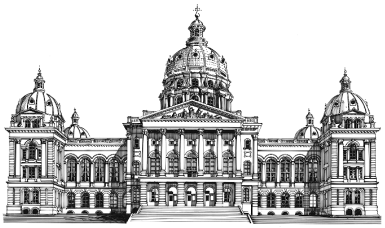
ISSUE REVIEW

Iowa Legislative Fiscal Bureau



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Chronic Renal Disease Program

ISSUE

The number of clients participating in the Chronic Renal Disease Program has increased steadily over the past 3 years. Conversely, the State appropriation for the program has declined.

AFFECTED AGENCIES

Department of Public Health (DPH)

CODE AUTHORITY

Chapter 135.45 - 48, Code of Iowa

BACKGROUND

End Stage Renal Disease (ESRD) is the complete cessation of kidney functions requiring kidney dialysis or kidney transplantation to sustain life. Prior to 1972, patients who were either unable to pay for these services, did not have adequate insurance, or were unable to receive Medicaid assistance had very few options available to them. Iowa became the first state to address this need by initiating the Chronic Renal Disease Program (CRDP) in 1972. Subsequently, 25 other states and 2 territories have followed the Iowa model to address the issue of financial assistance for ESRD patients.

Iowa's program began in 1972 with a total of 32 approved applicants and a budget of $30,000. By FY 1989, the average monthly patient count was 386, and the annual budget was nearly $900,000.

In 1973 Congress expanded Medicare coverage to financially assist persons with ESRD. Under this program, Medicare reimburses up to 80% of allowable medical costs for those insured through the Social Security Administration.

Medicare reimbursement for outpatient dialysis patients begins when a three-month waiting period has been completed. Kidney transplant and home dialysis patients are eligible immediately. Medicare eligibility extends for 3 years after the date of transplant unless disability is subsequently documented.

The CRDP was implemented as the payor of last resort. Although the CRDP does not address all of a patient's health related financial needs, it does give ESRD patients a financial

support system for those costs not covered by third-party payors. These costs include dialysis or kidney transplantation services, travel to and from transplant/dialysis facilities, drugs, home dialysis services, and Medicare and insurance premiums.

Program eligibility is based upon financial and medical resources available to each patient. The CRDP provides the greatest level of assistance to persons with the least available resources. The financial status categories are derived from the current U.S. Department of Health and Human Services' Poverty Income Guidelines.

CURRENT SITUATION

A unique aspect of the CRDP is creating some problems for those enrolled in the Program. Language in the appropriation bill requires expenditure reductions so the appropriated amount is not exceeded. Consequently, no funds may be transferred from elsewhere within the DPH. As a result, increasing caseloads are met with reductions in service.

Individuals diagnosed with ESRD who start dialysis must go 3 times a week for 4 or 5 hours each time. Because of this extensive medical treatment and deteriorating physical condition, the patient with chronic renal disease will eventually be unable to work, which often leads to the loss of health insurance. Patients with ESRD have

multiple health problems. Dialysis will cost an estimated $2,500 per month. Drugs can cost thousands of dollars for transplant patients, or as little as $400 per month for dialysis patients. Physician costs are approximately $55 per month, and insurance premiums often reach $900 per month. These costs are estimates based on a random sample of patients currently enrolled in the Program.

ALTERNATIVES

The Legislative Fiscal Bureau evaluated alternatives to the current CRDP in January 1990. Five mutually exclusive policy options and one added service option were considered. The Program's status of "payor of last resort" was also investigated. The policy options consisted of:

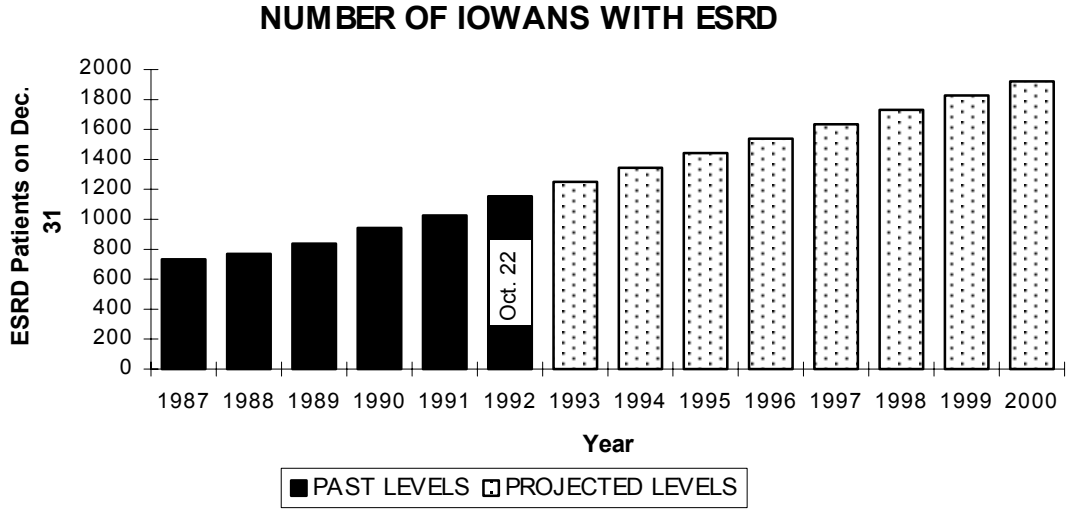
- Moving the program to the Department of Human Services (DHS) or to the county level
- Changing the reimbursement levels
- Shifting emphasis to preventative services
- State financing of private insurance premiums
- Creating Mobile Units to accommodate rural participants

The report concluded the alternatives designed to reduce administrative costs would either produce excessive hardships for those patients currently enrolled in the Program, or fail to result in cost savings. The report also concluded that creating Mobile Units to service rural patients would be prohibitively expensive. It was determined the Program was serving as the payor of last resort.

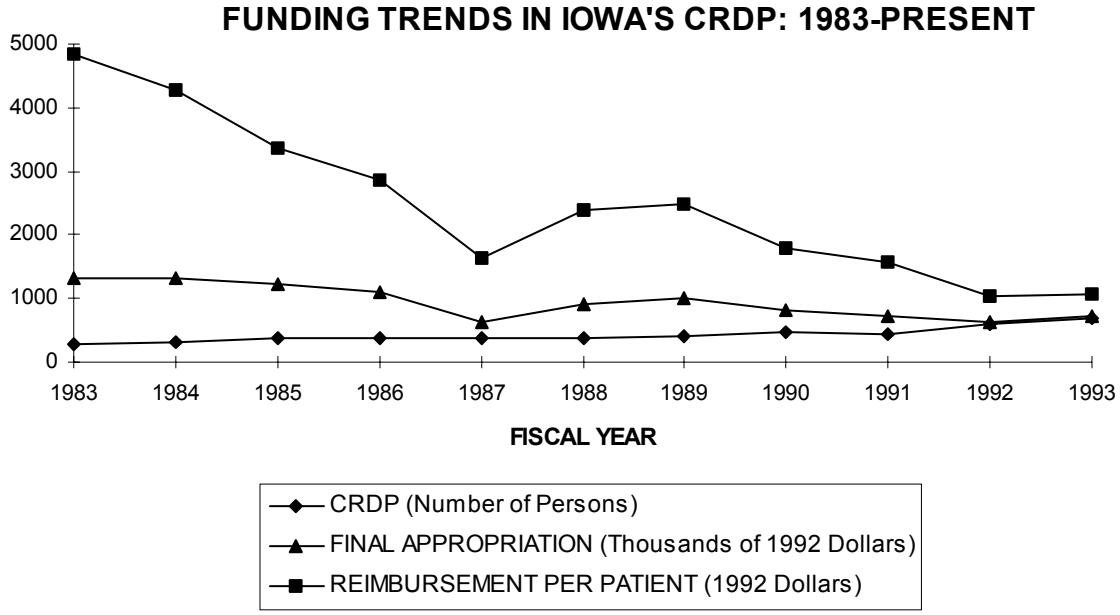
As funding has declined, administrators have chosen to eliminate some of the CRDP's services and while reducing reimbursement levels for other services. Another alternative would be to adopt changes in the means test. Currently, applicants with incomes less than 250% of the poverty level can expect some level of reimbursement. The choice is whether to reduce the number of patients in the program or the reimbursement levels to each patient. Currently, the latter option is utilized.

BUDGET IMPACT

Currently 685 patients are enrolled in the CRDP. The Program processed 488 applications in FY 1991 and 666 in FY 1992. A total of 5,912 claims were processed in FY 1991 and 6,076 in FY 1992. Evidence suggests that budgetary pressure will continue to rise due to expected growth in the number of ESRD patients statewide. The Institute of Medicine's 1991 report "Kidney Failure and the Federal Government" lists glomerulonephritis, diabetes, and hypertension as the major diseases causing kidney failure. As therapy for these diseases has expanded, early death has, and will probably continue to be prevented. Thus, there is a natural expectation of increasing numbers of ESRD patients. The Institute of Medicine's report predicts the number of ESRD patients under treatment will increase by nearly 70% in the current decade. The following chart illustrates the growth in the number of Iowans with ESRD.



As resources have fallen relative to the rise in the ESRD population, the number of patients serviced by the CRDP has increased. As indicated, rather than reducing the number of patients enrolled in the Program, services for each patient have been scaled back. In addition, rising health care costs place a further demand on the available funds. As a result reimbursements per patient have steadily declined over the last 10 years. The following chart illustrates the monetary effect the changes in the CRDP have had on the Program's participants. (Note: dollar amounts are expressed in 1992 dollars).



To stay within the Program Budget, the following services have not been covered since the third quarter of FY 1991: hospital, medical, home dialysis supplies, lodging, and home dialysis assistants. Reimbursement for the remaining services (pharmaceuticals, travel, and insurance) were cut from 85% to 75% in FY 1992. Future reductions in spending would likely be percentage cuts in reimbursement levels for the remaining services.

To return to a FY 1989 level of reimbursement per patient, the Program's annual budget would need to be approximately $1.7 million. This would represent a real increase of $960,000 (131.5%) over the FY 1993 final appropriation of $730,000. Due to medical costs increasing at nearly twice the rate of the general price level, the Program's annual budget will have to increase more than $2.2 million in FY 1994 if clients are to receive benefits comparable to those received in FY 1989.

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