No. 20-1263

IN THE

Supreme Court of the United States

GIANNA GALLARDO, AN INCAPACITATED PERSON, BY AND THROUGH HER PARENTS AND CO-GUARDIANS PILAR VASSALLO AND WALTER GALLARDO,

Petitioner,

v.

SIMONE MARSTILLER, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF FOR THE NATIONAL CONFERENCE OF STATE LEGISLATURES, THE NATIONAL LEAGUE OF CITIES, THE U.S. CONFERENCE OF MAYORS, AND THE GOVERNMENT FINANCE OFFICERS ASSOCIATION AS *AMICI CURIAE* SUPPORTING RESPONDENT

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INTEREST OF *AMICI CURIAE*[1]

The National Conference of State Legislatures ("NCSL") is a bipartisan organization that serves the legislators and staffs of the Nation's 50 States, its Commonwealths, and Territories. NCSL provides research, technical assistance, and opportunities for policymakers to exchange ideas on pressing issues. NCSL advocates for the interests of State governments before Congress and federal agencies, and regularly submits amicus briefs in cases, like this one, that raise issues of vital State concern.

The National League of Cities ("NLC") is the oldest and largest organization representing municipal governments throughout the United States. Working in partnership with forty-nine State municipal leagues, NLC is the voice of more than 19,000 American cities, towns, and villages, representing collectively more than 200 million people. NLC works to strengthen local leadership, influence federal policy, and drive innovative solutions.

The U.S. Conference of Mayors ("USCM") is the official nonpartisan organization of the more than 1,400 United States cities with a population of more than 30,000 people. Each city is represented in the USCM by its chief elected official, the mayor.

The Government Finance Officers Association ("GFOA") is the professional association of State, provincial, and local finance officers in the United States

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[1] Pursuant to Supreme Court Rule 37, *amici curiae* state that no counsel for any party authored this brief in whole or in part, and that no entity or person other than *amici curiae* and their counsel made any monetary contribution toward the preparation and submission of this brief. Both petitioner and respondent consented to the filing of this brief.

and Canada. The GFOA has served the public finance profession since 1906 and continues to provide leadership to government-finance professionals through research, education, and the identification and promotion of best practices. Its more than 19,000 members are dedicated to the sound management of government financial resources.

These groups submit this brief as *amici curiae* because their members will be directly affected by the Court's decision in this case. Through Medicaid, *amici*'s members fund necessary health care for their poorest inhabitants. *Amici* support the respondent in this case because, as this brief explains, Florida's Medicaid recovery statute, as construed by the Eleventh Circuit, provides an efficient, fair, and reasonable method for States to recover costs imposed on State budgets by tortfeasors through assignments by Medicaid recipients.

SUMMARY OF ARGUMENT

By participating in Medicaid, States accept a significant financial burden so that they can provide medical care to their neediest residents. The weight of that burden is increasing at a rapid pace, as it has done for at least the past twenty years.

To help ameliorate these fiscal pressures, Congress both allows and requires States to seek reimbursement for their outlays from certain third-party payors. In cases where the State pays for medical expenses required as the result of a tort, and in which the tort victim settles with the tortfeasor, a State has the power and obligation to seek reimbursement from whatever portion of the settlement represents payment for medical care. Over the years, Congress provided States with multiple tools to accomplish this aim. One of

those tools, 42 U.S.C. § 1396k(a)(1)(A), requires Medicaid recipients to assign to the State their rights to "payment for medical care from any third party." The text of this provision unambiguously treats all third-party payments for medical care as fungible, and entitles the States to seek reimbursement from the whole portion of a settlement attributable to medical care, regardless of whether the care was provided in the past or will be provided in the future. The court of appeals therefore correctly concluded that Florida could reimburse itself with all settlement funds for medical expenses, both past and future.

To avoid this straightforward result, the petitioner relies on a different, later-enacted provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(25)(H), which allows a State to subrogate a narrower subset of third-party funds for medical care. But that subrogation provision is merely another tool that Congress provided to States. Nothing in it purports to limit or impliedly repeal Section 1396k. The decision of the court of appeals should be affirmed.

ARGUMENT

I. STATES HAVE, AND REQUIRE, SUBSTANTIAL AUTHORITY IN SEEKING REIMBURSEMENT OF ASSIGNED MEDICAID COSTS AGAINST THIRD-PARTY TORTFEASORS.

A. The Ever-Increasing Cost Of Medicaid Imposes A Significant Burden On States.

States are tasked with covering the costs of desperately needed medical care for their poorest and most vulnerable citizens through Medicaid. These costs have been increasing for decades, and, at an annual

expenditure of more than $600 billion, Medicaid constitutes the single largest spending item for States. See Robin Rudowitz et al., Kaiser Fam. Found., *Medicaid Financing: The Basics* (May 7, 2021), http://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/. Medicaid costs typically consume more than a quarter of each State's budget. *Id.*

The resulting burden on States' finances is increasing rapidly. By some estimates, State Medicaid expenditures will grow by 8.4% this year, after growing by 6.3% in 2020. *Id.* Medicaid expenditures surged by more than 6% in twelve of the past twenty years. *Id.* Those increases reflect both growing enrollment and growing costs of care for each covered person. In the past decade, the average annual rate of per-enrollee spending more than quadrupled, increasing from 0.8% during the 2010–2013 period to 3.4% during the 2016–2019 period. *Id.* According to the Centers for Medicare and Medicaid Services, per-enrollee expenditures will increase 4.3% on average each year from 2019 to 2028. Ctrs. for Medicare & Medicaid Servs., *National Health Expenditure Projections 2019–28*, at 6 (Mar. 24, 2020), http://www.cms.gov/files/document/national-health-expenditure-projections-2019-28.pdf.

Although the Federal government contributes much of Medicaid's funding, States bear up to 50% of the cost. See Barb Rosewicz et al., Pew Charitable Trs., *States Collectively Spend 17 Percent of Their Revenue on Medicaid* (Jan. 9, 2020), http://www.pewtrusts.org/en/research-and-analysis/articles/2020/01/09/states-collectively-spend-17-percent-of-their-revenue-on-medicaid. As a practical matter, States have little choice but to participate in Medicaid on the Federal government's terms and accept the accompanying severe financial burden. Withdrawal from Medicaid—and the loss of Federal funding—would force States to

cut healthcare for their poorest, sickest, and most vulnerable residents. Cf. *Nat'l Fed'n of Indep. Bus.* v. *Sebelius*, 567 U.S. 519, 582 (2012) (plurality opinion) (characterizing the "threatened loss" of Federal Medicaid funding as "economic dragooning").

B. The Medicaid Statute Grants States Authority To Pursue Reimbursement Of Assigned Medicaid Costs From Third-Party Tortfeasors.

The heavy financial burden that States bear under Medicaid means that every option the States have for recouping costs is important. And the Medicaid statute in fact provides States with multiple tools to pursue recovery from third parties, including through assignments from recipients of Medicaid and subrogation from third-party tortfeasors.

Soon after enacting Medicaid, Congress empowered States to "take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan)" and "seek reimbursement." Social Security Amendments of 1967, Pub. L. No. 90-248, § 229(a), 81 Stat. 821, 904 (1968). Congress provided States with broad powers in implementing their Medicaid programs and has repeatedly expanded States' authority, supplying them with additional tools to collect third-party funding for the medical services they provide. See, *e.g.*, Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, § 11(b), 91 Stat. 1175, 1196 (1977) (adding 42 U.S.C. § 1396k); Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13622(c), 107 Stat. 312, 632–33 (1993) (adding current 42 U.S.C. § 1396a(a)(25)(H)).

As discussed below, the operative tool in this case, 42 U.S.C. § 1396k, makes no distinction between payments for past and future medical care. See *infra* at 10–11. Congress's decision to treat third-party payments for medical care as fungible reflects the financial realities under which States administer Medicaid. This case exemplifies this dilemma. Here, Gallardo's family estimated the value of her case at more than $20 million, but she received a settlement of only $800,000. Pet'r's Br. 16. That is less than the amount of money Florida's Medicaid program has already spent in this case, and that amount will continue to grow, because Gallardo is expected to require ongoing medical care. See *id.* Even though the injury here was inflicted by a third party, Florida will only be able to recoup a fraction of what it has spent and will spend.

Permitting States to use money allocated for future medical expenses to pay for expenses already incurred by Medicaid reasonably addresses this predicament. It allows States to recover needed funds. But it caps the State's potential recovery at the amount of expenses the State has actually incurred up to that point, ensuring that States will not receive a windfall at a tort victim's expense.

II. THERE IS NO CONFLICT BETWEEN THE MEDICAID ACT AND THE FLORIDA STATUTORY SCHEME.

The current version of the Medicaid Act gives States two principal tools for reimbursing their Medicaid expenditures. First, the Act requires recipients "to assign the State any rights" they have "to payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A). By its text, this provision reaches "any" compensation for medical services, past or future. Utilizing this grant of authority, Florida "auto-

matically assigns to the [State] any right, title, and interest [a Medicaid recipient] has to any third-party benefit" for medical care. Fla. Stat. § 409.910(6)(b). Because Florida's statute mirrors, rather than "directly conflict[s]" with the Medicaid Act, preemption does not apply. *PLIVA, Inc.* v. *Mensing*, 564 U.S. 604, 617–18 (2011).

Separately, the Medicaid Act also provides States a subrogation right with respect to certain "payment[s] by any other party for such health care items or services" provided by Medicaid. 42 U.S.C. § 1396a(a)(25)(H). Nothing in this subrogation provision, however, constrains or impliedly repeals the broader, separate, and unambiguous grant of authority in the assignment provision.

A. Section 1396k(a)(1)(A) Governs This Dispute.

As the Eleventh Circuit correctly recognized, the assignment provision of Section 1396k contains a broad mandate for Medicaid recipients to assign the State their rights to any third-party payments for medical care. Pet. App. 16. Specifically, Section 1396k(a)(1)(A) provides that States must require Medicaid recipients "to assign the State any rights" they may have "to support . . . and to payment for medical care from any third party." 42 U.S.C. § 1396k(a)(1)(A).

Pursuant to this mandate, Florida enacted a statute providing that the relevant state agency is automatically assigned rights to "any third-party benefit" for medical services received by the Medicaid recipient, up to the "amount of medical assistance provided by" Medicaid. Fla. Stat. § 409.910(6)(b). The agency is also entitled to "an automatic lien for the full amount of medical assistance provided by Medicaid to or on be-

half of the recipient for medical care furnished as a result of any covered injury or illness for which a third party is or may be liable." *Id.* § 409.910(6)(c). The statute makes clear that certain benefits, including "benefits not related in any way to a covered injury or illness" and "recovery in excess of the amount of medical benefits provided by Medicaid," are "not subject to the rights of the agency." *Id.* § 409.910(12).[2] The result is that Florida can seek recovery of the entire portion of a tort settlement representing compensation for medical expenses, up to the cost of the services provided by Medicaid. The statute does not limit Florida to compensation for past medical services.

Florida's statute comports with the plain language of Section 1396k. That provision is clear that the State must be assigned "any" rights to third-party payments for "medical care." Florida's statute does precisely that, and no more. The Florida statute automatically assigns the State agency the right to "any third-party benefit," *id.* § 409.910(6)(b), which refers only to "[t]hird-party benefits for medical services," *id.* § 409.910(3). In the case of a tort settlement, the agency is entitled to the allocation for "past and future

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[2] In the event the Medicaid recipient receives a judgment, award, or settlement from a third-party resulting from a tort claim, the statute allocates to the Florida agency "one-half of the remaining recovery" after attorney's fees and taxable costs. *Id.* § 409.910(11)(f)(1). In order to comply with this Court's decision in *Wos* v. *E.M.A. ex rel. Johnson*, 568 U.S. 627 (2013), the statute allows the Medicaid recipient to challenge this allocation and demonstrate that "the portion of the total recovery which should be allocated as past and future medical expenses is less than the amount calculated by the agency pursuant to the formula set forth in paragraph (11)(f)," Fla. Stat. § 409.910(17)(b).

medical expenses." *Id.* § 409.910(17)(b). Under no circumstances is the agency purporting to be entitled to non-medical expenses or recovery in excess of the amount of Medicaid benefits actually paid. *Id.* § 409.910(12).

The Florida statute is therefore consistent with this Court's decision in *Ahlborn*, which held that a State's potential reimbursement from a tort settlement is limited to only the "portion of [the] settlement that represents payments for medical care," without providing further limitations. *Ark. Dep't of Health & Hum. Servs.* v. *Ahlborn*, 547 U.S. 268, 282 (2006). In accordance with *Ahlborn*, the Florida statute does not seek an assignment of anything beyond the allocated portion for medical expenses.

B. Section 1396k(a)(1)(A) Is Not Limited To Past Medical Expenses.

Despite the unambiguous language of Section 1396k(a)(1)(A), petitioner asks the Court to read into the section the word "past" as it pertains to "payment for medical care." See Pet'r's Br. 30–33 The Court should decline to do so.

Section 1396k(a)(1)(A) contains no language that suggests Congress intended to limit the assignment of "payment for medical care" to payment for "past" medical care. The provision's legislative history confirms that Congress intended to treat payments for medical care as fungible—*i.e.*, without regard to whether such costs had already been incurred or were anticipated in the future. When it enacted this provision, Congress was especially concerned with "cases where absent parents who have been ordered by a court to provide for the medical support of their families have failed to do so," leaving Medicaid to pick up the tab. S. Rep. No. 95-453, at 30–31 (1977). As a result, Congress required

States to condition eligibility for Medicaid on enrollees "assign[ing] their medical support or indemnification rights to the State," without regard to whether the payor was liable for the particular service covered by Medicaid. *Id.* at 31; see 42 U.S.C. § 1396k(a)(1)(B).

Congress could have added language distinguishing between past and future medical payments and in fact, knows how to insert language to that effect if that was what it intended. For example, in Section 1396a(a)(25)(H), the provision on which petitioner relies heavily, Congress referred to "payment by any other party for such health care items or services" that have been "furnished to an individual." 42 U.S.C. § 1396a(a)(25)(H). Yet Congress chose to refer simply to "payment for medical care" in Section 1396k(a)(1)(A) without distinguishing between past and future medical care. That demonstrates Congress's intent not to limit Section 1396k(a)(1)(A) to only past medical expenses. See *Russello* v. *United States*, 464 U.S. 16, 23 (1983) ("[W]here Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." (alteration in original) (quoting *United States* v. *Wong Kim Bo*, 472 F.2d 720, 722 (5th Cir. 1972) (per curiam))).

In sum, petitioner is requesting that the Court further limit the available payments that the State is entitled to reach. Petitioner's reading is contrary to both the statutory text and the intent of Congress, and would severely limit the State's ability to recover its Medicaid expenditures.

C. Section 1396a(a)(25)(H) Does Not Apply And Cannot Limit Or Impliedly Repeal Section 1396k's Broader Grant Of Authority.

Petitioner relies on a separate provision—Section 1396a(a)(25)(H), the subrogation provision of the Medicaid Act—to argue that Florida's statute is preempted. Section 1396a(a)(25)(H) operates to subrogate to the State the rights to any third-party payments for health care "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." 42 U.S.C. § 1396a(a)(25)(H). Specifically, Section 1396a(a)(25)(H) requires the state to pass laws, under which "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.* In contrast to Section 1396k, this provision only reaches payments for past medical services.

Section 1396a(a)(25)(H), however, addresses only the subrogation of rights to the State and is entirely silent on whether a State can or cannot be assigned rights for the portion of a settlement pertaining to future medical costs. Nonetheless, petitioner argues that, because Section 1396a(a)(25)(H) more narrowly limits the State's rights to "payment [that] has been made," it also limits the State's rights to an assignment under Section 1396k. See Pet'r's Br. 33–34.

Statutes should be read "'as a symmetrical and coherent regulatory scheme,' and 'fit, if possible, all parts into an harmonious whole.'" *Food & Drug Admin.* v. *Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (citations omitted). As discussed *supra* 10–11, Section 1396k(a)(1)(A) squarely deals with the State's rights to an assignment and unambiguously permits States to reimburse themselves for medical expenses

incurred with "any" third-party "payment for medical care." Interpreting Section 1396a(a)(25)(H) to preclude the State from reaching into the allocation for future medical expenses would conflict with the broad grant of authority in Section 1396k(a)(1)(A).

And a better interpretation is available, one that will not put these two provisions into conflict. Section 1396a(a)(25)(H) should be read as providing a distinct, though overlapping, authority for the State to subrogate certain payments from a third party. Assignment is one tool for a State to recover its costs, and subrogation is another. In other words, under Section 1396k, the State can be assigned the rights to "payment[s] for medical care." At the same time, under Section 1396a(a)(25)(H), the State can subrogate a subset of those "payment[s] for medical care" which represents the "payment [that] has been made" by the State. This interpretation leaves the provisions in harmony, comports with the language of the provisions, and is consistent with Congress's intent.

Because Section 1396k preceded Section 1396a(a)(25)(H), the latter provision could only limit the former if it met the stringent test for implied repeal—something it cannot come even close to doing. "[R]epeals by implication are not favored and will not be presumed unless the intention of the legislature to repeal is clear and manifest." *Nat'l Ass'n of Home Builders* v. *Defs. of Wildlife*, 551 U.S. 644, 662 (2007) (internal citations and alterations omitted). The Court "will not infer a statutory repeal unless the later statute expressly contradicts the original act or unless such a construction is absolutely necessary in order that the words of the later statute shall have any meaning at all." *Id.* at 662–63 (internal citations and alterations omitted).

Here, there is no indication that the legislature intended to repeal Section 1396k by enacting Section 1396a(a)(25)(H). And as explained, adopting the interpretation that Section 1396a(a)(25)(H) provides a separate and distinct tool for States to recover its Medicaid expenditures, rather than limiting the operation of Section 1396k, would give meaning to both provisions without conflicting with each other. Thus, the Court should reject petitioner's strained interpretation of Section 1396a(a)(25)(H).

CONCLUSION

The decision of the court of appeals should be affirmed.

Respectfully submitted,

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