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 OF TEXAS, ALABAMA, GEORGIA, HAWAII, IDAHO, INDIANA, MICHIGAN, NEBRASKA, NEW MEXICO, OHIO AND SOUTH CAROLINA AS AMICI CURIAE IN SUPPORT OF PETITIONER

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INTEREST OF AMICI

Medicaid expenditures consume large portions of every State's budget. The amici curiae have an interest in mitigating the costs associated with administering their Medicaid programs, and in strengthening the federalism-protecting interpretive canons that should apply whenever a court interprets the federal Medicaid Act.

STATEMENT

In *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006), this Court held that the federal Medicaid Act precludes a participating State from imposing a lien on a beneficiary's property, except to the extent that the State seeks to recover its Medicaid expenditures from damages that the beneficiary obtains for medical expenses from a third-party tortfeasor. *See id.* at 284-285. But many times a jury verdict or settlement agreement will award the beneficiary a lump sum, without marking any portion of the damages as compensation for medical expenses. North Carolina law therefore requires the Medicaid beneficiary to designate up to one-third of her tort recovery as compensation for medical expenses, which must be used to reimburse the State for the medical expenditures it made on the beneficiary's behalf. Without this statutory allocation, the parties to a settlement could eliminate the State's subrogation rights by designating the entire award as compensation for pain and suffering, while leaving nothing for medical expenses.

Respondent E.M.A. entered into a settlement agreement for a lump-sum payment, which was not allocated among different categories of damages. The State of North Carolina imposed a lien against one-third of E.M.A.'s recovery, consistent with the statutory allocation that deems one-third of a Medicaid beneficiary's tort recovery to represent

compensation for medical expenses. The issue in this case is whether the relevant North Carolina statutes are "preempted" by the federal Medicaid Act as construed in *Ahlborn*. The Fourth Circuit held that North Carolina's statutory allocation is preempted, and that the State must provide individualized hearings to determine the "true value" of the medical-expenses portion of E.M.A.'s settlement. This Court granted certiorari.

SUMMARY OF ARGUMENT

The Fourth Circuit erred by holding that North Carolina's statutory provisions are "preempted" by the Medicaid Act, at least as applied to the situation in this case.

First, any conditions on the receipt of federal funds must be set out "unambiguously," and recipients of federal funds must accept them "voluntarily and knowingly." *See Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981); *see also Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2602 (2012) (opinion of Roberts, C.J.). The federal Medicaid Act, however, is silent on how States should determine the amount of a beneficiary's tort recovery that represents compensation for medical expenses—especially in cases such as this one, where the parties entered into a lump-sum settlement without agreeing on an allocation among the

different categories of injury. Nothing in the Medicaid Act precludes States from determining the amount of compensation for medical expenses through a statutory formula, rather than a contextualized individual hearing. And there is certainly no "unambiguous" language to this effect in the federal statutory provisions or regulatory guidance. The court of appeals therefore erred by imposing its "true-value hearing" solution over the statutory allocation adopted by the State of North Carolina.

Second, even if North Carolina's law is inconsistent with the provisions of the Medicaid Act, the court of appeals erred by holding the state law "preempted." The federal Medicaid Act does not require that a State choose between withdrawing from Medicaid and complying with every provision of the Medicaid Act. 42 U.S.C. § 1396c gives the Secretary of Health and Human Services discretion to withhold only a *portion* of federal Medicaid reimbursement from a non-compliant State, and States may—without violating *any* federal law—choose to accept this reduction in federal funding while remaining participants in the federal Medicaid program. A State law cannot be deemed "preempted" by a federal statute that does nothing more than specify criteria for federal reimbursement.

Unlike statutes such as Title VI and the Religious Land Use and Institutionalized Persons Act, the Medicaid Act does not impose forward-

looking obligations on States that accept federal Medicaid reimbursements; it merely dangles a carrot in front of the States by promising federal reimbursement to those that comply with the Medicaid Act's guidelines. A State does not violate federal law by failing to take the federal government up on this offer, and it does not violate federal law by acting in a manner that may provoke the Secretary of Health and Human Services into reducing or eliminating the state's Medicaid allotment. *See, e.g., Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2607.

ARGUMENT

I. THE FOURTH CIRCUIT ERRED BY FAILING TO APPLY THE CLEAR-STATEMENT REQUIREMENT OF *PENNHURST*.

The federal Medicaid Act is spending legislation; it offers to reimburse States for the expenses of their Medicaid programs so long as those state programs comport with federal guidelines. *See* 42 U.S.C. § 1396a (establishing criteria for state Medicaid programs); *id.* § 1396b (providing reimbursement to the States for most of their Medicaid-related expenditures). If the Secretary of Health of Human Services determines that a State's Medicaid program does not comport with the criteria for reimbursement established in § 1396a, he must decide whether to withhold *all* federal reimbursement from that State's Medicaid program, or withhold funding only from those *parts* of the State Medicaid plan that do not

comport with 42 U.S.C. § 1396a. *See id.* § 1396c ("[T]he Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply.").

Because the Medicaid Act is federal spending legislation, the clear-statement rule of *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), applies. This Court has long held that conditions on the receipt of federal funds must be set out "unambiguously," and that recipients of federal funds must accept those conditions "voluntarily and knowingly." *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (quoting *Pennhurst*, 451 U.S. at 17). But the Fourth Circuit never cited *Pennhurst* and never considered how its clear-statement requirement should inform the analysis in this case. Had the Fourth Circuit viewed the provisions in the Medicaid Act through the lens of *Pennhurst*, it would have been compelled to uphold the North Carolina statutes, at least as applied to the situation in this case.

The Medicaid Act withholds federal funding if a State imposes a lien against the "property of any

individual" on account of medical assistance paid under a state Medicaid plan. 42 U.S.C. § 1396p(a).[1] Yet it simultaneously instructs participating States to "seek reimbursement" for the medical expenses they have paid whenever a Medicaid beneficiary recovers damages from a tortfeasor who caused her medical bills. *Id.* § 1396a(a)(25)(B). Specifically, the Medicaid Act instructs Medicaid-participating States to enact

> 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.

Id. § 1396a(a)(25)(H). And every state Medicaid plan must, if it wishes to receive federal reimbursement, require Medicaid beneficiaries

> to assign the State any rights . . . to support (specified as support for the purpose of medical care by a court or

---

[1] The anti-lien provision in the Medicaid Act is subject to exceptions, but they are not applicable here. *See* 42 U.S.C. § 1396p(a)(1)(A)–(B).

> administrative order) and to payment for medical care from any third party.

Id. § 1396k(a)(1)(A).

Taken together, these statutory provisions unambiguously preclude a state Medicaid plan from imposing a lien against an individual's "property," except for damages that the beneficiary has recovered for medical expenses from a third-party tortfeasor. *See Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 284-285 (2006). A Medicaid-participating State—if it wishes to receive full federal funding—cannot impose a lien against a beneficiary's recovery for lost income, pain and suffering, punitive damages, or anything other than medical expenses. As this Court explained in *Ahlborn*:

> To 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. . . . But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property. As explained above, the exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care.

> Beyond that, the anti-lien provision applies.

Id.

This rule is easy to apply when the beneficiary and the State have stipulated that a specific portion of an award or settlement represents payment for medical expenses. *See, e.g.*, *Ahlborn*, 547 U.S. at 288 (noting that the state agency and the Medicaid beneficiary had stipulated that $35,581.37 of the beneficiary's settlement was "designated as payments for medical costs").

But matters become more complicated when a jury verdict or settlement agreement awards the plaintiff a lump sum without parceling the money into discrete categories of damages, or when parties to a settlement agreement attempt to thwart the State's rightful recovery by minimizing the amount allocated to medical expenses. In these situations, the State is not only entitled but *required* to recover the portion of the award that compensates the Medicaid beneficiary for medical expenses. *See* 42 U.S.C. §§ 1396a(a)(25)(B), 1396a(a)(25)(H), 1396k(a)(1)(A); *Ahlborn*, 547 U.S. at 282 ("[T]he federal third-party liability provisions *require* an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care.") (emphasis in original). Yet the true amount of the compensation for medical expenses is unknown and *cannot* be known. A jury that awards

compensatory damages without designating a specific portion for medical expenses cannot be reconstituted and questioned when the State seeks to recover its rightful share of the award. And when parties enter into a settlement agreement, it is impossible for the State (or anyone else) to prove that a specific amount constitutes compensation to the plaintiff for medical expenses. Finally, if the parties to a settlement try to limit the State by allocating little or nothing to medical expenses, then the State cannot recover its expenses if it is bound by the artificially low amount designated for medical expenses in the settlement agreement.

Although the federal Medicaid Act draws a clear and unambiguous distinction between damages that a beneficiary recovers for medical expenses, which are exempt from § 1396p(a)'s anti-lien provision, and damages recovered for other types of injuries, the Medicaid Act is silent on *how a State should determine* the amount of a jury award or settlement that represents compensation for medical expenses. An approach that allows the State to recover only funds that are specifically designated as damages for medical expenses in the jury verdict or settlement agreement is not acceptable, because many times the verdict or settlement will fail to allocate the award among the different categories of injuries, and settlement agreements can be manipulated by the parties to minimize or eliminate the amount of damages earmarked for medical expenses. *See*

Ahlborn, 547 U.S. at 288 (recognizing this danger). Indeed, the parties to a settlement have a shared incentive to minimize or zero out the amount allocated to medical expenses, as money allocated to medical expenses is worthless to the victim (because it will be taken by the State), and the tortfeasor doesn't care where the money goes once it leaves his pockets. In light of this obvious problem, a State deciding whether to accept federal Medicaid dollars would reasonably assume that the federal anti-lien provision would not deprive the States of the power to protect themselves from these types of manipulated settlement agreements. Far from containing a clear statement that the States *can't* enact legislation of the sort that North Carolina has adopted, the provisions of the Medicaid Act requiring participating States to recoup their medical expenditures from a beneficiary's tort recovery point in the opposite direction. Every Medicaid-participating State must establish some kind of mechanism for determining the amount of an award or settlement that is properly attributed to medical expenses.

There are many possible approaches available to the States. All of them present tradeoffs between decision costs and error costs. And each is consistent with the federal Medicaid Act—especially when the Act is construed (as it must be) in light of *Pennhurst*'s clear-statement requirement.

One possibility is for a State to hold a trial-like adversarial proceeding to determine the amount that a jury or parties to a settlement "intended" to award for medical expenses, or that represents a "fair" allocation to medical expenses. This approach might be thought to pursue the maximum possible accuracy in determining the amount properly allocated to medical expenses. But it imposes significant decision costs by requiring an adversarial hearing whenever the State seeks to recover its Medicaid expenditures from a beneficiary's tort recovery. *See* Pet. Br. 15 (noting these hearings "will entail presentation of liability and damage evidence from experts, imposing significant litigation costs and burdens on both the recipient and the State"). And it is far from clear that incurring these added decision costs will produce much in the way of improved accuracy. Rough cuts and approximations are unavoidable in these situations, and a regime that resolves each of these disputes through a case-by-case adversarial process will open the door to arbitrary and inconsistent decisionmaking. *See* Antonin Scalia, *The Rule of Law as a Law of Rules*, 56 U. CHI. L. REV. 1175 (1989) (showing how rules provide the benefits of "predicatability" and the "appearance of equal treatment," and how case-by-case discretion undermines these values).

Another possibility is to establish a statutory formula that designates one-third of a beneficiary's tort recovery (or some other fraction) as

compensation for medical expenses—even when the jury verdict or settlement agreement specifies a different amount. *See, e.g.*, N.C. GEN. STAT. § 108A-57. This approach has the advantage of providing an easy-to-apply rule that obviates the need for a hearing, and it prevents litigants from structuring settlement agreements that minimize the State's recovery by allocating an artificially low amount toward medical expenses. And by avoiding a regime of individualized hearings, it reduces the risk of arbitrary or inconsistent treatment among similarly situated beneficiaries.

Hybrid approaches are also available. A State might, for example, establish a *rebuttable* presumption that deems a fraction of a beneficiary's tort recovery compensation for medical expenses, while allowing the beneficiary to overcome this presumption with a preponderance of the evidence (or with clear and convincing evidence). The court of appeals thought that the Medicaid Act required North Carolina to adopt this type of regime, and precluded the State from *ever* treating as conclusive the statutory allocation established in N.C. GEN. STAT. § 108A-57. *See E.M.A v. Cansler*, 674 F.3d 290, 312 (4th Cir. 2012) ("[T]he sum certain allocable to medical expenses must be determined by way of a fair and impartial adversarial procedure that affords the Medicaid beneficiary an opportunity to rebut the statutory presumption . . . ."). As the court of appeals saw matters, an adversarial hearing is

required in *every* case in which the beneficiary wants to dispute the statutory provision that defines one-third of a tort recovery as damages for medical expenses. *Id.*

Another hybrid approach would establish an irrebuttable statutory presumption but exempt certain categories of cases from that presumption, such as: (1) cases in which a jury verdict specifically allocates the beneficiary's recovery between medical and non-medical expenses, and (2) cases in which the beneficiary and state agency stipulate that a certain portion of an award or settlement agreement represents compensation for medical expenses. In these two categories of cases, the "true" amount of recovery for medical expenses can be easily ascertained, so there is no need to resort to statutory allocations. In all other cases, the recovery for medical expenses will be one-third of the jury's award or settlement proceeds, because an effort to determine the "real" amount of recovery for medical expenses in these situations is likely to become a snipe hunt.

The court of appeals went off track by requiring an adversarial proceeding in *every* case in which the State and the beneficiary disagree over the amount that should be deemed recovery for medical expenses. And the court of appeals especially erred by requiring a hearing on the facts of this case, where the Medicaid beneficiary agreed to a lump-sum settlement that makes no allocation between

the funds recovered for medical expenses and those recovered for other injuries. The court of appeals's approach would be more understandable if it were possible to dissect a lump-sum tort recovery into payments to compensate the plaintiff for medical expenses and those for other purposes. But there is no non-arbitrary way to determine which part of these settlement proceeds represents the "true" payment for medical expenses—even after conducting a "fair and impartial adversarial procedure." *Cansler*, 674 F.3d at 312. It cannot be said that the Medicaid Act forbids North Carolina's resort to rule-based statutory allocations—at least in cases (such as this one) in which the beneficiary receives a lump-sum recovery from a settlement agreement.

The court of appeals's mistake was its tacit assumption that lump-sum settlement awards comprise discrete portions that were designed to compensate the beneficiary for medical expenses, and its further assumption that it is possible to ascertain the amount of money in this "medical expenses" portion through the mechanism of an adversary hearing. But there *is no way to determine* what portion of a lump-sum settlement represents the "true" amount of compensation for medical expenses. A judge or arbitrator will inevitably have to resort to decisionmaking shortcuts, such as rules of thumb, approximations, or outright guesses. It is simply not possible to eliminate (or even reduce)

error costs by insisting on a "fair and impartial adversarial procedure." And in this case, it is hard to see how the outcome of an adversarial hearing could be any more accurate than the result mandated by the North Carolina statutes. In all events, the federal Medicaid Act does not require adversarial hearings to determine the amount of a tort recovery that should be allocated toward medical expenses, and it certainly does not contain the "unambiguous[]" language on this point that would be needed to satisfy the requirements of *Pennhurst*.

The court of appeals was troubled by the possibility that a State might establish an unreasonably high percentage of a beneficiary's tort recovery as compensation for medical expenses. *See Cansler*, 674 F.3d at 311 ("[N]othing would prevent states from allocating 75%, 90% or even 100% of a settlement to medical expenses, thereby eviscerating the rule promulgated by *Ahlborn*."). The court of appeals was mistaken, however, to suggest that a ruling upholding the North Carolina statute would open the door to such regimes. A statutory allocation will be valid only if it supplies a plausible rule-of-thumb for determining the proportion of a tort recovery that should be deemed to represent compensation for medical expenses; otherwise it will contravene the construction of the anti-lien provision that this Court adopted in *Ahlborn*. North Carolina's regime undoubtedly passes muster under this standard. The court of appeals committed a slippery-

slope fallacy by denying that any principled distinction can be drawn between the North Carolina statutes and the hypothetical regimes described in its opinion. *See* Eugene Volokh, *The Mechanisms of the Slippery Slope*, 116 HARV. L. REV. 1026 (2003).

The Medicaid Act is silent on how States should determine the amount of a beneficiary's tort recovery that represents compensation for medical expenses—especially in cases such as this one, where the parties entered into a lump-sum settlement without ever agreeing on an allocation among the different categories of injury. *Any* approach to determining the portion of a lump-sum tort recovery that represents compensation for medical expenses will produce imprecision and guesswork. How to deal with these imprecisions, and how to calibrate the tradeoffs between decision costs and error costs, are decisions left to the States that must administer the Medicaid programs. The Medicaid Act does not require adversarial hearings to determine the amount of a tort recovery that should be allocated toward medical expenses, and it certainly does not contain the "unambiguous[]" language needed to satisfy the requirements of *Pennhurst*. The court of appeals erred by imposing its "true-value hearing" solution over the rule-based statutory allocation adopted by the State of North Carolina.

II. THE MEDICAID ACT IS INCAPABLE OF "PREEMPTING" STATE LAW, BECAUSE A STATE DOES NOT VIOLATE FEDERAL LAW MERELY BY ACTING IN A MANNER THAT REQUIRES FEDERAL MONEY TO BE WITHHELD.

There is a more fundamental problem with the court of appeals's opinion: A State law cannot be deemed "preempted" by a federal statute that does nothing more than specify criteria for federal reimbursement.

Some types of federal spending legislation, such as Title VI of the Civil Rights Act of 1964 and the Religious Land Use and Institutionalized Persons Act (RLUIPA), impose binding legal obligations on entities that accept federal funds. These statutes require any "program or activity receiving Federal financial assistance" to accommodate religious liberties and refrain from racial discrimination. *See* 42 U.S.C. § 2000d ("No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."); 42 U.S.C. § 2000cc(a)(2)(A) (requiring any "program or activity that receives Federal financial assistance" to accommodate religious liberties). Under these laws, entities must renounce or return federal aid *before* deviating from the specified conditions; otherwise they become federal lawbreakers if they violate the conditions imposed on

the receipt of federal funds. *See Cannon v. Univ. of Chi.,* 441 U.S. 677 (1979) (allowing private individuals to sue for injunctive relief against entities that accept federal money yet fail to comply with Title IX, which prohibits sex discrimination by universities receiving federal financial assistance).

Other types of federal spending legislation merely offer annual reimbursement to States that comply with certain conditions, or threaten to withhold federal funds from noncompliant States. One example is the statute relating to the 21-year-old drinking age. It states that

> [t]he Secretary shall withhold 10 per centum of the amount required to be apportioned to any State under each of sections 104(b)(1), 104(b)(3), and 104(b)(4) of this title on the first day of each fiscal year after the second fiscal year beginning after September 30, 1985, in which the purchase or public possession in such State of any alcoholic beverage by a person who is less than twenty-one years of age is lawful.

23 U.S.C. § 158 (a)(1)(A). Under this type of spending legislation, a State retains the prerogative to lower its drinking age to 18 even after accepting federal highway money. It may lose some future federal money as a consequence of that decision, but it is not breaking any federal law by deviating from criteria for reimbursement and provoking the

Secretary of Transportation to reduce the State's allocation of federal funds. No one would contend that a State is violating federal law by returning to an 18-year-old drinking age—even after accepting federal highway funds—and no one could maintain a "preemption" lawsuit if a State were to do so.

The Medicaid Act falls within the latter category of spending legislation. State laws cannot be "preempted" by the Medicaid Act because this statute does not obligate the States to do *anything*—even after a State receives reimbursement from the federal government for its Medicaid program. The Medicaid Act permits States to administer their Medicaid programs as they please; it merely requires the Secretary of Health and Human Services to reimburse States whose Medicaid programs satisfy the criteria specified in § 1396a. A State retains the lawful prerogative to establish a Medicaid program that deviates from § 1396a at any time, and then wait to see if the Secretary will turn off the spigot or merely reduce the amount of federal funding. There is *nothing unlawful* about state officials taking actions that might goad the Secretary into halting some or all of the State's Medicaid reimbursement payments. *See Nat'l Fed'n of Indep. Bus.*, 132 S. Ct. at 2607 (holding that States may choose to violate conditions in the Affordable Care Act and accept a reduction in federal Medicaid reimbursement). A State that departs from the Medicaid Act's reimbursement criteria does not even violate federal

law, let alone deprive any person of federally protected "rights" under 42 U.S.C. § 1983.

All of this becomes evident when one reads 42 U.S.C. § 1396c, which provides:

> If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—
>
> (1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or
>
> (2) that in the administration of the plan there is a failure to comply substantially with any such provision;
>
> the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

42 U.S.C. § 1396c. Nothing in this statute, or any other provision of the Medicaid Act, imposes forward-looking obligations on States that accept federal Medicaid reimbursements. The Medicaid Act does not reflect the approach of Title VI or RLUIPA; nowhere does the Medicaid Act say anything akin to: "No State that receives federal Medicaid funds shall . . . ." The Medicaid Act does nothing more than dangle a carrot in front of the States: If you administer a Medicaid program that satisfies the criteria of § 1396a, then the federal government will reward you by reimbursing some of your expenditures. A State does not violate federal law by failing to meet the terms of the federal government's offer, and a state statute cannot be deemed "preempted" by a federal statute that does nothing more than specify criteria for federal reimbursement.

So even if the Fourth Circuit were correct to conclude that North Carolina's statute fails to comport with provisions in the federal Medicaid Act, it erred by holding the statute "preempted." If the Fourth Circuit's interpretation of the Medicaid Act is correct, then North Carolina is no different from a State that lowers its drinking age below 21. It may have acted in a manner that will cause it to lose federal funding in the future, but it has not violated any legal obligation imposed by Medicaid Act or any other provision of federal law. If the Secretary of Health and Human Services decides that North Carolina's statute merits only a *partial* reduction in

federal funding under 42 U.S.C. § 1396c, North Carolina might choose to accept this partial reduction in federal funding rather than abandon the statutory allocation in N.C. GEN. STAT. § 108A-57. The Fourth Circuit's ruling robs North Carolina of the opportunity to make this perfectly lawful choice.[2]

CONCLUSION

The judgment of the Court of Appeals should be reversed.

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[2] In *Ahlborn*, the State of Arkansas never questioned whether private litigants could assert "preemption" claims under the Medicaid Act. Arkansas staked its entire case on its claim that its statutes complied with the Medicaid Act's anti-lien provision. *See* Brief for the Petitioners, *Ahlborn*, (No. 04-1506), 2005 WL 3156905. *Ahlborn* therefore cannot establish a precedential holding that the Medicaid Act is capable of preempting state law, or that private litigants may assert preemption claims whenever a State deviates from the Medicaid Act's criteria for reimbursement. *See Brecht v. Abrahamson*, 507 U.S. 619, 630-631 (1993), *superseded by statute on other grounds*, AEDPA, 28 U.S.C. § 2254(d) ("[S]ince we have never squarely addressed the issue, and have at most assumed [an answer], we are free to address the issue on the merits."); *Waters v. Churchill*, 511 U.S. 661, 678 (1994) (plurality opinion) ("These cases cannot be read as foreclosing an argument that they never dealt with."); *Legal Servs. Corp. v. Velazquez*, 531 U.S. 533, 557 (2001) (Scalia, J., dissenting) ("Judicial decisions do not stand as binding 'precedent' for points that were not raised, not argued, and hence not analyzed.").

Respectfully submitted.

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November 2012

APPENDIX
STATUTES INVOLVED

N.C. GEN. STAT. § 108A-57 .... 1a

N.C. GEN. STAT. § 108A-59 .... 3a

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STATUTES INVOLVED

North Carolina General Statute § 108A-57

Subrogation rights; withholding of information a misdemeanor

(a) Notwithstanding any other provisions of the law, to the extent of payments under this Part, the State, or the county providing medical assistance benefits, shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance, or of the beneficiary's personal representative, heirs, or the administrator or executor of the estate, against any person. The county attorney, or an attorney retained by the county or the State or both, or an attorney retained by the beneficiary of the assistance if this attorney has actual notice of payments made under this Part shall enforce this section. Any attorney retained by the beneficiary of the assistance shall, out of the proceeds obtained on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, but the amount paid to the Department shall not exceed one-third of the gross amount obtained or recovered.

The United States and the State of North Carolina shall be entitled to shares in each net recovery under this section. Their shares shall be promptly paid

under this section and their proportionate parts of such sum shall be determined in accordance with the matching formulas in use during the period for which assistance was paid to the recipient.

(b) It is a Class 1 misdemeanor for any person seeking or having obtained assistance under this Part for himself or another to willfully fail to disclose to the county department of social services or its attorney the identity of any person or organization against whom the recipient of assistance has a right of recovery, contractual or otherwise.

(c) This section applies to the administration of and claims payments made by the Department of Health and Human Services under the NC Health Choice Program established under Part 8 of this Article.

North Carolina General Statute § 108A-59

Acceptance of medical assistance constitutes assignment to the State of right to third party benefits; recovery procedure

(a) Notwithstanding any other provisions of the law, by accepting medical assistance, the recipient shall be deemed to have made an assignment to the State of the right to third party benefits, contractual or otherwise, to which he may be entitled.

It shall be the responsibility of the county attorney of the county from which the medical assistance benefits are received or an attorney retained by that county and/or the State to enforce this subsection, and said attorney shall be compensated for his services in accordance with the attorneys' fee arrangements approved by the Department of Health and Human Services.

(b) The responsible State agency will establish a third party resources collection unit that is adequate to assure maximum collection of third party resources.

(c) Notwithstanding any other law to the contrary, in all actions brought pursuant to subsection (a) of this section to obtain reimbursement for payments for medical services, liability shall be determined on the basis of the same laws and standards, including bases for liability and applicable defenses, as would be applicable if the action were brought by the

individual on whose behalf the medical services were rendered.

42 U.S.C. § 1396a(a)(18) (2006)

§ 1396a. State plans for medical assistance

(a) Contents
A State plan for medical assistance must—

* * * *

(18) comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid,[,] transfers of assets, and treatment of certain trusts;

* * * *

42 U.S.C. § 1396a(a)(25)(H) (2006)

A State plan for medical assistance must—

* * * *

(25) provide—

* * * *

(H) 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;

* * * *

42 U.S.C. § 1396c (2006)

Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

42 U.S.C. § 1396k (2006)

Assignment, enforcement, and collection of rights of payments for medical care; establishment of procedures pursuant to State plan; amounts retained by State

(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall—

(1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under this subchapter [42 USC §§ 1396 et seq.] and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is described in section 1396a(l)(1)(A) of this title or the individual is found to have good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and

(2) provide for entering into cooperative arrangements (including financial arrangements), with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a parent, with a State's agency established or designated under section 654(3) of this title) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the State plan with respect to (A) the enforcement and collection of rights to support or payment assigned under this section and (B) any other matters of common concern.

(b) Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State 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.

42 U.S.C. § 1396p (2006)

Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan[.]

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