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.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE SUPPORTING REVERSAL

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QUESTION PRESENTED

Individuals with end-stage renal disease are eligible to enroll in Medicare after they begin routine dialysis treatment or receive a kidney transplant. 42 U.S.C. 426-1. When an individual who is covered by a group health plan becomes eligible for Medicare on that basis, the Medicare Secondary Payer statute, 42 U.S.C. 1395y(b), provides for a 30-month coordination period during which the group health plan is the individual's primary insurer but Medicare is available as a secondary payer, if the individual enrolls in Medicare. The statute provides that, during the 30-month period, a group health plan "may not take into account that an individual is" eligible for Medicare because of end-stage renal disease. 42 U.S.C. 1395y(b)(1)(C)(i). The statute also provides that a group health plan "may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner." 42 U.S.C. 1395y(b)(1)(C)(ii). The question presented is as follows:

Whether a group health plan that provides uniform dialysis benefits to all individuals covered by the plan nonetheless violates the Medicare Secondary Payer statute's provisions regarding end-stage renal disease, 42 U.S.C. 1395y(b)(1)(C), where the plan's dialysis benefits are alleged to have been set at artificially low levels that have a disproportionate effect on individuals with end-stage renal disease, who need frequent dialysis, in order to cause such individuals to leave the plan and enroll in Medicare.

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INTEREST OF THE UNITED STATES

This case concerns provisions in the Medicare Secondary Payer statute, 42 U.S.C. 1395y(b), which require coordination of the benefits provided by Medicare and group health plans for individuals with end-stage renal disease. Congress has vested the Secretary of Health and Human Services with broad authority to administer Medicare, see 42 U.S.C. 1302 and 1395hh, and the Secretary has issued regulations to implement the Medicare Secondary Payer statute. The question presented implicates the Secretary's regulations and, more broadly, the proper administration of the Medicare Secondary Payer statute.

STATEMENT

A. Legal Background

1. The Medicare program, established in 1965 by Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.*, provides federally funded health insurance for the elderly and certain people with disabilities. As first enacted, Medicare was generally "the primary payer for medical services supplied to a beneficiary, even when such services were covered by other insurance such as an employer group health plan." *Zinman* v. *Shalala*, 67 F.3d 841, 843 (9th Cir. 1995). In 1980, Congress responded to rising costs in the program by enacting the Medicare Secondary Payer (MSP) statute, 42 U.S.C. 1395y(b), which makes Medicare a secondary payer to insurance plans covering the same beneficiary for the same benefits. See Medicare and Medicaid Amendments of 1980, Pub. L. No. 96-499, Tit. IX, Pt. B, Subpt. II, § 953, 94 Stat. 2647; see also H.R. Rep. No. 1167, 96th Cong., 2d Sess. 352 (1980). The statute was designed to "lower[] overall federal Medicare disbursements by requiring Medicare beneficiaries to exhaust" other insurance benefits "before resorting to their Medicare coverage." *United States* v. *Rhode Island Insurers' Insolvency Fund*, 80 F.3d 616, 618 (1st Cir. 1996).

The MSP statute provides that payment may not be made under the Medicare program for "any item or service to the extent that" payment for that item or service either "has been made" or "can reasonably be expected to be made" by specified forms of primary insurance. 42 U.S.C. 1395y(b)(2)(A)(i) and (ii). In those dual-coverage situations, Medicare remains available as a secondary payer. When the payment from the primary plan is "less than the amount of the charge for [an] item or service," Medicare pays "for the remainder of such charge,"

typically up to the amount that Medicare would pay in the absence of other insurance and subject to certain other limitations. 42 U.S.C. 1395y(b)(4)(A) and (B).

If payment from a primary plan "cannot reasonably be expected * * * promptly," then Medicare may make a conditional payment, 42 U.S.C. 1395y(b)(2)(B)(i), subject to the federal government's right to reimbursement from the primary plan, see 42 U.S.C. 1395y(b)(2)(B)(i) and (ii). If a primary plan fails to reimburse the Medicare program as required by the MSP statute, the United States may bring a civil enforcement action "against any or all entities that are or were required or responsible * * * to make payment with respect to the same item or service (or any portion thereof)." 42 U.S.C. 1395y(b)(2)(B)(iii). In such an action, the United States may "collect double damages." *Ibid.* The MSP statute also creates a private cause of action for double damages "in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement)" in accordance with the statute. 42 U.S.C. 1395y(b)(3)(A). Any recovery by a private plaintiff is subject to the government's right to reimbursement. 42 U.S.C. 1395y(b)(2)(B)(iii).

2. This case concerns provisions in the MSP statute regarding individuals who become eligible for Medicare as a result of end-stage renal disease (ESRD).

a. ESRD is the final stage of chronic kidney disease. *Essentials of Chronic Kidney Disease* 1-2 (Stephen Z. Fadem ed., 2015). At that stage of kidney disease, the kidneys no longer properly function to filter waste products and excess fluid from the blood, and the individual generally requires either regular dialysis treatment or a kidney transplant to survive. 42 C.F.R. 406.13(b); see National Inst. of Diabetes & Digestive & Kidney Diseases

(NIDDK), *What is Kidney Failure?* (las reviewed Jan. 2018), https://go.usa.gov/xeA5t. In the United States, the leading causes of kidney disease are diabetes and high blood pressure, and about 786,000 people have ESRD. NIDDK, *Kidney Disease Statistics for the United States* (Sep. 2021), https://go.usa.gov/xeAN3. Most individuals with ESRD receive regular dialysis, either at home or at an outpatient clinic, for the remainder of their lives. See *ibid.*

Since 1972, individuals with ESRD have been eligible for Medicare regardless of age. 42 U.S.C. 426-1; see Social Security Amendments of 1972, Pub. L. No. 92-603, Tit. II, § 299I, 86 Stat. 1463. To be entitled to benefits, an individual must be medically determined to have ESRD; must file an application; and must meet certain work-eligibility requirements or be the spouse or dependent child of someone who does. 42 U.S.C. 426-1(a)(1)-(3). Individuals meeting those criteria are entitled to benefits under Medicare Part A, 42 U.S.C. 1395c *et seq.*, covering hospital costs, and are eligible to enroll in Medicare Part B, 42 U.S.C. 1395j *et seq.*, covering certain other medical costs. 42 U.S.C. 426-1(a). The entitlement to benefits generally begins after three months of dialysis or in the month in which the individual receives a kidney transplant—whichever is earlier. 42 U.S.C. 426-1(b)(1)(A) and (B). Because routine dialysis is typically performed in outpatient facilities that are not covered by Medicare Part A, individuals with ESRD who seek to rely on Medicare to cover their treatment costs often need to enroll in Part B—and pay the associated premiums, deductibles, and coinsurance for that program. See Centers for Medicare & Medicaid Servs. (CMS), *Medicare Coverage of Kidney Dialysis & Kidney Transplant Services* 16, 31-33 (Sept. 2020).

b. The provisions of the MSP statute at issue in this case address the treatment of individuals with ESRD by any "group health plan," a term broadly defined to include employer-sponsored health insurance. See 26 U.S.C. 5000(b)(1) (defining "group health plan"); 42 U.S.C. 1395y(b)(1)(A)(v) (incorporating that definition into MSP statute). Such a group health plan "may not take into account" that an individual is "entitled to or eligible for benefits" under Medicare by virtue of ESRD during a 30-month period that begins with the first month in which the individual is entitled to Medicare Part A benefits on the basis of ESRD, or would have been entitled to such benefits if the person had applied. 42 U.S.C. 1395y(b)(1)(C)(i).[1]

That provision in effect creates a 30-month period for the coordination of benefits between Medicare and a group health plan for an individual who develops ESRD. During the 30-month coordination period, the group health plan is the individual's primary insurance (assuming the individual remains on the plan), and the plan may not "take into account" the individual's Medicare eligibility. 42 U.S.C. 1395y(b)(1)(C)(i); see 42 C.F.R. 411.108(a). If the individual is enrolled in Medicare during that period, Medicare is a secondary payer for expenses not covered by the group health plan—including for outpatient dialysis if the individual enrolls in Medicare Part B. See 42 C.F.R. 411.162(a)(1). After the 30-month period, the roles reverse: Medicare becomes the primary payer, and the group health plan

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[1] The text of clause (i) refers to a 12-month period, but, as set forth later in the subparagraph, Congress has extended the period to 30 months for items or services "furnished on or after August 5, 1997." 42 U.S.C. 1395y(b)(1)(C); see Balanced Budget Act of 1997, Pub. L. No. 105-33, Tit. IV, Subtit. G, Ch. 3, § 4631(b), 111 Stat. 486.

may provide coverage that is secondary to Medicare. See 42 C.F.R. 411.162(d) (examples).

The MSP statute also provides that a group health plan "may not differentiate in the benefits it provides between individuals having [ESRD] and other individuals covered by such plan on the basis of the existence of [ESRD], the need for renal dialysis, or in any other manner." 42 U.S.C. 1395y(b)(1)(C)(ii). That prohibition applies at all times, not simply during the 30-month coordination period. The statute specifies, however, that "paying benefits secondary" to Medicare after the 30-month period is permissible. 42 U.S.C. 1395y(b)(1)(C).

If a group health plan violates those provisions, CMS may determine that the plan is "nonconforming" and may refer the plan to the Internal Revenue Service. 42 C.F.R. 411.110, 411.130. Employers that contribute to nonconforming group health plans are subject to a substantial annual excise tax. 26 U.S.C. 5000(a) and (c). Also, as explained above, the MSP statute authorizes the government and private parties to bring civil suits for damages. 42 U.S.C. 1395y(b)(2)(B)(iii) and (3)(A).

B. The Present Controversy

1. Marietta Memorial Hospital in Marietta, Ohio, sponsors and self-funds a group health plan for its employees, known as the Marietta Memorial Hospital Employee Health Benefit Plan. See Compl. ¶¶ 13-14. The plan provides three levels of medical benefits to participants. Pet. App. 4. Generally, the most generous ("Tier I") benefits are available if the provider is part of Marietta Memorial's physician-hospital organization; less-generous ("Tier II") benefits are available for services from other "preferred providers"; and the least generous ("Tier III") benefits are available in all other cases. See J.A. 79-80.

For outpatient dialysis, the plan states that all benefits are paid at the Tier II level and that a deductible and 70% coinsurance apply (meaning that the plan pays 70% of the covered expense, after the deductible). J.A. 88; see J.A. 86. The annual deductible for Tier II benefits for an individual (as opposed to a family) is $1000. J.A. 83. The plan also states that "[t]here is no network for [outpatient dialysis] services," *i.e.*, no preferred provider, and that the plan will pay for outpatient dialysis at a "[r]easonable and [c]ustomary amount" set by the plan at 125% of the "Medicare allowable fee for the appropriate area." J.A. 91-92. The plan further states that participants requiring dialysis "are subject to cost containment review, claim audit and/or review, [and] negotiation and/or other related administrative services." J.A. 195. The plan has an annual out-of-pocket ceiling on the amount an individual is required to pay for Tier II benefits of $6850. J.A. 85.

Respondents—DaVita, Inc. and a subsidiary—are among the largest dialysis providers in the United States. See Pet. App. 4. According to their complaint, respondents began providing outpatient dialysis services to a pseudonymous individual with ESRD, "Patient A," in April 2017, while Patient A was a participant in the Marietta plan. Compl. ¶ 29. In July 2017, after three months of dialysis, Patient A became entitled to Medicare on the basis of ESRD. *Ibid.* In August 2018, Patient A left the plan, and "Medicare became Patient A's primary insurance." *Ibid.*; see Compl. ¶ 53.

In December 2018, respondents brought this action against petitioners—Marietta Memorial Hospital, the plan, and the plan's third-party administrator—to challenge the provisions in the plan regarding outpatient dialysis. Pet. App. 6. Respondents allege that the plan

"places dialysis patients, almost all of whom have ESRD, at a significant disadvantage" as compared to other plan participants by providing "artificially low" rates of reimbursement for outpatient dialysis. Compl. ¶¶ 55-56. Respondents allege that the "artificially low" reimbursement results from two features of the plan's design described above: all outpatient dialysis services are out-of-network, and the plan reimburses for such services at a rate set as a "percentage of the Medicare rate," which respondents allege to be significantly lower than the reasonable and customary rates that are standard in the industry for dialysis. *Ibid.*; see Compl. ¶¶ 25-27. Respondents further allege that those features of the plan harmed Patient A by resulting in "additional payment obligations" for outpatient dialysis "not faced by other plan enrollees who do not have ESRD or do not require dialysis," such as "higher co-pays, co-insurance, and deductibles." Compl. ¶ 58. And respondents allege that the plan was designed in this manner "to induce members of the Plan with ESRD to drop out of the Plan and instead enroll in Medicare." Compl. ¶ 59. Among other claims, respondents alleged a violation of the MSP statute and invoked the statutory private cause of action "as an assignee of Patient A and in [their] own right." Compl. ¶ 60; see Compl. ¶¶ 31-33.

2. The district court granted petitioners' motion to dismiss the complaint for failure to state a claim. Pet. App. 95-115. As relevant here, the court held that the complaint fails to state a claim for a violation of the MSP statute because the plan does not "treat[] those eligible for Medicare differently than those who are not," nor does it "treat[] those who have ESRD differently than those who do not." *Id.* at 104. Rather, the plan provides

that "all patients receiving dialysis" receive the same coverage. *Ibid.*

3. A divided panel of the court of appeals affirmed in part, reversed in part, and remanded for further proceedings. Pet. App. 1-92.

a. As relevant here, the panel majority held that the complaint plausibly alleges violations of the MSP statute's provisions regulating how group health plans may treat individuals who have ESRD. Pet. App. 40-41. With respect to the prohibition on "differentiat[ing] in the benefits [a plan] provides between individuals having [ESRD] and other individuals covered by such plan on the basis of the existence of [ESRD], the need for renal dialysis, or in any other manner," 42 U.S.C. 1395y(b)(1)(C)(ii), the majority acknowledged that the plan "does not explicitly discriminate" between the benefits it provides to participants with ESRD and other participants. Pet. App. 44. But invoking principles of "antidiscrimination law," the majority held that respondents had plausibly alleged impermissible differentiation on the theory that the plan's provisions regarding outpatient dialysis "target[]" individuals with ESRD, who represent the vast majority of patients needing those services. *Id.* at 43-44; see *id.* at 42 (noting the allegation in the complaint that outpatient "dialysis is 'needed almost exclusively by ESRD patients'") (citation omitted). The majority also interpreted the provision barring differentiation in benefits to permit respondents to proceed on a disparate-impact theory. *Id.* at 45-48. And with respect to the prohibition on "tak[ing] into account" ESRD-based Medicare eligibility, 42 U.S.C. 1395y(b)(1)(C)(i), the majority reasoned that respondents may be able to prove a violation by showing, through discovery, that petitioners "adopt[ed]

policies that [were] motivated by a desire to treat Medicare-entitled individuals differently." Pet. App. 51.[2]

b. Judge Murphy would have affirmed the district court's judgment in its entirety. Pet. App. 66-92. In his view, the MSP statute "bar[s] plans from targeting Medicare-eligible *participants* who have [ESRD]," but "do[es] not bar plans from distinguishing between covered *services*" on terms that apply equally to all individuals covered by the plan. *Id.* at 67. And he viewed the challenged features of the plan in this case as falling in the latter category: "The Marietta Plan does not * * * target anyone for different benefits. It offers the same benefits to all participants." *Ibid.* Judge Murphy observed that the text of the non-differentiation provision "does not bar neutral plans that may have a disparate impact" on individuals with ESRD, *id.* at 71, and instead bars plans that "give different benefits to individuals with" ESRD, *id.* at 74, such as by "chang[ing] the benefits that a participant receives" after a diagnosis of ESRD, *ibid.* In Judge Murphy's view, that interpretation is supported by the statutory context, which

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[2] The district court had additionally held that respondents cannot invoke the private cause of action in the MSP statute, 42 U.S.C. 1395y(b)(3)(A), under the circumstances of this case. Pet. App. 100-101. The panel majority disagreed, *id.* at 17-27, and petitioners did not seek this Court's review of that issue, which is not jurisdictional. See *Steel Co.* v. *Citizens for a Better Env't*, 523 U.S. 83, 89 (1998). Accordingly, this case does not present any occasion to address whether respondents have a cause of action under the MSP statute, either directly or by assignment from Patient A. The district court had also dismissed respondents' claims asserting violations of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.* See Pet. App. 107-114. The panel majority reversed with respect to two of respondents' ERISA claims, but those claims likewise are not before this Court. *Id.* at 27-39, 54.

primarily concerns the coordination of insurance benefits rather than discrimination, *id.* at 74-80, and by CMS's implementing regulations, *id.* at 80-82. And he viewed those same considerations as supporting a reading of the take-into-account provision that does not prohibit a group health plan from "offer[ing] a neutral benefits package that has a disparate impact on those who are Medicare eligible." *Id.* at 83; see *id.* at 83-87.

Judge Murphy cautioned that the panel majority's contrary view "would * * * prove unworkable" by permitting a provider to state a claim for a violation of the MSP statute whenever reimbursement rates for dialysis are alleged to be inadequate. Pet. App. 67. He observed that "many services are reimbursed at many different rates," and that the MSP statute does not provide any "guidance" about a "proper 'comparator[]'" for evaluating a claim like respondents'. *Ibid.* In his view, the statute should not be read to require federal courts to engage in "common-law rate regulation" of reimbursement for outpatient dialysis services. *Ibid.*

SUMMARY OF ARGUMENT

The Medicare Secondary Payer (MSP) statute does not prohibit a group health plan from imposing uniform limitations on coverage for dialysis, as long as the limitations apply without regard to Medicare eligibility or the existence of end-stage renal disease (ESRD).

A. The MSP statute operates, as a general matter, to make Medicare a secondary payer when a Medicare beneficiary is also covered by other insurance. The MSP statute contains additional provisions that further that purpose specifically with respect to the coverage of renal dialysis. When an individual who becomes eligible for Medicare as a result of ESRD is also covered by a group health plan, the MSP statute provides that the

plan "may not take into account" the individual's ESRD-based Medicare eligibility during a 30-month period for the coordination of benefits, during which time Medicare is available as a secondary payer if the individual chooses to enroll in Medicare. 42 U.S.C. 1395y(b)(1)(C)(i). The statute also provides that a group health plan "may not differentiate in the benefits it provides" to individuals with ESRD and individuals without ESRD "on the basis of the existence of [ESRD], the need for renal dialysis, or in any other manner." 42 U.S.C. 1395y(b)(1)(C)(ii).

Based on the allegations in the complaint and the plan documents attached to it, petitioners' group health plan does not impermissibly "take into account" an individual's Medicare eligibility based on ESRD. The plan provides the same level of benefits, including for outpatient dialysis services, without regard to whether a particular individual is eligible for Medicare on the basis of ESRD—with the sole and permissible exception of making the plan secondary to Medicare after the 30-month coordination-of-benefits period. And CMS's implementing regulations confirm that a plan impermissibly takes into account ESRD-based Medicare eligibility only when the plan provides for different benefits based on a particular individual's Medicare eligibility, which petitioners' plan does not do.

Respondents also fail to state a claim for a violation of the MSP statute's prohibition against differentiation in benefits. Petitioners' group health plan does not impermissibly "differentiate in the benefits it provides" to individuals with ESRD and individuals without ESRD, 42 U.S.C. 1395y(b)(1)(C)(ii), because petitioners' plan provides the same dialysis benefits to all individuals covered by the plan, whether or not they have ESRD—

again, with the permissible exception of paying benefits secondary to Medicare after the 30-month period.

The court of appeals' contrary view rested on a misreading of the statute's reference to differentiation "on the basis of * * * the need for renal dialysis." 42 U.S.C. 1395y(b)(1)(C)(ii). That language specifies that a plan cannot provide different benefits to individuals with ESRD and individuals without ESRD because of (on the basis of) the former's need for renal dialysis. But petitioners' plan does not provide different benefits to individuals with ESRD and those without in the first place.

More generally, the MSP statute does not dictate that a plan provide any particular minimum level of dialysis benefits. And CMS's implementing regulations expressly confirm that a plan is "not prohibited" under the MSP statute "from limiting covered utilization of a particular service," including dialysis, "as long as the limitation applies uniformly to all plan enrollees." 42 C.F.R. 411.161(c). Petitioners' group health plan is consistent with that regulation.

B. The 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. The MSP statute does not forbid a group health plan from imposing uniform limitations on dialysis benefits, even when an individual's need for frequent and long-term outpatient dialysis might be viewed as a proxy for having ESRD. The non-differentiation provision reaches only a particular kind of disparate treatment: providing different benefits to individuals with ESRD and individuals without ESRD. Petitioners' plan provides the same benefits to both groups.

The MSP statute also does not create disparate-impact liability. The language of the statute is materially different from provisions in civil rights laws that this Court has interpreted to provide for such liability, and nothing in the statute's context or history suggests that Congress wished to create disparate-impact liability here. Respondents' contrary view would inject substantial uncertainty into the statutory scheme and present practical problems. Respondents' core allegation is that petitioners' group health plan singles out individuals with ESRD for worse treatment than other individuals covered by the plan by providing relatively low benefits for outpatient dialysis. But the MSP statute itself provides no guideposts for evaluating whether a given plan's dialysis benefits are too low.

Aside from the MSP statute's non-differentiation requirement, other federal and state laws can address insurance coverage issues, including concerning dialysis. Reversing the judgment below would leave those other provisions in place and would not imply any approval of petitioners' plan as a policy matter. The only question presented here is whether respondents' allegations state a claim for a violation of the MSP statute—and they do not.

ARGUMENT

RESPONDENTS' ALLEGATIONS FAIL TO STATE A CLAIM FOR A VIOLATION OF THE MEDICARE SECONDARY PAYER STATUTE

Respondents allege that petitioners' group health plan is designed to single out individuals with ESRD for worse treatment than other plan participants, principally by limiting coverage for outpatient dialysis services, with the ultimate goal of shifting the cost of caring for individuals with ESRD to the Medicare program.

See Pet. App. 3, 6. Those allegations are troubling as a policy matter, but they do not state a claim for a violation of the MSP statute. The ESRD provisions in the MSP statute do not prohibit plans from establishing uniform limits on dialysis benefits, even if those limits have a disproportionate effect on individuals with ESRD, who require frequent dialysis.

A. A Group Health Plan May Uniformly Limit Dialysis Benefits Without Violating The MSP Statute

As previously explained (see pp. 2-3, *supra*), the MSP statute generally makes the Medicare program a secondary payer when a Medicare beneficiary is also covered by insurance that covers the same costs. 42 U.S.C. 1395y(b)(2)(A)(i). In those dual-coverage situations, the insurance is the primary plan, and Medicare is available as a secondary payer for amounts not covered by the primary plan, up to limits specified in the MSP statute. 42 U.S.C. 1395y(b)(4)(A). The MSP statute's cost-saving mechanism would easily be evaded if a primary plan could deny or reduce coverage for an individual whenever the individual is also a Medicare beneficiary. To address that possibility, Congress has enacted several provisions in the MSP statute forbidding certain types of insurance plans from taking into account Medicare entitlement or eligibility, including by only providing benefits secondary to Medicare. Those provisions are designed to prevent group health plans from adopting "any plan provision that would 'carve out' expenses covered by Medicare and thus, in effect, make the plan's coverage secondary to Medicare's." *Health Ins. Ass'n of Am., Inc.* v. *Shalala*, 23 F.3d 412, 414 (D.C. Cir. 1994), cert. denied, 513 U.S. 1147 (1995).

The provisions at issue in this case address individuals who become eligible for Medicare as a result of

ESRD while they are also covered by a group health plan. During such an individual's first 30 months of Medicare eligibility, a group health plan "may not take into account that [the] individual is entitled to or eligible for benefits under" the Medicare provisions applicable to persons with ESRD. 42 U.S.C. 1395y(b)(1)(C)(i). In addition, a group health plan "may not differentiate in the benefits it provides between individuals having [ESRD] and other individuals covered by such plan on the basis of the existence of [ESRD], the need for renal dialysis, or in any other manner," 42 U.S.C. 1395y(b)(1)(C)(ii), except by paying benefits secondary to Medicare after the 30-month coordination period, 42 U.S.C. 1395y(b)(1)(C).

Petitioners' group health plan does not violate those prohibitions. Under the plan, outpatient dialysis services are covered at the same level of benefits on the same terms for all plan participants, without regard to whether a given participant has ESRD or is eligible for Medicare on the basis of ESRD.

1. Petitioners' group health plan provides the same benefits regardless of an individual's ESRD-based Medicare eligibility

The allegations in respondents' complaint and the plan documents attached to it fail to state a claim for a violation of the take-into-account provision, 42 U.S.C. 1395y(b)(1)(C)(i). Those materials show that, as structured, petitioners' group health plan does not take into account an individual's ESRD-based Medicare eligibility during the 30-month coordination period. The plan instead provides uniform benefits, including dialysis benefits, to all individuals regardless of whether they are eligible for Medicare on the basis of ESRD.

To "take into account" means to "[t]o take into consideration." *The American Heritage Dictionary of the English Language* 11 (5th ed. 2016). And the MSP statute specifies that it is the "group health plan" that may not take into consideration ESRD-based Medicare eligibility. See 42 U.S.C. 1395y(b)(1)(C)(i) (stating that a "*group health plan* * * * may not take into account" an individual's ESRD-based Medicare eligibility during the coordination period) (emphasis added); see also 26 U.S.C. 5000(b)(1) (defining "group health plan"). The provision thus "regulates the 'formal program' or 'arrangement'" of health benefits that are provided to individuals in the plan—*i.e.*, it regulates the plan's operative terms—"not the motives of the 'entities' that adopted" those arrangements. Pet. App. 84 (Murphy, J., dissenting in part) (quoting 42 C.F.R. 411.21 (definition of "*Plan*")). The plan itself, in the benefits its terms provide to individuals, may not turn on whether a particular individual is eligible for Medicare because of ESRD. See *ibid.*

Petitioners' group health plan does not impermissibly "take into account" an individual's ESRD-based Medicare eligibility during the 30-month coordination period. 42 U.S.C. 1395y(b)(1)(C)(i). The plan provides all individuals covered by the plan with the same level of benefits for outpatient dialysis, which are uniformly covered at the plan's "Tier II" level of benefits, with a deductible and 70% coinsurance. J.A. 88. The plan also recognizes, consistent with the MSP statute, that the plan is the primary payer during the 30-month coordination period. J.A. 242-243. The plan does not provide for any in-network providers of outpatient dialysis services, see J.A. 91, but that is true for all plan participants, without regard to whether the individual is

eligible for Medicare based on ESRD. Likewise, the plan states that the plan administrator may apply "cost containment review" and other cost-controls to dialysis claims. J.A. 195. But the provision authorizing such measures applies to "[a]ll eligible Participants," *ibid.*, and respondents do not allege that the plan administrator took Patient A's ESRD-based Medicare eligibility into account under those provisions. Cf. Compl. ¶¶ 51, 55. Accordingly, respondents fail to state a claim for a violation of the "take into account" provision. 42 U.S.C. 1395y(b)(1)(C)(i).

The Ninth Circuit reached a similar conclusion in another suit also brought by respondent DaVita, in a decision postdating the Sixth Circuit's decision in this case. See *DaVita Inc.* v. *Amy's Kitchen, Inc.*, 981 F.3d 664, 669-670 (9th Cir. 2020). There, the Ninth Circuit correctly explained that a group health plan "plainly did not take into account" an individual's ESRD-based eligibility for Medicare when it "uniformly reimburse[d] all dialysis treatment, whether or not the beneficiary is eligible for Medicare or enrolled in Medicare." *Id.* at 669. Petitioners' plan here, on its face, likewise provides for uniform reimbursement for all outpatient dialysis claims.

CMS's implementing regulations reinforce the conclusion that a group health plan that provides uniform benefits to all plan participants, without regard to whether a particular individual is entitled to Medicare on the basis of ESRD, does not violate the take-into-account provision. The regulations set forth an illustrative list of examples of actions that "constitute taking into account that an individual is" entitled to or eligible for Medicare benefits on the basis of ESRD. 42 C.F.R.

411.108(a).[3] The examples include "[t]erminating coverage because the individual has become entitled to Medicare," "[i]mposing limitations on benefits for a Medicare entitled individual that do not apply to others enrolled in the plan," "[c]harging a Medicare entitled individual higher premiums," and "[p]aying providers and suppliers less for services furnished to a Medicare beneficiary than for the same services furnished to an enrollee who is not entitled to Medicare." 42 C.F.R. 411.108(a)(3), (5), (6), and (8).

The common thread of those examples is that they involve plan terms or actions that turn on a specific individual's Medicare eligibility or entitlement. See Pet. App. 86 (Murphy, J., dissenting in part). Each example focuses on whether the plan treats a particular individual differently than others enrolled in the plan on account of that individual's Medicare entitlement, in the sense that a Medicare beneficiary and a non-beneficiary using the same healthcare items or services would have different coverage or costs. Respondents do not identify anything similar in petitioners' plan.

2. Petitioners' group health plan does not differentiate in the benefits it provides to individuals with ESRD and individuals without ESRD

Respondents' allegations also fail to show that petitioners' group health plan impermissibly "differentiate[s] in the benefits it provides" in violation of the MSP statute. 42 U.S.C. 1395y(b)(1)(C)(ii). The plan's

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[3] The examples are phrased in terms of Medicare "entitlement," but a separate regulation incorporates them by cross-reference for the MSP statute's ESRD-specific "take into account" provision, which prohibits consideration of whether "an individual is *eligible for* or entitled to Medicare on the basis of ESRD during the coordination period." 42 C.F.R. 411.161(a)(1) (emphasis added).

outpatient dialysis benefits are the same for all individuals. And uniform standard and limitations for dialysis benefits, applicable to all individuals covered by the plan, do not constitute impermissible "differentiat[ion] in * * * benefits." *Ibid.*

a. That conclusion follows straightforwardly from the statutory text. See Pet. App. 71-74 (Murphy, J., dissenting in part); *Amy's Kitchen*, 981 F.3d at 670-671. The statute forbids a group health plan from:

> [1] "differentiat[ing] in the benefits it provides"
>
> [2] "between individuals having [ESRD] and other individuals covered by such plan"
>
> [3] "on the basis of the existence of [ESRD], the need for renal dialysis, or in any other manner."

42 U.S.C. 1395y(b)(1)(C)(ii).

The first two clauses are satisfied only if the plan provides different benefits ("differentiate[s] in the benefits it provides") as between two groups: individuals with ESRD and individuals without ESRD. 42 U.S.C. 1395y(b)(1)(C)(ii). And the third clause provides that such arrangements are impermissible when the differing treatment of the two groups occurs on the basis of the existence of ESRD, on the basis of the need for dialysis, or "in any other manner." *Ibid.*; cf. *Amy's Kitchen*, 981 F.3d at 671 (reading the provision to mean that a group health plan "may not provide differing benefits to persons with ESRD than to other insureds, no matter the reason and no matter the manner"). The only form of differential treatment that the statute permits is paying benefits secondary to Medicare after the 30-month coordination period in the case of individuals with ESRD who become eligible for Medicare on that basis. See 42 U.S.C. 1395y(b)(1)(C) ("except that clause

(ii) [*i.e.*, the non-differentiation provision] shall not prohibit a plan from paying benefits secondary to [Medicare] when an individual is entitled to or eligible for" benefits under Medicare on the basis of ESRD, "after the end" of the coordination-of-benefits period); see also 42 C.F.R. 411.161(d)(1) (same).

The "pertinent question" is therefore whether petitioners' group health plan "provides differing benefits to persons with ESRD than to all other insureds." *Amy's Kitchen*, 981 F.3d at 671; see Pet. App. 74 (Murphy, J., dissenting in part). It does not. As previously explained, petitioners' plan provides for the same benefits, including outpatient dialysis benefits, for all plan participants, with the exception of paying benefits secondary to Medicare after the 30-month period. See pp. 17-18, *supra*. An individual with ESRD who is covered by the plan, like any other plan participant, is covered at the "Tier II" level of benefits for outpatient dialysis. J.A. 88.

A group health plan would violate the MSP statute's non-differentiation provision if it were to single out plan participants with ESRD for different treatment with respect to the benefits afforded as compared to other individuals covered by the plan, such as by imposing a different set of co-payments or covering a different set of services. And, unlike the take-into-account provision, the plan is prohibited from engaging in such differentiation in benefits at *any* time, not simply during the 30-month coordination period, and for *any* individual with ESRD, not simply one who is entitled to Medicare as a result of ESRD. The two provisions are thus complementary and overlapping. See *Amy's Kitchen*, 981 F.3d at 670. And neither one is violated here.

b. In reaching a contrary conclusion, the court of appeals emphasized that the provision barring differentiation in benefits lists three ways in which it can be violated, one of which is differentiation on the basis of "the need for renal dialysis." 42 U.S.C. 1395y(b)(1)(C)(ii); see Pet. App. 42-43. The court reasoned that "a principal, distinguishing feature of being diagnosed with ESRD is one's significant need for dialysis," and that a plan therefore violates the non-differentiation provision if it "target[s]" dialysis itself. Pet. App. 43.

That reasoning is unsound. The reference to dialysis on which the court of appeals focused specifies one of the impermissible *bases* for differentiation in benefits. Here, however, the plan does not differentiate in the benefits (including dialysis benefits) it provides to individuals with ESRD and individuals without ESRD. On the face of the plan, the dialysis benefits are the same for all. The clause referring to impermissible differentiation "on the basis of * * * the need for renal dialysis," 42 U.S.C. 1395y(b)(1)(C)(ii), comes into play only if some differentiation in benefits occurs, and the question is whether the differentiation has occurred on an impermissible basis. To illustrate, a group health plan may differentiate between individuals in the benefits it provides in lawful ways, such as by providing more generous benefits to employees with longer tenures. See 42 C.F.R. 411.108(b)(1). If, as a result of doing so, the plan happens to provide different dialysis benefits to some individuals with ESRD and some individuals without ESRD, the plan has not violated the non-differentiation provision because the differentiation was on the basis of tenure, not on the basis of "the need for renal dialysis." 42 U.S.C. 1395y(b)(1)(C)(ii).

More broadly, the MSP statute does not dictate any precise level of dialysis benefits. Indeed, the text of the non-differentiation provision presupposes a preexisting set of benefits determined by the plan itself. See 42 U.S.C. 1395y(b)(1)(C)(ii) ("[a] group health plan * * * may not differentiate in the *benefits it provides*") (emphasis added). Accordingly, any allegation that a plan provides insufficiently generous coverage for outpatient dialysis does not, standing alone, state a claim for a violation of the MSP statute.

The broader context and purpose of the MSP statute confirm that interpretation. See, *e.g.*, *FDA* v. *Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) ("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.'") (citation omitted). The MSP statute is designed to control costs in the Medicare program by making Medicare the secondary payer to other available insurance. See pp. 2-3, *supra*. To be sure, the provision barring differentiation in benefits goes beyond that purpose and ensures equal treatment in the benefits a group health plan may provide in this one context. But it does so mainly in service of furthering the MSP statute's primary and secondary payer provisions by barring to that extent an incentive for individuals to drop their group insurance coverage. The MSP statute as a whole is not "a substantive healthcare law" in the sense of directly prescribing specific benefits that a group health plan must provide. Pet. App. 75 (Murphy, J., dissenting in part). It would be anomalous to find in a statute primarily addressing the coordination of benefits a provision requiring a group health plan to provide specific minimum benefits.

The relevant context also includes Congress's overarching decision to make individuals with ESRD eligible for Medicare. 42 U.S.C. 426-1. Group health plans may not impermissibly differentiate in the benefits they provide to individuals with ESRD and those without ESRD. But when a plan limits dialysis benefits for all plan participants on equal terms, individuals with ESRD may avail themselves of Medicare as a secondary payer during the 30-month coordination period. See 42 U.S.C. 1395y(b)(1)(C); 42 C.F.R. 411.162(a)(1). The statutory scheme thus contemplates that some plans may lawfully provide benefits at levels that leave the Medicare program to cover gaps.

c. CMS's implementing regulations further confirm that the non-differentiation provision generally requires that the same benefits be provided to all plan participants without regard to ESRD but does not dictate a particular level of benefits. In fact, the implementing regulations speak directly to the issue:

> (c) *Uniform Limitations on particular services permissible.* A plan is not prohibited from limiting covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would not be differentiating in the benefits it provides between plan enrollees who have ESRD and those who do not.

42 C.F.R. 411.161(c). Limiting dialysis coverage to 30 sessions per year may have a disproportionate effect on individuals with ESRD as compared to other individuals without ESRD who need dialysis less frequently or not at all. But the regulation quoted above confirms that the non-differentiation provision does not forbid such a

limitation, as long as it is applied equally to all individuals enrolled in the plan. Instead, as other examples in the regulations make clear, what the statute forbids is providing different benefits for individuals with ESRD as compared to individuals without ESRD. See 42 C.F.R. 411.161(b)(2)(i)-(iv).

The court of appeals erred in disregarding the regulation regarding uniform limitations on the theory that the regulation "conflicts with the text" of the MSP statute or other regulations. Pet. App. 50. As to the statute, by its plain terms the non-differentiation provision is implicated only if a group health plan provides different benefits to individuals with ESRD and individuals without ESRD; it follows that *uniform* limitations, applicable equally to all individuals, do not constitute impermissible differentiation. Indeed, in adopting these regulations, the agency understood itself to be merely giving effect to the "clear" and "self-implementing" language of the statute. 60 Fed. Reg. 45,344, 45,359-45,360 (Aug. 31, 1995).

The "internal conflict" in the regulations perceived by the court of appeals is also not a compelling basis for disregarding the uniform-limitations regulation quoted above. Pet. App. 50. The court pointed (*ibid.*) to two other provisions. The first, 42 C.F.R. 411.161(b)(1), merely parallels the statutory language in Section 1395y(b)(1)(C)(ii) prohibiting "differentiat[ion] in the benefits" provided to "individuals who have ESRD and others enrolled in the plan," while inserting an extra "or" for readability. The second, 42 C.F.R. 411.161(b)(2)(v), identifies the following as an example of an action by a group health plan that would be impermissible differentiation: "Failure to cover routine maintenance dialysis or kidney transplants, when a plan

covers other dialysis services or other organ transplants." The court took that example to support a theory under which even uniform limitations on dialysis—such as not covering "routine maintenance dialysis" for any individual, *ibid.*—may be impermissible if they have a disproportionate effect on individuals with ESRD. Pet. App. 49. Such a reading would be in obvious tension with the adjacent regulation stating that uniform limitations on particular services, including dialysis, are not prohibited.

The regulations should be interpreted "as a coherent whole." *United States* v. *Beggerly*, 524 U.S. 38, 46 (1998); see *Brown & Williamson Tobacco Corp.*, 529 U.S. at 133. To avoid an internal conflict with the unambiguous language of the uniform-limitations regulation, the provision on which the court of appeals focused is better read to mean that a plan may not choose to cover dialysis but then refuse to cover it in the same manner when needed by individuals with ESRD; in other words, the phrase "routine maintenance dialysis" refers here to dialysis sought by individuals with ESRD. 42 C.F.R. 411.161(b)(2)(v); cf. Pet. Br. 50. That understanding of the regulation accords with the preceding examples, which focus explicitly on providing different benefits to individuals with ESRD. See 42 C.F.R. 411.161(b)(2)(i)-(iv). That understanding also accords with the agency's previously stated view that a group health plan does not violate the non-differentiation provision if it "eliminate[s] coverage for all types of dialysis," but that a plan may not "eliminat[e] dialysis only for ESRD patients." U.S. Gen. Accounting Office, B-252171, *Medicare: Impact of OBRA-90's Dialysis Provisions on Providers*

and Beneficiaries 8 (Apr. 1994) (discussing agency's views).[4]

In any event, this case does not involve any alleged failure to cover routine maintenance dialysis, while covering other dialysis. 42 C.F.R. 411.161(b)(2)(v). Respondents' theory is that, although petitioners' plan covers outpatient dialysis, it imposes limitations on that service that disadvantage individuals with ESRD in order to cause them to leave the plan for Medicare. See Pet. App. 3. As the implementing regulations make clear, however, petitioners' group health plan is "not prohibited" from limiting its coverage for outpatient dialysis "as long as the limitation applies uniformly to all plan enrollees." 42 C.F.R. 411.161(c).

B. The Court Of Appeals' Contrary View Lacks Merit

Respondents allege that petitioners' group health plan imposes limitations on benefits for outpatient dialysis services as a proxy for discriminating against individuals with ESRD and that petitioners designed the plan that way to induce individuals with ESRD to drop out of the plan and enroll in Medicare. Compl. ¶¶ 55-59.

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[4] Section 411.161(b)(2)(v) also states that a group health plan would impermissibly differentiate in the benefits it provides if it were to cover "other organ transplants" but not "kidney transplants." 42 C.F.R. 411.161(b)(2)(v). It is not obvious as a statutory matter why declining to cover kidney transplants while covering other transplants would be impermissible differentiation if the limitation were imposed uniformly on all individuals, and the preamble to the agency's rulemaking does not shed any further light on the matter. See 60 Fed. Reg. at 45,356-45,357. In that limited respect, the regulation may sweep beyond the statute itself. But the transplant example is not directly implicated in this dispute about coverage for dialysis, and the implementing regulations as a whole make clear that the MSP statute does not prohibit uniform limitations on dialysis coverage.

The court of appeals was wrong to conclude that respondents' allegations state a claim for a violation of the MSP statute under either a discrimination-by-proxy or a disparate-impact theory. Pet. App. 45, 53. The MSP statute is not a conventional antidiscrimination law. The text and context of the MSP statute are materially different from the civil rights laws that were being interpreted in the body of case law invoked by the court. That mode of analysis is out of place here, and importing it would be unworkable.

1. The discrimination-by-proxy theory does not suffice to state a claim, where the plan provides the same benefits to all individuals

Federal civil rights laws and this Court's precedent construing them distinguish between two theories of liability: "intentional discrimination (known as 'disparate treatment') * * * [and] practices that are not intended to discriminate but in fact have a disproportionately adverse effect on [the protected class] (known as 'disparate impact')." *Ricci* v. *DeStefano*, 557 U.S. 557, 577 (2009). This Court has also concluded that, in some circumstances, the former theory can apply when the intentional discrimination is directed at a "proxy" for the protected class. *Rice* v. *Cayetano*, 528 U.S. 495, 514 (2000); see *id.* at 514-515 (concluding that Hawaiian ancestry functioned as "a proxy for race" in a state law, which was therefore an unconstitutional racial classification); cf. *Bray* v. *Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993) ("A tax on wearing yarmulkes is a tax on Jews.").

The court of appeals erred in relying on such a "proxy" theory here. Pet. App. 44-45. The MSP statute does not broadly prohibit all "discriminat[ion] against individuals with ESRD," *id.* at 44, but rather prohibits

only a specific form of differential treatment: providing different benefits to individuals with ESRD as compared to individuals without ESRD. See 42 U.S.C. 1395y(b)(1)(C)(ii) ("may not differentiate in the benefits it provides"). Limiting dialysis benefits for all individuals equally does not constitute "differentiat[ing] in the benefits" the plan provides, *ibid.*—even if needing frequent outpatient dialysis is viewed as a proxy for having ESRD—because the benefits are the same for all, and the statutory prohibition reaches only the provision of different benefits. Cf. *Cyan, Inc.* v. *Beaver Cnty. Emps. Retirement Fund*, 138 S. Ct. 1061, 1073 (2018) ("Even if Congress could or should have done more, still it 'wrote the statute it wrote—meaning, a statute going so far and no further.'") (quoting *Michigan* v. *Bay Mills Indian Cmty.*, 572 U.S. 782, 794 (2014)).

The court of appeals' approach would substantially alter the operation of the statutory scheme. Whether a group health plan violates the non-differentiation provision in the MSP statute could depend in part on what motivated the adoption of particular levels of dialysis benefits, and the same plan terms could be lawful in some circumstances and unlawful in others—depending on questions of subjective intent. See Pet. App. 52 (endorsing respondents' "motive-based interpretation"). Nothing in the text or history of the MSP statute suggests that Congress sought to draw such lines, or to require CMS to do so, in this context. And CMS's regulatory process for determining whether a plan fails to conform to the MSP statute does not contemplate the kind of factfinding that might be necessary to resolve disputed questions of subjective intent. See 42 C.F.R. 411.110 (basis for determination).

2. The MSP statute does not create disparate-impact liability for group health plans

The court of appeals also erred in concluding that the non-differentiation provision creates disparate-impact liability for group health plans. See Pet. App. 45-48. Nothing in the MSP provisions' text, context, or purpose "suggest[s] that Congress intended to sweep in actions that disproportionately affect persons with ESRD under a disparate-impact theory." *Amy's Kitchen*, 981 F.3d at 674; see Pet. App. 67 (Murphy, J., dissenting in part) (explaining that "the statutory text" does not "permit this theory").

The court of appeals emphasized that the statute forbids differentiation "in any other manner," 42 U.S.C. 1395y(b)(1)(C)(ii), which the court understood to be "results-oriented" language similar to the language of certain civil rights statutes that encompass disparate-impact claims. Pet. App. 46 n.15 (citation omitted); see *id.* at 45-48. But, as the Ninth Circuit persuasively explained, the non-differentiation provision's "text makes clear that the pertinent inquiry remains whether the plan's provisions 'result' in *different benefits for persons with ESRD*, not whether the plan's provisions disproportionately affect persons with ESRD." *Amy's Kitchen*, 981 F.3d at 674-675. This "tightly cabined" provision suggests that Congress was seeking to address "a carefully circumscribed concern" about plans providing different and worse benefits to individuals with ESRD. *Id.* at 675.

3. Respondents' contrary interpretation would be unworkable in practice

Respondents allege that petitioners engaged in intentional discrimination against individuals with ESRD by setting dialysis benefits at an "artificially low" level.

Compl. ¶ 56. For all the reasons discussed above, the MSP statute should not be read to prescribe any particular level of dialysis benefits. Adopting respondents' view would also invite a host of practical problems.

The MSP statute does not provide any benchmark for measuring whether the dialysis benefits that a given group health plan provides are "too low." As Judge Murphy explained in his partial dissent, in this context "many services are reimbursed at many different rates." Pet. App. 67; cf. J.A. 87-90 (summary chart of benefits for different services). And the MSP statute does not itself identify a "proper 'comparator[]'" for evaluating whether a plan has set dialysis benefits at unusually low levels in order to single out individuals with ESRD for worse treatment than other individuals covered by the plan. Pet. App. 67 (Murphy, J., dissenting in part). Under respondents' approach, every group health plan would be potentially subject to litigation scrutinizing plan terms that apply uniformly to all participants but that are alleged to have a disproportionate effect on individuals with ESRD—perhaps with an inquiry into the motive for particular coverage and benefits decisions.

Moreover, although this case concerns a group health plan's coverage terms for dialysis, the court of appeals' reasoning would also invite scrutiny of any benefit that provides less robust coverage for any disease or condition that is more prevalent among those with ESRD, as compared to the coverage for different diseases or conditions. To assess whether a group health plan conforms with the court of appeals' construction of the statute, it could be necessary to determine whether, for example, a plan's coverage level for cardiovascular disease creates a disadvantage for individuals with

ESRD relative to the plan's coverage levels for other diseases. See *Amy's Kitchen*, 981 F.3d at 676. And the MSP statute provides no guideposts for making such determinations.

4. Other laws may afford protections to individuals with ESRD

A determination by this Court that respondents' allegations fail to state a claim for a violation of the MSP statute would not detract from other federal and state laws that may address coverage of dialysis. For example, under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, although state laws relating to an ERISA plan are ordinarily preempted, 29 U.S.C. 1144(a), state laws regulating insurance are saved from preemption as applied to ERISA plans that are insured rather than self-funded, 29 U.S.C. 1144(b)(2). Under that savings clause, state insurance laws mandating particular benefits may be applied to insurance coverage provided through insured ERISA health plans. *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739-747 (1985); see *id.* at 730 n.10 (noting example of state-mandated coverage for "outpatient kidney-dialysis coverage"). Although the savings clause does not apply to self-funded group health plans like petitioners' plan, that is a feature of ERISA generally and is not unique to dialysis.

The Patient Protection and Affordable Care Act (Affordable Care Act), Pub. L. No. 111-148, 124 Stat. 119, may also indirectly induce some health insurance issuers to provide dialysis benefits to participants, beneficiaries, and enrollees. In particular, the Affordable Care Act requires health insurance coverage in the individual and small group markets that does not fall within a grandfathering provision to provide "essential

health benefits." 42 U.S.C. 300gg-6 and 18022; see 45 C.F.R. Pt. 156, Subpt. B. The package of essential health benefits (EHB) is determined in each State by an EHB-benchmark plan. 45 C.F.R. 156.111. As of 2018, 49 States and the District of Columbia included dialysis benefits in their EHB-benchmark plans. Suzanne M. Kirchoff, Cong. Res. Serv., R45290, *Medicare Coverage of End-Stage Renal Disease (ESRD)* 14 & n.59 (Aug. 16, 2018), https://go.usa.gov/xeJYQ.

ERISA also contains a nondiscrimination provision, 29 U.S.C. 1182, which states that group health plans subject to ERISA—such as petitioners' plan, see Pet. App. 4—"may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on" certain "health status-related factors," including disability. 29 U.S.C. 1182(a)(1). That provision generally does not prohibit a plan from establishing uniform "limitations or restrictions" on plan benefits "for similarly situated individuals." 29 U.S.C. 1182(a)(2)(B). But if a plan were to impose a limit directed at a particular participant with ESRD—for example, by announcing new limits on dialysis benefits shortly after the participant informed the plan that he had been diagnosed with ESRD—the participant could seek relief under ERISA. See 29 C.F.R. 2590.702(b)(2)(i)(D) (Example 2). Respondents pleaded claims under ERISA in this case, and the court of appeals remanded for further proceedings on two of them. See Pet. App. 39 n.14, 40-41, 54.

* * * * *

Respondents' allegations in this case fail to state a claim for a violation of the MSP statute. The statutory text compels that conclusion, and affirming that interpretation of the statute would not deprive individuals

with ESRD of the other protections that federal and state law provide to them. It also would not imply any approval of petitioners' conduct, which respondents allege to have been designed to adversely affect individuals with ESRD and impose costs on Medicare. Congress may wish to revisit the scope of the MSP statute in light of those allegations. But respondents' allegations do not state a claim under the current statute.

CONCLUSION

The judgment of the court of appeals should be reversed and the case remanded for further proceedings.

Respectfully submitted.

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