# ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, Ken Johnson, Amy Heppner, and Laurie Kirkwood provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley, Carolyn, Ken, Amy, and Laurie are senior members in the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

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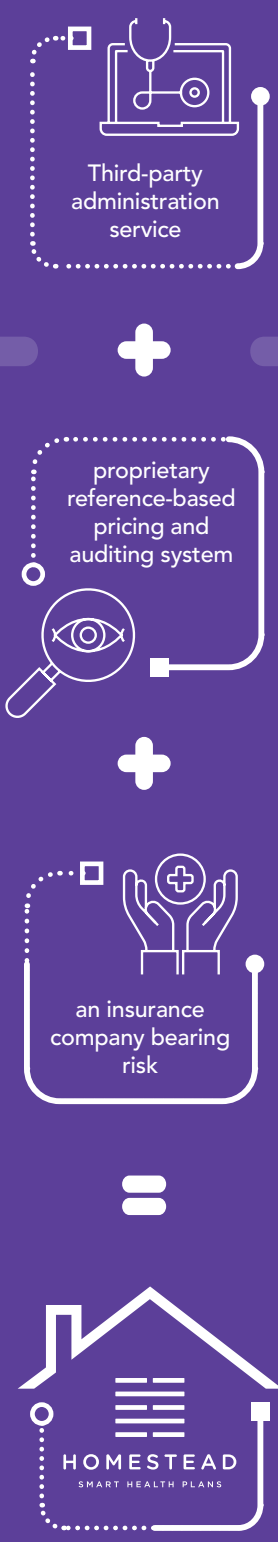

# MEDICARE SECONDARY PAYER ACT AND END STAGE RENAL DISEASE

On June 21, 2022 the United States Supreme Court issued its decision in *Marietta Memorial Hospital Employee Health Benefit Plan et al. v. DaVita Inc. et al.*, reversing the decision by the United States Court of Appels for the Sixth Circuit which found that a plan design singling out dialysis treatment for lower reimbursement violated the Medicare Secondary Payer Act (MSPA).

The MSPA makes Medicare a "secondary" payer to an individual's existing group health plan coverage for certain medical services, including dialysis, when that plan already covers the same services.

In 1972, Congress extended Medicare coverage for individuals with end-stage renal disease (ESRD), regardless of age or disability, after three months of dialysis. The Supreme Court ruled that since the plan provisions applied to all dialysis services, including individuals who did ***not*** have ESRD, the plan did not violate the MSPA.

In the Sixth Circuit, DaVita successfully argued that the MSPA provides for liability when a group health plan's inferior coverage of dialysis services, as compared to other services, disparately impacts those with ESRD even if it also applies to those without ESRD.

DaVita asserted that the plan's provisions had this "disparate impact" because 99.5% of outpatient dialysis patients have or will develop ESRD. And, since those with ESRD are eligible for Medicare, the plan's provisions were discriminatory under the MSPA.

The Supreme Court rejected this "disparate impact" analysis/standard in a 7-2 decision finding no basis to employ such an analysis under the MSPA. The Court went on to note that such a standard would be a "prescription for judicial and administrative chaos" because it would be impossible to provide a benchmark on when dialysis treatment would be considered inadequate.

More details with regard to the plan design, Medicare coordination of benefits for ESRD, the MSPA provisions, the Supreme Court's decision and other considerations are below.

## THE PLAN

The plan design challenged by DaVita had three tiers of coverage with out-of-network providers being in the bottom tier. ***All*** dialysis providers were considered out-of-network under this plan design; however, they were paid at the in-network tier 2 level.

DaVita alleged that there were further limitations on reimbursement for dialysis providers. Other out of network providers were compensated at "reasonable and customary" rates.

For dialysis services, however, DaVita alleged that reimbursements were capped at 87.5% of the Medicare rate, and that this was lower than the industry wide definition of what was reasonable and customary

fee for dialysis services. (Marietta Hospital explained that the plan bases its 70% co-insurance for tier 2 on 125% of the Medicare allowable fee for dialysis providers, resulting in actual reimbursement of 87.5%.)

Based on these provisions DaVita argued that it was reimbursed at a relatively lower rate under the plan both compared to in-network providers and to other out-of-network providers creating the alleged discrimination.

## MEDICARE AND ESRD COORDINATION OF BENEFITS UNDER THE MSPA

As mentioned above, Medicare covers individuals diagnosed with ESRD after three months of dialysis regardless of age. But there is a special coordination of benefits provision with regard to ESRD.

For those with ESRD, Medicare will pay secondary to a group health plan for dialysis for a 30-month coordination period. Unlike other Medicare coordination provisions, the group health plan will be primary (and Medicare secondary) even for plan coverage not based on active employee status.

So this coordination exists for those on COBRA as well as those on retiree coverage. This coverage can, of course, be very expensive for a self-funded group health plans. If, however, an individual makes a truly voluntary decision to drop group health plan coverage during the 30-month coordination period, Medicare then becomes the primary (and only coverage).

## THE ALLEGED MSPA VIOLATIONS

DaVita alleged two violations of the MSPA.

First, the MSPA prohibits a group health plan from differentiating in benefits between individuals with and without ESRD. DaVita argued that since dialysis services are used overwhelmingly by those with ESRD, limiting coverage for those services has a disparate impact on those with ESRD thereby creating the differentiation prohibited by the MSPA.

As a variation to this argument DaVita offered a "proxy theory" that singling out dialysis is simply a proxy for singling out individuals with ESRD and that, again, results in a differentiation of benefits.

Second, the MSPA prohibits a plan from "taking into account" Medicare/ESRD and DaVita argued, based on the same reasoning above, that a plan "takes into account" Medicare when it imposes a benefit limitation that overwhelmingly affects Medicare enrollees.

## THE DECISION

In a brief seven page majority opinion, Justice Kavanagh rejected all of DaVita's arguments. The Court noted that the MSPA "simply coordinates payments between group health plans and Medicare" and "does not dictate any particular level of dialysis coverage by a group health plan."
The Court stated that the MSPA is not a traditional anti-discrimination statute. Since the plan's dialysis reimbursement provisions applied, on their face, to both those with ESRD and those without, the Court ruled that the plan's provisions were neither making any benefit differentiation based on ESRD nor taking Medicare into account.

## OTHER CONSIDERATIONS

MSPA is not the only issue that might arise in designing a plan's coverage for dialysis services. There are also potential concerns under the Americans with Disabilities Act (ADA) as well. While beyond the scope of this article, there would need to be a demonstration, based on certain actuarial calculations or experience, that would justify the change.

Under EEOC guidance, the required demonstration, likely going to the solvency of the plan, can take several forms. Also, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) nondiscrimination provisions generally prohibit discrimination based on a health factor but careful plan design and timing of any amendment can likely limit those concerns.

## BOTTOM LINE

Based on MSPA concerns, many plan sponsors have hesitated to make changes with regard to coverage of dialysis services. The Supreme Court's decision removes those concerns for certain plan designs as long as the plan design focuses on all participants and beneficiaries receiving dialysis services and not just with ESRD. But the ADA and HIPAA issues remain and should be addressed.

Very similar ADA and HIPAA issues arise in a number of contexts such as excluding certain specialty drugs from a formulary or whether to exclude coverage for certain conditions such a hemophilia. Of course, many employers may view more robust coverage of dialysis services as an important part of their plan design and will not impose further restrictions even when legally permissible. ■