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

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ARGUMENT

Respondents and their amici, including the United States, fundamentally misconstrue North Carolina's third party recovery statute. They characterize the issue presented as whether the statutory "presumption" as to which part of a settlement represents medical damages must be "rebuttable" so that, on a case-by-case basis, it can be determined whether that "presumption" is correct.

North Carolina's statute does not create a "presumption." Unlike a "presumption" that is imposed after the fact on a settlement, North Carolina's allocation is not an approximation or a guess. The statute can never incorrectly predict the amount attributable to past medical expenses because the parties are required to include in any settlement the exact amount that the Medicaid program must be repaid. In, and only in, circumstances where repayment of the Medicaid lien in full would excessively deplete the recovery received by the Medicaid beneficiary, the statute provides the State's advance agreement to compromise its claim by capping the reimbursement at one-third of the total amount.

The statutory allocation provision at issue is not a "presumption" but instead a condition attached to the receipt of the benefit provided to a Medicaid recipient. The full extent of the State's subrogation claim is not set by the statute but instead is determined by the dollar amount of the Medicaid payments made on behalf of the recipient for necessary medical services. The one-third requirement does not presume or predict

what portion of a damage award represents recovery for past medical expenses; it is only a cap on the amount that must be paid to the State to satisfy the recipient's repayment obligations arising from the Medicaid benefits provided.

The portion allocated for past medical expenses is exact and, by law, that amount cannot be designated for any other purpose. Both Respondents' attacks on the statute and the decision by the Court of Appeals depend upon the "irrebuttable presumption" mischaracterization. Because North Carolina's statute provides *ex ante* instruction to the parties as to what amount they must include in their settlement for past medical expenses, it does not violate the Medicaid Act's anti-lien provision.

Respondents applied for Medicaid benefits when extensive medical services were necessitated by alleged acts of medical malpractice. E.M.A.'s injuries require on-going medical care and treatment, and Medicaid continues to provide necessary skilled nursing care.[1] Respondents' tort action alleging

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[1] Respondents note that because the portion of the settlement released to E.M.A. was placed in a Special Needs Trust she is not "ineligible for Medicaid services." (Resp. Br. 6) Respondents have previously indicated that E.M.A."receives skilled nursing care that is paid for by the Medicaid program" (J.A. 41), and that E.M.A. "receives skilled nursing care that is paid for by the North Carolina Medicaid program" (Opening Br. Of Appellants ("Open. Br.") 4, 4th Cir. Docket No. 10-1865).

negligence ultimately settled for $2.8 million. At the time of settlement the Medicaid program's payments were in excess of $1.9 million. Respondents have resisted North Carolina's right to recoup the portion of the settlement proceeds specified in N.C. Gen. Stat. § 108A-57, North Carolina's third-party recovery statute. Respondents assert that the statutory recovery amount exceeds the portion of the settlement that was intended as compensation for the recipient's past medical expenses.

North Carolina's statute structures a Medicaid recipient's recovery of compensation from a third-party for which Medicaid has provided past medical care. The statute prescribes the damages that are available to the recipient by defining the amount that must be used to satisfy the recipient's duty to repay the State for Medicaid's provision of necessary medical services. It further provides that this repayment obligation is a priority that must be satisfied before the recipient can recover other types of damages.

There is not an "allocating away" of the recipient's property because state law permits a settlement only if the Medicaid recipient designates the mandated amount to allow the State to recoup a portion of its payments for medical services. Additionally, North Carolina's statute sets forth the State's agreement to a compromise of its claim for full reimbursement for past medical services under specific circumstances. It provides – in advance of the initiation of any lawsuit or a discussion of settlement – mandatory allocation rules

that all parties can rely upon as they assess their legal status and obligations.

Enforcement of North Carolina's statutory provision furthers the purpose of the third-party recovery mandate set forth in the Medicaid Act. Furthermore, the provision provides advance notice of the applicable ground rules to all parties, thereby promoting consistency and predictability in the allocation process. N.C. Gen. Stat. § 108A-57 allows the State to recover a defined amount from any settlement to recoup a portion of the monies paid for necessary medical services.

A. North Carolina's Statute Is Not Inconsistent With This Court's Decision in *Ahlborn*.

The decision in *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006) did not reach and expressly left open the issue of how a state should determine what portion of a Medicaid recipient's damage settlement represents reimbursement for medical expenses. Indeed, as the United States expressly recognizes, "the question of how to apportion a settlement into payments for medical costs and payments for non-medical costs was not presented" in *Ahlborn*. (U.S. Br. 4-5)

The dispositive holding of *Ahlborn* is that the third-party recovery exception to the anti-lien provision "is limited to payments for medical care." 547 U.S. at 285. As observed by the United States,

> [t]he operation of the anti-lien provision in *Ahlborn* was straightforward. The State and the beneficiary had stipulated to the portion of the settlement – approximately $35,000 - that represented payment for medical expenses. 547 U.S. at 280-281. With the proper apportionment thus determined, the anti-lien provision prohibited the State from seeking to recover more than the medical-payments portion of the settlement. *Id.* at 285. In light of the parties' agreement, the Court had no need to address the methods a State might permissibly use to determine a proper allocation in the first place. *Id.* at 288.

(U.S. Br. 13 (emphasis supplied))

Respondents and their amici insist, however, that a case-by-case resolution of the amount that was "intended to compensate" the plaintiff for past medical services or that is "fairly attributable" to such damages is required by *Ahlborn* to avoid conflict with the Medicaid Act's anti-lien provision. These broad characterizations of the scope and content of the *Ahlborn* decision cannot withstand analysis.

1. Respondents repeatedly rely upon language describing the question for decision as whether Arkansas could "lay claim to more than the portion of Ahlborn's settlement that represents medical expenses." 547 U.S. at 280 (emphasis supplied). (Resp. Br. 10, 12, 14, 15, 16) Further conclusions are premised upon the phrase referencing the portion of

the settlement proceeds that "properly are designated as payments for medical costs." 547 U.S. at 288 (emphasis supplied). However, in proper context, the statements refer to a stipulation by the Medicaid lienholder as a party to the federal court action which conclusively answered the underlying factual question.[2]

2. Errors arise from Respondents' mischaracterization of the following guidance in *Ahlborn* concerning ways to avoid the risk of settlement manipulation when circumstances do not include the Medicaid lienholder's stipulation as to medical costs:

> Even in the absence of such a postsettlement agreement, though, the risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision.

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[2] Respondents' criticism of Petitioner's and the North Carolina Supreme Court's reliance on the "controlling stipulations" to define the scope of the *Ahlborn* decision (Resp. Br. 11, 19) is misplaced. The form of the determination– a stipulation – was not dispositive. Instead, the relevance and importance derives from the parties' binding agreement establishing what portion of the settlement represented payment for medical expenses – an agreement that included the Medicaid lienholder, the Arkansas DHHS.

547 U.S. at 288. First, Respondents claim that the North Carolina statute cannot be described as an "advance agreement" as to the amount of the State's recovery from a settlement because the referenced language contemplates an allocation "agreement between the Medicaid beneficiary and the state Medicaid program." (Resp. Br. 23 n.11) Plainly, the cited portion of this Court's decision references actions that the State can take to protect its interest to avoid unilateral action by the Medicaid recipient to diminish or eliminate recoupment of payment for past medical services. Second, Respondents' claim that the Court "expressly stated" that when the recipient and the state Medicaid program disagree the allocation of damages "should" be resolved in a judicial proceeding (Resp. Br. 29) misapplies the referenced language. In proper context, a judicial determination is a permissible but not a mandatory method to guard against settlement manipulation.[3]

3. Respondents assert that because the facts of the case do not "raise even the hint of settlement

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[3] Nor does this language support the claim by the United States that "in the Medicaid context, the State may not decree the portion to which it is entitled without affording the beneficiary some opportunity to challenge that assertion." (U.S. Br. 21) The Government offers no basis upon which to engraft a hearing requirement onto "rules and procedures for allocating tort settlements" that "might be employed to meet concerns about settlement manipulation." 547 U.S. at 288 n.18.

manipulation" and because "there was no allocation in the settlement" (Resp. Br. 32), the case is not "an appropriate vehicle for addressing settlement manipulation" (Resp. Br. 32-33). However, Respondents claim the Medicaid recipient's reimbursement obligation must be "proportionally reduced" because the recovery was less that the full amount of damages (Resp. Br. 15 n.5), and argue that "[t]he State should not be immune from sharing . . . proportionally" in the substantial reduction of the recipient's recovery which resulted from "the lack of available insurance" (Resp. Br. 18).

Respondents' call for the concept of proportionality to control issues of settlement allocation raises the potential for damage manipulation to the detriment of the State's reimbursement claim. (Pet. Br. 31-33) Indeed, in a different context the United States has recently maintained that under a pro rata theory, "[n]ot only would the apportionment percentages be subject to manipulation, but so too would the hypothetical total losses to the participant, which might bear little or no relation to the amount the plan paid and for which it seeks reimbursement." (U.S. Br. in *U.S. Airways v. McCutchen*, at 20-21, U.S. Supreme Court Docket No. 11-1285)

Furthermore, Respondents' current insistence that there was "no allocation in the settlement" is diametric to their previous representation that the state court judge "allocated the settlement between E.M.A. and her parents, awarding 88 percent of the

settlement to E.M.A., all of which was to be placed in a special needs trust to care for her medical and other needs during her lifetime. . . . He allocated 12 percent of the settlement to the parents for their claim for medical expenses through age 18 and Mrs. Armstrong's emotional distress." (Open. Br. 5-6)[4]

North Carolina's statute provides advance notice to all parties as to how to apportion a settlement for repayment for Medicaid's medical costs. The holding of *Ahlborn* is then applied to the apportioned settlement, with the State's recovery explicitly limited to the amount representing the recovery for past medical services. There is no inconsistency between this Court's prior decision and the terms of North Carolina's third-party recovery statute.

B. North Carolina's Third-Party Recovery Statute Does Not Contravene The Medicaid Act's Anti-Lien Provision.

North Carolina's third-party recovery statute apportions in advance of a settlement or judgment the

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[4] This claimed allocation, in combination with the argument that "[t]he claim for past medical expenses – those expenses for which the State is seeking reimbursement – belongs completely to E.M.A.'s parents." (Open. Br. 9), led to Respondents' previous assertion that "the proper outcome for this case is for the State of North Carolina to be awarded $112,000 – which amounts to one-third of the recovery for E.M.A.'s parents – from those funds held in trust" (Open. Br. 19).

medical services portion of any recovery of damages by a Medicaid recipient from a tortfeasor. (Pet. Br. 23-26) It provides a means of calculating the portion of any settlement that, by definition, represents payment for medical expenses and "then forbids the State from imposing a lien on the remainder of the settlement." (Pet. App. 82a) Respondents and their amici posit that the statute must be stricken because the end result of the North Carolina's procedure does not equate with the amount the parties "intended to compensate" for Medicaid's provision of medical services.

1. Respondents' fundamental mistaken premise is that North Carolina has established a statutory presumption that past medical expenses will account for one-third of tort settlements. They then argue that the "facts of the present case illustrate how the irrebuttable presumption" (Resp. Br. 16), results in the State recovering more than it should because

> it is not reasonable for Petitioner to assume that of the $2.8 million settlement, the sum of $933,333.33 was being paid for past medical expenses and the remaining sum of $1,866,666.67 was intended to suffice as payment for the entirety of E.M.A.'s non-medical damages, as well as legal fees and costs.

(Resp. Br. 17)

Respondents' position mischaracterizes the statute. It does not create a presumption as to how

settlements entered into by the parties to a medical malpractice action usually are allocated, or how the recovery in this case was actually allocated. Rather, the statute provides advance guidance as to the amount that must be set aside for repayment of the past medical services provided by the State before a plaintiff can recover for other categories and types of damages. The statute places limits on how settlements are allowed to be allocated. And the one-third provision in the statute is not an estimate of the medical expense component of the Medicaid recipient's settlement; it is instead a cap on the amount the State will receive in satisfaction of its lien for the provision of past medical services pursuant to its right to recover from third-party payments

Respondents further attack North Carolina's procedure as "arbitrary" because "the statute recognizes that the amount of medical expenses will frequently be less than one-third of the plaintiff's total damages." (Resp. Br. 26) Again, this argument confuses the concepts of allocation with presumption. The legislature did not create an internally contradictory provision arising from a presumption that payment for medical services comprise one-third of the total settlement. Instead, the statute imposes in advance a requirement that the State's medical services lien be accorded a repayment priority and sets forth a cap on the amount that must be allocated to that obligation. Respondents have not explained why such an allocation is invalid because it is based on two measurements, with the lesser one controlling.

2. Respondents' brief reflects further fundamental analytical flaws regarding the State's right of recovery from a Medicaid recipient's tort claim settlement.

a. First, they conflate the damages being sought with the recovery actually received, and imply that a proportional reduction in all categories of damages claimed is the appropriate methodology to govern the allocation of the recipient's settlement. While the plaintiffs' evidence indicated that "E.M.A. incurred damages in excess of $42 million as a result of her physician's malpractice" (Resp. Br. 3)[5], the parties to the negligence action reached an agreement to settle all claims for the sum of $2.8 million (Resp. Br. 4-5). Once the actual recovery is reached, the dollar amount of the different categories for which compensation is being sought is relevant only if Respondents are advocating that the recovery is to be subdivided on a proportional basis. That is because

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[5] Respondents rely upon a report developed by a life care planner which was used by an economic expert to determine the projected cost of the products and services needed by E.M.A. over her lifetime as a result of her injuries. (J.A. 91-112) In the opinion of the economic expert, the present value of such necessary goods and services was approximately $41 million, with over $37 million of that amount for "skilled nursing care." (J.A. 112) As such, Respondents damage claim is largely comprised of anticipated future medical expenses without any consideration of whether Medicaid will continue to provide such services.

the third-party recovery provision, N.C. Gen. Stat. § 108A-57(a), establishes the Medicaid recipient's obligation to repay the State out of the "proceeds obtained on behalf of the beneficiary." (Pet. App. 114a)

b. Second, Respondents equate the statutory compromise of the State's reimbursement right with the full value of Medicaid's claim for the provision of necessary medical services. Respondents claim that they were "forced to give up a substantial portion of [their] recovery simply because [the] treating physician was not sufficiently solvent to pay [the] claim in full," and argue that "[t]he State should not be immune from sharing in that loss proportionally." (Resp. Br. 18)[6] As demonstrated by the circumstances of this case, the State's statutory agreement to cap its recoupment at one-third of the total settlement

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[6] Respondents take out of context the discussion at pages 31-32 of the Petitioner's Brief of reasons why use of a proportional analysis or application of a pro rata reduction formula creates opportunities for settlement manipulation. (Resp. Br. 18 n.8) The same concerns for reducing "the State's recovery by inflating the amount of intangible damages sought" by the Medicaid recipient were recognized by the United States as a disadvantage to a proportional reduction process. (U.S. Br. 31) *See also* U.S. Br. in *U.S. Airways* at 20 (footnote omitted) (use of a "pro rata reduction theory to funds recovered in settlements with third parties would create opportunities for manipulation of the amounts apportioned for different categories of damage").

amount ($933,333.33) represents a substantial discount from full recovery ($1,900,000) – a reduction of almost one million dollars from the uncontroverted value of medical services provided. Respondents' position is that the State's claim must be further compromised by equating it with other components of projected damages.

3. The United States recognizes that North Carolina's statute determines in advance the medical costs portion of a settlement, and that such "[a]llocation rules govern a determination that is antecedent to the operation of the anti-lien provision: how to divide a settlement into a medical portion (recoverable) and a nonmedical portion (unrecoverable because it is the beneficiary's property)." (U.S. Br. 13) However, even though "state tort law determines a personal-injury plaintiff's substantive entitlement to damages in the first instance" (U.S. Br. 20), the United States asserts that North Carolina's statute "does not govern the damages a plaintiff may receive for particular claims or the procedures applicable in tort actions" (U.S. Br. 20). The United States maintains that N.C. Gen. Stat. § 108A-57 is therefore "preempted," not because it is impossible to comply with both the federal and state law but instead because it "frustrates the operation of the anti-lien provision" of the Medicaid Act. (U.S. Br. 16)

Characterizing the effect of N.C. Gen. Stat. § 108A-57 as specifically circumventing the anti-lien provision (U.S. Br. 21-22) disregards the legislative

context demonstrating that the third-party recovery statutes are consistent with North Carolina's longstanding exercise of its broad authority over tort actions. As previously shown (Pet. Br. 20-23), the concepts and policy considerations underlying the requirement that up to one-third of a tort settlement must be allocated for payment of past medical services is not unique to cases involving Medicaid recipients; instead, it is wholly consistent with legislation first adopted in 1935 creating a lien on personal injury recoveries in favor of the providers of medical supplies or services. *See* N.C. Gen. Stat. §§ 44-49 and 44-50 (2011). And, because the statute limits the State's recovery to the defined amount of any recovery attributable to the costs of past medical services, North Carolina' statute avoids violating the anti-lien provision in the way the Arkansas statute did in *Ahlborn*.[7]

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[7] Both Respondents and the United States argue that even though North Carolina's statute defines the portion of a Medicaid recipient's tort recovery that must be allocated for repayment of past medical services at a maximum of 33%,there is no reason why a State could not prospectively allocate 90% or 100% to medical costs. (Resp. Br. 25; U.S. Br. 22) Such a statute would not be preempted by the anti-lien provision because, by definition, the amount of the State's lien would be limited to monies that the recipient must allocate to past medical costs. However, a 90% or 100% requirement would raise the issue of whether the provision was specifically targeted at Medicaid recipients with an intent to evade the anti-lien provision.

North Carolina's statute is categorically different from the statute at issue in *Ahlborn* which the Court found "squarely conflicts with the anti-lien provision of the federal Medicaid laws." 547 U.S. at 280. The Arkansas statute totally overrode the anti-lien provision's requirement that a State's recovery of damages from a third-party be "limited to payments for medical care," *id.* at 285, because the asserted recovery exceeded the amount of the agreed-upon settlement that Arkansas had stipulated "represents compensation for medical expenses" *id.* at 280.

By contrast, N.C. Gen. Stat. § 108A-57 defines in advance the portion of a Medicaid recipient's settlement that represents payment for medical expenses "and then forbids the State from imposing a lien on the remainder of the settlement." (Pet. App. 82a) This advance directive by the State provides the parties with the precise amount that must be allocated to Medicaid's medical expenses in order to satisfy the State's lien. The Medicaid lien component necessarily becomes part of the fabric of the settlement because the parties know in advance the medical expenses portion because it is defined by statute.

C. A Post-settlement "True Value" Hearing Is Not Required By The Medicaid Act Nor Is The State Required To Directly Participate In The Underlying Tort Action.

Ascertainment of the bona fide "true value" of a personal injury lawsuit such as the medical malpractice action at issue here is not a realistic and

achievable requirement. (Pet. Br. 27-30) How to discern what portion of which category of damages was compromised by how much in order to arrive at the amount of the settlement is an inexact and subjective process at best. Here, Respondents maintain that their $42 million damage action was settled for a gross amount of $2.8 million for only one reason: because the "treating physician was not sufficiently solvent to pay [the] claim in full." (Resp. Br. 18) An after-the-fact construct of a purported allocation of the actual recovery between the various categories of damages would, as this Court has observed in a different context, "bear[] some resemblance . . . to slicing a shadow." *Container Corp. of Am. v. Franchise Tax Bd.*, 463 U.S. 159, 192 (1983).

1. Indeed, Respondents and their amici avoid mentioning the "true value" concept and instead embrace broadly a process in which the State "negotiate[s] with Medicaid beneficiaries to reach a fair and appropriate allocation of damages." (Resp. Br. 29)[8] And the United States suggests judicial or

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[8] Respondents expressly state that at any post-settlement hearing "the state Medicaid program would not be bound by a settlement agreement in which it was not a party." (Resp. Br. 29 n.13) *See also* Resp. Br. 32 (any settlement agreement crafted by the parties to allocate away the interests of the state Medicaid program "would not be binding on the State"). This position directly conflicts with the position of Respondents' amicus party when it asserts that the State cannot disregard allocations by the parties.

administrative hearings as one option within the scope of the "broad discretion" and "considerable leeway" of the States to develop methods of allocating settlements. (U.S. Br. 27) However, neither Respondents nor the United States have shown how a requirement for a post-settlement hearing as mandated by the Fourth Circuit is grounded in the Medicaid Act's anti-lien provision.

That various other states utilize post-settlement procedures to allocate between medical and nonmedical damages does not demonstrate that such processes are required or effective. Arguing that a State "could" or even "should" enact such a procedure does not establish that a State "must" provide for a case-by-case review to comply with the Medicaid Act's anti-lien provision. Nor does the observation that "[s]ixteen States and the District of Columbia explicitly provide the opportunity for a post-settlement" hearing (U.S. Br. 28) provide any indication that such procedures will not become mini-trials, involving complex and costly proceedings in which liability theories and defenses would have to be addressed and expert testimony required as to the

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(Fed. of Def. Br. 16) As previously explained, a recipient's designation of the amount of damages attributable to past medical expenses inadequately protects the State's lien and cannot override the statutory apportionment. (Pet. Br. 30-33)

various components of damages.[9] Indeed, as recently observed in a pending ERISA case, apportionment of damages between medical expenses and non-medical matters can be "costly and complex to adjudicate." (U.S. Br. in *U.S. Airways* at 21)

The inherently disadvantaged position of the State at such post-settlement hearings is tacitly acknowledged by the United States when it suggests that while the State may "institute procedural protections" requiring disclosure of pertinent information to allow meaningful participation in the hearing, the "State even then might not be on an equal footing with the beneficiary and the tortfeasor or its insurer," because such measures can only "mitigate the disadvantage." (U.S. Br. 32) It is of little solace that States can protect their interests by "provid[ing]

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[9] The post-settlement hearing here would be significantly different from the Workers' Compensation lien allocation proceedings referenced by Respondents' amicus. (Am. Assoc. for Justice Br. 17-24) The North Carolina Workers' Compensation Act was created "to ensure that injured employees receive sure and certain recovery for their work-related injuries without having to prove negligence." *Whitaker v. Town of Scotland Neck,* 357 N.C. 552, 556, 597 S.E.2d 665, 667 (2003). Division of the monies at issue primarily involves how much to allocate for future wages as provided for by a statutory formula. Moreover, if the employee sues a third party, the employer is not at a comparative disadvantage with the beneficiary concerning relevant information.

general guidance that the allocation should be equitable to both sides." (U.S. Br. 31)[10]

2. Nor must or should a State initiate its own action to enforce its subrogation rights to recover for the past payment for necessary medical services by Medicaid, as advocated by Respondents' amici (Am. Assoc. for Justice Br. 23; Fed. of Def. Br. 7) Indeed, as observed by the United States, States have "the discretion to stay out of the litigation and resolve allocation issues after the beneficiary and the third party have settled the beneficiary's claim." (U.S. Br. 28)

While North Carolina could have intervened in Respondents' malpractice action or brought its own suit, any recovery by the State necessarily requires the establishment of liability before the obligation of a third-party to pay for past medical services would arise. As previously noted by the United States, "[n]othing in the statutory text indicates that independent pursuit of an assigned claim is the sole statutorily permitted mode of recovery," and, because

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[10] Instead, the more persuasive analysis is the prior indication by the United States that "post hoc hearings are not a sufficient remedy in this instance." (U.S. Br. in *Ahlborn* at 17 n.7 ("[T]he hearing would have to answer how unproven personal injury claims have been subdivided into different manifestations of that injury, as discounted by proof difficulties and myriad other, subjective and individualized considerations that prompt plaintiffs to forego trials."))

of the dependence on the Medicaid recipient for evidence establishing liability, a State "could reasonably conclude that a beneficiary will be most effective in establishing liability when the beneficiary's own separate claims for relief are also on the line." (U.S. Br. in *Ahlborn* at 16)

Insistence on the State bringing its own action could have significant consequences on the recipient's ability to recover. The State would be pursing the full amount of its own claim – here, $1.9 million. The one-third statutory cap provision of N.C. Gen. Stat. § 108A-57 would not apply since it is applicable only to "proceeds obtained on behalf of the beneficiary." (Pet. App. 114a) Thus, in circumstances where there is a finite amount that can be recovered–here, $2.8 million because of malpractice insurance limits – the State's independent action could consume most if not all of the available monetary resources before the beneficiary's damage claims could be considered.

Additionally, the various claims that the State does not bear any portion of the litigation costs, including attorneys fees and that "the amount of the State's lien is not adjusted to account for those fees and costs," (Resp. Br. 17 n.7) cannot withstand analysis. It is true that the plaintiff pays her attorneys' fees. However, the statutory history of North Carolina's third-party recovery provision demonstrates that shielding two-thirds of any recovery was expressly intended to allow the plaintiff and her attorneys to divide the recovery in accordance with

their contract.[11] Furthermore, utilization of a statutory formula promotes appropriate policy goals because "a case-by-case determination of the medical expense portion of settlements could lead to variable results and increased litigation due to inconsistency in outcomes." *Andrews v. Haygood*, 362 N.C. 599, 604, 669 S.E.2d 310, 314 (2008), *cert. denied sub nom. Brown v. North Carolina Dep't of Health and Human Servs.*, 129 S. Ct. 2792 (2009).

Here, the State's claim has been compromised by almost one million dollars pursuant to the statutory provision capping recovery at one-third of the total recovery. The apparent purpose of a post-settlement hearing would be to effect a further reduction in the

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[11] North Carolina's third-party recovery statute previously provided for the payment of attorneys' fees, up to one-third of the recovery, before payment to the State and to the beneficiary. In *North Carolina DHHS v. Weaver*, 121 N.C. App. 517, 466 S.E.2d 717, disc. *rev. denied*, 342 N.C. 896, 467 S.E.2d 905 (1996), the North Carolina Court of Appeals held that N.C. Gen. Stat. § 108A-57 was not intended to regulate the contract between the Medicaid beneficiary and her attorney nor to limit the attorney to one-third of the recovery proceeds. The statute was thereafter amended to its present form, preserving the one-third cap on the amount of reimbursement to Medicaid but allowing the remaining two-thirds to be divided between the beneficiary and her attorney in accordance with their contract.

amount apportioned to repayment for past medical expenses.[12]

D. The Newly Announced Position Of The United States Concerning North Carolina's Third-Party Recovery Procedure Is Not Entitled To Deference.

North Carolina's third-party recovery procedure has operated with the knowledge of and the approval of the Centers for Medicare & Medicaid Services ("CMS"). (Pet. Br. 33-36) Pursuant to 42 U.S.C. § 1396a(a)(25)(A)(ii), CMS has a duty to monitor, on an ongoing basis, a state's plan for pursuing claims against third-parties. And yet, while North Carolina's statute has been essentially the same since 1996, CMS has never provided any indication that they disapprove of the procedure utilized in North Carolina, either before or after the decision in *Ahlborn*. Instead, in official correspondence to a member of Congress, CMS has stated that North Carolina's third-party recovery statute is not in "conflict with CMS' guidance." (Pet. App. 142a)

The United States now purports to disavow any statements made by CMS in the 2009 congressional

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[12] Neither Respondents nor their amici broach the possibility that the amount of attorneys fees, which can range from 33% to 40% of the gross recovery (Fed. of Def. Br. 10), is on the table in a post-settlement analysis seeking a "fair" allocation of the proceeds of the lawsuit when a tortfeasor's "limited resources" constrains full recovery.

reply memo, declaring that the response was "incorrect," and asserting that "[t]he Secretary's interpretation of the relevant provisions of the Medicaid Act and the 2006 CMS Guidance Memo is reflected in this brief." (U.S. Br. 25) The 2006 Guidance Memo is later described as "formal guidance" which sets forth "CMS's official advice to the States concerning permissible methods of recovering costs after *Ahlborn*." (U.S. Br. 26)

The federal government's newly minted re-interpretation of CMS guidance concerning North Carolina's third-party recovery rights and duties is not entitled to deference and is not persuasive. When a position of the United States has been developed *pendente lite*, the usual requirement for deference to regulatory interpretations made by an agency concerning the statute it administers has no application. *Atkins v. Parker*, 472 U.S. 114, 133 (1985). And "[a]n agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view," *INS v. Cardoza-Fonseca*, 480 U.S. 421, 448 n.30 (1987) (quoting *Watt v. Alaska*, 451 U.S. 259, 273 (1981)). Furthermore, an agency's ultimate conclusion as to whether a state law should be preempted is not entitled to deference. *PILVA, Inc. v. Messing*, 131 S. Ct. 2567, 2575 n.3 (2011).

Here, the 2006 CMS Guidance Memorandum describes *Ahlborn* as holding that "to the extent State

laws permit recovery over and above what the parties have appropriately designated as payment for medical items and services, the State was in violation of federal Medicaid laws." (U.S. Br. 23; Pet. App. 127a (emphasis supplied)) The emphasized key factor differentiates the circumstances presented here from those in *Ahlborn*: whereas Arkansas had stipulated to the portion of the third-party recovery representing payment for past medical services, North Carolina defines that amount by statute in advance of any lawsuit or settlement. The 2006 Guidance Memorandum further provides that States may enact "laws which provide for a specific allocation amongst damage[s]" (U.S. Br. 24; Pet. App. 129a), and that "a State could enact laws which give priority to the repayment of medical expenses" (U.S. Br. 24 n.5; Pet. App. 130a).

North Carolina's statutory provisions comport with the concepts outlined in the 2006 CMS Guidance Memorandum as well as the approaches recognized in *Ahlborn*: they establish criteria regarding how tort settlements are to be allocated when the Medicaid program has paid a recipient's medical expenses and they provide an advance agreement that the State will compromise its priority claim to reimbursement if the amount of the Medicaid lien exceeds one-third of the total recovery. Both the United States' attempt to diminish the significance of the 2009 congressional correspondence as merely a "workday advice letter" (U.S. Br. 25), as well as Respondents' dismissive assertion that the "letter is nothing more than an

effort by an HHS employee to appease the concerns of a Congressman" (Resp. Br. 34), miss the point. The appropriate consideration is not that the letter itself is entitled to any particular deference, but rather that it reflects the invariable position that North Carolina's third-party recovery statute is invariable with the 2006 CMS Guidance Memorandum.

North Carolina's statutes balance the tension between the Medicaid Act's third-party recovery and anti-lien provisions. Recipients are required to structure their settlement agreements to reimburse the State for the medical services it provided from the monies recovered from a liable tortfeasor. The portion attributed to repayment for past medicals is capped at one-third of the total recovery, thereby ensuring that the recipient has access to the majority of the settlement. Thus, North Carolina's procedures reflect the policy considerations previously articulated by the United States: "Medicaid's status as the payer of last resort can only be preserved . . . if Medicaid's third-party liability provisions are stringently enforced. . . . . Otherwise, Medicaid becomes a program of short-term financial expedience that enables long-term financial windfalls, rather than a payer of last resort for the truly indigent." (U.S. Br. in *Ahlborn* at 11)

CONCLUSION

For the foregoing reasons, and those stated in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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