No. 11-1197

In The Supreme Court of the United States

VERNON HADDEN,

Petitioner,

v.

UNITED STATES,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

BRIEF OF RETAIL LITIGATION CENTER, INC. AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER VERNON HADDEN

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STATEMENT OF INTEREST OF *AMICUS CURIAE*

The Retail Litigation Center, Inc.,[1] (hereinafter "RLC") is a public policy organization that identifies and engages in legal proceedings that affect the retail industry. The RLC, whose members include many of the country's largest and most innovative retailers, was formed for the purpose of providing courts with retail industry perspectives on important legal issues, and to highlight the potential industry-wide consequences of policies that are established by significant pending cases. The member entities whose interests are represented by the RLC operate throughout the United States, employing millions of people and providing goods and services to tens of millions more.

The issues raised by this Petition are of particular interest to the RLC's member organizations. Due to the widespread participation of these organizations in retail commerce, including the operation of retail facilities across the country that are accessed by millions of people every day, the organizations are

[1] Pursuant to Rule 37.2 of the Rules of the Supreme Court, counsel of record for all parties received notice at least 10 days prior to the due date of the *amicus curiae*'s intention to file this brief. All parties have consented to the filing of this brief. Those consents are being lodged herewith. Pursuant to Rule 37.6, no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae*, its members, or its counsel made a monetary contribution to its preparation or submission.

unavoidably faced with numerous claims for legal damages based upon claimed personal injuries. Many of these claimants are also Medicare beneficiaries.

The resolution of claims, whether litigated or not, is directly impacted by the application of the Medicare Secondary Payer Act (hereinafter referred to as "MSPA" or "the Act"). The interpretations of the Act by Medicare and the various Circuit Courts, including the decision of the Sixth Circuit here, have profoundly affected the ability of the RLC's member organizations to efficiently and fairly reach settlements in both undisputed and questionable claims that involve Medicare beneficiaries. The consequences are detrimental to both RLC members and claimants.

As a result of the decisions, the costs involved in addressing pre-litigation claims and in litigating claims have increased dramatically. Multiplied by the number of retail organizations represented by the RLC, and again by the number of claims made per organization, these costs in both money and time become wasteful in the extreme with no corresponding societal or economic benefit. Across the entire retail industry, the negative impact, for all parties, created by the improper interpretation of the MSPA expands exponentially.

SUMMARY OF THE ARGUMENT

Medicare's interpretation and application of the MSPA, as endorsed by the Sixth Circuit here as well as

by other circuit courts, exceeds the authority granted to it by Congress. The express language of the Act restricts Medicare's right of reimbursement to payments related to medical treatment, i.e., an "item or service." Medicare routinely goes well beyond that authority and demands full reimbursement from settlement funds, without regard to the purpose for which such funds were paid.

Not only does it exceed the bounds of Medicare's statutory authority, but this approach is also contrary to established public policy regarding the conduct of litigation and pre-litigation claim resolution. Medicare's overreach has created a legal environment that discourages timely and effective resolution of cases by settlement, encourages full litigation increasing overall litigation costs, and has effectively allowed Medicare to take monies from Medicare beneficiaries to which Medicare is not entitled.

The Sixth Circuit's analysis of the MSPA conflicts directly with the interpretation of the Act by the Eleventh Circuit, as found in *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010). *Bradley* recognized the adverse public policy consequences that would arise under Medicare's overly-broad interpretation of the MSPA.

The same principles that guided this Court's decision in *Ahlborn* should be applied in the Medicare context. Like the MSPA, the Medicaid statute requires reimbursement for medical expenses paid under that system when third-party tortfeasors are liable for the

medical expenses. See, *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006). This Court held in *Ahlborn* that Medicaid's right to reimbursement from settlements with third-party tortfeasors was limited to that portion of the settlement that represented payments for medical expenses. The express language of the MSPA requires the same principle to be applied in this case and in every case involving Medicare beneficiaries.

The pervasive and significant negative effects that have resulted and will continue to result from the Medicare policies endorsed by the Sixth Circuit make this case particularly appropriate for consideration by the Court. The Retail Litigation Center respectfully urges the Court to grant Hadden's petition for *certiorari*.

ARGUMENT

I. THE SIXTH CIRCUIT'S HOLDING IMPROPERLY RATIFIED MEDICARE'S UNDULY BROAD INTERPRETATION OF THE MSPA

The sole issue presented to the Sixth Circuit was whether Medicare's right to reimbursement for conditional payments must be compromised where the Medicare beneficiary received a compromised payment based upon claims made by the beneficiary against a primary payer. The court fundamentally

misread the statute, relying on the word "responsibility" rather than the critical phrase "with respect to an item or service."

According to the Sixth Circuit, the "key term" for resolution of this issue is "responsibility." *Hadden v. United States*, 661 F.3d 298, 302 (6th Cir. 2011). More specifically, the court stated:

> As used in § 1395y(b)(2)(B)(ii), "responsibility" is no longer an undefined term into which courts might funnel their own notions (or Hadden's) of equitable apportionment. It is instead a term of art, which defines several ways in which a primary plan's "responsibility" can be demonstrated for purposes of this section.
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> * * *
>
> Consequently, the scope of the plan's "responsibility" for the beneficiary's medical expenses – and thus of his own obligation to reimburse Medicare – is ultimately defined by the scope of his own claim against the third party. That is true even if the beneficiary later "compromise[s]" as to the amount owed on the claim, and even if the third party never admits liability.

Id.

However, the issue here does not deal with "responsibility." There is no question that a primary payer (such as Hadden as a result of the settlement from Pennyrile) "had a responsibility to make payment," 42 U.S.C. § 1935y(b)(2)(B)(ii), at least to some

degree. The question is not the responsibility for payment, but *the amount* of that responsibility in the context of the litigation in its entirety. Contrary to the holding of the Sixth Circuit, Medicare's recovery is limited by the statute to conditional payments made by Medicare "with respect to an item or service" to the extent that a primary payer also had a responsibility to make payment "with respect to such item or service." Specifically, the MSPA provides:

> A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment *with respect to such item or service*.

42 U.S.C. § 1395y(b)(2)(B)(ii) (emphasis added).

The Sixth Circuit placed too much emphasis on the word "responsibility" and ignored the remaining portions of the statutory provision. As this Court has noted:

> [A] word is known by the company it keeps (the doctrine of *noscitur a sociis*). This rule we rely upon to avoid ascribing to one word a meaning so broad that it is inconsistent with its accompanying words, thus giving "unintended breadth to the Acts of Congress."

Gustafson v. Alloyd Co., Inc., 513 U.S. 561, 575 (1995) (quoting *Jarecki v. G. D. Searle & Co.*, 367 U.S. 303,

307, 6 L. Ed. 2d 859, 81 S. Ct. 1579 (1961)). Instead of isolating the word "responsibility" and interpreting that word to mean essentially "full responsibility" no matter the circumstances, the Sixth Circuit should have considered the entire provision "against the background of what Congress was attempting to accomplish" with the MSPA. *Gustafson*, 513 U.S. at 575.

The Eleventh Circuit has offered a succinct description of the MSPA:

> The way the system is set up the beneficiary gets the health care she needs, but Medicare is entitled to reimbursement if and when the primary payer pays her. Among other avenues of reimbursement, Medicare is subrogated to the beneficiary's right to recover from the primary payer. 42 U.S.C. § 1395y(b)(2)(B)(iii). Medicare regulations extend that subrogation right to any judgments or settlements "**related to**" injuries for which Medicare paid medical costs, thereby casting the tortfeasor as the primary payer. 42 C.F.R. § 411.37 (2002).

Cochran v. U.S. Health Care Financing Administration, 291 F.3d 775, 777-78 (11th Cir. 2002) (emphasis added). The limitation on reimbursement by Medicare is not simply that the alleged primary payer must have been responsible, but also that the primary payer must have been responsible *for medical payments*, as opposed to some other form of damages.

Thus, the key words in the statute are "with respect to such item and service," not "responsibility,"

because the purpose of the MSPA is to allow reimbursement for payments made by Medicare for "items and services" (i.e., medical treatment) to the extent that a primary payer was responsible for the payment of "items and services," but not to the extent that its responsibility was extended to other claims.

II. THE COURT OF APPEALS DECISION IS CONTRARY TO THE REALITIES OF PERSONAL INJURY LITIGATION, SOUND PUBLIC POLICY, AND LONGSTANDING COMMON-LAW PRINCIPLES.

1. Medicare Ignores the Reality That Settlements Encompass Damages Other Than Medical Expenses and Impermissibly Treats Entire Recoveries as "Fair Game"

The effect of the Sixth Circuit holding is to treat every aspect of a beneficiary's recovery from a third-party tortfeasor (i.e., a primary payer) as a recovery for medical damages directly attributable to the claimed incident. Such an interpretation ignores the reality of a typical personal injury claim and the manner in which those claims are evaluated and resolved, whether litigated or not.

In the retail industry, personal injury claims take many forms. Claimants allege multiple theories of liability and numerous types of damages, of which medical expenses are only one, and some of which may arise either before or after the claimed incident.

Other damages include pain and suffering, emotional distress, lost wages (past and future), property damage, and even punitive damages. Depending on the venue and the asserted theory of liability, any number of different claims for non-medical damages can be made. The amounts claimed for each of these types of damages are rarely reduced to a sum certain.

In cases where the claimant is also a Medicare beneficiary, and where medical damages are claimed, the parties to the dispute do not evaluate the claim based solely upon the medical expenses, whether conditionally paid by Medicare or otherwise. Instead, the parties evaluate all aspects of the claim, as they would for any other claimant, considering non-medical damages as well as whether liability exists, a question that often has no clear answer absent full litigation both at the trial court and appellate levels. Thus, when a Medicare beneficiary settles a claim against an alleged tortfeasor (who is either insured or self-insured), that settlement amount *per force* will include payment for non-medical damages, as well as medical expenses, and is also typically discounted to some extent across the board.

Undeterred by the realities of the personal injury claims process, Medicare asserts here, and indeed in all similar cases, that it is entitled to reimbursement as to all settlement proceeds, whether those proceeds reflect payments for medical costs or not. In this case, Hadden settled his personal injury claim for a fraction of the actual value due to the application of Kentucky's comparative negligence laws and the

absence of the primary tortfeasor. There has been no contention that the settlement entered into by Hadden was not reasonable given all of the circumstances, or that the true value of the claim, had the primary tortfeasor been identified, would not have greatly exceeded the actual settlement amount. However, Medicare contended, and the Sixth Circuit agreed, that it is irrelevant whether the settlement monies represent payments for non-medical damages – they claimed that Medicare was entitled to *all* of the payments made to the claimant.

2. Medicare's Approach Improperly Discourages MSPA Claims and Settlements to the Detriment of All

That decision is not only contrary to the language of the MSPA, as discussed *supra,* it is contrary to Medicare's long-term interests and the long-standing policy encouraging settlement of claims without litigation.

The Sixth Circuit's decision will have an unavoidably chilling effect on the assertion of personal injury claims by Medicare beneficiaries, which would in turn decrease the cache of available funds from which Medicare seeks reimbursement. That is, the MSPA is only an effective tool for obtaining reimbursement for federal coffers when there is responsibility for payment demonstrated through a settlement, award or judgment pursued by a Medicare beneficiary. Medicare beneficiaries will not

pursue claims if the outcome only guarantees them that which they already have: their Medicare benefits. There is no penalty against the Medicare beneficiary who chooses not to pursue a loss.

Moreover, even when claims are made, settlement will often be severely discouraged due to the inability of a Medicare beneficiary to recover monies that represent non-medical damages, which can be substantial. In cases of questionable liability, or where extraordinarily high damages are claimed in the face of a minor or non-existent incident, the alleged tortfeasor will be unable to buy its peace from litigation, but will instead have to litigate such claims fully, resulting in increased litigation costs and an increased burden on the court system. For retail entities, such as those represented by the RLC, litigation costs will be especially substantial given the sheer volume of claims received in the industry.

The rule enunciated by the Sixth Circuit makes resolution of personal injury claims short of full litigation almost impossible. Even when claims are settled, the prospect of future litigation over demands for reimbursement by Medicare remains to overshadow the process. As noted by the dissent in *Hadden*, the panel majority has equated the term "responsibility" with "the amount that must be paid." *Hadden*, *supra*, at 305 (White, J., dissenting). However, in the real world of personal injury litigation and tort law, medical damages are only one aspect for consideration. By allowing Medicare to recover its full conditional payment, even though the beneficiary did not

recover full payment for either medical damages or non-medical damages, (or put another way, the primary payer did not become responsible for full payment with respect to such items and services), the Sixth Circuit interpretation of the MSPA upends the bedrock principles of traditional tort litigation.

Nothing in the MSPA suggests that Congress intended the Act to supersede or displace traditional common law principles regarding individual personal injury claims. Indeed:

> We presume that Congress legislates against the backdrop of established principles of state and federal common law, and that when it wishes to deviate from deeply rooted principles, it will say so.

U.S. v. Baxter International, Inc., 345 F.3d 866, 900 (11th Cir. 2003) (citing *United States v. Texas*, 507 U.S. 529, 534 (1993)).

The established backdrop of common-law personal injury claims includes the evaluation of potential recoveries or exposures far in excess of only medical expenses. The MSPA did not change that. Yet, the Sixth Circuit's ratification of Medicare's approach would require every personal injury case involving a Medicare beneficiary to be litigated all the way through trial, and then undergo a further legal

proceeding for the court to apportion a money judgment among the various types of damages claimed.[2]

3. The Requirement To Litigate Every Claim Fully Is Contrary To Sound Public Policy and Detrimental To Claimants

Such a requirement to litigate fully every personal injury claim brought by a Medicare beneficiary flies in the face of the overwhelming public policy favoring resolution of legal disputes by settlement rather than litigation. *See*, *e.g.*, *Marek v. Chesney*, 473 U.S. 1, 10 (1985) ("Some plaintiffs will receive compensation in settlement where, on trial, they might not have recovered, or would have recovered less than what was offered. And, even for those who would prevail at trial, settlement will provide them with compensation at an earlier date without the burdens, stress, and time of litigation. In short, settlements rather than litigation will serve the interests of plaintiffs as well as defendants"); *Stewart v. M.D.F., Inc.*, 83 F.3d 247, 252 (8th Cir. 1996) ("The judicial policy favoring settlement . . . rests on the opportunity to conserve judicial resources, not expend them further") (internal citation omitted); *Murchison v. Grand Cypress Hotel Corp.*, 13 F.3d 1483, 1486 (11th

[2] Even Medicare has admitted that it would respect such a court order allocating payments to non-medical losses. See Centers for Medicare and Medicaid Servs., Medicare Secondary Payer Manual, CMS Pub. 110-5, ch. 7, § 50.4.4 (2008).

Cir. 1994) ("We favor and encourage settlements in order to conserve judicial resources"); *Aero Corp. v. Allied Witan Co.*, 531 F.2d 1368, 1372 (6th Cir. 1976) ("Public policy strongly favors settlement of disputes without litigation . . . By such agreements are the burdens of trial spared to the parties, to other litigants waiting their turn before over-burdened courts, and to the citizens whose taxes support the latter. An amicable compromise provides the more speedy and reasonable remedy for the dispute").

Despite the overwhelming public policy implications, Medicare has consistently contended, as it did in this case, that it is entitled to reimbursement from all portions of a settlement recovery, even payments for non-medical damages. According to the Medicare Secondary Payer Manual:

> In general, Medicare policy requires recovering payments from liability awards or settlements, whether the settlement arises from a personal injury action or a survivor action, without regard to how the settlement agreement stipulates disbursement should be made. That includes situations in which the settlements do not expressly include damages for medical expenses. **Since liability payments are usually based on the injured or deceased person's medical expenses, liability payments are considered to have been made "with respect to" medical services related to the injury even when the settlement does not expressly include an amount for medical expenses.**

Medicare Secondary Payer Manual, CMS Pub. 110-5, ch. 7, § 50.4.4 (2008) (emphasis added). Medicare thus creates from whole cloth the legal fiction that the only element considered in a liability settlement is that of medical expenses, thereby excusing its unlawful taking of recoveries that have nothing to do with medical expenses. Damages for personal injury have never been limited to the recovery of only medical expenses, nor have settlements of personal injury claims been limited to evaluation based solely upon the amount of medical expenses incurred.

However, that is precisely the result that arises under the decision of the Sixth Circuit.[3] The inevitable consequence of such a rule is that parties cannot reach reasonable compromise settlements. Anytime Medicare's conditional payments exceed the real-life value of the claim, the claimant will have no incentive to settle the case, thus requiring either an abandonment of the claim or a full trial with all of the expense and consumption of judicial resources that entails. Requiring litigation ultimately disadvantages claimants who often receive less money when they proceed to

[3] In fairness, it is not only the Sixth Circuit that has compelled such an inequitable result. The Ninth Circuit, for example, also rejected the idea of apportionment where a Medicare beneficiary receives a compromised settlement. See, *Zinman v. Shalala*, 67 F.3d 841 (9th Cir. 1995) (rejecting the contention that the phrase "item or service" limits Medicare's recovery to settlement monies that are actually paid for the purpose of compensating a tort claimant for medical expenses).

trial than they would have received from settlement.[4] Entities defending against such claims, such as members of the retail industry, cannot buy their peace against weak or frivolous claims, and cannot even settle legitimate claims for the true settlement value. Instead, in cases involving Medicare beneficiaries under the interpretation of the Sixth Circuit, each and every claim would require expensive, resource-depleting, and generally unnecessary litigation, all the way to a judgment. Such an approach is contrary to sound public policy and detrimental to all involved.

III. THE SIXTH CIRCUIT'S INTERPRETATION OF THE MSPA CONFLICTS WITH THE RATIONALE ARTICULATED BY THE ELEVENTH CIRCUIT IN *BRADLEY V. SEBELIUS* REGARDING MEDICARE'S RIGHT TO REIMBURSEMENT FROM SETTLEMENT PROCEEDS

The Sixth Circuit concluded that Medicare was entitled to a full recovery for its payments, regardless

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[4] Jonathan D. Glater, *Study Finds Settling is Better Than Going to Trial*, The New York Times (August 7, 2008), http://www.nytimes.com/2008/08/08/business/08law.html, citing Kiser, R., et al., *Let's Not Make a Deal: An Empirical Study of Decision Making in Unsuccessful Settlement Negotiations*, 5 J. Empirical Legal Studies 3, at 551-91 (Sept. 2008) (analyzing 2,054 contested litigation cases in which settlement negotiations had first been conducted and finding plaintiffs received less in 61.2% of full trials than they would have received in settlement).

of whether the Medicare beneficiary obtained a payment representing a full recovery for his or her medical expenses. That conclusion conflicts directly with the analysis offered by the Eleventh Circuit in *Bradley v. Sebelius*, 621 F.3d 1330 (11th Cir. 2010), which articulated the inescapably harmful public policy consequences of the approach espoused by Medicare and endorsed in *Hadden*:

> Counsel for the survivors and the estate acted sensibly, in a cost-effective manner. The nursing home neglect claim was settled for the full value of the available insurance. Clearly, if the language of the field manual applied, in practice, it would lead to an absurd Catch-22 result. Forcing counsel to file a lawsuit would incur additional costs, further diminishing the already paltry sum available for settlement. This flies in the face of judicial and public policy.
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> There is a second reason that the Secretary's position, as adopted by the district court, is in error. Historically, there is a strong public interest in the expeditious resolution of lawsuits through settlement. Throughout history, our law has encouraged settlements.
>
> The Secretary's position would have a chilling effect on settlement. The Secretary's position compels plaintiffs to force their tort claims to trial, burdening the court system.

> It is a financial disincentive to accept otherwise reasonable settlement offers. It would allow tortfeasors to escape responsibility.

Id. at 1338-39.

The public policy expressed by the decision in *Bradley* is consistent with the policy that has long been expressed throughout federal and state courts alike. That policy is intended to foster the resolution of disputes through compromised agreements between the parties rather than resorting to litigation. The policies implemented by Medicare, and accepted by the Sixth Circuit, turn that policy on its head. There is no rational basis for interpreting the MSPA in a way that not only discourages settlement, but in fact effectively prevents settlement in many cases. The Sixth Circuit decision thus squarely and unfortunately conflicts with the Eleventh Circuit's decision.

IV. THE SAME PRINCIPLES THAT GUIDED THIS COURT'S DECISION IN *AHLBORN* SHOULD BE APPLIED TO THE MSPA

The Sixth Circuit decision improperly discounts this Court's decision in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), on the basis that *Ahlborn* dealt with an interpretation of the federal statutes related to Medicaid and not Medicare. While that much is true, the legal principles expressed in *Ahlborn* are equally applicable here because the statutory right of Medicaid to

obtain reimbursement for medical expenses paid under that program is the functional equivalent of the right to reimbursement provided to Medicare.

In *Ahlborn*, the Arkansas Department of Health and Human Services ("ADHS") paid $215,645.30 in medical expenses under the State's Medicaid plan for treatment incurred by the beneficiary following a car accident. *Ahlborn*, 547 U.S. at 272-73. The beneficiary later filed a lawsuit against the alleged tortfeasors, claiming damages as a result of the accident, which included not only past medical costs, but also "permanent physical injury; future medical expenses; past and future pain, suffering, and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future." *Id.* at 273. The case was ultimately settled out of court for $550,000.00. *Id.* at 274.

The settlement did not provide for any allocation between the different types of claimed damages. *Id.*

Following the settlement, the ADHS asserted a lien for the full amount of medical payments made under Medicaid. *Id.* In the beneficiary's declaratory judgment action, the district court ruled that the ADHS was entitled to full recovery. The Eighth Circuit Court of Appeals then reversed, holding that ADHS was entitled only to that portion of the settlement that represented payments for medical care. *Id.* at 274-75. This Court affirmed the decision of the Eighth Circuit.

Although *Ahlborn* dealt with Medicaid and not Medicare, the reimbursement schemes are functionally equivalent, and are premised upon extremely similar statutory language.[5] The primary difference is that, under Medicaid, the State, not the federal government, is charged with the obligation to seek reimbursement. *See*, 42 U.S.C. § 1396a(a)(25)(B). However, both systems are ultimately governed by federal statutory law espousing identical policies, i.e., the recovery of medical payments made by the government where there exists a "primary payer" that is responsible for those payments. The parties at issue (government, beneficiary, tortfeasor) are the same, and the issue of apportionment raised in *Ahlborn* is identical to the issue raised by Hadden's petition.

As Medicare has here, ADHS asserted that it was entitled to reimbursement from the entire proceeds of the settlement, not just that portion representing medical expenses.[6] *Ahlborn*, 547 U.S. at 279. However,

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[5] *Compare* 42 U.S.C. § 1396a(a)25(A) (in which the State is tasked with pursuing claims against third parties who are by "statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service") *with* 42 U.S.C. § 1395y(b)(2)(B) (in which repayment for an "item or service" by a primary plan is required if responsibility is demonstrated by a "judgment, a payment conditioned upon the recipient's compromise, waiver, or release").

[6] Interestingly, ADHS also agreed, as does Medicare by virtue of its MSP Manual, that it would not have sought reimbursement for more than the amount allocated to medical expenses if that amount was allocated by a court judgment. *Ahlborn*, 547 U.S. at 282 n. 12.

this Court disagreed. The Court stated, in pertinent part:

> The text of the federal third-party liability provisions . . . focuses on recovery of payments for medical care. Medicaid recipients must, as a condition of eligibility, "assign the State any rights . . . *to payment for medical care* from any third party," not rights to payment for, for example, lost wages.

Id. at 280 (quoting 42 U.S.C. § 1396k(a)(1)(A)) (emphasis by the Court). The Court went on to reject ADHS's interpretation that the statute allowed full reimbursement out of the third-party recovery, whether representing medical expenses or not:

> But that reading ignores the rest of the provision, which makes clear that the State must be assigned "the rights of [the recipient] to payment by any other party *for such health care items or services*." Again, the statute does not sanction an assignment of rights to payment for anything other than medical expenses – not lost wages, not pain and suffering, not an inheritance.

Id. at 281 (quoting 42 U.S.C. §§ 1396a(a)(25)(H)) (emphasis by the Court). Thus, the Court held that ADHS was only entitled to reimbursement of that amount of the settlement representing medical costs. *Id.* at 292.

The Sixth Circuit's dismissal of *Ahlborn's* holding is flawed for the same reason that its decision in this case is flawed: it focused on the wrong language. The

panel majority determined that the "key" term in the Medicaid statute was "liability," just as it determined that the key word in the Medicare statute was "responsibility." *Hadden*, 661 F.3d at 303 ("So, 'liability' was the critical term [in *Ahlborn*]; and the Court construed it to mean that the state was limited to the portion of the settlement that . . . represented compensation for medical expenses").

Contrary to this determination by the Sixth Circuit, this Court did not emphasize the term "liability," but consistently, and expressly, emphasized the terms "payment for medical care" or "for such health care items and services." Thus, this Court's analysis, underscored by its own emphasis, concluded that the scope of reimbursement provided by the Medicaid statute is limited solely to payments from third parties that are related to medical care.

The same must be true under the Medicare statute, which uses strikingly similar language to provide for a right of recovery from a "primary payer" based upon payments made by Medicare for an "item or service" only to the extent that the primary payer has a "responsibility to make payment **with respect to such item or service**." 42 U.S.C. § 1395y(b)(2)(B)(ii) (emphasis added). Any attempt to distinguish between these two systems of government benefits for medical treatment and the recovery of said payments from third-parties that are primarily responsible for said payments is mere sophistry.

CONCLUSION

The petition for a writ of *certiorari* should be granted.

Respectfully submitted,

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