No. 20-1641

In the
Supreme Court of the United States

MARIETTA MEMORIAL HOSPITAL, ET AL.,
Petitioners,

v.

DAVITA INC., ET AL.,
Respondents.

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

---

BRIEF OF *AMICUS CURIAE* DIALYSIS PATIENT CITIZENS IN SUPPORT OF RESPONDENTS AND AFFIRMANCE

Jackson Williams
DIALYSIS PATIENT CITIZENS
1001 Connecticut Ave, NW
Suite 1230
Washington, DC 20036

NICHOLAS NELSON
Counsel of Record
JEFFREY S. ROBERTS
FAEGRE DRINKER BIDDLE & REATH LLP
2200 Wells Fargo Ctr.
90 S. Seventh St.
Minneapolis, MN 55402
(612) 766-7205
nicholas.nelson@faegredrinker.com

Counsel for Amicus Curiae Dialysis Patient Citizens

January 26, 2022

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTEREST OF *AMICUS CURIAE* 1

SUMMARY OF THE ARGUMENT. 2

ARGUMENT 4

I. Medicare Alone, Without Support From Private Health Plans, Cannot Ensure The Availability of Dialysis Nationwide 5

II. Petitioners' Position Would Create Structural Incentives For Health Plans To Deny Other Kidney-Related Care 9

III. Giving Up Their Private Health Plans Often Forces ESRD Patients To Accept Inferior Coverage 12

CONCLUSION. 16

TABLE OF AUTHORITIES

CASES

DaVita Inc.v. Virginia Mason Mem'l Hosp.,
981 F.3d 679 (9th Cir. 2020). 6

STATUTES

H.R. Rep. No. 105-149 6

OTHER AUTHORITIES

2022 Medicare Part A & B Premiums and Deductibles, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/newsroom/fact-sheets/2022-medicare-parts-b-premiums-and-deductibles2022-medicare-part-d-income-related-monthly-adjustment 13

Ctrs. for Medicare and Medicaid Servs., *CY 2022 End Stage Renal Disease Prospective Payment System Final Rule* (CMS-1749-F), https://www.cms.gov/newsroom/fact-sheets/cy-2022-end-stage-renal-disease-prospective-payment-system-final-rule-cms-1749-f 14

Dental Services, Medicare.gov, https://www.medicare.gov/coverage/dental-services 13

Ensure ALL Medicare ESRD Patients Have Access to Medigap Plans, Dialysis Patient Citizens (Sept. 2019) https://www.dialysispatients.org/sites/default/files/medigap_201909.pdf 15

Frequently Asked Questions about Dialysis Access Surgery, Beth Israel Deaconess Med. Ctr., https://www.bidmc.org/centers-and-departments/transplant-institute/dialysis-access-center/frequently-asked-questions-about-dialysis-access-surgery 11

Seyed Bahman Gaderien et al., *Diabetes and End-Stage Renal Disease; A Review Article on New Concepts*, 4 J. Renal Injury Prevention 28(2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4459725/. 13

Eleni A. Georgakopoulou et al., *Dental Management of Patients Before and After Renal Transplantation*, 13 Baltic Dental and Maxillofacial J. 107 (2011), https://www.sbdmj.com/114/114-01.pdf 14

Gov't Accountability Office, *End Stage Renal Disease: CMS Should Improve Design and Strengthen Monitoring of Low-Volume Adjustment*, Report 13-287 (2013) 8

Yoshio N. Hall et al., *Predictors of end-stage renal disease in the urban poor*, J. Health Care Poor Underserved. 2013 Nov; 24(4) 12

Emily Kopp & Jay Hancock, *The High Cost of Hope: When the Parallel Interests of Pharma and Families Collide*, The Daily Beast (Oct. 15, 2018), https://www.thedailybeast.com/the-high-cost-of-hope-when-the-parallel-interests-of-pharma-and-families-collide. 10

Medicare.gov, *Part B Costs*, https://www.medicare.gov/your-medicare-costs/part-b-costs. 13

Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy* (Mar. 2019), mar19_medpac_entirereport_sec_rev.pdf 7, 8

Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy* (Mar. 2021), mar21_medpac_report_to_the_congress_sec.pdf 7

Amber O. Molnar et al., *Risk Factors for Unplanned and Crash Dialysis Starts: A Protocol for a Systematic Review and Meta-Analysis*, 5 Systematic Revs. 1, 1-2 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4950106/ 11

Nat'l Council on Aging, *How Much Does Medicare Part D Cost?*, https://www.mymedicarematters.org/costs/part-d/ 13

Nat'l Inst. of Diabetes and Digestive and Kidney Diseases, *Diabetic Eye Disease*, https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/diabetic-eye-disease 14

Nat'l Insts. of Health, *Hearing Loss Is Common in People with Diabetes* (June 16, 2008), https://www.nih.gov/news-events/news-releases/hearing-loss-common-people-diabetes. 14

Nat'l Kidney Found., *Hemodialysis Access: What You Need to Know*, at 7-9 (2006), https://www.kidney.org/sites/default/files/11-50-0216_va.pdf 11

Ryan et al., *Identifying Barriers to Preemptive Kidney Transplantation in a Living Donor Transplant Cohort*, 4 Kidney Transplantation 356 (2018), https://journals.lww.com/transplantationdirect/pages/articleviewer.aspx?year=2018&issue=04000&article=00002&type=Fulltext 10

Adam A. Shpigel et al., *A Comparison of Payments to a For-Profit Dialysis Firm from Government and Commercial Insurers*, 179 JAMA Internal Med. 1136 (2019). 8

United States Renal Data System, *2021 Annual Data Report: End Stage Renal Disease* (2021) . . 15

Ward, Michael M., *Socioeconomic Status and the Incidence of ESRD*, 51 Am. J. Kidney Dis. 563 (2008). 15

INTEREST OF *AMICUS CURIAE*[1]

By reducing coverage for kidney dialysis, Petitioners in this case are harming patients with end-stage renal disease ("ESRD") who depend on dialysis to stay alive. *Amicus* Dialysis Patient Citizens ("DPC") is the nation's largest patient-led organization representing individuals with ESRD. On behalf of over 30,000 patient members, DPC is dedicated to improving the quality of life for dialysis patients. DPC empowers dialysis patients to be their own advocates, and DPC's Board of Directors is composed of people with ESRD. DPC's members rely on affordable access to dialysis to survive. When private health insurance plans slash benefits for ESRD patients and force them onto Medicare—as Petitioners have done here—they reduce patients' access to life-saving treatment and increase the financial burdens these vulnerable, seriously ill, and disproportionately low-income individuals must shoulder as they fight to survive.

Congress enacted the statutes at issue in this case to prevent exactly these harms to patients who are already dealing with a life-threatening illness. To prevent private health plans like Petitioners from imposing these harms on its members, DPC has an urgent interest in ensuring that the statutes are properly construed.

---

[1] All parties have consented to the filing of this brief. No counsel for a party authored the brief in whole or in part. Other than *amicus*, its members, and its counsel, no person made any monetary contribution intended to fund the preparation or submission of this brief.

SUMMARY OF THE ARGUMENT

Although the Medicare statute requires private health plans to share the cost of dialysis treatment, Petitioners argue that they have found a not-very-subtle way to circumvent that requirement. Their health plan pays so little for dialysis (compared to other medical treatments) that ESRD patients are likely to drop their private coverage and switch to Medicare. Petitioners suggest that the only victims of these anti-dialysis plan provisions are dialysis providers. That is gravely wrong. If Petitioners' arguments prevail, the result would be profound and serious harms to dialysis patients themselves.

These harms take several forms. First, Petitioners' scheme threatens to make outpatient dialysis treatment completely unavailable in many parts of the country. Dialysis is expensive, and health plans have tremendous financial incentives to avoid paying for it. If it were legal to shift privately-insured patients to Medicare, as Petitioners argue, then many or most health plans likely would do so. But Medicare alone simply cannot sustain the availability of dialysis throughout the country. At a large portion of the nation's dialysis facilities, Medicare dialysis payments do not cover the facilities' cost of providing service. These facilities depend on higher payments from private health plans to stay financially solvent. Shifting more of those facilities' patients to Medicare will threaten the continued viability of many outpatient dialysis facilities. Dialysis will become practically unavailable in many regions.

Second, allowing private insurers to avoid paying for dialysis coverage will eliminate their financial incentives to cover other kidney-related health care that is extremely important to ESRD patients. Numerous treatments are available that either delay the need for dialysis or prepare a patient to eventually receive dialysis more effectively. A health plan that must share the cost of dialysis treatment can save money by paying for these treatments, often greatly improving the patient's quality of life. By contrast, a health plan that will not bear the cost of dialysis will face financial pressure *not* to cover the cost of that preventive care.

Third, and most immediately, an ESRD patient who switches to Medicare for dialysis coverage often loses significant health and financial benefits from his or her private health plan. The benefits provided by Medicare are often much more limited than those provided by private plans. Private insurance may well cover other members of an ESRD patient's family; Medicare usually does not. And ESRD patients themselves often have other serious diseases and co-morbidities, such as diabetes, that require sophisticated treatment from specialists. Forcing ESRD patients onto Medicare therefore can cause them serious harm by reducing their access to specialists who do not accept Medicare and by increasing the financial burdens on patients. ESRD patients are already severely ill and usually unable to work because of their illness and the intensive, time-consuming dialysis treatments they must regularly receive to stay alive. They should not be forced to shoulder additional financial and medical harms—especially harms that Congress sought to

prevent by enacting the statute Petitioners' conduct here violates.

In sum, Petitioners' position would cause large-scale harms of precisely the kind that the Medicare dialysis-coverage provisions are structured to prevent. The Court should confirm that those provisions are more than a hollow promise, and bar discriminatory plan terms like the ones at issue here.

ARGUMENT

As Respondents' brief well explains, the nearly 800,000 Americans with end-stage renal disease depend on intensive, expensive dialysis treatment in order to stay alive. As a practical matter, that treatment is available mostly at outpatient dialysis facilities, some of which are run by Respondent DaVita. These clinics serve ESRD patients almost exclusively.

To protect ESRD patients and to address the unique challenges they face, Congress enacted several dialysis-specific provisions in the Medicare statute. They provide that Medicare will cover dialysis costs for virtually all ESRD patients regardless of age—but they require that a patient's private health plan continue as the primary payer for 30 months. They also prohibit health plans from discriminating against ESRD patients by attempting to shift the costs of their dialysis treatment to Medicare sooner. In this way, Congress ensured that *both* the public and private health insurance systems would share in the substantial costs of providing life-sustaining dialysis treatments to ESRD patients.

These provisions are of course structured to save Medicare substantial amounts of money, but they are far more than financial protections for the public fisc. Rather, by carefully apportioning coverage for ESRD patients between Medicare and private health plans, Congress provided vital protections for the patients themselves. If Petitioners here are correct, and insurers can circumvent that statutory apportionment, then ESRD patients will suffer serious harm—harm of exactly the type that the statutes are structured to prevent.

I. Medicare Alone, Without Support From Private Health Plans, Cannot Ensure The Availability of Dialysis Nationwide.

The most far-reaching way in which Petitioners' scheme will harm ESRD patients is by threatening to make life-sustaining outpatient dialysis unavailable, as a practical matter, in significant swaths of the country.

As Respondents' brief explains, until now, the vast majority of private insurance plans have respected Medicare's anti-discrimination rules and provided evenhanded coverage for outpatient dialysis services. Petitioners, however, have tried to evade those rules by adopting a unique and inferior reimbursement scheme for those services. Their health plan provides no in-network coverage for outpatient dialysis, reimbursing it at only 87.5% of the already-low Medicare rate. The plan does not reimburse any other medical procedure at such a low rate. Moreover, the plan subjects dialysis—and only dialysis—to "cost containment review," "claim audit[ing]," and "negotiations and/or other related administrative services." (J.A.195.)

If these efforts to shunt ESRD patients onto Medicare are vindicated in this case, other health plans will face tremendous financial pressure to adopt similar measures. As the statutes reflect, dialysis coverage is costly. In 1997, for instance, the House of Representatives Budget Committee estimated that extending private insurers' primary-payer obligations to 30 months (from the previous 18 moths) would result in a ten-year savings to Medicare of $19.2 billion. H.R. Rep. No. 105-149, at 1404 tbl.2. And because Medicare provides backup coverage for virtually all outpatient dialysis, it is an exceptionally tempting cost-cutting target for health plans: insurers risk far less of an outcry if they reduce or eliminate coverage for dialysis than for other costly medical procedures.

Indeed, for these reasons, other health plans have already begun to adopt anti-dialysis measures similar to Petitioners'. For instance, the Ninth Circuit recently decided a case involving another health plan from Washington State that uses the same anti-dialysis 125%-of-Medicare rate as Petitioners' plan here. *Compare DaVita Inc. v. Virginia Mason Mem'l Hosp.,* 981 F.3d 679, 683 (9th Cir. 2020), *with* J.A. 14, 91-92. And if this Court accepts Petitioners' argument that health plans may reimburse outpatient dialysis at lower rates than other medical treatments, there would be nothing to stop health plans from slashing their reimbursement rates even further.

If the Court finds that Petitioners' anti-dialysis measures do not violate the MSPA, such provisions will very likely become commonplace in private health plans. And if that occurs, an ESRD diagnosis will result

in the patient being forced to immediately shift off of private insurance and onto Medicare.

That will not just cost Medicare billions of dollars—it also will cause substantial harm to ESRD patients. The reality is that Medicare payments alone are not sufficient to ensure that dialysis treatment remains available throughout the country. As is true for many medical procedures, Medicare often reimburses dialysis facilities for less than the actual cost of service.[2] Currently, approximately 40% of dialysis facilities lose money on every Medicare-reimbursed dialysis treatment they perform.[3] And in some recent years, the total cost to providers of *all* Medicare-reimbursed dialysis, nationwide, has exceeded the total Medicare payments for those treatments.[4] The problem is especially acute in rural areas, where dialysis facilities face higher costs and therefore greater deficits from Medicare payments.[5]

This means that the 90% of ESRD patients who are enrolled in Medicare rely heavily on the remaining 10% who still have private insurance in order to cross-

---

[2] Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy* at 156 (Mar. 2019), mar19_medpac_entirereport_sec_rev.pdf

[3] Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy* at 189 tbl.6-6 (Mar. 2021), mar21_medpac_report_to_the_congress_sec.pdf

[4] Medicare Payment Advisory Comm'n *supra* n.2., at 174 & tbl.6-5 (in 2017, the nationwide "Medicare margin" for freestanding dialysis facilities was -1.1%).

[5] *Ibid.* (the 2017 Medicare margin for rural dialysis facilities was -5.5%).

subsidize their treatment.[6] It also means that these payments from private insurers are crucial to keeping outpatient dialysis facilities open for *every* ESRD patient, whether they are covered by private insurance or Medicare.

Respondent DaVita's particular experience is illustrative. A third-party review of public information showed that, in 2017, government sources (Medicare and Medicaid combined) paid DaVita, on average, $248 for a dialysis treatment—less than DaVita's average cost per treatment of $269.[7] DaVita could continue operating only because, for the small portion of its patients who had private insurance, DaVita received an average of $1041 per dialysis treatment.[8]

The reality, then, is that shifting ESRD patients *en masse* from private insurance to Medicare will place many dialysis facilities at risk of insolvency. The greatest threat would be to rural dialysis centers, which (with their higher costs) face a greater shortfall from Medicare payments.[9] With the likely closure of

---

[6] *See* Adam A. Shpigel et al., *A Comparison of Payments to a For-Profit Dialysis Firm from Government and Commercial Insurers*, 179 JAMA Internal Med. 1136, 1137 (2019) (at DaVita facilities in 2017, "[c]ommercial payers represented 10.5% of volume but generated 33% of revenue").

[7] *Ibid.*

[8] *Ibid.*

[9] Medicare Payment Advisory Comm'n, *supra* n.2, at 173. Although Medicare has increased reimbursements to certain small rural providers, the program's administration has been criticized as failing to compensate eligible facilities. *Ibid.*; *see also* Gov't Accountability Office, *End Stage Renal Disease: CMS Should Improve Design and Strengthen Monitoring of Low-Volume*

many outpatient dialysis clinics—especially those in relatively remote areas—there would be a grave risk that dialysis will become effectively unavailable in several regions of the country. If ESRD patients in those areas cannot relocate, they will not have access to life-sustaining treatment. The statutory plan to ensure dialysis access for all Americans would fail, with tragic results for patients.

II. Petitioners' Position Would Create Structural Incentives For Health Plans To Deny Other Kidney-Related Care.

A mass shift of ESRD patients to Medicare would jeopardize more than just dialysis availability—it would also pose a systemic risk to many other kinds of kidney care, even for patients who retain private insurance.

Generally, when a health plan covers treatments for expensive medical conditions, it has strong financial incentives to provide robust preventive and preparatory care. If the health plan can prevent an expensive condition from developing or worsening, it can avoid the escalating costs that come with treating the condition itself. Thus, the health plan has a financial incentive to pay for care that will benefit the

---

Adjustment, Report 13-287, at 11 (2013), https://www.gao.gov/assets/gao-13-287.pdf. In this regard, rural outpatient dialysis clinics should not be confused with rural hospitals, which have access to far more stable funding sources. Medicare allows many rural hospitals to bill Medicare for their full costs, guaranteeing that they will never lose money. Outpatient dialysis providers are not eligible for such treatment. Moreover, local hospitals often benefit from philanthropy and community investments, which rarely are available to outpatient dialysis providers.

patient by preventing, delaying, lessening, or preparing for a serious illness.

But these incentives would be reversed in a situation where the health plan knows that the cost of care can be shifted to someone else (such as Medicare) as soon as the patient develops the expensive condition. In that situation, paying for care to prevent or delay the condition will not help the plan's finances, and indeed will hurt them. The insurer's and patient's interests thus are no longer aligned. One of the only realistic tools to re-align them is robust anti-discrimination provisions that prevent the insurer from ducking its responsibility to pay for treating the costly condition.

Such is the case with ESRD. There are preventive and preparatory treatments for kidney failure that can greatly benefit patients by avoiding, delaying, or lessening the need for dialysis. To give one example, one genetic disease that can cause kidney failure in children can be treated with an expensive drug.[10] To give another, some patients can greatly benefit from receiving kidney transplants *before* their kidneys fail (and thus before they are eligible for Medicare).[11] And when doctors foresee that a patient is likely to develop

---

[10] Emily Kopp & Jay Hancock, *The High Cost of Hope: When the Parallel Interests of Pharma and Families Collide*, The Daily Beast (Oct. 15, 2018), https://www.thedailybeast.com/the-high-cost-of-hope-when-the-parallel-interests-of-pharma-and-families-collide.

[11] Ryan et al., *Identifying Barriers to Preemptive Kidney Transplantation in a Living Donor Transplant Cohort,* 4 Kidney Transplantation 356 (2018), https://journals.lww.com/transplantationdirect/pages/articleviewer.aspx?year=2018&issue=04000&article=00002&type=Fulltext

ESRD and to need dialysis, the risk of clotting and infection in dialysis can be greatly reduced by a preparatory surgery to create a surgical connection called a "fistula"—which must be done two to three months *before* it can be used in dialysis.[12] These preventive and preparatory treatments can be exceptionally important to a prospective ESRD patient. Suffering kidney failure without proper preventive or preparatory care—a phenomenon known as "crashing" onto dialysis—causes a heightened risk of various complications and extended hospital stays.[13]

Petitioners' position would expose ESRD patients to a heightened risk of these harms. When a private insurance plan knows it will have to pay the costs of a patient's dialysis, its financial incentives are aligned with the patient's medical interests in receiving this preventive and preparatory care. The plan will save on the cost of dialysis by covering these treatments to prevent, delay, or lessen the need for it. But that would not be true if, as Petitioners have tried to do here, health plans could drive patients onto Medicare as soon as they need dialysis. In that situation, a plan would reap no financial reward for delaying the onset of ESRD or the need for dialysis. Indeed, paying for these

---

[12] *Frequently Asked Questions about Dialysis Access Surgery*, Beth Israel Deaconess Med. Ctr., https://www.bidmc.org/centers-and-departments/transplant-institute/dialysis-access-center/frequently-asked-questions-about-dialysis-access-surgery; Nat'l Kidney Found., *Hemodialysis Access: What You Need to Know*, at 7–9 (2006), https://www.kidney.org/sites/default/files/11-50-0216_va.pdf

[13] Amber O. Molnar et al., *Risk Factors for Unplanned and Crash Dialysis Starts: A Protocol for a Systematic Review and Meta-Analysis*, 5 Systematic Revs. 1, 1–2 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4950106/

preventive or preparatory treatments would *harm* the plan's bottom line.

The result is not difficult to foresee. If Petitioners' view were to prevail, health plans would find it hard to resist the financial pressure to cut not just dialysis coverage, but also other forms of care for people with declining kidney function. Thus, for many or most patients diagnosed with chronic kidney disease, the outlook would be bleak indeed.

III. Giving Up Their Private Health Plans Often Forces ESRD Patients To Accept Inferior Coverage.

Finally, the most immediate harm to ESRD patients from Petitioners' position would be simply the loss of private health coverage with benefits that many patients prefer over Medicare's.

As the relevant statutes recognize, when ESRD patients have a choice between their private coverage and Medicare, they often prefer to keep their private coverage for the 30-month coordination period. There are good reasons for this. ESRD patients with Medicare coverage tend to have worse kidney-related health outcomes than those with private insurance.[14] Private insurance often provides a wider choice of doctors, and coverage for more treatments. Private insurance also often covers an ESRD patient's spouse and children, who usually are not eligible for Medicare. Even for the

[14] Yoshio N. Hall et al., *Predictors of end-stage renal disease in the urban poor,* J. Health Care Poor Underserved. 2013 Nov; 24(4): 1686–1700, tbl. 2.

ESRD patient him- or herself, Medicare does not cover dental treatment.[15]

Moreover, for many patients, the cost of Medicare may be substantial. For example, under Medicare Part B—which pays for dialysis treatments—patients who do not qualify for low-income benefits must pay an income-adjusted monthly premium of at least $170.10.[16] Medicare Part B patients also must pay 20% co-insurance on all outpatient procedures—including dialysis—with no out-of-pocket maximum.[17] Similarly, Medicare's prescription-drug benefit also requires participants to pay premiums, deductibles, and co-insurance.[18]

These difficulties hit ESRD patients especially hard. Patients suffering from kidney failure often have a heightened need for other medical treatment as well. For instance, the most common cause of ESRD in the United States is diabetes.[19] Diabetes not only presents its own challenges, but also significantly increases a

---

[15] *Dental Services*, Medicare.gov, https://www.medicare.gov/coverage/dental-services

[16] *2022 Medicare Part A & B Premiums and Deductibles*, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/newsroom/fact-sheets/2022-medicare-parts-b-premiums-and-deductibles2022-medicare-part-d-income-related-monthly-adjustment.

[17] Medicare.gov, *Part B Costs*, https://www.medicare.gov/your-medicare-costs/part-b-costs

[18] Nat'l Council on Aging, *How Much Does Medicare Part D Cost?*, https://www.mymedicarematters.org/costs/part-d/

[19] Seyed Bahman Gaderien et al., *Diabetes and End-Stage Renal Disease; A Review Article on New Concepts*, 4 J. Renal Injury Prevention 28, 28 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4459725/

person's risk of other serious ailments—for instance, it increases the risk of serious eye disease[20] and nearly doubles the likelihood of hearing loss.[21] Other difficulties are encountered by those ESRD patients who are lucky enough to receive a kidney transplant. Those patients must take anti-rejection medications that make them prone to life-threatening infections—especially tooth infections,[22] for which treatment is not covered by Medicare.

Dialysis patients on Medicare also face significant financial burdens. Most ESRD patients must receive over 150 dialysis treatments per year to stay alive. At the current base Medicare allowable cost for dialysis of approximately $258,[23] the 20% co-insurance obligation can cost dialysis recipients more than $50 per treatment—three times a week, every week, indefinitely. Between monthly premiums and coinsurance requirements, ESRD patients on Medicare

---

[20] *See* Nat'l Inst. of Diabetes and Digestive and Kidney Diseases, *Diabetic Eye Disease*, https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/diabetic-eye-disease

[21] Nat'l Insts. of Health, *Hearing Loss Is Common in People with Diabetes* (June 16, 2008), https://www.nih.gov/news-events/news-releases/hearing-loss-common-people-diabetes

[22] Eleni A. Georgakopoulou et al., *Dental Management of Patients Before and After Renal Transplantation*, 13 Baltic Dental and Maxillofacial J. 107, 107–10 (2011), https://www.sbdmj.com/114/114-01.pdf

[23] *See* Ctrs. for Medicare and Medicaid Servs., *CY 2022 End Stage Renal Disease Prospective Payment System Final Rule (CMS-1749-F)*, https://www.cms.gov/newsroom/fact-sheets/cy-2022-end-stage-renal-disease-prospective-payment-system-final-rule-cms-1749-f

may have to pay several thousand dollars out-of-pocket annually just to obtain dialysis—before considering the cost of any other treatments the patient may need.[24]

Thus, if schemes to force ESRD patients onto Medicare like Petitioner's here are allowed, then vulnerable ESRD patients—who are disproportionately low-income[25]—will suffer increased financial burdens for life-sustaining medical care. The Court should not sanction conduct that so plainly violates the statute Congress enacted to protect ESRD patients from such serious harms.

* * *

Dialysis care is exceptional in its life-sustaining importance, in its intensity for the patient, and in its expense. Our national system for paying the cost of dialysis therefore also is exceptional: Medicare guarantees dialysis coverage for every American who needs it. But this in turn creates unique temptations and opportunities for private insurers to shunt dialysis patients directly onto Medicare. And if left unchecked,

---

[24] For some Medicare recipients, some of these costs could be defrayed by the "Medigap" program—but that program generally does not help ESRD patients. Because most ESRD patients are under age 65, Federal law does not require states to offer Medigap coverage to them—and about half of the states do not. *See Ensure ALL Medicare ESRD Patients Have Access to Medigap Plans*, Dialysis Patient Citizens (Sept. 2019) https://www.dialysispatients.org/sites/default/files/medigap_201909.pdf.

[25] *See* United States Renal Data System, *2021 Annual Data Report: End Stage Renal Disease* ch. 1 (2021) (tbl. 1.2); Ward, Michael M., *Socioeconomic Status and the Incidence of ESRD*, 51 Am. J. Kidney Dis. 563, 565-566 (2008).

private insurers could engage in discriminatory conduct that inflicts grave harm on dialysis patients—threatening the financial viability of outpatient dialysis clinics in many parts of the country, eliminating health plans' incentives to cover treatments that prevent or prepare patients for dialysis, and forcing dialysis patients off their private health plans just at the moment they need them most.

Congress recognized these unique pressures and responded to them with the anti-discrimination statutes at issue in this case. But if Petitioners' argument here prevails, those statutes will become a dead letter, and dialysis patients will be exposed to all the harms that the statutes were intended to prevent. The Court should reject that outcome and hold that Petitioners' plan terms are unlawful.

CONCLUSION

The judgment should be affirmed.

Respectfully submitted,

NICHOLAS NELSON
Counsel of Record
JEFFREY S. ROBERTS
FAEGRE DRINKER BIDDLE & REATH LLP
2200 Wells Fargo Ctr.
90 S. Seventh St.
Minneapolis, MN 55402
(612) 766-7205
nicholas.nelson@faegredrinker.com

Jackson Williams
DIALYSIS PATIENT CITIZENS
1001 Connecticut Ave, NW
Suite 1230
Washington, DC 20036

Counsel for Amicus Curiae Dialysis Patient Citizens