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AMENDMENTS TO KIDNEY DISEASE PROGRAM (H R 8423)

CURRENT STATUS

H.R. 3112, to amend Titles II and XVIII of the Social Security Act, was introduced in the House of Representatives on February 3, 1977, by Congressmen Dan Rostenkowski of Illinois and Charles A. Vanik of Ohio, and sent to the Committees on Ways and Means and Interstate and Foreign Commerce. After holding hearings and considering specific legislation, the Subcommittee on Health of the Ways and Means Committee reported out a clean bill (H.R. 8423), which the full Committee ordered to be reported out by voice vote on July 25. On September 12, H.R. 8423 passed in the House of Representatives. It is now in the Senate Finance Committee, where, as of this date, no action has been scheduled.

BACKGROUND

H.R. 8423 amends Title II and XVIII of the Social Security Act for the purpose of reforming the end-stage renal disease (ESRD) program. This program, authorized in 1972, allows the federal government to pay for the medical care involved in treating kidney diseases.

The existing program allows the federal government to assume the costs of a kidney transplant operation if the transplant occurs within a month of the kidney removal operation. (It is

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usual to perform the transplant 6 to 8 weeks after the removal of the diseased kidney.) This coverage extends for 12 months and, if the transplanted kidney fails after the coverage period ends, the patient is responsible for further costs throughout a waiting period until Medicare coverage again resumes.

Secondly, the existing program allows for the purchase or rental of medical equipment of a value over \$50; reimbursement by the government is made in monthly installments equal to amounts which would be paid if the equipment had been rented.

PROBLEMS WITH THE CURRENT PROGRAM

The program in the first year of its operation covered about 9,000 cases and now covers about 36,000 at a present cost (FY 1978) of \$900 million. A kidney transplant now costs \$20,000-\$25,000. To this is to be added the expenses for drugs and physician services (\$3,000 the first year after the operation and about \$2,000 per year thereafter). Both renal transplants and dialysis are very complicated, awkward, and expensive medical procedures. Their rising costs and increasing demands for them have led many legislators to seek ways in which the existing program can be expanded and at the same time contained in its costs.

PURPOSES AND PROVISIONS OF THE PRESENT BILL

The report of the Ways and Means Committee states that the bill has five objectives: (1) to provide incentives for the use of self-dialysis (in the home), which the Committee believes is less expensive, as an alternative to the more expensive institutional dialysis; (2) to remove disincentives in the current program to transplantation, by extending Medicare coverage; (3) to encourage more cost effective delivery of services to patients who dialyze in the home and in institutions; (4) to provide, through peer review organizations, national objectives and means for the most effective use of resources for treating renal disease; and (5) to provide for continuing review of the program with the objective of studying alternative ways to improve it.

H.R. 8423 contains provisions intended to achieve these objectives.

(A) Incentives for Self-Dialysis: (1) The bill waives the three-month waiting period for patients who enter a self-dialysis training program before the end of the third month after the month his dialysis course begins. (2) It provides for the coverage of disposable medical supplies required for home dialysis. (3) It provides for coverage of periodic supportive services (emergency visits and servicing of equipment) to self-dialyzing

beneficiaries. (4) It provides coverage for services of a self-care dialysis unit maintained at a renal dialysis clinic or facility. (5) It authorizes reimbursement to facilities for dialysis equipment purchased by facilities for the exclusive use of patients who dialyze at home.

(B) Removal of Disincentives to Transplantation: (1) The bill begins coverage for a patient the month he is hospitalized, if the transplant occurs that month or within the next two months (thus the present waiting period is curtailed). (2) The bill extends the period of Medicare coverage from the current 12 to 36 months. (3) The bill allows immediate resumption of coverage without a waiting period when a transplant fails. (4) The bill covers expenses for live kidney donors and for the donor's period of recovery.

(C) Reimbursement: The bill allows the Secretary of Health, Education, and Welfare to make use of a number of procedures to implement incentive reimbursement methods for services provided by dialysis facilities to patients who dialyze at home or in the facility.

(D) Professional Peer Review Organizations: The bill gives responsibility to these organizations to establish goals for identification and placement of suitable candidates in self-care settings and transplantation and for assessing the performance of facilities. It establishes the "national objective" that a majority of new beneficiaries of the program must be self-dialyzing patients or be transplants.

(E) Review and Alternatives: The bill requires the Secretary of HEW to submit an annual report to the Congress on the costs and operation of the program and on new developments in research and to conduct experiments aimed at improving the program without impairing its quality.

DISCUSSION OF THE PROPOSAL

The principal argument for the bill is that it will contain the costs of an important but increasingly expensive medical procedure. This argument is based on the assumption that dialysis in the home will be cheaper than institutional dialysis. Critics of the bill, which include several medical experts in renal disease and the techniques of self-dialysis, have dissented from this assumption. They have also made several other points, the more significant of which are summarized below.

(A) Cost of the Proposed Program to the Government: Under the present system, payment is made on the basis of 80% of reasonable charge up to a screen of \$138. Under the proposed system, payment would be made on the basis of a reimbursement of

costs. According to Dr. Eugene Schupak, President of National Medical Care Incorporated, the new system would cost the federal government an additional \$12 per case. Dr. Schupak estimates that, given this increased cost in addition to other responsibilities which the government would have to assume under the proposal, the additional cost will be upwards of \$300,000,000.

(B) Cost of Home Dialysis: Dr. Schupak also testified that cost reductions provided by home dialysis are highly dubious. The procedure inevitably involves very expensive medical equipment and supplies. "Dialysis," said Dr. Schupak, "cannot realistically be safely accomplished for much less than \$20,000 per year, regardless of the location." Dr. Edmund G. Lowrie, Director of the Hemodialysis Unit of the Peter Bent Brigham Hospital in Boston, who has been one of the pioneers of home dialysis, has compiled estimates that show the expense of the procedure. Dr. Lowrie states, "I do not feel that the cost of home dialysis is significantly less than that of limited care. The difference certainly does not justify a 50% mandated quota for home dialysis" as required by H.R. 8423. Dr. Lowrie found that the total cost, including initial costs of equipment, training, salary of a dialysis assistant, the tax loss to the federal government as well as the direct costs, was \$22,158.00. These figures, he added, were conservative.

(C) Discrimination: Dr. Schupak also testified that the part of the bill allowing Medicare coverage during the first month discriminates against those unable to use home dialysis. This category includes those low-income patients whose homes do not have the electrical or plumbing facilities required by home dialysis. These patients, not using home dialysis, are not eligible for the benefits of those provisions of the bill that supposedly remove the disincentives to home dialysis.

The most poignant testimony in this respect was given by Mr. Charles C. Smith, himself a low-income dialysis patient who almost died after his transplant failed. Mr. Smith stated that "home dialysis is basically a middle-class procedure and is best applied to patients with a good education, a stable home, and close, capable, concerned families." The low-income patient must not only wait three months for coverage to begin but also must persuade his landlord to put in new plumbing and wiring. The bill also tries to encourage transplants, but does not consider the higher mortality of elderly patients who have them. Nor does the bill insist on the same high standards for home dialysis as the government does for institutional dialysis. Mr. Smith concluded that this was "a measure which would jeopardize precious human lives in an attempt to save the government some money."

(D) Quotas: The national objectives for which the bill provides require "that a majority of new patients being accepted for end-stage renal disease treatment should be in self-dialysis

settings or be transplanted." Opponents of this bill believe that the government--not the doctor or the patient--will be determining the medical treatment to be given under the program, and on the basis of saving money, not preserving the quality of the care. Thus, they believe that the bill substitutes a government-mandated system of health care for renal disease in place of the individual judgment and conscience of the participants.

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