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No. 12-98

In the
Supreme Court of the United States

ALBERT A. DELIA, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF THE NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Petitioner,

v.

E.M.A., A MINOR, BY AND THROUGH HER GUARDIAN AD LITEM, DANIEL H. JOHNSON, WILLIAM EARL ARMSTRONG AND SANDRA ARMSTRONG,
Respondents.

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

BRIEF FOR THE PETITIONER

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QUESTION PRESENTED

The Medicaid Act requires participating states to seek reimbursement from third-party tortfeasors for health-care expenditures they made to Medicaid recipients who are tort victims. 42 U.S.C. §§ 1396a(a)(25), 1396k(a) (2006). To enforce that requirement when the recipient and a third-party resolve their tort dispute through judgment or settlement, North Carolina law provides that the State has a subrogation right to, and may assert a lien upon, the lesser of one-third of the recipient's recovery or the State's actual medical expenditures. N.C. Gen. Stat. § 108A-57 (2011).

The question presented is whether N.C. Gen. Stat. § 108A-57 is preempted by the Medicaid Act's anti-lien provision as it was construed in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), an issue on which the North Carolina Supreme Court and the United States Court of Appeals for the Fourth Circuit are in conflict.

LIST OF PARTIES TO THE PROCEEDING BELOW

Appellants listed by the court below were E.M.A., a minor, by and through her Guardian *ad Litem*, William W. Plyler, William Earl Armstrong and Sandra Armstrong. By Order filed May 18, 2012, the United States District Court of the Western District of North Carolina substituted Daniel Johnson for William W. Plyler as the Guardian *ad Litem*.

Appellee below was Lanier M. Cansler, in his official capacity as Secretary of the North Carolina Department of Health and Human Services. The current Acting Secretary of the North Carolina Department of Health and Human Services is Albert A. Delia. By Order filed May 29, 2012, the United States District Court of the Western District of North Carolina modified the caption of the case below to reflect the substitution.

TABLE OF CONTENTS

QUESTION PRESENTED i

LIST OF PARTIES TO THE PROCEEDING BELOW ii

TABLE OF AUTHORITIES vii

OPINIONS BELOW 1

JURISDICTION 1

STATUTORY PROVISIONS INVOLVED 1

STATEMENT 2

A. Medicaid Is the Payer of Last Resort 2

B. The Third-Party Assignment and Recovery Provisions and the Anti-Lien Provision of the Medicaid Act 4

C. North Carolina Has Implemented a Third-Party Recovery Program as Required by Federal Medicaid Law 6

D. Factual Background and Procedural History 7

1. State court tort action and settlement 8

2. Litigation in the district court 11

3. The Fourth Circuit's decision 12

SUMMARY OF ARGUMENT 14

ARGUMENT 16

NORTH CAROLINA'S THIRD-PARTY RECOVERY STATUTES ARE NOT PRE-EMPTED BECAUSE THE MEDICAID ACT DOES NOT DIRECT HOW SETTLEMENTS MUST BE APPORTIONED 16

A. The Medicaid Act Leaves to the States the Determination of What Portion of Damages Recovered from a Third Party is Properly Allocable to Medical Expenses 17

1. State procedures for allocating tort settlements by Medicaid recipients are not precluded by the anti-lien provision 18

2. States have traditionally exercised broad authority over tort actions, including the amount of damages that a party may recover 20

3. North Carolina's statutes apportion, in advance of a settlement or judgment, the medical services portion of any recovery of damages 23

B. The Fourth Circuit Erred in Holding That There is a "True Value" of Tort Claims that Can, and Must, Be Determined through Evidentiary Hearings or the Parties' Designation . . . 26

1. A post-settlement "true value" hearing, as required by the Fourth Circuit, is untenable 27

2. A recipient's designation of the amount of damages attributable to past medical expenses inadequately protects the state's lien 30

C. North Carolina's Third-Party Recovery Procedure Operates with the Knowledge of and the Approval of the Centers for Medicare & Medicaid Services 33

CONCLUSION 36

APPENDIX:

North Carolina General Statute § 44-49 (2011) . . . . App. 1

North Carolina General Statute § 44-50 (2011) . . . . App. 3

TABLE OF AUTHORITIES

CASES

Andrews v. Haygood, 362 N.C. 599, 669 S.E.2d 310 (2008), *cert. denied sub nom. Brown v. North Carolina Department of Health and Human Services*, 129 S. Ct. 2792 (2009) . . . . . . i, 11, 12, 26, 34, 35

Arkansas Department of Health & Human Services v. Ahlborn, 547 U.S. 268 (2006) . *passim*

Atkins v. Rivera, 477 U.S. 154 (1986) 3

Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) . . 36

Douglas v. Independent Living Center of S. Cal., 132 S. Ct. 1204 (2012) 34, 35, 36

Frew v. Hawkins, 540 U.S. 431 (2004) 3

Geier v. America Honda Motor Co., 529 U.S. 861 (2000) 21

Memorial Hospital v. Maricopa County, 415 U.S. 250 (1974) 3

N.C. Department of Health and Human Services v. Armstrong, 690 S.E.2d 293 (N.C. Ct. App. 2010) 10

National Cable & Telecommunications Association v. Brand X Internet Services, 545 U.S. 967 (2005) 36

National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 (2012) 2, 19, 20

Owasso Independent School District Number I-011 v. Falvo, 534 U.S. 426 (2002) 3

Price v. Wolford, 608 F.3d 698 (10th Cir. 2010) 32, 33

W. Va. University Hospitals, Inc. v Casey, 499 U.S. 83 (1991) 17

Wisconsin Department of Health & Family Services v. Blumer, 534 U.S. 473 (2002) 34

STATUTES, RULES AND LEGISLATIVE MATERIALS

42 U.S.C. § 1396, *et seq* (2006) 2

42 U.S.C. § 1396-1 (2006) 4

42 U.S.C. § 1396a (2006) 2

42 U.S.C. § 1396a(a)(25) (2006) . . . . i, 19

42 U.S.C. § 1396a(a)(25)(A) (2006) 4

42 U.S.C. § 1396a(a)(25)(A)(ii) (2006) 34

42 U.S.C. § 1396a(a)(25)(B) (2006) 4

42 U.S.C. § 1396b (2006) 2

42 U.S.C. § 1396c (2006) 3

42 U.S.C. § 1396k (2006) 5

42 U.S.C. § 1396k(a) (2006) . . . . i, 19

42 U.S.C. § 1396k(b) (2006) 4

42 U.S.C. § 1396p (2006) 11

42 U.S.C. §1396p(a)(1) (2006) 5

42 U.S.C. § 1396p(d)(4)(A) (2006) 9

28 U.S.C. § 1254(1) (2006) 1

42 C.F.R. § 433.136 (2012) 5

42 C.F.R. § 433.139(b)(1) (2012) 4

42 C.F.R. § 433.140(a)(1) (2012) 3

S. Rep. No. 99-146 (1985), as reprinted
in 1986 U.S.C.C.A.N. 42. 3

N.C. Gen. Stat. § 1-508 (2011) 10

N.C. Gen. Stat. § 1B-1, *et seq*. (2011) 22

N.C. Gen. Stat. § 1D-25 (2011) 22

N.C. Gen. Stat. § 44-49 (2011) 22

N.C. Gen. Stat. § 44-50 (2011) 22, 23

N.C. Gen. Stat. § 90-21.19 (2011) 22

N.C. Gen. Stat. § 108A-54 (2011) 2

N.C. Gen. Stat. § 108A-57 (2011) . . . . i, 6, 9, 11
13, 23, 24

N.C. Gen. Stat. § 108A-57(a) (2011) 4, 6, 8, 13

N.C. Gen. Stat. § 108A-59 (2011) 6, 11

N.C. Gen. Stat. § 108A-59(a) (2011) 6

N.C. Gen. Stat. § 143-299 (2011) 22

N.C. Gen. Stat. § 143-299.2 (2011) 22

SECONDARY SOURCES

Thomas H. Cohen, Bureau of Justice Statistics,
Tort Bench and Jury Trials
in State Courts, 2005 (2009) 29

Thomas H. Cohen & Kristen A. Hughes, Bureau of Justice Statistics, *Medical Malpractice Insurance Claims in Seven States, 2000-2004* (2007) 29

Nat'l Ass'n. of State Budget Officers, Fiscal Year 2010 State Expenditure Report (2011) 2

North Carolina Quarterly Medicaid Assistance Expenditures For the Medical Assistance Program, Form CMS 64 Certification, Quarter Ending 06/30/2012 5

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit (Pet. App. 1a-70a) is reported at 674 F.3d 290. The opinion of the United States District Court for the Western District of North Carolina (Pet. App. 71a-85a) is reported at 722 F. Supp. 2d 653.

JURISDICTION

The judgment of the United States Court of Appeals for the Fourth Circuit was entered on March 22, 2012. (Pet. App. 1a-70a) On June 14, 2012, the Chief Justice extended the time within which to file a petition for writ of certiorari to and including July 20, 2012. The petition was granted on September 25, 2012. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant provisions are reprinted in an appendix to the petition. (Pet. App. 114a-123a)

STATEMENT

North Carolina participates in the jointly-funded, cooperative federal-state program established by Title XIX of the Social Security Act, which is also known as the Medicaid Act, 42 U.S.C. § 1396, *et seq*. The Medicaid Act authorizes federal funding so that the states can provide payments for medical assistance to qualifying needy individuals who are unable to afford their own medical costs. Funding is conditioned on the adoption of a State Plan that complies with specific federal requirements. 42 U.S.C. § 1396a (2006). The North Carolina Department of Health and Human Services ("DHHS") is the regulatory body charged with establishing and administering the State's Medicaid program. N.C. Gen. Stat. § 108A-54 (2011).

In North Carolina, the federal funding component specified in 42 U.S.C. § 1396b has ranged from 64% to 71% during the State's last five fiscal years. Medicaid spending accounts for over 20 percent of the average state's total budget; states devote a larger percentage of their budgets to Medicaid than to any other item. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2604, 2663 (2012) (citing Nat'l Ass'n of State Budget Officers, Fiscal Year 2010 State Expenditure Report, p. 11, Table 5 (2011)).

A. Medicaid Is the Payer of Last Resort.

Participation in the Medicaid program is optional, but once a state chooses to participate, it must comply

with the requirements of the federal law. *Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 547 U.S. 268, 275 (2006); *Frew v. Hawkins*, 540 U.S. 431, 433 (2004); *Atkins v. Rivera*, 477 U.S. 154, 156-57 (1986). The federal government may penalize a state's non-compliance by a reduction or the complete withholding of federal funding to the state. 42 U.S.C. § 1396c (2006); *see also* 42 C.F.R. § 433.140(a)(1) (2012) (applies specifically to a state's failure to seek reimbursement from liable third party).[1]

Medicaid is "the primary federal program for providing medical care to indigents at public expense." *Memorial Hosp. v. Maricopa County*, 415 U.S. 250, 262 n.19 (1974). "Medicaid is intended to be the payer of last resort" for needy individuals. S. Rep. No. 99-146, at 279 (1985), as reprinted in 1986 U.S.C.C.A.N. 42, at 312. All "other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." *Id.*

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[1] Petitioner does not concede that Respondent has a private cause of action through which she may enforce the anti-lien provision of the Medicaid Act. Petitioner did not press that issue below or seek certiorari on that issue, however, and is not asking the Court to resolve the case on that ground. *See Owasso Indep. Sch. Dist. No. I-011 v. Falvo*, 534 U.S. 426, 430-31 (2002) (leaving open question whether the Family Educational Rights and Privacy Act of 1974 is privately enforceable under § 1983). For a discussion as to why there is no private right of action here see Amicus Brief of Texas *et al.*

Accordingly, applicants may obtain Medicaid benefits only if their income and resources are "insufficient to meet the cost of necessary medical services." 42 U.S.C. § 1396-1 (2006). If payment from identified, verified third parties (such as insurance policies) that are probably liable is available at the time a claim is filed, those resources must first be exhausted before a medical provider can be paid by Medicaid. 42 C.F.R. § 433.139(b)(1) (2012).

B. The Third-Party Assignment and Recovery Provisions and the Anti-Lien Provision of the Medicaid Act.

States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for a recipient's medical care, 42 U.S.C. § 1396a(a)(25)(A), and, when such liability is found to exist, to seek reimbursement for such assistance to the extent of such legal liability. 42 U.S.C. § 1396a(a)(25)(B) (2006). The state is then required to return the federal share of the proceeds, which is determined by the matching formula in effect at the time the Medicaid program paid for the medical services, to the Centers for Medicare and Medicaid Services ("CMS"). *See* N.C. Gen. Stat. § 108A-57(a) (2011); 42 U.S.C. § 1396k(b) (2006). The remainder is retained by the state Medicaid program to be used to fund additional Medicaid services. In its last five fiscal years, North Carolina has returned to the federal government annual amounts ranging from $9.7 million to $17.0 million from its third-party recoveries for the

provision of medical services. *See North Carolina Quarterly Medicaid Assistance Expenditures For the Medical Assistance Program, Form CMS 64 Certification*, Quarter Ending 06/30/2012.

The state must accomplish its duties by requiring Medicaid beneficiaries to assign to the state their rights to third-party recoveries for medical expenses. 42 U.S.C. § 1396k (2006). (Pet. App. 120a-122a) These provisions are collectively known as the third-party recovery requirements. A third party is defined as any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State Plan. 42 C.F.R. § 433.136 (2012).

A separate provision of the Act, which is commonly referred to as the "anti-lien provision," protects a Medicaid recipient's property during her lifetime from liens related to medical expenditures made under the Medicaid program. 42 U.S.C. § 1396p(a)(1) (2006). In relevant part, this provision provides that "[n]o lien may be imposed against the property of any individual prior to [her] death on account of medical assistance paid or to be paid on [her] behalf under the State plan." *Id.*

This Court reconciled these two seemingly conflicting provisions in *Ahlborn*, by determining that the third-party recovery provisions are an exception to the anti-lien provision. Since the third-party recovery provisions only require the recovery of reimbursements

for medical services, the anti-lien provision does not allow the state to recover its Medicaid expenditures from proceeds that comprise damages for items other than medical care. *Ahlborn*, 547 U.S. at 284-85. Neither the Medicaid Act, nor the decision in *Ahlborn*, however, specifies how a state should determine what portion of the damages in a personal injury settlement represents reimbursement for medical expenses.

C. North Carolina Has Implemented a Third-Party Recovery Program as Required by Federal Medicaid Law.

North Carolina has complied with its federally approved State Plan for Medical Assistance by enacting an assignment statute at N.C. Gen. Stat. § 108A-59, and a subrogation statute at N.C. Gen. Stat. § 108A-57. The assignment statute provides, as a condition of eligibility, that Medicaid recipients are "deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise, to which [the recipient] may be entitled." N.C. Gen. Stat. § 108A-59(a) (2011) (Pet. App. 116a). Implementation of the recipient's statutory assignment is governed by N.C. Gen. Stat. § 108A-57(a) (2011) (Pet. App. 114a-115a), which requires the attorney for the recipient to enforce the Medicaid program's subrogation rights. The amount of the Medicaid program's subrogated recovery is the lesser of one-third of the gross amount recovered from the third party or the amount paid by the Medicaid program for medical assistance to the recipient.

North Carolina's statutes therefore designate in advance an allocation of settlement proceeds between medical costs and other damages while capping the State's reimbursement at one-third of the total recovery even if the actual Medicaid payment for medical expenses is far greater.

D. Factual Background and Procedural History.

E.M.A. suffered severe injuries at birth resulting in a diagnosis of cerebral palsy with profound physical disabilities. (J.A. 14, ¶22) E.M.A.'s injuries allegedly resulted from the negligence of the medical professionals who attended to her delivery.

E.M.A.'s mother, Sandra Armstrong, applied to the Petitioner Department of Health and Human Services for Medicaid services on E.M.A.'s behalf on April 26, 2000. Pursuant to North Carolina law, she signed an application form which stated in part, that, as a condition of accepting medical assistance, she "agreed to give back to the State any and all money that is received by me or anyone listed on the application . . . for payment of medical and/or hospital bills for which the Medical Assistance program has or will make payment." (Pet. App. 6a; J.A. 30, ¶2)

As a result of her injuries, E.M.A. received medical treatment resulting in payments by DHHS in excess of $1.9 million. (J.A. 14, ¶23) All of the State's payments "were for the cost of the minor Plaintiff's medical care

as a result of the injuries she suffered at her birth." (J.A. 15, ¶24)

1. State court tort action and settlement.

E.M.A.'s guardian *ad litem* and her parents filed a personal injury lawsuit in February 2003 against E.M.A.'s medical care providers for malpractice. The plaintiffs sought compensatory damages resulting from defendants' negligence. The state court complaint alleged that as a proximate result of such negligence "[s]ubstantial medical and life care expenses have been incurred and will continue to be incurred." (J.A. 64, ¶¶45 and 46)

In preparation for settlement negotiations in the state court litigation, counsel for E.M.A.'s guardian *ad litem* and parents was advised by DHHS that, as of September 2006, the Medicaid program had expended in excess of $1.9 million in public funds for medical care directly related to the injuries E.M.A. sustained at her birth. (J.A. 33, ¶¶20, 23, 24) Under North Carolina law, any attorney retained by the beneficiary who has notice of Medicaid payments has a duty to enforce the State's right of recovery. N.C. Gen. Stat. § 108A-57(a).

The plaintiffs settled their medical malpractice action for a lump sum payment, which was not allocated as to different types of damages. A hearing to approve the settlement was held November 13, 2006

in state court. (J.A. 17, ¶34; J.A. 119-20) Because the amount of the State's payments for medical services exceeded one-third of the total recovery, the state court determined the maximum potential amount of the lien pursuant to N.C. Gen. Stat. § 108A-57 was $933,333.33, and ordered that amount to be held in escrow by the county clerk of court until the actual amount of the lien owed to DHHS could be determined. (J.A. 87, ¶13; J.A. 17, ¶35)

On November 14, 2006, the state court entered its order approving the settlement between the parties to the medical malpractice action, which provided that the settlement schedule specifying the dollar amounts implementing the settlement shall be filed under seal. (J.A.78-90) The order approving settlement provided that plaintiffs would waive and relinquish all claims against defendants and directed plaintiffs to file a dismissal with prejudice as to defendants upon payment of the agreed upon amounts. (J.A. 88, ¶¶14 and 15)

The state court order approving the settlement also established an Irrevocable Special Needs Trust for E.M.A. which allowed E.M.A. to receive her portion of the settlement proceeds while still maintaining Medicaid eligibility for her future medical expenses. (J.A. 85, ¶5) Because the trust was established in accordance with 42 U.S.C. § 1396p(d)(4)(A), E.M.A. remains eligible for Medicaid benefits and the State has continued to pay substantial amounts for her on-going medical care. E.M.A. is qualified to receive

Medicaid as a result of her continued need for skilled nursing care and therapy. (J.A. 14, ¶22)

In December 2006, DHHS moved to intervene in the state court medical negligence litigation seeking disbursement of the escrowed funds. (J.A. 19-20, ¶44) A hearing was scheduled for March 27, 2007; however, on March 23, 2007 the guardian *ad litem* for E.M.A. filed a complaint for declaratory judgment in the United States District Court for the Western District of North Carolina. At the March 27, 2007 hearing, the state court denied the State's motion to intervene in the medical negligence action finding that the November 2006 order approving the minor settlement had fully discharged all defendants. The court permitted Respondents to dismiss the action, with the funds available to satisfy the Medicaid lien remaining in escrow.[2]

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[2] On September 24, 2007, DHHS filed a state court complaint pursuant to N.C. Gen. Stat. § 1-508 seeking review of the superior court's order and distribution of the medical negligence settlement funds held by the Catawba County Clerk of Court. Respondents moved to abate the lawsuit because of the prior pending federal court case arising out of the same subject matter. The state trial judge denied the motion finding that the federal declaratory judgment action involved substantially different parties and issues. On appeal, the North Carolina Court of Appeals reversed. *N.C. Dept. of Health and Human Servs. v. Armstrong*, 690 S.E.2d 293 (N.C. Ct. App. 2010).

2. Litigation in the district court.

The federal complaint, filed on behalf of E.M.A. in the Western District of North Carolina, alleged that N.C. Gen. Stat. §§ 108A-57 and 108A-59 ("the North Carolina Medicaid third-party recovery statutes") violate 42 U.S.C. § 1396p (the federal "Medicaid anti-lien law") and are unconstitutional to the extent they allow the Medicaid program to assert a lien on compensation for damages other than medical expenses. The complaint requested that the State Medicaid program be enjoined from asserting a lien on the minor plaintiff's proceeds. (J.A. 25, ¶3) The federal complaint was subsequently amended to add E.M.A.'s parents, Sandra and William Armstrong, as additional parties. (J.A. 12, ¶11)

The district court stayed the action awaiting a decision in a pending case by the North Carolina Supreme Court, *Andrews v. Haygood*, 362 N.C. 599, 669 S.E.2d 310 (2008), *cert. denied sub nom. Brown v. N.C. Dep't of Health and Human Servs.*, 129 S. Ct. 2792 (2009) (Pet. App. 86a-113a). On December 12, 2008, the North Carolina Supreme Court upheld the State's statutory procedure, ruling that it was consistent with the Medicaid Act's anti-lien law as construed in *Ahlborn*. The court in *Andrews* concluded that the North Carolina law provides a reasonable method for determining "the medical expense portion of a settlement," one that "protects [the recipient's] interests while promoting efficiency in Medicaid

reimbursement cases throughout North Carolina." (Pet. App. 95a)

On June 28, 2010, the district court granted summary judgment in favor of DHHS holding that the North Carolina third-party liability provisions are consistent with the Medicaid Act's anti-lien provisions as construed in *Ahlborn*. (Pet. App. 71a-85a) The district court found that the "Arkansas reimbursement statute [in *Ahlborn*] violated the federal anti-lien provision because it permitted the State to impose a lien beyond the portion of a settlement allocated to medical care." (Pet. App. 82a) By contrast, the district court declared that the North Carolina statute "provides a means of calculating that portion, and then forbids the State from imposing a lien on the remainder of the settlement." (Pet. App. 82a) The district court found the decision of the North Carolina Supreme Court in *Andrews* persuasive, noting that North Carolina's statute prevents a Medicaid recipient from suffering an "excessive depletion of a plaintiff's recovery to satisfy the State's reimbursement lien" because the recovery is capped at one-third of the total recovery. (Pet. App. 82a-83a)

3. The Fourth Circuit's decision.

The United States Court of Appeals for the Fourth Circuit vacated the judgment of the district court. The court held that North Carolina's statutory allocation and cap on the State's recovery does not comport with *Ahlborn* because "it permits DHHS to assert a lien

against settlement proceeds intended (or otherwise properly allocable) to compensate the Medicaid recipient for other claims, such as pain and suffering or lost wages (i.e., in cases where one-third of the recipient's total settlement recovery is greater than the amount DHHS expended on the recipient's behalf)."[3] (Pet. App. 42a) The court ruled that N.C. Gen. Stat. § 108A-57(a) could not be upheld as a special rule or procedure for allocating tort settlements, (Pet. App. 52a), and also found that North Carolina's statutory lien conflicted with the relevant guidance published by the CMS.

The Fourth Circuit concluded that the amount of a recovery that is allocable to medical expenses must be determined pursuant to an adversarial proceeding that affords the Medicaid recipient an opportunity to rebut the statutory presumption. (Pet. App. 53a) The court therefore vacated the decision of the district court and remanded for an evidentiary hearing to

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[3] The Fourth Circuit misstates North Carolina law, which provides that the Medicaid lien is the lesser of the amount of assistance paid by DHHS on behalf of the recipient or one-third of the recovery. N.C. Gen. Stat. § 108A-57. The statutory lien would never result in a recovery of more than the amount DHHS expended on medical services for the recipient even if one-third of the recovery exceeds the amount expended by DHHS. The Fourth Circuit did not repeat this misstatement elsewhere in its opinion, and it does not appear to have been the basis for its holding.

determine the proper amount of DHHS's Medicaid lien. (Pet. App. 55a)

SUMMARY OF ARGUMENT

North Carolina's third-party recovery statutes are not preempted by the Medicaid Act's anti-lien provision because they define the amount of a damage award representing compensation for past medical expenses and then preclude the State from imposing a lien on the remainder of the settlement. Neither the Medicaid Act nor the *Ahlborn* decision specify how a state should determine what portion of a settlement constitutes reimbursement for medical expenses. And North Carolina's third-party recovery procedures have been expressly approved by the CMS, the agency charged with administering the Medicaid program.

North Carolina's procedure apportions in advance of settlement or judgment by a Medicaid recipient the medical services component of any damage recovery. The statutory provisions provide a fair and efficient process for allocating tort settlements that is consistent with the State's long-standing statutory history of apportioning damage recoveries to protect the claims of medical care providers.

Only the State can decide whether to reduce or compromise its Medicaid lien. Allowing the parties to a tort action to structure a settlement so as to minimize the component attributable to medical expenses previously paid by Medicaid is contrary to

the intent of the relevant federal and state statutes mandating the recovery of third-party payments as well as to the fundamental status of Medicaid as the payer of last resort. Nor will a post-settlement, "true value" hearing as contemplated by the Fourth Circuit's decision result in a fair and objective evaluation of the State's entitlement to reimbursement pursuant to its Medicaid lien. There is no "true value" when a personal injury lawsuit is settled; it is ultimately worth what the defendants will pay to be released from liability and what the plaintiffs will accept to dismiss their action.

The State cannot meaningfully participate at such a proceeding because it has no knowledge as to why the parties arrived at the precise settlement figure they did and also has no access to the assessments and considerations that motivated the decision. And the post-settlement hearing will entail presentation of liability and damage evidence from experts, imposing significant litigation costs and burdens on both the recipient and the State.

North Carolina's statutory allocation provisions obviate the need for a "true value" hearing because the parties have full knowledge in advance of any negotiated settlement of the amount of the State's medical service expenditures. The Medicaid lien component must necessarily become part of the settlement calculus. Conducting a post-settlement "true value" hearing would allow the parties to offer self-serving statements as to the structure of their

settlement. The State would have no knowledge or other basis to challenge such statements.

ARGUMENT

NORTH CAROLINA'S THIRD-PARTY RECOVERY STATUTES ARE NOT PREEMPTED BECAUSE THE MEDICAID ACT DOES NOT DIRECT HOW SETTLEMENTS MUST BE APPORTIONED.

In *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), this Court interpreted the Medicaid Act in the context of a state's attempt to claim the majority of the proceeds of a settlement between a Medicaid recipient and the tortfeasor. Arkansas, in its capacity as a party to a federal court declaratory judgment action, had stipulated that only one sixth of the settlement proceeds represented payments for medical expenses, but it sought recovery of its entire Medicaid payment. This Court held that the anti-lien provisions, when read in conjunction with the third-party reimbursement provisions, permitted Arkansas to recover only the portion of the settlement proceeds that properly represented medical expenses.

The Medicaid Act, however, does not regulate how a state should determine what portion of a personal injury damage settlement represents reimbursement for medical expenses. This Court in *Ahlborn* did not supply the absent regulation consistent with the

longstanding doctrine that "[t]o supply omissions transcends the judicial function." *W. Va. Univ. Hosps., Inc. v Casey*, 499 U.S. 83, 101 (1991) (citations omitted). North Carolina's third-party recovery statutes are not preempted by the Medicaid Act's anti-lien provision because they define the amount of a damage award representing compensation for past medical expenses and then preclude the state from imposing a lien on the remainder of the settlement. Nothing in the Medicaid Act overrides the states' longstanding power to regulate tort actions in that manner.

A. The Medicaid Act Leaves to the States the Determination of What Portion of Damages Recovered from a Third Party is Properly Allocable to Medical Expenses.

Ahlborn was limited to the narrow issue of whether Arkansas could recover its Medicaid expenditures from the portion of a settlement that all parties, including the State, agreed represented compensation for matters separate from medical costs. *Ahlborn* did not attempt to define how to identify the portion of a recovery that represents reimbursement for medical expenses. Because of the controlling stipulations, the Court had no reason to address any particular method for determining how much of a settlement, in the absence of a stipulation, represents payment for medical expenses.

Ahlborn did not preclude a state's ability to statutorily assert its priority to recover monies appropriately attributable to medical expenses as a part of the settlement process. As shown below, a state law such as North Carolina's, which establishes in advance rules for how settlement recoveries are allocated, is consistent with the Medicaid Act, including its anti-lien provision.

1. State procedures for allocating tort settlements by Medicaid recipients are not precluded by the anti-lien provision.

A state's ability to allocate a recipient's tort settlement necessarily follows from the forced assignment requirement of the Medicaid Act. Without the ability to protect its lien for Medicaid expenditures, the state would only be able to recover the amount the recipient claims represents third-party compensation for past medical expenses. The anti-lien provision, however, does not give recipients that power to undermine the Act's third-party recovery provisions.

Ahlborn found that the Medicaid Act's "third-party liability provisions *require* an assignment" of the right to recover that portion of a settlement that represents payment for medical care, 547 U.S. at 282, declaring "[t]here is no question that the State can require an assignment" of a Medicaid recipient's right to receive payments for medical care, and that the State's prerogative is "expressly provided" for in the third-

party recovery provisions of the Medicaid Act. *Id*. at 284. This Court concluded that "[t]o the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision." *Id.*

However, neither the Medicaid Act nor *Ahlborn* specifies how a state should determine what portion of a personal injury damage settlement represents reimbursement for medical expenses. *Ahlborn* recognized that states may have "special rules and procedures for allocating tort settlements," but ultimately "express[ed] no view on the matter" and "le[ft] open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation." *Id*. at 288 n.18.

The determination of how to allocate damages in a tort claim action has been left to the states. As Justice Ginsburg recognized in *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566, 2632 (2012):

> [a]ny fair appraisal of Medicaid would require acknowledgment of the considerable autonomy States enjoy under the Act. . . . Subject to its basic requirements, the Medicaid Act empowers States to select dramatically different levels of funding and coverage, alter and experiment with different financing and delivery modes, and opt to cover (or not to cover) a range of particular procedures and

> therapies. States have leveraged this policy discretion to generate a myriad of dramatically different Medicaid programs over the past several decades.

(Ginsburg, J., concurring in part, concurring in the judgment in part and dissenting in part) (citations omitted). As discussed in Section (A)2., *infra*, determining the rules that apply to tort actions, including the allocation of damage recoveries, is one of those powers that Medicaid leaves to the states.

North Carolina's Medicaid lien statute reflects a proper exercise of the legislative prerogative where federal law provides no procedure for states to employ in furtherance of their third-party recovery obligation. The statutory formula provides a fair, certain and effective solution that balances the recovery of taxpayer monies paid for necessary medical care with the individual needs of a recipient who has been injured by the negligence of a third party. North Carolina's statute cannot be said to conflict with federal law regulating how to allocate settlements, when there is no such federal law.

2. States have traditionally exercised broad authority over tort actions, including the amount of damages that a party may recover.

The Medicaid Act's provisions regarding recoveries from third-party tortfeasors (or their insurance

companies) operate within the context of a tort system that is largely governed by state law. States have longstanding control over the parameters of tort actions, including the regulation of issues regarding the scope of damages that may be recovered. Indeed, it has been observed that "the provision of tort remedies to compensate for personal injuries . . . [is] within the scope of the States' historic police powers." *Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 894 (2000) (Stevens, J., dissenting).

A state can allow or disallow certain types of claims (*e.g.*, pain and suffering; loss of consortium; emotional distress; lost wages and earning capacity); a state can have a contributory negligence rule or a comparative negligence rule; it can have various assumption of risk rules; it can impose caps on certain types of recoveries; and it can bar claims not brought within the requisite time set forth in a statute of limitations. A state has authority to adopt tort rules declaring, for example, that punitive damages or pain-and-suffering damages may not exceed a certain amount. A plaintiff therefore has no absolute entitlement, separate and apart from what state law allows, to recover any particular amount for any particular type of damages.

In North Carolina, the statutory allocation of Medicaid settlements is reinforced by the broad range of the General Assembly's enactments regulating various aspects of tort actions. For example, legislation governs how damages are allocated when

two or more persons become jointly or severally liable in tort for the same injury pursuant to the "Uniform Contribution Among Tort-Feasors Act," N.C. Gen. Stat. § 1B-1, *et seq*. (2011). Punitive damages are capped at $250,000 or three times the amount of compensatory damages by N.C. Gen. Stat. § 1D-25. Noneconomic damages in medical malpractice actions are capped at $500,000 by N.C. Gen. Stat. § 90-21.19. And tort claims against the State are barred unless brought within three years after accrual, N.C. Gen. Stat. § 143-299, with the maximum amount that the State can be made to pay cumulatively to all claimants arising out of any one occurrence capped at $1,000,000. N.C. Gen. Stat. § 143-299.2 (2011).

The North Carolina Medicaid third-party recovery statutes at issue are part and parcel of the State's longstanding exercise of its power to oversee tort actions. North Carolina has specifically recognized a statutory medical lien on proceeds of tort settlements for over 70 years. This medical lien, which predates the existence of the Medicaid program, applies when injured persons have obligations for medical bills at the time of judgment or settlement.

Tracing back to legislation first adopted in 1935, N.C. Gen. Stat. § 44-49 creates a "lien upon any sums recovered as damages for personal injury in any civil action in this State" for providers of medical supplies or services. (App. 1-2) N.C. Gen. Stat. § 44-50 further provides that such lien "shall also attach upon all funds paid to any person in compensation for or

settlement of the injuries, whether in litigation or otherwise," and specifies an allocation formula under which "[t]he lien provided for shall, in no case, exclusive of attorneys' fees, exceed fifty percent (50%) of the amount of damages recovered."[4] (App. 3-4) Thus, the concepts and policy considerations underlying the statutory formula contained in N.C. Gen. Stat. § 108A-57 are not unique to settlements involving Medicaid recipients; instead, they are wholly consistent with North Carolina's long-standing statutory allocation of tort settlements to protect the providers of medical supplies and services.

3. North Carolina's statutes apportion, in advance of a settlement or judgment, the medical services portion of any recovery of damages.

As previously discussed, *Ahlborn* recognized that states may have "special rules and procedures for allocating tort settlements," but ultimately "express[ed] no view on the matter" and "le[ft] open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation." *Id.* at 288 n.18. And while noting that the issue was not squarely before it, this Court

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[4] In the situation where attorney's fees are set at 33%, the medical services lien formula for non-Medicaid recipients is the functional equivalent of the lien formula set out in N.C. Gen. Stat. § 108A-57 applicable to Medicaid recipients.

acknowledged that one way to avoid manipulation of a settlement so as to "allocate away the State's interest" was to obtain "the State's advance agreement to an allocation." *Id.* at 288.

North Carolina's statutes utilize both approaches addressed by *Ahlborn*: they establish criteria regarding how tort settlements are to be allocated when the Medicaid program has paid a recipient's medical expenses and they provide an advance agreement that the State will reduce its lien if the amount of the Medicaid lien exceeds one-third of the total recovery. North Carolina law does this by requiring a recipient's attorney who has actual notice of payments made on behalf of the recipient to enforce the Medicaid program's subrogation rights. N.C. Gen. Stat. § 108A-57.

Thus, before a settlement is ever reached, the recipient's attorney is aware of the precise amount that must be allocated to satisfy the Medicaid lien; the Medicaid lien is, necessarily, a part of the settlement negotiations. There is no possibility that the parties could be uncertain as to the amount that represents reimbursement for medical expenses. The parties must allocate the settlement in conformity with the statute. Furthermore, because the parties to the settlement agreement know in advance what the medical expenses portion of any settlement will be, the recipient can fully and accurately evaluate any settlement offer.

North Carolina law recognizes that an injured recipient has suffered cognizable damages other than medical damages. As an incentive for the recipient to pursue the action, and, as compensation for her non-medical damages, North Carolina law shields a substantial portion of the recipient's recovery from the Medicaid lien. The Medicaid lien is limited to the amount paid by Medicaid, not to exceed one-third of the settlement even if the actual Medicaid payment for medical expenses is far greater and even if future Medicaid expenses for the recipient are expected to be substantial. This ensures that the recipient has access to the majority of the proceeds to pay attorneys fees and costs as well as to apply to categories of damages other than medical expenses.

The statutory formula also guarantees that, if the case has weaknesses, or if the tortfeasor has limited funds, or if, for any other reason, the case must be settled for cents on the dollar, the Medicaid lien is automatically compromised in order to ensure that the recipient still retains the greater portion of the settlement to apply to her litigation costs and non-medical damages.

Thus, the recipient retains full discretion to compromise her claims but has no legal basis to unilaterally foreclose the Medicaid lien by omitting or understating the medical damages. The amount which will go to Medicaid is set by statute. The Medicaid lien is part of the fabric of the settlement. Irrespective of whether the parties to a settlement purport to

"designate" the amount of the medicals or not, the Medicaid lien is protected since it is established and defined by statute.

As recognized by the district court below, North Carolina's statute "provides a means of calculating that portion [of a settlement representing payment for medical expenses], and then forbids the State from imposing a lien on the remainder of the settlement." (Pet. App. 82a) As such, the statute "protects [Medicaid recipients'] interests while promoting efficiency in Medicaid reimbursement cases throughout North Carolina." (Pet. App. 79a-80a) And, as recognized by the North Carolina Supreme Court in *Andrews*, "[w]eighing these and other public policy considerations is the province of our General Assembly." (Pet. App. 96a)

B. The Fourth Circuit Erred in Holding That There is a "True Value" of Tort Claims that Can, and Must, Be Determined through Evidentiary Hearings or the Parties' Designation.

As previously shown, the parameters of tort recoveries are governed by state law, including the amount of damages that may be recovered. The decision of the Fourth Circuit suggests, however, that irrespective of the amount of a settlement reached by the parties, there is an ascertainable "true value" of the case that should control what portion of any settlement is subject to the State's third-party recovery

rights. However, a post-settlement hearing will be burdensome to both the Medicaid recipient and the State while not establishing a bona fide "true value" from which to allocate a tort settlement.

1. A post-settlement "true value" hearing, as required by the Fourth Circuit, is untenable.

The Fourth Circuit erred by reading into *Ahlborn* a requirement that a hearing "must determine the true value of the case," (Pet. App. 50a), and that the amount of North Carolina's statutory lien "must be subject to adversarial testing" (Pet. App. 53a). *Ahlborn* did not hold that a post-settlement hearing must be conducted to allocate damages. In response to concerns expressed by Arkansas and the United States that private litigants might manipulate settlement allocations, this Court observed that such a risk can be avoided either by obtaining the state's advance agreement to an allocation or, "if necessary, by submitting the matter to a court for decision." *Ahlborn*, 547 U.S. at 288. This mere suggestion of a court review does not support the Fourth Circuit's requirement for an evidentiary hearing to establish what portion of the settlement proceeds are "properly allocable to past medical expenses." (Pet. App. 54a) *Ahlborn* held nothing of the sort, and other language in the opinion leaving open the possible adoption of special rules and procedures confirms that states have other available options that are consistent with the Medicaid Act.

Nor would it make sense to require such hearings. There is no objective "true value" of a case that can be divined by post-settlement analysis. Necessarily, settlements reflect subjective and individualized considerations that prompt plaintiffs to forgo trials. Even if a judge holds a full-blown post-settlement hearing to determine what damages the plaintiff could have recovered if the case had gone to trial, that does not inform the question of what portion of which category of damages the jury would have accepted and to what extent so as to establish a hypothetical "true value." Nor is there any realistic basis for determining what portions of the settlement are properly allocable to different types of damages when parties settle for less than the asserted amount of their claim.

Furthermore, any post-settlement "true value" hearing would be wasteful, time consuming, and costly for both the state and the plaintiff. Parties settle tort actions in large part to spare themselves the large expenses of a trial. Yet the Fourth Circuit rule would require frequent mini-trials that could amount to proceedings as involved and costly as a trial itself. Liability theories and defenses would have to be addressed and expert testimony would be required on the various components of damages.

The state would necessarily be at a decided disadvantage at any post-settlement hearing, without critically-important knowledge essential to assess any "true value" of the case as well as the reasons why the parties arrived at the precise settlement figure they

did. The state comes to the case only with its proof of damages and no independent proof of liability, being largely, if not entirely dependent upon the recipient for that evidence. Meaningful participation by the state would require access to the parties' privileged settlement assessments and communications as well as to information protected by the attorney-client privilege.

The post-settlement "true value" hearing contemplated by the Fourth Circuit would be necessary in most cases but would not result in a fair or objective evaluation of the State's Medicaid lien. Experience shows that the vast majority of tort actions settle. Data from 2005 analyzed by the Bureau of Justice Statistics found that only 4% of all tort dispositions resulted from bench and jury trials. Thomas H. Cohen, Bureau of Justice Statistics, *Tort Bench and Jury Trials in State Courts, 2005* (2009) at 1. Additionally, another study indicated that "[a]bout 95% of medical malpractice insurance claims settled prior to trial." Thomas H. Cohen & Kristen A. Hughes, Bureau of Justice Statistics, *Medical Malpractice Insurance Claims in Seven States, 2000-2004* (2007) at 7.

North Carolina's statutory allocation provision obviates the need for a "true value" hearing because the amount of the State's lien for past medical service payments is known in advance of any settlement negotiations, and the statutory formula allows a precise determination by the recipient as to the portion

of any settlement to be repaid to the State. A post-settlement proceeding built around self-serving testimony on behalf of a plaintiff as to how a settlement was structured, for which the State would have virtually no basis to challenge, would substantially undercut the State's ability to enforce its third-party recovery rights.

2. A recipient's designation of the amount of damages attributable to past medical expenses inadequately protects the State's lien.

A Medicaid recipient has no right to reduce her reimbursement obligation because the recovery was less than the full amount of her damages. The reimbursement lien is part of a quid pro quo for her immediate access to medical care even though a third party was responsible for her injuries. Allowing either a binding designation by the plaintiff or applying a pro rata reduction to the medical damages component of a damage recovery would transfer control over the State's lien to the recipient.

The Fourth Circuit opinion takes out of context language from *Ahlborn* when it declares that state laws are prohibited if they "permit recovery over and above what the parties have appropriately designated as payment for medical items and services." (Pet. App. 46a) *Ahlborn* found that Arkansas, as a party to the federal court declaratory judgment action brought by the recipient, had conclusively stipulated to the

portion of the settlement proceeds that were "properly . . . *designated* as payments for medical costs." 547 U.S. at 288 (emphasis added). In proper context, the use of the word "designated" refers to the agreed stipulation and offers no support for the contention that a plaintiff and a tortfeasor have the power to "designate" which portion (if any) of a settlement is recoverable as reimbursement for the payment of past medical expenses by a state that has not agreed to such designation.

Plainly, there is an incentive for the recipient to allocate claims artificially to other categories other than past medical expenses in order to benefit at the expense of the state. Indeed, both plaintiff and defendant have an interest in minimizing the amount the plaintiff has to pay out to the state in satisfaction of the Medicaid lien. It defies common sense to allow a plaintiff to control the self-interested allocation that would place the state in the position of challenging a personal injury attorney's estimate of the amount of damages recoverable and diminishes the likelihood of achieving any such recovery.

Nor can use of a simplistic "proportional analysis" resulting in a pro rata reduction of the medical lien when the settlement does not fully compensate for the "true value" of the case withstand analysis. (Pet. App. 50a) Evidence regarding medical damages is stronger than many other elements of a tort recovery; they are easily reduced to dollar amounts; they do not entail speculation and they are not easy to manipulate or

exaggerate. Thus, although other damages may be discounted because they are difficult to prove or speculative, there is no logic in reducing the medical damages in the same proportion. Furthermore, medical bills are an obligation and a priority that must be addressed even if that means that the recipient is not made whole on all other damages. Not all damages have equal weight.

Additionally, application of a pro rata reduction theory to funds recovered in settlement with third parties would create opportunities for manipulation of the amount apportioned for different types of damages. That is, the more the recipient is able to inflate her claim for non-medical damages, the more the recipient would be able to keep and the less Medicaid would receive in reimbursement. Any suggestion that recipients will not manipulate their hypothetical total damages, but will, instead, recognize a personal responsibility to repay the Medicaid program is belied by the facts of this case where the recipient accepted almost two million dollars of services paid for by taxpayers and then sought to deny the Medicaid program even a single dollar of the $2.8 million dollar settlement.

While the Fourth Circuit indicated its rejection that a "proportional analysis" was appropriate, it remanded the case with instructions for the district court to find the "true value" of the case. (Pet. App. 50a) The decision then cited with approval language in *Price v. Wolford*, 608 F.3d 698, 707-08 (10th Cir.

2010), that could support a proportional reduction in the Medicaid lien on the grounds that liability is uncertain or on the grounds that the defendant is unable to pay any more. (Pet. App. 50a-51a n.12) The Fourth Circuit characterized *Wolford* as having "helpfully indicated the kind of considerations that might be salient in assessing the propriety of a particular lien determination," noting that "[t]he usual reasons [for paying less than the full amount of the Medicaid lien] would be that the liability of the settling defendant is uncertain or that the defendant lacks the money to pay for his full liability (or both)." (Pet. App. 50a-51a n12) As such, the opinion inappropriately suggests the utilization of a proportional analysis as part of the "true value" determination.

It would be irrational to allow a recipient to structure a settlement in such a way as to reflect minimal compensation for medical expenses. And utilization of a pro rata formula would similarly force the State to bear the financial consequences of her actions contrary to the intent of the relevant federal and state statutes.

C. North Carolina's Third-Party Recovery Procedure Operates with the Knowledge of and the Approval of the Centers for Medicare & Medicaid Services.

The Centers for Medicare and Medicaid Services ("CMS"), which is a branch of the Department of Health and Human Services, administers the Medicaid program. *Douglas v. Indep. Living Ctr. of S. Cal.*, 132 S. Ct. 1204, 1205 (2012). This Court has recognized Congress's "extremely broad [delegation of] regulatory authority to the Secretary in the Medicaid area." *Ahlborn*, 547 U.S. at 292 (citing *Wis. Dept. of Health & Family Servs. v. Blumer*, 534 U.S. 473, 497 n.13 (2002) (citations omitted)).

CMS is mandated by 42 U.S.C. § 1396(a)(25)(A)(ii) to monitor, on an ongoing basis, a state's plan for pursuing third parties. CMS is aware of North Carolina's statutory methodology for allocating damages and has specifically declared that North Carolina's statute comports with the anti-lien provision as it was construed in *Ahlborn*. CMS maintains that North Carolina's statutes are consistent with the Medicaid Act and specifically approved the analysis of North Carolina's procedures in the State Supreme Court decision in *Andrews*. *See* December 23, 2009, Reply Memo of the Centers for Medicare & Medicaid Services to [North Carolina Congressman] Howard Coble. (Pet. App. 139a-142a)

The Fourth Circuit cited a July 3, 2006 CMS Memorandum, "State Options for Recovery Against Liability Settlements in Light of U.S. Supreme Court Decision in *Arkansas Department of Human Services v. Ahlborn*," Centers for Medicare & Medicaid Services ("CMS Memorandum") (Pet. App. 124a-138a), as

support for its holding that North Carolina's statute conflicts with the Medicaid Act. (Pet. App. 45a-47a) However, that CMS Memorandum, after delineating the key findings of *Ahlborn*, listed actions that states may take, including (1) "enact laws which provide for a specific allocation amongst damage[s], i.e., pain and suffering, lost wages, and medical claims;" and (2) "require that cases can only be compromised with the consent of the state." (Pet. App. 129a)

The North Carolina third-party recovery statute is a law "provid[ing] for a specific allocation amongst damage[s]" - it provides that up to one-third of a total recovery must be designated as payment for past medical costs. (Pet. App. 47a) Additionally, North Carolina has put in place a law "requir[ing] that cases only be compromised with the consent of the state." (Pet. App. 47a) North Carolina's subrogation statute provides the State's consent to compromise by automatically reducing its lien to one-third of the recovery if the recovery does not equal at least three times the amount of the Medicaid lien. And, as previously shown, CMS has specifically stated that neither the North Carolina statute nor the *Andrews* decision conflicts with the CMS Memorandum. (Pet. App. 139a-142a) Thus, the Fourth Circuit misread and misapplied the relevant CMS guidance.

The Medicaid Act commits to the federal agency the power to administer a federal program. Where the agency has acted under this grant of authority, the decision "carries weight." *Indep. Living Ctr. of S. Cal.,*

Inc., 132 S. Ct. at 1210 ("[O]rdinarily review of agency action requires courts to apply certain standards of deference to agency decisionmaking."). *See Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs.*, 545 U.S. 967 (2005) (describing deference reviewing courts must show); *Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837 (1984) (same). CMS's approval of North Carolina's processes is entitled to deference.

CONCLUSION

The Judgment of the Court of Appeals for the Fourth Circuit should be reversed.

Respectfully submitted,

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November 2012 **Counsel of Record*

APPENDIX INDEX

North Carolina General Statute
§ 44-49 (2011) . . . . App. 1

North Carolina General Statute
§ 44-50 (2011) . . . . App. 3

N.C. Gen. Stat. § 44-49 (2012)

CHAPTER 44. LIENS
ARTICLE 9. LIENS UPON RECOVERIES FOR PERSONAL INJURIES TO SECURE SUMS DUE FOR MEDICAL ATTENTION, ETC.

N.C. Gen. Stat. § 44-49 (2012)

§ 44-49. Lien created; applicable to persons non sui juris.

(a) From and after March 26, 1935, there is hereby created a lien upon any sums recovered as damages for personal injury in any civil action in this State. This lien is in favor of any person, corporation, State entity, municipal corporation or county to whom the person so recovering, or the person in whose behalf the recovery has been made, may be indebted for any drugs, medical supplies, ambulance services, services rendered by any physician, dentist, nurse, or hospital, or hospital attention or services rendered in connection with the injury in compensation for which the damages have been recovered. Where damages are recovered for and in behalf of minors or persons non compos mentis, the liens shall attach to the sum recovered as fully as if the person were sui juris.

(b) Notwithstanding subsection (a) of this section, no lien provided for under subsection (a) of this section is valid with respect to any claims whatsoever unless the physician, dentist, nurse, hospital, corporation, or other person entitled to the lien furnishes, without charge to the attorney as a condition precedent to the creation of the lien, upon request to the attorney

N.C. Gen. Stat. § 44-49 (2012)

representing the person in whose behalf the claim for personal injury is made, an itemized statement, hospital record, or medical report for the use of the attorney in the negotiation, settlement, or trial of the claim arising by reason of the personal injury, and a written notice to the attorney of the lien claimed.

(c) No action shall lie against any clerk of court or any surety on any clerk's bond to recover any claims based upon any lien or liens created under subsection (a) of this section when recovery has been had by the person injured, and no claims against the recovery were filed with the clerk by any person or corporation, and the clerk has otherwise disbursed according to law the money recovered in the action for personal injuries.

HISTORY: 1935, c. 121, s. 1; 1947, c. 1027; 1959, c. 800, s. 1; 1967, c. 1204, s. 1; 1969, c. 450, s. 1; 2001-377, s. 1; 2001-487, s. 59.

N.C. Gen. Stat. § 44-50 (2012)

CHAPTER 44. LIENS
ARTICLE 9. LIENS UPON RECOVERIES FOR PERSONAL INJURIES TO SECURE SUMS DUE FOR MEDICAL ATTENTION, ETC.

N.C. Gen. Stat. § 44-50 (2012)

§ 44-50. Receiving person charged with duty of retaining funds for purpose stated; evidence; attorney's fees; charges.

A lien as provided under G.S. 44-49 shall also attach upon all funds paid to any person in compensation for or settlement of the injuries, whether in litigation or otherwise. If an attorney represents the injured person, the lien is perfected as provided under G.S. 44-49. Before their disbursement, any person that receives those funds shall retain out of any recovery or any compensation so received a sufficient amount to pay the just and bona fide claims for any drugs, medical supplies, ambulance services, services rendered by any physician, dentist, nurse, or hospital, or hospital attention or services, after having received notice of those claims. Evidence as to the amount of the charges shall be competent in the trial of the action. Nothing in this section or in G.S. 44-49 shall be construed so as to interfere with any amount due for attorney's services. The lien provided for shall in no case, exclusive of attorneys' fees, exceed fifty percent (50%) of the amount of damages recovered. Except as provided in G.S. 44-51, a client's instructions for the disbursement of settlement or judgment

N.C. Gen. Stat. § 44-50 (2012)

proceeds are not binding on the disbursing attorney to the extent that the instructions conflict with the requirements of this Article.

HISTORY: 1935, c. 121, s. 2; 1959, c. 800, s. 2; 1969, c. 450, s. 2; 1995, c. 538, s. 6(b); 1995 (Reg. Sess., 1996), c. 674, s. 3; 2001-377, s. 2.