No. 20-1641

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

JOINT BRIEF OF PETITIONERS

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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

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

The corporate disclosure statement included in the joint petition of Marietta Memorial Hospital Employee Health Benefit Plan (the "Plan"), Marietta Memorial Hospital ("Marietta Hospital") and Medical Benefits Mutual Life Insurance Co. ("MedBen" and, with the Plan and Marietta Hospital, "Petitioners") remains accurate.

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INTRODUCTION

The question in this case is whether a commercial dialysis provider may use the Medicare Secondary Payer Act (MSPA) to modify terms of a patient's group health plan to obtain a higher reimbursement for its dialysis services. Two providers dominate the dialysis market. Faced with that impediment to negotiation, the Marietta Memorial Hospital Employee Health Benefit Plan reimburses the cost of outpatient dialysis services at a standard rate not to exceed 125% of the Medicare allowable rate. That benefit applies uniformly to all plan participants. It is the same for those who have end stage renal disease (ESRD), which qualifies them for Medicare coverage regardless of age, and those for whom dialysis treats other forms of kidney disease. One of the two major dialysis providers asserts in this case that the MSPA entitles it to a more profitable reimbursement.

The MSPA is a coordination-of-benefits statute that Congress enacted to conserve Medicare resources. During a thirty-month coordination-of-benefits period after an ESRD diagnosis, a group health plan, as primary payer, may not "take into account" the fact that an "individual is entitled to or eligible for" Medicare benefits by virtue of having ESRD. The plan must remain the primary payer of dialysis expenses during that time. Nor may a plan "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)(i)-(ii).

DaVita asserts that a group health plan violates the MSPA by providing dialysis benefits based on the Medicare rate, even though those benefits are identical for all plan participants. Seeking a more lucrative reimbursement, it argues that, because most people who need dialysis have ESRD, the MSPA actually compares dialysis benefits to other plan benefits to make sure that dialysis claims have priority. Rather than simply prohibit any difference between benefits for individuals who have ESRD and other plan participants, which is what the actual text says, DaVita maintains that the MSPA also requires a group health plan to reimburse the full "undiscounted charges" of dialysis providers for all dialysis patients.

Alone among the courts that have considered the issue, the Sixth Circuit has broadened the MSPA beyond its actual text and agreed that DaVita has stated a claim. It has ruled in a split decision that a group health plan, with a dialysis benefit that is uniform and applies to all participants, may violate the MSPA even if it "has not directly targeted ESRD patients[,] by differentially treating the service that they need far more than anyone else." Pet. App. 45. "In short, 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." *Id.* at 41.

It was error to transform the MSPA, a coordination-of-benefits statute, into an antidiscrimination law meant to regulate the benefits themselves. As the dissent explained, (1) the "take into account clause"

"bar[s] only group health plans that contain terms *expressly targeting* Medicare-eligible individuals who are eligible because of their end stage renal disease" and (2) "a plan that uniformly offers the same benefits to all groups does not violate" the "differentiation" clause. Pet. App. 70-71; 83-84 (Murphy, J., concurring in judgment in part and dissenting in part). Moreover, the MSPA "lacks the defining features of the specific anti-discrimination laws that the Supreme Court has read to impose disparate-impact liability." Pet. App. 76.

The Ninth Circuit echoed the dissent several weeks later in a twin case brought by DaVita, soundly rejecting a similar MSPA challenge to such reimbursement of DaVita's charges for dialysis services. *See DaVita, Inc. v. Amy's Kitchen, Inc.*, 981 F.3d 664 (9th Cir. 2020). The court reviewed dialysis coverage terms that the Amy's Kitchen group health plan likewise adopted in reaction to "'significant inflation' of prices charged by dialysis providers" and the "specific targeting" of the group health plan "by the dialysis providers as profit centers." *Id.* at 668. The court ruled that a group health plan that "takes no notice whatsoever of whether the claimant is eligible for Medicare" does not violate the "take into account" clause. *Id.* at 670. Moreover, said the court, "a plan that provides identical benefits to someone with ESRD as to someone without ESRD does not 'differentiate' between those two classes." *Id.* at 678.

The Ninth Circuit also correctly held that the MSPA does not support disparate-impact claims, noting 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 explaining that this Court "requires both a more detailed study of the statutory text and a consideration of other relevant factors." *Id.* at 674.

The Sixth Circuit dissent and the Ninth Circuit opinion have pointed the law in the right direction. Under the canons of statutory construction, the MSPA has no between-the-lines requirement that group health plans reimburse dialysis providers in accordance with any other plan benefit or at specific rates preferred by dialysis providers. Nor is there any basis for disparate-impact liability. Plan terms that treat all participants the same are not a sufficient basis to state a claim for violation of the MSPA. The Court should reverse the judgment below.

OPINIONS BELOW

The Sixth Circuit opinion is reported at 978 F.3d 326 and reproduced at Pet. App. 1-94. 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 Pet. App. 95-117.

STATEMENT OF JURISDICTION

The Sixth Circuit entered its judgment on October 14, 2020. The judgment became final on December 23,

2020, when the Sixth Circuit denied rehearing en banc. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This case involves the MSPA (42 U.S.C. § 1395y(b)) and the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. §§ 1132(a), 1182(a)(1)). Relevant portions are reproduced at Pet. App. 55-65 and 118-25.

STATEMENT OF THE CASE

A. Statutory Background

The MSPA establishes a timeframe within which group health plans are the primary payers of dialysis expenses for plan participants with ESRD who are also enrolled in Medicare. It provides that Medicare payment of dialysis charges generally "may not be made . . . to the extent that . . . payment has been made, or can reasonably be expected to be made," by a group health plan. 42 U.S.C. § 1395y(b)(2)(A)(i). The coordination period during which the group health plan is primary payer, originally twelve months, is now thirty months. 42 U.S.C. § 1395y(b)(1)(C).

The "take into account" and "differentiation" prohibitions sustain the thirty-month coordination-of-benefits period by preventing group health plans that provide dialysis benefits from shifting primary payer

responsibility to Medicare during that interval. Referring to 42 U.S.C. § 426-1, which affords Medicare coverage to individuals with ESRD, the statute provides that a group health plan:

> (i) may not take into account that an individual is entitled to or eligible for benefits under this subchapter under section 426-1 of this title during the [30]-month period which begins with the first month in which the individual becomes entitled to benefits under part A [. . .]; and
>
> (ii) 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;
>
> except that clause (ii) shall not prohibit a plan from paying benefits secondary to this title when an individual is entitled to or eligible for benefits under this title under section 226A [the Medicare ESRD exception] after the end of the [30]-month period described in clause (i).

42 U.S.C. § 1395y(b)(1)(C).

1. The Medicare Secondary Payer Act (MSPA) coordinates Medicare coverage with group health plan benefits for plan participants who have end stage renal disease (ESRD).

Group health plans cover nearly 50% of the American people. Sponsored by employers or employee-based organizations, they ordinarily offer more comprehensive coverage at lower cost than individual plans. The premiums and coverage are important to employers, employees and job applicants. Sponsoring organizations have limited resources, however. To cover a broad range of medical expenses, the plan terms specify rates at which they agree to reimburse health care providers for designated services. [1]

Treatment of kidney disease through dialysis is one potential need of participants in group health plans. As the Ninth Circuit explained in the *Amy's Kitchen* case, "[d]octors classify chronic kidney disease into five stages. The last stage, Stage 5, is known as kidney failure or ESRD. More than 700,000 people in the United States have ESRD. To survive, a person with ESRD requires either a kidney transplant or routine maintenance dialysis, a treatment that performs the functions of a kidney." *Amy's Kitchen*, 981 F.3d at 667 (citations omitted).[2]

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[1] *See generally* Kaiser Family Foundation, *Employer Health Benefits 2020 Summary of Findings* (2020); Chauncey Crail & Alena Hall, *What You Need to Know about Group Health Insurance for Open Enrollment*, Forbes (Nov. 1, 2021).

[2] *See also* Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy* 167 (March 2021);

2. Dialysis treats not only ESRD but also other forms of kidney disease.

"People with ESRD are not the only recipients of dialysis." *Id*. "The other common recipients . . . are those with 'acute kidney injury,' described by the National Kidney Foundation as 'a sudden episode of kidney failure or kidney damage that happens within a few hours or a few days.' Acute kidney injury has many different causes and correlated diseases." *Id.* (citations omitted). Notably, a recent "study cited by the National Kidney Foundation concluded that 'people hospitalized with COVID-19 are at significant risk of acute kidney injury.'" *Id.* at 667-68.

3. Medicare independently covers individuals who have ESRD.

Along with group health plans, Medicare covers dialysis services for individuals with ESRD, regardless of their age. ESRD is one of the few exceptions to the Medicare age requirement. Even under age 65, an individual with ESRD is entitled to Medicare Part A benefits (hospitalization) and eligible to apply for Part B benefits (outpatient medical services), including reimbursement of the cost of dialysis treatment. *See Social Security Amendments of 1972*, Pub. L. No. 92-603, § 299I, 86 Stat. 1329, 1463 (1972) (making "every individual" who is "medically determined to have chronic

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https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/End-Stage-Renal-Disease-ESRD/ESRD (last modified Dec. 1, 2021).

renal disease and who requires hemodialysis or renal transplantation" eligible for Medicare); Act of June 13, 1978, Pub. L. 95-292, § 266A, 92 Stat. 307 (1978) (changing eligibility criterion to persons who are "medically determined to have end stage renal disease"). The 21st Century Cures Act allows all Medicare eligible individuals who have been diagnosed with ESRD to enroll in Part C Medicare Advantage plans. Pub. L. 114-255, 130 Stat. 1033 (2016).

4. Congress has enlisted group health plan resources to help defray Medicare ESRD costs.

In 1981, one year after passage of the original Medicare Secondary Payer Act (which pertained to other overlapping payments), Congress responded to rising dialysis costs by adding to the MSPA the provision that payment by Medicare "may not be made" for dialysis treatments and related expenses "to the extent that payment . . . has been made under any group health plan." Medicare and Medicaid Amendments of 1981, Pub. L. 97-35, § 2146, 95 Stat. 783, 800 (1981). The moratorium on Medicare primary payment responsibility applied at first "during the 12-month period which begins with . . . the month in which a regular course of renal dialysis is initiated." § 2146, 95 Stat. at 801. Subsequent legislation has extended the number of coordination months to thirty. *See* 42 U.S.C. § 1395y(b)(1)(C).

Congress added the "take into account" and "differentiate" provisions to the MSPA in 1989. Pub. L. 101-239, § 6202,103 Stat. 2106, 2231 (1989).

5. During the thirty-month coordination period, the group health plan is primary payer and Medicare is a secondary payer for enrolled plan participants who have ESRD.

Codified today at 42 U.S.C. § 1395y(b), the MSPA coordinates payment for dialysis benefits by group health plans with Medicare secondary payments. Persons with ESRD become entitled to Medicare regardless of age, at the beginning of the fourth month after receiving their first dialysis treatment (except for those participating in in-home dialysis, which makes them immediately eligible and entitled). 42 U.S.C. § 426-1.[3]

As a result:

- Individuals with ESRD, or their group health plan (if any), are solely responsible for the cost of dialysis treatments during the three-month waiting period before Medicare eligibility begins;

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[3] ESRD-related eligibility is afforded to those who have worked for a prescribed time under Social Security, the Railroad Retirement Board (RRB) or as a government employee; persons who receive or are eligible for Social Security or RRB benefits; or persons who are the spouse or dependent child of an individual in either of the first two categories. *See* 42 U.S.C. § 426-1(b).

- During the following thirty months (the coordination period), the group health plan would be the primary payer for covered dialysis services, and Medicare a secondary payer, for plan participants who enroll in Medicare on the basis of ESRD, 42 U.S.C. § 1395y(b)(4); and
- Medicare becomes the primary payer by default after the thirtieth month if the ESRD patient is enrolled. *See* 42 U.S.C. § 1395y(b)(1)(C).

B. Statement of the Case

1. Parties

a. Petitioners are an Ohio non-profit hospital, its group health plan and the third-party administrator.

Marietta Memorial Hospital is a non-profit community hospital located in Marietta, Ohio. It self-funds the Plan, which is an employer group health plan for its employees and their dependents, and serves as Plan Administrator. Jt. App. 7. Self-funding means that the Hospital bears its own financial risk. MedBen is the third-party administrator of the Plan. *Id*. It is located in Newark, Ohio. Jt. App. 15

b. Respondents are major for-profit dialysis providers.

DaVita is a for-profit "leading provider of quality dialysis care in the United States" by business volume,

with an estimated 200,000 patients treated at nearly 2,400 dialysis treatment centers across the nation. Jt. App. 8-10. According to the Medicare Payment Advisory Commission, the dialysis sector "is highly consolidated, with two large dialysis organizations (LDOs) – Fresenius Medical Care and DaVita – dominating the industry." In 2019, according to the Commission, "these LDOs accounted for three-quarters of facilities and Medicare treatments."[4]

DaVita brings the claims asserted in this case by virtue of an "Assignment of Benefits" that it required from Patient A, a Plan participant who was diagnosed with ESRD. Patient A received dialysis services from DaVita beginning on April 15, 2017. Jt. App. 10, 15. Patient A received dialysis treatment while enrolled in the Plan. Jt. App. 15. DaVita received payment in accordance with the Plan terms. Jt. App. 15-17. With the benefit of the assignment that it obtained from Patient A, DaVita has brought its claims "in its own capacity and as assignee of Patient A." Jt. App. 7.

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[4] Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy* 174 (March 2021).

2. The Marietta Memorial Hospital Employee Health Benefit Plan reimburses dialysis providers on the same basis as if they were Preferred Providers, subject to a Medicare-based cap because of their market dominance.

DaVita challenges terms of the Plan that (a) designate dialysis services as "out-of-network"; (b) peg reimbursement for dialysis services to the Medicare rate; and (c) establish cost-containment review, claim audits and other procedures for charges by dialysis providers. Jt. App. 25-26. It claims that benefits such as these may induce dialysis patients "to abandon their employer plan and move onto Medicare." *Id.*

At its irreducible essence, however, this case is a billing dispute, not a coverage debate. The 102-page Summary Plan Description is annexed to the Complaint and, therefore, has the same status as the allegations of the Complaint itself for purposes of a motion to dismiss. Jt. App. 43-275. It shows that the DaVita allegations present a grossly incomplete explanation of the Plan benefits and structure and a highly omissive portrayal of the Medicare program. *Id.*; *see also* 2 Moore's Federal Practice – Civil, § 10.05 [5] (Matthew Bender 3d ed.) ("in the case of a conflict between the exhibit and the pleading, the exhibit controls").

The true impetus of the Complaint is found in its allegations that DaVita "has been damaged as a result

of Defendants' failure to provide appropriate reimbursement as primary payer for its enrollees and other illegal practices in violation of the MSPA" and "causing the Plan to pay DaVita at rates far below the amounts to which DaVita is entitled." Jt. App. 29, 39.

a. The Plan provides the same coverage to all participants.

The Plan provides medical, dental and vision benefits to Hospital employees and their dependents. Jt. App. 78. There are three levels of medical coverage, available to all participants. Tier I, the highest reimbursement level, applies to services rendered by Preferred Providers who are part of the Marietta Memorial Physician-Hospital Organization ("PHO"), which is a collaborative partnership between the Hospital and its physicians to provide coordinated care and negotiated payment rates with third-party payers. Tier II reimburses services, rendered by Preferred Providers who are not part of the PHO, at a Preferred Provider level.

Tier I coverage and Tier II coverage are both considered in-network for purposes of the applicable participant out-of-pocket maximums and participant cost-sharing. Jt. App. 78-80. Tier III (the "lowest level") is out-of-network and the default reimbursement level for providers who are not Preferred Providers. Jt. App. 79-81.

The Plan offers the same dialysis benefits, including uniform reimbursement of dialysis treatments, to

all participants. *Id.*, Jt. App. 88. There is no distinction among the participants based on ESRD.

b. The Plan reimburses dialysis providers the same as in-network Preferred Providers even when they are out-of-network.

Although DaVita is not a Preferred Provider under the Plan, the Plan explicitly pays it as a Preferred Provider under Tier II. DaVita alleges that the Plan discriminated against Patient A by providing no in-network benefit. As the Plan documents state, however, outpatient dialysis expenses are "Paid at Tier II level," as are five other categories of out-of-network services. Jt. App. 87-90.

As such, the Plan reimburses expenses of dialysis and the other five categories of services at the same level as the services of Preferred Providers in Tier II who are not part of the PHO. Though technically out-of-network, dialysis charges thus are paid, from the participant's perspective, as if rendered by a Tier II Preferred Provider even though DaVita is not a Preferred Provider. DaVita's claim that the lack of an in-network provider has harmed plan participants does not square with the actual terms of the Plan. It is simply inaccurate.

By treating all outpatient dialysis claims as Tier II Preferred Provider claims, the Plan also cuts in half the participants' standard deductible amount (to $1,000 for individuals/$2,000 for families per calendar

year) compared to the Tier III deductible ($2,000/$4,000), and caps the out-of-pocket costs, which are "Unlimited" for Tier III services. *Id.*, Jt. App. 83-84.

In other words, after the participant has reached the deductible limit, the Plan pays 70% of the Plan's maximum allowable amount (for dialysis, 125% of the Medicare rate, discussed below) – the same percentage that it pays to Tier II Preferred Providers for other medical services – whether or not the participant has ESRD. Jt. App. 87-88. The participant likewise is potentially responsible for dialysis costs up to the deductible limit and the remaining 30% of the Plan's maximum allowable amount, up to the annual out-of-pocket maximum established for Tier II benefits ($6,850 for individuals/$13,700 for families per calendar year beginning in 2017).

c. Medicare enrollment allows plan participants to benefit from the Medicare secondary coverage, which protects them from extra costs.

The MSPA defines the secondary payment responsibilities that Congress has vested in Medicare. "Where payment for an item or service by a primary plan is less than the amount of the charge for such item or service and is not payment in full," the MSPA currently states, "payment may be made under this title [by Medicare] (without regard to deductibles and coinsurance under this title) for the remainder of such charge[.]" 42 U.S.C. § 1395y(b)(4). Medicare enrollment is a prerequisite to such secondary coverage. Under the

applicable regulations, "[n]o Medicare benefits are payable on behalf of an individual who is eligible but not yet entitled." 42 C.F.R. § 411.162(a)(1).

By making all individuals with ESRD eligible for Medicare, and through the MSPA, Congress has incentivized individuals with ESRD to enroll in Medicare in order to avail themselves of the secondary coverage (including cost-sharing limitations) during the coordination period.

d. Medicare protects enrolled plan participants from balance billing and limits cost-sharing to the Medicare allowable deductible and coinsurance.

The regulations of the Centers for Medicare & Medicaid Services (CMS) insulate ESRD patients who enroll in Medicare from exposure to balance billing. (Balance billing is the process of attempting collection, from a participant, of any residual amount charged by a dialysis provider but not paid for by the plan as primary payer or Medicare as secondary payer because provider charges exceed allowable payments by those payers.)[5]

Under the CMS regulations, "[a]ll approved ESRD facilities must accept the prospective payment rates established by [Medicare] as payment in full for

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[5] Implicitly indicating that no balance billing occurred here, DaVita argued in its opposition to the motions to dismiss that it "need not plead that it actually balance billed Patient A" in order to bring its claim for ERISA benefits. RE 24, Page ID # 257.

covered renal dialysis services." 42 C.F.R. § 413.172(b). Along with subsidizing the coinsurance portion of the bill (*i.e.*, paying the net amount of the Medicare rate, after the group health plan has paid its share), and reducing exposure to the deductible portion, Medicare regulations thus also eliminate the prospect of balance billing for participants with ESRD who are also enrolled in Medicare.[6]

e. The MSPA protects participants in conjunction with the Plan.

As further inducement to also enroll in Medicare (it is not an "either-or" choice), cost-sharing is then additionally limited for participants who become Medicare beneficiaries, due to the elimination of balance billing. Jt. App. 84-86. Cost-sharing for such a participant would be limited to the Medicare deductible and coinsurance, which can only be billed if those amounts exceed the primary group health plan payment (meaning that the participant often has no cost-sharing at all for dialysis services). Without enrolling in Medicare, such a participant could be balance billed by an out-of-network provider for any unpaid charges after the group health plan payment, which could be a significant cost to the participant.

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[6] *See* MSP Manual Ch. 3, § 10.1, Limitation on Right to Charge a Beneficiary Where Services Are Covered by a GHP (Rev. 37, Issued 10.14.05), www.cms.gov/regulations-andguidance/guidance/manuals/downloads/msp105c03.pdf.

CMS urges plan participants with ESRD to consider the fact that "[i]f your group health plan coverage has a yearly deductible, copayment, or coinsurance, signing up for Medicare Part A and Part B could help pay those costs during the coordination period."[7] Because of the MSPA coordination-of-benefits framework, plan participants who enroll in Medicare (while keeping their primary group health plan coverage) can receive dialysis treatments with little to no out-of-pocket cost for those treatments as compared to group health plan coverage alone.

f. The Plan pays dialysis costs by reference to the approved Medicare rate.

Faced with the peculiar dominance of the dialysis market by two particular providers, including DaVita, and reserving the Plan Administrator's discretion, the Plan reimburses dialysis providers for services to any participant at a rate not to exceed 125% of the "Medicare allowable fee" and provides for cost-containment and claim audit procedures. Jt. App. 91-92; *see also Amy's Kitchen*, 981 F.3d at 668.

As set forth in the Summary Plan Description, the Plan's share is 70%, meaning that the Plan pays 87.5% of the Medicare rate as its share of the reimbursement. Jt. App. 88.

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[7] CMS, *Medicare Coverage of Kidney Dialysis & Kidney Transplant Services*, CMS Product No. 02179, Rev. Sept. 2020, at 13, www.medicare.gov/media/4416.

The "Medicare allowable fee" is the "Prospective Payment System" (PPS) that Medicare uses to govern dialysis provider reimbursements. The Medicare payment is "intended to cover all operating and capital costs that efficient providers would incur in furnishing dialysis treatment episodes in dialysis facilities or in patients' homes."[8] The base payment rate in 2021 is $253.13. Medicare adjusts the base payment rate to account for regional, patient and technological variations. *Id.* The Plan bases its reimbursements to dialysis providers on this Medicare-approved base rate plus twenty-five percent.

The MSPA does not require that primary plan payments exceed the Medicare base rate. In fact, Congress predicated Medicare's secondary payment obligation on the very assumption that group health plans lawfully may pay less than Medicare (otherwise, there would be no occasion for a Medicare secondary payment). After a group health plan makes its primary payment, the Medicare secondary payment may be made up to an amount that "may not exceed" the "greater" of the "reasonable cost" or either "the amount which would be payable under the primary plan (without regard to deductibles and coinsurance under such plan)" or the "reasonable charge or other amount which would be payable under this title (without regard to deductibles and coinsurance under this title."). 42 U.S.C. § 1395y(b)(4).

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[8] Medicare Payment Advisory Comm'n, *Outpatient Dialysis Services Payment System: Payment Basics* (Nov. 2021). *See* 42 C.F.R. § 411.33.

g. DaVita seeks a higher reimbursement from the group health plan during the coordination-of-benefits period, while the Plan is primary payer.

Rather than continue to accept a reference-based payment calculated according to the Medicare rate, DaVita seeks an order in this litigation requiring that it be paid instead "at its ***undiscounted charges*** or, at a minimum, at the reasonable and customary rates for dialysis as typically understood in the industry," as to which it gives no specifics. Jt. App. 32 (emphasis added). By contrast, "Preferred Providers" "have agreed to provide services and supplies to Covered Persons under this Plan in accordance with previously determined ***discounted fee schedules***." Jt. App. 81 (emphasis added).

h. The Plan provides thirty months of primary coverage of dialysis expenses.

The Summary Plan Description confirms that, "if any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first thirty (30) months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law." Jt. App. 242-43.

3. The DaVita Complaint is one of a series of such pleadings that DaVita has filed around the nation to seek greater reimbursements from group health plans.

This case arises from the United States District Court for the Southern District of Ohio. DaVita seeks relief under the MSPA private right of action (42 U.S.C. § 1395y(b)(3)(A)), which allows recovery of double damages "in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with" the MSPA, and ERISA (29 U.S.C. §§ 1132(a), 1182(a)(1)).

a. This action is one of many similar cases brought by DaVita.

The Complaint in this case is one of many similar pleadings that DaVita has recently filed in courts across the country in its quest for more remunerative reimbursements by group health plans. *See DaVita, Inc. v. Amy's Kitchen, Inc.*, 981 F.3d 664 (9th Cir. 2020); *DaVita, Inc. v. Virginia Mason Mem'l Hosp.*, 981 F.3d 679 (9th Cir. 2020); *Star Dialysis, LLC v. WinCo Foods*, 401 F. Supp. 3d 1113 (D. Idaho 2019); *Dialysis of Des Moines, LLC v. Smithfield Foods Healthcare Plan*, No. 2:18-cv-653, 2019 U.S. Dist. LEXIS 174713, 2019 WL 8892581 (E.D. Va. Aug. 5, 2019).

b. DaVita bases its Complaint on its own rewording of Plan terms that apply uniformly to all participants.

DaVita and its affiliate (DVA Renal Healthcare, Inc.) filed their complaint in this case on December 19, 2018. The Complaint asserted claims against the Plan and the 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). DaVita claims that the payment provisions for outpatient dialysis services under the Plan are "illegal because they violate the 'take into account' and 'anti-differentiation' prohibitions of the MSPA." Jt. App. 31-32.

DaVita asserted separate ERISA claims against the 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." Jt. App. 33-39. In Count VII, DaVita sought injunctive relief under ERISA against the Plan and the Hospital for alleged discrimination on the basis of ESRD status in "violation of 29 U.S.C. § 1182(a)(1)." Jt. App. 40.

The gravamen of the Complaint is that ESRD patients need dialysis, the Plan allegedly reimburses dialysis expenses on a different basis from its reimbursement of other claims, and therefore those reimbursement terms are alleged to unlawfully discriminate against ESRD patients. The Complaint acknowledges that not all dialysis patients have ESRD. *See*, *e.g.*,

Jt. App. 6 (¶ 6), 11 (¶ 20), 26-27 (¶ 52), 28 (¶ 55) (stating that "almost all," "[v]irtually all" or "[n]early" all dialysis patients have ESRD); *see also Amy's Kitchen*, 981 F.3d at 671 ("DaVita concedes that dialysis is not exclusively a treatment for ESRD.").

Dispensing with the pivotal distinction between ESRD patients and other dialysis patients, the Complaint treats Medicare-eligible ESRD participants as the only covered dialysis patients, by incorrectly paraphrasing the Plan terms and the MSPA, using "discriminate" rather than "differentiate" and substituting "dialysis patients" for "individuals having [ESRD]." *See*, *e.g.*, Jt. App. 4; ("federal law requires commercial payers to maintain for ***dialysis patients*** the same coverage and benefits provided to all other covered patients") (emphasis added); Jt. App. 27 ("DaVita (and its ***dialysis patients***) are subjected to the discriminatory Plan provisions.") (emphasis added).

Other similar paraphrases also incorrectly gloss over the text of the Plan and DaVita's own admissions. Jt. App. 25 (¶ 50); 29 (¶ 57-58); 31-32 (¶ 67) ("by imposing limitations ***for a Medicare-entitled individual*** that do not apply to others enrolled in the Plan") (emphasis added). The rewording obscures, but does not change, the fact that this case concerns Plan terms that apply uniformly to all Plan participants.

4. The district court dismissed the Complaint because the Plan treats all dialysis patients the same, which is what the MSPA requires.

The district court granted the motions of Petitioners to dismiss all claims.

a. The district court recognized that the same Plan terms apply to all participants.

"It cannot be the case that the Plan has 'taken into account' or 'considered' an individual's Medicare status," the court reasoned, "if all patients receiving dialysis (including those ineligible for Medicare) are governed by the same standards. Nor can it be the case," said the court, "that Defendants have 'differentiate[d]' between individuals with ESRD and individuals without ESRD when all Plan enrollees receiving dialysis (including those without ESRD) are subject to the same provisions." Pet. App. 104.

b. The district court correctly determined that disparate impact law does not apply.

The district court also expressly rejected the argument that the MSPA implicitly provides for a disparate impact claim. Pet. App. 101-07. Focusing on the "difference" between the text of the MSPA and the language of the invidious discrimination statutes on which Respondents relied, the court concluded that "it is that

difference why those statutes allow for disparate impact claims but the MSPA does not." Pet. App. 105. The MSPA "does not contain this type of 'results-oriented' language," the court observed. *Id.* The court accordingly dismissed Counts I and II. The court likewise dismissed Count VII (ERISA discrimination) on the ground that "[t]he Plan treats all similarly situated individuals equally: all those requiring dialysis are treated exactly the same." *Id.* at 108.

c. The district court soundly dismissed the claims for equitable relief.

The court also dismissed Counts III through VI, which sought equitable relief, on the ground that the assignment required of Patient A included only claims for benefits, not equitable relief. *Id.* at 107-14. The Sixth Circuit affirmed that part of the judgment. There is no issue in this Court as to the dismissal of Counts III-VI. Pet. App. 54.

5. The Sixth Circuit reversed, based on a theory of indirect discrimination, becoming the only court that has accepted the DaVita interpretation.

A split panel of the Sixth Circuit affirmed in part and reversed in part. Pet. App. 1-94. The majority determined that the MSPA "prohibits primary plans from discriminating against individuals with ESRD without expressly stating that these individuals will be treated differently." Pet. App. 40. The

differentiation provision, said the court of appeals, "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." Pet. App. 41. The court applied the same reasoning to the "take into account" provision. Pet. App. 51.

Regarding indirect discrimination, the Sixth Circuit read a disparate-impact standard into the MSPA and ERISA, and invited discovery on DaVita's claims for denial of benefits, on the basis that it could establish a discriminatory violation. Pet. 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." Pet. App. 40. The majority ruled that "the catch-all provision [of the MSPA] could support a disparate-impact claim against the Plan." Pet. App. 45. To reach that conclusion, the majority relied on *Tex. Dep't of Hous. & Cmty. Affairs v. Inclusive Cmtys. Project, Inc.*, 576 U.S. 519 (2015), a case interpreting the Fair Housing Act. Pet. App. 45-48.

"In short," said the majority, "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." Pet. App. 41. The court thus reversed the dismissal of the DaVita claims for benefits under the MSPA and ERISA. *See* Pet. App. 54.

6. The dissent recognized the uniformity of the Plan terms and correctly distinguished the MSPA from antidiscrimination laws.

Rejecting this paradigm shift, Judge Eric E. Murphy dissented. He concluded that: (1) the "take into account clause" "bar[s] only group health plans that contain terms *expressly targeting* Medicare-eligible individuals who are eligible because of their end stage renal disease[,]" and (2) "a plan that uniformly offers the same benefits to all groups does not violate" the "differentiation" clause. Pet. App. 70-71; 83-84. "This reading follows from the relevant text, context, regulations, and precedent." *See* Pet. App. 70.

Responding to the indirect discrimination theory, the dissent emphasized that the Plan "offers the same benefits to all participants," and the MSPA prohibitions "bar plans from targeting Medicare-eligible *participants* who have end stage renal disease; they do not bar plans from distinguishing between covered *services*." Pet. App. 67. With limited resources, group health plans commonly pay health care providers' charges at various rates. The dissent thus asked, "[w]hat if a plan's rates for dialysis are higher than its rates for some services but lower than its rates for others? Which are the proper 'comparators'"? *Id.*

The dissent reasoned that the MSPA is not an antidiscrimination law; it is a coordination-of-benefits measure that "lacks the defining features of the specific antidiscrimination laws that the Supreme Court

has read to impose disparate-impact liability." Pet. App. 76 (Murphy, J., concurring in the judgment in part and dissenting in part) (citing *Inclusive Cmtys.*, 576 U.S. at 530-40).

7. The Ninth Circuit found that a similar plan complies with the MSPA.

Shortly after, the Ninth Circuit affirmed the dismissal of similar MSPA and ERISA claims. *See Amy's Kitchen*, 981 F.3d 664. 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 diagnosed with ESRD. The Ninth Circuit rejected its argument that the plan (similar to the one at issue here) violates the "take into account" and "differentiation" provisions by allegedly paying less for dialysis than for other medical services.

The court also held that the MSPA does not support disparate-impact claims, noting 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 explaining that "*Inclusive Communities* requires both a more detailed study of the statutory text and a consideration of other relevant factors." *Id.* at 674. 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]," the Ninth Circuit determined. *Id*. at 671.

SUMMARY OF ARGUMENT

1. The purpose of the MSPA is to conserve Medicare resources. The origin, words, context and purpose of the "take into account" and "differentiation" clauses all point in one direction. The MSPA coordinates group health plan benefits. It does not prescribe them.

2. The MSPA does not concern itself with the entire universe of dialysis care, as many dialysis patients are not Medicare-eligible. For this reason, the text of the MSPA focuses on individuals who have ESRD, which is the Medicare-eligible form of kidney disease, not other kidney conditions that require dialysis. The sole focus of the "take into account" clause is "an individual who is entitled to or eligible for" Medicare benefits by virtue of ESRD. The "differentiation" clause prohibits express distinctions between "individuals having end stage renal disease" and "other individuals covered by such plan."

3. The Sixth Circuit erroneously perceived the "take into account" provision as ambiguous, and turned to the accompanying administrative regulations and disparate-impact analysis to discern its meaning. The court erred in deviating from the plain language of the statute. It compounded that error by misreading the extra-textual sources that it consulted.

4. The Sixth Circuit veered from the text and purpose of the "differentiation" provision in allowing it to serve as the basis for an antidiscrimination claim based on alleged disparate treatment. This Court cannot and should not read a disparate-impact cause of

action into the MSPA, because the MSPA lacks the necessary statutory text to do so and it is not intended to remedy any long-standing invidious historical discrimination. *See Inclusive Cmtys.*, 576 U.S. at 521.

5. As every court but one that has considered the matter has ruled, terms of a group health plan that provide for primary coverage during the coordination period and apply to all participants equally do not violate either provision, and are not a sufficient basis to state a claim for violation of the MSPA.

ARGUMENT

I. THE "TAKE INTO ACCOUNT" CLAUSE REQUIRES PRIMARY COVERAGE OF A PLAN PARTICIPANT ENTITLED TO OR ELIGIBLE FOR MEDICARE DURING THE THIRTY-MONTH COORDINATION-OF-BENEFITS PERIOD.

A group health plan that provides dialysis benefits has sole responsibility according to its terms for reimbursement of dialysis expenses incurred by the participant during the first three months after an ESRD diagnosis. The plan then becomes primary payer, and Medicare a secondary payer, starting in month four. Thirty months later, the plan lawfully may switch roles and assume the role of secondary payer behind Medicare. Although a group health plan may not "differentiate in the benefits it provides between individuals having end stage renal disease and other

individuals" who the plan covers, 42 U.S.C. § 1395y(b)(1)(C)(ii), that requirement "shall not prohibit a plan from paying benefits secondary to [Medicare]" after the coordination period ends, as the MSPA expressly contemplates. 42 U.S.C. § 1395y(b)(1)(C).

The "take into account" and "differentiation" clauses operate together as bookends that mitigate Medicare expenses for that thirty-month period and thereby serve the purpose of the MSPA to conserve Medicare resources. At the front end, the "take into account" clause holds in place the position of the preexisting coverage available to an individual at the onset of ESRD. A plan that provides dialysis coverage for such an individual must remain primary for thirty months after the participant has undergone the first three months of dialysis. 42 U.S.C. § 1395y(b)(1)(C)(i).

At the back end, the MSPA releases that obligation at the conclusion of the thirty-month period by providing that the plan may thereafter "take into account" an individual's Medicare status and assume the role of secondary payer behind Medicare. 42 U.S.C. § 1395y(b)(1)(C). *See Amy's Kitchen*, 981 F.3d at 670 ("take into account" clause "prohibits a plan from taking Medicare eligibility into account during the 30-month coordination period and permits a plan to become the secondary payer after the coordination period").

Departing from the clear text and operation of the "take into account" clause, the Sixth Circuit construed it as "ambiguous" because it "appears susceptible to . . .

conflicting meanings" suggested by DaVita. Pet. App. 52. It was error for the court to do so.

A. Like its operation, the actual text of the "take into account" clause is clear.

Nothing in the plain text of the "take into account" provision bars "neutral plans that treat Medicare-eligible individuals the same as everyone else – regardless of any disparate impact or plan-sponsor intent." Pet. App. 83-84 (Murphy, J., concurring and dissenting).

First, the MSPA speaks in inanimate terms when it designates the subject of the "take into account" prohibition. The clause applies to a "group health plan." It therefore "regulates the 'formal program' or 'arrangement,' not the motives of the 'entities' that adopted it." Pet. App. 84 (citing 42 C.F.R. § 411.21 definition of "Plan"); *see also* 42 U.S.C. § 1395y(b)(2)(A) ("In this subsection, the term 'primary plan' means a group health plan or large group health plan, to the extent that [the Medicare primary payer] clause . . . applies[.]").

Second, the phrase "take into account" shows that the clause bars the plan from "giving 'consideration' to, or making 'allowance' for, something." *Id.* at 84.

Third, the "something," is the entitlement of any particular individual to, or eligibility for, Medicare coverage. "Unlike the differentiate clause," as the dissent observed, the "take into account" clause "shifts the

focus from *all* individuals with end stage renal disease to *certain* individuals with that disease." *Id.* The clause "says that, for 30 months, the plan may not consider the fact that 'an individual is entitled to or eligible for' Medicare benefits." *Id.* It therefore "has a narrower scope [than the "differentiation" clause] because Medicare *does not* cover all individuals with end stage renal disease. It instead starts covering individuals only after they have received dialysis treatment for three months (or have had a kidney transplant)." *Id.* As the dissent concluded, the clause "prohibits plan terms that consider an individual's Medicare eligibility under § 426-1, not terms that consider an end-stage-renal-disease diagnosis." *Id.*

The "take into account" clause would "bar only group health plans that contain terms *expressly targeting* Medicare-eligible individuals who are eligible because of end stage renal disease." *Id.* at 83.

B. The Ninth Circuit soundly looked to the actual terms of the group health plan in that case to see whether they "take notice" of Medicare eligibility or entitlement.

The Ninth Circuit has embraced the proposition that the face of the plan terms is dispositive of claims under the "take into account" clause. It sensibly concluded that the Amy's Kitchen plan did not "take into account" an individual's eligibility for or entitlement to Medicare because:

> [M]any persons who receive dialysis are ineligible for Medicare: those with acute kidney injury are not, by virtue of that injury, eligible for Medicare, and even those who have ESRD are eligible for Medicare only after the first three months of dialysis treatment. Yet the Plan takes no notice whatsoever of whether the claimant is eligible for Medicare. Claims are paid at the same rate whether the claimant has acute kidney injury, is in the first months of ESRD treatment, or is eligible for Medicare.

Amy's Kitchen, 981 F.3d at 670.

The Ninth Circuit further explained that a plan that uses Medicare rates to set its own reimbursement rate does not take into account any participant's Medicare eligibility: "[n]or does it matter, for purposes of the MSP[A], that the Plan calculates its reimbursement rate by taking into account, along with other factors, the amount that Medicare pays for dialysis treatment of other individuals. The MSP[A] bars consideration of the individual claimant's eligibility for Medicare, a factor that the Plan ignores." *Id.*

C. Canons of statutory construction make the unambiguous MSPA text dispositive.

The text of the "take into account" clause should have been the exclusive concern of the Sixth Circuit. This case "begins and ends with the text." *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*,

140 S. Ct. 2367, 2380 (2020) (quoting *Octane Fitness, LLC v. ICON Health & Fitness, Inc.*, 572 U.S. 545, 553 (2014)). "[O]nly the words on the page constitute the law adopted by Congress and approved by the President." *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1738 (2020).

DaVita nonetheless essentially "asks [this Court] to add words to the law" and inject meaning that cannot be plainly read from the text. According to DaVita, "individual" means "benefits" and "ESRD patient" means "all dialysis patients." Such an amendment of the MSPA "is Congress's province." *EEOC v. Abercrombie & Fitch Stores, Inc.*, 135 S. Ct. 2028, 2033 (2015).

D. The Sixth Circuit erroneously failed to consider the context of the "take into account" prohibition.

Consideration of the context also ought to have restrained the Sixth Circuit. Courts must consider the inter-relationship of statutory provisions in determining the meaning of legislation based upon its plain text. *See, e.g., Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 666 (2007) (It is a "fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme."); *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (courts must interpret a statute "as a symmetrical and coherent regulatory scheme," fitting "all parts into an harmonious whole") (citations omitted).

The meaning that the court of appeals has imputed to the "take into account" clause makes even less sense in the context of the statutes with which the clause coexists.

1. The Sixth Circuit interpretation would clash with ERISA, which does not require group health plans to include any specific dialysis coverage.

It would be entirely inconsistent with ERISA to apply an implicit requirement of priority dialysis benefits over all other potential benefits that a health plan may provide. As this Court has noted, "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 Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995); *see also Lockheed Corp. v. Spink*, 517 U.S. 882, 889 (1996) (same). Rather, "employers have large leeway to design disability and other welfare plans as they see fit." *M&G Polymers USA, LLC v. Tackett*, 574 U.S. 427, 435 (2015) (quotation and alteration omitted).

It would be incompatible with that ERISA mainstay for there to be an indirect requirement that self-insured group health plans provide a fixed level of benefits, and give priority to reimbursement of all "undiscounted charges" for one particular benefit without cost-containment review, claim audits, negotiation or

even any reference to the Medicare standard payment. *See* Jt. App. 24-27 ("Defendants' Wrongful Conduct"), 30-33 (Count II, "Claim for ERISA Benefits Pursuant to 29 U.S.C. § 1132(a)(1)(B)"). Indeed, that would create an unavoidable conflict between the MSPA and ERISA's dictate that "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).[9]

Such a reading would likewise affront the pertinent ERISA regulations. In implementing the nondiscrimination provisions of ERISA Title VII under the Health Insurance Portability and Accountability Act (HIPAA), 29 C.F.R. § 2590.702(b)(2)(i)(B) provides that a plan "may limit or exclude benefits in relation to a specific disease or condition [or] limit or exclude benefits for certain types of treatments or drugs," so long as "the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries." Accordingly, uniform benefits provided to all

[9] Although certain of the cited authorities pre-date the Patient Protection and Affordable Care Act, as amended (ACA), Pub. L. 111-148, 124 Stat. 119 (2010), and the ACA does provide for limited coverage mandates applicable to self-insured group health plans (such as coverage of preventive services without cost-sharing), the ACA does not alter the fact that self-insured plan sponsors retain significant flexibility in designing their benefits under ERISA. Moreover, the ACA demonstrates that Congress can and will expressly require the provision of specific benefits in self-insured plans when it intends to do so, which it has not done with the MSPA.

participants, as is the case under the Plan, are entirely permissible under this provision.

2. The Sixth Circuit interpretation would be unworkable with the two other "take into account" prohibitions.

The MSPA prohibits plans from "taking into account" ***three*** Medicare-eligibility characteristics for coordination-of-benefits purposes. ESRD is only one of them. The MSPA also applies to (a) persons age 65 and over who remain employed and (b) certain disabled persons. *See* 42 U.S.C. § 1395y(b)(1)(A)(i)(I)-(II). What "take into account" means as to one of those provisions, it means as to all.

a. Employed persons age 65 and above

For the "[w]orking aged under group health plans," the MSPA provides that group health plans "may not take into account" the fact that a covered "individual (or the individual's spouse) . . . is entitled to [Medicare] benefits." *See* 42 U.S.C. §§ 1395y(b)(1)(A)(i)(I).

Consider the plight of a multi-generational group health plan if the "take into account" prohibition implicitly means that provider reimbursements must be unrestricted as to benefits that are especially relevant to the "[w]orking aged." Persons age 65 and over may have different health care priorities (*e.g.*, osteoporosis, heart conditions, skilled nursing and rehabilitation for slower recovery) than their

under-65 counterparts. The Sixth Circuit approach would require plans to, in the parlance of DaVita, fully reimburse on a priority basis the "undiscounted charges" of companies that provide services that seniors "need far more than anyone else." Pet. App 45.

b. Disabled individuals in large group health plans

Such a requirement would run headlong into the next section of the MSPA, which pertains to "[d]isabled individuals in large group health plans." Under the MSPA, a "large group health plan . . . may not take into account that an individual . . . is entitled to [Medicare] benefits" by virtue of his or her approval to receive disability benefits under the Social Security Disability Insurance program. 42 U.S.C. § 1395y(b)(1)(B). By definition, disabled individuals may need certain medical services "far more than anyone else" (*e.g.*, care for inflammatory arthritis, respiratory disorders). Under the Sixth Circuit approach, a plan would "take into account" their status and violate the MSPA if it failed to prioritize benefits that would be more useful to disabled individuals than to others or to pay the "undiscounted charges" for expenses associated with those benefits.

c. A triple bind with the ESRD provision

In the unlikely event that a group health plan could provide prioritized benefits to both of these

divergent groups and ESRD participants all at the same time, and paid their "undiscounted charges," it would be left with far less resources to dedicate to the health care needs of all other plan participants – a hugely consequential substantive policy choice that cannot plausibly be attributed to Congress speaking in cryptic code when it adopted the MSPA.

3. Courts seek harmonious construction of related statutes.

In neglecting the context of the "take into account" clause, the Sixth Circuit has failed to observe the canon of statutory construction that courts must interpret related statutes "as a harmonious whole rather than at war with one another." *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1619 (2018); *see also United States v. Estate of Romani*, 523 U.S. 517, 530 (1998) (proper inquiry when interpreting two statutes is "how best to harmonize" them); Antonin Scalia & Brian A. Garner, *Reading Law: The Interpretation of Legal Texts* 252 (2012) ("Laws dealing with the same subject – being *in pari materia* – should if possible be interpreted harmoniously").

E. The Sixth Circuit interpretation would thwart the statutory objective of conserving Medicare resources.

If interpretation of the unambiguous "take into account" clause required any other extra-textual support, which it does not, the statutory purpose would also

readily dispel the claim that DaVita makes. "Courts 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" and reduce federal health care costs. *Stalley v. Catholic Health Initiatives*, 509 F.3d 517, 524 (8th Cir. 2007) (collecting cases); *see also Bio-Med. Applications of Tenn., Inc. v. Cent. States Se. & Sw. Areas Health & Welfare Fund*, 656 F.3d 277, 282 (6th Cir. 2011) (MSPA serves Congress's goal of preventing the "shifting of costs from private plans to the public fisc").

DaVita espouses an interpretation that would defeat this objective. It obviously would cost plans more to reimburse "undiscounted charges" and forego cost-containment review, claim audits and negotiation, as DaVita seeks. Jt. App. 24-27, 30-33. In that event, either the overall cost of coverage (including participant monthly contributions) necessarily would rise to maintain benefit levels, and/or plans would be forced to cut other benefits in order to control costs while paying the prioritized dialysis claims. If increased costs to all plan participants to allow for payment of the dialysis providers' undiscounted charges, along with associated reduction of other plan benefits, became an impetus to drop plan coverage and enroll solely in Medicare, thus making Medicare the primary payer during what otherwise would have been the thirty-month coordination period, the relief sought by DaVita would dramatically increase, not reduce, Medicare expenditures.

F. There is no basis for disparate-impact liability under the "take into account" prohibition.

Even if the statutory language had the breadth that the Sixth Circuit attributes to it, there would be no reason to permit disparate-impact claims. With respect to the "take into account" clause, Judge Murphy recognized in his dissent that "nowhere does the take-into-account clause contain the type of 'results-oriented' language that the Supreme Court has required for disparate-impact liability." *Id.* at 85. The Sixth Circuit majority devoted the bulk of its disparate-impact analysis to interpretation of the "differentiation" clause. Petitioners have set forth below, in their argument as to the "differentiation" clause, the reasons that neither provision properly serves as a platform for disparate-impact liability.

G. CMS regulations that implement the "take into account" prohibition confirm its plain meaning.

Based on its erroneous characterization of the "take into account" clause as "ambiguous," the court of appeals reviewed CMS regulations that give examples of impermissible "taking into account" in order to find a plausible meaning. *See id.* at 52-53; 42 C.F.R. § 411.108. There was no reason to consider the regulations – the statute is clear. Nor was there any basis for the inference of ambiguity:

- 42 C.F.R. § 411.108(a)(4) highlights "denying or terminating coverage because an individual is entitled to Medicare on the basis of disability without denying or terminating coverage for similarly situated individuals who are not entitled to Medicare on the basis of disability." Here, the Plan makes no distinction based on Medicare eligibility or entitlement, and has neither denied nor terminated any coverage.
- 42 C.F.R. § 411.108(a)(5) calls out "[i]mposing limitations on benefits for a Medicare entitled individual that do not apply to others enrolled in the plan, such as providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, providing for lower annual or lifetime benefit limits, or more restrictive preexisting illness limitations." Here, Medicare-entitled individuals have exactly the same coverage as other Plan participants.

Based on the regulations, the court of appeals accepted the argument that the clause has a "motive-based definition" in which it "means to consider or think of it, which means that plans are prohibited from adopting policies that are motivated by a desire to treat Medicare-entitled individuals differently." Pet. App. 51. The court indulged the assumption that "discovery may reveal evidence of the defendants' illicit motive." *Id.* "If DaVita shows, through discovery, a 'near-perfect overlap' between Medicare-entitled patients (via ESRD diagnosis) and dialysis patients," the court ruled, then it "may show that, compared to other

Plan enrollees, Medicare-entitled individuals are subject to reduced benefits." *Id.* at 53 (citation omitted). In looking beyond "an individual . . . entitled to or eligible for" Medicare benefits, the court of appeals improperly departed from the more austere text of the statute.

If resort to the "take into account" regulations were necessary, which it is not, the Court would find that the pertinent CMS regulations corroborate the straightforward statutory text. In 42 C.F.R. § 411.161(a), CMS has specified that "[e]xamples of actions that constitute taking into account are listed in § 411.108(a)," on the basis of "ESRD, age, or disability." In turn, 42 C.F.R. § 411.108 provides eleven illustrations of what the agency with day-to-day enforcement responsibility and experience deems to constitute "taking into account" by group health plans. The illustrations highlight *differential*, not *uniform*, treatment. Indeed, all of the examples of "taking into account" involve express termination, limitation or imposition of restrictions on coverage for Medicare-eligible or Medicare-entitled individuals that do not apply to other plan participants.

II. PROVISION OF THE SAME BENEFITS UNIFORMLY TO ALL PLAN PARTICIPANTS DOES NOT VIOLATE THE "DIFFERENTIATION" CLAUSE.

It was just as erroneous for the Sixth Circuit to broaden the meaning of the "differentiation" clause. As Judge Murphy put it, the question is whether the

clause would "prohibit a plan that treats all *participants* the same, but provides worse coverage for *services* commonly used by those with end stage renal disease?" Pet. App. 70. The answer of the MSPA is "no."

The threshold inquiry is whether a plan "differentiate[s] in the benefits it provides" between (1) "individuals having end stage renal disease" and (2) "other individuals covered by such plan." If the benefits are the same, there is nothing further to ask. The MSPA inquiry stops there. Only if there were a difference in benefits would there be an issue as to whether the plan has "differentiated" "on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner." Here, the Plan provides the same benefits uniformly to all participants. That fact is conclusive and fatal to any claim for violation of the "differentiation" clause.

A. Judge Murphy's dissent lays out the fallacy of the Sixth Circuit's analysis.

There is no basis in the actual text of the "differentiation" provision for the Sixth Circuit's conclusion. The majority opinion does not treat the clause as ambiguous. Pet. App. 48. Because there is no ambiguity, the text should be the sole focus of judicial inquiry. Careful parsing of the "component parts" to establish its meaning leads to the inescapable conclusion that a plan "that uniformly offers the same benefits to all groups does not violate this clause." Pet. App. 70 (Murphy, J., dissenting).

First, the subject is "*group health plan*," defined by law, as the "thing that cannot engage in differentiation." Pet. App. 71. The differentiation clause "thus regulates the *program*, not the *entity* that picks its terms." *Id.*

Second, the verb that Congress selected was "*differentiate*" between, meaning that the plan terms cannot "create differences between the listed categories." *Id.* 71-72. A plan that "applies these coverage choices to all participants . . . has not established differences between 'individuals.' It has treated all individuals equally," Judge Murphy concluded. Pet. App. 72 (citing dictionary definitions).

Third, the term "*individuals*" identifies "the categories that the plan terms may not create differences between" and thus "bars terms that establish differences between two groups of *individuals*; it does not bar terms that establish differences between *services*." *Id.* 72.

Fourth, the inclusion of the term "*benefits*" means that the clause "prohibits a plan from giving individuals with [ESRD] a different 'entitlement to have payment made' for a healthcare service as compared to the entitlement offered to other participants for the same service." *Id.* 72 (citation omitted).

"Putting these phrases together," Judge Murphy reasoned, courts should read the clause "as barring plan terms that give different benefits to individuals with end stage renal disease, either by name or by definitions that impliedly target that group." *Id.* 74. The

Plan indisputably makes no distinction on the basis of "the existence of end stage renal disease."

B. The Ninth Circuit correctly followed the same approach, under virtually identical circumstances, as Judge Murphy.

The Ninth Circuit agreed when it reviewed DaVita's claims as to the substantially similar Amy's Kitchen group health plan. *See Amy's Kitchen*, 981 F.3d at 670-71. "Even the broadest possible reading of the second half of the statutory text – prohibiting differentiation in the provision of benefits for *any* reason and in *any* manner – does not change" the finding that the Amy's Kitchen plan does not violate the differentiation provision of the MSPA, the court ruled. *Id.*

The court observed that "[u]nder the Plan, individuals with ESRD receive identical benefits, including dialysis benefits, as those who do not have ESRD. Renal dialysis is a potential treatment for *all* persons, not just for those with ESRD, and the Plan uniformly reimburses a provider for renal dialysis whether or not the patient has ESRD. Accordingly, the Plan does not – in any way or for any reason – differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan." *Id.* (citation omitted).

In the sound view of the Ninth Circuit, "the pertinent question remains whether the plan provides differing benefits to persons with ESRD than to all other insureds. Because Amy's Plan provides identical

benefits, including dialysis benefits, to all insured persons, the Plan does not run afoul of the MSP." *Id.* at 671.

Indeed, the Sixth Circuit's reading stands alone and should be rejected. *See DaVita, Inc. v. Marietta Mem'l Hosp. Emp. Health Benefit Plan*, No. 2:18-cv-1739, 2019 U.S. Dist. LEXIS 160793, 2019 WL 4574500, at *4 (S.D. Ohio Sept. 20, 2019); *Dialysis of Des Moines, LLC v. Smithfield Foods Healthcare Plan*, No. 2:18-cv-653, 2019 U.S. Dist. LEXIS 174713, 2019 WL 8892581, at *5 (E.D. Va. Aug. 5, 2019); *DaVita, Inc. v. Amy's Kitchen, Inc.*, 379 F. Supp. 3d 960, 973 (N.D. Cal. 2019); *Nat'l Renal All., LLC v. Blue Cross & Blue Shield of Ga., Inc.*, 598 F. Supp. 2d 1344, 1354 (N.D. Ga. 2009); *see also* Pet App. 82 (Murphy, J., dissenting) ("As far as I am aware, every district court to consider this question has interpreted [the anti-differentiation] clause as I do.").

C. The Sixth Circuit's interpretation of the "differentiation" clause could increase Medicare costs.

DaVita promotes a reading of the "differentiation" clause that would serve the monetary interests of DaVita but not the statutory objectives of the MSPA. The DaVita interpretation is likely to be far more lucrative for DaVita. But if the associated higher monthly contributions or reduced levels of other benefits inevitably result in Plan exodus by members with ESRD or others who are eligible for Medicare, it would

be counter-productive to the congressional objective of Medicare resource conservation under the MSPA.

D. CMS regulations that implement the "differentiation" provision confirm the meaning of the statutory text.

Like the "take into account" prohibition, the text of the differentiation clause is clear and dispositive. No resort to other sources is necessary for understanding it. If it were necessary to look elsewhere, however, the logical source would be the relevant regulations promulgated by CMS that would be entitled to deference if there were any ambiguity. *See Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 844 (1984).

CMS provides, in 42 C.F.R. § 411.161(b)(2), five examples of what would "constitute differentiation in plan benefits (and that may also constitute 'taking into account' Medicare eligibility or entitlement)." Four involve express distinctions based upon ESRD status. The fifth (42 C.F.R. § 411.161(b)(2)(v)) involves singling out the service ("routine maintenance dialysis") on which ESRD patients, alone among dialysis recipients, rely.

Moreover, under 42 C.F.R. § 411.161(c), "[a] plan is not prohibited from limiting covered utilization of a particular service as long as the limitation ***applies uniformly*** to all plan enrollees." 42 C.F.R. § 411.161(c) (emphasis added); *Amy's Kitchen*, 981 F.3d at 676. Thus, the regulation makes plain that a

plan complies when it provides the same reimbursement rates for ESRD and non-ESRD patients. *See* 42 C.F.R. § 411.161(b)(2)(iv) (plan violates the MSPA by "[p]aying providers and suppliers less for services furnished to individuals who have ESRD than for the same services furnished to those who do not have ESRD").

E. The "differentiation" clause is not a suitable basis for disparate-impact liability.

The Sixth Circuit improperly ruled that DaVita had stated an MSPA claim on the basis that "the Plan discriminates against ESRD patients based on their ***need for dialysis*** by targeting the primary treatment that individuals with ESRD (1) need exclusively, with the exception of rare, non-ESRD patients, and (2) need with far greater frequency than those few non-ESRD dialysis-users." Pet. App. 43 (emphasis added). "[I]t represents a flawed understanding of antidiscrimination law," said the majority, not to allow for the possibility that, if there is a "near-perfect overlap between ESRD patients and dialysis patients, a jury could reasonably conclude that discrimination against the latter constitutes discrimination against the former." *Id.* at 44-45. The court erroneously found support for that conclusion in two of the three rationales that the "differentiation" clause proscribes.

1. None of the three ways of prohibited "differentiation" applies here.

It is true, as the Sixth Circuit observed, that the "differentiation" provision "specifies three different ways in which a plan may unlawfully discriminate against individuals with ESRD." Pet. App. 41-42. The clause prohibits "differentiat[ion] in the benefits it provides" based on "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). That does not alter the threshold requirement that a plan must first have "differentiate[d] in the benefits it provides" in order for an MSPA claim to even arise. Nor do any of the three rationales properly serve as a basis for disparate impact liability.

a. "Existence of ESRD"

There is no claim that the Plan implicates the first criterion, *i.e.*, that it violates the MSPA by "explicitly fashioning differential benefits for ESRD patients by virtue of them having ESRD." Pet. App. 42. That should have ended the inquiry.

b. "Need for renal dialysis"

Nor does the Plan differentiate in the benefits provided for "individuals having end stage renal disease" based on the "need for renal disease." It was error to create a new standard based on the second criterion. To Judge Murphy, the prohibition of distinctions based on "the need for renal dialysis" means that a plan "may

not avoid that illegal differentiation by changing the label of the first group from individuals with 'end stage renal disease' to individuals who 'need renal dialysis.'" *Id.* 73. For example, a plan could not attempt to evade the ESRD label by setting one dialysis reimbursement rate for individuals who needed thirty or more dialysis treatments the previous year and a different dialysis reimbursement rate for those who needed far fewer dialysis treatments.

c. "In any other manner"

Nor was it proper to discern a claim for disparate treatment based upon the third criterion ("in any other manner"). That phrase may subsume the first two. In the words of Judge Murphy, however, the "in any other manner" language simply "bars other 'ways' or 'methods' that plans might establish differences between individuals who have end stage renal disease and others." Pet. App. 73 (citing 9 *Oxford English Dictionary* 324 (2d ed. 1989)). In any event, the phrase does not dispense with the *sine qua non* for liability purposes, that a plan has actually provided different benefits specific to ESRD-diagnosed participants alone.

2. The MSPA does not serve the same sort of purpose as classic disparate-impact laws.

The MSPA performs a vital role in the financing of American healthcare and serves the laudable objective of facilitating shared fiscal responsibility for dialysis

treatment of ESRD. Its purpose is to conserve Medicare funds and protect taxpayers – not eradicate discriminatory practices. *See Bio-Med.*, 656 F.3d at 295 ("[I]t is axiomatic that the Act's purpose was to protect Medicare's fiscal integrity.").

The MSPA does ***not*** determine who receives dialysis coverage under Medicare. Congress made that decision when it included within the scope of Medicare individuals who are "medically determined to have end stage renal disease." Social Security Amendments of 1972, Pub. L. No. 92-603, § 299I, 86 Stat. 1329, 1463 (1972); Act of June 13, 1978, Pub. L. 95-292, § 266A, 92 Stat. 307 (1978). The MSPA serves only to enlist and coordinate benefits that group health plans provide for dialysis coverage in order to defray Medicare costs.

Making ends meet is an entirely different sort of legislative objective from the correction of historical injustices that work and manifest themselves directly and indirectly. For example, the Fair Housing Act, Title VII of the 1964 Civil Rights Act and the Age Discrimination in Employment Act all have protection of the rights of individuals and elimination of discriminatory practices as their purpose, and it is that purpose that undergirds the availability of claims under those statutes based on disparate impact. *See Inclusive Cmtys.*, 576 U.S. at 521 ("Recognition of disparate-impact claims is consistent with the FHA's central purpose," which, "like Title VII and the ADEA, was enacted to eradicate discriminatory practices within a sector of our Nation's economy.").

3. The combined statutory text and purpose of the MSPA do not give rise to disparate-impact liability.

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 Cmtys.*, 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 features 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 (2005) (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) (quoting Title VI, 1964 Civil Rights Act, which provides that "[n]o . . . individual . . . shall . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination").

Moreover, the "in any other manner" phrase, when used in antidiscrimination statutes (which the MSPA is not), generally 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). "Retaliation, by its definition, is an intentional act." *Jackson*, 544 U.S. at 174. Hence, the more apt comparison is with the statutory language at issue in *Jackson* and *Alexander* and antidiscrimination statutes that prohibit retaliation. If the MSPA were an antidiscrimination statute, it would be similarly interpreted, as allowing only claims of intentional discrimination and not those alleging a disparate impact.

The Court recently underscored the exacting combination of textual basis and statutory purpose necessary to establish disparate impact liability. In *Brnovich v. Democratic Nat'l Comm.*, 141 S. Ct. 2321 (2021), the Court held that the "disparate-impact model employed in Title VII and Fair Housing Act" was not useful even in interpreting the Voting Rights Act (VRA) because the "text of the relevant provisions of Title VII and the Fair Housing Act differ from that of VRA §2," and it "is not obvious why Congress would conform rules regulating voting to those regulating employment and housing." *Id.* at 2340-41.

4. Like Judge Murphy, the Ninth Circuit has soundly recognized the lack of any basis for disparate-impact liability.

The Ninth Circuit engaged in the same text-and-purpose analysis to reach the same correct conclusion as Judge Murphy in the Sixth Circuit. "Congress chose to prohibit actions that 'differentiate' rather than 'discriminate,'" the court noted, a semantic consideration that "strongly suggests that Congress did *not* intend to create a disparate-impact theory of liability." 981 F.3d at 674. "Congress certainly was aware of the important term 'discriminate,' which long has carried a particular meaning. We find it significant that Congress chose to avoid that common term in favor of a different verb, 'differentiate,'" the Ninth Circuit concluded. *Id.* "Nor is there any indication that Congress acquiesced in a disparate-impact theory that has been widely adopted by the federal courts. If anything, the MSP[A]'s statutory history and additional provisions suggest the opposite conclusion." *Id.* at 675.

"Finally," said the court, "we consider the statute's 'central purpose.' . . . [T]here is little evidence, either in the legislative history of the MSP[A] or in other sources, that persons with ESRD have been subjected to historical or entrenched societal discrimination akin to the discrimination faced by the classes of persons protected by the FHA, Title VII, the ADEA, and the ADA." *Id.* The Ninth Circuit's analysis comports with this Court's clear instruction that "antidiscrimination laws must be construed to encompass disparate impact

claims when their text refers to the consequences of actions and not just to the mindset of the actors, ***and where that interpretation is consistent with statutory purpose***." *Inclusive Cmtys.*, 576 U.S. at 533 (emphasis added).

III. THE SEPARATE ERISA CLAIMS FALL WITH THE MSPA CLAIMS.

Respondents also seek to prosecute their MSPA-based claims through two ERISA provisions. If ERISA provided a statutory basis for the relief that Counts II and Count VII seek, those claims would fail for the same reasons as the underlying MSPA claims. ERISA is unavailing for Respondents. As Judge Murphy correctly noted, the private right of action in 29 U.S.C. § 1132(a)(1)(B) "allows plan participants to sue to *enforce* their rights under a plan's terms. It does not allow them to *invalidate* those terms – as DaVita seeks to do." Pet. App. 86. The other ERISA provision, 29 U.S.C. § 1182(a)(1), "applies to a plan's rules of *eligibility*, not to its rules concerning *covered benefits*." *Id.* at 367-68.

Without any analysis, the Sixth Circuit applied its flawed MSPA disparate-impact theory to this entirely separate law. If left standing, this off-hand application will have the potential to create significant harm, financial and otherwise, for self-insured group health plan sponsors seeking to comply with this provision, which otherwise affords significant flexibility in plan design and does not require the provision of specific benefits. The demise of this portion of the ruling would

confirm that Congress alone has authority to make such a material change to ERISA.

CONCLUSION

The Court should reverse the judgment below.

Respectfully submitted,

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