Dialysis costs: Medicare as primary payer could save $1 billion

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The complex relationship between public and private health insurance often creates unintended financial consequences for federal programs. For patients with end-stage renal disease (ESRD), the Medicare Secondary Payer (MSP) Act dictates which insurer pays first for dialysis care, a policy intended to save federal dollars. But the actual fiscal impact of this legislation has remained a subject of debate among health policy experts and those managing chronic kidney disease.

A recent analysis published in the Journal of the American Society of Nephrology examined the fiscal implications of the MSP Act for ESRD, revealing that the policy's cost-saving potential is highly dependent on the relative pricing of private versus Medicare rates.1 The study found that Medicare assuming primary payer status for all dialysis care would have saved the government a substantial sum annually.1

KEY TAKEAWAYS

- The Pivot: The Medicare Secondary Payer Act only saved federal dialysis spending when private prices were less than 3.05 times Medicare rates.
- The Data: Medicare becoming the primary payer for all dialysis care would have saved the government $1 billion annually.
- The Action: Policymakers should re-evaluate the MSP Act's structure for ESRD to ensure genuine federal savings, particularly given current private market pricing.

Patients diagnosed with end-stage renal disease face a life-altering diagnosis requiring regular dialysis or kidney transplantation. Medicare typically covers ESRD patients, but the Medicare Secondary Payer Act mandates that private insurance plans pay first for a 30-month coordination-of-benefits period. This policy aims to shift costs from the federal government to private insurers. The actual effectiveness of this cost-shifting mechanism, however, has been less clear, particularly when accounting for broader economic effects like forgone tax revenue.1

League and McDevitt, in their 2026 analysis, investigated the fiscal impact of this policy. They modeled the financial effects of the MSP Act for ESRD, considering both direct spending reductions and the indirect impact on tax revenue. The researchers sought to determine the conditions under which the MSP Act genuinely saved federal funds and to quantify the potential savings if Medicare were to become the primary payer for all dialysis care from the outset.1

The Policy's Limited Savings

The analysis revealed that the Medicare Secondary Payer Act only modestly reduced federal dialysis spending. The policy saved money for the government exclusively when private prices for dialysis were less than 3.05 times Medicare rates.1

This threshold is important, as private insurance reimbursement rates for dialysis often significantly exceed Medicare's rates. When private prices surpassed this 3.05-fold multiple, any direct savings from shifting primary payer status were effectively negated or even reversed due to the broader economic implications, including forgone tax revenue.1

The authors calculated that if Medicare were to assume primary payer status for all dialysis care, the government would have saved approximately $1 billion annually.1 This figure highlights a substantial potential for federal savings that the current MSP Act structure fails to capture. The current policy, designed to reduce federal outlays, appears to be inefficient under prevailing market conditions where private dialysis prices are often considerably higher than Medicare's reimbursement. This dynamic creates a situation where the intended cost-saving mechanism actually costs the government more in the long run. For clinicians managing patients with ESRD, understanding these financial dynamics can be as important as the clinical management itself, especially when considering the broader healthcare system. For a deeper examination of the complexities of federal healthcare policy, one might consult resources on Medicare exclusions.

Unpacking the Economic Impact

The core of the issue lies in the differential between private and public reimbursement rates. Private insurers typically pay more for dialysis services than Medicare. When private insurance is the primary payer, it pays these higher rates. While this initially seems to save Medicare money, the analysis by League and McDevitt considered the full fiscal picture. They accounted for the fact that higher private payments often translate into higher profits for dialysis providers, which can then lead to increased corporate tax revenues. But this benefit is often outweighed by the direct cost to the private system and, indirectly, to the overall economy.1

The study's methodology involved a comprehensive economic model that integrated various factors, including dialysis treatment costs, private insurance premiums, Medicare expenditures, and federal tax revenues. This allowed for a more holistic assessment of the MSP Act's true fiscal impact beyond just the immediate shift of payment responsibility. The finding that the policy only saved money under specific pricing conditions underscores the need for a more refined approach to federal healthcare spending policies.1

The 30-month coordination period, during which private insurance pays first, was originally intended to leverage the higher payment rates of commercial plans. But the analysis demonstrates that this strategy is only effective within a narrow band of private-to-Medicare price ratios. When private prices are too high, the overall federal fiscal benefit diminishes, or even reverses. This suggests that the policy's design may be outdated given current market realities in dialysis care. The implications extend beyond just dialysis, touching on broader issues of healthcare economics and policy. For example, the ongoing debate around social care funding often grapples with similar questions of public versus private responsibility and cost-effectiveness.

The Catch: Forgone Tax Revenue

One of the key insights from the study was the inclusion of forgone tax revenue in the fiscal calculation. When private insurers pay more for dialysis, these higher payments are often passed on to patients through higher premiums or to employers through increased costs. This can reduce disposable income and corporate profits, indirectly affecting tax revenues. The authors' model incorporated these complex interactions, revealing that the seemingly straightforward cost-shifting of the MSP Act has a more intricate and often less beneficial federal fiscal outcome than commonly assumed.1

The study's findings challenge the conventional wisdom surrounding the MSP Act's efficacy in controlling federal spending for ESRD. It suggests that a policy designed to save money for Medicare might, under certain market conditions, lead to a net loss for the government when all fiscal factors are considered. This is particularly relevant for nephrologists and general practitioners who manage patients requiring dialysis, as the financial structure of their care directly impacts the broader healthcare system. For those interested in the broader context of healthcare management and policy, the Oxford Handbook of Health Care Management offers a comprehensive overview.

The open-label design of the policy itself is the obvious caveat; there is no control group to compare against a world without the MSP Act. The analysis relied on modeling, which inherently involves assumptions about market behavior and economic interactions. But the model was robust, integrating multiple data points to provide a comprehensive fiscal picture. The authors did not, for instance, account for potential changes in provider behavior if Medicare immediately became the primary payer, which could influence pricing or service availability. Still, the core finding regarding the 3.05-fold price ratio remains a significant benchmark for policy evaluation.1

The study did not examine the specific mechanisms by which private prices for dialysis became so inflated relative to Medicare rates. This remains an area for further investigation, as understanding the drivers of these price discrepancies is essential for developing more effective cost-containment strategies. The findings highlight that simply shifting the payer burden does not automatically equate to federal savings, especially when the underlying cost structures are vastly different between public and private systems. This complex financial market is a constant challenge for policymakers, as seen in debates over for-profit firms in social care.

CLINICAL IMPLICATIONS

The notion that the Medicare Secondary Payer Act unequivocally saves federal dollars for ESRD care is a comfortable illusion. This analysis demonstrates that the policy's effectiveness is contingent on private dialysis prices remaining below a specific multiple of Medicare rates. When private insurers pay significantly more, the federal government's fiscal benefit evaporates, sometimes even turning into a net loss when forgone tax revenue is factored in.

Clinicians often navigate these complex payment structures without full awareness of their broader economic impact. But understanding that the current system may be costing the government $1 billion annually by not making Medicare the primary payer from day one should prompt a re-evaluation of policy. This is not merely an accounting exercise; it reflects inefficiencies that ultimately affect resource allocation within the healthcare system.

For policymakers, the message is clear: a policy designed to shift costs may, in practice, be counterproductive. The 3.05-fold price ratio is a stark benchmark. If private dialysis prices consistently exceed this, the MSP Act for ESRD is not serving its intended purpose and requires structural reform to genuinely contain federal spending.

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REFERENCES

1. 1. League R, McDevitt RC. The Fiscal Impact of the Medicare Secondary Payer Act for ESRD. J Am Soc Nephrol. 2026.

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