HB 4114 STAFF MEASURE SUMMARY

House Committee On Health Care

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Meeting Dates: 2/4, 2/11

WHAT THE MEASURE DOES:

Requires Medicaid and regulated health insurers to cover renal dialysis for individuals diagnosed with end stage renal disease. Limits licensed outpatient renal dialysis facilities from billing or attempting to collect fees that exceed the Medicare payment rates established by the Centers for Medicare and Medicaid Services. Requires outpatient dialysis facility to provide services regardless of an individual's ability to pay. Limits an enrollee's out-of-pocket costs for renal dialysis to no more than 10 percent of an insurers allowable charge for the renal dialysis.

REVENUE: May have revenue impact, but no statement yet issued.
FISCAL: May have fiscal impact, but no statement yet issued.

ISSUES DISCUSSED:

- Access to and affordability of outpatient dialysis services among patients with end state renal disease
- Coverage of and reimbursement for dialysis services among Medicare, Medicaid, and commercial insurers
- Varying payer-mix and reimbursement rates among insurers for outpatient dialysis services; market competition
- Potential financial impact on outpatient dialysis services and existing capacity of in-state dialysis centers, particularly in rural localities
- Different dialysis types and settings including acute and peritoneal treatments

EFFECT OF AMENDMENT:

No amendment.

BACKGROUND:

End-stage renal disease (ESRD), a condition of permanent kidney failure occurs when chronic kidney disease reaches an advanced state and the kidneys are no longer able to work as they should to meet the body's needs. Individuals with ESRD need dialysis or a kidney transplant in order to survive. Individuals who are uninsured with ESRD may receive emergency-only dialysis in a hospital setting pursuant to the federal Emergency Medical Treatment and Labor Act (EMTALA), compared to regular, ongoing scheduled standard dialysis in an outpatient setting, available to the insured. Research indicates that individuals who receive emergency-only dialysis in a hospital, which is often more expensive than receiving dialysis in an outpatient setting, experience higher rates of mortality. Several states have enacted laws to address whether permanent dialysis treatment is an emergency medical treatment or routine treatment—for the purposes of Medicaid reimbursement. The federal courts have reached different conclusions whether dialysis constitutes an emergency medical condition and is covered by state Medicaid programs.

The federal Affordable Care Act (ACA) affected the scope and cost of health coverage for many ESRD patients by prohibiting plans from denying benefits based on health conditions (i.e., pre-existing conditions), capping enrollee cost-sharing, with most states requiring health plans to include dialysis as a covered benefit. Reimbursement rates for outpatient dialysis treatment vary among commercial, Medicare, and Medicaid insurers with commercial payers reimbursing at higher rates than Medicare or Medicaid. For individual's with ESRD who receive dialysis

treatment, the type of insurance they are eligible for and actually enrolled in may affect affordability and access to provider facilities and services.

House Bill 4114 creates insurer requirements and billing restrictions for outpatient dialysis treatment facilities in Oregon.