DPC
DIALYSIS PATIENT CITIZENS

Improving Life Through Empowerment

February 3, 2020

House Committee on Health Care
Oregon State Legislature
900 Court Street NE
Salem, OR 97301

Re: HB 4114

Dear Chairwoman Salinas and Committee Members:

Dialysis Patient Citizens (DPC) writes to offer its comments on the above referenced bill that will be discussed at the upcoming Committee hearing on February 4, 2020 at 3pm PT.

DPC's membership, currently 28,000 nationwide, is restricted to kidney disease patients and their family members. Approximately 400 of our members reside in Oregon. DPC is a patient-led organization. Our by-laws require that the President, Vice President and at least 51% of the Board be current dialysis patients. The non-dialysis patients serving on our Board are former dialysis patients with kidney transplants. Nearly all our volunteer board members have represented their peers on CMS technical expert panels and/or advisory committees of other health care organizations such as the National Quality Forum and Patient-Centered Outcomes Research Institute. DPC also conducts an Annual Membership Survey to ascertain patients' experiences with their care and views on health policy issues. DPC is committed to promoting access to high-quality dialysis care for individuals with ESRD; to prevention of, delayed onset of, and safe transition to ESRD among individuals with chronic kidney disease; and access to kidney transplantation as well as to other alternatives to dialysis that may emerge.

Depending on how you count them, HB 4114 is the eighth iteration of a multi-state effort by special interests against dialysis providers for their refusal to support unionization of its employees. Each of these measures attempted to cripple dialysis providers either by increasing their expenditures or decreasing its revenues. It appears that this bill is intended to do both.

To suggest that these measures represent a reasoned or principled approach to containing health care costs is false. Most observers would agree that health care costs in the U.S. are high and rising at an unsustainable pace, and that high prices are the culprit. Some experts advocate for

all-payer rate-setting to address this; others advocate a single-payer system with administered prices, like Medicare. But if you search the published health policy literature, you will find no law review article, no medical journal article, no book, no think-tank study, no expert panel white paper suggesting that current Medicare rates could be imposed across the board on any type of provider. In fact, you will find the opposite: numerous commentaries suggesting that this would bankrupt providers and reduce access to care. Even the Center for American Progress's Medicare Extra proposal, the leading "Medicare for All" proposal, does not contemplate paying current Medicare rates to providers. Congress' principal advisers on Medicare prices, MedPAC, specifically build into their recommendations cross-subsidization from commercial payers and have continually approved rates that result in negative Medicare margins for dialysis clinics and hospitals.

Oregon recognized this reality when it set rates for hospitals participating in the state health plan. In her testimony to the House Committee on Health Care in 2017 regarding SB 1067, Speaker Kotek noted that "the current average inpatient/outpatient cost for the self-insured plans is approximately 237 percent of Medicare. The bill targets 200 percent for in-network claims because it is an achievable benchmark that still moves us in the right direction."[1]

Nor will you find scholarly literature suggesting that dialysis prices are responsible, in any meaningful way, for increased health care costs. During 2018, the NAIC's Health Insurance and Managed Care Committee held a series of hearings on health care costs. No presenter, whether an unaffiliated expert or insurance industry lobbyist, mentioned dialysis. Again, you will find the opposite: numerous commentaries that point the finger at prescription drug prices, hospital monopolies, and single-specialty group physician practices.

There are literally thousands of health economists, health services researchers, and health actuaries working in academia, think tanks, and consulting firms. If supporters of the bill ever attempted to retain an expert to offer evidence that dialysis is a major contributor to U.S. health care costs, the results of his or her analysis have never been made public. Special interest groups have actually been fairly transparent that its campaign does not urge evidence-based policymaking but rather utilizes demagoguery in pursuit of its vendetta.

We are disturbed that Oregon is not following the same analytical process here that it exercised with SB 1067 two years ago. Two years ago actuaries were consulted to determine market conditions. This time, HB 4114 would impose an arbitrary payment at an unrealistic and punitive level. If this rate were to be enforced, dialysis facilities in Oregon would close, or would have to be spun off to non-profit entities subsidized by foundations or by the state. Any remaining for-profit services would no doubt have to be offered in super-sized clinics located only in regions with high population density.

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[1] Oregon Legislative Assembly, Staff Measure Summary: SB 1067 A, (2018) Available at https://www.oregon.gov/oha/PEBB/docs/OEBB-PEBB%20Innovation%20Workgroup/20181016/IW%20Attachment%204c-SB106-HB3418%20summaries%20and%20testimony.pdf

In explaining SB 1067's approach, Speaker Kotek cited a study that "found the cost of health care in Oregon is 17 percent higher than neighboring states with no correlating increase in the quality of care." No such benchmarking has taken place here. HB 4114 simply and unapologetically singles out dialysis and dialysis patients for special hardships.

This is not only immoral, but illegal under federal law. The Dialysis Patient Choice provision of the Medicare Secondary Payer (MSP) law lets kidney patients keep their commercial coverage for up to 30 months before Medicare becomes primary payer. To buttress patients' ability to exercise this choice, the Dialysis Patient Choice provision also includes an anti-discrimination clause known as the "non-differentiation" requirement. Congress included this right because it foresaw exactly what is happening today: an opportunistic actor fomenting resentment against expensive dialysis patients and those who care for them.

Federal law says that a group health plan "may not differentiate in the benefits it provides between individuals having ESRD and other individuals covered by such plan on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner" during the 30-month period. Illegal actions include "paying providers and suppliers less for services furnished" to an individual with ESRD. Because states sponsor group health plans, a state, as well as any insurer invoking a discriminatory state law, would be subject to legal sanctions if it differentiates in how it pays for dialysis.

If the state caps prices for dialysis, the state must do so on an equal footing with other providers and other types of patients. This means it must undertake exactly the same process it did in enacting SB 1067 – it must conduct a good faith market analysis, and account for the fact that while only about half of hospital patients are Medicare beneficiaries, 90 percent of dialysis patients are; it must not reduce reimbursements more than 15.6% from the prevailing average, as it did with hospitals; and it cannot apply to all payers unless SB 1067 is amended to apply to all payers.

AB 290 in California has been enjoined by a federal court. Yet supporters of the bill, which include insurers and unions, still log a "win" with a state law that is pre-empted, because providers accrue legal fees while the cost of defending the law is borne by taxpayers, not them. We hope that the legislature will not subject Oregon taxpayers to the cost of defending this clearly illegal measure.

Sincerely,

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Chief Executive Officer
Dialysis Patient Citizens

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DPC is a 501(c)(4) non-profit organization governed by dialysis patients.