No. _____

In The
Supreme Court of the United States

MARIETTA MEMORIAL HOSPITAL EMPLOYEE HEALTH BENEFIT PLAN, MARIETTA MEMORIAL HOSPITAL, AND MEDICAL BENEFITS MUTUAL LIFE INSURANCE CO.,

Petitioners,

v.

DAVITA INC., AND DVA RENAL HEALTHCARE, INC.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

JOINT PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

(1) Congress enacted the Medicare Secondary Payer Act as a means to conserve Medicare resources. Among other things, the Act provides that group health plans may not "take into account" the fact that a plan participant with end stage renal disease is eligible for Medicare benefits. Does a group health plan that provides uniform reimbursement of all dialysis treatments observe that prohibition?

(2) Under the Medicare Secondary Payer Act, a group health plan also may not "differentiate" between individuals with end stage renal disease and others "in the benefits it provides." Does a plan that provides the same dialysis benefits to all plan participants, and reimburses dialysis providers uniformly regardless of whether the patient has end stage renal disease, observe that prohibition?

(3) Is the Medicare Secondary Payer Act a coordination-of-benefits measure designed to protect Medicare, not an antidiscrimination law designed to protect certain providers from alleged disparate impact of uniform treatment?

PARTIES TO THE PROCEEDING

This joint petition seeks review of the Sixth Circuit's expansion of the Medicare Secondary Payer Act, a law designed to conserve Medicare resources, to include individual claims against group health plans for alleged discrimination based on uniform treatment.

Petitioners are the Marietta Memorial Hospital Employee Health Benefit Plan, Marietta Memorial Hospital and Medical Benefits Mutual Life Insurance Co.

Respondents are DaVita, Inc., and DVA Renal Healthcare, Inc.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 29.6, Petitioners Marietta Memorial Hospital Employee Health Benefit Plan, Marietta Memorial Hospital and Medical Benefits Mutual Life Insurance Co. each state that they have no parent corporation and that no publicly held company owns 10% or more of their respective stock, if any.

RELATED PROCEEDINGS

This joint petition arises from the following proceedings in *DaVita, Inc., et al. v. Marietta Memorial Hospital Employee Health Benefit Plan, et al.*:

- In the United States Court of Appeals for the Sixth Circuit, Docket No. 19-4039, Final Judgment Entered: December 23, 2020.

RELATED PROCEEDINGS – Continued

- In the United States District Court for the Southern District of Ohio, Eastern Division, Docket No. 2:18-cv-1739, Judgment Entered: September 20, 2019.

There are no other proceedings in state or federal trial or appellate courts, or in this Court, directly related to this case within the meaning of Rule 14.1(b)(iii).

TABLE OF CONTENTS

TABLE OF CONTENTS – Continued

TABLE OF CONTENTS – Continued

TABLE OF AUTHORITIES

Page

CASES

TABLE OF AUTHORITIES – Continued

TABLE OF AUTHORITIES – Continued

Page

STATUTES AND REGULATIONS

TABLE OF AUTHORITIES – Continued

OTHER AUTHORITIES

TABLE OF AUTHORITIES – Continued

Page

JOINT PETITION FOR A WRIT OF CERTIORARI

Marietta Memorial Hospital Employee Health Benefit Plan (the "Plan"), Marietta Memorial Hospital ("Marietta Hospital") and Medical Benefits Mutual Life Insurance Co. ("MedBen") jointly and respectfully petition this Court, pursuant to this Court's Rule 12.4, to issue a writ of certiorari to the Sixth Circuit in the case entitled *DaVita, Inc., et al. v. Marietta Memorial Hospital Employee Health Benefit Plan, et al*., No. 19-4039.

OPINIONS BELOW

The opinion of the Sixth Circuit is reported at 978 F.3d 326 and reproduced at App. 1-92. The opinion of the United States District Court for the Southern District of Ohio is electronically reported at 2019 U.S. Dist. LEXIS 160793 and reproduced at App. 95-115.

JURISDICTION

The Sixth Circuit issued its judgment on October 14, 2020. That judgment became final on December 23, 2020, when the Sixth Circuit denied the petitions of the Plan, Marietta Hospital and MedBen for rehearing en banc. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS AND RULES INVOLVED

The statutes and rules involved are 29 U.S.C. § 1132(a), 29 U.S.C. § 1182(a)(1), 42 U.S.C. § 1395y(b) and 42 C.F.R. § 411.161.

STATEMENT OF THE CASE

Over half of our nation's population depends upon employer group health plans to insure the costs of medical care. The plans have finite resources. To cover a broad range of medical expenses, the plans specify rates at which they reimburse healthcare providers for designated services that plan participants receive. Plans achieve their maximum effectiveness by striking a balance that includes services and reimbursements best suited to the needs of their constituencies.

This case presents a direct conflict between the Sixth and Ninth Circuits over the extent to which plans must reimburse dialysis charges that their members incur. Brought by the nation's largest dialysis provider, the case establishes that employer group health plans in the Sixth Circuit now run the risk of double damages and loss of tax status if they reimburse dialysis coverage at anything other than the "most favored nation" rate. Under the Sixth Circuit's decision, all other medical procedures, from childbirth to elder care, must now stand in line behind payment for dialysis treatment. In the Ninth Circuit, by contrast, plans remain free to apportion their resources equitably

among the wide-ranging medical needs of their members. Dialysis reimbursements must be uniform, but they do not necessarily supersede indemnification of other medical expenses.

The circuit split arises by virtue of the opposite ways in which the Sixth Circuit and Ninth Circuit interpret key provisions of the Medicare Secondary Payer Act ("MSPA"), 42 U.S.C. § 1395(y)(b), and the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1132(a)(1)(B), 29 U.S.C. § 1182(a)(1). Congress enacted the MSPA as a coordination-of-benefits measure, designed to protect Medicare resources. The MSPA provides that employer group health plans may not "take into account" an insured's eligibility for Medicare or "differentiate" between participants who have end stage renal disease ("ESRD") and other participants in terms of plan benefits. The ERISA provisions pertinent to this case give plan participants a cause of action to enforce the "terms of the plan" and prohibit plans from discriminating on the basis of health status in defining "eligibility."

The Sixth Circuit and Ninth Circuit have a fundamental disagreement over three dispositive issues: (1) whether uniform reimbursement of all dialysis treatments, regardless of whether a beneficiary is eligible for Medicare, impermissibly "takes into account" the entitlement of an individual to Medicare benefits; (2) whether a plan that provides the same benefits to all participants unlawfully "differentiates" when it uniformly reimburses a provider for dialysis services

regardless of whether the patient has ESRD; and (3) whether an MSPA violation occurs if uniform reimbursement rates have a disparate impact on plan participants.

The Sixth Circuit says "yes" to each question. The Ninth Circuit says "no." Plans that operate in both circuits are caught in a vexatious trap. Their tax status and double damages are at stake if they are deemed to violate the MSPA. Plans that serve members in the other circuits face the same consequences. They are now forced to guess, at their own peril, between the Sixth Circuit and Ninth Circuit interpretations. Further appellate adjudication will add little insight to resolution of the conflict: the Sixth and Ninth Circuits have spoken with consummate clarity in defining the alternatives.

The circuit split affects the entire nation. Caught in the middle are the employer group health plans that, as the bedrock of the nation's health insurance system, must make actuarially sound and legally correct underwriting decisions; the millions of working families that depend upon employer group health plans to widen the scope and defray the cost of their medical care; dialysis patients, who depend upon stability of their treatment; and the Medicare system itself, which can ill-afford the dysfunction of circuit-by-circuit definition of rules for coordination with employer group health plans. The only apparent beneficiary is respondent DaVita, Inc., the nation's largest dialysis provider, which has brought this action as well

as the two actions in the Ninth Circuit and other related cases.

The dissenting opinion of Judge Eric E. Murphy in the Sixth Circuit points the way forward. It rejects the "capacious" statutory interpretation that the panel majority adopted. Along with the unanimous opinions of the Ninth Circuit, it succinctly explains the literal limits of the MSPA. The solution is clear and the circumstances are urgent.

REASONS FOR GRANTING THE PETITION

I. The Split between the Sixth and Ninth Circuits Is Consequential and Definitive.

The issues for review are narrow questions of federal statutory interpretation that have nationwide implications.

A. Employer group health plans are the fundamental providers of health insurance coverage in the United States.

The three questions for review are central not only to the applicable law but also to our nation's economy. Employer group health plans play a crucial role in financing health care and the medical services sector:

> The central role that employers play in financing health care is a distinctive feature of the U.S. health care system, and the provision of health insurance through the workplace has

> important implications well beyond its role as a source of health care financing. Currently, as has been the case for the last half century, employer sponsored insurance (ESI) dominates the U.S. health insurance landscape.

Thomas C. Buchmueller, *et al.*, *Employer-Sponsored Health Insurance and the Promise of Health Insurance Reform*, 46 Inquiry J. 187, 187 (2009). "Most nonelderly Americans receive their health insurance coverage through their workplace." Ellen O'Brien, *Employers' Benefit from Workers' Health Ins.*, 81(1) Milbank Q. Multidisciplinary J. Population Health & Health Pol. 5, 5 (2003).

"[E]mployment-based plans cover two-thirds of nonelderly Americans and pay most of working families' expenses for health care and about one-quarter of national health spending." *Id.*; *see also* Thomas C. Buchmueller, *et al.*, *The Business Case for Employer-Provided Health Benefits: A Review of the Relevant Literature* 18 (2000) ("The vast majority of private health insurance is received through the workplace not because of the benevolence of employers, but because there are several economic advantages to employer provision relative to individual purchased insurance.").

In 2019, 92% of our population was insured and 56.4% of those individuals were insured under employment-based plans, the majority of which are self-funded. Katherine Keisler-Starkey & Lisa Bunch, *Health Insurance Coverage in the United States: 2019*, U.S. Census Bureau, Figure 1. According to the

2020 Kaiser Family Foundation survey of employer-sponsored health benefits, approximately 157 million people are covered under employer-sponsored insurance. *See* Kaiser Family Foundation, *Employer Health Benefits 2020 Summary of Findings*, p. 1, n.1 (2020).

Uniformity in application of group health plan rules is a matter of overriding practical importance not only for the plans themselves but also for the plan members, including those with ESRD, and the Medicare system. As it currently stands, however, an employer that provides health insurance across circuit lines has no trustworthy basis for deciding what across-the-board provisions it must include for its insureds. Under the MSPA, risk-averse plan sponsors in the Sixth Circuit, Ninth Circuit and every other circuit are left with two strategies to assure MSPA compliance and manage costs: (1) exclusion of dialysis treatment from coverage (for self-funded employer group health plans), or (2) complete termination of the employer group health plan.

Neither result is desirable. If self-funded employer group health plans exclude dialysis treatment altogether rather than risk noncompliance with the MSPA, members with ESRD are likely to switch promptly to Medicare. Dialysis providers will lose revenue from those plans and increase their charges to employer group health plans that continue to cover dialysis. If these self-funded group health plans then exclude dialysis, a "dialysis death spiral" ensues. If a group health plan is terminated in its entirety, some previously covered individuals may obtain coverage under a

spouse's or parent's plan if available, on the individual market, or under Medicare or Medicaid, if eligible. Many may forego coverage or be unable to obtain it. Most individuals with ESRD will likely enroll promptly in Medicare, for which their health status gives them automatic eligibility. In the end, the result would be that very few – if any – self-funded group health plans might offer dialysis benefits. Medicare would become coverage of first, not last, resort – precisely the situation that the MSPA was intended to avoid.

B. This case presents exceptionally important questions and is an ideal vehicle for their resolution.

This case presents a worthy vehicle to restore certainty to critical provisions of the MSPA. The split between the Sixth and Ninth Circuits involves cases with virtually identical facts and similar parties. Reversal of the Sixth Circuit on the questions presented will not only determine the outcome of the remand proceedings in the District Court, but also fully resolve the dispositive issues and allow the MSPA to operate free of contradiction between the two circuits. Doing so now is of the utmost importance to group health plans, and is even more urgent for those insured by the plans. The Court should act now to restore order to the process by which group health plans establish dialysis coverage.

1. The petitioners' employer group health plan reimburses providers uniformly for dialysis treatment.

With an estimated 200,000 patients treated at approximately 2,400 dialysis treatment centers across the United States, DaVita is the largest provider of dialysis treatment nationwide. Compl., RE 1, Page ID # 5, 7. DaVita alleges that it provided dialysis services to "Patient A," a patient suffering from ESRD, at one of its locations beginning on April 15, 2017. *Id*., Page ID # 6-7. Patient A was a member of the Marietta Memorial Hospital Employee Health Benefit Plan. *Id*. MedBen is the third-party administrator of benefits for the Plan. *Id*. at Page ID # 4. Patient A received dialysis treatment while enrolled in the Plan. *Id.* at Page ID # 10.

Under the terms of the Plan, "dialysis-related services and products," like those that DaVita provided to Patient A, are subject to an "alternative basis for payment" and reimbursement "will not exceed the maximum payable amount applicable . . . which is typically one hundred twenty-five percent (125%) of the current Medicare allowable fee." *Id*., Page ID # 9. The Plan further categorizes outpatient dialysis services, regardless of patient type, diagnosis or Medicare eligibility, as out-of-network. *Id*., Page ID # 9-10. The Plan clearly states that it "does not provide its enrollees any network of providers for outpatient dialysis service." *Id*., Page ID # 16-17.

DaVita received full reimbursement for Patient A's dialysis treatment under the terms of the Plan. *Id.* at Page ID # 11. On August 31, 2018, Patient A ***voluntarily*** enrolled in Medicare, and Medicare became the patient's primary insurance. *Id.* at Page ID # 19.

2. The District Court dismissed the dialysis providers' claims, based on a literal reading of the MSPA.

Seeking an even larger reimbursement for their dialysis services, DaVita and its affiliate (DVA Renal Healthcare, Inc.) filed their seven-count complaint against the Plan, Marietta Hospital and MedBen in the United States District Court for the Southern District of Ohio on December 19, 2018. The complaint asserted claims against the Plan and Marietta Hospital for violation of the MSPA (Count I) and an ERISA claim for benefits under 29 U.S.C. § 1132(a)(1)(B) against all defendants (Count II), alleging that the Plan's payment provisions regarding out-patient dialysis services were "illegal because they violate the 'take into account' and 'anti-differentiation' provisions of the MSPA," and that "by imposing limitations on the benefits for a Medicare-entitled individual that do not apply to others enrolled in the Plan, these provisions run afoul of the MSPA's intent that Medicare eligible patients not be disadvantaged in relation to other individuals who are covered under the Plan but are not eligible for or entitled to coverage under Medicare." *Id*., Page ID # 22-23. DaVita contended that the offending payment plan provisions "should be severed from the

Plan," and that it is entitled to "recovery of benefits." *Id*., Page ID # 23-24.

Based upon the alleged MSPA violations, and casting MedBen as a "fiduciary" that "exercises discretionary authority and control over the decisions to pay benefits under the Plan," DaVita asserted separate claims against Marietta Hospital (Count III) and MedBen (Counts IV-VI) under 29 U.S.C. § 1132(a)(3) for "breach of fiduciary duty under ERISA," "co-fiduciary liability in violation of ERISA § 405," and "knowing participation in fiduciary breach under ERISA," and sought payment of Plan benefits. *Id*., Page ID # 24-29. In Count VII, DaVita sought injunctive relief under ERISA against the Plan and Marietta Hospital for alleged discrimination on the basis of ESRD status in "violation of 29 U.S.C. § 1182(a)(1)." *Id*., Page ID # 29.

The District Court dismissed DaVita's claims for violation of the MSPA and its ERISA claims, premised on the same allegations, against all defendants, holding that (1) the claims did not fall within the limited scope of the private right of action under the MSPA, and (2) defendants did not violate either the "take into account" or "anti-differentiation" provisions of the MSPA because the Plan did not treat persons who are eligible for Medicare differently than those who are ineligible. App. 99-107. The District Court also expressly rejected the argument that the MSPA provided for a

disparate impact claim.[1] App. 101-07. DaVita timely appealed.

3. The Sixth Circuit reversed, ruling that uniform treatment can constitute unlawful discrimination.

A split panel of the Sixth Circuit affirmed in part and reversed in part on October 14, 2020. App. 1-94. The court adopted the proposition that the MSPA "prohibits primary plans from discriminating against individuals with ESRD without expressly stating that these individuals will be treated differently." App. 40. The non-differentiation provision, said the court, "prohibits both express anti-ESRD discrimination based on an individual's ESRD status and indirect anti-ESRD discrimination based on an individual's ESRD-specific need for renal dialysis or based on any other factor." App. 41. The court applied the same reasoning to the "take into account" provision. "In short," said the court, "a plan may be engaging in unlawful discrimination against individuals with ESRD even if it does not explicitly single these individuals out for differential treatment." App. 41. The decision upheld the dismissal of DaVita's equitable and fiduciary duty claims, but

[1] The District Court also held that DaVita lacked standing to bring the breach of fiduciary duty claims, as the assignment from Patient A did not properly assign those claims. App. 107-14. The Sixth Circuit upheld this finding. App. 54. On remand, DaVita has filed an Amended Complaint that drops its breach of fiduciary duty claims and notes that Patient A, whose reimbursement claims it continues to pursue by assignment, is now deceased. RE 62.

reversed the denial of its claim for benefits under ERISA and the MSPA. *See* App. 54.

In doing so, the Sixth Circuit read a "disparate impact" standard into the MSPA and held that discovery on DaVita's claims for denial of benefits could establish a discriminatory violation on that basis. App. 53-54. The majority held that the "basic question" was "whether the MSPA prohibits primary plans from discriminating against individuals with ESRD without expressly stating that these individuals will be treated differently." App. 40. The majority ruled that "the catch-all provision [of the MSPA] could support a disparate-impact claim against the Plan." App. 45. To reach that conclusion, the majority relied on *Texas Dept. of Hous. & Cmty. Affairs v. Inclusive Cmtys. Project, Inc*., 576 U.S. 519 (2015) (Kennedy, J.), a case interpreting the Fair Housing Act. App. 45-48.

Building upon that conclusion, the Sixth Circuit majority's decision embedded in a footnote the assertion that courts may even reform a plan's terms under 29 U.S.C. § 1132(a)(3) – an assertion and prayer for relief that DaVita did not plead in its Complaint – and then enforce the ***reformed*** plan under 29 U.S.C. § 1132(a)(1)(B). App. 31-34, n.12. Yet, while it is true that 29 U.S.C. § 1132(a)(3) allows for plan reformation, there is nothing in the text of ERISA that contemplates reformation based solely on a 29 U.S.C. § 1132(a)(1)(B) claim for benefits.

Judge Murphy dissented in part based on his conclusion that the MSPA is ***not*** an anti-discrimination

law; it is a coordination-of-benefits measure that "lacks the defining features of the specific anti-discrimination laws that the Supreme Court has read to impose disparate-impact liability." App. 76 (Murphy, J., concurring in the judgment in part and dissenting in part) (citing *Inclusive Communities*, 576 U.S. at 530-40). He reasoned that the "take into account" provision does not include the "any other manner" language relied upon by the majority, or any other "results oriented" language that this Court requires for disparate impact liability. App. 77 ("The differentiate clause [of the MSPA] contains no similar 'results-oriented' verb.") (citing *Inclusive Communities*, 576 U.S. at 535).

4. Soon afterward, the Ninth Circuit expressly held that the Sixth Circuit's decision is "incomplete," and – like dissenting Judge Murphy – found that the MSPA does *not* support disparate-impact claims.

In the meantime, two companion cases also brought by DaVita proceeded through the Ninth Circuit. In *DaVita Inc. v. Amy's Kitchen, Inc.*, 981 F.3d 664 (9th Cir. 2020), the Ninth Circuit affirmed the district court's dismissal of all MSPA and ERISA claims. *Id*. at 674. DaVita brought that action alleging the ***same*** denial of benefits claims as alleged in this action under ERISA and the MSPA on behalf of a patient suffering from ESRD. Like Judge Murphy's dissenting opinion in the present case, the Ninth Circuit rejected DaVita's argument that a plan violates the MSPA's "take into

account" and "differentiation" provisions by allegedly paying less for dialysis than for other treatments.

The Ninth Circuit explicitly addressed the Sixth Circuit opinion, expressing the view that the majority's conclusion was "incomplete," and held instead that the MSPA does not support disparate-impact claims. *Id.* In doing so, the Ninth Circuit noted that "[n]ot every list of actions followed by a broad catch-all clause means that Congress intended to encompass a disparate-impact theory[,]" and explained that "*Inclusive Communities* requires both a more detailed study of the statutory text and a consideration of other relevant factors." *Id.* Overall, the Ninth Circuit determined that, because the Amy's Kitchen Plan "provides identical benefits, including dialysis benefits, to all insured persons, the Plan does not run afoul of the MSP[A]." *Id*. at 671.

5. The conflict between the Sixth and Ninth Circuits is ripe for review, and needs no time for further percolation.

In opposing stay of the mandate pending certiorari proceedings, DaVita suggested in the Sixth Circuit that the questions presented will not be ripe for review until there has been further "percolation." BL-79, pp. 3-4. As one scholar has explained, however, a "percolation argument loses most of its force when applied to questions of federal statutory interpretation." Daniel J. Meador, *A Challenge to Judicial Architecture:*

Modifying the Regional Design of the U.S. Courts of Appeals, 56 U. Chi. L. Rev. 603, 633 (1989).

"There Congress has spoken on the matter, and it is important for the judiciary to implement congressional intent in a straightforward, clear manner without generating uncertainties over a prolonged period of time." *Id*.

> The statutory questions involved are typically not earthshaking; indeed, they often involve quite narrow points. Yet they are important to persons affected by them and to those who must plan and conduct activities, ***especially those engaged in activities stretching across circuit lines***. The percolation that produces intercircuit inconsistencies and incoherence may provide intellectual stimulation for academicians, but in the world of human activity it works costly inequities.

Id. at 634 (emphasis added). Similarly, as Chief Justice Rehnquist eloquently articulated, there is a need for "definitive answers" when dealing with "problems of statutory construction which confront the federal courts":

> If we were talking about laboratory cultures or seedlings, the concept of issues "percolating" in the courts of appeals for many years before they are really ready to be decided by the Supreme Court might make some sense. But it makes very little sense in the legal world in which we live. We are not engaged in a scientific experiment or in an effort to square the circle, with respect to which

> endeavors, hoped for dramatic and earth-shaking success at the end of the line may justify many years of cautious preparation and experimentation. But what lawyers and litigants in our country's federal courts are seeking to know may be, for example, the meaning of a particular subsection of the Internal Revenue Code. If we were all members of a monastic order presided over by Plato or by Saint Thomas Aquinas, we might accede to the idea that there need be no rush to judgment on such a question, and that an occasional hypothetical or tentative answer proposed and thought about for a while may help us reach the ultimately "correct" solution. But there is no obviously "correct" solution to many of the problems of statutory construction which confront the federal courts; Congress may have used ambiguous language, the legislative history may shed no great light on it, and prior precedent may be of little help. What we need is not the "correct" answer in the philosophical or mathematical sense, but the "definitive" answer, and the "definitive" answer can be given under our system only by the court of last resort. It is of little solace to the litigant who lost years ago in a court of appeals decision to learn that his case was part of the "percolation" process which ultimately allowed the Supreme Court to vindicate his position.

Justice William H. Rehnquist, *The Changing Role of the Supreme Court*, 14 Fla. St. U. L. Rev. 1, 11 (1986).

Consistent with these principles, it has not been unusual for this Court to grant certiorari to review a

fresh circuit split or a split between just two circuits. *See, e.g.*, *IBP, Inc. v. Alvarez*, 546 U.S. 21, 24 (2005) (Stevens, J.) (certiorari to resolve a conflict between the First and Ninth Circuits related to the Fair Labor Standards Act); *Spector v. Norwegian Cruise Line Ltd.*, 545 U.S. 119, 125 (2005) (Kennedy, J.) (certiorari to resolve a conflict between the Fifth and Eleventh Circuits related to the Americans with Disabilities Act); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 364 (2002) (Souter, J.) (certiorari to resolve a split between the Fifth and Seventh Circuits related to employee benefit plans under ERISA); *Vimar Seguros y Reaseguros, S.A. v. M/V Sky Reefer*, 515 U.S. 528, 532 (1995) (Kennedy, J.) (certiorari to resolve a split between the First and Eleventh Circuits just four months after the First Circuit created the split); *Hess v. Port Auth. Trans-Hudson Corp*., 513 U.S. 30, 51-52 (1994) (Ginsburg, J.) (certiorari to resolve a narrow split between the Second and Third Circuits).

The Court has issued writs of certiorari to review circuit splits between just the Sixth and Ninth Circuits on important issues related to federal statutes. *See Union Bank v. Wolas*, 502 U.S. 151, 154 (1991) (Stevens, J.) ("The importance of the question of law decided by the Ninth Circuit, coupled with the fact that the Sixth Circuit had interpreted § 547(c)(2) in a contrary manner . . . persuaded us to grant the [] petition for certiorari."); *Idaho Sheet Metal Works, Inc. v. Wirtz*, 383 U.S. 190, 196 (1966) (Harlan, J.) (granting certiorari to resolve "irreconcilable interpretations of [] critical

statutory language" between the Sixth and Ninth Circuits).

Further "percolation" of these issues will do nothing to resolve the conflict between the Sixth and Ninth Circuits. While a subsequent court of appeals could disagree with either circuit, it cannot resolve the split. Nor would a subsequent appellate decision necessarily add any new or different analysis to the narrow, but important, questions of federal statutory interpretation that the circuit split presents. There is no need for the delay that a percolation period would impose. Given the nationwide effect of the questions presented on all dialysis patients and their families, who are among the 157 million Americans who are covered by employer group health plans, a uniform answer is needed now.

Resolution of the circuit split in favor of Petitioners would conclusively decide this litigation. The questions presented by this petition are central to all causes of action set forth in Respondents' complaint and amended complaint. The District Court entered final judgment based on a motion to dismiss. The Sixth Circuit reversed and remanded. Reinstatement of the District Court judgment, accordingly, would terminate these proceedings. Affirmance of the Sixth Circuit likewise would be dispositive of the legal issues that the motion to dismiss raised.

II. On the Merits, This Court Should Correct the Sixth Circuit's Extrapolation of the MSPA.

Consistency in approach to statutory construction is essential for a shared understanding of the rights, obligations and privileges prescribed in legislation. Indeed, providing clarity in the law is one of this Court's foremost purposes. *See Hughes v. United States*, 138 S. Ct. 1765, 1779 (2018) (concurring in decision because "doing so helps to ensure clarity and stability in the law") (Sotomayor, J.); *Gisbrecht v. Barnhart*, 535 U.S. 789, 812 (2002) (Scalia, J., dissenting) (expressing concern that the majority's decision "establishe[d] no clear criteria and hence [would] generate needless satellite litigation"); *Doggett v. United States*, 505 U.S. 647, 669 (1992) ("[T]he law draws force from the clarity of its command and the certainty of its application.") (Souter, J.); *Regan v. New York*, 349 U.S. 58, 64 (1955) (Reed, J.) ("The law strives to provide predictability so that knowing men may wisely order their affairs."). The majority's decision runs afoul of the text and purpose of the MSPA and this Court's precedent on statutory interpretation. Clarification by this Court is necessary.

A. ERISA gives group health plans broad discretion to define the benefits that they provide.

At issue in this action is the Marietta Hospital ERISA Plan, of which MedBen is the benefit manager and third-party administrator. ERISA was enacted to

encourage and facilitate employers' provision of health coverage and other benefits to their employees. ERISA does not require employers to offer benefit plans. Rather, Congress enacted ERISA with the underlying purpose of promoting efficiency, predictability and uniformity so as to keep down costs and encourage employers to offer benefit plans in the first instance. *Conkright v. Frommert*, 559 U.S. 506, 507 (2010) (Roberts, C.J.). A primary goal of ERISA is to "enable employers to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits." *Egelhoff v. Egelhoff*, 532 U.S. 141, 148 (2001) (Thomas, J.) (quotation marks omitted).

In line with its goals of efficiency, uniformity and predictability, ERISA's regulatory scheme is "built around reliance on the face of written plan documents" that set forth "exactly" the benefits provided to members. *Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995) (O'Connor, J.) (citation omitted). Accordingly, "the rule that contractual 'provisions ordinarily should be enforced as written is especially appropriate when enforcing an ERISA welfare benefits plan.'" *M&G Polymers USA, LLC v. Tackett*, 574 U.S. 427, 435 (2015) (Thomas, J.) (quoting *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 571 U.S. 99, 108 (2013)) (Thomas, J.) (alteration omitted). Close adherence to the written terms of a plan "is the linchpin of a system that is not so complex that administrative costs, or litigation expenses, unduly discourage

employers from offering welfare benefits plans in the first place." *Id*. (citation and alteration omitted).

This Court has repeatedly emphasized that ERISA plans have broad discretion to define the benefits that they provide. "ERISA does not create any substantive entitlement to employer-provided health benefits or any other kind of welfare benefits," and "[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans." *Curtiss-Wright*, 514 U.S. at 78; *see also Lockheed Corp. v. Spink*, 517 U.S. 882, 884 (1996) (Thomas, J.) (same). Rather, "employers have large leeway to design disability and other welfare plans as they see fit." *M&G Polymers*, 574 U.S. at 435 (quotation and alteration omitted).

B. The MSPA is a coordination-of-benefits measure, designed to protect Medicare.

Starting in 1972, Medicare was the primary payer for services for ESRD patients. In 1980, Congress enacted the MSPA to shift costs from Medicare to private sources by changing the order of responsibility between governmental and private health plans, including ERISA plans, to pay for treatment for patients with ESRD. *See* MSP Manual, Chapter 1, § 10. Under that change, Medicare became the secondary payer and other healthcare coverage became primary payers for individuals eligible for or entitled to Medicare benefits. Courts have repeatedly emphasized that the MSPA's central purpose is to conserve Medicare funds, and

thus private plans and insurers must assume primary responsibility for ESRD patients' treatment costs for a "coordination period" of up to thirty months following Medicare eligibility.[2]

In addition to requiring that private plans serve as the "primary" payers in situations where both Medicare and a private plan could provide coverage, the MSPA prohibits plans from (1) "differentiat[ing]" between benefits provided to ESRD patients versus non-ESRD patients, or (2) "tak[ing] into account" the fact that a beneficiary is eligible for Medicare due to ESRD. 42 C.F.R. § 411.161(a)-(b). Congress enacted these provisions because allowing a plan to eliminate benefits solely on the basis of ESRD or ESRD-based Medicare eligibility or entitlement would allow plans to opt out of their primary payment obligations and therefore negatively impact Medicare's finances. *See Bio-Med. Apps. of Tenn., Inc. v. Cent. States Se. & Sw. Areas Health & Welfare Fund*, 656 F.3d 277, 282 (6th Cir. 2011) (the "take into account" provision serves Congress's goal of preventing the "shifting of costs from private plans to the public fisc"). In accordance with ERISA's guiding principles, however, the MSPA's anti-differentiation and take-into-account provisions do not affirmatively require plans to provide a fixed set of

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[2] "It is possible for patients to drop out of private coverage (and go with Medicare) during the coordination period." *Nat'l Renal Alliance, LLC v. Blue Cross & Blue Shield of Ga., Inc.*, 598 F. Supp. 2d 1344, 1347 (N.D. Ga. 2009); *see also* MSP Manual, Chapter 1, § 10.1 (Medicare beneficiaries are "free to reject employer plan coverage in which case they retain Medicare as their primary coverage").

benefits for ESRD patients, nor do they preclude limits on dialysis treatment so long as those limitations are applied uniformly to all plan members. *See* 42 C.F.R. § 411.161(c) (permitting uniform limitation on coverage for renal dialysis to 30 sessions).

To effectuate its purpose of protecting Medicare's finances, the MSPA provides a governmental right of action to recover payments conditionally made by Medicare. 42 U.S.C. § 1395y(b)(2)(B). The statute further allows private parties to sue where a primary plan "fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A)" of the Act, which set forth the statute's requirements and the circumstances in which Medicare may step in and pay amounts for which the primary plan is liable. *Id*. § 1395y(b)(3)(A).

As appellate courts have noted, "[c]ourts considering the [MSPA's private right of action] have generally agreed that the apparent purpose of the statute is to help the government recover conditional payments from insurers or other primary payers." *Stalley v. Catholic Health Initiatives*, 509 F.3d 517, 524 (8th Cir. 2007) (collecting cases). The private right of action "is clearly based in turn upon the subrogation right of the government to obtain a portion of the recovery. This recovery of costs by Medicare is the primary purpose of the MSP[A]." *Frazer v. Transcon. Ins. Co.*, 374 F. Supp. 2d 1067, 1077 (N.D. Ala. 2004); *see also Bio-Med.*, 656 F.3d at 296 (MSPA serves Medicare's interests by "empower[ing] healthcare providers to sue private insurers who violate the Act," and "then enabl[ing] Medicare

to pursue its reimbursement out of the proceeds recovered by the victorious healthcare providers"). In line with this purpose, the MSPA requires private litigants who recover reimbursement for denied claims that were paid by Medicare to turn the amount paid over to the government upon the government's request. *See* 42 U.S.C. § 1395y(b)(2)(B)(ii).

C. The Sixth Circuit decision is contrary to the text of the MSPA.

The Sixth Circuit majority opinion runs completely counter to the norms of statutory interpretation. "[W]hen the meaning of the statute's terms is plain," as this Court recently observed, "our job is at an end. The people are entitled to rely on the law as written[.]" *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1749 (2020) (Gorsuch, J.). The majority decision transforms the statute, however, from a coordination-of-benefits law designed to protect ***Medicare*** into an anti-discrimination statute designed to protect ***certain providers***.

Although the plan at issue offers the same benefits to all participants, the majority has interpreted the MSPA to mean that the plan nonetheless allegedly "takes into account" Medicare eligibility and "differentiates" benefits in violation of the MSPA. *See* 42 U.S.C. §§ 1395y(b)(1)(C)(i), (ii). This decision is in stark contrast to the regulations applicable to the MSPA, which define "taking into account" or "differentiating" to mean "pay[ing] providers and suppliers less for services furnished to a Medicare beneficiary than

for the same services furnished to an enrollee who is not entitled to Medicare." 42 C.F.R. §§ 411.108(a)(8), 411.161(b)(2)(iv). Similarly, equitable relief is available under ERISA if a plan establishes eligibility rules that differentiate between similarly situated plan participants based on health status or medical condition. *See* 29 U.S.C. § 1182(a)(1)(A), (E).

Under the applicable regulations, the terms of a plan accordingly do not "take into account" Medicare eligibility unless they provide different benefits or levels of coverage to those who are eligible for Medicare versus those who are not. 42 C.F.R. § 411.108(a) provides that a plan "takes into account" ESRD-based Medicare eligibility when it limits benefits for Medicare-eligible ESRD patients, but not for "similarly situated individuals who are not entitled to Medicare" on the basis of ESRD diagnosis. *Id.*

In the face of this clear guidance, the Sixth Circuit nevertheless determined that the absence of maximum dialysis reimbursement rates to the dialysis provider gives rise to an inference of unlawful disparate treatment based upon the "take into account" and "anti-differentiation" provisions. By creating this new standard, the Sixth Circuit makes it hazardous to rely on the MSPA as written. It will now be difficult, and in many cases impossible, for a plan to defend itself in the Sixth Circuit against a private cause of action any time that a member with ESRD drops his or her private health insurance for any reason, including the cost associated with the private plan.

If the Sixth Circuit's interpretation stands, it will severely undermine the proposition that "a law is the best expositor of itself" and give ascendance to "refined arguments to show that the statute does not mean what it says." *See Pennington v. Coxe*, 6 U.S. (2 Cranch) 33, 52 (1804) (Marshall, J.); *United States v. Wurzbach*, 280 U.S. 396, 398 (1930) (Holmes, J.); *see also* A. Scalia & B. Garner, *Reading Law: The Interpretation of Legal Texts* 56 (2012) ("The words of a governing text are of paramount concern, and what they convey, in their context, is what the text means."). Restoration of the plain meaning of the MSPA by this Court is necessary to conform to the norms of statutory interpretation.

D. The Sixth Circuit's decision departs from this Court's precedent on disparate treatment as a basis for discrimination and ERISA benefit claims.

Both the Ninth Circuit and Judge Murphy disagreed with the Sixth Circuit majority's conclusion and correctly acknowledged that the MSPA is not an anti-discrimination law; it is a coordination-of-benefits measure that "lacks the defining features of the specific anti-discrimination laws that the Supreme Court has read to impose disparate-impact liability." App. 76 (Murphy, J., concurring in the judgment in part and dissenting in part); *see also Amy's Kitchen*, *supra*, 981 F.3d at 674 (undertaking a "more detailed study of the statutory text and a consideration of other relevant factors" than the Sixth Circuit and noting that the use of "differentiate" rather than "discriminate" by Congress

in the MSPA "strongly suggests that Congress did *not* intend to create a disparate-impact theory of liability") (emphasis in original).

The "take into account" provision does not include the "any other manner" language upon which the Sixth Circuit majority relied, or any other "results oriented" language that this Court requires for disparate impact liability. *See Inclusive Communities*, 576 U.S. at 535. The "anti-differentiation" provision states only that a health plan "may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner." 42 U.S.C. § 1395y(b)(1)(C)(ii).

There is a complete disconnect between the Sixth Circuit majority's holding and the plain language and purpose of the statute and its implementing regulations. *See* Section II.B-C, *supra*. The Sixth Circuit has unaccountably imported the "disparate impact" standard into this administrative measure from an entirely unrelated body of anti-discrimination law. Only when a statute contains a narrow prohibition of *intentional* discrimination followed by catchall language such as "otherwise make unavailable," or "otherwise adversely affect," may claims be proved by evidence of disparate impact of the challenged practice. *See Inclusive Communities*, 576 U.S. at 545-46 (text of Fair Housing Act, like Title VII of the 1964 Civil Rights Act and the Age Discrimination in Employment Act, allows plaintiffs to prove a statutory violation through disparate impact).

Contrastingly, when a statute contains language such as "preventing exclusion from participation in," "denying the benefits of," or "being subject to discrimination," this Court has allowed ***only*** claims based on theories and evidence of intentional discrimination. *See Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 173-74 (2005) (O'Connor, J.) (Title IX, 1964 Civil Rights Act, which provides that "[n]o person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subject to discrimination," requires proof of intentional discrimination); *Alexander v. Choate*, 469 U.S. 287, 293 (1985) (Title VI, 1964 Civil Rights Act, which provides that "[n]o person . . . shall . . . be excluded from participation in, denied the benefits of, or be subjected to discrimination," requires proof of intentional discrimination).

Moreover, the "in any other manner" phrase, when used in anti-discrimination statutes (which the MSPA is not), operates to prevent retaliatory activity. For example, the Family and Medical Leave Act ("FMLA") bars employers from "discharg[ing] *or in any other manner* discriminat[ing] against any individual for opposing any practice made unlawful by [the FMLA]." 29 U.S.C. § 2615(a)(2) (emphasis added). "Retaliation, by its definition, is an intentional act." *Jackson*, 544 U.S. at 174. Retaliation cases, therefore, are not subject to disparate impact claims targeting unintentional discrimination. *See id.*; *see also* 29 U.S.C. § 215(a)(3) (FLSA anti-retaliation provision, preventing intentional discrimination, prohibiting employer from discharging "*or*

in any other manner discriminat[ing] against" employee) (emphasis added); 15 U.S.C. § 78u-6(h)(1)(A) (whistleblower anti-retaliation provision preventing intentional discrimination by discharging, demoting, suspending, threatening, harassing "*or in any other manner* discriminating against" a whistleblower because of legally protected acts) (emphasis added).

The Sixth Circuit adopted its "disparate impact" rule in opposition to this directly applicable authority from this Court and the text of these comparable statutes. The Ninth Circuit's well-reasoned decision considered that authority and those texts, and properly rejected the "disparate impact" argument. The more apt comparison of the MSPA is with the statutory language at issue in *Jackson* and *Alexander* and anti-discrimination statutes that prohibit retaliation. If the MSPA were an anti-discrimination statute (which it is not), it would be similarly interpreted, as allowing only claims of intentional discrimination and not those alleging a disparate impact.

Tellingly absent from the Sixth Circuit majority's opinion is any reference to the ADA. The ADA provides non-discrimination protection to ESRD patients and others who need dialysis. *See Fiscus v. Wal-Mart Stores, Inc.*, 385 F.3d 378, 385 (3d Cir. 2004) (holding district court "erred in deciding that elimination of waste from the blood is not a major life activity under the ADA."). Notably, the ADA allows risk-factor adjustments in healthcare benefits for different types of disabilities, including kidney-related disabilities. *See, e.g.*, 42 U.S.C. § 12202(c)(1); 28 C.F.R. § 62.212(a)(1); *Barnes*

v. Beham Grp., Inc., 22 F. Supp. 2d 1013, 1020 (D. Minn. 1998). Omission of the ADA is indicative of the incomplete character of the analysis underlying the Sixth Circuit's adoption of the disparate impact standard.

E. The Sixth Circuit's decision neglects the purpose of the MSPA.

As both the Ninth Circuit and Judge Murphy recognized, every other court to consider this issue has determined that the MSPA does not bar a plan that offers uniform benefits to all enrollees. App. 82 (Murphy, J.) ("As far as I am aware, every district court to consider this question has interpreted this clause as I do.") (collecting cases); *Amy's Kitchen*, 981 F.3d at 675 ("[U]ntil just a couple of months ago, no court had held that the MSP[A] encompasses a disparate-impact theory of liability.") (citing *Nat'l Renal All., LLC v. Blue Cross & Blue Shield of Ga., Inc.*, 598 F. Supp. 2d 1344, 1354-55 (N.D. Ga. 2009)). The purpose of the MSPA is to protect Medicare – it is not an anti-discrimination statute.

CONCLUSION

For these reasons, the Marietta Memorial Hospital Employee Health Benefit Plan, Marietta Memorial Hospital and Medical Benefits Mutual Life Insurance

Co. jointly and respectfully urge the Court to issue a writ of certiorari to the Sixth Circuit.

Respectfully submitted,

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