U.S. RENAL CARE®
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February 3, 2020

Chair Andrea Salinas House Committee on Health Care

Dear Chair Salinas:

U.S. Renal Care currently provides in-care and in-home dialysis services to 25,000 patients in over 350 dialysis facilities across 32 states and Guam. At U.S. Renal Care, we strive to provide the highest quality care, with a patient-centric approach and the best available service for our patients and their families.

As a small provider with a very small footprint in Oregon, it might not be clear why HB 4114 is important to us. Interfering with the current and very fragile payment system for dialysis patients could impact access to care. The smaller providers may be forced to close or consolidate with larger chains as clinics would receive less funding to improve operations or grow.

Community Access

U.S. Renal Care has a unique perspective of partnership with local physicians for investment and operation of our Portland dialysis facilities. As a small provider with local partnership we are particularly vulnerable to shifts in the reimbursement process. To decrease our less than 10% of contracted commercial payment to the smaller Medicare allowed will create a negative incentive for our partners to remain invested in these facilities as they will not be covering the expenses of operations for their portion of ownership. Thus creating the likelihood of consolidation or closure of the locations. Because the four USRC locations are community based and operated in partnership with local community based Nephrologists, our ability to sustain operations should this bill pass is very low. The impact to the community in which we operate will be negative.

Payment for Dialysis and ESKD Care

In 1972 Congress created an ESKD entitlement within the Medicare program. Since that time, federal policymakers have crafted an intentional public-private partnership to balance the needs of individuals with ESKD with those of the general public. In turn, private health insurers are at most, required to cover dialysis and ESKD 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.

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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, 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 supports economically-challenged dialysis clinics to remain open for all patients.

Besides the obvious interference with contract negotiations for fair market pricing, we see HB 4114 as an incentive for insurers to more easily identify and potentially steer their beneficiaries with ESKD onto alternative coverage (Medicare). Both situations have impact for the ability to meet expenses as well as to increase out of pocket expenses for patients who may currently enjoy full coverage via insurance and Medicare as secondary payer.

As noted, there are quite a few possibly unintended consequences to this legislation and we urge the committee to step back and work with the providers to devise a system that meets the stated goals of the legislation. Providers currently do not turn away patients based on type of coverage, reimbursement, or ability to pay out of pocket costs. Providers do not currently have the ability to treat emergent acute or ESKD patients and this bill would likely not create a system where that could happen. Providers currently negotiate under fair market processes with commercial insurers for mutually agreed upon rates and there is no reason for a government pricing system to overtake the free market in this scenario. US RenalCare does not support this legislation for all of the stated reasons above and we hope this will not move forward in the current form.

Sincerely,

Francine Attrill

Francine Attrill
VP Public and Commercial Reimbursement Policy
US Renal Care