Read for yourself.
Proposition 8. Dangerous Dialysis Proposition.

Below is the full text of Proposition 8, the Dangerous Dialysis Proposition. We've highlighted portions of text to demonstrate how and why Prop. 8 will endanger the lives of vulnerable dialysis patients. The initiative sets severely low limits on what insurance companies are required to pay for dialysis care. These limits do not cover the cost of providing care, forcing many clinics to cut back services or even close. This will jeopardize access to care for dialysis patients, putting their lives at risk.

SEC. 3. Section 1226.7 is added to the Health and Safety Code, to read:

1226. 7. (a) Reasonable limits on charges for patient care by chronic dialysis clinics; rebates of amounts charged in excess of fair treatment payment amount.

(1) For purposes of this section, the "fair treatment payment amount" shall be an amount equal to 115 percent of the sum of all direct patient care services costs and all health care quality improvement costs incurred by a governing entity and its chronic dialysis clinics.

(2) For each fiscal year starting on or after January 1, 2019, a governing entity or its chronic dialysis clinics shall annually issue rebates to payers as follows:

(A) The governing entity shall calculate the "unfair excess charged amount," which shall be the amount, if any, by which treatment revenue from treatments provided by all of the governing entity's chronic dialysis clinics exceeds the fair treatment payment amount.

(B) The governing entity or its chronic dialysis clinics shall, on a pro rata basis based on the amounts paid and reasonably estimated to be paid, as those amounts are included in treatment revenue, issue rebates to payers (other than Medicare or other federal, state, county, city, or local government payers) in amounts that total the unfair excess charged amount.

(C) The governing entity or chronic dialysis clinic shall issue any rebates required by this section no less than 90 days and no more than 210 days after the end of its fiscal year to which the rebate relates.

(D) Where, in any fiscal year, the rebate the governing entity or chronic dialysis clinic must issue to a single payer is less than twenty dollars ($20), the governing entity or chronic dialysis clinic shall not issue that rebate, and shall provide to other payers in accordance with subparagraph (B) the total amount of rebates not issued pursuant to this subparagraph.

(E) For each fiscal year starting on or after January 1, 2020, any rebate issued to a payer shall be issued together with interest thereon at the rate of interest specified in subdivision (b) of Section 3289 of the Civil Code, which shall accrue from the date of payment by the payer.

Requires community dialysis clinics to issue annual "rebates" to health insurance companies. In effect, this provision limits what health insurance companies are required to pay for dialysis care in California.

These limits do not cover the cost of providing care, forcing many clinics to cut back services or even close. This will jeopardize access to care for dialysis patients, putting their lives at risk.

The initiative's arbitrary limits and rebate provisions only apply to private health insurance and other private payers. They exclude government payers such as Medicare, Medi-Cal, CalPERS, cities, counties, school districts and other state and local government providers of health benefits that cover 90% of all dialysis patients in California.

Insurance companies are allowed to keep the rebates. There is no language in the initiative whatsoever requiring insurance companies to pass the rebates to consumers or employers to offset insurance costs.

Allows insurance companies to receive 10% interest on top of rebate payments from dialysis clinics.

(3) For each fiscal year starting on or after January 1, 2019, a governing entity shall maintain and provide to the department, on a form and schedule prescribed by the department, a report of all rebates issued under paragraph (2), including a description of each instance during the period covered by the submission when the rebate required under paragraph (2) was not timely issued in full, and the reasons and circumstances therefor. The chief executive officer or principal officer of the governing entity shall certify under penalty of perjury that he or she is satisfied, after review, that all information submitted to the department under this paragraph is accurate and complete.

New bureaucratic reporting requirements mandate that each individual clinic complete a form detailing all charges, rebates to insurance companies and the reasons therein. Requires Department of Public Health to review hundreds of filings every year at a cost of "millions of dollars" each year, according to the State Legislative Analyst. <u>None of these reports relate to quality of care provided.</u>

(4) In the event a governing entity or its chronic dialysis clinic is required to issue a rebate under this section, no later than 210 days after the end of its fiscal year the governing entity shall pay a penalty to the department in an amount equal to five percent of the unfair excess charged amount, provided that the penalty shall not exceed one hundred thousand dollars ($100,000). Penalties collected pursuant to this paragraph shall be used by the department to implement and enforce laws governing chronic dialysis clinics.

On top of the required 10% interest payment to insurance companies, initiative also requires another 5% penalty on community dialysis clinics if they exceed the limit. Penalties can reach $100,000 per violation.

(5) If a chronic dialysis clinic or governing entity disputes a determination by the department to assess a penalty pursuant to this subdivision or subdivision (b), or the amount of an administrative penalty, the chronic dialysis clinic or governing entity may, within 10 working days, request a hearing pursuant to Section 131071. A chronic dialysis clinic or governing entity shall pay all administrative penalties when all appeals have been exhausted and the department's position has been upheld.

(6) If a governing entity or chronic dialysis clinic proves in any court action that application of this section to the chronic dialysis clinic or governing entity will, in any particular fiscal year, violate due process or effect a taking of private property requiring just compensation under the Constitution of this State or the Constitution of the United States, the provision at issue shall apply to the governing entity or chronic dialysis clinic, except that as to the fiscal year in question the number "115" whenever it appears in the provision at issue shall be replaced by the lowest possible whole number such that application of the provision to the governing entity or chronic dialysis clinic will not violate due process or effect a taking of private property requiring just compensation. In any civil action, the burden shall be on the governing entity or chronic dialysis clinic to propose a replacement number and to prove that replacing "115" with any whole number lower than the proposed replacement number would, for the fiscal year in question, violate due process or effect a taking of private property requiring just compensation.

Though the initiative acknowledges it's provisions could be interpreted as an unconstitutional taking of private property, it offers no process for relief from a confiscatory price setting except filing lawsuits every year in court. Thus, hundreds dialysis clinics in California will be forced to seek judicial relief in the courts year-after-year, clogging the court system.

(b) Compliance reporting by chronic dialysis clinics.

(1) For each fiscal year starting on or after January 1, 2019, a governing entity shall maintain and submit to the department a report concerning the following information for all of the chronic dialysis clinics the governing entity owns or operates in California-

Excessive bureaucratic reporting requirements that add to California Department of Health administrative costs and responsibilities yet <u>none are related to quality of care provided.</u>

(A) the number of treatments performed;

(B) direct patient care services costs;

(C) health care quality improvement costs;

(D) treatment revenue, including the difference between amounts billed but not yet paid and estimated realizable revenue;

(E) the fair treatment payment amount;

(F) the unfair excess charged amount;

(G) the amount, if any, of each payer's rebate, provided that any individual patient shall be identified using only a unique identifier that does not reveal the patient's name or identity; and

(H) a list of payers to whom no rebate was issued pursuant to subparagraph (D) of paragraph (2) of subdivision (a) and the amount not issued, provided that any individual patient shall be identified using only a unique identifier that does not reveal the patient's name or identity.

(2) The information required to be maintained and the report required to be submitted by this subdivision shall each be independently audited by a certified public accountant in accordance with the standards of the Accounting Standards Board of the American Institute of Certified Public Accountants, and shall include the opinion of that certified public accountant as to whether the information contained in the report fully and accurately describes, in accordance with generally accepted accounting principles in the United States, the information required to be reported under paragraph (1).

(3) The governing entity shall annually submit the report required by this subdivision to the department on a schedule, in a format, and on a form prescribed by the department, provided that the governing entity shall submit the information no later than 210 days after the end of its fiscal year. The chief executive officer or other principal officer of the governing entity shall certify under penalty of perjury that he or she is satisfied, after review, that the report submitted to the department under paragraph (1) is accurate and complete.

(4) In the event the department determines that a chronic dialysis clinic or governing entity failed to maintain the information or timely submit a report required under paragraph (1) of this subdivision or paragraph (3) of subdivision (a), or that the amounts or percentages reported by the chronic dialysis clinic or governing entity under paragraph (1) of this subdivision were inaccurate or incomplete, or that any failure by a chronic dialysis clinic or governing entity to timely issue in full a rebate required by subdivision (a) was not substantially justified, the department shall assess a penalty against the chronic dialysis clinic or governing entity not to exceed one hundred thousand dollars ($100,000). The department shall determine the amount of the penalty based on the severity of the violation, the materiality of the inaccuracy or omitted information, and the strength of the explanation, if any, for the violation. Penalties collected pursuant to this paragraph shall be used by the department to implement and enforce laws governing chronic dialysis clinics.

(c) Definitions.

For purposes of this section:

(1) "Direct patient care services costs" means those costs directly associated with operating a chronic dialysis clinic in California and providing care

Clinics would be required to submit, and the Department of Public Health required to review on an annual basis, the following:

- **Number of treatments provided**
- **Costs of providing care**
- **Amount billed for care**
- **What the initiative categorizes as allowable charges**
- **Amount of rebates to insurance companies**
- **List of payers that are not eligible**

More potential fines against community clinics ranging up to $100,000 each.

to patients in California. Direct patient care services costs shall include, regardless of the location where each patient undergoes dialysis, only (i) salaries, wages, and benefits of non-managerial chronic dialysis clinic staff, including all clinic personnel who furnish direct care to dialysis patients, regardless of whether the salaries, wages, or benefits are paid directly by the chronic dialysis clinic or indirectly through an arrangement with an affiliated or unaffiliated third party, including but not limited to a governing entity, an independent staffing agency, a physician group, or a joint venture between a chronic dialysis clinic and a physician group; (ii) staff training and development; (iii) pharmaceuticals and medical supplies; (iv) facility costs, including rent, maintenance, and utilities; (v) laboratory testing; and (vi) depreciation and amortization of buildings, leasehold improvements, patient supplies, equipment, and information systems. For purposes of this section, "non-managerial chronic dialysis clinic staff" includes all clinic personnel who furnish direct care to dialysis patients, including nurses, technicians and trainees, social workers, registered dietitians, and non-managerial administrative staff, but excludes managerial staff such as facility administrators. Categories of direct patient care services costs may be further prescribed by the department through regulation.

(2) "Governing entity" means a person, firm, association, partnership, corporation, or other entity that owns or operates a chronic dialysis clinic for which a license has been issued, without respect to whether the person or entity itself directly holds that license.

(3) "Health care quality improvement costs" means costs, other than direct patient care services costs, that are related to the provision of care to chronic dialysis patients and that are actually expended for goods or services in California that are required to maintain, access or exchange electronic health information, to support health information technologies, to train nonmanagerial chronic dialysis clinic staff engaged in direct patient care, and to provide patient centered education and counseling. Additional costs may be identified by the department through regulation, provided that such costs are actually spent on services offered at the chronic dialysis clinic to chronic dialysis patients and are spent on activities that are designed to improve health quality and to increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(4) "Payer" means the person or persons who paid or are financially responsible for payments for a treatment provided to a particular patient, and may include the patient or other individuals, primary insurers, secondary insurers, and other entities, including Medicare and any other federal, state, county, city, or other local government payer.

(5) "Treatment" means each instance when the chronic dialysis clinic provides services to a patient.

(6) "Treatment revenue" for a particular fiscal year means all amounts actually received and estimated realizable revenue for treatments provided in that fiscal year. Estimated realizable revenue shall be calculated in accordance with generally accepted accounting principles, and shall be a reasonable estimate based on (i) contractual terms for patients covered under commercial healthcare plans with which the governing entity or clinics have formal agreements; (ii) revenue from Medicare, Medicaid, and Medi-Cal based on rates set by statute or regulation, and estimates

The initiative's initiative's definition of allowable costs that can be billed to private health insurers are labeled as "patient care services costs" and "healthcare quality improvement costs." According to the Berkeley Research Group, these allowable costs only account for 69% of the average clinic's total operating costs. As a result, even with the 115% limit, the initiative would force the overwhelming majority of clinics (83%) to operate at a loss.

This is restrictive because the initiative's definition of allowable costs excludes necessary costs of providing high quality patient care in a dialysis clinic as well as some expenses required by federal regulators, including:

- **physician medical director (required by federal regulator CMS)**
- **nurse clinical coordinators/ managers**
- **regulatory compliance**
- **facility administrators**
- **community-based kidney disease education**
- **staff who help patients navigate complicated insurance options**
- **facility security**
- **human resources**
- **payroll and accounting**
- **legal services**
- **insurance**

of amounts ultimately collectible from government payers, commercial healthcare plan secondary coverage, patients, and other payers; and (iii) historical collection experience.

SEC. 4. Section 1226.8 is added to the Health and Safety Code, to read:

1226.8 (a) A chronic dialysis clinic shall not discriminate with respect to offering or providing care, and shall not refuse to offer or provide care, to patients on the basis of the payer for treatment provided to a patient, including but not limited to on the basis that the payer is a patient, private payer or insurer, Medi-Cal, Medicaid, or Medicare.

(b) A chronic dialysis clinic shall not terminate, abridge, modify, or fail to perform under any agreement to provide services to patients covered by Medi-Cal, Medicaid, or Medicare on the basis of requirements imposed by this chapter.

SEC. 5. Section 1266.3 is added to the Health and Safety Code, to read:

1266. 3. It is the intent of the People that California taxpayers not be financially responsible for implementation and enforcement of the Fair Pricing for Dialysis Act. In order to effectuate that intent, when calculating, assessing, and collecting fees imposed on chronic dialysis clinics pursuant to Section 1266, the department shall take into account all costs associated with implementing and enforcing Sections 1226.7 and 1226.8.

SEC. 6. Nothing in this act is intended to affect health facilities licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code.

SEC. 7. The State Department of Public Health shall issue regulations necessary to implement this act no later than 180 days following its effective date.

SEC. 8. Pursuant to subdivision (c) of Section 10 of Article II of the California Constitution, *this Act may be amended either by a subsequent measure submitted to a vote of the people at a statewide election; or by a statute validly passed by the Legislature and signed by the Governor, but only to further the purposes of the Act.*

SEC. 9. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

The initiative's flaws can only be amended by another vote of the people. The Legislature or regulators cannot fix fundamental flaws because the initiative requires all changes to "further the purpose". This provision severely restricts any modifications that might be needed in the future to address problems restricting access to care for vulnerable patients.

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