No. 20-1641

IN THE
Supreme Court of the United States

MARIETTA MEMORIAL HOSPITAL EMPLOYEE HEALTH BENEFIT PLAN, ET AL.,
Petitioners,

v.

DAVITA INC., ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF OF THE SELF-INSURANCE INSTITUTE OF AMERICA, INC. AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

CHRISTOPHER J. WALKER
Counsel of Record
THE OHIO STATE UNIVERSITY
MORITZ COLLEGE OF LAW
55 West 12th Avenue
Columbus, OH 43210-1391
(614) 247-1898
christopher.j.walker@gmail.com

Counsel for Amicus Curiae

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INTEREST OF *AMICUS CURIAE*[1]

The Self-Insurance Institute of America, Inc. ("SIIA") is a member-based association dedicated to protecting and promoting the business interests of companies involved in the self-insurance industry. Self-insurance is a risk transfer strategy used by tens of thousands of employers across the country to finance their group health plans. Members of SIIA include self-insurance sponsors, third-party administrators, excess/stop loss insurance carriers, and other industry service providers.

A self-insured group health plan is one in which the employer assumes the financial risk for providing healthcare benefits to its employees. In practical terms, self-insured employers pay for out-of-pocket claims as incurred instead of paying a fixed premium to an insurance carrier, which is known as a fully insured plan. According to a 2020 report, 67% of workers with employment-based health insurance receive benefits through a self-insured group plan. Kaiser Family Found., *Employer Health Benefits: 2020 Annual Survey* 161-65 (2020). With approximately 157 million people covered by employer-sponsored plans, *see id.* at 6, that means more than 100 million individuals in the United States participate in a self-insured employment group health plan.

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[1] Pursuant to Supreme Court Rule 37.6, *amicus curiae* states that no counsel for any party authored this brief in whole or in part and that no entity or person, aside from *amicus curiae*, its members, or its counsel, made any monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Supreme Court Rule 37.3, counsel of record for all parties have consented to this filing.

This case presents an issue of exceptional importance to SIIA and its members, as well as to the more than 100 million individuals who are currently covered by a self-insured group health plan. The decision below misinterprets the Medicare Secondary Payer Act to restrict group health plans from setting reimbursement rates for dialysis services at anything other than an unspecified "most favored nation" rate. Accordingly, self-insured plans, which generally have great flexibility in determining healthcare coverage, would have to sacrifice their coverage of other medical services to pay for dialysis services at a rate as high as twenty-five times the Medicare rate. The impact of this holding for many of the tens of thousands of self-insured plans would be catastrophic. Their sponsoring employers would face a Hobson's choice of not covering other critical health benefits for their employees, not covering dialysis services, or canceling their self-insured group plans altogether.

INTRODUCTION AND SUMMARY

For decades, courts, the Department of Health and Human Services, employers, group health plans, and plan providers have uniformly understood the Medicare Secondary Payer Act to be a coordination-of-benefits law. This law, as the title suggests, prioritizes in certain circumstances payment from private health insurance first and then from Medicare if Medicare reimburses at a higher rate. The Court of Appeals, however, reinterpreted the statute as an antidiscrimination law designed to protect dialysis providers from alleged disparate impact of uniform treatment. In so doing, the Sixth Circuit's holding would require employment group health plans to pay dialysis providers a "most favored nation" rate—a rate much higher than

the Medicare reimbursement rate such that Medicare would never be a "secondary payer" under the Act.

The Sixth Circuit's outlier statutory interpretation is erroneous for all the reasons detailed in Petitioners' brief on the merits as well as in Judge Eric Murphy's trenchant dissent from the decision below. This brief focuses on two additional points, based on *amicus* and its members' deep understanding of the statutory and regulatory scheme as well as their longstanding involvement in the health insurance industry.

I. The Sixth Circuit's decision rests on a critical misunderstanding of the text, structure, and design of the Medicare Secondary Payer Act. The statute is not an antidiscrimination law, much less one that provides a private cause of action for disparate-impact claims. Instead, since its enactment in 1980 and through its various amendments over the years, Congress has made clear that the statute is a coordination-of-benefits law. Its purpose is to reduce Medicare expenditures and extend the life of the Medicare Trust Fund. It does so by shifting Medicare to secondary payer in some circumstances—including as relevant here, for services related to end-stage renal disease—and making group health plans primary payers for those services.

That the Medicare Secondary Payer Act is not a disparate-impact antidiscrimination law should come as no surprise to those familiar with the legislative process. The original statute and the relevant amendments were enacted through reconciliation—a fast-track legislative process that exists to raise revenue and reduce federal spending and that prohibits funding objectives that are merely incidental to non-budgetary substantive provisions. Congress would not hide a major antidiscrimination law in an omnibus budget reconciliation mousehole.

II. The decision below has tremendous implications for group health plans, and self-insured plans in particular. Under the Sixth Circuit's statutory interpretation, group health plans would forfeit their ability to set prices for dialysis services at anything other than a "most favored nation" rate. Accordingly, self-insured plans would have to prioritize coverage of dialysis services at this much higher rate over all other medical services, from primary healthcare and vaccinations and prenatal and natal care to cancer treatment and urgent and emergency care. And the increased cost would be exorbitant—potentially increasing the dialysis services costs from around Medicare's reimbursement rate of $35,000 annually per individual with end-stage renal disease to perhaps nearly $900,000.

It is important to underscore that these substantial cost increases would not benefit individuals with end-stage renal disease. They would receive the same services they already receive. Nor would it save Medicare money. Indeed, if the costs to treat end-stage renal disease are too high, many of the tens of thousands of employers with self-insured plans would likely cancel coverage for dialysis services, shifting even more costs onto Medicare. Dialysis providers like Respondent DaVita would be the financial beneficiaries.

ARGUMENT

I. The Medicare Secondary Payer Act Is a Coordination-of-Benefits Statute, Not an Antidiscrimination Statute.

To prevail, Respondent DaVita must convince the Court that when Congress enacted the Medicare Secondary Payer Act, it created an antidiscrimination law similar to the Civil Rights Act and the Fair Housing Act. Indeed, DaVita must not only show that it is an

antidiscrimination law, but one that imposes disparate-impact liability. To impose disparate-impact liability, Congress's "central purpose" in enacting the law must be to "eradicate discriminatory practices within a sector of the Nation's economy." *Texas Dep't of Hous. & Cmty. Affairs v. Inclusive Cmtys. Project*, 576 U.S. 519, 539 (2015).

As detailed in Petitioners' brief on the merits, *see* Pet'rs Br. 31-36, 45-49, the relevant provisions of the Medicare Secondary Payer Act fall far short, as a textual matter, of prohibiting disparate impact. Instead, as Judge Murphy correctly concluded in his dissent from the Sixth Circuit's majority opinion, the statute "prohibits plans that offer participants with end stage renal disease different benefits from others. . . . Yet a plan that uniformly offers the same benefits to all groups does not violate this clause. That is so even if this neutral plan has a disparate impact on those with end stage renal disease because it provides lower reimbursement for services that they use." *DaVita v. Marietta Mem'l Hosp. Emp. Health Benefit Plan*, 978 F.3d 326, 360 (6th Cir. 2020) (Murphy, J., dissenting); *see also id.* at 365 (concluding that the statute "bar[s] only group health plans that contain terms *expressly targeting* Medicare-eligible individuals who are eligible because of their end stage renal disease").

This conclusion regarding the statutory text is reinforced by the statute's structure, history, and design. *See, e.g.*, *UARG v. EPA*, 573 U.S. 302, 320 (2014) (reiterating that 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'" (quoting *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000))); *K Mart Corp. v. Cartier*, 486 U.S. 281, 291 (1988) ("In

ascertaining the plain meaning of the statute, the court must look to the particular statutory language at issue, as well as the language and design of the statute as a whole."). *Amicus* details that statutory history and structure in Part I.A, and then examines in Part I.B how the statutory history, structure, and overall design reinforce the plain language of the Medicare Secondary Payer Act.

A. The Statutory History and Structure of the Medicare Secondary Payer Act

Since 1965, Medicare has provided health insurance to individuals aged 65 and older and has expanded to cover some younger individuals with disabilities. Concerned about conserving Medicare resources and prolonging the viability of the Medicare Trust Fund, Congress enacted the Medicare Secondary Payer Act in 1980. Originally, the statute designated Medicare as the secondary payer when a private automobile, liability, or no-fault insurance policy would cover the costs of medical care related to an accident. Omnibus Reconciliation Act of 1980, Pub. L. No. 96–499, § 953, 94 Stat 2599 (amending 42 U.S.C. § 1395y). This was one of four "major Medicare and Medicaid savings provisions" included in the 1980 omnibus reconciliation legislation, and it was estimated that these provisions would "result in legislative savings of approximately $128 million in fiscal year 1981." H.R. Rep. 96–1167, at 352-53 (1980).

One year later Congress expanded the Medicare Secondary Payer Act to cover certain Medicare beneficiaries in employment group health plans. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97–35, § 2146, 95 Stat 357 (amending 42 U.S.C. § 1395y). Congress has since amended the statute on numerous occasions, usually through the omnibus reconciliation

process. *See* Cong. Research Serv., RL33587, *Medicare Secondary Payer: Coordination of Benefits* 26 tbl.A-1 (2014) [hereinafter 2014 CRS Report] (listing and summarizing some of the legislative developments).

Under the current statutory framework, Medicare is the secondary payer when the qualifying individual can receive payment from:

- an employment group health plan of a certain size, based on either the beneficiary's or a spouse's current employment;
- a large employment group health plan, for disabled workers;
- any employment group health plan, for beneficiaries with end-stage renal disease;
- a Department of Veterans Affairs program;
- medical, automobile, or no-fault liability insurance;
- a workers' compensation program; or
- the federal black lung program.

Id. at 2 tbl.1. The Medicare secondary payer program saves Medicare about $8 billion per year. *See id.* at 24 tbl.5 (reporting savings for fiscal years 2006 through 2012). In fiscal year 2020, for instance, the program resulted in $8.93 billion in Medicare savings. Ctrs. for Medicare & Medicaid Servs., *Financial Report: Fiscal Year 2020* 31 (2020).

Two sets of statutory amendments are particularly relevant here.

1. Coverage for End-Stage Renal Disease and Differentiate Clause. In 1972, Congress expanded Medicare to cover qualifying individuals under the age of 65 who suffer from end-stage renal disease. Social Security Amendments of 1972, Pub. L. No. 92–603,

§ 299I, 86 Stat. 1239; *see also* 42 U.S.C. § 426–1 (detailing Medicare's end-stage renal disease program). This was the first time Congress extended Medicare to cover a medical condition, instead of based on age. *See* Cong. Research Serv., R45290, *Medicare Coverage of End-Stage Renal Disease (ESRD)* 1 (2018).

Not surprisingly, Medicare quickly became the primary insurer for services related to individuals with end-stage renal disease. The costs of that coverage are substantial. Medicare beneficiaries with end-stage renal disease comprise only 1% of Medicare enrollees but account for around 7% of Medicare spending. *Id.* In 2013, for instance, Medicare spent around $60,000 per individual with end-stage renal disease. *Id.* at 8. Moreover, the number of individuals in the United States receiving treatment for end-stage renal disease has risen dramatically, from around 56,000 in 1980 to more than 700,000 in 2016. *Id.* at 2.

Over the years, Congress has enacted numerous statutes to reduce the costs to Medicare of treatment for individuals with end-stage renal disease. *See id.* at 1 (providing examples). Most important to this case is the 1981 expansion of the Medicare Secondary Payer Act. The 1981 omnibus reconciliation legislation designated employment group health plans as primary insurers for services related to end-stage renal disease for the first 12 months (now 30 months[2]) for individuals eligible for Medicare based solely on that condition. Pub. L. No. 97–35, § 2146, 95 Stat 357 (1981) (amending 42 U.S.C. § 1395y).

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[2] *See* Balanced Budget Act of 1997, Pub. L. No. 105–33, § 4631(b), 111 Stat 251 (amending 42 U.S.C. § 1395y(b)(1)(C) to change from 12 months to 30 months).

In addition to amending the Medicare Secondary Payer Act, the legislation amended the Internal Revenue Code to include what courts and parties have coined the "differentiate clause":

> The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section if the plan differentiates 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.

Id. § 2146(b) (amending 26 U.S.C. § 162). Subsequent legislation, discussed below, refashioned and moved this provision from the Internal Revenue Code to the section of the code that includes the main provisions of the Medicare Secondary Payer Act. *See* 42 U.S.C. § 1395y(b)(1)(C)(ii).

As detailed in the Conference report accompanying the 1981 omnibus reconciliation bill, the House bill did not include any amendments to the Medicare Secondary Payer Act; instead, these amendments were found in the Senate bill. H.R. Conf. Rep. 97–208, at 955-56 (1981). The Conference agreed to adopt the Senate bill, with the modification that the Secretary of Health and Human Services have administrative discretion to have Medicare pay first and seek reimbursement from group health plans "until such time as the Secretary determines that the beneficiary's plan has begun to make payments promptly"—"to minimize patient anxiety about the source of promptness of payment and to avoid delays in reimbursement . . . ." *Id.* at 956.

When it comes to understanding the design and purpose of these amendments to the Medicare Secondary Payer Act, the Senate committee report is most helpful. The committee report observes that "since Medicare pays first and provides very comprehensive benefits for those with end-stage renal disease, private plans pay little of the expenses incurred by most end-stage renal patients." S. Rep. 97–139, at 735 (1981). To address this problem, the Senate "bill changes the benefit coordination arrangements between the Medicare end-stage renal program and any other health benefits" to make Medicare the secondary payer during the coordination period (originally 12 months, but now 30 months). *Id.* The committee report notes that "in the event payment by the private plan or policy is less than any amount charged for the covered item or service, Medicare (in its role as secondary payer) would pay no more than the program would otherwise have paid in the absence of such private coverage" and combined no more than "the amount recognized as reasonable under Medicare." *Id.* at 735-36.

The Senate committee report is unequivocal about the purpose of these amendments to the Medicare Secondary Payer Act:

> The Committee expects physicians and providers and suppliers of health services to end-stage renal patients to recognize that the purpose of this provision is *only* to change the coordination of benefits relationships between Medicare and private health benefit coverage to the extent that any private coverage is present at the onset of end-stage renal disease. Reimbursement for covered expenses for care of such patients is still assured, though the apportionment of such expenses between private plans and Medicare

> will be somewhat different for the initial 12-month [now 30-month] coverage of those patients who have other health benefit coverage.

Id. at 736 (emphasis added). The Senate Budget Committee reported estimated savings to Medicare of these amendments as $95 million in 1982, $165 million in 1983, and $180 million in 1984. *Id.*

With respect to the differentiate clause, the Senate committee report includes a one-sentence explanation that the group health plan would not be tax deductible as a business expense for the employer "if such plan contains a discriminatory provision that reduces or denies payment of benefits for renal patients." *Id.* The Conference report repeats this summary when describing the Senate bill. H.R. Conf. Rep. 97–208, at 956 (1981).

The Senate committee report also includes a sentence, repeated in the Conference report, that "[t]he committee is also concerned about potential job discrimination resulting from the provision, and directs the Secretary to investigate promptly complaints of this nature, and report his findings to the Congress." S. Rep. 97–139, at 736 (1981); *accord* H.R. Conf. Rep. 97–208, at 956 (1981). That directive was not added to the statutory text.

One final aspect of the 1981 omnibus reconciliation bill is worth noting to underscore Congress's focus on saving Medicare funds on coverage for end-stage renal disease. Although not part of the amendments to the Medicare Secondary Payer Act, the Conference considered two other bills to include in the omnibus reconciliation legislation that addressed how to reduce the costs of treatment for Medicare patients with end-stage renal disease.

First, the Conference declined to include the House amendments that would have allowed for Medicare coverage "for nutritional therapy (when it is used as a means of delaying or substituting for the provision of kidney dialysis)." H.R. Conf. Rep. 97–208, at 946 (1981). Instead, the Conference report charges the Secretary of Health and Human Services to further study the issue and submit a report to Congress—with no accompanying statute directive. *Id.*

Second, the Conference included the House bill's directions for the Secretary to set Medicare rates for renal dialysis services in a way that reduces costs. *Id.* at 948-49. The bill gives the Secretary discretion to adopt separate rate-setting formulas that "will more effectively encourage the more efficient delivery of dialysis services and will provide greater incentives for increased use of home dialysis than through the single composite weighted formulas." Pub. L. No. 97–35, § 2145(a)(8), 95 Stat 357 (1981) (amending 42 U.S.C. § 1395rr). These amendments appear in § 2415, entitled "Incentive Reimbursement Rate for Renal Dialysis Services," which immediately precedes the amendments to the Medicare Secondary Payer Act (§ 2416).

2. Take-into-Account Clause and Enforcement Scheme. In 1989, Congress enacted a second set of amendments to the Medicare Secondary Payer Act that are central to this case, again via omnibus reconciliation. *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101–239, § 6202, 103 Stat. 2106. Two of those amendments are relevant here, and both are found in § 6202(b), which is entitled "Uniform Enforcement and Coordination of Benefits."

First, Congress moved the differentiate clause previously codified in the Internal Revenue Code to 42 U.S.C. § 1395y, the section of the code that includes

the main provisions of the Medicare Secondary Payer Act. In so doing, Congress reframed the provision from a requirement for tax deductibility to a general requirement that

> [a] group health plan . . . (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.

42 U.S.C. § 1395y(b)(1)(C). Similarly, it added a separate condition to that new subsection as (i)—that a group health plan "may not take into account that an individual is entitled to benefits under [Medicare] during the 12-month period [now 30-month period] . . . ." *Id.* Courts and parties refer to this provision as the "take-into-account clause."

Second, Congress amended the enforcement scheme for "nonconforming" group health plans, which include those that fail to comply with the differentiate and take-into-account clauses. It repealed the Internal Revenue Code provision that prohibited an employer from deducting the costs of its group health plan if the plan violates the differentiate clause. Pub. L. No. 101–239, § 6202(b)(3), 103 Stat. 2106 (1989). It replaced that with a 25% excise tax on costs for "nonconforming" plans, *id.* § 6202(b)(2), as well as created a cause of action by the United States to recover payments made that should have been covered by outside insurance as primary insurer. *Id.* § 6202(b)(1).

The 1989 omnibus reconciliation legislation also created a private cause of action for damages under the Medicare Secondary Payer Act. *Id.* The text for the private cause of action remains the same today:

> There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).

42 U.S.C. § 1395y(b)(3)(A).

As detailed in the Conference report to the 1989 omnibus reconciliation legislation, these amendments to the Medicare Secondary Payer Act came from the House bill. H.R. Conf. Rep. 101–386, at 819-23, 825 (1989). The Conference report explains that § 6202(b) of the omnibus legislation "[r]estructures and changes provisions in current law related to Medicare as secondary payer requirements." *Id.* at 822. And it includes the differentiate and take-into-account clauses among the "[r]equirements of group health plans" under the Medicare Secondary Payer Act. *Id.* at 822-23. In describing the clauses, the Conference report parrots the proposed statutory language. *See id.* It does not label or describe them as antidiscrimination provisions—nor does the House committee report.

In discussing the enforcement provisions, the Conference report notes that the House bill "[e]stablishes a private cause of action for damages (double the amount otherwise provided) where a primary plan fails to provide for primary payment or appropriate reimbursement." *Id.* at 823. It also summarizes the new excise tax approach as "impos[ing] on any employer or employee organization that contributes to a nonconforming large group health plan . . . a tax equal to 25 percent of the employer's or employee organization's expenses incurred during the calendar year for each large group health plan . . . ." *Id.* at 823-24. Again, nothing in the Conference report or House committee

report refers to the enforcement mechanisms as redressing discriminatory actions. Instead, the statute and reports use the term "nonconforming" for group health plans that do not comply with the differentiate and take-into-account clauses. *See id.*

The Conference report notes that there were no Senate amendments to this part of the House bill, and the Conference agreed to include these House provisions "with a change to include liability insurance (including a self-insured plan) in the definition of 'primary plan' to which Medicare's secondary payer provisions apply." *Id.* at 825-26.

One final provision of the House bill, which the Conference agreed to include in the final legislation, bears mention. The House bill added a "[c]oordination of benefits" subsection that directs Medicare to serve as secondary insurer if the payment from the primary plan is less than the amount charged and, as the Conference report summarizes it, "[p]rovides that Medicare's payment cannot exceed the amount that Medicare would have paid as primary payer." *Id.* at 824. This provision is codified at 42 U.S.C. § 1395y(b)(4).

B. The Statutory History and Structure Confirm the Statute Does Not Create Disparate-Impact Liability.

The above account of the history, structure, and design of the Medicare Secondary Payer Act confirms what is plain in the statutory text—that Congress had no intention for the statute to be an antidiscrimination law that imposes disparate-impact liability. A few aspects of that statutory history and structure are worth amplifying.

1. As evident from the context, structure, and history of the Medicare Secondary Payer Act, the central

purpose of the law has remained unchanged since its enactment in 1980: It is a coordination-of-benefits law intended to reduce Medicare expenditures and extend the life of the Medicare Trust Fund. The statute seems to have been quite effective on that front. It saves Medicare around $8 billion per year, including $300 million per year for treatment related to end-stage renal disease. *See* 2014 CRS Report, at 24 tbl.5 (reporting savings for fiscal years 2006 through 2012).

The contextual evidence is particularly compelling when it comes to the secondary payer provisions related to end-stage renal disease. Congress expanded the Medicare Secondary Payer Act in response to the rising costs of Medicare coverage for end-stage renal disease. Accompanying the 1981 omnibus reconciliation legislation that made this expansion, the Senate committee report expressly declares "that the purpose of this provision is *only* to change the coordination of benefits relationships between Medicare and private health benefit coverage to the extent that any private coverage is present at the onset of end-stage renal disease." S. Rep. 97–139, at 736 (1981) (emphasis added).

Reducing Medicare costs for end-stage renal disease was critical. The Senate committee report estimates $440 million in savings to Medicare over the first full three years from the expansion of Medicare secondary payer status for treatment of end-stage renal disease. *Id.* Another section of the 1981 omnibus reconciliation legislation, entitled "Incentive Reimbursement Rates for Renal Dialysis Services," addresses setting rates and providing incentives to drive down the Medicare expenses related to end-stage renal disease. *See* Pub. L. No. 97–35, § 2145, 95 Stat 357 (1981).

2. Reading disparate-impact liability into the Medicare Secondary Payer Act—as the Sixth Circuit did

and Respondent DaVita argues this Court should—would require group health plans to pay dialysis providers an unspecified "most favored nation" rate. As further discussed in Part II, such a rate would be much higher than the Medicare base rate, resulting in Medicare never being a secondary payer when it comes to individuals with end-stage renal disease.

Here, the title of the law—the Medicare *Secondary* Payer Act—is not just a title. From its first enactment and through its various amendments, Congress has structured the law such that Medicare would be the secondary payer whenever the group health plan as primary payer did not pay the full Medicare rate for the service in question. The Senate committee report accompanying the 1981 omnibus legislation observes that, "in the event payment by the private plan or policy is less than the amount charged for the covered item or service, Medicare (in its role as secondary payer) would pay no more than the program would otherwise have paid in the absence of such private coverage." S. Rep. 97–139, at 735-36 (1981).

The 1989 omnibus reconciliation legislation went further and codified a coordination-of-benefits provision for what Medicare as secondary insurer would cover when private insurance as primary insurer failed to reimburse the full Medicare rate for the service. 42 U.S.C. § 1395y(b)(4). Respondent DaVita's attempt to read disparate-impact liability into the statute would erase this coordination-of-benefits provision and the possibility that a group health plan may cover services at a rate lower than the Medicare rate.

3. As persuasively set forth in Judge Murphy's dissent and further developed in Petitioners' brief on the merits, the statutory text of the differentiate and take-into-account clauses fall far short of suggesting that

the Medicare Secondary Payer Act is an antidiscrimination law that imposes disparate-impact liability.

Nothing in the statutory design or legislative history, exhaustively documented in Part I.A, provides support for the required finding for disparate-impact liability that the "central purpose" of the statute is to "eradicate discriminatory practices within a sector of the Nation's economy." *Inclusive Communities*, 576 U.S. at 539. As the Ninth Circuit concluded, "We doubt that Congress intended, in a statute aimed almost entirely at saving Medicare money, to require group health plans to ensure that its plans have no disproportionate effects on persons with [end-stage renal disease]." *DaVita v. Amy's Kitchen*, 981 F.3d 664, 676 (9th Cir. 2020).

To the contrary, the statute's enforcement scheme strongly suggests that Congress did not intend for the Medicare Secondary Payer Act to be an antidiscrimination law. When Congress added the differentiate clause in the 1981 omnibus reconciliation legislation, it did not provide for any cause of action to redress a violation. Indeed, Congress placed the provision in the Internal Revenue Code and provided that the penalty for noncompliance was that the employer would not be able to deduct as a business expense the costs of the group health plan. Pub. L. No. 97–35, § 2146(b), 95 Stat 357 (1981) (amending 26 U.S.C. § 162).

Such enforcement scheme is nothing like what Congress usually enacts when it intends to create an antidiscrimination law with disparate-impact liability. *See, e.g.*, *Marietta Memorial*, 978 F.3d at 362-64 (Murphy, J., dissenting) (discussing the central features of antidiscrimination laws and how the Medicare Secondary Payer Act lacks them); *Amy's Kitchen*, 981

F.3d at 671-76 (agreeing with and further expanding on Judge Murphy's analysis).

When Congress added the take-into-account clause in the 1989 omnibus reconciliation legislation and refashioned the differentiate clause as a general requirement for a group health plan under the Medicare Secondary Payer Act, it also created a private cause of action. Importantly, however, the private cause of action has nothing to do with redressing discrimination. It merely allows a civil action for damages "in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) . . . ." 42 U.S.C. § 1395y(b)(3)(A).

Moreover, nothing elsewhere in the text of the 1989 omnibus reconciliation legislation or in its legislative history suggests that Congress added a private cause of action to redress discrimination. There's no reference to discrimination, much less that antidiscrimination was the central purpose for the amendments to the Medicare Secondary Payer Act. As the Ninth Circuit concluded in *Amy's Kitchen*, "there is little evidence, either in the legislative history of the [Medicare Secondary Payer Act] or in other sources, that persons with [end-stage renal disease] 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." 981 F.3d at 675.

4. To be sure, Respondent DaVita in the briefing in the lower courts relied on two mentions of discrimination in the legislative history for the various omnibus reconciliation bills that have amended the Medicare Secondary Payer Act over the years. Neither is on point, much less meets the high burden of "central

purpose" to read disparate-impact liability into a statute. *Inclusive Communities*, 576 U.S. at 539.

First, when Congress expanded the statute to cover end-stage renal disease and added the differentiate clause in 1981, the Senate committee report summarizes the differentiate clause as prohibiting tax deductibility for a group plan "if such plan contains a discriminatory provision that reduces or denies payment of benefits for renal patients." S. Rep. 97–139, at 736 (1981). This summary is repeated in the Conference report. H.R. Conf. Rep. 97–208, at 956 (1981).

These reports' use of "discriminatory" does not come close to demonstrating an intent to create disparate-impact liability. *See* Pet'rs Br. 51-58. The language is fully consistent with Judge Murphy's and the Ninth Circuit's reading that the differentiate clause only requires that group health plans do not differentiate in the benefits provided for the same services for individuals with and without end-stage renal disease. There is no dispute that the plan at issue complies with that.

Moreover, this stray reference to "discriminatory" is included in the legislative reports accompanying the 1981 omnibus reconciliation legislation—legislation that did not even create a private cause of action. Instead, the only penalty for noncompliance was that the employer would not be able to deduct the costs of the group health plan. Importantly, as noted above, when the private cause of action was added in 1989, there was no mention of discrimination anywhere in the statutory text or legislative history.

Finally, if anything should be inferred from the use of the term "discriminatory" in the committee and Conference reports, it is that Congress in the statutory text chose not to use "discriminate," but instead

"differentiate." Differentiate, without more, is not remotely close to the type of "results-oriented" verb in a statute that would suggest disparate-impact liability—such as "otherwise adversely affect." *Inclusive Communities*, 576 U.S. at 531 (finding that language sufficient to create disparate-impact liability under Title VII of the Civil Rights Act). Nor is "discriminate," for that matter. *See id.* at 530-35 (finding that the "otherwise discriminate" language in Title VII was not sufficient to create disparate-impact liability); *see also Marietta Memorial*, 978 F.3d at 362-63 (Murphy, J., dissenting) (applying *Inclusive Communities* to this statute and concluding that "[t]he differentiate clause contains no similar 'results-oriented' verb").

Second, the Senate committee report and the Conference report accompanying the 1981 legislation note that "[t]he committee is also concerned about potential job discrimination resulting from the provision, and directs the Secretary to investigate promptly complaints of this nature, and report his findings to the Congress." S. Rep. 97–139, at 736 (1981); *accord* H.R. Conf. Rep. 97–208, at 956 (1981). This directive was not enacted in the statutory text, and again it was included in the legislative history for legislation that did *not* create a private cause of action.

Nor, of course, does this concern have anything to do with a group health plan "differentiat[ing] in the benefits it provides" to plan members with and without end-stage renal disease. Instead, the concern is about "potential job discrimination," such as employers firing or not hiring someone with end-stage renal disease if the group health plan was the primary insurer. The Ninth Circuit wisely relegated its dismissal of this legislative history to a footnote, noting that this "level of concern pales in comparison to, for example, Congress'

deep concern with the entrenched historical discrimination in housing on the basis of race." *Amy's Kitchen*, 981 F.3d at 675 n.3 (citing *Inclusive Communities*, 576 U.S. at 528-30).[3]

5. When it comes to interpreting the Medicare Secondary Payer Act, it is critical to understand that the original statute and all of the relevant amendments were enacted through the omnibus budget reconciliation process. Created in 1974, reconciliation is a fast-track legislative process (not subject to the Senate filibuster) used to raise federal revenue and reduce federal spending. *See* Anita S. Krishnakumar, *Reconciliation and the Fiscal Constitution: The Anatomy of the 1995-96 Budget "Train Wreck"*, 35 Harv. J. on Legis. 589, 590-93 (1998); *see also* 2 U.S.C. § 636 (detailing

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[3] In its briefing in *Amy's Kitchen*, Respondent DaVita referenced a committee report accompanying an unrelated 1985 omnibus budget reconciliation bill that described the 1981 differentiate clause as providing that "no deductions are permitted for contributions to a group health plan that differentiates directly or indirectly on the basis of the existence of end stage renal disease or the need for renal dialysis." S. Rep. No. 99–146, at 363 (1985). It argued the reference to "indirectly" suggests disparate-impact liability.

Such use of legislative history takes Judge Harold Leventhal's famous observation that citing legislative history is like "looking over a crowd and picking out your friends" to an entirely new and tenuous level. Patricia M. Wald, *Some Observations on the Use of Legislative History in the 1981 Supreme Court Term*, 68 Iowa L. Rev. 195, 214 (1983) (quoting conversation). This is not even the same crowd! The 1985 legislative history post-dates enactment by four years. Indeed, it did not even amend the differentiate clause. And when Congress refashioned the differentiate clause four years later, no one mentioned in the legislative history that it covers indirect or disparate-impact discrimination—much less was such a results-oriented adjective, adverb, or verb added to the statutory text. *See* Part I.A.2 *supra*.

congressional procedures for consideration of reconciliation legislation).

Reconciliation has always been understood to address deficit reduction—both raising revenue and reducing spending. Not surprisingly, however, members of Congress have attempted to add non-budgetary substantive proposals to reconciliation legislation. *See generally* Krishnakumar, *supra*, at 591-600 (detailing history of reconciliation). In the early years, the Senate resisted such gamesmanship through norms and negotiation. Then, in 1985, it adopted the "Byrd Rule" to address the problem with more formal constraints. Under the Byrd Rule, Congress prohibits "extraneous" provisions in reconciliation bills, including any provision that "produces changes in outlays or revenues which are merely incidental to the non-budgetary components of the provision." 2 U.S.C. § 644(b)(1).

In light of the unique aspects of reconciliation legislation and the Byrd Rule's "pivotal role in shaping those bills," scholars have argued that courts should adopt a "Parliamentarian's canon," which would "counsel not to interpret a reconciliation bill in a way that would have clearly violated the Byrd Rule." Jesse M. Cross & Abbe R. Gluck, *The Congressional Bureaucracy*, 168 U. Pa. L. Rev. 1541, 1677 (2020); *see also* Victoria F. Nourse, *A Decision Theory of Statutory Interpretation: Legislative History by the Rules*, 122 Yale L.J. 70, 96 n.103 (2012) (arguing that, "when faced with a difficult case of ambiguity, courts . . . may give language the legal effect demanded by the congressional rules"); *cf.* Jonathan S. Gould, *Law Within Congress*, 129 Yale L.J. 1946, 2022 (2020) (arguing that courts should "look to parliamentary precedent—especially rulings of the chair—to help them interpret ambiguous statutory provisions" (footnote omitted)).

To be sure, the 1981 omnibus reconciliation legislation that expanded the Medicare Secondary Payer Act to cover end-stage renal disease and first introduced the differentiate clause predated the Byrd Rule's enactment in 1985. But the general principles of reconciliation still apply, in that Congress would not enact a major antidiscrimination law with disparate-impact liability via omnibus budget reconciliation.

More importantly, the 1989 reconciliation legislation is the critical one. It created the private cause of action. It added the take-into-account clause as well as refashioned the differentiate clause from a condition for tax deductibility into a plan requirement under the Medicare Secondary Payer Act. Even if the text and context were not unambiguous to the contrary, one could not plausibly argue that Congress's central purpose in those 1989 amendments was to redress discrimination through disparate-impact liability. That would have violated the Byrd Rule. It would have impermissibly made the Medicare savings objective "merely incidental to the non-budgetary components of the provision." 2 U.S.C. § 644(b)(1).

II. The Sixth Circuit's Misinterpretation of the Medicare Secondary Payer Act Could Upend the Health Insurance Market.

Employment group health plans provide insurance to around 157 million individuals in the United States, *see* Kaiser Family Foundation, *supra*, at 6, which is more than half of all individuals insured nationwide. *See* Katherine Keisler-Starkey & Lisa Bunch, U.S. Census Bureau, *Health Insurance Coverage in the United States: 2020* 5 fig.1 (2021). Self-insured plans cover more than 100 million individuals in the United States. Kaiser Family Foundation, *supra*, at 161-65.

When it comes to dialysis services, many group health plans have implemented cost-control measures to preserve plan resources and respond to significant price inflation imposed by dialysis providers. *See* Pacific Health Coalition *Amicus Curiae* Br. 19-37 (detailing noncompetitive dialysis market). Some plans pay out dialysis claims at less than the Medicare rate. The plan at issue, for instance, reimburses dialysis services at 87.5% percent of the Medicare rate. *Marietta Memorial*, 978 F.3d at 332. If the individual has end-stage renal disease and is enrolled in Medicare, Medicare as secondary payer would reimburse the dialysis provider for the difference between the private plan reimbursement and the Medicare rate. 42 U.S.C. § 1395y(b)(4). Other plans, like the one involved in *Amy's Kitchen*, subject each claim for dialysis service to a cost-review process to ensure it is "the Usual and Reasonable Charge," and not an inflated charged based on "the effects of market concentration or discrimination in charges." 981 F.3d at 669 (quoting plan terms); *see also id.* ("The 'Usual and Reasonable Charge' differs from the 'Customary, Usual, and Reasonable Charge' that applies to reimbursements for some other types of medical treatment.").

Under Respondent DaVita's disparate-impact interpretation of the Medicare Secondary Payer Act, employment group health plans would have to set the reimbursement rate for dialysis services at an unspecified "most favored nation" rate. In its complaint, for instance, Respondent DaVita demanded reimbursement "at its undiscounted charges or, at a minimum, at the reasonable and customary rates for dialysis as typically understood in the industry." J.A. 32, ¶ 67.

It is difficult to predict the exact rate that would be required. But we do have a few publicly available

datapoints. For example, one study reported that Respondent DaVita's average revenue in 2017 from "commercial payers" was $1,041 per treatment. Christopher P. Childers et al., *A Comparison of Payments to a For-Profit Dialysis Firm from Government and Commercial Insurers*, 179(8) JAMA Internal Med. 1136, 1137 (2019). In 2016, a large commercial insurer reportedly paid a dialysis provider more than $4,000 per treatment. Compl. ¶ 7, *UnitedHealthCare of Fla. v. Am. Renal Assocs.*, No. 9:16-CV-81180 (S.D. Fla., filed July 1, 2016), https://perma.cc/RH85-BAEU.

Litigation has demonstrated that in 2013 a dialysis provider charged a self-insured group health plan around $5,000 per treatment. Pls.' Mot. Summ. J. Ex. A–4, at 3, *Lubbock Cty. Hosp. Dist. v. Specialty Care Mgmt.*, No. 5:16-CV-037-C (N.D. Tex., filed Feb. 15, 2017), https://perma.cc/A8DY-Y7VX. Other litigation has revealed that in 2015 a provider charged an out-of-network rate of about $6,000 per treatment. *Dialysis Newco v. Cmty. Health Sys. Grp. Health Plan*, 938 F.3d 246, 249 (5th Cir. 2019).

To put these numbers in perspective, the Centers for Medicare & Medicare Services in 2019 set the Medicare base rate for dialysis treatment at $239.33 per treatment with some adjustments ($35,348 annually). 84 Fed. Reg. 60,648, 60,707-08 (Nov. 8, 2019). This rate is based on the agency's determination of provider costs, allowing reasonable profits to efficient providers. *See id.* In other words, if group health plans were required to reimburse dialysis services at a "most favored nation" rate, the plans could potentially see a twenty-five-fold increase in costs from Medicare's annual reimbursement rate of $35,000 per individual with end-stage renal disease to perhaps more than $900,000.

This would leave group health plans with a difficult choice: raise the employee contributions beyond what employees would likely be willing to pay or reduce coverage for other important healthcare benefits. Employers with self-insured plans, which generally have great flexibility in determining healthcare coverage, may have two additional options. They could exclude dialysis treatment from coverage—though Respondent DaVita would no doubt sue and argue such exclusion violates its interpretation of the Medicare Secondary Payer Act. Or they could eliminate their self-insured plans entirely, opting for a more-expensive and less-flexible fully insured plan. None of these solutions is desirable for employers or employees.

This discussion about the potentially catastrophic impact of Respondent DaVita's interpretation should impress one final point: This case is not about compensating individuals with end-stage renal disease for alleged disparate treatment. Individuals with end-stage renal disease will receive the same treatment. It is the dialysis providers like Respondent DaVita that benefit in terms of increased profit margins if group health plans continue to cover the dialysis services.

Nor is the case about saving Medicare money. In the short term, there may be some savings, as all private plans would be covering dialysis services for the first thirty months above the Medicare rate. But with the dialysis rates so high, many employers would consider eliminating dialysis services from their plans or, where permissible, canceling their group health plans. At the very least, employers would need to raise employee contributions considerably. Those responses would encourage many plan members with end-stage renal disease to switch to Medicare.

The end result would be that Medicare would become the primary and sole insurer for more individuals with end-stage renal disease during what would have been a thirty-month coordination period. This is what Congress expressly sought to prevent when it amended the Medicare Secondary Payer Act to cover end-stage renal disease. And dialysis providers like Respondent DaVita—not individuals with end-stage renal disease or Medicare—would be the financial beneficiaries.

CONCLUSION

For the foregoing reasons, this Court should reverse the decision of the Court of Appeals.

Respectfully submitted,

CHRISTOPHER J. WALKER
Counsel of Record
THE OHIO STATE UNIVERSITY
MORITZ COLLEGE OF LAW*
55 West 12th Avenue
Columbus, OH 43210-1391
(614) 247-1898
christopher.j.walker@gmail.com

* Institutional affiliation is provided for identification purposes only.

Counsel for Amicus Curiae

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