February 9, 2024

The Honorable Cathy McMorris Rodgers
Chairwoman
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Jason Smith
Chairman
House Ways and Means Committee
1139 Longworth House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Ways and Means Committee
1139 Longworth House Office Building
Washington, DC 20515

Dear Chairwoman Rodgers, Chairman Smith, and Ranking Members Pallone and Neal:

The undersigned groups – plan sponsors and providers of health coverage for millions of Americans – oppose H.R. 6860, the *Restore Protections for Dialysis Patients Act*. We urge you and other members of the House to refrain from supporting this unnecessary bill that would increase costs for employers and employees without improving the quality of dialysis services.

Employers are strongly committed to our health plan participants and fulfill robust coverage requirements and protections for individuals with end-stage renal disease (ESRD) pursuant to the Medicare Secondary Payer (MSP) Act and its regulatory requirements. We believe recent case law reiterates these existing obligations and preserves the status quo as it relates to protections for individuals with ESRD. However, proponents of H.R. 6860 assert that the U.S. Supreme Court decision in *Marietta Memorial Health Benefit Plan v. Davita Inc* somehow changed these long-standing requirements, altering how employers as plan sponsors comply with the law. To be clear, the *Marietta* decision did not change the relationship between patients, employer-sponsored coverage, and dialysis providers. The decision merely reaffirmed that the MSP Act is a coordination of benefits statute.[1]

The facts are that under the MSP Act, an individual who is determined to have ESRD becomes eligible for Medicare. Employers provide primary coverage (and Medicare secondary coverage) for these individuals for the first 30 months after the determination is made. Once this 30-month period ends, or an individual is no longer employed or eligible for employer-sponsored coverage, then Medicare becomes primary. When Medicare is the secondary payer, it will only pay for

[1] Because the Centers for Medicare and Medicaid Services ("CMS") have consistently interpreted the MSP Act as a coordination of benefits statute, the existing regulatory and enforcement bodies at CMS tasked with enforcing the MSP Act lack the resources and structure necessary to actually implement these parity requirements, leaving private litigation as the primary enforcement tool for the provisions of H.R. 6860.

services if the primary payer reimburses the provider less than the Medicare reimbursement rate for the service.

Additionally, the MSP Act, together with ERISA, HIPAA and the ACA already protect patients by prohibiting discriminatory plan designs and actions, making H.R. 6860 unnecessary. These prohibitions:

- prohibit the termination of coverage for individuals with ESRD, when there is no basis for doing so unrelated to ESRD;
- prohibit the termination of coverage because a patient has become eligible for Medicare;
- prohibit refusing to enroll an individual because they are Medicare eligible;
- prohibit the imposition of benefit limitations on dialysis for individuals with ESRD, but not other individuals requiring dialysis;
- prohibit failing to cover routine maintenance dialysis or kidney transplants when the plan covers other dialysis services or other organ transplants;
- prohibit failing to pay primary benefits;
- prohibit charging Medicare-eligible individuals higher premiums;
- prohibit paying providers less for Medicare-eligible patients than for a non-Medicare-eligible patients.[2]

H.R. 6860 goes beyond the statutory intent of the litany of laws including the MSP Act, ERISA, HIPAA, and the ACA regarding the coordination of benefits preserved under *Marietta* by creating an ill-defined parity mandate[3] for dialysis benefits versus other disease states. Employers believe that health care dollars, both paid by plans and participants, should be spent on improving the health and wellbeing of their employees and improving access to care, not in defending regulatory compliance audits and litigation that is designed not to improve outcomes or the delivery of dialysis services, but to protect a primary revenue stream of dialysis providers. More regulation and litigation will be required to judge coverage and reimbursements between conditions[4], further increasing the cost of coverage without increasing the availability of coverage[5].

Contrary to the assertions of the bill's proponents, most dialysis coverage is in-network for employer plans. In fact, where it is not, dialysis providers are reimbursed at out-of-network rates,

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[2] Reference: 42 CFR 411.108(a) (1-3) and (5-11). 42 CFR 411.161(b)(2).
[3] H.R. 6860 exacerbated the parity problem in prior bills by expanding the definition of "differentiate" by including the undefined words "directly or indirectly." This could mean anything – and thus lead to additional regulation and litigation. [H.R. 6860, Sec. 3 (1)(ii)]
[4] Possibly beyond conditions requiring dialysis services.
5 By focusing exclusively on "provider networks" [Sec. 3 (2)] H.R. 6860 would interfere with ERISA and ERISA plans' ability to employ innovative approaches to reduce health care costs such as cash pay agreements and reference-based pricing.

normally much higher than what Medicare pays. An analysis[6] in JAMA Internal Medicine found that median dialysis price for dialysis paid by employer plans was 6 times that of the highest Medicare rate during the period ($1,476 vs. $240). This adds up to $230,256 each year for a privately insured patient versus $37,440 for one on Medicare.

Moreover, because the "parity" requirement at the heart of H.R. 6860 remains so vague, and the manner in which that requirement will apply so uncertain, Congress risks the potential for employer-sponsored coverage to either reduce benefits for other disease states, or, and just as importantly, eliminate the innovation and value-based insurance design that has been at the heart of the employer-sponsored health system for decades. This loss of innovation could occur because new care management and incentive programs applicable to non-dialysis services could either be impossible or inapplicable to dialysis services, thus limiting plans' ability to innovate and promote high-quality, low-cost health coverage.

While we recognize the concerns expressed by dialysis providers regarding shortfalls in their Medicare payments, it is inappropriate to shift any Medicare underpayments further onto employers and the millions of employees who receive employer sponsored health insurance coverage. We ask instead that Congress consider how to better, more transparently reimburse dialysis providers under Medicare to address their financial concerns.

As *Marietta* affirmed, the MSP requirements are working as intended. Additional legislation is not warranted and would only impose an additional strain on employers' ability to offer and employees to enroll in affordable health coverage. As such, the undersigned organizations strongly oppose this legislation. Thank you for your attention to our concerns on this important issue.

Sincerely,

[Signatures Below]

cc: The Honorable Mike Johnson
Speaker

The Honorable Hakeem Jeffries
Minority Leader

Members, U.S. House of Representatives

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[6] **Variability in Prices Paid for Hemodialysis by Employer-Sponsored Insurance in the US From 2012 to 2019,** Riley J. League, MA; Paul Eliason, PhD; Ryan C. McDevitt, PhD; et al, JAMA Network Open, February 28, 2022. doi:10.1001/jamanetworkopen.2022.0562

Signatory Organizations

American Benefits Council

American Health Policy Institute

Business Group on Health

Corporate Health Care Coalition (CHCC)

HR Policy Association

National Association of Benefits and Insurance Professionals

National Coalition on Benefits

Partnership for Employer-Sponsored Coverage (P4ESC)

The ERISA Industry Committee

The Self-Insurance Institute of America (SIIA)

U.S. Chamber of Commerce

Warner Pacific