No. 20-1641

In the Supreme Court of the United States

MARIETTA MEMORIAL HOSPITAL EMPLOYEE HEALTH BENEFIT PLAN, ET AL., PETITIONERS,
v.
DAVITA INC., ET AL., RESPONDENTS.

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

BRIEF OF CONGRESSMAN WILLIAM THOMAS AS *AMICUS CURIAE* SUPPORTING RESPONDENTS

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QUESTIONS PRESENTED

1. Whether the Medicare Secondary Payer Act's ("MSPA") prohibition on group health plans differentiating between individuals with end-stage renal disease ("ESRD") and those without "on the basis of . . . the need for renal dialysis" or "in any other manner," 42 U.S.C. § 1395y(b)(1)(C)(ii), forbids a plan from targeting ESRD patients for disfavored treatment by providing inferior benefits for outpatient dialysis services on which ESRD patients uniquely depend to live.

2. Whether the MSPA's prohibition of plans "tak[ing] into account" an ESRD patient's eligibility for Medicare, 42 U.S.C. § 1395y(b)(1)(C)(i), forbids a group health plan that has been designed with participants' ESRD-related Medicare eligibility in mind.

3. Whether the MSPA prohibits group health plans with terms that have a disparate impact on plan enrollees with ESRD.

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INTEREST OF *AMICUS CURIAE*[1]

Amicus Curiae Congressman William Thomas represented the Bakersfield, California area in the United States House of Representatives from 1978–2007. *See* Biographical Directory of the United States Congress, *Thomas, William Marshall*.[2] Congressman Thomas was a longtime member of the House Ways and Means Committee and the primary architect of the Medicare legislation enacted by Congress from 1995 to 2007. *See* Biographical Directory, *supra*; FCIC at Stanford Law School, *Hon. Bill Thomas*.[3]

Congressman Thomas became the chairman of the Ways and Means Committee's Subcommittee on Health in 1995. *See* FCIC, *supra*. In that role, he spearheaded the Medicare provisions in the Balanced

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[1] Under Rule 37.6, *Amicus Curiae* Congressman William Thomas affirms that no counsel for a party authored this brief, in whole or in part, and that no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. Other than *Amicus Curiae* and his counsel, the only entities to have made a monetary contribution to this brief's preparation or submission are the McManus Group, LLC and Fresenius Medical Care. All parties have consented to the filing of this merits-stage amicus brief in writing. Rule 37.3.

[2] Available at https://bioguide.congress.gov/search/bio/T000188 (all websites last visited on Jan. 25, 2022).

[3] Available at http://fcic.law.stanford.edu/about/biographies/bill-thomas.

Budget Act of 1997, drafting the House bill and leading the conference-committee negotiations resulting in the final agreement that ultimately became law. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, tit. IV, 111 Stat. 251 (1997). The Medicare provisions that Congressman Thomas designed enhanced the Medicare Secondary Payer Act's coordination-of-benefits period for individuals with ESRD, Pub. L. No. 105-33, tit. IV, § 4631, 111 Stat. at 486; *infra* p. 11—the component of Medicare at issue in this case, Pet.App. 9–14.

In 2001, Congressman Thomas became the Chairman of the full Ways and Means Committee, authoring more landmark Medicare legislation. *See* Biographical Directory, *supra*; FCIC, *supra*. In that position, Congressman Thomas authored the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003), which built upon the Medicare reforms in the Balanced Budget Act of 1997. Those reforms included, for example, the creation of more private-plan options for senior citizens via Medicare Advantage's comprehensive medical plans, as well as an outpatient drug benefit delivered through competitive private-insurance plans (*i.e.*, Medicare Part D). *See* Congressional Research Service, RL31966, *Overview of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*

1–2 (Dec. 6, 2004).[4] Like the Balanced Budget Act of 1997, the Medicare Modernization Act of 2003 also strengthened the MSPA at issue here by clarifying that the government may demand reimbursement for Medicare expenses (plus a penalty) from group health plans that fail to make required payments for the health costs of Medicare beneficiaries. *See* Pub. L. No. 108-173, § 301, 117 Stat. at 2221; Congressional Research Service, RL33587, *Medicare Secondary Payer: Coordination of Benefits* 26(May 8, 2014);[5] Pet.App. 12–13 (quoting 42 U.S.C. § 1395y(b)(2)(B)(iii)).

Given Congressman Thomas' focus on Medicare during his distinguished career in Congress, he is uniquely qualified to comment on the core design of the MSPA provisions at issue in this case.

INTRODUCTION AND SUMMARY OF ARGUMENT

In 1972, Congress expanded Medicare to cover individuals diagnosed with end-stage renal disease, a devastating illness involving the permanent cessation of kidney function. Congress added these individuals to Medicare to ensure that they would receive the

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[4] Available at https://crsreports.congress.gov/product/pdf/RL/RL31966/2.

[5] Available at https://crsreports.congress.gov/product/pdf/RL/RL33587/15.

then-emerging, cost-prohibitive, lifesaving dialysis treatment that they needed.

While Congress' core goal was as deeply laudable in 1972 as it is today, this expansion of Medicare to individuals with ESRD also created an unfortunate, perverse incentive for private group-health plans. That is, after 1972, these plans had every financial incentive to exclude coverage of the leading ESRD treatment—dialysis—thereby saving themselves a lot of money at the public's expense. These group health plans' economically inevitable exclusion of dialysis forced ESRD individuals off of these plans' own enrollment rolls and onto Medicare. This significantly burdened the public fisc and led to worse health outcomes for many ESRD patients.

Congress responded with a series of amendments to the MSPA, ending this perverse-incentive problem. With these amendments, Congress coordinated the payment of treatment for ESRD individuals by requiring group health plans to be the primary payer of benefits for these individuals for twelve months (eventually extended to thirty months), with Medicare as the secondary payer. Then, with the MSPA's "anti-differentiation provision," Congress prohibited group health plans from adopting plan provisions that discriminate against, as relevant, "the need for renal dialysis" or—in a broadly worded phrase covering any unforeseen discriminatory scheme—"in any other manner."

Finally, with the MSPA's "take-into-account provision," Congress bolstered the anti-differentiation provision's protections by prohibiting group health plans from taking an ESRD individual's Medicare eligibility into account. And since this decisive action from Congress, nearly all group health plans have complied with these MSPA amendments, creating a functioning dialysis market that enables ESRD individuals to obtain this lifesaving treatment, despite its cost, without threatening the public fisc.

Petitioners cynically believe that they have found a loophole that would allow any group health plan to render Congress' careful protection of the public fisc a dead letter, turning the clock back to the period immediately after 1972. Rather than treat dialysis patients on an equal footing as the MSPA plainly requires, Petitioners have adopted a health plan that includes numerous provisions targeting dialysis—and only dialysis—for disfavored treatment. These dialysis-targeting provisions violate the text and core design of the MSPA's anti-differentiation provision, including its catchall "in any other manner" term, as well as its take-into-account provision. Petitioners' transparent effort to force ESRD individuals out of their group health plans and onto Medicare is indistinguishable from the perverse actions of group health plans immediately after 1972. Simply put, if this Court adopts Petitioners' position, that will defeat entirely Congress' core design in enacting the amendments to the MSPA at issue here.

ARGUMENT

I. Congress Carefully Designed The MSPA To Protect The Public Fisc

In interpreting a statute, this Court "begins with the text," *Ross v. Blake*, 578 U.S. 632, 638 (2016) (citation omitted), reading the words "in their context and with a view to their place in the overall statutory scheme," *Gundy v. United States*, 139 S. Ct. 2116, 2126 (2019) (quotation omitted). This Court also often looks to "statutory history" to "shed[ ] further light" on the statutory language, because "[w]hen Congress acts to amend a statute," it "intends its amendment to have real and substantial effect." *United States v. Quality Stores, Inc.*, 572 U.S. 141, 148–49 (2014) (citation omitted). This Court construes a statute to give "effect . . . to all its provisions, so that no part will be inoperative or superfluous, void or insignificant." *Corley v. United States*, 556 U.S. 303, 314 (2009) (citation omitted).

The present case turns on the interpretation of the ESRD-related amendments to the MSPA. Once Congress extended Medicare coverage to individuals with ESRD in 1972, this inadvertently financially encouraged group health plans to force their ESRD enrollees off of their plans and onto Medicare. *Infra* Part I.A. Congress ended this perverse financial incentive with its amendments to the MSPA, which amendments maintained ESRD individuals' full access to lifesaving treatments, while stopping group

health plans' practice of prematurely forcing these individuals onto Medicare. *Infra* Part I.B. Congress thus successfully designed these amendments to preserve the public fisc. *Infra* Part I.C.

A. Congress In 1972 Expanded Medicare To Cover Individuals With ESRD, But This Laudable Reform Also Inadvertently And Perversely Incentivized Private Plans To Force ESRD Individuals Onto Medicare

In 1972, Congress amended Medicare to extend Medicare coverage to individuals with ESRD, regardless of age or disability. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 299I, 86 Stat. 1429, 1463–64 (1972); Pet.App. 9. Medicare thus became "the primary payor of benefits for end-stage renal patients." S. Rep. No. 97-139 (1981), 1981 WL 21357 at *735; Pet.App. 9. This "marked the first time" that Congress allowed individuals "to enroll in Medicare based on a specific medical condition rather than on age." Congressional Research Service, R45290, *Medicare Coverage Of End-Stage Renal Disease (ESRD)* 1 (Aug. 16, 2018).[6] To this day, ESRD remains the only disease that makes an individual specifically eligible for Medicare, regardless of age or disability, in this manner. *See* Medicare.gov, *What's*

[6] Available at https://crsreports.congress.gov/product/pdf/R/R45290/4.

Medicare?;[7] Congressional Research Service, *Medicare Secondary Payer*, *supra*, at 6 n.25; *see generally id.* at 6 n.24 (noting that Congress has waived the waiting period for Medicare eligibility for disabled individuals with amyotrophic lateral sclerosis (*i.e.*, ALS)).

Congress extended Medicare coverage to individuals with ESRD due to the lethality of this disease, the prohibitive costs of treating it effectively, and the "indirect [economic] costs" that this disease inflicts on the Nation. S. Rep. No. 92-1230, at 1243–44 (1972) (statement of Sen. Hartke). In 1972, kidney disease was "the fifth leading cause of death in this country." *Id.* at 1243. While doctors "ha[d] learned how to treat or cure" this disease, treatments like dialysis—which is extremely efficacious, and was at that time relatively new—were "not available to most Americans because of their cost." *Id.*; *see generally* Congressional Research Service, *Medicare Coverage of End-Stage Renal Disease (ESRD)*, *supra*, at 3–6 (discussing main treatments of ESRD, including dialysis). For example, "[m]ore than 8,000 Americans w[ould] die th[at] year from kidney disease who could have been saved if they had been able to afford an artificial kidney machine [*i.e.*, dialysis] or transplantation." S. Rep. No. 92-1230 at 1244; Congressional Research Service, *Medicare Coverage of End-Stage Renal Disease (ESRD)*, *supra*, at 6

[7] Available at https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare.

("ESRD patients initially had difficulty obtaining the new treatments because of cost and limited availability."). In addition to the human tragedy of these avoidable deaths, this imposed "indirect costs" like "lost future income." S. Rep. No. 92-1230 at 1243–44. In terms of these indirect costs, "kidney disease is the highest ranking killer, costing the country $1.5 billion annually," *id.*, roughly $10 billion in today's dollars. It is the only disease, to this day, that is explicitly covered by Medicare without regard to age or disability in this manner. *See supra* p. 8.

Congress' laudable expansion of Medicare to individuals with ESRD also inadvertently created a perverse incentive for group health plans to shift their costs to the public fisc. These plans quickly realized that they could avoid the significant costs of vital ESRD treatments by including "provisions that [were] intended to prevent payment of benefits where the insured is also entitled to benefits as a result of coverage under programs such as Medicare." S. Rep. No. 97-139, 1981 WL 21357 at *735. "[S]ince Medicare pa[id] first and provide[d] very comprehensive benefits for those with end-stage renal disease, private plans pa[id] little of the expenses incurred by most end-stage renal patients," shifting these costs to Medicare and the public fisc instead. S. Rep. No. 92-1230 at 1243–44. This shifting of ESRD enrollees to Medicare also harmed these individuals' health quality, in addition to burdening the public fisc, since private delivery of care leads to better health outcomes as compared to government-

run, fee-for-service programs like Medicare. *See* Kevin D. Dayaratna, *Studies Show: Medicaid Patients Have Worse Access And Outcomes Than The Privately Insured*, The Heritage Foundation Backgrounder No. 2740 (Nov. 9, 2012) (collecting studies).[8]

B. Congress Solved This Perverse-Incentive Problem With Comprehensive Amendments To The MSPA

Starting with the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 (1981), Congress enacted important, carefully interlocking reforms that prohibited group health plans from forcing ESRD enrollees off of their health plans and onto Medicare, ending the perverse-incentive problem described immediately above. Pub. L. No. 97-35, § 2146(a) & (b), 95 Stat. 357, 800–801; S. Rep. No. 97-139, 1981 WL 2135 at *735–36; Pet.App. 10.

The Omnibus Budget Reconciliation Act of 1981 first amended the MSPA to require the coordination of payments made by Medicare and group health plans for the treatment of individuals with ESRD. Pub. L. No. 97-35, § 2146(a), 95 Stat. at 800–801; S. Rep. No. 97-139, 1981 WL 21357 at *735–36; Pet.App. 10. As amended in 1981, the MSPA required

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[8] Available at https://www.heritage.org/health-care-reform/report/studies-show-medicaid-patients-have-worse-access-and-outcomes-the.

group health plans covering individuals with ESRD to be the primary payers of that individual's ESRD treatment for an initial period, with Medicare as the secondary payer. Pub. L. No. 97-35, § 2146, 95 Stat. at 800–01; S. Rep. No. 97-139, 1981 WL 21357 at *735–36. While Congress initially set this ESRD coordination-of-benefits period at twelve months, Pub. L. No. 97-35, § 2146, 95 Stat. at 801, Congress ultimately expanded this period to thirty months. First, in the Omnibus Budget Reconciliation Act of 1990, Congress extended the original twelve-month period to eighteen months. Pub. L. No. 101-508, tit. IV, § 4203, 104 Stat. 1388, 1388-107–08. Then, in the Balanced Budget Act of 1997, Congress again extended this period to thirty months. Pub. L. No. 105-33, § 4631, 111 Stat. at 486.

The Omnibus Budget Reconciliation Act of 1981 also added Medicare's broad, ESRD anti-differentiation provision to the MSPA. Pub. L. No. 97-35, § 2146(b), 95 Stat. at 801; S. Rep. No. 97-139, 1981 WL 21357 at 736; *see also* Pet.App. 10, 41–51. With this expansive statutory enactment, Congress prohibited a group health plan from receiving valuable tax deductions "if the plan differentiates 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." Pub. L. No. 97-35, § 2146(b); S. Rep. 97-139, 1981 WL 21357 at *735; Pet.App. 10–11. Or, as the Senate Report describes it, the Act "den[ies] deduction[s] as a business

expense to any employer [for] the expenses paid or incurred by such employer for a health plan, if such plan contains a *discriminatory provision* that reduces or denies payment of benefits for renal patients." S. Rep. 97-139, 1981 WL 21357 at *735 (emphasis added). This provision—including its comprehensive "any other" manner language, a catchall to capture any unforeseen plan methodologies meant to discriminate against ESRD enrollees that were not explicitly stated in the statute—penalizes those group health plans that use ESRD-discriminatory tactics, securing Congress' goal of preventing plans from prematurely offloading expensive ESRD enrollees onto Medicare. *See id.* at 735–36; Pet.App. 10.

Congress thereafter strengthened the MSPA's anti-differentiation provision with the Omnibus Budget Reconciliation Act of 1989, adding the take-into-account provision. Pub. L. No. 101-239, §6202(b)(1)(B), 103 Stat. 2106, 2230 (1989); *see* Pet.App. 51–53. Under this provision, a group health plan may not "take into account that an active individual . . . is entitled to [Medicare] benefits" due to a diagnosis of ESRD during the MSPA coordination period. Pub. L. No. 101-239, §6202(b)(1)(B), 103 Stat. at 2230. This further prevents group health plans from avoiding the MSPA's coordination period with ESRD-related discriminatory plan terms, bolstering Congress' protections of the public fisc and its goal of keeping ESRD individuals on their private plans.

Today, the language of the MSPA's anti-differentiation provision and the take-into-account provision remain substantively unchanged, even after "several decades of amendments" to Medicare by Congress in other respects. Pet.App. 11; *see* Congressional Research Service, *Medicare Coverage Of End-Stage Renal Disease (ESRD)*, *supra*, at 1. These provisions still broadly prevent group health plans from shirking their responsibilities to provide primary coverage for the treatment of individuals with ESRD during the MSPA's relevant coordination period, the very perverse behavior that group health plans had engaged after 1972. *See supra* Part I.A.

C. Through Its Amendments To The MSPA, Congress Protected The Public Fisc From The Perverse-Incentive Problem That It Had Created In 1972

Congress enacted these reforms to the MSPA to save substantial public funds. At the time of the Omnibus Budget Reconciliation Act of 1981, Congress estimated that its amendments would save $95 million in 1982, $165 million in 1983, and $180 million in 1984. S. Rep. No. 97-139, 1981 WL 21357 at *735–36. Congress likewise expected significant cost savings when, for example, it extended the MSPA's coordination-of-benefits period to thirty months in the Balanced Budget Act of 1997. The Congressional Budget Office estimated that this extension, along with other changes to Medicare in the Omnibus Budget Reconciliation Act of 1990,

would "save $7.5 billion between 1998 and 2002" alone, Congressional Budget Office, *CBO Memorandum: Budgetary Implications of the Balanced Budget Act of 1997* at 45 (Dec. 1997),[9] while the House Report estimated that the extension of the MSPA period for ESRD would save $19.2 billion over ten years, H.R. Rep. No. 105-149 at 1,404 (1997).[10]

All of these savings accrue in the same, carefully designed way. Specifically, Congress' amendments to the MSPA keep group health plans—rather than Medicare—as the primary payer of treatment for individuals with ESRD for a longer period of time, thus shortening the time that Medicare must cover these individuals' significant health costs. Further, these savings compound every year that these provisions remain in effect, creating lasting

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[9] Available at https://www.cbo.gov/sites/default/files/105th-congress-1997-1998/reports/bba-97.pdf.

[10] The Balanced Budget Act of 1997 also furthered Congress' goal of increasing private delivery of health care—rather than delivery via government-run, fee-for-service programs—for the entire Medicare population, not just for those with ESRD. Specifically, this law established the Medicare+Choice program (later renamed Medicare Advantage), which offered multiple private-plan options to Medicare enrollees. *See* Statement of William J. Scanlon, U.S. General Accounting Office, *Impact of 1997 Balanced Budget Act Payment Reforms on Beneficiaries and Plans* 1 (June 9, 1999), *available at* https://www.gao.gov/assets/t-hehs-99-137.pdf.

protection for the public fisc that helps maintain Medicare's solvency.

The continuing high cost of ESRD treatments today underscores the wisdom of Congress' design in the MSPA's ESRD-related provisions, as well as the continued vital importance of these protections. Individuals with ESRD remain among the most expensive class of Medicare enrollees to treat, given the high volume of dialysis treatments that they require and the cost of treating the common co-morbidities from which these individuals suffer. *See* Congressional Research Service, R46655, *Medicare Advantage (MA) Coverage of End Stage Renal Disease (ESRD) and Network Requirement Changes* 1, 13 (Jan. 11, 2021).[11] According to the Medicare Payment Advisory Commission, in 2018 individuals with ESRD comprised 0.8% of the 60.9 million individuals on Medicare—or 487,200 people—yet accounted for 4.8% of Medicare's $767 billion of expenditures, or $36.8 billion. *See* Medicare Payment Advisory Commission, *A Data Book: Health Care Spending And The Medicare Program* 19 (July 2021);[12] *see generally* U.S. Renal Data System, Annual Data Report, End Stage

[11] Available at https://crsreports.congress.gov/product/pdf/R/R46655.

[12] Available at https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/data-book/july2021_medpac_databook_sec.pdf.

Renal Disease: Chapter 9 (2021).[13] Thus, "[a] disproportionate share of Medicare expenditures is on behalf of Medicare beneficiaries with ESRD." Medicare Payment Advisory Commission, *supra*, at 19. Indeed, "[o]n average, these beneficiaries incur spending that is more than six times greater than spending for aged beneficiaries (ages 65 years and older without ESRD) and more than four times greater than spending for beneficiaries under age 65 with a disability (non-ESRD)." *Id.* For example, and more granularly, individuals with ESRD who underwent dialysis that was reimbursed by Medicare cost Medicare about $8,000 per month, as compared to the $1,000 per month cost that Medicare incurs for the typical beneficiary. Congressional Research Service, *Medicare Advantage*, *supra*, at 13. Nor is there any indication that these trends will change in the future, as "[t]he ESRD population is growing, and most patients with ESRD undergo dialysis." Medicare Payment Advisory Commission, *supra*, at 187 (emphasis omitted).

Equally important as Congress' goal to protect the public fisc was its understanding that preserving private coverage for a portion of ESRD individuals would help sustain the ESRD-treatment ecosystem, since commercial reimbursement rates are substantially greater than Medicare reimbursement rates—which rates do not cover the full cost of care.

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[13] Available at https://adr.usrds.org/2021/end-stage-renal-disease/9-healthcare-expenditures-for-persons-with-esrd.

The vast majority of individuals with ESRD are on Medicare, with only a minority receiving coverage from a private health plan. *See* Medicare Payment Advisory Commission, *supra*, at 28; Congressional Research Service, *Medicare Coverage of End-Stage Renal Disease (ESRD)*, *supra*, at 7–8. Medicare reimburses outpatient dialysis services at a fraction of the cost of the reimbursement rates from private health insurance plans, which rates private health plans negotiate with the providers directly.[14] For example, in 2017, "commercial insurers" paid Respondent DaVita—"one of the largest dialysis suppliers" in the country—at multiple "times the rate of [its] government peers" for outpatient dialysis services. Christopher P. Childers, *et al.*, *A Comparison Of Payments To A For-Profit Dialysis Firm From Government And Commercial Insurers*, JAMA Intern. Med. 2019; 179(8):1136–38 (May 13, 2019) ($248 in revenues per treatment for government insurers, but $1041 in revenue per

[14] This is consistent with Medicare reimbursement rates outside of the dialysis sphere, which are usually substantially less than commercial-insurance reimbursement rates. However, the multiple for dialysis facilities as compared to other health care providers is much greater while the share of privately covered patients is much lower. *See* Eric Lopez, *et al.*, *How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature*, Kaiser Family Foundation (Apr. 15, 2020), *available at* https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/.

treatment for commercial insurers).[15] These low reimbursement rates do not cover the costs to provide these outpatient dialysis services, meaning that the relatively small private-insurance-funded ESRD population that companies like Respondents serve is subsidizing the access to lifesaving dialysis of the much larger Medicare-funded ESRD population, *see id.* (explaining that "mean expenses" per treatment were $269)—a subsidy that necessarily saves substantial Medicare dollars in the public fisc.[16]

Finally, and notably, beyond its plan to save substantial public funds, Congress enacted its reforms to the MSPA with the understanding that private coverage leads to better health outcomes for ESRD individuals. *See* Dayaratna, *supra*. Individuals with ESRD who have private health insurance are more likely to obtain a kidney transplant (the only viable alternative treatment to dialysis, *see* Congressional Research Service *Medicare Coverage Of End-Stage Renal Disease (ESRD)*, *supra*,

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[15] Available at https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2732689.

[16] Private health insurance's subsidization of Medicare recipients' access to dialysis facilities explains why Congress did not enact an annual provider payment update for dialysis until 2008, with the Medicare Improvements for Patients and Providers Act of 2008. Pub. L. No. 110-275, 122 Stat. 2494 (2008); *see generally* Congressional Research Service, RL 34592, *P.L. 110-275: The Medicare Improvements for Patients and Providers Act of 2008* at 17–18 (July 23, 2008), *available at* https://crsreports.congress.gov/product/pdf/RL/RL34592/7.

at 3–6) than those receiving coverage via Medicare, *see* Kristen L. King, *et al.*, *Trends In Disparities in Preemptive Kidney Transplantation in the United States*, Clin J. Am. Soc. Nephrol. 2019 Oct 7;14(10):1500–11 (Epub Sept. 26, 2019).[17] Further, individuals with ESRD who have private health insurance will often receive a better suite of health-care benefits, such as vision and dental insurance, than that offered by Medicare. *Compare* Medicare.gov, *Eye Exams (Routine)* (explaining that Medicare does not include vision benefits);[18] Medicare.gov, *Dental Services* (same as to dental benefits).[19] These additional benefits are critical for treating the comorbidities of ESRD, including especially diabetes. *See* Johns Hopkins Medicine, *Diabetic Nephropathy (Kidney Disease)*;[20] Mayo

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[17] *See also* J.D. Schold, *et al.*, *Association of Candidate Removals From the Kidney Transplant Waiting List and Center Performance Oversight*, Am. J. Transplant. 2016 Apr;16(4):1276–84 (Epub Jan. 14, 2016); Kristen L. Johansen, *et al.*, *Association of Race and Insurance Type with Delayed Assessment for Kidney Transplantation among Patients Initiating Dialysis in the United States*, Clin. J. Am. Soc. Nephrol. 2012 Sep;7(9):1490-7 (Epub July 26, 2012).

[18] Available at https://www.medicare.gov/coverage/eye-exams-routine.

[19] Available at https://www.medicare.gov/coverage/dental-services.

[20] Available at https://www.hopkinsmedicine.org/health/conditions-and-diseases/diabetes/diabetic-nephropathy-kidney-disease.

Clinic, *Diabetes And Dental Care: Guide To A Healthy Mouth* (Nov. 3, 2020);[21] Mayo Clinic Health System, *Diabetes And Your Eyes* (Nov. 6, 2014).[22]

II. Petitioners' Atextual, Easy-To-Replicate Scheme Would Gut Congress' Objectives In Its Amendments To The MSPA, Re-Imposing The Very Harms To The Public Fisc That Congress Sought To Avoid

Since Congress provided that Medicare is secondary to employer-provided group coverage for ESRD under the MSPA's ESRD coordination, anti-differentiation, and take-into-account provisions, *supra* Part I.B, nearly all group health plans have complied with the clear text and design of these provisions by maintaining primary coverage for their ESRD enrollees without discrimination. This public-private coordination has ensured that individuals with ESRD continue to obtain the lifesaving treatments that they need—either through private group-health plans or through Medicare—without jeopardizing the public fisc. *Supra* Part I.B–C.

Petitioners cynically believe that they have found a loophole that allows them to include multiple ESRD-discriminatory terms in their group health

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[21] Available at https://www.mayoclinic.org/diseases-conditions/diabetes/in-depth/diabetes/art-20043848.

[22] Available at https://www.mayoclinichealthsystem.org/hometown-health/speaking-of-health/diabetes-and-your-eyes.

plan, thus recreating the very perverse incentives that Congress sought to end with its amendments to the MSPA. Pet.App. 4–5. Petitioners' plan places "*all* dialysis providers . . . out-of-network and [ ] thus subject to lower reimbursement amounts than [other] providers[.]" Pet.App. 5. Then, the plan subjects dialysis providers to an "alternative basis for payment," which is "typically" 125% of the "current Medicare allowable fee." Pet.App. 5. Finally, "for the dialysis service itself," the plan reimburses at "87.5% of the Medicare rate," which is "already lower than the industry-wide definition of a 'reasonable and customary' fee." Pet.App. 5; *see also* Resp'ts Br. 12–16. So, with these multiple unfavorable terms, Petitioners' plan singles out individuals who need dialysis—and only these individuals—for markedly reduced benefits and higher cost-sharing, attempting to push these individuals off of the plan and onto Medicare, thereby avoiding the significant costs of treating these individuals.

Petitioners' plan violates the plain text of the MSPA's anti-differentiation provision and take-into-account provision. *Ross*, 578 U.S. at 638; *Gundy*, 139 S. Ct. at 2126. Beginning with the anti-differentiation provision, Petitioners' plan impermissibly differentiates on "the need for renal dialysis," 42 U.S.C. § 1395y(b)(1)(C)(ii), by singling out dialysis treatment *alone* for unfavorable benefits, despite this treatment's inextricable link to individuals with ESRD, *see Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993) ("A

tax on wearing yarmulkes is a tax on Jews."); Congressional Research Service, *Medicare Coverage of End-Stage Renal Disease (ESRD)*, *supra*, at 5. It also differentiates between ESRD individuals "in any other manner," § 1395y(b)(1)(C)(ii)—which is an "expansive" phrase covering "*any other*" form of discrimination that Congress may not have specifically foreseen at the time of this provision's enactment, *Harrison v. PPG Industries, Inc.*, 446 U.S. 578, 588–89 (1980), including Petitioners' plan here. As for the take-into-account provision, Petitioners' plan impermissibly "take[s] into account" that an individual with ESRD may be eligible for Medicare during the coordination period, §1395y(b)(1)(C)(i), by "expressly target[ing] dialysis treatment" with the intent to "move ESRD enrollees prematurely onto Medicare"—which is only possible because of these enrollees' Medicare eligibility—as Respondents persuasively explain, Resp'ts Br. 43–44.

Petitioners' scheme—if approved by this Court—would introduce an enormous loophole into the MSPA, evaporating the savings to the public fisc that Congress sought to achieve. By offering uniquely unfavorable coverage for dialysis treatment, as compared to its other offerings, Petitioners' plan effectively forces individuals with ESRD onto Medicare prematurely—*the very mechanism that Congress amended the MSPA to prevent*. *See supra* Part I.B. And, of course, the loophole in the MSPA that Petitioners claim to have found would not end with their plan alone. If they prevail here, then many

other group health plans across the country could—*and, being economically rational, surely would*—quickly adopt the ESRD-discriminatory features of Petitioners' plan so as to realize significant cost savings at the expense of Medicare and, in turn, the public fisc. That would inevitably push even more individuals with ESRD off of their group health plans and onto Medicare, burdening the public fisc in the exact manner that Congress was concerned about when it amended the MSPA.

This unavoidable cascade of plans evading Congress' protections in the MSPA would upend the foundational, shared partnership between private health insurance and Medicare that is necessary to sustain dialysis care for all individuals with ESRD. If group health plans can now effectively force their ESRD enrollees onto Medicare by adopting discriminatory plan terms like those of Petitioners, then these plans would cease paying the robust reimbursement rates to facilities for dialysis treatment that they currently pay. *See supra* Part I.C. Without this robust funding that private group-health plans provide, the financial viability of dialysis centers would be put at risk, and dialysis care for ESRD individuals enrolled in Medicare and across the board could collapse. That is not a risk worth taking—and it is contrary to Congress' design in enacting the amendments to the MSPA.

CONCLUSION

This Court should affirm the judgment of the Sixth Circuit.

Respectfully submitted,

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