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

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INTRODUCTION

The Medicare Secondary Payer Act (MSPA) is a coordination-of-benefits statute, not a mandate of specific benefits. Rejecting textual focus as "myopic," Respondents ask the Court to effectively amend each key term of the differentiation and take-into-account clauses. Resp'ts' Br. 19. Their aggressive agenda for transforming the MSPA has no place within the four corners of the statute. It depends on a revisionist interpretation of the MSPA that goes beyond its express words and proceeds from new factual allegations that have no basis in the record or elsewhere. Statutory interpretation "begins and ends with the text." *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, No. 19-431, 591 U.S. ___, slip op. at 15 (2020) (quoting *Octane Fitness, LLC v. ICON Health & Fitness, Inc.*, 572 U.S. 545, 553 (2014)). The text allows for only one conclusion. The MSPA coordinates benefits. It does not prescribe them.

ARGUMENT

Respondents base their argument for implied parity of benefits on a syllogism that does not work. They claim that "differential treatment of outpatient dialysis is differential treatment of individuals with ESRD" in violation of the MSPA. *Id.* at 2-3, 18. That is a false equivalence under the MSPA and the record.

I. Respondents have failed to state a differentiation claim.

Respondents recognize that the MSPA "does not guarantee a substantive entitlement to any fixed level of dialysis benefits." Resp'ts' Br. 39; *see also id.* at 20, 40, 45-46. And they do not dispute that the Marietta Memorial Hospital Employee Health Benefit Plan (Plan) provides the same benefits to individuals with end stage renal disease (ESRD) as to others. Those concessions are dispositive under the literal terms of the MSPA.

A. The differentiation clause requires parity of individuals, not benefits.

Respondents downplay the predicate of the differentiation prohibition. The clause requires that a plan "may not differentiate *in the benefits it provides* between *individuals with end stage renal disease* and *other individuals covered by such plan*[.]" 42 U.S.C. §1395y(b)(1)(C)(ii) (emphases added). This Court "must presume that Congress 'says in a statute what it means and means in a statute what it says there.' "). *Rotkiske v. Klemm*, No. 18-328, 589 U.S. ___, slip op. at 5 (2019) (quoting *Connecticut Nat'l. Bank v. Germain*, 503 U.S. 249, 254 (1992)). Thus, a plan does not violate the prohibition if individuals with ESRD have the same benefits as individuals without ESRD.

Here, the benefits are precisely the same for all participants. For this reason, Respondents' semantic attack on the differentiation clause falters at the threshold. Their primary strategy is to repeatedly

paraphrase that critical part of the statute in their brief and in the Complaint. *See*, *e.g.*, Resp'ts' Br. 18 (referring to the provision as addressing "impermissible differentiation of ESRD enrollees" or "differentiation of ESRD"); 21 ("differentiation of ESRD enrollees"); 23 (same; "differential treatment of dialysis"); 24 ("differentiation of ESRD enrollees"); 27 ("differentiation of ESRD"); 39 ("ESRD differentiation"); *see* Jt. App. 4 (¶ 2), 25 (¶ 50), 27 (¶ 53), 29 (¶¶ 57-58), 31-32 (¶ 67). But the actual language used by Congress controls and does not permit Respondents' modifications.

Respondents seek to create a difference of another dimension by claiming inaccurately that the Plan "singles out" the services that they provide by including specific terms for outpatient dialysis treatments. Resp. Br. 13, 16 n.5, 19, 22. They are wrong. Cost-management is a pervasive concern of plan fiduciaries, and plainly is not limited to outpatient dialysis. For this very reason, the Plan also provides, for example, that "[s]ervices obtained through White Fence Surgical Suites, Northpointe Surgical Suites, Southeast Ohio Surgical Suites and Lancaster Specialty Surgery Center will not be covered under the Plan, regardless of whether the Provider is part of any designated Preferred Provider network." Jt. App. 52-53.

It does not further their cause to argue that the Plan covers outpatient dialysis and inpatient dialysis on different terms.[1] Resp'ts' Br. 15. As an initial matter,

[1] Although the legal issues are dispositive, Petitioners present below the reasons why there is no factual merit to the

the Plan provides the same benefits for inpatient and outpatient dialysis to all participants – an uncontested point that deprives their alternative theory of differentiation of any viability. Moreover, the Plan reimburses these services at different rates because Marietta Memorial Hospital (Hospital) offers inpatient dialysis at its own facilities, but not outpatient dialysis services. Jt. App. 79.

B. The "need for renal dialysis" branch of the differentiation clause does not supersede the statutory comparison of "individuals with ESRD" and "other individuals covered by the plan."

Although the lack of actual differentiation should be the end of the matter, Respondents then ask the Court to take an unduly expansive view of the "need for renal dialysis" phrase. Resp'ts' Br. 23. They contend, despite the express words of the statute, that Congress has thereby "textually defined differential treatment of dialysis to be the same as differentiation of ESRD enrollees." *Id.* That is far more work than Congress built the phrase to do.

Respondents' alleged correlation of inpatient and outpatient dialysis with acute kidney injury and ESRD respectively. *See* Section I.F.1, *infra*.

1. "Individuals having ESRD" is the definitive distinction.

Congress adopted a specific comparator ("individuals having end stage renal disease") as a laser-focused means to a specific legislative end (coordination of Medicare costs for treatment of individuals with ESRD). Any broader reach would have been superfluous, and neither necessary nor proper. Respondents would have the Court discard the precisely-calibrated term "end stage renal disease" as an obsolete shibboleth in favor of a new approach that overshoots the mark.

The words of a statute control. "It is a fundamental principle of statutory interpretation that 'absent provision[s] cannot be supplied by the courts.'" *Rotkiske*, *supra*, at 2 (quoting A. Scalia & B. Garner, *Reading Law: The Interpretation of Legal Texts* 94 (2012)). To add provisions would be "not a construction of a statute, but, in effect, an enlargement of it by the court." *Nichols v. United States*, No. 15-5238, 578 U.S. ___, slip op. at 6 (2016). "It is Congress, not this Court, that balances [the] interests. We simply enforce the value judgments made by Congress." *Rotkiske*, *supra*, at 6; Robert A. Katzmann, *Judging Statutes* 104-05 (2014) ("When judges interpret the words of statutes, they . . . are maintaining an unspoken covenant with the citizenry on whose trust the authority and vitality of an independent judiciary depend, to render decisions that strive to be faithful to the work of the people's representatives memorialized in statutory language.").

If there is no differentiation of benefits between "individuals having end stage renal disease" and "other individuals covered by such plan," any question about manner of differentiation vanishes. The MSPA asks (1) whether there is a differentiation in benefits between individuals with ESRD and others covered by the plan; and (2) if so, whether the differentiation is based on any of the three specified manners. Respondents improperly transform those two questions into one – whether there is a differentiation of dialysis benefits from other plan benefits – through their interpretation of the "need for renal dialysis" phrase.

2. The "need for renal dialysis" phrase bars differentiation of benefits for individuals with ESRD who require that form of treatment.

Respondents stretch the "need for renal dialysis" provision beyond its capacity in promoting it as a substitute for differentiation between the two groups of individuals established by the statute. On its face, the phrase means only that a plan may not provide different benefits to those individuals with ESRD who need renal dialysis as their therapy option. (A kidney transplant is the alternative treatment that individuals with ESRD need.)

As the Ninth Circuit concluded, "a plan may not provide differing benefits to persons with ESRD . . . because an individual with ESRD needs renal dialysis." *See DaVita Inc. v. Amy's Kitchen*, *Inc.*, 981 F.3d 664, 671 (9th Cir. 2020). The Sixth Circuit dissent

similarly noted that a plan may not avoid the differentiation prohibition by "changing the label." Pet. App. 73.[2]

This reading preserves the separate meaning of the phrase as an illustration of a manner in which a plan may not differentiate the benefits that it provides to an "individual[] having end stage renal disease." Each of the three "manner" phrases works in that constructive fashion. *See Yates v. United States*, 574 U.S. 528, 529, 544-45 (2015) (words immediately surrounding a word that is "last in the list of terms" "cabin the contextual meaning of that term" because "[h]ad Congress intended [an] all-encompassing meaning . . . it is hard to see why it would have needed to include the examples at all") (citations omitted); *id.* at 546 (generic word necessarily interpreted as related to example words because Congress otherwise "would have had no reason to refer specifically to" the example words and thus such would be "misleading surplusage"); *CSX Transp., Inc. v. Alabama Dep't of Revenue*, 562 U.S. 277, 295 (2011) ("We typically use [the canon] *ejusdem generis* to ensure that a general word will not render specific words meaningless.").

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[2] Respondents provide a hypothetical that lacks parallel construction and thus is readily distinguishable. Resp'ts. Br 23. Renal dialysis is one of two forms of ESRD treatment. Sickle cell anemia likewise has more than one treatment. Respondents' hypothetical does not distinguish among those options by specifying one of them (for example, blood transfusions). *See* Mayo Clinic, Sickle cell anemia, https://www.mayoclinic.org/diseases-conditions/sickle-cell-anemia/diagnosis-treatment/drc-20355882 (last visited Feb. 16, 2022).

By contrast, when read as Respondents urge, the "need for renal dialysis" phrase would reclassify the very distinction that Congress meant to reinforce. "[I]ndividuals having ESRD" would become a dead letter. It would be understood instead as "individuals needing dialysis" – as in, "a group health plan may not differentiate in the benefits it provides between ***individuals needing dialysis*** and other individuals covered by such plan." (The Plan would still pass muster because its benefits are the same for all.) Surely Congress did not mean to collapse the distinction that it had just created, particularly when not all individuals needing dialysis are Medicare-eligible on that basis. The phrase does not reverse-engineer an unspoken mandate for parity of dialysis benefits.

3. When Congress requires parity of health care benefits, it does so explicitly.

The absence of explicit parity language further dispels the notion of an implied obligation that plans provide outpatient dialysis benefits "the same as" other benefits. Resp'ts' Br. 39. When Congress wants to require parity or minimum benefit levels, it does so expressly. *See*, *e.g.*, 29 U.S.C. §1185a (parity for mental health and substance use disorder benefits with medical and surgical benefits); 42 U.S.C. §1395rr (parity of ESRD benefits for age-entitled and diagnosis-entitled individuals); 42 U.S.C. §1395y(b)(1)(A)(i)(II) (requiring "same benefits under the plan under the same conditions" for still-employed individuals age 65

and above and their spouses as paid to individuals under age 65); 29 U.S.C. §1185 (minimum hospital stay for mothers and newborns); 42 U.S.C. §300gg-13(a)(4) (ACA minimum preventive care and screening requirements); 29 U.S.C. §1185b (WHCRA reconstructive surgery benefits when plan provides medical and surgical mastectomy benefits).

C. Respondents fail to identify a parity standard.

Respondents also fail to explain how their atextual approach would work. They contend that "[t]he anti-differentiation provision requires only that dialysis be treated the same as, not 'prioritized' above, other services." Resp'ts' Br. 39. Yet neither they nor their amici commit to what would be "the same as other services" that the often-complicated terms of a group health plan cover.

Respondents indirectly suggest at least five comparators, but settle on none: (1) a position commensurate with their view of in-network status; (2) reasonable and customary rates in the market that they uniquely dominate; (3) their undiscounted charges; (4) Tier I reimbursement; and (5) Tier II reimbursement unconnected to the Medicare rate.[3]

[3] Respondents identify their actual cost as $290 per treatment. Resp'ts. Br 12. That is different from what they told the SEC. Their 10-Q for the third quarter of 2021 states the cost as $242.09 as of September 30, 2021. *See* Davita Inc., Quarterly Report (Form 10-A), 30 (Oct. 28, 2021). There is no evidence in the record that Respondents do not recover their entire cost under either Medicare or the Plan.

Resp'ts' Br. 13-16. Their amicus briefs suggest a sixth: whatever amount is necessary to profitably subsidize their operating income.

The lack of an obvious answer confirms that Congress did not intend the MSPA to serve as a vehicle for Respondents' self-serving definition of benefit parity. Indeed, when Congress enacts parity requirements, it provides specific standards to guide group health plans and health insurance issuers. *See*, *e.g.*, 29 U.S.C. §1185a(a) (for purposes of parity in mental health and substance use disorder benefits, prescribing standards as to annual and lifetime limits, financial requirements and treatment limitations, out-of-network providers, compliance requirements, and other matters).

Further complication is found in the fact that any comparable-benefits obligation would not be confined to ESRD treatment. As Respondents note, other adverse health conditions are commonly associated with ESRD. They include cardiovascular disease and diabetes. If there were an interstitial MSPA mandate for parity, would logic not compel a plan to provide coverage "the same as for other services" for treatment of those related illnesses, and thus multiply the search for comparators?

D. The revisionist interpretation would hurt group health plans and participants.

Respondents warn that failure to adopt their approach would "upend" the MSPA and "add[] costs to

the Medicare fisc annually in the billions." Resp'ts' Br 28. That claim is unfounded. Along with the Ninth Circuit, "every district court to consider" the MSPA has held that it "does not bar a plan that offers the same benefits 'to all enrollees equally.' " Pet. App. 82. Indeed, the federal judiciary first recognized thirteen years ago that "lower reimbursement rates for dialysis treatment received at out-of-network facilities" did not violate the MSPA "because [they] provide the same level of reimbursement for out-of-network dialysis treatment regardless of the insured's reason for receiving the treatment." *Nat'l Renal All., LLC v. Blue Cross & Blue Shield of Ga., Inc.*, 598 F. Supp. 2d 1344, 1354 (N.D. Ga. 2009).

In the following years, Medicare has ***not*** been inundated with the "billions" in additional costs that Respondents forecast. And the federal government stands with Petitioners in rejecting the Respondents' interpretation of the MSPA. *See* U.S. Amicus Br. 12-14.

It is Respondents' position that gives cause for alarm. Plans will bear significantly increased dialysis costs if forced to pay undiscounted charges set in the non-competitive concentrated market that Respondents control. The charges would be even higher if, as several amici claim (without documentation), there is a tacit political understanding that group health plan funds may be conscripted for the profits of commercial dialysis providers before serving participants' other health care needs. Reimbursement at such elevated level would leave less finite resources for coverage of other participant health care needs. The inevitable

consequence would be an increase in participant premiums or decrease in other plan coverage. In such case, Respondents will benefit. Plans and participants will be hurt. Medicare enrollment would make even more sense for a participant under these circumstances.

E. The MSPA does not address invidious discrimination.

Respondents also seek a metamorphosis of the word "differentiate." They claim that it is interchangeable with the word "discriminate." It is not. Congress is not shy when it bans discrimination. Title VII of the Civil Rights Act of 1964, the Age Discrimination in Employment Act, the Fair Housing Act, and the Americans with Disabilities Act prohibit "discrimination" outright. *See* 42 U.S.C. §2000e-2(a); 29 U.S.C. §623(a); 42 U.S.C. §3604(a), (b); 42 U.S.C. §12112(b).

By contrast, the MSPA identifies itself as a "coordination of benefits" measure that prohibits "differentiation" of plan benefits as a means to establish Medicare as a secondary payer of health care costs for individuals with ESRD. 42 U.S.C. §§1395y(b)(1)(C)(ii), (b)(4). Not one of its 6,582 words is "discriminate" or any of its grammatical conjugations. It is implausible to suggest that Congress simply backed away from the straightforward way in which it guarantees civil rights when it intends to do so.

1. Discrimination by proxy.

Discrimination-by-proxy has no basis in MSPA claims. The theory commonly serves as a substitute for intent. *See*, *e.g.*, *Erickson v. Farmland Indus.*, 271 F.3d 718, 725 (8th Cir. 2001) (requiring direct evidence that defendant used proxy to accomplish discrimination). The MSPA is not a discrimination statute and does not include an intent requirement. *See* Section II, *infra*. Moreover, Respondents concede that ESRD and acute kidney injury (AKI) are different from each other. *See* Resp'ts' Br. 31-32. This distinction makes a difference because Congress used a specific term when it drew the lines of the MSPA prohibition – "individuals having end stage renal disease." The substitute implicitly suggested by Respondents – "individuals who need dialysis" – describes a different and broader class.

The distinction makes a difference for the additional reasons that there is no perfect overlap and nothing immutable about the need for dialysis or the ratio between inpatient and outpatient dialysis for ESRD and for AKI. Just as COVID-19 has caused an upsurge in dialysis, a future virus could affect kidneys in a way that requires outpatient dialysis for massive numbers of Americans without ESRD, changing the ratio materially. Dialysis itself is not necessarily permanent. Although state-of-the-art now, it one day may become obsolete, much like the iron lung for polio treatment after new breathing therapies developed.

Respondents only cite distinguishable cases involving classes protected by discrimination statutes

that protect personal civil rights rather than coordinate benefits or protect the public fisc. *Id*. at 30-31; *Rice v. Cayetano*, 528 U.S. 495 (2000) (voting statute violated Fifteenth Amendment); *Sch. Bd. of Nassau Cnty. v. Arline*, 480 U.S. 273 (1987) (Rehabilitation Act); *Newport News Shipbuilding & Dry Dock Co. v. EEOC*, 462 U.S. 669 (1983) (Pregnancy Discrimination Act); *Schmitt v. Kaiser Found. Health Plan of Wash.*, 965 F.3d 945 (9th Cir. 2020) (antidiscrimination prohibitions applicable to race, color, national origin, age, sex, and disability); *Erie Cnty. Retirees Ass'n v. Cnty. of Erie*, 220 F.3d 193 (3d Cir. 2000) (ADEA); *Sullivan v. Vallejo City Unified Sch. Dist*., 731 F. Supp. 947 (E.D. Cal. 1990) (Rehabilitation Act); *Bowers v. NCAA*, 563 F. Supp. 2d 508 (D.N.J. 2008) (ADA and Rehabilitation Act).

Respondents quote Justice Scalia's aside in *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263 (1993), but notably omit the actual holding of the case. The Court ***rejected*** the contention of *ipso facto* invidious discrimination. "Our cases do not support that proposition," Justice Scalia wrote for the Court. *Id.* at 271. The *Bray* decision stands squarely in the way of the reasoning that Respondents use in this case to establish their own form of *ipso facto* invidious discrimination.

Indeed, the MSPA would be a peculiar antidiscrimination law. ***First***, its beneficiary would be the public fisc, not a protected class of individuals. *See* 42 U.S.C. §§1395y(b)(2)(B)(ii) (United States action to recover conditional payments), 1395y(b)(3)(A) (private right of action to recover conditional payments for principal benefit of government, not plan participant).

Second, if Congress was concerned about invidious discrimination against individuals with ESRD, why would it apply the MSPA only to group health plans?

Third, it would be strange for an anti-discrimination law to condone the alleged discrimination before and after the coordination period. The MSPA does not take effect until after three months of dialysis, and its differentiation clause "shall not prohibit a plan from paying benefits secondary" beginning thirty months later. 42 U.S.C. §1395y(b)(1)(C). It would be as if the 1964 Civil Rights Act allowed employers to discriminate with impunity during the first three months of an individual's employment and resume the discrimination thirty months later.

Nor did the United States "all but concede[] outpatient dialysis is a proxy for ESRD." Resp'ts' Br. 26. Instead, the United States argues that, even if outpatient dialysis "might be viewed as a proxy for having ESRD," Respondents' claims would still fail. U.S. Br. 13. Its amicus brief clearly argues that "[t]he court of appeals erred in relying on theories of discrimination-by-proxy or disparate-impact liability, ***drawn from federal civil rights laws***, to find that respondents have stated a claim." *Id*. (emphasis added).

2. Disparate impact.

Respondents identify no convincing substitute for the statutory language through which the Court has recognized disparate-impact liability ("otherwise adversely affect," "otherwise make unavailable," "in a way that adversely affects"). *See* 42 U.S.C. §2000e-2(a)(2); 29 U.S.C. §623(a)(2); 42 U.S.C. §3604(a); 42 U.S.C. §12112(b).

Nor do they dispute that the MSPA is a coordination-of-benefits statute, the purpose of which is to keep primary coverage of individuals with ESRD primary during the coordination period, rather than a statute to address historical invidious discrimination. Their argument remains grounded in the dismissive proposition that Congress haplessly prohibited "differentiation in the benefits it provides" to "individuals having end stage renal disease" when it really meant something else – "all individuals who receive dialysis treatments." To thus blur the lines would be to manufacture a cause of action rather than entertain a claim authorized by the process of bicameralism and presentment. *See* U.S. Const., art. I, § 7.

F. Respondents base their proposed overhaul of the MSPA on assumptions outside the record that are demonstrably wrong.

As set forth above, Respondents' legal arguments fail based on statutory text. In addition, their brief makes factual arguments that lack a basis in the

record or reality. While these factual arguments do not alter the MSPA text, Petitioners address them to provide the Court with confidence that reversing the Sixth Circuit will have positive impacts for participants and group health plans without negatively impacting Medicare.

1. The supposed correlation of inpatient and outpatient dialysis with AKI and ESRD.

The linchpin of Respondents' differentiation argument is an alleged dichotomy between outpatient dialysis for individuals with ESRD and inpatient dialysis for individuals with AKI. *See* Resp'ts' Br. 5, 15, 26, 31-32, 35 n.8, 41. Respondents claim that the Plan thus provides one set of dialysis benefits to individuals with ESRD (outpatient benefits, reimbursed at 70% of 125% of the Medicare rate under Tier II) and another to other individuals, such as those with AKI (inpatient, reimbursed at 90% under Tier I). *Id.*

That claim, which makes its debut in this Court, has no basis. ***First***, neither source that Respondents cite addresses their premise that dialysis for AKI is administered "typically in an (inpatient) hospital setting associated with the condition that caused the injury." *Id.* at 5. Instead, they state only that persons with AKI need dialysis for limited periods of time, ***not*** that they only receive dialysis as inpatients. *See id.*

Second, the premise is completely wrong. The Trade Preferences Extension Act of 2015 required Medicare payment for outpatient dialysis furnished to

an individual with AKI on or after January 1, 2017. Pub. L. 114-27, 129 Stat. 362, 418-19 (2015). The 2021 United States Renal Data System reported that "[b]etween the beginning of 2017 and the end of 2019, the number of adults who initiated outpatient dialysis for AKI each quarter steadily climbed, reaching nearly 3500 patients per month during the fourth quarter of 2019." *See* USRDS, Annual Data Report (2021), Ch. 4 at 1, 16.

Third, an individual normally treated for ESRD as an outpatient who is hospitalized for other reasons at the Hospital can receive inpatient dialysis under Tier I. In any event, the Plan provides the same dialysis benefits uniformly to all irrespective of diagnosis.

Fourth, the argument equates inpatient dialysis with in-network dialysis, and outpatient dialysis with out-of-network dialysis, when no such automatic association exists.

2. The phantom specter of balance billing.

Respondents' balance billing assertions are a decoy for the nightmare scenario that would unfold if Respondents prevail. Respondents seek primary payment of their "undiscounted charges" or "reasonable and customary rates" in the industry that they dominate. Jt. App. 32. Upon entry of the requested final judgment in their favor, the Plan would be subject to paying 70% of the full, undiscounted, amount charged

for each treatment, and the participant 30%. *Id*. at 88, 91-92. Respondents would eliminate the potential for balance billing only by thus being paid in full, which solely benefits them.

For participants, the effect would be devastating. The billing rates of commercial dialysis providers have ranged, for individuals with private health coverage, from $1,041 to at least $6,000 per treatment. *See* Amicus Curiae Self-Ins. Inst. of Am. Br. 26; Pacific Health Coal. Amicus Br. 35-37. Individuals enrolled exclusively in the Plan now pay 30% of 125% of the $257.90 current Medicare rate ($96.71 per treatment) after their deductible. They suddenly would owe 30% of an exponentially larger amount ($1,800 per treatment, if Respondents' charges were $6,000).

For self-insured group health plans, the impact would be just as catastrophic. They could "potentially see a twenty-five fold increase in costs from Medicare's annual reimbursement rate of $35,000 per individual with [ESRD] to perhaps more than $900,000." *See* Amicus Curiae Self-Ins. Inst. of Am. Br. 26. A 500-member plan "may need to increase each Member's premium by $1,800 annually to cover a single dialysis case at $900,000 per year." Amicus Curiae Pacific Health Coal. Br. 17.

Otherwise, with finite resources to cover a wide range of health care needs, the already-tough choices inherent in every plan design would become even more brutal. The larger chunk of Plan resources spent on outpatient dialysis reimbursements would leave far less for treatment of other health conditions, including heart

disease, stroke, cancer, asthma, influenza, pneumonia, diabetes and HIV/AIDs, all of which disproportionately affect members of communities of color.[4]

Understood in that light, the dialysis benefit under the Plan is a bulwark for participants against what Respondents seek. The starting point for transparent assessment of the balance billing argument is the fact that, at a minimum, the structure of dialysis benefits under the Plan has ***no adverse practical effect on any participant***. Individuals with ESRD pay a far smaller amount now than if Respondents would have their way. Respondents want the sweet without the bitter – the ability to obtain reimbursement of their full undiscounted charges, which would benefit no one but them, without the inconvenience of cost containment or claim audit procedures. That is the crux of the issue.

Even the Centers for Medicare & Medicaid Services (CMS) recognizes the very real challenge posed by the lopsided dominance of the commercial dialysis market. Medicare-eligible individuals with ESRD gained access to Medicare Advantage (MA) plans (sponsored by private insurers under contract with CMS) beginning in January 2021 under the 21st Century Cures Act. MA plans must maintain a provider network that affords adequate access to covered services to meet the needs of the population served,

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[4] *See* U.S. Dep't of Health and Human Services, Office of Minority Health, Profile: Black/African Americans www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=61 (last visited Feb. 16, 2022).

including compliance with maximum provider time and distance network adequacy standards. *See* 42 C.F.R. §422.116. Recognizing the reality that not even MA plans can unilaterally require dialysis providers to contract for a reasonable in-network rate, CMS removed outpatient dialysis providers from the maximum time and distance standards so that inability to maintain in-network outpatient dialysis providers will not prejudice MA plans. *See* 85 Fed. Reg. 33796 (June 2, 2020); 42 C.F.R. §422.116(b).

Respondents use the balance billing argument purely for leverage. Balance billing is 100% in their control, except in states (not including Ohio) where state law prohibits it (federal law does not prohibit such billing). Respondents could balance bill even if the Plan reimbursed their charges at 500% or more of the Medicare rate. Anticipated collections from plan participants apparently are not material. Respondents' own financial statements state only that Respondents' "accounts receivable are principally due from Medicare and Medicaid programs and commercial plans." *See* 2020 DaVita Inc., Annual Report (Form 10-K) F-18 (Feb. 11, 2022).

Indeed, Respondents never assert in this litigation that they balance bill participants not enrolled in Medicare. Respondents thus lack standing to even raise a balance billing issue. *See* Defs.' Mot. Dismiss 9-10, ECF No. 18 (S.D. Ohio Feb. 15, 2019); Defs.' Reply Supp. Mot. Dismiss 7-8, ECF No. 38 (S.D. Ohio Apr. 19, 2019). To balance bill now, with self-professed awareness of the consequences, would be a surprising departure from past practice.

3. Unsupported statements about dialysis coverage.

Respondents base their differentiation argument on the additional unsubstantiated and unlikely proposition that dialysis coverage normally has parity with other benefits. *See*, *e.g.*, Resp'ts' Br 2, 12, 13, 28, 39. The reality is that plan benefit designs vary widely, as do individual participant circumstances. Nor do Respondents provide any citation for their claim that "most patients do not choose to simultaneously pay for private insurance and Medicare" – a claim that is counter-intuitive since the MSPA is a coordination-of-benefits law that inherently assumes dual coverage. Resp'ts' Br 16.

II. Respondents have failed to state a take-into-account claim.

Respondents insist that the "plain meaning" of the take-into-account clause requires "an inquiry into the intent of [the] drafting plan documents." Resp'ts' Br. 44. Their attempt to transform the MSPA by refusing to let the Plan speak for itself is unwarranted.

First, there is no logical reason that intent would be relevant, so long as primary coverage for an ESRD participant remains primary during the coordination-of-benefits period, which is the MSPA's objective. A glaring omission from Respondents' quotation of S. Rep. 97-139 as to legislative purpose proves the point. Missing from page 8 of their merits brief is the key sentence: "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*." S. Rep. 97-139 (emphasis added).

Second, if subjective intent were dispositive, a benefit level that is lawful in one plan may be unlawful in another. Two identical plans could end up on opposite sides of the law, with serious consequences for one (a 25% excise tax and double recoveries of conditional Medicare payments), but not the other. Congress could not have intended such an anomaly.

Third, the context further establishes that "a plan paying benefits secondary" to Medicare is what Congress meant the clause to prevent during the coordination period. *See Gundy v. United States*, 139 S.Ct. 2116, 2123 (2019) ("the words of a statute must be read in their context and with a view to their place in the overall statutory scheme"). Under the differentiation clause, a plan may never "differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan." 42 U.S.C. §1395y(b)(1)(C)(ii). The provision that follows spotlights what the take-into-account clause prohibits during the thirty-month coordination period but allows when it expires: "after the end of the [30]-month period described in [the take-into-account] clause," the differentiation clause "shall not prohibit a plan from ***paying benefits secondary***

to this subchapter when an individual is entitled to or eligible for benefits under this title under [the Medicare ESRD exception][.]" *Id.* (emphasis added).

Fourth, elsewhere in the MSPA, Congress used language not present in the take-into-account clause to prohibit actions outside plan terms. Under the MSPA, "[i]t is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to [Medicare] benefits . . . not to enroll (or to terminate enrollment) under a group health plan . . . which would (in the case of such enrollment) be a primary plan[.]" 42 U.S.C. §1395y(b)(3)(C). Under the Negative-Implication Canon, the inclusion of only this specific prohibition of actions of "an employer or other entity" confirms that the other MSPA prohibitions apply strictly to plan terms. *See* Scalia & Garner, *supra*, 107 ("The expression of one thing implies the exclusion of others.").

Fifth, creation of an intent element could turn judges into super-fiduciaries tasked with second-guessing complicated benefit-balancing decisions – a fundamental shift in ERISA jurisprudence that would "undermin[e] the deference owed to plan administrators when the plan vests discretion in them." *See Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 120 (2008) (Roberts, C.J., concurring). The dialysis benefit, if any, would not be the only focus. The MSPA includes take-into-account provisions for individuals age 65 and over and individuals with disabilities. *See* 42 U.S.C. §1395y(b)(1)(A)(i)(I)-(II). The intent of drafters as to items and services that these groups "need far more

than anyone else" likewise would be subject to scrutiny.

Sixth, Respondents fail to clarify what "consideration" would be actionable. To them, "take into account" means even to "contemplate" or just "think of" something. Resp'ts' Br 43. Respondents suggest no limits; where the line would be drawn; what would distinguish an actionable thought from an innocent one; and whether causation or materiality principles would apply. Instead, they absurdly seem to argue that ignorance of the law is a requirement, and that plan fiduciaries should screen themselves and participants from knowledge of the Medicare options that CMS itself recommends. Resp'ts' Br 43-44. *See McNeill v. United States*, 563 U.S. 816, 822 (2011) ("absurd results are to be avoided") (citation omitted).

Seventh, the focus is "an individual." A plan "may not take into account that ***an individual*** is entitled to or eligible for" Medicare benefits during the coordination period. 42 U.S.C. §1395y(b)(1)(C)(i) (emphasis added). Subjective consciousness of the Medicare framework is irrelevant. Only the treatment of "an individual" matters under the take-into-account clause, and it is the plan terms that specify how the plan treats an individual.

III. The Court should enter final judgment because the two ERISA claims are completely derivative of the MSPA claims.

The remaining ERISA claims are part-and-parcel of the MSPA claims. Count II recites the alleged MSPA violations as the sole basis of the ERISA claim under 29 U.S.C. §1132(a)(1)(B). Jt. App. 30-32. Count VII recites the alleged MSPA violations as the sole basis of the ERISA claim under 29 U.S.C. §1182(a)(1). *Id*. at 40, 324. The Sixth Circuit summarized: "[i]n short, if DaVita is able to prove that the defendants engaged in unlawful discrimination under the MSPA, it would thus demonstrate that, under §1132(a)(1)(B) and §1182 of ERISA, Patient A was denied benefits due under the Plan and suffered unlawful discrimination, respectively." Pet. App. 54.

Resolution of the MSPA issues will exhaust the two ERISA claims. They are entirely dependent. Respondents do not dispute that fact, and pled the claims that way.

The Questions Presented are issue-specific as to the MSPA, not claim-specific. The Court should bring this litigation to a close through its MSPA ruling. *See Alice Corp. Pty. Ltd. v. CLS Bank Int'l*, 573 U.S. 208, 226-27 (2014) (because claim was "no different from the [already addressed] claims in substance" and therefore "add[ed] nothing of substance to the underlying abstract idea," claim failed as already-decided claims had).

CONCLUSION

The Court should enter final judgment for Petitioners.

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