“A Win for Employers”

STATEMENT by the SAGAMORE INSTITUTE CENTER FOR HEALTHCARE AFFORDABILITY on the SUPREME COURT RULING RELEASED IN:

Marietta Memorial Hospital Employee Health Benefit Plan et al. v DaVita Inc. et al.
596 US 20-1641 June 21, 2022

The June 21, 2022 ruling in this case is a win for employers and health insurance plan managers, a win for free market economics in health insurance, and a win for the affordability of health insurance.

THE MATTER AND THE RULING

The legal issue in this case is that DaVita accused the Marietta Memorial Hospital Employee Health Benefit Plan (Marietta) of violating the Medicare Secondary Payer Act’s (“MSP”, 1980-1981) requirement that a health benefits plan, “may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan” so as to provide an incentive for individuals to drop coverage in an employer-sponsored health benefits plan and enroll in Medicare. As a secondary issue, DaVita claimed that this practice also amounted to prohibited “taking into account that an individual is entitled to or eligible for Medicare” due to end stage renal disease (ESRD).

The legal issue was cover for the economic issue that drove this case. Always follow the money. DaVita provides dialysis services, and filed this lawsuit because the Marietta plan did not pay DaVita’s bills at its billed rate. Instead, Marietta followed a common health insurance industry protocol of reducing the billed amount to a number that is based on the Medicare allowable amount for the service (125% of the Medicare allowable rate), and paid benefits based on that adjusted “allowable charge”. [There are other cases similar, and the Court aggregated two that received differing rulings at Appeals Courts, in order to address and settle the issues.]

Prior to MSP, most individuals enrolled in Medicare upon turning 65, and employer plans commonly had an eligibility age limit, which meant that cost of health insurance for the “working aged” over 65 was paid by the federal government. Individuals with ESRD can also qualify for Medicare. As a matter of new public policy, the Medicare Secondary Payer Act shifted that cost of health insurance for the working aged and those working with ESRD to the private sector. MSP prohibited employer plans from creating incentives for those individuals to enroll in Medicare.

Medicare covers 90% of the people of all ages with end stage renal disease (kidney failure), the most common reason people seek dialysis service in the US, while the private sector covers 10%. Thus, fully 90% of patient services for dialysis are paid at Medicare’s fixed ‘allowable rate’. That rate is acceptable to DaVita for 90% of its bills. *So one would imagine that DaVita would not object much to receiving 125% of the Medicare rate for its remaining 10% of patients.*

The vast majority of dialysis patients have end stage renal disease. Less than 1% of DaVita’s dialysis patients need the service for another reason (such a kidney injuries).

The Court correctly observed that dialysis and end stage renal disease are not, therefore, completely mutually inclusive, since some patients have another reason for dialysis. Further, not all end stage renal disease patients are eligible for Medicare. And no plan language made distinction between covered

individuals who had end stage renal disease and those who did not; nor did any plan language make a distinction in benefits payable between people who were eligible for Medicare and those who were not.

The Court ruled that the health plan did not violate the Medicare Secondary Payer Act, because the Marietta plan's benefits for dialysis apply uniformly to all covered persons, whether they have end stage renal disease or not, and whether they are eligible for Medicare or not.

The ruling of the Court was written by Justice Kavanaugh, joined by Chief Justice Roberts, Justices Thomas, Breyer, Alito, Gorsuch and Barrett. Justice Kagan filed a dissent in part, in which Justice Sotomayor joined. You can find the ruling at: SupremeCourt.gov/opinions/slipopinion/21

We believe that the Court got this ruling right, both in terms of the law, and in terms of supporting sound free market principles in America.

MARKET ISSUES

Free market competition produces price and quality competition for consumers.

DaVita is one of the dominant providers of dialysis services, with 37% market share. Its largest competitor (Fresenius) has 38% market share. With 75 % market share for dialysis services held by two companies, this oligopoly stifles free market competition, and engages in fee gouging private health insurance plans that account for 10% of patients, yet account for 33% of revenues (2017 data, DaVita). This is consistent with research data from multiple sources that shows that private sector plans commonly pay 3-5 times the rate Medicare pays for the same service.

Nobody wants to pay 3 or 5 times the price that 90% of other customers pay for the same service.

Whether health insurance plans had freedom to curb those price abuses is what this case was really about. This case was a ruse by DaVita to claim that the reason its bills to the private sector were not being paid at outrageously inflated prices was because plans were illegally discriminating against plan participants. Everyone saw through that, and thankfully, so did a wide majority of our Supreme Court justices.

Smart Plan Document design, combined with correspondingly smart claim processing protocols, is the only way for private sector health insurance plans to stop outrageous price manipulation in the dialysis business. Smart plan managers have always avoided discriminating against people with end stage renal disease, and avoided discriminating against people who are Medicare eligible, when designing cost control measures.

While most private sector plans specify that the "allowable charge" for dialysis services will be based on the Medicare allowable rate, many plans use 120% or even 110% of the Medicare allowable rate. So it is interesting that DaVita would pick this legal fight with a plan that set the maximum allowable charge for dialysis services at the more generous rate of 125% of the Medicare allowable rate. Note too that DaVita filed this lawsuit in 2018, many years after it began routinely accepting payments from health insurance plans that reduced DaVita's billed charges with a maximum allowable charge. So, one could observe that in 2018, DaVita decided that it wanted to be paid more by private sector plans, and to do so it would have to stop a common industry practice that eliminates fee gouging. DaVita decided to try to make a legal argument to claim that health insurance plans were actually violating MSP provisions, to try to press our courts into service to do what it could not do itself.

It could be argued that DaVita (and its largest competitor) engage in predatory and/or discriminatory pricing against private sector plans, by charging private sector plans 3 to 5 times the amount they charge Medicare for 90% of patients.

An adverse ruling in this case would have stifled creative solutions to excessive fees by medical service providers, and would have left plans at the mercy of provider "billed rates".

This ruling is a clear and significant win for private sector health insurance plan sponsors and plan managers trying to fairly manage costs.

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