No. 04-1506

In The
Supreme Court of the United States

ARKANSAS DEPARTMENT OF
HEALTH AND HUMAN SERVICES, et al.,

Petitioners,

v.

HEIDI AHLBORN,

Respondent.

**On Writ Of Certiorari To The
United States Court Of Appeals
For The Eighth Circuit**

REPLY BRIEF FOR THE PETITIONERS

MIKE BEEBE, Arkansas Attorney General
LORI FRENO, Assistant Attorney General
(*Counsel of Record*)
323 Center Street, Suite 200
Little Rock, AR 72201
(501) 682-1314 Fax: (501) 682-2591

*Attorneys for Petitioners
Arkansas Department of
Health and Human Services, et al.*

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INTRODUCTION

The parties and court of appeals agree that the Arkansas Department of Health and Human Services ("Department") may lawfully place a lien upon some portion of the settlement proceeds at issue; they merely disagree on the size of the portion. A straightforward reading of the third party liability ("TPL") provisions of federal Medicaid law reflect Congress's intent that the Medicaid program recover from third-party settlements the *full* cost of medical assistance provided to the recipient before she may retain any of the settlement proceeds. This interpretation is consistent with Medicaid's anti-lien provision, which protects certain "property" of a recipient from pre-death liens, and likewise squares with Congress's intention that Medicaid remain the "payer of last resort." Nothing in the language of the Medicaid statute nor its legislative history supports Respondent's position that Congress, through the anti-lien provision, limited Medicaid's recovery right to a compromise value of its claim. Moreover, Respondent's position is inconsistent with that of the Secretary of the United States Department of Health and Human Services, which Congress charged with the day-to-day administration of this highly complex administrative scheme.

I. Medicaid's TPL Provisions Mandate Full Reimbursement To The Medicaid Program From Third Party Personal Injury Settlement Proceeds

The strained interpretation of the TPL provisions reached by Respondent Heidi Ahlborn and the court of appeals is contrary to the plain language of those provisions and frustrates Congress's intent that Medicaid remain the "payer of last resort." S. Rep. No. 99-146 at 279

(1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 312. Through these unambiguous provisions, Congress mandated that the Medicaid program receive full reimbursement from proceeds of a third-party settlement before the recipient may retain any of the remaining proceeds. Likewise, a reasonable reading of the provisions does not authorize a recipient to compromise Medicaid's claim for medical costs.

First, 42 U.S.C. § 1396a(a)(25)(A) requires that states determine whether there are third parties who are potentially liable to pay for the care and services that the state Medicaid plan provided to the recipient. Next, 42 U.S.C. § 1396a(a)(25)(B) commands that if such liability is found, that the state must seek reimbursement from such third parties "*to the extent of* such legal liability,"[1] with the only exception being situations in which the amount that the state "can reasonably expect to recover exceeds the cost of such recovery." (emphasis added). Although Congress afforded the states this narrow opportunity to compromise third-party claims,[2] it set forth a general rule that the

[1] The fact that a tortfeasor and recipient might enter into a compromise settlement does not extinguish the tortfeasor's "legal liability" to Medicaid. Rather, the TPL provisions provide that the third party remains liable to Medicaid to the extent that the program made payments on the recipient's behalf for medical costs triggered by the third party. *See* 42 U.S.C. § 1396a(a)(25)(A), (B), and (H) (2000).

[2] As Amicus United States explained in its brief, "[w]here the State is notified and given an opportunity to participate in settlement negotiations, it may compromise its claim in appropriate circumstances, based on its assessment of the existence or extent of the defendant's liability. But that is a judgment for the State to make, pursuing the objectives of and within the limits imposed by the federal Medicaid program." Br. 13-14. In the present case, however, Ahlborn denied the State this opportunity by unilaterally reaching a settlement with liable third parties and presenting it to the State as a *fait accompli*.

Medicaid program is to be reimbursed by third parties to the maximum extent possible.

Congress's full-reimbursement intent is again reflected in 42 U.S.C. § 1396a(a)(25)(H), which provides:

> That *to the extent that payment has been made under the State plan for medical assistance* in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which*, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual*, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services.

(emphasis added). In this provision, Congress twice articulated the scope of recovery that state laws must require, making plain Medicaid's right to full reimbursement up "to the extent that payment has been made under the State plan for medical assistance," and "to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished an individual." *Id.*

Congress' language mandating that states effectuate laws under which they are "considered to have acquired the rights of such individuals to payment by any other party for such health care items and services" has but one reasonable interpretation: states acquire a Medicaid recipient's full right to payment from a liable third party "to the extent that payment has been made under the State plan." This construction is fully consistent with 42 U.S.C. § 1396a(a)(25)(A) and (B), which require states to ascertain possible third party liability and to seek

reimbursement "to the extent of such legal liability." Nothing in 42 U.S.C. § 1396a(a)(25) supports Ahlborn's position that she may compromise her entire cause of action and then force the State to accept from such a settlement merely a small portion of what Medicaid paid out for her care.

Congress's intention that Medicaid be the "payer of last resort" is likewise embodied in 42 U.S.C. § 1396k, which conditions Medicaid eligibility upon a recipient's assignment to the State of "any rights" to "payment for medical care from any third party." 42 U.S.C. §1396k(a)(1)(A) (2000). Nothing in the TPL provisions support Ahlborn's reading of "payment for medical care from any third party" as limiting Medicaid's reimbursement right to only that portion of a settlement recovery that the parties consider to be compensation for medical costs. Although a recipient may compromise her own claims in a third-party settlement, as did Ahlborn in the present case, it would frustrate Congress's full Medicaid reimbursement aim to allow a recipient and third party to compromise Medicaid's claim for medical costs.

In furtherance of this goal, Congress also established a payment priority in favor of Medicaid in 42 U.S.C. § 1396k(b), which provides:

> Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained *as is necessary to reimburse it for medical assistance payments* made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the

> remainder of such amount collected shall be paid to such individual.

(emphasis added). As applied to the present case, a straightforward reading of this provision instructs that states must retain from any third-party settlement enough money to fully reimburse Medicaid "for medical assistance payments made on behalf of a [recipient]" before the recipient may retain any of the proceeds. This provision, which creates a payment priority in favor of the Medicaid program, in conjunction with Congress's admonition in 42 U.S.C. § 1396a(a)(25) that states must seek reimbursement "*to the extent of* such legal liability," and "to the extent that payment has been made under the State plan," leave little doubt as to the broad scope of the recipient's assignment to Medicaid.[3]

Disregarding these straightforward statutory mandates, Ahlborn attempts to severely limit Medicaid's recovery rights by invoking Medicaid's "anti-lien" provision. 42 U.S.C. § 1396p(a)(1). Ahlborn's theory is that, notwithstanding that her right to recover her medical expenses from a third party had to be assigned to Medicaid as a condition of receiving benefits, her cause of action is a form of "property" under Arkansas law, and thus the Department was prohibited from pursuing Medicaid's claim for reimbursement from her compromise settlement with a liable third party except for some reduced portion

[3] The Respondent recognizes that "[n]either the anti-lien statute nor any of the other federal statutes prohibit the state from pursuing its [claim for medical care] independently." Resp. Br. 8. Although this is true, nothing in the Medicaid statute requires the State to litigate its claims directly and opposed to recovering from a third party settlement.

that is considered to be "payment for medical care."[4] The parties agree that the Department has a right to some portion of the third party settlement proceeds; they merely disagree on the size of that portion.

Initially, the parties agree that Ahlborn's cause of action constitutes "property" under Arkansas law, and that this Court has likewise recognized a vested cause of action to be property. Resp. Br. 7. Critically, the State law at issue does not authorize the placement of a lien on Ahlborn's cause of action, but rather expressly prohibits such a lien. *See* Ark. Code Ann. § 20-77-301(a) and (b) (2001) (providing that no action taken by the Department to recover Medicaid costs from a liable third party "shall be a bar to any action upon the claim or cause of action of the recipient . . . [n]or shall any action operate to deny to the recipient the recovery for that portion of any damages not covered hereunder"). In compliance with the federal TPL provisions, however, State law requires as a condition of Medicaid eligibility that a recipient "automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party . . . to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant."[5] Ark. Code Ann. § 20-77-307(a) (2001).

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[4] Ahborn and the parties with whom she settled did not allocate settlement proceeds between medical and non-medical damages. J.A. 44-45, 49. Because the Department did not learn about the final settlement until after it was completed, J.A. 23, 24, 42, it did not authorize the settlement nor agree to accept a compromise value for its claim. It was only after Ahlborn filed a declaratory judgment action in federal court that the parties stipulated to an allocation *solely* for the purpose of enabling the federal court to rule on the statutory construction issue as a matter of law. J.A. 18-19.

[5] Contrary to Ahlborn's contention that "Arkansas had enacted a law which automatically assigned to DHS all portions of a Medicaid

(Continued on following page)

This assignment is directed to the third-party payment, not Ahlborn's right to pursue a claim for damages. Because Arkansas law authorizes the placement of a lien upon a third-party recovery only to the extent necessary to reimburse Medicaid, as opposed to on a recipient's entire cause of action, it does not run afoul of the anti-lien provision.

Furthermore, Arkansas law places no restriction on a Medicaid recipient's right to pursue a cause of action. Rather, it merely protects Medicaid's federally-mandated right to full reimbursement. As an illustration, Ahlborn chose to pursue a lawsuit as a result of the auto accident at issue. She valued her cause of action at over three million dollars, and had the option to pursue third-party tortfeasors for that entire amount. Rather than go to trial, Ahlborn elected to compromise her claims. Arkansas law in no way restricted her from compromising her own claims, but nothing in the Medicaid Act, including the anti-lien provision, authorized her to compromise any portion of Medicaid's claim for full reimbursement.

Disregarding the mandatory and straightforward language of the TPL provisions, Amicus Association of American Trial Lawyers ("ATLA") argues that Congress

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recipient's recovery," Resp. Br. 3, the assignment is limited to the total amount paid by Medicaid on behalf of the recipient. Ark. Code Ann. § 20-77-307(a) (2001). Additionally, due to the placement of the assignment provision in Title 20, Chapter 77, Subchapter 3 of Arkansas Code Annotated entitled "Third-Party Liability," *see* Ark. Code Ann. § 20-77-30 *et seq.*, Ahlborn's concern that the assignment provision could be read to apply to property received "from a wealthy aunt" is misplaced. Resp. Br. 4-5. *See also Arkansas Dep't of Human Servs. v. Estate of Ferrell,* 336 Ark. 297, 303 (1999) ("Subchapter 3 [of Title 20, Chapter 77], titled 'Third-Party Liability,' addresses the means by which [the Department] can recover Medicaid expenditures when a third party is at fault in causing injuries to the Medicaid recipient").

intended that a Medicaid recipient be allowed "to retain an equitable portion of any recovery" received in a third-party settlement. Br. 7. In support of this argument, ATLA refers to the "made whole" doctrine, a common law equitable subrogation doctrine providing that "a health insurer may not obtain reimbursement for medical payments from a third-party tortfeasor until the injured plaintiff has been fully compensated for his damages." Br. 7 n. 5. Such an equitable subrogation doctrine has no place in the present analysis, however, because the federal TPL provisions plainly mandate full Medicaid reimbursement. Additionally, the Medicaid program is not a "health insurer." Finding the made whole doctrine inapplicable to the State Medicaid program in *Arkansas Dep't of Human Services v. Estate of Ferrell*, the Arkansas Supreme Court explained:

> [The Department] is not a private insurance company. It is a state agency statutorily charged with the responsibility to administer the federal Medicaid program. Federal law requires states which choose to participate in the Medicaid program to "take all reasonable measures to ascertain the legal liability of third parties" . . . It also requires the state to seek recovery of reimbursement from the third party to the limit of their liability after Medicaid claims payment.

984 S.W.2d 807, 808-09 (Ark. 1999) (*citing* 42 U.S.C. § 1396a(a)(25) and 42 C.F.R. §§ 433, 138, 139).

Furthermore, because the made whole doctrine's purpose is to "limit[ ] the ability of an *insurer* to exercise its right of subrogation until the insured has been fully compensated or made whole," J. Parker, *The Made Whole Doctrine: Unraveling the Enigma Wrapped in the Mystery of Insurance Subrogation,* 70 Mo. L. Rev. 723, 737 (2005)

(emphasis added), it would not apply to health care providers who provide services to an uninsured patient. Thus, assuming *arguendo,* that Ahlborn had not applied for Medicaid assistance but rather accumulated $320,000[6] in medical bills, her medical providers (e.g., hospital, doctors) would have a lien on her entire $550,000 settlement recovery that could not be reduced through the "made whole" doctrine. As the Petitioners discussed in their Brief, Congress surely did not intend that Medicaid receive less favorable treatment with regard to reimbursement than a private medical provider. Pet. Br. 46.

Advocating for a "rule of equitable apportionment," ATLA correctly recognizes that it would be "inappropriate . . . for this Court to establish specific procedures for state court judicial proceedings to allocate settlement proceeds." Br. 21. It thus proposes that "state courts and legislators" perform the task. *Id.* Aside from the fact that such a rule would run afoul of the federal TPL provisions and frustrate Congress's full reimbursement goal, it would also jeopardize the uniform application of federal law.

ATLA posits that a rule of equitable apportionment would increase Medicaid's third party liability reimbursements. Br. 19. First and foremost, as a result of Congress's full reimbursement mandate, federal law would not condone such a rule. Regardless, the proposition is mere

[6] The Department received bills from Ahlborn's health care providers for approximately $320,000 for accident-related expenses. J.A. 22, 42. The Medicaid program's ultimate financial obligation to the providers, however, was $215,645.30, the payment of which fully extinguished Ahlborn's financial obligation. *Id.* Thus, by virtue of her participation in the Medicaid program, Ahlborn's actual medical costs were reduced by over $100,000.

speculation. ATLA argues that Medicaid recovered "only" 1.6 *billion* dollars in 2004 from liable third-party payments, which constitutes but a small percentage of the amount for which third parties allegedly were liable. Br. 17 (emphasis added). However, it offered no evidence as to why full recovery was not made, and certainly there are a myriad of reasons. For example, a motorist who causes an auto accident that triggers tremendous Medicaid expenditures might be judgment proof but for a $25,000 liability insurance policy.

ATLA also argues that the full reimbursement rule advanced by the Department "would discourage settlements and impede the efficient resolution of legal disputes." Br. 9. Undoubtedly, settlements are a major component of our civil system of justice. ATLA's argument is flawed from both a legal and practical perspective, however, as it fails to recognize: (1) Congress's mandate that states pursue liable third parties "to the extent of [their] legal liability," and (2) that Congress afforded states only a narrow opportunity to compromise third-party claims. 42 U.S.C. § 1396a(a)(25)(B) (2000). Consequently, application of the appeals court's rule that states are entitled to recover only that portion of a settlement considered to be compensation for medical costs would not end the states' statutory duty to continue to seek full recovery, and thus would not end the litigation. And third parties would likely not be amenable to settling a case with a recipient unless Medicaid's claim was fully satisfied, thus ending the entire dispute. In any event, although the states' opportunity to settle cases is a narrow one, if it is notified and given an opportunity to participate in settlement negotiations, it may compromise its claim in appropriate circumstances.

II. The Secretary's Adjudications And Interpretations Addressing Medicaid, Which Is A "Complex And Highly Technical Regulatory Program," Are Entitled To Deference And Respectful Consideration

In discussing the degree of deference due to the Secretary, Ahlborn erroneously refers to formal adjudications of the Departmental Appeals Board of the United States Department of Health and Human Services as "opinion letters." Resp. Br. 17. The parties appear to agree that informal policy interpretations issued by an agency charged with the administration of a statute, such as those contained in an "opinion letter," are entitled to less than *Chevron* deference. *See* Resp. Br. 18-19, Pet. Br. 44-45. Unlike an informal policy interpretation, however, Departmental Appeals Board decisions that are reached through formal adjudication are entitled to *Chevron* deference. *See* Pet. Br. 37-41.

Amicus ATLA argues that no degree of deference is due to the Secretary's "formal" or "informal" interpretations. Br. 8-9 n. 6. First, they argue that the "administrative rulings are flatly inconsistent with the text of the act, which nowhere grants priority to a state Medicaid agency's claim for reimbursement." *Id.* This argument ignores Congress's full reimbursement mandate set forth throughout the TPL provisions, as well as the requirement of 42 U.S.C. § 1396k(b) that the state shall retain any amount collected under the assignment provision "as is necessary to reimburse it for medical assistance payments made on behalf of [the recipient]," with only the remainder being paid to the recipient.

Second, ATLA argues that the present issue "involve[s] only a straightforward issue of statutory construction." Br.

8-9 n. 6. The Department agrees that the language of the Medicaid statutes is "straightforward" and unambiguous, but disagrees with Ahlborn and ATLA's reading. *Id.* To the extent that an ambiguity exists, however, courts should defer (or give "respectful consideration") to the agency that is responsible for the day-to-day administration of Medicaid's highly complex administrative scheme. Finally, ATLA's argument that the Secretary's interpretation "should be disregarded as entirely self-serving" is unfounded, as it fails to recognize Congress's "extremely broad [delegation of] regulatory authority to the Secretary in the Medicaid area," *Wisconsin Dept. of Health & Family Servs. v. Blumer,* 534 U.S. 473, 497 n. 13 (2002) (citations omitted).

CONCLUSION

For the foregoing reasons and those stated in Petitioners' opening brief, the decision of the court of appeals should be reversed.

Respectfully submitted,

MIKE BEEBE,
Arkansas Attorney General
LORI FRENO,
Assistant Attorney General
(*Counsel of Record*)
323 Center Street, Suite 200
Little Rock, AR 72201
(501) 682-1314
Fax: (501) 682-2591

Attorneys for Petitioners
Arkansas Department of
Health and Human Services, et al.