain a person with chronic renal failure was out of the question. But by 1967 the equipment and techniques were far better, and long-term dialysis became technically possible. The issue then became one of access to the treatment. Dialysis machines were found only in larger hospitals and the number was in no way adequate to treat tens of thousands of people with chronic renal failure.

Inevitably there was also the issue of payment. Health insurance companies balked at the huge costs projected by their actuaries if they covered the service. Many of the chronic renal failure patients were too ill to work and, therefore, had no health insurance at all.

### **“The God Committee”**

Seattle created a dialysis allocation committee in 1962 to decide who would be allowed access to treatment. The committee first considered the patient’s medical condition, but this screening still left the Seattle Artificial Kidney Center with more candidates than they could treat. An anonymous committee of local citizens was formed to further winnow the patients based on considerations of social worth. This committee became known as “The God Committee.” The fact that patients were being, in essence, condemned to death based on their answers concerning church atten-

## Medicare Preventive Services

- Initial Preventive Physical Examination
- Cardiovascular Disease Screenings
- Diabetes Screenings
- Diabetes Self-Management Training
- Medical Nutrition Therapy
- Pap Test and Pelvic Screening Exam
- Colorectal Cancer Screening
- Prostate Cancer Screening
- Bone Mass Measurements
- Glaucoma Tests
- Flu Shot
- Pneumococcal Vaccine
- Hepatitis B Vaccine
- Smoking Cessation

dance and participation in Boy Scouts led to public outcry and intense press scrutiny.

In November 1962, *Life* magazine published an article entitled, “Who Shall Live, Who Shall Die?” written by Shana Alexander. In 1965, NBC released a documentary concerning the Seattle dialysis allocation committee.

### Medicare Coverage Begins

In 1972 President Nixon signed Public Law 92-603, which made patients who required dialysis or kidney transplantation eligible for Medicare coverage regardless of their age as long as they met the other standard requirements for Medicare coverage. In 1973 10,000 Americans were receiving renal dialysis, and the cost of their treatment had been assumed by the Medicare program.

Medicare eligibility begins after 3 months of dialysis and continues until 12 months after the last dialysis (for the fortunate patients who have kidneys that recover). Patients who undergo kidney transplantation lose their Medicare coverage 36 months after the transplant, unless they are over 65 or disabled, in which case they remain Medicare eligible.

More recently Congress has addressed the problems experienced by transplant patients when they lose their Medicare eligibility. Initially Medicare only covered 12 months of immunosuppressive drugs. Since

the annual cost can be as high as \$10,000, patients found themselves unable to afford the medications, which led to organ rejection and the need to go back on dialysis. Medicare coverage for immunosuppressants was later extended for 36 months after the month of the transplant if patients had Medicare coverage only because of kidney failure. In 2000, Congress repealed the time limitation for people who already had, or became eligible for Medicare due to age or disability before they had end-stage renal disease, or after they had a Medicare-covered transplant. These transplant patients now enjoy Medicare coverage of their immunosuppressants as long as they need them.

### Spiralling Costs

The cost of the treatment of renal failure has grown dramatically since 1973. There were 10,000 patients on dialysis then. The number is now about 325,000, and the annual cost to the taxpayer is about \$18 billion dollars. About a quarter of these patients are eventually transplanted. During the first year after transplant, the monthly medical costs are about \$7500, exceeding the monthly cost of providing dialysis, which is about \$4500. But in the second year, the monthly medical cost of the transplanted patient drops to about \$1200. Transplantation saves Medicare dollars and greatly improves the quality of life of the transplanted patient.

Medicare coverage was originally limited to Americans over the age of 65 or younger people who were considered disabled by Social Security for 24 months. Ten years after the program was created, Medicare eligibility rules were expanded by Congress to include patients of any age who required dialysis or renal transplantation. Currently more than 90% of people on dialysis are benefiting from Medicare coverage. However, not enough is being done to prevent renal failure in the first place. Diabetes (often due to obesity) and hypertension are two treatable causes of renal failure. Patients and physicians need to redouble their efforts to control these diseases and hopefully avoid the need for dialysis. Physicians should know about the prevention services that are covered by Medicare. MPM

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