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HEALTH-CARE LAW

Does a Group Health Plan That Provides Uniform Dialysis Benefits to All Covered Individuals, Nonetheless, Violate the Medicare Secondary Payer Act's Provisions Regarding End-Stage Renal Disease Where the Plan's Dialysis Benefits Are Alleged to Have a Disproportionate Effect on Individuals with End-Stage Renal Disease in Order to Incentivize Such Individuals to Leave the Plan and Enroll in Medicare?

CASE AT A GLANCE

There is a circuit split on the issue of whether the Medicare Secondary Payer Act can be appropriately characterized as an antidiscrimination statute and support a disparate-impact theory of liability for group health plans with benefit designs and payment provisions that allegedly target individuals with end-stage renal disease (ESRD) by incentivizing them to enroll in Medicare prematurely. The Sixth Circuit has held that the Medicare Secondary Payer Act was intended to protect Medicare beneficiaries with ESRD from being disproportionately impacted by benefit designs that disadvantaged dialysis services, even if the plan terms do not expressly target Medicare patients. The Ninth Circuit, on the other hand, held in a twin case that the Medicare Secondary Payer Act cannot be appropriately construed as an anti-discrimination statute and its violation requires that the group health plan explicitly treat Medicare-eligible beneficiaries with ESRD differently than other individuals. The Supreme Court granted *certiorari* to the petitioner, a self-insured group health plan, which argues that the Sixth Circuit's decision is erroneous and inconsistent with the statute.

Marietta Memorial Hospital Employee Health Benefit Plan v. DaVita, Inc.

Docket No. 20-1641

Argument Date: **March 1, 2022** From: **The Sixth Circuit**

by Thomas R. Barker and Haider Andazola

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Introduction

In 1972, Congress extended Medicare coverage to nearly all individuals diagnosed with end-stage renal disease (ESRD), thereby making Medicare the primary payer for these individuals. ESRD beneficiaries, however, are extremely costly. These individuals have multiple comorbid conditions (for example, diabetes or heart failure) and, because their kidneys have failed, require dialysis at least three times per week to maintain life. To

address the growing costs of ESRD beneficiaries, Congress amended the Medicare Secondary Payer Act (MSPA) in 1981 to require group health plans to pay for an enrollee's dialysis treatment for a period of 12 months, after which Medicare would become the primary payer. The period has since been extended to 30 months.

When it made the ESRD-related amendments to the MSPA, Congress noted that "most health plans... contain[ed] provisions that [we]re intended to prevent

payment of benefits where the insured [wa]s also entitled to benefits as a result of coverage under a program such as [M]edicare.” Today, the MSPA sets forth two important prohibitions applicable to group health plans, commonly referred to as the “take into account” and “nondifferentiation” prohibitions. Specifically, the MSPA provides that group health plans:

- (i) may not take into account that an individual is entitled to or eligible for benefits under [Medicare] during the [30-month] period which begins with the first month in which the individual becomes entitled to benefits under [Medicare], or, if earlier, the first month in which the individual would have been entitled to benefits under [Medicare] if the individual had filed an application for such benefits; and
- (ii) 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....

If a group health plan violates these requirements and “cannot reasonably be expected” to pay the provider “promptly,” Medicare will step in as a backup payer and make “conditional payments” to the provider to ensure that the ESRD patient does not experience interruptions in care. The statute then provides, in addition to a government enforcement mechanism, a private cause of action for damages “in the case a primary plan [] fails to provide for primary payment (or appropriate reimbursement) in accordance with paragraphs (1) and (2)(A).” Paragraph (1) refers to the MSPA’s antidiscrimination provision at 42 U.S.C. § 1395(y)(b)(1), and paragraph (2)(A) refers to the MSPA’s Medicare-secondary-payment provision at 42 U.S.C. § 1395(y)(b)(2)(A).

Issue

Does a group health plan that provides uniform dialysis benefits to all individuals covered by the plan nonetheless violate the Medicare Secondary Payer Act’s provisions regarding end-stage renal disease where the plan’s dialysis benefits are alleged to have been set at artificially low levels that have a disproportionate effect on individuals with end-stage renal disease, who need frequent dialysis, in order to incentivize such individuals to leave the plan and enroll in Medicare?

Facts

DaVita, the respondent, is a leading national provider offering dialysis treatments to hundreds of thousands of patients in 2,400 locations across the United States. Marietta Memorial Hospital (Marietta), the petitioner, is a non-profit community hospital located in Marietta, Ohio, which self-funds an employer group health plan (the Plan) for its employees and their dependents.

Between April 15, 2017, and August 31, 2018, “Patient A,” who was diagnosed with ESRD, received dialysis services from DaVita while enrolled in the Plan. DaVita, pursuant to an “Assignment of Benefits” executed by Patient A, received payment in accordance with the terms of the Plan as established by Marietta. According to the terms of the Plan, *all* dialysis providers were treated “out-of-network” and reimbursed at the lowest rates under the Plan. More specifically, dialysis providers were reimbursed an amount not to exceed 125 percent of the current Medicare allowable fee, and the dialysis service itself was reimbursed at 87.5 percent of the Medicare rate. Moreover, as “out-of-network” providers, DaVita’s patients faced higher cost sharing for each dialysis session than would otherwise apply if such services were provided in-network. Importantly, all dialysis providers offering dialysis services to any patient—regardless of whether they needed dialysis on an acute or chronic basis—were treated the same way. Finally, the Plan also subjected dialysis to heightened scrutiny and applied “cost containment review” and “claim audit and/or review” procedures to dialysis services. Patient A dropped coverage under the Plan and enrolled into Medicare on August 31, 2018.

On December 19, 2018, DaVita, on behalf of itself and Patient A, filed a complaint against Marietta, alleging that the Plan treats dialysis providers differently from other medical providers in violation of the MSPA. DaVita essentially argued that the Plan, by offering inferior benefits to individuals with ESRD, incentivized plan enrollees to drop their private coverage and enroll in Medicare, which violated the antidiscriminatory purpose of the MSPA by “tak[ing] into account” that an individual is entitled to Medicare by virtue of their ESRD, and by “differentiating” the level of benefits offered to enrollees who need dialysis versus those that do not.

Marietta moved to dismiss the complaint, which the district court granted with prejudice, holding in relevant part that the Plan had not discriminated unlawfully against individuals with ESRD through its reimbursement

system. The Sixth Circuit, however, reversed. The court held that the “basic question” on appeal was whether the MSPA prohibited primary plans from discriminating against individuals with ESRD without expressly stating that these individuals would be treated differently. The court held that the take-into-account and nondifferentiation provisions of the MSPA prohibited both express discrimination based on an individual’s ESRD status and discrimination based on an individual’s ESRD-specific need for renal dialysis. Marietta sought *certiorari* at the Supreme Court.

Case Analysis

At the outset, Marietta characterizes the MSPA as a statute intended to conserve Medicare resources for the 30-month coordination period, not as a statute intended to prescribe benefits or otherwise serve as an antidiscrimination law. Marietta argues that the MSPA cannot be read to implicitly provide for a disparate-income claim because, as the district court observed, the MSPA does not contain “results-oriented” language that have characterized other antidiscrimination statutes.

As such, Marietta asserts that the take-into-account clause is meant to regulate the formal terms of a group health plan, and not the “motives” of the group health plan adopting it. Moreover, the take-into-account clause presupposes that the individuals in question are being targeted *because* they are eligible for Medicare *pursuant* to their ESRD diagnosis (that is, individuals who have received dialysis treatment for three months). In other words, as long as the group health plan treats all individuals with ESRD the same, the plan cannot be said to target Medicare-eligible beneficiaries by “tak[ing] into account” their Medicare eligibility. The only way a group health plan can violate the take-into-account prohibition, according to Marietta, is if the group health plan expressly targets *only* ESRD patients who are eligible for Medicare because they have received at least three months of dialysis treatments. As long as the Plan treats all ESRD enrollees the same, however, the Plan cannot be said to “take into account” their Medicare eligibility.

With respect to the nondifferentiation clause, Marietta argues that the threshold question is whether the Plan, assuming that it treats all *participants* the same (that is, does not take-into-account ESRD-based Medicare eligibility), nevertheless “differentiates” in the *benefits* it provides to enrollees with ESRD relative to other enrollees. Marietta argues that because the Plan offers

identical benefits, including dialysis benefits, to those with ESRD versus those who do not have ESRD, the nondifferentiation clause is not implicated by the Plan. Marietta states that the Sixth Circuit erroneously read into the non-differentiation clause a disparate-impact standard that considered whether the Plan’s terms (that is, out-of-network treatment for dialysis providers, fractional Medicare-based payment rates, cost-containment strategies, and so on) could be viewed as discriminating against ESRD patients by targeting the primary treatment that they need: dialysis. Marietta maintains that such an analysis is not only inconsistent with the coordination-of-benefits purpose of the MSPA, but it also leapfrogs the threshold requirement that the Plan must have first “differentiate[d] in the benefits it provides.”

DaVita, for its part, asserts that the MSPA is *both* a coordination-of-benefits measure *and* an anti-discrimination statute by prohibiting discrimination that would drive ESRD patients off private plans and onto Medicare, even where such discrimination is not explicitly contained in the Plan’s terms. DaVita views the Sixth Circuit’s reading of the statute as one which gives the statute its “full and fair” meaning, particularly as “no plan would be foolish enough to enshrine [discrimination] in so many words in its terms.”

DaVita argues that the Sixth Circuit was correct in construing the take-into-account clause in a manner consistent with implementing regulations at 42 C.F.R. § 411.108(a), which include “[i]mposing limitations on benefits for a Medicare[-]entitled individual that do not apply to others enrolled in the plan, such as providing less comprehensive health coverage, excluding benefits, reducing benefits,” among other policies. DaVita emphasizes that ESRD patients need dialysis much more frequently than do the rare non-ESRD users of dialysis (for example, patients with acute kidney injury) and that the Plan is clearly structured to disfavor dialysis by singling it out for lower reimbursement and heightened claim scrutiny, thereby plainly and disproportionately impacting ESRD patients. According to DaVita, because it plausibly alleged that the Plan discriminates against ESRD patients who are legally entitled to Medicare by reducing their benefits relative to other Plan enrollees, it stands that DaVita’s claim should be able to proceed to the merits.

Moreover, DaVita argues that, in addition to prohibiting discrimination based on the existence of ESRD per the take-into-account clause, the nondifferentiation clause also prohibits plans from differentiating ESRD patients

“in any other manner,” which DaVita and the Sixth Circuit interpreted to be an expansive “catch-all” provision that encompasses a disparate-impact theory of liability based on *Texas Department of Housing & Community Affairs v. Inclusive Communities Project, Inc.*, 576 U.S. 519 (2015). *Inclusive Communities* considered disparate-impact liability under the Fair Housing Act (FHA) pursuant to the prohibition at Section 804(a) of the FHA, which makes it unlawful to “refuse to sell or rent after the making of a bona fide offer, or to refuse to negotiate for the sale or rental of, or otherwise make unavailable or deny, a dwelling to any person because of race, color, religion, sex, familial, status, or national origin.” The Court in *Inclusive Communities* focused on the meaning of “otherwise make unavailable” and likened it to the phrase “otherwise adversely affect” in Title VII of the Civil Rights Act and the Age Discrimination in Employment Act, concluding that this language “refers to the consequences of an action rather than the actor’s intent” and “encompasses disparate impact-claims.”

DaVita argues that the Sixth Circuit correctly drew a parallel between the phrase “otherwise make unavailable” in *Inclusive Communities* with the phrase “in any other manner” under the MSPA’s nondifferentiation provision to support the latter’s creation of a disparate-impact theory of liability. Marietta argues that the context in which the Court interpreted the phrase “otherwise make unavailable” supports interpreting the phrase as establishing a disparate-impact analysis because the purpose of the FHA was to address discriminatory housing practices, but the MSPA does not bear a similar purpose, and thus imbuing the phrase “in any other manner” with an antidiscrimination purpose is inappropriate.

Significance

The Supreme Court’s decision in *Marietta v. DaVita* will resolve a split, albeit a relatively small one, among the Sixth and Ninth Circuits with respect to whether or not the MSPA can support a disparate-impact theory of liability. In the weeks following the decision issued by the Sixth Circuit, the Ninth Circuit rendered a decision in a twin case also brought by DaVita, *DaVita, Inc. v. Amy’s Kitchen, Inc.*, 981 F.3d 664 (9th Cir. 2020), wherein the Ninth Circuit rejected adopting the Sixth Circuit’s disparate-impact theory of liability, holding that Amy’s Kitchen’s group health plan does not violate the take-into-account prohibition because the plan “takes no notice whatsoever of whether the claimant is eligible for Medicare.” Moreover, according to the Ninth Circuit,

Amy’s Kitchen’s group health plan did not violate the nondifferentiation provision because, like in *Marietta*, the plan “provides identical benefits to someone with ESRD as to someone without ESRD [and] does not ‘differentiate’ between those two classes.”

In addition to resolving a Circuit split, the Supreme Court’s decision could have wide-reaching economic impacts on the employer-sponsored insurance market if the Court rules in favor of DaVita. At its core, the lawsuit represents DaVita’s dissatisfaction with the low reimbursement rates group health plans provide to dialysis providers, which DaVita alleges is a discriminatory practice under the MSPA. Therefore, if the Supreme Court rules in favor of DaVita and DaVita wins on the merits at the district court (that is, demonstrates that the Plan incentivized ESRD patients to go onto Medicare), DaVita will undoubtedly use the litigation as leverage to negotiate higher reimbursement rates with group health plans. Given that group health plans cover nearly 50 percent of Americans, increased rates for dialysis services may contribute to a not insignificant impact on the premiums that many Americans and their employers face for health coverage.

A decision in favor of DaVita could also indirectly represent a “chink” in the armor that the Employee Retirement Income Security Act (ERISA) has served for self-funded group health plans. Historically, ERISA has broadly shielded self-funded group health plans from *state* regulation through federal preemption, including state regulation seeking to define the minimum level of benefits that self-funded group health plans may offer to their employees; the federal government has also largely taken a hands-off approach in this area, thereby leaving self-funded group health plans with enormous flexibility to set the terms of their health coverage. But if the Supreme Court accepts a disparate-impact theory of liability under the MSPA as it relates to dialysis services even when the group health plan offers uniform benefits to all enrollees, *private* parties could compel group health plans to institute certain benefit designs at the risk of litigation.

Also notable is that the Department of Justice (DOJ), as *amicus curiae*, disagrees with DaVita’s proposed reading of the MSPA and instead aligns with Marietta’s position that the MSPA cannot be read to provide for a disparate-impact theory of liability. The federal government, specifically the Centers for Medicare & Medicaid Services (CMS), is tasked with administering the MSPA, and the DOJ asserts that DaVita’s proposed interpretations of

the MSPA would be inconsistent with CMS's historical understanding of the statute. The DOJ asserts that the MSPA does not "dictate that a plan provide any particular minimum level of dialysis benefits" and that the court of appeals "erred in relying on theories of discrimination-by-proxy or disparate-impact liability..." This litigation is noteworthy not in least part because it could be viewed as being inconsistent with the Biden-Harris Administration's commitment to addressing health inequities for disabled individuals as outlined in Executive Order 13985, which includes many individuals diagnosed with ESRD.

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