PARTNERSHIP FOR EMPLOYER-SPONSORED COVERAGE

# Oppose Dialysis Industry Bills

Employers provide broad coverage to employees, including dialysis services if needed. This dialysis coverage is governed under the Medicare Secondary Payer Act. Most employer-provided dialysis coverage is in-network. In some cases, where a dialysis provider refuses to participate in-network at the offered reimbursement rate or there are quality issues, the dialysis provider is reimbursed at a lower out-of-network rate, which is generally still higher than what Medicare pays. Employees face no barriers to dialysis coverage.

The dialysis market is highly concentrated, with only two major dialysis providers. The Partnership for Employer-Sponsored Coverage (P4ESC) opposes legislation (e.g., the *Restore Protections for Dialysis Patients Act*) that seeks to extend their market dominance through federal law by manipulating plan designs. If successful, this legislation would likely create a roadmap for similar efforts by other providers that care for chronic conditions.

## Solutions

P4ESC urges Members of Congress to oppose dialysis legislation, such as the *Restore Protections for Dialysis Patients Act*. Despite the deceptive bill title, there is no evidence that employees actually lack access to dialysis services on either an in-network or out-of-network basis. The only question is how much the dialysis company will be reimbursed.

Congress might consider a study to identify more clearly the vast gap between the dialysis company claims and reality.

## Background

Employers are strongly committed to our obligations under the Medicare Secondary Payer Act for end-stage renal disease (ESRD) patients. We believe that the proposed legislation would create an unnecessary coverage mandate with overly vague and unworkable parity requirements that would create confusion, spur wasteful spending and disputes, reduce quality, and increase costs to employees and employer plans.

Proponents of this legislation misinterpret the U.S. Supreme Court case on dialysis coverage. The Court held in June 2022 in *Marietta Memorial Hospital Employee Health Benefit Plan v. Davita Inc.*[1] that health plan network status (i.e., in- or out-of-network) and thus reimbursement for coverage of dialysis does not in itself violate the Medicare Secondary Payer Act. Employer

[1] *Marietta Memorial Hospital Employee Health Benefit Plan v. Davita Inc.*, 596 U.S. ___ (2022)

health plans in fact cover dialysis treatment without regard to the existence of secondary coverage under Medicare.

Employer plans seek to provide broad coverage and deploy a range of cost containment and care management mechanisms to provide that coverage. In-network coverage is preferred because reimbursement rates are negotiated and patient outcomes are often measured, which leads to improved quality of care. Coverage varies based on treatment modality and location. For example, treatment and coverage for lower back pain, treated in an in-patient facility, differs from coverage for diabetes care, treated in a physician's office. There can be no uniform parity comparator because there is not uniform reimbursement rate among covered conditions.

In *Marietta*, the employer-sponsored benefit plan had a three-tier network with the highest tier 1 reimbursement reserved for the hospital's own medical providers (including in-house dialysis treatment). Davita – covered in-network at the lower tier 2, but not a Marietta Memorial Hospital provider – sought that very highest (tier 1) level of reimbursement and litigated to get it. The Supreme Court rightly rejected this proposition because in-network, highest level reimbursement (far beyond what Medicare pays) is not and should not be a legal requirement. Instead, it is appropriately a function of negotiations between the plan and the provider. Moreover, we note the circumstances in *Marietta* are highly unusual. Most U.S. employers cannot provide their own medical providers to treat their own employees and family members as hospitals can.

As published[2] between 2012-2019, employer plans reimbursed dialysis providers at a median price of $1,476 for a single dialysis session. Medicare reimbursed $240 for that same session, approximately one-sixth of what private plans paid. This legislation would further compound this disparity and not meaningfully benefit patients whose plans are already providing robust, compliant coverage.

P4ESC remains deeply concerned that this legislation has not been heard in committee. Committee review and debate is needed to consider a diversity of stakeholder views and tailor the focus of any proposals to avoid inequities and unintended consequences. We strongly urge that this legislation not be brought up for a vote or offered as an amendment to another bill without the necessary committee review.

[2] **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