

The Fiscal Impact of the Medicare Secondary Payer Act for ESRD

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Key Points

- The Medicare Secondary Payer Act modestly reduced federal dialysis spending when accounting for the effect on forgone tax revenue.
- The policy saved money only when private prices were <3.05 times Medicare rates.
- Medicare assuming primary payer status for all dialysis care would have saved the government \$1 billion annually.

Abstract

Background The Medicare Secondary Payer Act (MSPA) requires that employer group health plans serve as the primary payer for individuals with ESRD for 30 months, with Medicare serving as the secondary payer. After 30 months, Medicare becomes the primary payer. The net fiscal consequences of this policy for the federal government are unknown.

Methods We estimated the net federal fiscal effect of the MSPA for patients receiving dialysis and identified the private-to-Medicare spending ratio (R) at which the policy breaks even, accounting for the forgone tax revenue associated with tax-deductible private health care spending. We conducted an economic evaluation using published data on spending and utilization for ESRD, private-to-Medicare spending ratios for dialysis, dialysis chain financials, and federal tax parameters. Primary outcomes were expressed per privately insured dialysis patient-year, with a national aggregate calculated from incident ESRD counts.

Results At current tax rates, the break-even spending ratio was $R < 3.05$. Using central price ratio estimates of $R = 2.99$, the MSPA reduced federal outlays by \$2217 per privately insured dialysis patient-year, or \$75 million annually, relative to Medicare being the primary payer for dialysis patients without a coordination period. Ignoring the effect of the MSPA on tax revenue overstated the estimated savings from the MSPA by 4500%. Altering the MSPA so Medicare became the primary payer for dialysis treatments while retaining the coordination period for other services for dialysis patients would have increased federal savings to \$29,981 per privately insured dialysis patient-year or \$1 billion annually.

Conclusions Under current prices and tax rates, the MSPA modestly reduced federal spending, while counterfactual policy changes would result in larger savings.

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Introduction

For the past 50 years, Medicare has covered most treatments for ESRD in the United States, spending over \$45 billion on dialysis patients in 2022.¹ Beginning with the 1972 amendments to the Social Security Act, Medicare extended coverage on the basis of a specific diagnosis of ESRD rather than age or disability, reflecting policymakers' view that dialysis and kidney transplantation were life-saving, yet prohibitively expensive, therapies. Initially, Medicare reimbursed dialysis facilities on a reasonable-

cost basis, covering reported facility expenses with few limitations. Concerns about rising costs, inconsistent billing, and rapid growth in the dialysis population later led to successive payment reforms.

One such reform, the Medicare Secondary Payer Act (MSPA), stipulates that for those who qualify for Medicare because of ESRD—that is, their kidneys have permanently ceased functioning and they require a regular course of long-term maintenance dialysis or have had a kidney transplant—any employer group health plan (EGHP)

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serves as the primary payer for up to 30 months, while Medicare pays second. After the 30 month period ends, Medicare becomes the primary payer.

Enacted in 1980, the MSPA originally targeted workers' compensation and liability claims, but was quickly extended to group-health coverage for beneficiaries with ESRD.² In 1981, Congress made employer plans primary for the first 12 months after Medicare ESRD entitlement. The Omnibus Budget Reconciliation Act 1990 then lengthened the period to 18 months, with the Balanced Budget Act 1997 resulting in the current 30-month rule, citing projected Medicare savings of \$1.8 billion over 10 years.³

Although the effect on Medicare outlays has been well documented, the net savings to the federal government of shifting dialysis costs from Medicare to employer plans that fully account for forgone tax revenue have received less attention. Employer health-plan spending is fully tax deductible to the firm and excluded from employee wages, meaning employer health care spending reduces federal tax revenue, to the point where it has become the largest federal tax expenditure, valued at \$231 billion in FY 2024.⁴ Because the prices paid by private insurers for dialysis care are many multiples of the price paid by Medicare, payments by privately insured patients on dialysis represent a significant amount of forgone tax revenue. Whether the MSPA ultimately saves or costs the Treasury therefore depends on the balance between reduced Medicare payments and forgone tax revenue.

This study estimates the net federal spending related to the 30-month coordination period of the ESRD MSPA using the most recent cost and tax data available.

Methods

Analytic Perspective

Estimates of the net fiscal effect to the federal government of requiring EGHPs to continue as primary payers for dialysis patients during the 30-month coordination period come from summing (1) Medicare program outlays and (2) receipts from individual payroll and income taxes plus corporate income taxes under both the current coordination period rules as well as a counterfactual scenario in which Medicare pays directly for these patients' care. This exercise combines existing estimates of the cost of insuring dialysis patients by Medicare and EGHPs with estimates of the marginal tax expenditure from employer-funded health care. The key parameters for this calculation are the amount of Medicare spending per dialysis patient when Medicare is the primary payer (M_1) or when Medicare is the secondary payer (M_2), the amounts spent by EGHPs when Medicare is primary (P_1) or secondary (P_2), the average marginal federal tax rate on individual income (t), the average pre-tax profit margin of for-profit dialysis care organizations (m), and the effective corporate tax rate (c). While full details of the calculations appear in the [Supplemental Appendix](#), the savings from the MSPA are given by

$$(M_1 + tP_1 - c \cdot m \cdot [M_1 + P_1]) - (M_2 + tP_2 - c \cdot m \cdot [M_2 + P_2])$$

The savings from the MSPA depend on the ratio of the cost for a private insurer to cover a dialysis patient and

how much that same patient would cost Medicare. We call this cost ratio R . The intuition is that because higher spending by employers on health care results in lower wages,^{5–7} and lower wages result in lower tax revenue, any reduction in Medicare spending from the MSPA is at least partially offset by lower tax revenue. For high enough values of the cost ratio R that satisfy the inequality below, the MSPA becomes a net cost to the federal government:

$$R > (1 - c \cdot m + [t - c \cdot m] \cdot s \cdot p) / ([1 - c \cdot m] \cdot s \cdot m + t - c \cdot m)$$

Details of this calculation are in the [Supplemental Appendix](#).

Results

Estimates of the parameters of the model came from the sources in [Table 1](#). Because existing sources do not specifically estimate spending for patients covered by the MSPA, we use estimates of spending on incident in-center hemodialysis patients as our primary estimates, demonstrating robustness of our conclusions to using estimates of spending on prevalent dialysis patients.

As reported in [Table 2](#), the annual net cost to the federal government of a dialysis patient under the current MSPA rules was estimated to be \$111,750. This was composed of \$2370 in Medicare outlays and \$121,203 in forgone tax revenue on individual income less \$11,822 in tax revenue from health care organizations.

By contrast, the annual net cost to the federal government of a dialysis patient under a counterfactual scenario in which Medicare serves as the primary payer for patients with ESRD without a coordination period was estimated to be \$113,967. This was composed of \$108,737 in Medicare outlays and \$10,140 in forgone tax revenue on individual income less \$4909 in tax revenue from health care organizations.

Switching from the current MSPA rules to Medicare serving as the primary payer (denoted No MSPA in [Table 2](#)) for all dialysis patients would have a fiscal effect of \$2217 per enrollee per year, under assumptions favorable to the MSPA. With nearly 34,000 dialysis patients covered by EGHP,¹ the MSPA resulted in a net fiscal savings to the federal government of just under \$75 million annually compared with Medicare serving as the primary payer for these patients. By contrast, a naive analysis looking only at the effect on Medicare spending would suggest the MSPA saved \$108,737 – \$2370 = \$106,367 per person per year or nearly \$3.6 billion annually. While shifting all dialysis patients to Medicare would increase Medicare spending by over \$100,000 per patient-year, this would be offset by an increase in federal tax revenue nearly as large. As such, incorrectly considering only Medicare spending would result in an estimate of the savings to the government from the MSPA over 45 times larger than when correctly considering the effect on tax revenue as well.

Using the estimates in [Table 1](#) of the tax rates, organization profit margins, and share of spending by the secondary insurer, the MSPA represented net fiscal savings to the federal government when the ratio of private to Medicare spending R was <3.05. [Figure 1](#) reports the annual

Table 1. Model parameter estimates and sources

Parameter	Source	Estimates
Annual Medicare spending per dialysis patient when primary payer (M_1) ^a	USRDS (2024) ¹	\$109,259
Annual Medicare spending per dialysis patient when secondary payer (M_2) ^c	League <i>et al.</i> (2022) ⁸ Lin (2021) ⁹	\$108,737 ^b \$2370
Annual private insurance spending per dialysis patient when primary payer (P_1) ^a	Trish <i>et al.</i> (2021) ¹⁰	\$233,372
Annual private insurance spending per dialysis patient when secondary payer (P_2) ^e	League <i>et al.</i> (2022) ⁸ USRDS (2024) ¹	\$324,940 ^b \$27,315
Average marginal federal tax rate on labor income (t) ^f	League <i>et al.</i> (2022) ⁸ Guzman and Koller (2024) ¹¹ IRS (2025 ^a) ¹² IRS (2025 ^b) ¹³	\$27,184 ^b 37.3%
Health care organization pre-tax margin (m) ^g	DaVita (2025) ¹⁴ Fresenius (2025) ¹⁵	17.2% ^b 5.1%
Effective corporate tax rate (c) ^h	IRS (2024) ¹⁶	21%

All spending estimates are adjusted for inflation from the midpoint of the sample period of the relevant study to September 2025 prices. These are sources that limit their analysis to patients in the coordination period. Alternative estimates are used to explore robustness. In cases that require an extrapolation from existing estimates, the assumptions err on the side of being favorable to the Medicare Secondary Payer Act. That is, the assumptions will make the estimates more likely to align with the conventional wisdom that the Medicare Secondary Payer Act generates large fiscal savings for the federal government.^{3,9} USRDS, United States Renal Data System.

^aLeague *et al.* (2022) is for incident patients where Medicare is the primary payer, while United States Renal Data System (2024) is for all dialysis patients regardless of insurance status.

^bThe estimates used for the primary analysis.

^cLin (2021) reports total Medicare spending during the coordination period for patients that switch from private insurance to Medicare at the end of the coordination period. The figure reported here is annualized by multiplying by 12/30.

^dLeague *et al.* (2022) is for incident patients with employer-sponsored insurance, while Trish *et al.* (2021) is for all dialysis patients with private individual health insurance. Trish *et al.* (2021) reports monthly expenditure, which is multiplied by 12 here.

^eAssumes private insurers cover all patient cost sharing, which we assume is 25% of Medicare spending. This assumption is more favorable to the Medicare Secondary Payer Act generating savings.

^fThe median 2023 household income in the United States was \$80,610.8 which for all filing statuses other than married filing jointly faced a marginal federal income tax rate of 22%.¹² For such a household, the marginal payroll tax rate is 15.3% (12.4% social security tax and 2.9% Medicare tax).¹³ Assumes full pass-through of health care costs to wages, consistent with empirical evidence.⁵⁻⁷

^gAssumes the operating income margins of DaVita and Fresenius represent the average profit margin on health care spending for dialysis patients. DaVita's reported margin is used as the primary measure because it is more favorable to the Medicare Secondary Payer Act generating savings and more heavily weighted toward dialysis care.

^hAssumes all health care organizations treating dialysis patients are subject to the minimum corporate tax rate, which is a conservative assumption more favorable to the Medicare Secondary Payer Act generating savings.

federal savings from the MSPA for various values of R . Our primary estimate of the cost ratio was $\$324,940/\$108,737=2.99$, very close to the break-even point. Alternative estimates indicated that for prevalent patients this ratio was $\$233,372/\$109,259=2.14$, making the MSPA's

savings clearer. While estimates that rely on the incident patient population may better reflect the costs of patients in the 30-month coordination period, the true costs are likely somewhere between those of the incident and prevalent patient populations. The vertical lines in Figure 1 mark

Table 2. Comparison of annual federal fiscal cost

Fiscal Component	Current MSPA	No MSPA
Medicare outlays	\$2370 (M_2)	\$108,737 (M_1)
Plus: Forgone individual	\$121,203 ($t \cdot P_2$)	\$10,140 ($t \cdot P_1$)
Income tax revenue		
Less: Corporate tax receipts	\$11,822 ($c \cdot m \cdot [M_2 + P_2]$)	\$4909 ($c \cdot m \cdot [M_1 + P_1]$)
Net annual cost to federal	\$111,750	\$113,967
Government		
Net federal savings from	\$2217	
MSPA per patient-yr		
Aggregate annual savings (33,775 EGHP+MSPA patients) ¹⁷	\$74,879,175	

All spending estimates are adjusted for inflation from the midpoint of the sample period of the relevant study to September 2025 prices. These are sources that limit their analysis to patients in the coordination period. Alternative estimates are used to explore robustness. In cases that require an extrapolation from existing estimates, the assumptions err on the side of being favorable to the Medicare Secondary Payer Act. That is, the assumptions will make the estimates more likely to align with the conventional wisdom that the Medicare Secondary Payer Act generates large fiscal savings for the federal government.^{3,9} EGHP, employer group health plan; MSPA, Medicare Secondary Payer Act.

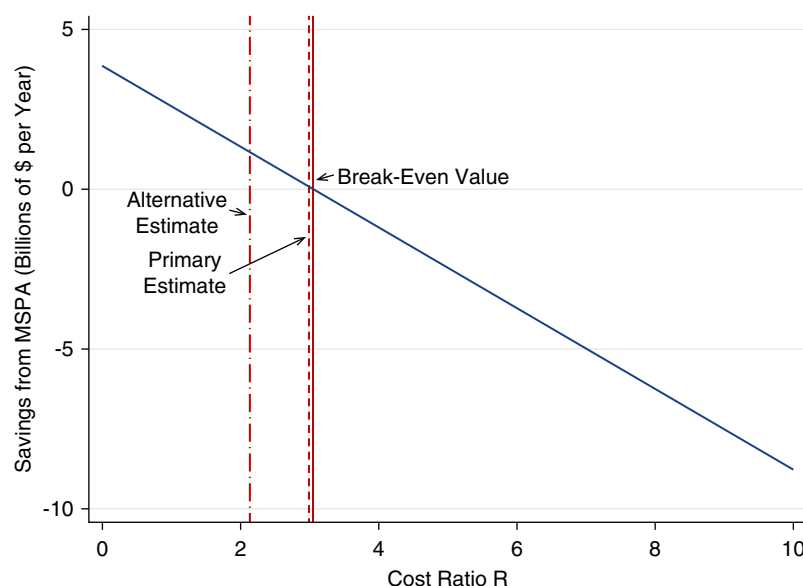


Figure 1. Estimated savings from MSPA for different values of R . Figure reports the projected savings in billions of dollars per year from the MSPA for different values of Cost Ratio R . The solid vertical line denotes the break-even value of R , meaning that for values of R greater than this value, the MSPA is a net fiscal cost, and for values of R less than this value, the MSPA results in net fiscal savings. The dashed vertical lines denote our estimates of the current value of R , with the short-dashed line indicating our primary estimate using spending estimates for incident dialysis patients and the long-dashed line indicating our alternative estimate using spending estimates for prevalent dialysis patients. MSPA, Medicare Secondary Payer Act. Figure 1 can be viewed in color online at www.jasn.org.

these cost ratios. While the total annual savings from the MSPA at our primary estimate of the cost ratio was \$75 million, our alternative parameter estimates indicated savings of approximately \$1.2 billion. If the cost ratio were 1 (for example, if private insurance prices were the same as Medicare's), the MSPA would result in \$2.6 billion in savings. By contrast, at very high private prices, the MSPA would become a net fiscal cost. For example, at a cost ratio of 5, the MSPA would cost \$2.5 billion annually, with the cost rising to more than \$8.8 billion for a cost ratio of 10. For context, the ratio approached 7 for dialysis-specific care in 2019.¹⁸

Discussion

Our analysis demonstrated that the MSPA yields net savings for the federal government only when the cost to privately insure a patient is less than approximately three times the cost for Medicare to insure them. While a narrow focus on Medicare outlays suggests the MSPA saves more than \$3.6 billion annually, this view ignores the substantial tax revenue forgone because of the tax deductibility of employer-sponsored health insurance. When accounting for these tax expenditures, the break-even private-to-Medicare payment ratio is 3.05; below this threshold, the policy saves federal dollars, but above it, the MSPA becomes a net fiscal cost.

This fiscal tipping point is critical because the markup for dialysis care is significantly higher than for other medical services. Estimates for the private-to-Medicare price ratio for dialysis range from 3.15 to 6.17,^{18,19} all which exceed the break-even threshold. Under these conditions,

the MSPA represents a net fiscal cost to the federal government for dialysis-specific care. Conversely, the price ratio for nondialysis services for ESRD patients is estimated to be between 1.2 and 2.7,^{20,21} making the savings on nondialysis care from the MSPA clearer.

The disparity between the cost ratio for dialysis and nondialysis care points to two possible policy responses that could generate large savings for the federal government. The first is to carve dialysis treatments out of the MSPA. Under this proposal, Medicare would assume the cost of dialysis care immediately, while the private insurer would remain the primary payer for all other care during the coordination period. This approach would save the federal government an estimated \$1 billion annually relative to eliminating the MSPA—or \$938 million relative to current law—and would allow the government to recapture the forgone tax revenue associated with high private dialysis prices while continuing to save Medicare resources on nondialysis services where the private-to-Medicare spread is smaller. Details of the calculation of these savings are in the [Supplemental Appendix](#).

An alternative policy response would be to implement a cap on the price private insurers can pay for dialysis services. Such a cap has been proposed previously for dialysis in California under Proposition 8 in 2018 as well as for other health care services, particularly for out-of-network bills.²² Given the break-even cost ratio of 3.05, we estimate a cap at 300% of Medicare's price for dialysis would result in savings to the government of \$30,407 per patient-year or \$1 billion annually. One benefit of this proposal relative to the carve-out policy is that it would require no additional Medicare spending and would

instead increase savings by reducing forgone tax revenue. Details of these calculations are also given in the [Supplemental Appendix](#).

These findings provide context for ongoing policy debates following the Supreme Court's 2022 decision in *Marquette Memorial Hospital Employee Health Benefit Plan v. DaVita, Inc.* The Court ruled that group health plans could limit dialysis benefits, effectively shifting patients to Medicare before the 30-month coordination period ends. In response, bipartisan legislation such as the Restore Protections for Dialysis Patients Act has been introduced to close this loophole. While proponents argue such legislation would protect Medicare resources, our results show that simply forcing private plans to pay their current high rates (where $R=2.99$) generates net savings of \$75 million because Medicare savings are largely offset by lost tax revenue. Savings to the federal government over 14 times as large could be achieved by carving out the services where the difference between Medicare and private prices are the largest: dialysis services. Furthermore, a methodology focused on net fiscal costs highlights the importance of accounting for forgone tax revenue when calculating the fiscal effect of any proposed legislation, as is often done by the Congressional Budget Office.

Historical precedent supports adjusting payment policies when hidden fiscal costs become apparent. For example, the Medicare Modernization Act of 2003 reformed Part B drug reimbursement from 95% of the Average Wholesale Price to 106% of the Average Sales Price after analyses showed the old formula created perverse incentives and hidden costs. For the MSPA, the recent surge in private prices for dialysis—the median price for dialysis paid by private insurers increased from \$1349 to \$1655 (22.7% growth) from 2012 to 2019 compared with virtually no change in the Medicare base rate of around \$240 over that period¹⁸—has made this issue central for policy discussions.

While reforming the MSPA may protect the government's coffers, shifting dialysis costs to Medicare could impact the financial stability of dialysis organizations. Large dialysis organizations derive significant profits from privately insured patients, and reducing this revenue could theoretically lead to clinic closures or industry consolidation. At the same time, the \$1.1 billion in annual federal savings generated by this proposal could be reinvested to mitigate such risks: Savings could be directed toward increasing Medicare base rates or funding value-based policies, such as the ESRD Treatment Choices model, to reward efficiency and ensure continued patient access to care. They could also be used to promote greater innovation in ESRD treatments.

This analysis has several limitations. First, the estimates rely on published data for Medicare and private insurer spending, tax rates, and corporate profit margins, which may not fully reflect variation across patient populations, geographic regions, or health plans.

Second, the analysis assumes full pass-through of employer health care spending to wages. Although this assumption is consistent with empirical evidence, if the pass-through to employee wages is lower, then the savings from the MSPA would be larger than we estimate. Furthermore, while the analysis does not require assuming

that dialysis beneficiaries earn a certain level of income because *expected* (rather than realized) health care costs are what get passed on to employees in the form of lower wages, if dialysis beneficiaries disproportionately work for firms that compete in low-wage or high-wage labor markets, the relevant individual income tax rate may differ from that of the median household.

Third, the framework treats Medicare and private insurers as paying proportional shares when acting as secondary payers, which simplifies the complex dynamics of negotiated prices and cost sharing. Insofar as changes to the MSPA could increase insurer profits or the negotiating leverage of insurers relative to dialysis organizations, the analysis would understate fiscal savings.

Finally, the analysis focuses on direct fiscal effects and does not incorporate potential implications for access, quality of care, or patient outcomes. Given the much higher payment rates of private payers, expanding Medicare's role as the primary payer could reduce revenue for dialysis organizations. At the same time, any fiscal savings to the federal government could also be deployed to directly target issues of access and quality.

This study demonstrated that the MSPA, while successful at shifting dialysis costs away from Medicare, provided only modest net savings to the federal government after accounting for forgone tax revenue. Although a narrow focus on Medicare outlays suggested substantial savings, these savings were largely offset by the tax deductions associated with employer-sponsored health insurance. Indeed, the MSPA generated savings only when the private-to-Medicare spending ratio was below 3.05, a condition that was marginally satisfied for incident dialysis patients but exceeded when only dialysis-specific costs were considered. These findings—the first net fiscal analysis in the literature—highlight the importance of evaluating health financing policies from a full fiscal perspective rather than solely from the standpoint of individual program expenditures. A targeted reform, such as carving out dialysis services from the MSPA while retaining private coverage as primary for other care, could yield substantially greater fiscal benefits, saving an estimated \$1 billion annually, or more than 14 times the current savings, while maintaining continuity of coverage. Policymakers should therefore reconsider the structure of the MSPA to better align fiscal efficiency with patient care needs.

Disclosures

Disclosure forms, as provided by each author, are available with the online version of the article at <http://links.lww.com/JSN/F687>.

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Data Availability Statements

Original data generated for the study will be made available upon reasonable request to the corresponding author. Data Type: Software Executable Code. Reason for Restricted Access: All inputs are from public, published sources with citations provided. More detailed calculations are available from the authors on request.

Supplemental Material

This article contains the following supplemental material online at <http://links.lww.com/JSN/F688>.
[Supplemental Appendix.](#)

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