

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 THE NATIONAL ASSOCIATION FOR
THE ADVANCEMENT OF COLORED PEOPLE
AS *AMICUS CURIAE* IN SUPPORT OF
RESPONDENTS**

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INTEREST OF *AMICUS CURIAE*¹

The National Association for the Advancement of Colored People (“NAACP”) is the nation’s oldest and largest civil rights organization. It was founded in 1909 when eruptions of anti-Black violence, particularly lynchings, were horrifically commonplace. The principal objectives of the NAACP are to ensure the political, educational, social, and economic equality of rights, including seeking the enactment and enforcement of federal, state, and local laws securing civil rights.

The NAACP’s interest in this case stems from its work related to the health of Black families, which has never been more urgent. The NAACP works to create and maintain an inclusive culture of healthy people and communities with emphases on healthy diet, vaccinations, and preventative care. It collaborates with communities to improve the social determinants of health—racism, poverty, exclusion, inferior schools, unsafe housing, poor nutrition, and toxic environments.

Among other points of emphasis, the NAACP has focused on kidney failure or end stage renal disease (“ESRD”), a devastating illness that disproportionately affects communities and families of color. Black Americans are nearly four times as likely to develop ESRD than Whites. U.S. Renal Data Sys., Nat’l Inst. of Diabetes & Digestive & Kidney Diseases,

¹ The parties have consented to the filing of this brief. Under Rule 37.6 of the Rules of this Court, *amicus* states that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus* or its counsel made a monetary contribution to its preparation or submission.

2021 Annual Data Report: Epidemiology of Kidney Disease in the United States, fig. 1.8 (2021) (“USRDS Annual Report”), <https://adr.usrds.org/2021/end-stage-renal-disease/1-incidence-prevalence-patient-characteristics-and-treatment-modalities>. Hispanic Americans are approximately twice as likely. *Id.* However, Black and Hispanic Americans are far less likely to receive a kidney transplant or even pre-ESRD care. *Id.* at figs. 1.10, 1.11. These disparities are longstanding, *id.* at fig. 1.8, and mirror broader inequities in the American health care system. See, e.g., R. Thebault et al., *The Coronavirus Is Infecting and Killing Black Americans at an Alarming High Rate*, Wash. Post (Apr. 7, 2020), <https://www.washingtonpost.com/nation/2020/04/07/coronavirus-is-infecting-killing-black-americans-an-alarmingly-high-rate-post-analysis-shows/?arc404=true>; M. MacDorman et al., *Racial and Ethnic Disparities in Maternal Mortality in the United States Using Enhanced Vital Records, 2016-2017*, 111 Am. J. Pub. Health 1673, 1676 (2021).

The NAACP has launched a series of town hall events in communities across the country to improve knowledge about kidney disease and dialysis treatment options. In 2019, the NAACP passed a resolution demanding greater equity in treatment for kidney disease and ESRD. See NAACP, *2019 Resolutions*, <https://naacp.org/resources/2019-naacp-resolutions>. And in recent years, it has engaged with the federal government to prevent private health care plans, like Petitioners’, from designing terms to force ESRD patients to enroll in Medicare prematurely.

According to the allegations of the complaint, Petitioners refused to provide in-network dialysis services and “single[d] out dialysis services for ... reimbursement limitations,” JA13, specifically by

reimbursing dialysis treatment and dialysis-related drugs at abnormally low rates. JA13-15. That “differential treatment of dialysis patients directly and severely impacted Patient A” by causing Patient A to drop coverage under Petitioners’ plan and enroll in Medicare before the 30-month coordination-of-care period was over. JA14-15. If other plans take similar actions, which they will unless the decision below is affirmed, then many ESRD patients will quickly be pushed off their private coverage and a wide range of individuals who receive an ESRD diagnosis will be drastically affected. As a result, ESRD patients and their families will suffer the very harms that Congress meant to avoid when it established and expanded the now 30-month coordination period, in which patients are entitled to retain their existing health plans as the primary source of coverage. This brief focuses on three key sources of harm:

- **ESRD patients would become less suitable candidates for kidney transplants.** Although dialysis preserves the lives of ESRD patients in the short-term, it is no panacea. Only a transplant can provide enduring relief from the ravages of kidney failure. In part because there are persistent shortages of transplantable kidneys, transplant eligibility is also closely restricted. One factor considered for transplant eligibility is the candidate’s insurance status and, specifically, access to dental care. Because Medicare does not cover certain important health services (such as dental care) that are essential to maintaining eligibility for a kidney transplant, Petitioners’ approach would make fewer ESRD patients eligible for a potentially life-saving transplant.

- **Many families would lose employer-based health insurance.** Medicare covers individuals only. It does not provide coverage to the families of Medicare beneficiaries. So, if an ESRD patient is pushed off a private plan and onto Medicare, the patient's family will lose eligibility for the private plan without gaining any substitute coverage under Medicare.
- **ESRD patients will suffer disruption in their longstanding network of physicians as they are shunted from one insurance system to another without the transition period that Congress intended.** ESRD patients typically suffer from other significant health conditions that require continuous care to avoid serious and sometimes irreversible impairment to health. The 30-month coordination period gives patients time to transition their care to new providers if their private plan providers do not take Medicare. Petitioners' approach would cut against Congress's wise plan, instead pressing ESRD patients to move prematurely to Medicare.

Congress meant to spare ESRD patients from all of this when it established special measures to provide for their care through a combination of private and public insurance. Because ESRD is a devastating illness, and because Black Americans and other communities of color are significantly overrepresented among those suffering from ESRD, the NAACP has a strong interest in ensuring that statutory protection for ESRD patients is preserved to the full measure that Congress intended. The NAACP accordingly urges the Court to affirm the judgment below.

SUMMARY OF ARGUMENT

This Court has received briefs from Petitioner and its *amici* (including the United States) that discuss the implications of the Court's decision for the parties' finances, for the Medicare Trust Fund, for the health care system more broadly, and for certain legal doctrines.

Largely missing from the picture painted by these briefs is what the Court's decision in this case will mean for the lives and health of ESRD patients and their families. The brief for the United States is a case in point. It describes the policy ramifications of Petitioners' plan as "troubling," United States Br. at 15, but appears to limit its concern to the cost implications for the Medicare Trust, *id.* at 23. But make no mistake: Patients suffering from ESRD have an enormous stake in the outcome of this case. Petitioners' position, if adopted, will have a potentially catastrophic impact on large numbers of ESRD patients, particularly patients of color.

ESRD is the final stage of chronic kidney disease. When patients reach this point, their kidneys no longer function, meaning, most importantly, that they have stopped filtering waste from the blood. This waste builds up and becomes toxic. Without a kidney transplant or dialysis, these patients will not survive more than a few weeks. N. O'Connor, *Survival After Dialysis Discontinuation and Hospital Enrollment for ESRD*, 8 Clin. J. Am. Soc. Nephrol. 2117, 2118 (2013), <https://cjasn.asnjournals.org/content/8/12/2117>.

Both transplant and dialysis require significant changes in lifestyle and wraparound health care services. To be eligible for a transplant, a patient must demonstrate acceptable cardiovascular, liver, lung, urinary tract, and dental health, adequate insurance

coverage, and a stable home environment. UC Davis Health, Transplant Ctr., *The Evaluation Process*, <https://health.ucdavis.edu/transplant/about/the-evaluation-process.html> (last visited Jan. 25, 2022). For a transplant to succeed, patients must adapt to new dietary, medication, and mental health regimes. Am. Kidney Fund, *Life After Transplant*, https://www.kidneyfund.org/kidney-disease/kidney-failure/treatment-of-kidney-failure/kidney-transplant/life-after-transplant/#:~:text=Avoid%20being%20around%20people%20who,such%20as%20walking%2C%20or%20biking_ (last visited Jan. 25, 2022).

Most ESRD patients, however, must learn to live on dialysis—either as an interim measure while waiting for a transplant, or in many cases, as the sustaining treatment for the rest of their lives. For the vast majority, that means traveling to an outpatient dialysis center three times per week. Upon arriving at the center, patients typically endure a four-hour dialysis session, during which their arm or leg is connected via tubes to an artificial kidney, and their blood is filtered and cleaned. Nat’l Kidney Found., *Hemodialysis* (2015), <https://www.kidney.org/atoz/content/hemodialysis>. Additional time is spent traveling to and from the dialysis center, getting connected to the machine, and stopping any bleeding afterward. And still more time is spent visiting the other physicians who care for the large number of other health complications that accompany ESRD.

By expanding Medicare to cover ESRD patients regardless of age, Pub. L. No. 92–603, § 299I, 86 Stat. 1429, 1463–64 (1972), and enacting the Medicare Secondary Payer statute, 42 U.S.C. § 1395y(b) (“MSPA”), Congress sought to further two critical goals. First, Congress sought to protect the Medicare

Trust Fund from bearing a disproportionate share of the extraordinary costs of treating ESRD. Second, however, Congress plainly meant to serve the health interest of ESRD patients by guaranteeing the availability of dialysis and transplant care. These goals are mutually reinforcing. By ensuring that plans do not discriminate against ESRD patients, see *id.* § 1395y(b)(1)(C), they allow those patients to receive the most comprehensive and consistent care, thus preserving life and health while also protecting the public fisc.

As the Court below (App. 41-54) and Respondents (at 31-32, 43-44) have well explained, the MSPA does not permit health care plans to take actions that are designed to and will drive ESRD patients from their private plans to Medicare. Yet that is precisely what Petitioners have allegedly done, and the court of appeals was correct to hold that Respondents had stated viable claims based on the text of the MSPA. This Court need go no further to affirm the judgment below, as the NAACP urges it to do.

The Court should also affirm because only an affirmance is consistent with Congress's policy judgment. As we demonstrate below, Petitioners' position could have catastrophic consequences for ESRD patients and their families. Private plans frequently offer benefits, not available from Medicare, that are necessary to obtain a transplant. For example, at this point, Medicare does not cover dental treatment (except in certain extreme circumstances where the dental treatment requires hospitalization), even though transplant applicants must demonstrate that they do not have untreated cavities that may cause infection and rejection of a donated kidney. In addition, if ESRD patients are forced to leave their private insurance plans for Medicare, many families

will lose the benefit of employer-provided coverage. Medicare protects individuals, not families. And even if there is no drop in coverage for ESRD patients, there will generally be a shift in providers as Medicare and private networks do not line up perfectly. As a result, ESRD patients already coping with significant life changes will be forced to identify and develop new relationships with new physicians for life-saving care.

All of these negative consequences are avoidable. The Court need only adopt the straightforward textual reading of the MSPA advanced by Respondents. The Court should do so, and should affirm.

ARGUMENT**THE MSPA PROTECTS ESRD PATIENTS BY PROHIBITING HEALTH CARE PLANS FROM DISCRIMINATING AGAINST THEM, AS PETITIONERS ARE ALLEGED TO HAVE DONE**

Dialysis is a medical miracle—allowing ESRD patients to continue living as a machine filters their blood like a functioning kidney would. It is also incredibly expensive. Congress has passed a series of statutes that guarantee coverage for this life-saving care, allocate costs between private plans and Medicare, and, importantly, ensure that ESRD patients, who are critically ill, can remain on private plans for a significant period of time after diagnosis (30 months), thus avoiding disruption in their care and in their family’s coverage. The Petitioners’ plan allegedly frustrates this carefully balanced structure by intentionally making it intolerable for ESRD patients to remain on the plan. Petitioners’ key defense is that the plan’s relevant provisions are *also* intolerable for the narrow set of individuals who need dialysis but do not have ESRD. The Court should reject that defense, and should affirm.

1. End Stage Renal Disease.

Approximately 37 million people in the United States—one out of every seven—suffer from chronic kidney disease (“CKD”). See CDC, *Chronic Kidney Disease in the United States, 2021* at 1, <https://www.cdc.gov/kidneydisease/publications-resources/ckd-national-facts.html> (last updated Mar. 4, 2021). CKD can range from Stage 1 (where a patient’s kidneys are essentially functioning at 90 percent or greater) to Stage 5 or ESRD (where a patient’s kidneys are functioning at less than 15 percent). Am. Kidney Fund, *Stages of Chronic Kidney*

Disease, <https://www.kidneyfund.org/kidney-disease/chronic-kidney-disease-ckd/stages-of-chronic-kidney-disease/> (last updated Sept. 15, 2021).

The risk of developing CKD rises as people age. Nat'l Inst. of Diabetes & Digestive & Kidney Diseases, *What Is Chronic Kidney Disease?* (June 2017), <https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd/what-is-chronic-kidney-disease>. In addition, individuals with diabetes, high blood pressure, and heart disease are more likely to develop CKD. *Id.* For instance, a diabetic's high blood glucose can damage the kidneys' blood vessels, and as a result, one in three individuals with diabetes develop CKD. *Id.*

CKD can progress to ESRD, particularly without proper treatment. As of 2019, there were 782,818 individuals in the country who had been diagnosed with ESRD. USRDS Annual Report at fig. 1.5. According to the CDC, for every two women who develop ESRD, three men do; and Black Americans are three times likelier to develop CKD than White Americans. CDC, *Chronic Kidney Disease in the United States, 2021*, *supra*, at 3.

When a person develops ESRD, their kidneys do not function sufficiently to filter their blood and remove wastes and extra fluid in their body. Common symptoms include swelling, headaches, nausea, pain, confusion, and a loss of appetite. Nat'l Inst. of Diabetes & Digestive & Kidney Diseases, *What Is Kidney Failure?*, <https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd/what-is-chronic-kidney-disease> (last updated Jan. 2018). ESRD patients—even with proper treatment—can develop high blood pressure, heart disease, anemia, mineral and bone disorders, and malnutrition. *Id.*

Absent intervention, ESRD is fatal because the human body must filter waste and excess water to survive. There are two treatment options to avoid death: a kidney transplant or dialysis. Among Americans with ESRD, approximately 71% are on dialysis and 29% are living with a kidney transplant. CDC, *Chronic Kidney Disease in the United States, 2021, supra*, at 3.

Kidney transplants are the preferred treatment for individuals with ESRD. For most people, obtaining a kidney transplant requires registering on the transplant waitlist. Suzanne M. Kirchhoff, Cong. Res. Serv., *Medicare Coverage of End-Stage Renal Disease (ESRD)* 4 (Aug. 16, 2018) (“CRS Report”). Getting on the waitlist, however, requires a person to meet numerous criteria, including screenings for adequate cardiovascular, lung, liver, and ambulatory function, for psychosocial status, and for financial considerations. UC Davis Health, *supra*. These criteria disqualify many ESRD patients. CRS Report at 4. And there are more than five times as many individuals on the restrictive waitlist as kidneys available in any particular year. Resp. Br. 4 (citing sources).

Whether an ESRD patient has private insurance, Medicare, or a mix of private and public insurance impacts the likelihood of gaining a place on the waitlist and ultimately getting a transplant. Research has found the ESRD patients enrolled in Medicare (without private insurance) are less likely to be waitlisted. Yue-Harn Ng et al., *Does Racial Disparity y in Kidney Transplant Waitlisting Persist After Accounting for Social Determinants of Health?*, 104 *Transplantation* 1445, 1452 (2020); accord D. Keith et al., *Insurance Type and Minority Status Associated with Large Disparities in Prelisting Dialysis among*

Candidates for Kidney Transplantation. 3 Clin. J. Am. Soc. Nephrol. 463, 464-65 (2008). Unsurprisingly, research has also found that patients on private insurance are ultimately more likely to receive a transplant. Jiacong Luo et al., DaVita Clinical Rsch., *The Impact of Employment Status or Insurance Type on Outcomes Among Patients with End-Stage Renal Disease* (2017), http://www.davitaclinicalresearch.com/wpcontent/uploads/2017/10/ROPS_WorkIns_POST_2017-10-28a_FINAL.pdf.

Most patients living with ESRD are undergoing dialysis. Dialysis, put most simply, is a medical procedure during which a person's blood is filtered and cleaned outside the kidney. Cleveland Clinic, *Dialysis*, <https://my.clevelandclinic.org/health/treatments/14618-dialysis> (last visited Jan. 25, 2022). There are two kinds: (1) hemodialysis—where an ESRD patient's arm or leg is hooked up via tubes to an artificial kidney, and (2) peritoneal dialysis—where a patient's blood is filtered inside their body using a catheter. CRS Report at 5. Hemodialysis, by far, is the most common, and most patients undergo it at an outpatient clinic. See *id.* at 5; USRDS Annual Report at fig. 1.2 (showing that in 2019, 85.1% of Americans with ESRD underwent in-center hemodialysis).

Hemodialysis, the type of dialysis at issue here, requires a drastic change in lifestyle. First, a person needs to have hemodialysis at least three times a week. Cleveland Clinic, *Dialysis*, *supra*. Each session lasts three to five hours. *Id.* That time does not include transportation to or from the outpatient clinic, the amount of time between arriving and being connected to the artificial kidney, or the amount of time it takes to stop the fistula bleeding following the filtering process. After a session, even where bleeding is stopped easily, a person feels wiped out. Second,

hemodialysis requires a severe change in diet, most significantly limiting the intake of liquid. Cleveland Clinic, *Dialysis, supra*. Third, dialysis requires planning life events and scheduling changes around dialysis. Patients who want to travel, for instance, must arrange dialysis at their destination. If there is a holiday, they have to alter their schedule to obtain the requisite care on the outpatient center's more limited schedule. Nat'l Kidney Found., *Travel Tips: A Guide for Kidney Patients*, <https://www.kidney.org/atoz/content/traveltip> (last visited Jan. 24, 2022). Fourth, outpatient dialysis is incredibly expensive, particularly without adequate insurance. The cost of providing a single dialysis treatment (for the provider, let alone the patient) can be approximately \$290. Resp. Br. 12. ESRD patients require three treatments per week, every week, and so annual costs for dialysis alone reach tens of thousands of dollars per year. All told, total annual health care expenditures for dialysis patients are approximately \$90,000. See UC San Francisco, *The Kidney Project: Statistics* (Nov. 19, 2019), <https://pharm.ucsf.edu/kidney/need/statistics>.

While hemodialysis takes up a significant portion of an ESRD patient's time, it is rarely the only medical appointment on the calendar. ESRD patients frequently have a host of other medical complications, including diabetes, high blood pressure, and heart disease. See Nat'l Inst. of Diabetes & Digestive & Kidney Diseases, *What Is Chronic Kidney Disease?* (June 2017), <https://www.niddk.nih.gov/health-information/kidney-disease/chronic-kidney-disease-ckd/what-is-chronic-kidney-disease>. An ESRD patient requires an entire team of health care professionals, including, in many cases, a nephrologist (a kidney specialist), dialysis nurse (who monitors dialysis administration), transplant coordinator (who teaches

what to do before and after a transplant), a renal dietitian (who trains on food and drink intake), a cardiovascular specialist (to monitor and treat increased blood pressure), a podiatrist (to address swollen feet), and a dentist (to address any cavities or dental infections). *What Is Kidney Failure?*, *supra*. These appointments also require coordination and time.

Although it is possible to live on dialysis for years, the median life expectancy of an ESRD patient undergoing hemodialysis and without a transplant is only 48 months. USRDS Annual Report at fig. 6.7. And each of those months is trying, difficult, and costly. With a successful transplant, the likelihood of death is substantially reduced. M. Kaballo et al., *A Comparative Analysis of Survival of Patients on Dialysis and After Kidney Transplantation*, 11 Clin. Kidney J. 389, 389-90 (2017).

2. Congress Intended to Protect ESRD Patients from Discrimination.

For 50 years, Congress has understood how difficult life is for ESRD patients and sought repeatedly to offer them increasing protection.

In the early 1970s, Congress recognized that ESRD presents “the most tragic irony of the twentieth century”: “We have learned how to treat [ESRD], yet these treatments are not available to most Americans because of their cost.” S. Rep. No. 92-1230 at 1243 (1972) (Sen. Hartke). Congress accordingly took the unprecedented step of extending Medicare to nearly all individuals with ESRD, regardless of age, to ensure the availability of dialysis and transplant care. See Pub. L. No. 92-603, § 299I, 86 Stat. 1429, 1463-64 (1972).

This expansion of coverage spawned some unanticipated consequences that required additional congressional action. Specifically, once Medicare covered ESRD treatment (*i.e.*, dialysis or transplant costs), private health care plans included provisions that denied coverage where the beneficiary was entitled to coverage under Medicare. S. Rep. No. 97-139 at 735 (1981).

In response, Congress passed the Medicare Secondary Payer statute, Pub. L. No. 97-35, § 2146(a), 95 Stat. 357, 800-01 (1981), which “change[d] the benefit coordination arrangements between the Medicare End-Stage Renal Program and any other health benefits to which an individual may be entitled.” S. Rep. No. 97-139 at 735. The statute created a coordination period, during which the private insurance plan would be the primary payer for ESRD treatment costs and Medicare would serve as the secondary payer. This switch was designed, in part, to save Medicare hundreds of millions of dollars. *Id.* at 735-36. But in doing so, Congress was emphatic that “[r]eimbursement for covered expenses for care of [ESRD] patients [would] still [be] assured.” *Id.* at 736.

Congress accomplished these dual goals through an iterative process. At first, Congress directed the Internal Revenue Service to deny business tax deductions for providing health insurance to employees if the health insurance plan “contain[ed] a discriminatory provision that reduces or denies payment of benefits for renal patients.” *Id.* In 1984, it created a cause of action allowing the government to enforce the MSPA’s provisions, see Pub. L. No. 98-369, tit. III, § 2344(a), 98 Stat. 494, 1095 (1984), and two years later, Congress created a private right of action, see Pub. L. No. 99-509, § 9319(b), 100 Stat. 1874, 2011 (1986). Finally, in 1989, Congress buttressed the anti-

discrimination provisions by prohibiting health care plans even from “tak[ing] into account that an individual is entitled to [Medicare] benefits [due to an ESRD diagnosis] during the [coordination] period.” Pub. L. No. 101-239, § 6202(b)(1)(C), 103 Stat. 2106, 2231 (1989).

At this point, these enactments boil down to two key provisions. First, there is the anti-differentiation provision, which states that a 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). Second, there is the take-into-account provision, which states that a plan “may not take into account that an individual is entitled to or eligible for [Medicare] benefits” during the coordination period. *Id.* § 1395y(b)(1)(C)(i).

3. Petitioners’ Actions Allegedly Violate the MSPA’s Protections for ESRD Patients.

The complaint alleges that Petitioners’ plan differentiates between the benefits it provides to ESRD patients and others and that it takes into account patients’ ESRD diagnosis—both in violation of 42 U.S.C. § 1395y(b)(1)(C). JA26. As Respondents explain (at 21-47), Petitioners’ actions, as alleged, violate the plain terms of the MSPA.

Petitioners allegedly violated the anti-differentiation provision. The anti-differentiation provision precludes a plan from “differentiat[ing] in the benefits it provides between individuals having [ESRD] and other individuals covered by [the] plan” in three ways: (1) “on the basis of the existence of end stage renal disease,” (2) “on the basis of ... the need for

renal dialysis,” or (3) “in any other manner.” 42 U.S.C. § 1395y(b)(1)(C)(ii). Collectively, these three clauses prevent both facial and more cleverly disguised discrimination. See Resp. Br. 22-25.

Respondents alleged that Petitioners intentionally violated this provision by adopting plan terms designed to shift ESRD patients off the plan’s rolls and onto Medicare. The complaint asserted, for instance, that Petitioner MedBen—the plan’s third-party administrator—“touts its ability to reduce the amounts employers spend on dialysis procedures provided to ESRD patients.” JA7; see *id.* (“MedBen states that ‘by implementing [its] proprietary dialysis health plan language, employers can realize a substantial savings on the procedure.’”). Indeed, MedBen purportedly claimed that one client that amended its plan in accordance with MedBen’s advice saw its “dialysis costs f[a]ll by 80%.” *Id.*; see also JA29 (“MedBen specifically emphasizes the high cost of dialysis treatment for ESRD patients in promoting to its customers MedBen’s proprietary (and illegal) methods that purport to reduce costs related to dialysis reimbursement.”).

Respondents alleged that the plan here followed MedBen’s advice and, in doing so, violated the anti-differentiation’s second and third clauses. See JA6, 13-16. Specifically, the plan did so by capping reimbursement on outpatient dialysis services and dialysis drugs (but not inpatient dialysis) and imposed a 30% coinsurance obligation on outpatient dialysis patients. Resp. Br. 31. These terms are abnormally unfavorable to ESRD patients, who virtually alone depend on outpatient dialysis approximately 150 times per year, and these terms allegedly have the effect of forcing patients, like Patient A, toward Medicare. JA27.

It is not difficult to see what is happening here. The third-party administrator allegedly advertised a proprietary set of plan terms designed to shift ESRD patients off private plans and onto Medicare. The plan adopted these terms, and they had their desired effect. This is discrimination and differentiation and unfair treatment no matter the test. And it fits comfortably within the second clause. It does not matter whether Petitioners avoided using magic words or treated shabbily a small amount of non-ESRD patients too. Targeted and intentionally discriminatory conduct does not become non-discriminatory when it is calibrated to harm a few extra people. This Court has long recognized, for example, that when an enactment targets activities “engaged in exclusively or predominantly by a particular class of people, an intent to disfavor that class can readily be presumed.” *Bray v. Alexandria Women’s Health Clinic*, 506 U.S. 263, 270 (1993); see *id.* (“[a] tax on wearing yarmulkes is a tax on Jews”); see App. 44-45. Here, ESRD patients are virtually the only patients who use outpatient dialysis on a routine basis. A slate of terms that treats outpatient dialysis users so harshly will necessarily drive ESRD patients toward Medicare enrollment, as Petitioners allegedly did with Patient A. At a minimum, the case should be permitted to advance beyond the motion to dismiss stage.

The Court need not reach potentially more complex questions regarding whether a plaintiff could state a valid MSPA claim without alleging bad-faith or intentional conduct. Here, the complaint alleges that Petitioners adopted a plan that was specifically and intentionally designed to discriminate against outpatient dialysis services, and those who require such care, and further alleges that Petitioners accomplished exactly what they set out to do: they

shoved ESRD patients out of their plan. That alleged conduct violates this statute.

Petitioners allegedly violated the take-account provision. Section 1395y(b)(1)(C)(i) precludes a plan from “tak[ing] into account that an individual is ... eligible for benefits” under Medicare during the coordination period. Respondents alleged that Petitioners considered or took account of patients ESRD diagnosis when they targeted outpatient dialysis treatment for unfavorable treatment and did so based on a motivation to “induce members of the Plan with ESRD to drop out of the Plan and instead enroll in Medicare.” JA29; see JA26.

For the reasons explained by Respondents (at 43-44), these allegations are sufficient to state a claim based on a violation of the statute’s plain text. The Court need go no further; the decision below may be affirmed on this ground alone.

4. Adopting Petitioners’ Position Will Dramatically Harm ESRD Patients.

Affirming the court of appeals’ judgment is not only consistent with the text of the statute, but also with Congress’s expressed policy judgment to protect ESRD patients. If plans are allowed to intentionally adopt terms designed to shift ESRD patients from private insurance to Medicare, as Petitioners are alleged to have done here, it would cause significant damage to patients coping with ESRD, thwarting Congress’s effort to protect those patients (as well as the public fisc) from the consequences of abrupt or premature coverage changes.

The negative consequences of such a move for ESRD patients are numerous and yet to be fully revealed. Just three show how far-ranging and devastating they can be for ESRD patients and their families.

First, forcing ESRD patients to give up their private insurance and enroll in Medicare will in many cases diminish patients' ability to qualify for a kidney transplant—which is the best long-term treatment option for many facing kidney failure.

As described above, p. 11, *supra*, most people obtain kidney transplants through the transplant waiting list. Getting on the waitlist requires patients to meet a rigorous set of criteria designed in part to ensure that the recipient's body does not reject the donor's kidney. Among other criteria, such as sufficient heart, lung, and liver function, potential transplant recipients must also show that their teeth are in good health and that they have dental care because a cavity could lead to an infection that could in turn cause the body to reject the kidney. See Laura Fabuel, *Dental Management in Transplant Patients* (November 21, 2010), <http://www.medicinaoral.com/odo/volumenes/v3i1/jcedv3i1p43.pdf>. The risk runs the other way as well—the immunosuppressive drugs that organ recipients must take to reduce the odds that their body rejects the donated kidney can also lead to severe dental problems. C. Thomas, Nat'l Kidney Found., *Is It Time to Visit the Dentist?* (July 1, 2015), <https://www.kidney.org/content/it-time-visit-dentist>.

Many private insurance plans include dental coverage for at least routine care, but Medicare does not pay for dental treatment at all, except in the rare circumstance where “the individual ... requires hospitalization in connection with the provision of [dental] services.” 42 U.S.C. § 1395y(a)(12); see also Ctrs. for Medicare & Medicaid Servs., *Medicare Dental Coverage*, <https://www.cms.gov/medicare/coverage/me>

dicare dental coverage (last updated Dec. 1, 2021) (explaining scope of statutory “blanket exclusion”).²

Plans that prematurely force ESRD patients onto Medicare before completion of the coordination period thus create obstacles to obtaining a kidney transplant, and in that way reduce the odds that patients suffering from kidney failure will obtain the new kidney that could save their lives. It means those patients must continue receiving dialysis, further complicating their lives and driving up costs for Medicare, in conflict with Congress’s stated intent.

Second, forcing ESRD patients onto Medicare can affect not only their health care but also their families’ insurance. Medicare is individual health coverage. Under the Social Security Act, a Medicare beneficiary is defined as “*an individual* who is entitled to benefits under part A or enrolled under part B.” 42 U.S.C. § 1395a(b)(6)(a) (emphasis added). With very few exceptions, Medicare does not offer dependent coverage for a beneficiary’s family members. Michelle Andrews, Kaiser Family Found., *Retirees Can Find Insuring Young Adult Children Difficult* (Nov. 23, 2010), <https://khn.org/news/michelle-andrews-on-medicare-and-adult-children/>. Thus, if a family has health coverage through an ESRD patient’s employer, once the ESRD patient enrolls in Medicare, the rest of the family often loses coverage, forcing those family members to obtain coverage by other means at likely higher cost, at the very time where an ESRD diagnosis and the accompanying need for constant dialysis care

² The same site explains that Medicare will pay for “[a]n oral or dental examination performed on an inpatient basis as part of comprehensive workup prior to renal transplant surgery,” but that Medicare will not cover any dental treatment that the examination shows to be necessary.

are disrupting family life and diminishing the time available for family members to work and earn income.

Third, and relatedly, changing from private insurance to Medicare can also force a change in care providers. ESRD patients require multidisciplinary care. See pp. 13-14, *supra*. It is not enough to have a nephrologist and a dialysis nurse; many patients also require a transplant coordinator, a renal dietitian, a cardiovascular physician, a podiatrist, and a dentist in addition to other providers. And patients obviously benefit when these myriad providers coordinate their treatment strategies. Ctrs. for Medicare & Medicaid Servs., *Chronic Kidney Disease Disparities: Educational Guide for Primary Care 4*, (Apr. 2021), <https://www.cms.gov/files/document/chronic-kidney-disease-disparities-educational-guide-primary-care.pdf>.

Private insurance plans ordinarily have a certain networks of providers. Upon diagnosis (and likely even before when individuals are dealing with CKD), ESRD patients often have an established set of physicians and other providers within that network. There is no guarantee, however, that all of these providers will also accept Medicare. Thus, if patients with ESRD are forced off of private plans and onto Medicare, they may experience disruptions in treatment, whether because of difficulties in finding a new provider, because the new provider lacks the familiarity with the patient and the patient's prior course of treatment, or even because the new provider is of lower quality, or has not yet had the opportunity to earn the patient's full trust. Unsurprisingly, research shows that forced transitions can cause a breakdown in trust between patients and physicians, which for ESRD patients is particularly important. Charlotte Paddison et al., *Experiences of Care Among*

Medicare Beneficiaries With ESRD: Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey Results, 61 Am. J. Kidney Diseases 440 (Mar. 1, 2013), [https://www.ajkd.org/article/S0272-6386\(12\)01329-7/fulltext](https://www.ajkd.org/article/S0272-6386(12)01329-7/fulltext).

* * *

ESRD triggers one of very few exceptions to Medicare's age eligibility rules. An ESRD diagnosis entitles someone to coverage virtually immediately, regardless of age. By making this exception, Congress demonstrated its commitment to ensuring ESRD patients can receive life-saving care. However, this care is far from free, and Congress also passed anti-discrimination provisions to protect ESRD patients and to prohibit private health plans from adopting both blunt and clever schemes to push the high cost of ESRD care entirely onto the federal government. According to the complaint, Petitioners intentionally designed a plan to do just that, and achieved their aim. That is discrimination, pure and simple. This Court should recognize, as the court of appeals correctly held, that the plain text of the MSPA precludes such conduct. Any other conclusion would risk allowing plan sponsors to inflict exactly the harms on ESRD patients that Congress intended to foreclose.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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