March 22, 2019

Senator Laurie Monnes Anderson
Chair, Senate Health Committee
State Capitol, Room 453
Salem, OR 97301

**Subject: SB 900 – Relating to outpatient dialysis treatment**

Chair Monnes Anderson,

On behalf of DaVita's nearly 500 caregivers in Oregon, who treat and care for more than 1,850 individuals with kidney failure throughout the state, I write to oppose SB 900. SB 900 will hurt Oregon's dialysis patients in two ways: first, by driving charities that provide premium assistance out of Oregon entirely—hurting low-income individuals relying on this type of assistance to maintain their insurance and second, by likely restricting dialysis patient access to care as clinics receive less funding from insurers and struggle to stay financial solvent—hurting all Oregonians on dialysis, including future patients. It's also important to note that in 2014, the Department of Consumer and Business Services issued a memorandum addressing premium assistance and urged health issuers to accept premium assistance to avoid discriminatory practices.

## ESRD and Dialysis

End-stage renal disease (ESRD) is the last stage of kidney disease. People who have ESRD no longer have functioning kidneys and need regular dialysis treatments, or a kidney transplant, to survive. Patients on dialysis must be treated three times a week, for three to four hours at a time. Currently, nearly 4,600 Oregonians are dependent on this life-saving care.

## Payment for Dialysis and ESRD Care

For almost 50 years, dialysis and other care for patients with ESRD has been paid for through a complex system of government and private insurance. In 1972 Congress created an ESRD entitlement within the Medicare program. Since that time, federal policymakers have crafted an intentional public-private partnership to balance the needs of individuals with ESRD with those of the broader public. As part of that system, private health insurers are generally required to cover dialysis and ESRD treatment for their members for up to 30 months. After that time, a patient's care is mostly covered (80%) by Medicare. Patients without private insurance are typically covered by Medicare for 80% of their treatment costs, or by Medicaid. Some of those patients obtain private insurance as "wrap-around" coverage for the remaining 20%. Across the entire system, close to 90% of dialysis patients use some form of government insurance (e.g., Medicare, Medicaid, VA) to pay for their care, and only approximately 10% use commercial insurance (e.g., employer-group coverage, individual plans, COBRA).

It is important to recognize that government insurance (Medicare) does not reimburse the full cost of dialysis care. As a result, the private insurance payments received for approximately 10% of dialysis patients cross-subsidize treatment for the 90% of dialysis patients who have government insurance. This system helps keep economically-challenged dialysis clinics open for all patients.

Additionally, there are many reasons individuals on dialysis would seek to maintain private insurance coverage. Individuals paid for and benefitted from private coverage before they were sick—now they want to use the coverage they've paid for when they need it most. Individuals with commercial insurance have a relatively higher rate of transplant (vs. Medicare and Medicaid). Family members lose health insurance if a dialysis patient moves to Medicare (Medicare is an individual benefit) so any dependents would have to try to enroll in separate insurance and may/may not qualify. Finally, government insurance may not have as robust a network as the patient's private insurance (which is especially important in light of the multiple specialists dialysis patients see).

Charitable Premium Assistance

SB 900 seeks to impose unprecedented restrictions and obligations on charitable premium assistance, undermining a safety net has been in place for decades. Charitable organizations provide financial assistance to low-income patients with a number of serious health issues, including ESRD, so they can afford to pay the premiums for private or government insurance coverage. Patients qualify for assistance purely based on financial need, and the assistance is independent of the insurance plan or provider they have chosen.

The federal government approved the current system for ESRD charitable premium assistance over 20 years ago. In 1997, the Office of the Inspector General for the Department of Health and Human Services (OIG) issued an advisory opinion letter stating that the proposed charitable premium assistance practices—and the relationship between charitable premium assistance providers and dialysis providers—did not violate federal health care laws. In its opinion, the OIG explicitly recognized society's interest in enabling ESRD patients to maintain health coverage in the face of a life-threatening, chronic disease.

Additionally, in 2014, the Oregon Department of Consumer and Business Services held a series of stakeholder meetings to address the issue of premium assistance. These meetings were fact-based and non-partisan resulting in an agency bulletin which established criteria by which health plans should accept premium assistance from third-party organizations. *DCBS memo attached.

Proponents of SB 900 maintain it is needed to prohibit inappropriate provider steering of patients for purposes of higher reimbursement. However, a few critical facts undermine this assertion:

- The majority of premium assistance that dialysis patients receive (~70%) is for help with government coverage-related costs (Medicare, Medicare-related), where on balance health care providers are under-reimbursed.

- Premium assistance is available *regardless* of the insurance coverage is trying to maintain – and it remains available in the many instances where an individual transitions from commercial health insurance to government coverage.

- Providers contributing to charitable premium assistance organizations cannot control whether their contributions are used by grant recipients to assist in obtaining commercial insurance.

- The number of dialysis patients utilizing commercial insurance has remained steady (~10%) for decades. Approximately one in six of these patients will use assistance at some time to maintain their commercial insurance, insurance that they have generally maintained for many years before ESRD diagnosis.

In fact, SB 900 effectively allows and enables insurers to more easily identify and potentially steer their beneficiaries with ESRD onto alternative coverage (Medicare). The bill requires charities offering premium assistance to notify insurers about the specific patients who will receive premium assistance—but does ***not*** require insurers to accept premium assistance for ESRD patients (even after that charity met the requirements or any patients not covered by the small number of exceptions). SB 900 does not clearly compel insurers to accept premium assistance. As a result, insurers could potentially single out ESRD patients who will receive charitable premium assistance and reject such payment. We are concerned that a large number of patients will lose their preferred coverage as a result.

SB 900 ignores the fundamental realities of the dialysis finance ecosystem and threatens to undermine access to care for many current and future Oregonians with kidney failure. Because SB 900 would allow insurers to drastically lower the reimbursement rate previously negotiated by the insurer and the provider – it will have a significant financial impact on the state's dialysis clinics.

**SB 900 will directly harm low-income dialysis patients throughout the state by eliminating the availability of third-party premium assistance in Oregon.**

SB 900 may well result in all Oregon patients losing the ability to receive charitable premium assistance. It is our understanding that the American Kidney Fund (AKF), the charity which oversees the largest and most active premium assistance program for dialysis patients, has serious concerns about their ability to comply with SB 900 based on the strict federal guidance their program operates under (HHS OIG 97-1). Said differently, SB 900 could cause all Oregon dialysis patients who currently utilize AKF premium assistance (~1,040 individuals) to lose it were AKF to determine compliance with SB 900 would violate federal guidance, and therefore cease operating in Oregon.

**SB 900 will indirectly harm all Oregon dialysis patients by weakening the dialysis delivery system across the state.**

SB 900 ignores the fundamental realities of the dialysis finance ecosystem and threatens to undermine access to care for many current and future Oregonians with kidney failure. SB 900 dramatically upends a part of the dialysis financing system (patients on private insurance utilizing premium assistance), but does not account for the significant change the bill would force by proposing to increase reimbursement for government insurance programs like Medicare or Medicaid. Because SB 900 would allow insurers to drastically lower the reimbursement rate previously negotiated by the insurer and the provider, it will have a significant financial impact on dialysis clinics. As a result, dialysis clinics across Oregon would feel significant financial strain—especially in rural areas and the urban core, where clinics treat mostly Medicare and Medicaid patients. Certainly, were SB 900 to become law, the pace at which dialysis clinics could be opened to meet the growing demand for dialysis care in Oregon (4.8%YoY growth in ESRD) or the ability of clinics to maintain convenient patient treatment times would be significantly restricted, if not stopped altogether as a result of new financial realities. As access is crimped, critically ill patients would be forced to either drive to clinics farther away or seek treatment in hospital emergency rooms, which is significantly costlier than the outpatient setting. In sum, SB 900 undermines access to care for all Oregonians on dialysis.

Separate from the arguments regarding patient care and clinic stability, the information mandated by the bill determines whether a health plan honors previously agreed-to contracted reimbursement rates or is allowed to significantly reduce reimbursement to providers. In order to make that decision, health plans will need additional information to identify who is a “financially-interested entity” and who is a “financially-interested provider”. SB 900 does not allow regulatory oversight into this transfer of information—the consequences of which bring the potential for significant downside for Oregon consumers. This seems wrong.

The Affordable Care Act rightly eliminated discrimination on the basis of pre-existing conditions. SB 900 seeks to use charitable premium assistance as the new “pre-existing condition”, one of being a low-income patient with a chronic health condition trying to hold on to health insurance. Oregon should reject this effort to undermine a vital safety net that benefits so many of its most vulnerable citizens. Therefore, on behalf of the thousands of dialysis patients in Oregon DaVita has the privilege of caring for, I implore you to vote against SB 900.

Sincerely,

Jeremy Van Haselen
Vice President, State Government Affairs