

Ensuring Equitable Access to Dialysis: The Medicare Secondary Payer Act in *Marietta Memorial Hospital Employee Health Benefit Plan v. DaVita, Inc.*

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Although Medicare provides near-universal coverage for ESKD treatment in the United States, private insurers account for much of the profit margins of dialysis companies.¹ This arrangement, which influences the distribution and availability of dialysis throughout the country,² rests on the Medicare Secondary Payer Act. The act envisions a scheme in which private insurers typically cover the first 30 months of dialysis, with Medicare becoming the primary insurer thereafter. On June 21, 2022, the Supreme Court decided *Marietta Memorial Hospital Employee Health Benefit Plan v. DaVita, Inc.*, which alters the terms of this long-standing arrangement in ways that could affect the availability of dialysis to marginalized, underserved, and rural populations. Although *Marietta Health Benefit Plan* has been overshadowed by higher-profile recent Supreme Court cases involving abortion, vaccine mandates, and religious freedom, the case highlights the unique challenge of paying for ESKD care. Policy makers must respond to the decision to ensure that the ESKD payment scheme protects access to dialysis for all populations.

BACKGROUND

In 1981, in an effort to rein in rising Medicare costs, Congress passed an amendment

extending the Medicare Secondary Payer Act to dialysis. Under the act, employer- or union-sponsored group plans—the source of health insurance for most Americans—were presumed to be the primary payer for the first year of dialysis, although later amendments would extend this period to its current 30 months. Importantly, however, Congress never explicitly required that a patient with ESKD remain on private insurance for the first 30 months of dialysis nor did it require that private insurers provide specified benefits, treatment modalities, or particular reimbursement rates. Instead, the law mandated that during the initial 30-month period, private insurance plans neither “differentiate” between patients with ESKD and patients without ESKD nor “take into account” Medicare entitlement in coverage decisions. Medicare subsequently interpreted the mandates to allow limitations in dialysis benefits that apply to every beneficiary.^{3,4}

The mandates were the subject of *Marietta Health Benefit Plan*. The *Marietta Health Benefit Plan* treated all dialysis providers as out of network and limited payments to dialysis units to 87.5% of the Medicare rate—far lower than the reimbursement rates private insurers usually pay, which can be three to four times the Medicare rate.¹ DaVita objected, arguing that the plan provisions discriminated against patients with ESKD in violation of the Medicare

Secondary Payment Act by failing to provide beneficiaries any in-network option for dialysis care and exposing them to higher deductibles and copays. The Sixth Circuit Court of Appeals agreed with DaVita, citing the plan provisions’ disparate effect on patients with ESKD. However, in a similar case a few months later, the Ninth Circuit reached the opposite conclusion, creating a circuit split and prompting the Supreme Court to take up the case.

RULING AND IMPLICATIONS

The Supreme Court, in an opinion written by Justice Kavanaugh, sided with the health plans. The opinion focused on a simple question. Did plan benefits depend on ESKD status or Medicare eligibility? The court found that they did not; every member received the same dialysis benefits. The Medicare Secondary Payer Act does not mandate a specific level of coverage for dialysis; it merely requires that patients with ESKD

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are not treated differently than other beneficiaries. Indeed, even though Congress can and does write coverage mandates throughout the Medicare statute, it chose not to do so here. To the court, it was irrelevant that limiting dialysis benefits will disparately affect patients with ESKD more than patients with AKI or other patients. However, a dissent by Justice Kagan joined by Justice Sotomayor focused on the fact that limiting dialysis coverage is a near-perfect proxy for differentiating between patients with ESKD and others.

Whether the court's decision reflects a sound legal interpretation of the Medicare Secondary Payer Act, it is poised to drastically affect the delivery of dialysis. One likely effect of limiting private insurance benefits for patients with ESKD will be to shift patients onto the Medicare rolls earlier in their treatment, presenting financial challenges for dialysis units. Because Medicare reimbursement for ESKD dialysis services is often break-even,¹ the business models of dialysis units depend on private insurance payments to ensure their profitability. This situation is magnified for smaller, more independent units as they do not have access to economies of scale, so even small decreases of aggregate payment may threaten their viability.

The court's decision in favor of insurers could promote further consolidation in the dialysis industry. Falling Medicare reimbursement has already been associated with dialysis unit consolidation,⁵ which disproportionately affects marginalized populations.⁶ Lower per-person reimbursement would mean that more patients would have to be dialyzed to keep the facility open. If this happens, dialysis companies would likely prioritize units in larger cities or central locations with larger catchment areas to maximize revenues to the detriment of smaller and rural units. Because increasing distance to units has been linked to higher ESKD mortality and some patients may opt to forgo dialysis care than travel longer distances,⁷ such consolidation could have devastating effects for patients with ESKD.

THE PATH FORWARD

There are at least three policy responses that could help protect patients with ESKD.

First, Congress could intervene in dialysis markets. Any reform would require balancing two competing concerns. Dialysis providers argue that private insurers need to pay more than Medicare rates to ensure that providers can be viable business concerns, and insurers argue that they are constrained in negotiating when two large players dominate the dialysis market. Congress could strike a balance by mandating that employer health plans provide certain levels of coverage during an initial period of dialysis while shortening that period to less than its current 30 months to limit plan expenditures.

Other proposed reforms, such as reimbursement caps or tying private insurance rates to Medicare reimbursement, would likely be politically contentious or too blunt a tool to account for differences between markets, care settings, and populations. For instance, California's attempt to cap dialysis reimbursement for a subset of patients has been held in federal court for over 2 years. An attempt to tie private insurance rates to Medicare reimbursement is already under way as Medicare Advantage expands to patients with ESKD, but insurers have had difficulty using that limited reimbursement to cover beneficiaries, negotiate with dialysis providers, and ensure that other beneficiaries maintain their coverage.^{8,9}

Second, Congress or Medicare could directly address the provision of dialysis to marginalized, underserved, and rural areas through targeted grant programs or increased reimbursement. Medicare already accounts for underserved and rural areas as well as competition in the dialysis market in setting annual reimbursements for the ESKD program, although Medicare's pilot payment programs (e.g., the Kidney Care Choices Model, the home

dialysis/transplant mandator pilot, and Comprehensive ESRD Care) are not as focused on these goals.⁹ As such, Congressional mandates with additional funding could be used to refocus these programs and ensure that Medicare payment promotes dialysis expansion in underserved areas by targeting funding.

Third, states and localities can provide additional support. Although the Medicare ESKD program has made much of dialysis policy a federal matter, states have a role both in promoting competition and in protecting their populations. Local authorities raise the barriers to opening up new and smaller units with certificates of need, licensing requirements, and other state requirements. This is not to say that such regulations are wholly unnecessary, but these regulatory bottlenecks disproportionately affect smaller providers, favoring larger chains with the wherewithal to navigate red tape. Considering that smaller, independent dialysis units provide disproportionate care in underserved areas,² targeted programs to lower regulatory barriers, secure funding, and encourage facilities to open in underserved areas can help limit the fallout from federal policy changes.

As payors attempt to find new ways to pay for this essential care, *Marietta Health Benefit Plan* reminds us of the link between dialysis payment and dialysis distribution and availability. Patients with ESKD are some of the nation's sickest and often, most marginalized. Coverage policy can work to ensure that these patients receive the care they need.

DISCLOSURES

J.D. Glickman reports consultancy with CVS Renal; honoraria from Home Dialysis University (International Society for Peritoneal Dialysis) and UpToDate; and an advisory or leadership role with Cricket Health. All remaining authors have nothing to disclose.

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AUTHOR CONTRIBUTIONS

J.D. Glickman, G. Maliha, and M.S. McCoy conceptualized the study; G. Maliha wrote the

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