No. 21-806

In The

Supreme Court of the United States

HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY, et al.,

Petitioners,

v.

IVANKA TALEVSKI, PERSONAL REPRESENTATIVE OF THE ESTATE OF GORGI TALEVSKI, DECEASED,

Respondent.

On Writ of *Certiorari* to the U. S. Court of Appeals for the Seventh Circuit

BRIEF *AMICI CURIAE* RETIRED LAWYERS IN SUPPORT OF RESPONDENT AND SUGGESTING THE WRIT OF *CERTIORARI* BE DISMISSED AS IMPROVIDENTLY GRANTED

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INTEREST OF *AMICI CURIAE*

RETIRED LAWYERS IN SUPPORT OF RESPONDENT[1, 2]

We are members of the Bar of the Court, retired from the private practice of law. We paid FICA taxes during our wage-earning years, and we receive Medicare benefits.

Counsel of Record, William J. Rold, is a member of LeGaL, New York City's LGBT Bar Association, and he litigated about the civil rights of institutionalized people for over four decades. He is associate editor of *Law Notes*, a publication of LeGAL Foundation that highlights legal developments affecting LGBT people's civil rights. He represented the American Public Health Association as *amicus curiae* before the Court in *West v. Atkins,* 487 U.S. 42 (1988). He represented the American Bar Association at the National Commission on Correctional Health Care. He was a member of the Institutional Review Board of Columbia University Medical Center, overseeing ethical questions involving human subjects in research.

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[1] Statement per Supreme Court Rule 37.6: No counsel for a party authored this brief, in whole or in part; and no party or its counsel made a monetary contribution to fund the preparation or submission of this brief.

[2] As noted on the Docket, per Supreme Court Rule 37.3(a), Petitioners and Respondent have filed letters of "blanket consent" for submission of *amicus curiae* briefs.

Co-counsel, John W. Cleveland, was a juvenile Court Judge in Tennessee and a contract administrative law judge for the Tennessee Department of Education, hearing cases under the "Individuals with Disabilities Education Act," 20 U.S.C. §§ 1400, *et seq.* One of his adult children is transgender.

Co-counsel, Arthur S. Leonard is the Robert F. Wagner Professor of Labor and Employment Law, Emeritus, at New York Law School and a founder of LeGaL. He is editor-in-chief of *Law Notes*. He was co-editor of SEXUALITY LAW (3d ed.) (Durham: Carolina Academic Press, 2019); and lead editor in AIDS LAW & POLICY: CASES AND MATERIALS (2d ed.) (Houston: John Marshall Publications, 1995).

We write to help ensure that elders – particularly, vulnerable elders – have full equality in the administration of the laws. We have a keen interest in protecting elders who change from people with means to people with little – exhausting the Medicare they have paid for all their working lives and becoming "eligible" for Medicaid through poverty.

They face discrimination in nursing homes, including the issues here: inappropriate settings and involuntary medication. It is worse if they are LGBT. Robust enforcement of the Nursing Home Bill of Rights is an important tool for their protection.

PRELIMINARY STATEMENT

We write separately, and limit our brief to the First Question Presented –

> Whether… the Court should reexamine its holding that spending clause legislation gives rise to privately enforceable rights under 42 U.S.C. § 1983

-- because we believe that consideration of a sweeping limitation of implied causes of action under Congress' Spending Clause Power is inappropriate in this case, which involves protection from abuse of nursing home patients whether their beds are paid for by Medicaid, Medicare, or privately.

We suggest that the writ should be dismissed as improvidently granted on this point, because Medicare is a Taxing Power statute, Medicaid is a Spending Power statute, and private pay occurs for the most part because elders are forced by the government to impoverish themselves to be eligible for Medicaid. We do not believe that other briefs submitted to the Court in this case will develop this point.

A brief chart illustrates coverage of nursing home beds by source of payment. Medicaid, in fact, pays for less than half of patient beds overall, and fewer than twenty percent for

patients with dementia. Medicare and private pay cover 70% of nursing home care for patients with dementia.

PAYMENT FOR NURSING HOME CARE BY SOURCE[3]

All Patients:		Dementia Patients:	
Medicaid	46%	Medicare	45%
Medicare	12%	Medicaid	19%
Out of Pocket	33%	Out of Pocket	25%
Other	9%	Other	10%

There are many reasons for this discrepancy: patients with dementia (like Mr. Talevski) live longer, have decreased ability for management at home, and have more hospitalizations. *See* discussion, *infra,* pages 13-15 and 29-30.

Even at its fullest, Medicaid covers fewer than half of nursing home patients. This point was not addressed by the Seventh Circuit. Yet, Spending Power analysis, alone, does not address the fact that Congress intended to provide a Nursing Home Bill of Rights for all nursing home residents, regardless of source of payment.

LGBT elders in nursing homes suffer the same over-medication to cope with understaffing

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[3] "All Patients" from Klauber and Wright, "The 1987 Nursing Home Reform Act," AARP PUBLIC POLICY INSTITUTE (2001) 2; "Dementia Patients" from Alzheimer's Association, ALZHEIMER'S DISEASE FACTS AND FIGURES (Chicago: 2022) 65, *citing* Health Care Cost Institute, "Current Medicare Beneficiary Survey from 2018" (2021).

and failures in planning appropriate transfers and discharges as suffered by Mr. Talevski. Worse, this trauma occurs in a nursing home environment of institutionalization and isolation that is exacerbated by discrimination by their peers and by staff.

FACTS RELEVANT TO *AMICUS* BRIEF

Amici add what follows to Respondent's factual statement from this very limited record. Gorgi Talevski received both Medicare and Medicaid benefits in 2016-2017, while he resided at a skilled nursing facility ["Valparaiso"], owned by an Indiana County and managed by a private entity. The Complaint says that Medicare paid for 22 days of care during three hospitalizations at "Doctors Hospital," at a cost of nearly $30,000. [81a]. We believe this amount is understated. It omits two hospitalizations and other care Medicare typically covers. The amount of his private pay, if any, is unknown.

Mr. Talevski had been hospitalized five times in 2016-2017 by the time an Indiana administrative law judge ["ALJ"] heard his accusations about Valparaiso's unlawful transfers. The first two hospitalizations

(totaling 21 days)[4] were undoubtedly also covered by Medicare, Part A (*see infra,* Section A-3), since Mr. Talevski is a "dually eligible" patient.[5]

Mr. Talevski's family engaged an independent neurologist to investigate their claim that Valparaiso overmedicated Mr. Talevski, by prescribing six psychotropics and leaving him "chemically restrained." The neurologist tapered the meds, and Mr. Talevski "began to recover." (78a-79a) The cost of this neurologist was likely covered by Medicare, Part B. (*See infra,* Section A-3).

Valparaiso justified its transfer of Mr. Talevski to "Doctors Hospital," an acute-care psychiatric hospital, on the grounds that his actions with female residents and staff were "inappropriate" (*id.*).[6] When it refused to accept

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[4] This history is in the ALJ's favorable decision (89a-90a) about Mr. Talevski's claim that Valparaiso was engaging in "patient dumping." (81a).

[5] "Dually eligible" refers to patients eligible for both Medicare and Medicaid. "Beneficiaries Dually Eligible for Medicare and Medicaid," cms.gov/MLN006977 (Febr. 2022).

[6] *See* ALJ decision (89a-92a) (listing allegations). Petitioners try to characterize these incidents negatively, to explain their transfer decisions, but the details are not in the Complaint – and the ALJ decision was not before the District Court. Although the ALJ decision was before the Seventh Circuit and is in the Appendix here, it would (fn. cont'd)

his third discharge it tried "to force his transfer to an all-male dementia facility in Indianapolis" (Complaint, 79a) – some six hours round-trip for visiting.

The ALJ ruled against Valparaiso on the involuntary transfer, finding that Valparaiso had "not completed… relocation planning," as required by Indiana's regulations implementing federal protections on involuntary transfer. (ALJ decision, 93a-94a, 98a), nor did it give Mr. Talevski adequate time to re-adjust to skilled nursing before returning him to "Doctors Hospital." (*Id.*, 97a). The ALJ also found that limiting placement to an "all-male" facility was not justified by the record and that transfer to Indianapolis "would be an extreme hardship." (*Id.,* 98a). Eventually, "Doctors Hospital" discharged him to a different nursing home.

While Medicaid likely paid for a significant part of Mr. Talevski's long-term nursing home services at Valparaiso, Medicare also covers skilled nursing under Part A in limited circumstances, where the care is related to hospitalization for a "spell of illness." (*See infra,* Sections A-3, A-5, and B). Medicare may have

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not be appropriate on a motion to dismiss to give evidentiary consideration to contested matters regarding Valparaiso's transfers of Mr. Talevski. *See Scheuer v. Rhodes,* 416 U.S. 232, 236 (1974) (error and "premature" for District Court to consider Governor's proclamations in weighing sufficiency of civil rights Complaint of victims of Kent State shooting).

paid for part of his post-discharge stay at Valparaiso and likely for part of his placement in skilled nursing by "Doctors Hospital" after Valparaiso refused his return.

The record does not parse this complicated accounting, which could have included private pay.[7] Suffice it to say that a substantial part of Mr. Talevski's care was reimbursed by Medicare and Medicaid and that both are entangled.

All of Valparaiso's 164 beds are certified for both Medicare and Medicaid coverage.[8] So are the beds of 92% of America's nursing homes, but Indiana in an outlier.[9]

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[7] Private pay includes months during which the patient has exhausted Medicare coverage but has too much money (income/resources) for Medicaid. The patient must assign income to the nursing home and "spend down" resources to meet monetary ceilings for Medicaid, which vary from state to state. The patient is prohibited from transferring assets for the purposes of obtaining Medicaid eligibility, and the state can "look back" on transactions for five years prior to the month of Medicaid application and impose a penalty of Medicaid ineligibility for "unlawful" "transfers of assets." 42 U.S.C. § 1396p(c); *see, e.g.,* Kutzin and Pleat, Chapter 8, "Medicaid: Transfer of Assets," in NEW YORK ELDER CARE (New York: Matthew Bender 2021).

[8] Valparaiso Care & Rehabilitation, "Overall Rating," Medicare.gov (July 27, 2022).

[9] "Nursing Home Data Compilation 2015 Edition," CSM, 12, Figure 1.4 ("Type of Certification"). In 2015, one-third of Indiana's nursing homes were government-owned. *Id.*,

(fn. cont'd)

LGBT PATIENTS IN NURSING HOMES

The number of older LGBT individuals in the United States is estimated to reach seven million by the year 2030, and 70% will require "some form of long-term care."[10] Yet, due to "multiple barriers" – isolation, invisibility, stigma, discrimination, violence -- LGBT adults are five times less likely to have access to health care and social services."[11]

31, Table 1.2f ("Change in Number of Nursing Homes by Type of Ownership"). Today, the number has tripled to 90% -- or more than 500 homes. Evans, *et al.,* "Nursing Home Residents Suffer as County Hospitals Rake in Millions," INDIANAPOLIS STAR (March 11, 2020, updated Febr 2, 2021).

[10] *Smith, et al.*, "Mental Health Care for LGBT Older Adults in Long-Term Care Settings: Competency, Training, and Barriers for Mental Health Providers," 42:2 CLINICAL GERONTOLOGIST 198, 198 (2019). Some say this is an underestimate, repressed by the numbers of LGBT people (particularly transgenders) from the "silent generation" (1925-1945) who decline to be identified. The numbers will grow beyond forecast as "baby boomers" (1946-1964) reach nursing home age and will explode when the "out and proud" generation becomes seniors. Coffey, "LGBT Aging: Understanding and Supporting Us," SOCIETY OF CERTIFIED SENIOR ADVISORS JOURNAL 51-57 (2019).

[11] *Id.*, *citing* Erdley, *et al,* "Breaking Barriers and Building Bridges: Understanding the Pervasive Needs of Older LGBT Adults and the Value of Social Work in Health Care," 57 JOURNAL OF GERONTOLOGICAL SOCIAL WORK 362-385 (2014).

With a few exceptions LGBT organizations have not prioritized issues relating to LGBT seniors until the 21st Century.[12] Many LGBT seniors today came of age in an era when "homosexuality" was considered a mental illness, and their peers in nursing homes commonly make "offhand comments" about "fags and dykes."[13] LGBT elders find themselves living in nursing homes "without adequate protection" and facing hostility, discrimination, and refusal of some heterosexuals to share rooms with them.[14]

Violation of equal treatment and of LGBT dignity is also perpetrated by nursing home staff.[15] Nearly half of residents polled said they experienced negative staff reaction after sharing their sexual orientation or gender identity, and over one-fifth reported feeling they could not be

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[12] Knauer, "LGBT Elder Law: Toward Equity in Aging" 32 HARV. J. L & GENDER 1, 5 (2009).

[13] Wolfenson, "The Risks to LGBT Elders in Nursing Homes and Assisted Living Facilities and Possible Solutions," 26 TULANE J. OF LAW AND SEXUALITY 123, 124-25 (2017).

[14] *Id.; see also*, Nat'l Senior Citizens L. Ctr., "LGBT Older Adults in Long-Term Care Facilities: Stories from the Field," JUST. AGING (2010, updated 2015) 6, 10.

[15] Hovey, "Nursing Wounds: Why LGBT Elders Need Protection from Discrimination and Abuse Based on Sexual Orientation and Gender Identity," 17 ELDER L.J. 95, 108-09 (2009) (staff hostility).

"forthcoming."[16] Residents report withholding of basic care, including "bathing, toileting, and feeding."[17] A survey reported half of employees considered their co-workers "intolerant" of LGBT residents.[18]

LGBT seniors experience "difficulties expressing their sexuality while residing in nursing homes," with reports of banning same-sex partners or precluding conjugal visits. LGBT seniors who engage in sexual activity have been subjected to separation and transfer.[19] Many LGBT seniors "are moved to places they have no reason to be, like psychiatric

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[16] Smith, *supra* n.10, 199; *accord* Nat'l Senior Citizens L. Ctr, *supra* n.14, *id.*

[17] Knauer, "Gen Silent: Advocating for LGBT Elders," 19 ELDER L.J. 289, 320 (2012).

[18] Hovey, *supra* n.15, 110. On the hopeful side, in another survey ninety percent of nursing home employees (from doctors to nurse's aides) said they would "welcome" more training on serving their LGBT population. Smith, *supra* n.10, 200.

[19] Hovey, *supra* n.15, 110.

wards."[20] Residents have been "prayed over" and told "hell would await them."[21]

All of this has led to what scholars call "re-closeting" – a hiding of LGBT elders' sexuality and gender identity as a survival tool[22] -- to escape the "othering" of LGBT nursing home residents that is both "real and profound,"[23] Even younger LGBT's view their elder LGBT peers as isolated, lonely, and fearful.[24]

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[20] Gross, "Aging and Gay, and Facing Prejudice in Twilight," N.Y.TIMES (Oct. 9, 2007); *see also,* Nat'l Senior Citizens L. Ctr, *supra* n.16 10-14 (accounts of lesbian, whom the home refused to address by name used all her life; and male couple, separated for sexual behavior, with one sent to a psychiatric ward).

[21] Nat'l Senior Citizens L. Ctr, *supra* n.16, 11.

[22] Wolfenson, *supra* n.13, 126.

[23] White and Gendron, "LGBT Elders in Nursing Homes, Long-Term Care Facilities, and Residential Communities," Chapter 21, in HANDBOOK OF LGBT ELDERS (Harley and Teaster, ed.) (New York: Springer 2016), 419-21.

[24] *Id.*, 421, *citing* Johnson, *et al.,* "Gay and Lesbian Perceptions of Discrimination in Retirement Care Facilities," 49(2) J. OF HOMOSEXUALITY 83, 86 (2005).

DEMENTIA PATIENTS IN NURSING HOMES

Now, because the case requires it, we layer on top of everything else, the issues of dementia and sexual expression. Mr. Talevski had dementia, and Valparaiso sent him to a mental hospital claiming he was sexually "inappropriate." The ALJ overturned the "discharge decision" from Valparaiso, as well as its limiting new placement to a male-only facility.

Patients with dementia commonly "act out" sexually and nursing homes over-react. This is a particular problem with LGBT patients with dementia. *Amici* see Mr. Talevski's plight within the living memories of many elder LGBT people, whose sexuality and gender identification was suppressed – and whose expression of same was historically treated as a psychiatric problem.

Treating Mr. Talevski as an asexual child, if that is what happened, led to overmediation and an improper discharge plan – from which he should have been protected under the Nursing Home Bill of Rights. LGBT patients with dementia experience this, plus all-too-frequent homo- and trans-phobia from peers and staff.

Sexuality does not stop at the nursing home lobby, nor is its essence necessarily taken by dementia. *See, generally,* Tennenbaum, "Sexual

Expression and Intimacy between Dementia Nursing Home Residents: Balancing the Current Interests and Prior Values of Heterosexual and LGBT Residents," 21 TEMPLE POL. & CIV RTS. L. REV. 459 (2012). "Intimacy and sex" are "central to life satisfaction and psychological well-being."[25]

"[M]any demented patients – even those with severe dementia – are capable of some complex thought and may maintain a sense of what is of value to them…." *Id.* at 463.[26] Unlike the course of many terminal illnesses, dementia may have considerable space "between competency and death,"[27] and the nursing home's response should likewise respect nuance. Patients can appreciate the comfort of human touch, even if they cannot remember what they had for breakfast. On this record, we cannot

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[25] *Id.* 460; *see also,* Tennenbaum, "To Be or To Exist: Standards for Deciding Whether Dementia Patients in Nursing Homes Should Engage in Intimacy, Sex, and Adultery," 42 IND. L. REV. 675, 680-88, 716 (2009) (discussing the importance of sex and intimacy to nursing home patients).

[26] *Citing,* Jaworska, "Advance Directives and Substitute Decision-Making," STAN. ENCYCLOPEDIA OF PHIL. (2009) (if patients with dementia are "capable of valuing, their choices … should be respected").

[27] Hajjar and Kamel, "Sexuality in the Nursing Home, Part 1: Attitudes and Barriers to Sexual Expression," 4 J. AM MED. DIRS. ASS'N (2012) 152, 156 (noting the pleasurable experiential states in dementia between competency and death).

determine whether Mr. Talevski's sexual expression was consensually intimate or predatory in nature. There is reason to believe that Valparaiso overreacted, because the ALJ found that it did not give Mr. Talevki time to re-adjust to skilled care before sending him back to "Doctors Hospital," and it confined his alternative placement to a male-only facility.

Amici have a sense of *déjà vu* in the way Valparaiso handled this patient. Whatever the answer, *amici* want to "ensure," as Professor Tennenbaum puts it: "that gay and lesbian elders are provided the same opportunities for sexual expression and intimacy as other residents." 21 TEMPLE POL. & CIV RTS. L. REV. at 460.

SUMMARY OF ARGUMENT

A broad ruling on Spending Power generally is unnecessary in this case, and it is unworkable on these facts, given the disparate authority under which Congress has acted and Mr. Talevski's actual receipt of benefits under both Medicare and Medicaid. Workers pay FICA taxes for Medicare, Part A (hospitals), under Congress' Taxing Power. They also pay premiums for Medicare, Part B (physicians). They expect something for their money – and it is not grants to the states.

Medicare patients have an expectation of future health benefits from their taxes and

premiums. They are "principals," not "third party beneficiaries."

Nursing home care is covered by both Medicare and Medicaid. Almost all nursing home patients and providers are qualified or certified under both programs.

Medicaid, however, is not funded by workers' FICA taxes or premium payments. It is an exercise of Congress' Spending Power alone, funded in the form of grants to the states without patient contribution.

That Congress used the same Nursing Home Bill of Rights language in both Titles XVIII (Medicare) and XIX (Medicaid) means that it intended patients to have protections in nursing homes whoever is paying for the bed and that nursing homes' federal funding was at risk, if they denied to anyone (even private pays) their protections under the Nursing Home Bill of Rights. Valparaiso's framed Bill of Rights reprinted in Respondent's Brief (at 34-5) does not have the disclaimer: "See if this applies to you."

Because the Seventh Circuit did not recognize this issue – and the parties have not briefed it – the Court should dismiss the writ of *certiorari* as improvidently granted. If it reaches the Second Question Presented, it should affirm, although *amici* are not writing on this point.

In the interests of judicial restraint, the Court should avoid Petitioner's request for a sweeping decision on Spending Power. "If it is not necessary to decide more, it is necessary not to decide more." *PDK Laboratories, Inc. v. USDEA,* 362 F.3d 786, 799 (D.C. Cir. 2004) (Roberts, J., concurring).

ARGUMENT

THE COURT SHOULD DISMISS THE WRIT OF *CERTIORARI* AS IMPROVIDENTLY GRANTED ON THE FIRST QUESTION BECAUSE IT CONFLATES CONGRESS' TAXING POWER WITH ITS SPENDING POWER

From its earliest antecedents, through the Social Security Act, to the passage of Medicare in 1965, Congress has used its Taxing Power to provide for national tax-based social welfare programs, as wage-earners know well from the FICA deductions from their pay. By contrast, Medicaid is funded from general revenue and dispensed as grants to the states for health care for the indigent under Congress' Spending Power.

In the ruling below, the Seventh Circuit treated these powers as equivalent -- by conflating Medicare (Title XVIII of the Social Security Act) with Medicaid (Title XIX of the Social Security Act) because they have the same language in the Nursing Home Bill of Rights. *Compare* 42 U.S.C. § 1395i-3 (Medicare) *with* 42

U.S.C. § 1396r (Medicaid).[28] The Seventh Circuit analyzed the case as presenting a Spending Power question only, dispensing with discussion of Medicare, as do the parties and most *amici.* The Solicitor General double cites to both programs, but she does not discuss the Taxing Power genesis of Medicare.

This violates the rule that a statute, if possible, should be construed to avoid "redundancy"[29] or "surplusage."[30] *Amici* submit that the apparent reason for placing the same language in both Titles was to assure that nursing home patients have the same protections, regardless of the funding from which the beds are paid. Legislative history of the 1987 Omnibus Reconciliation that produced the Nursing Home Bill of Rights is in accord: "[A]ll residents of nursing facilities should receive high quality care, regardless of their source of payment."[31]

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[28] The implementing regulations – 42 C.F.R., Parts 405 (Medicare) and 430 (Medicaid) – are also parallel.

[29] *Gustafson v. Alloyd Co.,* 513 U.S. 561, 575 (1995).

[30] *Connecticut National Bank v. Germain,* 503 U.S. 249, 253 (1992); *see also, American Hospital Ass'n v. Becerra,* No. 20-1114, 596 U.S. ___ (June 15, 2022) (Slip Op'n, 12) (construe statutes so as not to "eviscerate" key parts).

[31] H.R Rep. No. 100-391(1), 458 (1987), *reprinted in* 1987 U.S.C.C.A.N. 2313-201, -286, and -290-91. The fact that both Titles were addressed in a reconciliation package

(fn. cont'd)

A. Medicare Is Primarily a Taxing Power Statute.

1. Historical Antecedents.

The notion that Congress could tax employers to pay for workers' health and disability care dates from the earliest days of the Republic. The Fifth Congress required ships docking in the Nation's ports: (1) to certify the number of sailors and how long they had been at sea; and (2) to pay to the Treasury of the United States an excise tax of twenty cents per sailor for each month at sea – to be used by the President to provide for "sick or disabled seamen, in the hospitals or other proper institutions… and to cause buildings, when necessary, to be erected as hospitals…." The employer was authorized to "retain [such twenty cents per month] out of the wages of such seamen."[32]

Congress was silent on whether the sailors whose wages were withheld had a private cause of action if denied needed medical care. Five

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meant that the bill satisfied the rules of Congress for reconciliation, not that the whole thing was a Spending Power enactment. To mention a few of its myriad subjects, the bill contained provisions on farm policy, rural electrification, national park conservation, disposal of nuclear waste, and the Panama Canal Treaty.

[32] Fifth Congress, Session II, Chapter 77, §§ 1, 3 (July 16, 1798).

years later, Chief Justice Marshall, writing for a unanimous Court, implied a cause of action based on statutory rights in *Marbury v. Madison,* 5 U.S. (1 Cranch) 137 (1803).

Although the case is remembered for other things, the Court spoke of claims to pensions for wounded Revolutionary War veterans and for their widows and orphans. *Id.* at 163. There is no express private cause of action for such beneficiaries,[33] but Chief Justice Marshall asked the rhetorical question: "would the wounded veteran be without a remedy?" *Id.* at 164. The *Marbury* Court said "no":

> … where a specific duty is assigned by law, and individual rights depend upon the performance of that duty, it seems equally clear that the individual who considers himself injured, has a right to resort to the laws of his country for a remedy.

Id. at 166. The veterans paid for pensions with life or limb, but the rule applies no less to claims for property purchased. *Id.* at 165.

An implied cause of action can easily be found within this framework, should the sailors entering port be denied the promised medical care, based on the statute and their expectations

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[33] Second Congress, Session II, Chapter 17 (Febr. 28, 1793), *modified by* Third Congress, Session I, Chapter 57 (June 7, 1794).

from the tax withheld from their pay. Medicare, as we know it today, is not different in kind.

2. The New Deal and Its Constitutionality.

The original Social Security Act did not include national health insurance. President Franklin Roosevelt was afraid that public (and physicians') opposition to "socialized medicine" would "sink" the whole package if he included it with old-age pensions and unemployment insurance.[34]

Congress passed the Old-Age Benefits Act, as Title II to the Social Security Act, to provide an income insurance pension for the elderly. Eventually it included survivors and disabled, and it was called Old-Age, Survivors and Disability Insurance ("OASDI") – or Social Security, as we know it today. It was funded under Title VIII of the Act by an excise tax on employers and an income tax on employees (in equal amounts), the employees' share to be withheld from wages. The taxes -- called FICA (for Federal Insurance Contributions Act) – were paid to the federal Treasury.

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[34] Hoffman, HEALTHCARE FOR SOME: RIGHTS AND RATIONING IN THE UNITED STATES SINCE 1930 (Chicago: Univ. of Chicago Press, 2012), xxv-xxvi, 15.

The amount of the pensions was to be determined through an accounting that considered taxes paid, longevity of work, and actuarial tables. Congress did not create a national savings account. There is no right to withdraw taxes paid or to obtain a refund should a taxpayer die before eligibility; and there is no one-to-one relationship between taxes and benefits. There is, however, a widespread public expectation that FICA taxes will pay for benefits in the future.

Although Title II of the Act contemplated funding of an "Old-Age Benefits Account," funded by FICA, the particulars required further legislation at the time the Court considered the constitutionality of the Act. In three cases, all decided the same day, the Court upheld the framework of FICA and FUTA (the current acronym for the Federal Unemployment Tax Act – the excise tax on employers under Title IX of the Social Security Act, now funding unemployment compensation). *Helvering v. Davis,* 301 U.S. 619 (1937); *Steward Machine Co. v. Davis,* 301 U.S. 548 (1937); and *Carmichael v. Southern Coal,* 301 U.S. 495 (1937). All three decisions upheld Congress' authority to act under the Taxing Power.

We begin with *Steward*, even though it concerns unemployment, because it most fully describes the Taxing Power underlying the FUTA excise tax. Under Title IX of the Act, employers (but not employees) were required to

pay an excise tax to the federal Treasury based generally on the number of their employees in the covered industry. Congress contemplated the use of FUTA, under Title III of the Act, to fund unemployment benefits to employees out of work through no fault of their own, provided that the states chose to enroll in the program by administering it and paying a share of the fund. Even though further legislation was needed to establish the Article III benefits – and the states had yet to enroll – the Court upheld the program under Congress' Taxing Power. 301 U.S. at 581 (holding that, under Article I, § 8, of the Constitution, "the subject matter of taxation open to the power of the Congress is as comprehensive as that open to the power of the states.")[35]

The Court upheld the dual FICA taxation program on employers and employees for Old-Age Benefits under Title VIII of the Act in *Helvering v. Davis,* by briefly referring to its decision in *Steward.* 301 US. at 644. As to using the taxes, the Court wrote: "Whether wisdom or unwisdom resides in the scheme of benefits set forth in Title II, it is not for us to say. The answer to such inquiries must come from Congress…." *Id.*

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[35] In *Carmichael,* 301 U.S. at 527, the Court ruled that Title III's requirement that the states financially participate and administer the unemployment programs if they chose to enroll did not intrude on their sovereignty.

3. Medicare and FICA.

President Truman tried without success to add national health insurance to the Social Security Act in 1945. The self-employed were added to Social Security in 1954 (which still excluded health care), and they were required to pay both halves of the FICA tax.[36] It would take another twenty years for Medicare to pass.

President Johnson signed Medicare in 1965, establishing hospital benefits under Title XVIII, Part A, by adding a Medicare ("Hospital Insurance Tax") component to the FICA tax on employers and employees in Title VIII. Medicare, Part B (Title XVIII) paid elective benefits for physician services, funded through premiums deducted from monthly Social Security checks.

In both coverages (Part A and Part B), claimants are direct taxpayers or premium-payors – *principals* -- not "third party beneficiaries," as some suggest by analyzing this case only under Title XIX. When patients go to the hospital or to see a doctor, one of the first

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[36] Generally, the self-employed may deduct the "employers' half" as an adjustment to income. IRS.gov, Forms SE, line 13, and 1040, Sched. 1, line 15 (2021).

things they do is assign *their* Medicare benefits to the provider.[37]

Federal workers were added to Social Security and Medicare in 1982.[38] Much of the New Deal Taxing Power history in the Court was revisited in a lawsuit brought by federal judges arguing that the Medicare FICA deduction from their wages violated the Compensation Clause of Article III. In *United States v. Hatter,* 532 U.S. 557 (2001), the Court ruled that it did not. Even as to judges appointed prior to the addition of federal workers to the programs, Congress had the Taxing Power to reduce salary of federal judges by the Medicare portion of FICA, so long as the tax is "generally applicable" and "non-discriminatory." *Id.* at 567. In short, if applied evenly, the Taxing Power trumps the Compensation Clause.

In 1988, Congress required the states to pay Medicare, Part B, premiums for low-income individuals through Medicaid, as part of the

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[37] In 1972, President Nixon signed legislation providing Medicare for the disabled. There is a Medicare waiting period of two years for disabled, except for patients with end-stage renal disease. All of this history is summarized concisely in "A Brief History of Medicare in America," medicareresources.org (2022).

[38] Tax Equity and Fiscal Responsibility Act of 1982, 86 Stat. 559-563, *codified* 26 U.S.C. §§ 3101(b)(4) – (6).

Medicare Catastrophic Coverage Act.[39] Although most of the law was repealed, the Medicaid "buy-in" of Medicare, Part B, remains, codified at 42 U.S.C. §§ 1395v and 1396a. This is why we are confident that Mr. Talevski's neurologist was paid by Medicare.

Medicare also pays under Part A for "extended" care in skilled nursing homes following a "spell of illness" in a hospital. As noted, *infra,* pages 29-30*,* this benefit is of short duration, and it is subject to myriad limits, co-pays and qualifications under 42 U.S.C. § 1395e. It is impossible to ascertain from this record whether Medicare, Part A, paid for any of Mr. Talevski's skilled nursing care, at Valparaiso or at the facility to which "Doctors Hospital" discharged him – or how much, if any, he or his family paid privately.

Later, in upholding the non-Medicaid part of the Affordable Care Act,[40] the Court's controlling vote relied on the Taxing Power[41] (not the Commerce Clause) in sustaining Congress' authority to require the purchase of health insurance. *National Federation of Independent Businesses v. Sebelius,* 567 U.S. 519, 132 S.Ct. 2566 (2012). Congress' Taxing

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[39] Pub. L. 100-360, 102 Stat. 684, 748, § 301 (July 1, 1988).

[40] A/K/A the "Patient Protection and Affordable Care Act," Pub. L. 111-148 (2010)

[41] 26 U.S.C. § 5000A.

Power exceeded its authority under the Commerce Clause. 132 S.Ct. at 2594-95.

4. Current Impact of Medicare and FICA.

Employers and employees continue to pay FICA for Social Security and Medicare. Workers' deduction for Social Security's part of FICA is 6.2% of wages, matched by their employer, for a total of 12.4%. Payments are capped at $147,000 in wages annually.[42]

Medicare's part of FICA is 1.45% of wages, matched by the employer, for a total of 2.9%. There is no wage cap, but there is a surtax on employees of 0.9% for wages exceeding $200,000, which the employer withholds but does not match.[43]

To manage Medicare and coordinate its interaction with Medicaid (*see, infra,* Sections A-5 and B), the Carter Administration, as part of its government reorganization, created the Health Care Financing Administration ["HCFA"], as part of the Department of Health, Education, and Welfare ["HEW"]. In 1980, Education got its own department, and HEW became the Department of Health and Human Services ["HHS"]. In 2001, in the hope of greater Medicare/Medicaid coordination,

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[42] Internal Revenue Service, Topic 751, "Social Security and Medicare Withholding Rates" (May 20, 2022) 8.

[43] *Id.*

HCFA became the Centers for Medicare and Medicaid Services (or "CMS," as we know it today).[44]

The expectation of health care under Medicare in exchange for FICA deductions and premiums paid applies to everyone who has paid. It is not limited to those who meet the poverty guidelines of Medicaid.

5. Dementia and Medicare.

Approximately 6.5 million people over age 65 have dementia in the United States.[45] A person with dementia typically lives through years of morbidity before death. The average is 4-8 years, although there are cases as long as twenty years.[46] Eighty percent of those who die of dementia will do so in a nursing home, compared to 28% of people dying from all other conditions.[47]

The aggregate annual cost of caring for patients with dementia is $321 billion dollars. It is paid mostly from Medicare. *See* funding

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[44] CNN.com, "Medicare Agency Renamed as Prelude to Reforms," www.cnn.com (June 14, 2001).

[45] Alzheimer's Association, *supra* n.3, 19.

[46] *Id.,* 35, *citing* Todd, *et al.,* "Survival with Dementia and Predictors of Mortality: A Review," 28(1) INT'L J. OF GERIATR. PSYCHIATRY, 1109-24 (2012).

[47] *Id.*, *citing* Mitchell, *et al.*, "A National Study of the Location of Death for Older Persons with Dementia," 53(2) J. OF AM. GERIATRIC SOC. 299-305 (2005).

percentages, *supra,* page 4. People with dementia have twice as many hospital stays per year as other older people.[48] Medicare beneficiaries with dementia have ten times the cost in annual "per person payments" as other patients for skilled nursing services annually – and over 25 times the cost for regular nursing homes.[49] When patients with dementia have co-morbidity (such as kidney disease, congestive heart failure, or COPD), their average annual Medicare costs overall increase a minimum of $10,000 – and the cost of their Medicare skilled nursing home care more the doubles.[50]

Thirty-seven percent of "short stay" (< 100 days) nursing home residents – the patients most likely to access Medicare – have dementia. For long-term nursing home residents (> 100 days) – those most likely to have exhausted their Medicare benefits -- 59% have diagnoses of dementia.[51] Twenty-four percent of Medicare beneficiaies with dementia reside in a nursing home, compared with 1% of Medicare beneficiaries with other conditions.[52]

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[48] *Id.*, 62.

[49] *Id.*, 65, *citing* Health Care Cost Institute, "Current Medicare Beneficiary Survey for 2018" (2021).

[50] *Id.,* 68. The record does not disclose if Mr. Talevski had other illnesses.

[51] *Id.,* 69, *citing* Health Care Cost Institute, *supra* n. 49.

[52] *Id.*

These statistics are undoubtedly influenced by Medicare's failure to cover long-term nursing care unconnected to a hospitalization and its general 100-day cap on nursing home benefits, even for those who qualify.[53] The "deserving poor" shadow on Medicaid (*see infra*, Section B) continues to force elderly to reduce themselves to poverty (however stark that is in their state or territory) to qualify for a Medicaid nursing home bed.

B. Medicaid Is a Spending Power Statute.

Unlike Medicare, "Medicaid is a miscellany of fifty-six health insurance programs run by the states and territories."[54] Its passage in 1965 has been characterized as the "caboose" to Medicare's train.[55]

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[53] For Medicare to pay for skilled nursing care, the beneficiary must have a qualifying hospital stay, a physician must order skilled care, and the condition requiring skilled care must relate to the hospitalization. *Id.*, 71, *citing* CMS, "Skilled Nursing Facility Care" (Dec. 18, 2021). Mr. Talevski likely qualified for some of this, subject to the 100-day limit.

[54] Meeks, "Private Enforcement of Spending Conditions after *Douglas,*" 161 UNIV. OF PA. L. REV. 56, 57 (2012), *citing* KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID: A PRIMER (2010), 5.

[55] Huberfield, "Federalizing Medicaid," 14 U. PA. J. CONST. L. 431, 432 (2011), *citing* Marmor, THE POLITICS OF MEDICARE (New York: DeGruyter 1973), 68, 79.

"Medicaid has always been treated quite differently from Medicare."[56] It does not provide national health insurance for younger, non-disabled middle class. It also retains to this day two aspects of "welfare medicine" as that notion has developed in the literature: limiting assistance to the "deserving poor"; and delivering care through state and local government, with a strong sense of states' rights.[57]

The Affordable Care Act was the first attempt to require the states, through Medicaid, to expand health care coverage well beyond the federal poverty level and to include childless adults, with the risk that a non-complying state could forfeit all Medicaid funding. *Sebelius,* 132 S.Ct. at 2601. In striking this mandatory provision, the Court reviewed its 1937 holding in *Steward* that found "no undue influence" by Congress in its proposed cooperative unemployment insurance taxing plan with the states. 301 U.S. at 590. By contrast, the Spending Power use for Title XIX in the Affordable Care Act did more than "give incentives." It "required the states to regulate"

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[56] Huberfield, *supra* n.55, 432.

[57] *Id., citing* Stevens, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974), 51; Super, "Laboratories of Destitution: Democratic Experimentalism and the Failure of Anti-Poverty Law," 157 U. PA. L. REV. 541, 567 (2008) (comparing centralized approach in other developed countries).

in areas where they had chosen not to do so, at the price of forfeiture of billions of dollars they were already receiving. *Id.*

In *Steward,* Congress spent revenue that was properly assessed under the Taxing Power. The plan would "channel money to the States that would otherwise have gone into the Federal Treasury for use in providing national unemployment services."[58] Unlike *Steward – or South Dakota v. Dole*, 483 U.S. 203, 208 (1987) (where a state risked 5% of federal highway funding if it did not raise its minimum age for drinking alcohol to 21) -- the Medicaid forfeiture in the Affordable Care Act was "so coercive as to pass the point at which `pressure turns into compulsion.'" *Sebelius,* 132 S.Ct. 2602, *quoting Steward,* 301 U.S. at 591.

Sebelius illustrates that Taxing Power and Spending Power can support or fail to support different parts of the same statute. Here, however, we are talking about identical language in two Titles of the same statute directed at the same Congressional purpose. They should each do their designed work.

Nursing home patients receive both Medicare and Medicaid. Sometimes nursing

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[58] *Id.* at 2603*, citing Steward*, 301 U.S. at 590. "Predicating tax abatement on a State's adoption of a particular type of unemployment legislation was therefore a means to 'safeguard [the Federal Government's] own treasury.'" *Id., quoting* 301 U.S. at 591.

home roommates are covered by different funding programs. Sometimes a patient's coverage can shift from Medicare to Medicaid without her changing beds. It would be inappropriate to construe language to protect the Medicare patient but not her Medicaid roommate against over-medication and unsafe transfers – or *vice versa* – or to leave the private pay patient out entirely. It would be folly to place any patient at the mercy of nursing home accountants to determine whether protections apply.

"The plain purpose of these provisions is to protect rights afforded to individuals." *Grammar v. John J. Kane Reg'l Ctrs.,* 570 F.3d 520, 530 (3d Cir. 2009), *cert. denied,* 559 U.S. 939 (2010).[59] Nursing homes, however funded, must have a plan that provides "services and activities" designed to "attain or maintain the [resident's] highest possible physical and mental health, and psychosocial well-being."[60]

In *Blum v. Yaretsky,* 457 U.S. 991 (1982), the Court found that transfer decisions of private nursing homes were not "state action" because of the deference then given to those

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[59] *See* Cyran, "Implied Causes of Action Under § 1396r: Why G*rammar* reminds Nursing Home Residents to Actively Participate in Their Own Care," 115 DICKINSON L. REV. 253, 259 (2010) (Congress intended to benefit both Medicare and Medicaid patients).

[60] H.R Rep. No. 100-391(1), *supra* n.31, 453-4.

decisions by local governmental entities. We submit that the Nursing Home Bill of Rights is, at least in part, a response to that decision, giving patients' rights to be free of restraining medication or arbitrary transfer. The dissent of Justice Brennan in *Blum* echoes in the Nursing Home Bill of Rights, passed just five years later. He wrote:

> These transfers eject helpless, disoriented people from the places they have lived for months or even years to facilities, not of their own choosing, that they have never seen before. The evidence is overwhelming that, without extraordinary preparatory efforts that are hardly ever made, *any* move is harmful for the preponderance of the frail elderly.

457 U.S. at 1017 (Emphasis in original.)[61] Since 1987, Congress has "increased the level of regulation of the nursing home industry."[62]

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[61] *Citing* Vladeck, UNLOVING CARE: THE NURSING HOME TRAGEDY (New York: Twentieth Century Fund 1980), 140; *see also,* Cyran*, supra* n.59 at 274 n.152 (relating Justice Brennan's dissent in *Blum* to the passage of the Nursing Home Bill of Rights).

[62] Cyran*, supra* n.59, 275-76.

Last Term, in *American Hospital Ass'n v. Becerra, supra* n.30, the Court implied a Medicare statutory cause of action for hospitals to challenge reimbursements for prescription drugs under Title XVIII, Part D. Writing for a unanimous Court, Justice Kavanaugh noted the "strong presumption" of judicial review unless it is "preclude[d]" by the statutory language. (Slip Op'n, 7.) As a patient who was a victim of the misuse of such drugs, Mr. Talevski seeks no less.

C. The Writ of Certiorari Was Improvidently Granted on the First Question Presented.

It is rare for the Court to dismiss a writ of *certiorari* as improvidently granted, and the disposition is not found expressly in the Supreme Court Rules. It happens roughly 2-3 times a Term, usually through a *per curiam* Order, without an opinion of the Court.[63] Most of what we understand is gleaned from separate opinions of Justices.[64]

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[63] Solimine and Gely, "The Supreme Court and the DIG: An Empirical and Institutional Analysis," 2005 WISC. L. REV. 1421, 1421 (2005). A rare exception is the opinion in *Rice v. Sioux City Memorial Park Cemetery, Inc.*, 349 U.S. 70, 78 & n.2 (1955), *citing Layne & Bowler Corp. v. Western Weil Works, Inc.,* 261 U.S. 387, 393 (1923) (Chief Justice Taft writing for a unanimous Court).

[64] *See, e.g.*, *Nike, Inc. v. Kasky*, 539 U.S. 654 (2003) *(per curiam); id.* at 663 (Stevens, J., concurring and explaining why a DIG was appropriate); *id.* at 667 (Breyer, J., dissenting from the DIG).

The cognoscenti warn not to suggest a DIG, or even to use the colloquial acronym, lest counsel be seen as critical of the Court. We believe, however, that the failure of the Seventh Circuit and of other briefing before the Court to develop the Taxing Power point -- and the myriad ways nursing homes are paid -- warrants raising DIG with the Court on the First Question.

The Court issued a DIG last term in *Arizona v. City and County of San Francisco,* No. 20-1775, 596 U.S. ___ (June 15, 2022). The Court had granted *certiorari* on the issue of whether states desiring to defend an immigration rule (the "public charge" limitation) -- that the federal government was no longer defending – could intervene to defend the law. In the meantime, the federal government issued new regulations, and they were challenged as violative of the Administrative Procedure Act – and the case also presented questions of mootness, standing, the scope of relief in an APA action, "and more." A *per curiam* DIG was issued after oral argument.[65]

The background is taken from the concurrence of Chief Justice Roberts (joined by Justices Thomas, Alito and Gorsuch), finding that the case had become a "mare's nest" that

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[65] Statistically, a high majority of DIGs, if issued, occur after briefing and argument. Solimine and Gely, *supra* n.63, 1427-28.

could "stand in the way of our reaching the question presented on which we granted *certiorari*, or at the very least, complicate our resolution of that question." *Id.,* Concurring Slip Op'n, 3.

In *Mitchell v. Wisconsin,* 139 S.Ct. 2525 (2019), involving taking a blood alcohol sample from an unconscious driver, the lower courts and the parties treated the case as involving "motorists' implied consent." When the Court resolved the case on "exigent circumstances" grounds, Justice Gorsuch dissented, writing that the case should have been DIGged because the application of the exigent circumstances doctrine in this area (an unconscious offender) posed complex and difficult questions that neither the parties nor the courts below discussed." *Id.* at 2551.[66]

The lacuna in *Mitchell* is like the failure to address Medicare in this case. This is not just a Spending Power case unless a significant part of the picture is ignored. When the legal questions that prompted the granting of the writ change and have not been addressed below, the Court should DIG the case. *See Unicolors, Inc. v. H & M Hennes-Mauritz, L.P.,* 142 S.Ct. 941 (2022),

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[66] Justice Gorsuch also dissented in favor of a DIG on procedural grounds in *Shoop v. Twyford,* No. 21-511, 596 U.S. ___ (June 21, 2022) (no collateral order to appeal); and *Mission Product Holdings, Inc., v. Tempnology, LLC,* 139 S.Ct. 1652, 1666-67 (2019) (mootness).

where a new theory of fraud was adopted after the writ was issued. Justice Thomas, joined by Justices Alito and Gorsuch, dissented in favor of a DIG. *Id.* at 949.

Failure to identify the specific constitutional principle at issue justifies a DIG, because it is "threshold," and the Court ought not proceed with further analysis without it. *McDonough v. Smith,* 139 S.Ct. 2149, 2161 (2019) (Justice Thomas dissenting, joined by Justices Kagan and Gorsuch). When, as here, there is only the Court below to review (i.e., no conflict) and there is not adversary briefing on the point, a DIG is justified. *Czyzewski v. Jevic Holding Corp.,* 137 S.Ct. 973, 987 (2017) (Justice Thomas, joined by Justice Alito, dissenting).

The Court can DIG the First Question, even if it reaches the Second Question.[67] There is no need for a sweeping "one-size-fits all" Spending Clause decision, when more than half the care for dementia patients in nursing homes (and for doctors and back and forth to hospitals) is paid by Medicare, funded under the Taxing Power.[68]

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[67] The Court did this in *Board of Trustees of University of Alabama v. Garrett,* 531 U.S. 356, 360 n.1 (2001) (hearing claims under Title I of the Americans with Disabilities Act but DIGging claims under Title II due to insufficient briefing).

[68] We rely on the briefs of Respondent and supporting *amici* on the Second Question Presented, believing that (fn. cont'd)

CONCLUSION

For the reasons stated, *amici* suggest that the Court should dismiss the Writ of Certiorari as Improvidently Granted on the First Question Presented; and, should it reach the Second Question, the Court should affirm the Seventh Circuit.

Brooklyn, New York
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Respectfully submitted,

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the Seventh Circuit should be affirmed on this point if the Court reaches it.

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