The article by League and colleagues notes that, in their study, spending for patients with employer-sponsored health insurance increased by more than $14,000 per month in the year following the initiation of dialysis, and the level of spending more than doubled Medicare fee-for-service (FFS) spending for the care of patients receiving dialysis. Although spending for all major categories of care increased with initiation of dialysis, spending for the dialysis treatments themselves, which averaged about $10,000 per month, dominated the increase.

These results for the employer-sponsored insurance market provide a crucial piece of the dialysis spending puzzle. The same authors also found that the median price paid per dialysis session by employer-sponsored insurers was more than 6 times as high as that paid by Medicare FFS. Trish and colleagues recently provided another piece of the puzzle by demonstrating similar spending associated with dialysis in the individual insurance market. Medicare FFS spending includes most patients receiving dialysis owing to the entitlement to Medicare coverage for patients with chronic kidney failure regardless of age along with the prohibition (recently removed) of Medicare Advantage enrollment by those not already enrolled before kidney failure. Medicare FFS spending has been well described by the United States Renal Data System, but less has been known about spending for those with Medicare Advantage. Lin and colleagues recently addressed this issue, noting that Medicare Advantage payments for dialysis averaged 27% above Medicare FFS rates and prices paid to large dialysis chains were similar across markets, suggestive of all-or-nothing contracting. Although the 27% premium pales in comparison with the 6-fold difference noted for the employer-sponsored market, it still stands as an outlier to most other services paid that Medicare Advantage plans typically pay similar or even lower prices than Medicare FFS.

Taken together, this body of literature suggests that the distribution of payers will be a crucial determinant of total spending for the care of patients with kidney failure and that powerful incentives exist to modify that distribution. This issue has received considerable attention in the context of the individual market, where dialysis facilities have been accused of supporting premium payments to steer patients into higher paying plans, and Trish and colleagues noted that even shifting a relatively small number of such patients could meaningfully increase premiums in that market. As noted by League and colleagues, it is not clear whether such efforts are underway to encourage patients to remain in the employer-sponsored market rather than switching to Medicare coverage. Currently, patients with kidney failure who were not already Medicare eligible face a 3-month waiting period after the initiation of in-center dialysis (waived for those receiving home dialysis) followed by a 30-month period during which the employer-sponsored plan remains primary if employer coverage is maintained. Therefore, a policy decision to shorten or extend this primary coverage period would substantially affect total spending and dialysis facilities’ revenues. Effective in 2021, the 21st Century Cures Act removed the prohibition of new Medicare Advantage enrollment by patients with kidney failure. Given the increasing share of all Medicare enrollees electing Medicare Advantage coverage, it is likely that a similar shift away from Medicare FFS would occur among patients with kidney failure. At current prices, such a shift would further enhance dialysis facilities’ revenues, but plans with a larger number of patients receiving dialysis may pay more attention to bargaining with providers over those prices.

Extreme disparities in the magnitude of dialysis service payments between patients as a function of their health insurance are potentially problematic. Patients with private insurance have an outsized influence on the financial bottom line for the dialysis facility, contributing to perverse

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incentives that can undermine their care. Most notably, there is an incentive to maintain such patients on dialysis rather than referring them for transplantation. There is modest empirical support for these concerns, such as a study reporting associations between for-profit status of the dialysis chain and reduced rates of referral, waitlisting, and transplantation. Furthermore, the financial risk of losing such patients to death or transplant for small facilities in particular may have contributed to the increasing consolidation of the dialysis market, with 2 large chains now owning nearly three-quarters of dialysis facilities. Nevertheless, any policy attempt to bring better parity in payments, such as by lowering reimbursement to Medicare rates for all, needs to be approached with caution. Although a recent Medicare Payment Advisory Commission analysis suggests dialysis facility margins for patients enrolled in Medicare average 2.7%, facilities in the lowest 2 quintiles of patient treatment volume have substantially negative margins. Revenue from privately insured patients may therefore be assisting some facilities to remain financially viable and helping to subsidize infrastructure that supports all the patients in a facility. As such, reimbursement policy needs to be carefully considered to ensure that the quality of delivered care will not be impaired.

Dialysis has long served as a laboratory for payment system reforms, including early bundled payment and quality pay-for-performance initiatives. More recently, the Center for Medicare and Medicaid Innovation used dialysis as the setting for the Comprehensive End-Stage Renal Disease Care Model, its first accountable care model to include only patients with a specific clinical condition and to center incentives and patient attribution on the dialysis facilities and nephrologists who provide specialty care for that condition. Although that model has concluded, Center for Medicare and Medicaid Innovation has launched 2 successor models—the mandatory (by region) End-Stage Renal Disease Treatment Choices Model and the voluntary Kidney Care Choices Model—demonstrating their continued interest in changing incentives for the care of this high cost, vulnerable population. Under the updated strategic goals of the Center for Medicare and Medicaid Innovation for the coming decade, developing multipayer alignment has been highlighted as a key to achieving system-wide transformation. The work by League and colleagues, along with the other literature described herein, strongly suggests that dialysis should maintain its status as a leading laboratory for building and testing payment system reforms.
