No. 19-539

In the
Supreme Court of the United States

OFFICE OF RECOVERY SERVICES,
Petitioner,

v.

JOHN R. LATHAM,
Respondent.

On Petition for Writ of Certiorari to the Utah Supreme Court

REPLY BRIEF FOR PETITIONER

SEAN D. REYES
Utah Attorney General
TYLER R. GREEN
Utah Solicitor General
Counsel of Record
STANFORD E. PURSER
Deputy Solicitor General
WILLIAM W. MILLER
TONY S. LEBLANC
Assistant Attorneys General
350 N. State Street, Suite 230
Salt Lake City, UT 84114-2320
(801) 538-9600
tylergreen@agutah.gov

Counsel for Petitioner

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

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I. There is a square split.

Latham admits that the Utah Supreme Court's decision deepens to 3-1 a square split among State courts of last resort on the question presented. *See* BIO 2 ("True, a decade ago the Idaho Supreme Court took a different view" than the decision below). So there is no dispute that the question presented meets a predicate for plenary review. *See* S. Ct. R. 10(b).

Because he cannot dispute the split's existence, Latham tries to minimize its importance. His efforts buckle under their own weight.

A. Latham first denigrates *In re Matey*, 213 P.3d 389 (Idaho 2009), as a "barely-reasoned decision," BIO 14, embodying "a brief, one-paragraph analysis," *id.* at 2. That criticism is surprising given Latham's preferred precedent. Take *E.M.A. ex rel. Plyler v. Cansler*, 674 F.3d 290 (4th Cir. 2012), which Latham lauds as the wellspring of the three long-side decisions. *See* BIO 2-3, 11, 15. Unlike *In re Matey*, *Plyler* does not even analyze the question. Instead, it announced Latham's preferred rule by *ipse dixit* in one sentence. *Plyler*, 674 F.3d at 312 ("As the unanimous *Ahlborn* Court's decision makes clear, federal Medicaid law limits a state's recovery to settlement proceeds that are shown to be properly allocable to past medical expenses."). Even the Utah Supreme Court acknowledges that *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), doesn't go that far. *See* Pet. App. 10a ("It is correct that the *Ahlborn* Court did not

expressly differentiate between past and future medical expenses in its holding.").

What's more, the West Virginia Supreme Court—like the Idaho Supreme Court—analyzes this question in one paragraph. *In re E.B.*, 729 S.E.2d 270, 292-93 (W. Va. 2012). The Florida Supreme Court, in turn, spends two paragraphs on it. *Giraldo v. Agency for Health Care Admin.*, 248 So.3d 53, 56 (Fla. 2018). So much for the length of *In re Matey*'s analysis disqualifying the split from plenary review.

Latham's second, "more critical[]" attack (BIO 12) on *In re Matey* also fails. Latham emphasizes that *In re Matey* "pre-date[s] this Court's decision in *Wos [v. E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013)]," BIO 12, and suggests "that with further percolation the Idaho Supreme Court will reconsider its decision in light of the binding precedent of *Wos*," *id.* at 17. But *Wos* is *not* binding precedent on the question presented here. The BIO itself confirms as much: Latham cites no language from *Wos* requiring any court to adopt his preferred rule. Rather, he quotes language from only the Fourth Circuit's underlying decision in *Plyler*, *see* BIO 2-3, 15, which *Wos* did not adopt or embrace.

B. Latham next urges the Court to "abstain[] from statutory interpretation" until it hears from the Centers for Medicare and Medicaid Services. BIO 17. According to Latham, that "approach" will "'produce better informed and uniform legal rulings by allowing courts to take advantage of an agency's specialized knowledge, expertise, and central position within a regulatory regime.'" *Id.* (quoting *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 646 (2003)). This

contention does not counsel against a grant for three reasons.

1. The cases Latham cites do not support that outcome. His quote from *Walsh* is not even language in the opinion; it is language in the syllabus—and in a part of the syllabus summarizing a separate opinion. *See* 538 U.S. at 646 (summarizing opinion of Breyer, J.). Nor did the actual *Walsh* majority invoke CMS's views when analyzing whether Maine's Medicaid prescription-drug program should be preliminarily enjoined for allegedly violating the dormant Commerce Clause. *See id.* at 668-70.

Latham's reliance on *Armstrong v. Exceptional Child Center, Inc.*, 575 U.S. 320 (2015), is similarly faulty. *See* BIO 18. The text he quotes in *Armstrong* appears in the dissenting opinion. *See id.* (quoting 575 U.S. at 345) (Sotomayor, J., dissenting). And the *Armstrong* majority did not invoke CMS's views to support its holding that the Supremacy Clause creates no private right of action to enforce 42 U.S.C. § 1396a(a)(30)(A). *See id.* at 324-27.

Finally, *Schweiker v. Gray Panthers*, 453 U.S. 34 (1981), is inapposite. *Schweiker* addressed the legality of CMS regulations passed under 42 U.S.C. § 1396a(a)(17)(B), which requires States to "grant [Medicaid] benefits to eligible persons 'taking into account only such income and resources as are, *as determined in accordance with standards prescribed by the Secretary*, available to the applicant.'" 453 U.S. at 43-44 (quoting 42 U.S.C. § 1396a(a)(17)(B)). Given that "explicit delegation of substantive authority," *id.* at 44, CMS's construction there was "entitled to more than

mere deference or weight," *id.* (quoting *Batterton v. Francis*, 432 U.S. 416, 426 (1977)). Of course, no similar delegation appears in 42 U.S.C. §§ 1396a(a)(25)(H) or 1396k(a)(1)(A).

2. If it is "premature" (BIO 17) to resolve this split before CMS interprets §§ 1396a(a)(25)(H) or 1396k(a)(1)(A), *Ahlborn* and *Wos* were premature, too. The Court granted certiorari in both of those cases without waiting for CMS's formal or informal guidance on those questions presented. Indeed, the Court did not even call for the views of the Solicitor General in either case before granting certiorari. Since Latham does not distinguish this acknowledged split from the splits the Court resolved in *Ahlborn* and *Wos* without waiting on CMS, there is similarly no reason to postpone plenary review here.

3. More fundamentally, Latham's suggestion confuses—or invites this Court to abdicate—its constitutional role. After all, "the power of 'the interpretation of the laws'" is "'the proper and peculiar province of the courts.'" *Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 222 (1995) (quoting The Federalist No. 78) (brackets omitted). And when, as here, the interpretive question admittedly requires "resolv[ing] conflicts among the . . . state courts concerning the meaning of provisions of federal law," that "task" belongs "*initially and primarily*" to this Court. *Braxton v. United States*, 500 U.S. 344, 347-48 (1991) (emphasis added). "[A]bstain[ing] from statutory interpretation in favor of" admittedly nonexistent CMS views (BIO 17) could not depart more fully from that role.

* * * * *

We've come full circle: the question presented implicates an acknowledged split that is already deeper than the splits resolved in *Ahlborn* and *Wos* without first seeking CMS's views. The same course is warranted here. The Court should grant certiorari, letting CMS again weigh in at the merits stage.

II. The issue is exceptionally important and recurring.

Latham does not dispute—because he cannot dispute—ORS's three explanations about this acknowledged split's critical importance: First, States and their employees should operate under identical rules when administering a nearly $600 *billion* joint federal-state program. They currently do not. Second, because they do not, at least one State is already "violat[ing] federal law" by either "fail[ing] to recover what it must" or "tak[ing] a beneficiary's property beyond medical expenses." *Wos*, 568 U.S. at 649 (Roberts, C.J., dissenting). Third, leaving the Utah Supreme Court's judgment in place will cause the amount of third-party tort reimbursements ORS recovers to plummet. *See* Pet. 14-16.

Instead of disputing ORS's explanations, Latham offers two reasons why the question presented is not really important. Neither withstands scrutiny.

A. Latham suggests that this interpretative question is irrelevant because ORS can resolve allocation disputes by contract when negotiating "the portion of the settlement from which it could recover its past medical expenses." BIO 21. But ORS had no reason to negotiate the portion of Latham's settlement

allocable to past medical expenses. Until the decision below, no governing law required ORS to do that. And even going forward, Latham's suggestion disregards reality. This case shows why.

ORS approved Latham's settlement so as to capture the defendants' $800,000 offer—an amount not guaranteed to survive a trial. Before approving that settlement, ORS tried to negotiate with Latham over what portion of it should be allocated to *all* medical expenses *generally*.

But Latham or his lawyers would not even agree with ORS on that *broader* allocation. Indeed, that's precisely why Latham sued ORS in Utah state district court—to determine "how to calculate ORS' portion of the settlement in light of" *Ahlborn*. Pet. App. 26a; *see id.* at 26a-30a (deciding the portion of Latham's settlement allocable to medical expenses).

It strains credulity to think that Latham would have agreed to allocate *past* medical expenses when he in fact refused to stipulate to an allocation of *all* medical expenses. His decision is not surprising, however, since *Ahlborn* itself creates incentives for Medicaid recipients *not* to stipulate; it expressly contemplates that a State and Medicaid recipients can, "if necessary, . . . submit[]" allocation disputes "to a court." 547 U.S. at 288.

B. Latham also suggests that certiorari is not warranted because reinstituting Utah's prior rule would "impact so few cases," and result in "negligible" average recoupments of $3.2 million per year for Utah's Medicaid budget. BIO 19. This characterization betrays

an altogether sadder kind of disregard for the issue here.

First, consider just these undisputed facts. Utah spent $104,065.32 on medical care to save Mr. Latham's life after a serious, acute medical crisis. *See, e.g.*, BIO 6. If that sum approximates Utah's costs to cover acute care for other Medicaid patients' medical crises, $3.2 million is enough money to save an additional 31 Utahns' lives per year—hardly a "negligible" result.

Second, Latham disregards the singular role that §§ 1396a(a)(25) and 1396k(a) play in Medicaid's third-party tortfeasor reimbursement regime. They create the lone exception to Medicaid's general anti-lien provision. *See Ahlborn*, 547 U.S. at 283-85; 42 U.S.C. § 1396p(a)(1). In other words, the funds that States recover under those statutes represent 100% of the tort recoveries available to shore up Medicaid budgets. If those inflows dry up—and Latham does not dispute that, under his rule, very nearly will—no other third-party tort reimbursements will take their place. If a court's decision is to close that spigot, it should be this Court's decision after plenary review.

III. The decision below is incorrect.

Given the admitted conflict and undisputed importance of the question presented, Latham's contentions about the merits would not justify denying certiorari even if they were correct. But they are wrong.

A. Most prominently, following *Ahlborn*'s lead, *see* 547 U.S. at 276-77, 281, 284-85, ORS discussed at length the critical role that § 1396k(a) plays in Congress's third-party reimbursement regime—and how the Utah Supreme Court misread that provision. *See* Pet. 3, 5, 16-17, 19. Latham's answers to those arguments? Silence. In fact, § 1396k(a) appears only once in Latham's brief—as a mere citation in a quote from *Ahlborn*. BIO 22. Latham's non-response speaks volumes more than his actual arguments.

B. A related point. ORS explained how the Utah Supreme Court's opinion makes § 1396k(b) a nullity: the opinion eliminates any chance that a State will have a "remainder" to distribute to a Medicaid recipient after it satisfies its lien. Pet. 17-18. Latham's attempt to rebut this point only confirms this error.

According to Latham, ORS allegedly "repeats" an argument that *Ahlborn* rejected—the "'assumption either that Medicaid will have paid all the recipient's medical expenses or that Medicaid's expenses will always exceed any third-party recovery earmarked for medical expenses.'" BIO 22-23 (quoting *Ahlborn*, 547 U.S. at 282 n.11). Noting that Medicaid recipients could have paid some medical expenses from their own pockets (or have other private-insurance coverage), Latham contends that "a 'remainder' could readily exist under § 1396k(b) even if the State agency is limited to compensation for its past medical expenses from the portion of a settlement intended to cover past medical expenses." BIO 23.

Latham's argument is plainly correct *if* the State's assignment for "past medical expenses" lets the State

collect reimbursements for both past *state-paid* medical expenses *and* past *recipient*-paid medical expenses. Whether the State's assignment covers both categories depends on the statutory text, since the assignment is a creature of statute. And according to the Utah Supreme Court, § 1396a(a)(25)(H) is the text that creates this assignment. *See* Pet. App. 13a-16a.

But if the Utah Supreme Court is correct—that is, if the State's assignment for "past medical expenses" in fact arises from § 1396a(a)(25)(H)—that assignment cannot cover both categories of past medical expenses. For by its plain terms, § 1396a(a)(25)(H) applies only "to the extent that *payment has been made under the State plan*." (Emphasis added). Only then is a State "considered to have acquired the rights of such individual [Medicaid recipient] to payment by any other party *for such health care items or services*"—that is, for health care items or services *the State* has paid for under its plan. *Id.* (emphasis added). In short, § 1396a(a)(25)(H)'s plain text refers *only* to past *state-paid* medical expenses. A past recipient-paid medical expense simply is not a "payment [that] has been made under the State plan." *Id.*

Therein lies Latham's problem. Because the Utah Supreme Court read § 1396a(a)(25)(H) to create both the assignment *and* the lien, that statute's textual limits must apply equally to both devices. The lien and the assignment necessarily become coextensive—with each limited to past *state-paid* medical expenses. By operation of law, then, every dollar a State would collect under its assignment would correspond to a dollar for which "payment has been made under the

State plan," *id.*, and thus be subject to the State's lien. So by definition, this interpretation of § 1396a(a)(25)(H) precludes a remainder from existing—making § 1396k(b) a nullity.

But Medicaid does not work that way, for the very reasons ORS explains. The State's assignment extends beyond past state-paid expenses precisely *because* it originates not in § 1396a(a)(25)(H) but in § 1396k(a)(1)(A), whose text requires an assignment of "*any rights* . . . to payment for medical care from any third party." *Id.* § 1396k(a)(1)(A) (emphasis added). Because that broad assignment is limited neither by time nor initial payor, it gives a State the right to collect payment for all past and future medical expenses. From those funds, the State retains the amount necessary to satisfy its lien for past state-paid medical expenses, *see id.* § 1396a(a)(25)(H), and pays the remainder to the Medicaid recipient, *id.* § 1396k(b). The Utah Supreme Court's departure from this straightforward approach, with its resulting nullification of § 1396k(b), mandates reversal.

C. The Court need not linger on Latham's remaining merits arguments. First, Latham faults ORS for allegedly "impl[ying], incorrectly, that it has no choice but to seek reimbursement to the full extent of its pre-settlement estimate of $104,065.32 that it agreed upon with Mr. Latham." BIO 21. But on this point, ORS follows federal rules requiring the States to "distribute collections" to themselves in "an amount equal to State Medicaid expenditures for the individual on whose right the collection was based." 42 C.F.R. § 433.154(a). This rule comports with the long-

established federal policy of requiring a State, "in either an out-of-court settlement or a court judgment," to "do all in its power to obtain full restitution of the amounts expended on the beneficiary's behalf." *See* Pursuing Tort Recoveries: Fact Sheet, June 2000, attached to Memorandum from Gale Arden, Director of CMS's Center for Medicaid and State Operations Disabled and Elderly Health Programs Group (DEHPG) to all Associate Regional Administrators for Medicaid and State Operations regarding State Options for Recovery Against Liability Settlements in Light of U.S. Supreme Court Decision in *Arkansas Department of Human Services v. Ahlborn* (July 3, 2006).

Next, Latham contends that the "plain meaning" of 42 U.S.C. § 1396a(a)(25)(B) "requires ORS to recover only the amount of past medical expenses for which the third party is actually legally liable, i.e., under the settlement agreement, not the amount the agency and a plaintiff come up with on their own." BIO 21. He further contends that the defendants' "'[l]egal liability' was fixed at settlement, when" they "assumed liability of $800,000 total." *Id.*

But the defendants here expressly *disclaimed* legal liability in the settlement memorandum, which both Latham and his counsel signed. *See* Compl. Ex. D, ¶ 4 ("There will be no admission of liability in the settlement documents but, rather, recognition that this is a disputed claim."). In other words, defendants have *never* fixed their legal liability. They have only paid to resolve a disputed claim. So if Latham's interpretation

were correct, no portion of the $800,000 settlement could satisfy ORS's lien.

Third, Latham cites § 1396a(a)(25)(H) and contends that ORS can "recover only to the extent of Mr. Latham's own right to recover for past medical expenses paid by Medicaid." BIO 22. This argument again confuses the scope of ORS's lien under § 1396a(a)(25)(H) with the source and scope of ORS's assignment—an issue on which Latham errs for reasons already discussed.

Finally, Latham argues by appealing to emotion, calling ORS's argument "untenable," "particularly perverse," and "absurd[]." BIO 23-24. That is so, he contends, because the funds he received from his settlement make him ineligible for Medicaid, and "[w]hen Medicaid has no responsibility for a former recipient's future medical costs, there is no basis for it to reimburse itself out of funds designated to cover those costs." *Id.* at 23.

Even if his appeals to emotion belong here, rather than in Congress, they do not undermine the petition's certworthiness. Latham himself pegs his future medical expenses at about $6.4 million. *See id.* at 6-7. Taking him at his word, it seems inevitable that Latham will qualify for Medicaid again; his $800,000 settlement falls well short of $6.4 million. And he might qualify for Medicaid again sooner than expected, since his settlement is subject not only to ORS's federally mandated lien for past state-paid medical expenses—now capped at roughly $70,000—but also to other expenses. Attorneys' contingency fees—typically set at between 30 to 40 percent of a settlement, or

roughly $240,000 to $320,000 here—are one example of a non-medical expense that depletes funds available for Latham's future medical care and hastens his return to Medicaid coverage.

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CONCLUSION

The Court should grant the petition for a writ of certiorari.

Respectfully submitted.

SEAN D. REYES
Utah Attorney General
TYLER R. GREEN
Utah Solicitor General
Counsel of Record
STANFORD E. PURSER
Deputy Solicitor General
WILLIAM W. MILLER
TONY S. LEBLANC
Assistant Attorneys General
350 N. State Street, Suite 230
Salt Lake City, UT 84114-2320
Telephone: (801) 538-9600
Email: tylergreen@agutah.gov

Counsel for Petitioner

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