COMPLIANCE ALERT

SCOTUS Decision on End-Stage Renal Disease

EPIC Insurance Brokers & Consultants

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Quick Facts

- In June 2022, the Supreme Court of the United States (SCOTUS) ruled that group health plans may limit coverage for dialysis on a uniform basis for all plan participants without violating Medicare Secondary Payer (MSP) rules.
- The MSP rules apply to most group health plans.
- When coverage limitations apply uniformly to all participants requiring such treatments or services, and not just those with end-stage renal disease (ESRD), the limitation does not violate MSP rules.

Background

In June 2022, SCOTUS released an **opinion** indicating that group health plans may limit coverage for dialysis on a uniform basis for all plan participants without violating Medicare Secondary Payer (MSP) rules. Individuals may become eligible for Medicare based on age, disability or end-stage renal disease (ESRD).

When individuals become eligible for Medicare, MSP rules dictate which plan is the primary payer when an individual is entitled to Medicare and is also enrolled in an employer's group health plan. In addition, MSP rules prohibit a group health plan from "taking into account" the individual's Medicare eligibility or entitlement when determining eligibility and coverage under the group health plan.

MSP rules apply to most group health plans, but not health flexible spending accounts (FSAs) and qualified small employer health reimbursement arrangements (QSEHRAs). For age-based and disability-based Medicare, there are exemptions for small employers and individuals whose eligibility is not tied to current employment status; however, for ESRD-based Medicare, such exemptions do not apply.

For ESRD-based Medicare, the MSP rules impose two different requirements:

- The group health plan must pay primary to Medicare for the first 30 months of ESRD-based Medicare eligibility; and
- The group health plan cannot differentiate benefit offerings for those with ESRD (and eligible for Medicare) from those who do not have ESRD. This is true both during and after the 30-month coordination period, except that the plan can pay secondary to Medicare after 30 months.

SCOTUS Decision

The language in the MSP rules makes it clear that there cannot be any differentiation in how a group health plan provides coverage based on the existence of ESRD (before, during or after the 30-month coordination period), other than allowing the plan to pay secondary to Medicare once the 30-month coordination period is exhausted. However, there has been some question as to whether group

health plans may place limits on coverage for things such as dialysis (e.g., limited network, lower reimbursement rates), if the limits are not specific to those with an ESRD diagnosis.

In the case before the Supreme Court, Marietta Memorial Hospital's group health plan provided only limited reimbursement for outpatient dialysis via out-of-network coverage. The limited coverage was uniform for all plan participants, not just for participants with ESRD. DaVita, a major provider of dialysis services, claimed Marietta's limited coverage violated the MSP rules, arguing that the limited reimbursement had a disparate impact on participants with ESRD. SCOTUS ruled in favor of Marietta's group health plan, finding that when the coverage limitations apply uniformly to all participants requiring such treatments or services, and not just those with ESRD, it does not violate MSP rules. The SCOTUS opinion states that the MSP statute "cannot be read to encompass a disparate-impact theory." In addition, the opinion indicates that "the statute does not dictate any particular level of dialysis coverage," and that it is not appropriate for the courts to determine what level of benefits would qualify as adequate.

Summary

For plans not already excluding or placing limits on dialysis and other related treatments or services, this ruling may encourage them to do so. Employers offering fully insured plans may not have much flexibility to adjust coverage levels, but employers offering self-funded plans could adopt plan terms that limit their exposure to these high claim costs. Plans choosing to do so should ensure the limits or exclusions apply uniformly to all participants, not just to those with ESRD (or eligible for ESRD-based Medicare).

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