No. 20-1263

IN THE

Supreme Court of the United States

GIANINNA 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

REPLY BRIEF FOR PETITIONER

SCOTT L. NELSON
PUBLIC CITIZEN LITIGATION GROUP
1600 20th Street NW
Washington, DC 20009
(202) 588-1000

FLOYD FAGLIE
STAUNTON & FAGLIE, PL
189 E. Walnut Street
Monticello, FL 32344
(850) 997-6300

BRYAN S. GOWDY
Counsel of Record
MEREDITH A. ROSS
CREED & GOWDY, P.A.
865 May Street
Jacksonville, FL 32204
(904) 350-0075
bgowdy@appellate-firm.com

Counsel for Petitioner

December 2021

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page

Cases

United States Code

Regulations

State Laws

Other Authorities

ARGUMENT

Florida's textual arguments rest almost entirely on its assertion that Medicaid's assignment provision, 42 U.S.C. § 1396k(a)(1)(A), should be read in isolation from the remainder of the Medicaid Act. Only by sequestrating § 1396k(a)(1)(A) can Florida even attempt to justify a recovery that is expressly prohibited by § 1396p's anti-lien and anti-recovery provisions and that exceeds what is authorized by the plain text of §§ 1396a(a)(25)(A), (B), and (H). Florida makes only a token attempt to integrate these provisions into a cohesive whole or to abide by the rationale of *Arkansas Dep't of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006). Under that rationale—embraced by Petitioner and the United States—§ 1396k and the other third-party provisions echo and reinforce one another in limiting any implied exception to the Act's protection of beneficiaries' property.

I. Petitioner's and the United States' arguments align.

Petitioner and the United States agree that the Act "entitles a State to the portions of a recipient's recovery that represent compensation for the medical expenses paid by Medicaid, but not to the portions that represent compensation for medical expenses (past or future) not paid by Medicaid." U.S. Br. 10. More specifically, a State is entitled to the portions of a recovery representing compensation for *medical care, services, or items* Medicaid has paid for, up to the amount Medicaid paid. § 1396a(a)(25)(A), (B), (H).

A slight variant of Florida's hypothetical (Resp. Br. 44) illustrates how this rule operates. Suppose a provider bills $100,000 for a surgery but accepts $50,000 from Medicaid *and a co-pay from the beneficiary* as full

payment; a tortfeasor then settles its liability for the surgery for $20,000. Because Medicaid made payments for that medical service, it is entitled to the entire $20,000 and need not remit any payment to the beneficiary—notwithstanding the co-payment. Only if the tortfeasor paid more than $50,000 for the surgery would Medicaid be required under § 1396k(b) to remit funds (the amount exceeding $50,000) to the beneficiary.

The United States is also correct that "distinguishing between funds for 'past' and those for 'future' medical expenses" may emphasize "the wrong thing" in some circumstances. U.S. Br. 10. The issue in every case is whether the amount for which Medicaid seeks reimbursement reflects compensation for medical services paid for by Medicaid. As applied to this case, however, that principle requires the Court to address the difference between Ms. Gallardo's tort recovery for past medical expenses (compensating almost exclusively for services that Medicaid had paid for) and for future medical expenses (compensating exclusively for services that Medicaid had *not* paid for). The Court must address that issue because this declaratory action challenges the validity of Florida's statute expressly authorizing Florida to take from the portion of Petitioner's recovery compensating for "future medical expenses." JA 17 ¶ 3.[1]

---

[1] The question whether Medicaid is entitled to the minuscule part of Ms. Gallardo's recovery reflecting expenses paid by a private insurer (JA 26 ¶ 31) is neither presented nor ripe and must be addressed first by a Florida administrative law judge. Under Petitioner's and the United States' interpretation of the Medicaid Act, resolution of that issue will turn on whether the insurer paid for the *same* care, service, or item paid for by Medicaid. Only if

(*Footnote continued*)

II. Florida rejects *Ahlborn's* whole-text method.

Petitioner and the United States read the third-party provisions as an integrated whole. Pet. Br. 30, 47; U.S. Br. 20-21. And for good reason—the unanimous *Ahlborn* Court followed this same method. It interpreted the anti-lien and third-party provisions (§§ 1396p(a)(1); 1396a(a)(25)(A), (B), (H); and 1396k) together—not separately—and concluded: "[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." 547 U.S. at 282.

Rejecting this whole-text method, Florida analyzes § 1396k's text in isolation and largely ignores the other third-party provisions and the anti-lien and anti-recovery provisions. *E.g.*, Resp. Br. 12-15. The 14 amici States do the same, 14 States Br. 10-13, with a brief nod to a "harmonious" reading, *id.* 15-16. The other amici interpret § 1396k as "separate" from, and "broader" than, the other third-party provisions. Legislatures Br. 7 ("Nothing in [§ 1396a(a)(25)(H)] … constrains or impliedly repeals the broader, separate, and unambiguous grant of authority in [§ 1396k].").

Neither Florida nor its amici rebut the whole-text arguments of Petitioner and the United States. Instead, they focus on Petitioner's *secondary* argument—on which the United States takes no position—that the general-specific and more-recently-enacted canons resolve any potential conflict between § 1396k and § 1396a(a)(25)(H) in favor of the latter. Pet. Br.

---

the insurer and Medicaid paid for the same care, service, or item will Medicaid be entitled to the entire portion of Ms. Gallardo's recovery representing past medical expenses.

33-34. For example, Florida claims Petitioner and the United States read § 1396a(a)(25)(H) as "narrower" than § 1396k. Resp. Br. 30. However, as the United States explains, "context shows that [the] clause [in § 1396k(a)(1)(A)] … incorporates the *same limitation* as the other [third-party] provisions"—that is, it reaches only "the liability of third parties for medical expenses that *are paid by Medicaid*." U.S. Br. 20-21 (emphasis added). Similarly, Petitioner contends that Florida's isolated reading of § 1396k is "anomalous in the context" of the third-party liability and payment-recovery provisions (§ 1396a(a)(25)(A), (B), (H)). Pet. Br. 32.

III. The amici's "whole-text" arguments contravene principles of textualism.

Although Florida fails to offer a whole-text argument, its amici attempt one. The 14 States contend the assignment/cooperation and payment-recovery provisions "work together to achieve a core goal of Medicaid: ensuring that third parties pay before Medicaid does"—a goal they infer from a Senate committee report referring to Medicaid as a "payer of last resort." 14 States Br. 16, 18; *see also* Resp. Br. 1, 2, 3, 10, 12, 13, 19, 39, 40 (referring to Medicaid as "payer of last resort"). This argument is grounded in purposivism, not textualism.

This Court in *Ahlborn*—*rejecting* a state Medicaid agency's reliance on the legislative history the 14 States cite—said the agency had "properly observed that Congress, in crafting the Medicaid legislation, intended that Medicaid be a 'payer of last resort.' S. Rep. No. 99-146, p. 313 (1985)." 547 U.S. at 291 (quoted at 14 States Br. 18). But, *Ahlborn* stated, "[t]hat does not mean … Congress meant to authorize States to seek

reimbursement from Medicaid recipients themselves; in fact, with the possible exception of a lien on payments for medical care, the statute expressly prohibits liens against the property of Medicaid beneficiaries." *Id*. at 291-92. *Ahlborn* properly recognized that a statute's "purpose must be derived from the text, not from extrinsic sources such as legislative history." Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 56 (2012); *see also* Brett M. Kavanaugh, *Book Review*, 129 Harv. L. Rev. 2118, 2124 (2016) (disputing that unenacted committee reports are authoritative in construing a statute). Indeed, "no law pursues its purpose at all costs," and "textual limitations upon a law's scope are no less a part of its 'purpose' than its substantive authorizations." *Rapanos v. United States*, 547 U.S. 715, 752 (2006) (plurality op.) (Scalia, J.).

Rather than subordinating the Act's terms to a non-textual "purpose" derived from legislative history, the Court should respect the express textual limitations of the third-party, anti-lien, and anti-recovery provisions, which work together to achieve Congress's true ends. Congress expressed its purposes in multiple provisions prohibiting a State from taking a beneficiary's property and limiting Medicaid's reimbursement pool to third-party liabilities "for the medical expenses that are paid by Medicaid." U.S. Br. 20 (emphasis omitted).

Florida's other amici invoke the whole-text canon to argue that two of the third-party provisions (§ 1396a(a)(25)(H) and § 1396k) should be read to provide "distinct, though overlapping" functions. Legislatures Br. 11. This argument, however, does not fit "all parts" of the statute into a "harmonious whole," *id*. 12, because it fails to account for § 1396a(a)(25)(A)-(B).

IV. An isolated reading of § 1396k(a)(1)(A) fails to account for the "anchor" third-party liability provision.

Section 1396a(a)(25)(A)-(B) is the "main" or "anchor" third-party provision that marks the boundaries of: (i) the Medicaid "expenses that are eligible *for* reimbursement" and (ii) "the pool *from which* the State may obtain the reimbursement." U.S. Br. 13 (emphasis added). The provision's plain text establishes these bounds: a State may seek reimbursement "to the extent of" "the legal liability of third parties … to pay for care and services *available under the plan*." § 1396a(a)(25)(A) (emphasis added); *see* U.S. Br. 13-14.

The language Congress enacted in 1968 excludes from the reimbursement "pool" the "legal liability of third parties … to pay for care and services" that are not *available under the State plan*. In 2013, Congress added language to expand this pool by deleting "to the extent of such legal liability" from subparagraph (B). Pet. Br. 12. In 2018, however, Congress retroactively repealed the 2013 expansion and shrank the pool to its original boundaries. *Id*. 13 & n.2.

Florida and its amici do not account for the limited reimbursement pool established by the third-party liability provision. Although Florida refers to subparagraph (A) several times, it hardly ever mentions—and never squarely grapples with—subparagraph (B)'s limitation or Congress's deliberate choice to restore that limitation. Similarly, the amici collectively have a single scant reference to the provision. 14 States Br. 7-8.

Section 1396a(a)(25)(A)-(B)'s direction that States "ascertain" the available pool of third-party liabilities

and "seek" reimbursement was "modest" and failed to provide clear authority to Medicaid agencies and courts until it was supplemented by the assignment/cooperation and payment-recovery provisions. Pet. Br. 47-48. These two provisions—rather than identifying different *pools* of third-party liabilities from which reimbursement may be sought—granted States two complementary *tools* for obtaining reimbursement from the *same pool* of third-party liabilities. U.S. Br. 12 ("Subparagraphs (A)-(B) set forth the State's general duty to seek reimbursement from third parties, while subparagraph (H) and Section 1396k specify the legal tools the State must have for carrying out that duty."). Petitioner's and the United States' reading gives each provision its own function and integrates them into a workable whole. Florida's and its amici's readings do not.

V. A State may not seek reimbursement from a bigger pool under § 1396k than under § 1396a(a)(25)(H).

The State's reimbursement tools—§ 1396k and § 1396a(a)(25)(H)—"serve overlapping functions," like a belt and suspenders. U.S. Br. 29. Assignment and subrogation—the common-law rights analogous to the rights granted by § 1396k and § 1396a(a)(25)(H)—also overlap in many respects despite differing in their procedures and source. Pet. Br. 41-46, 48-49. *Ahlborn* instructs that these complementary mechanisms "echo," "reiterate," and "reinforce" one another. *Id.* 8, 21, 31, 32, 47.

Florida agrees that § 1396k and § 1396a(a)(25)(H) provide "overlapping tools." Resp. Br. 11, 36. But under Florida's reading, the provisions do not actually "overlap." Florida instead asserts that § 1396k allows

"broader" reimbursement than § 1396a(a)(25)(H), Resp. Br. 37, so that § 1396k's reimbursement pool *completely* covers § 1396a(a)(25)(H)'s, and then some. *Accord* Legislatures Br. 12. Under Florida's theory, the recoveries authorized by the former subsume—rather than overlap with—those available under the latter.

As the United States explains, Florida's reading of the provisions rests on a slender textual reed: "One clause" in § 1396k(a)(1)(A) is "worded differently" from the other third-party provisions because it "lacks an express reference to whether Medicaid has paid the relevant medical expenses." U.S. Br. 21. But "[r]efusing to recognize that limitation would create a severe mismatch" among the third-party provisions. *Id.* This mismatch "makes little sense"—it is "in tension with *Ahlborn*," and "[n]o sound reason exists to suppose Congress meant the State's share to vary depending on the tool that the State used." *Id.* 27-28; *see* Scalia & Garner, *supra* 252 (courts generally presume Congress enacts related statutes that make sense when read *in pari materia*).

Florida tries to rationalize this "mismatch" by citing *other* statutory schemes—Medicare, ERISA, and federal employee insurance—that authorize a bigger reimbursement pool of third-party liabilities. Resp. Br. 37, 40-42. Yet Florida does not—and cannot—argue that the text of these statutes is similar to Medicaid's. These non-Medicaid texts—which lack anti-lien and anti-recovery provisions—are significantly different.

Take the Medicare statute. Its language is far broader than Medicaid's third-party provisions. *Compare* 42 U.S.C. § 2651(a) *with* §§ 1396a(a)(25)(A)-(B),

(H), 1396k. The Medicare statute subrogates the United States to "any right or claim," and provides that it may take an assignment to the injured person's "claim or cause of action … to the extent of that right or claim." § 2651(a). This language lacks the Medicaid statutes' limitations, as it fails to distinguish between medical and non-medical damages or between damages for care paid or unpaid by the government. Moreover, other Medicare language—"to be furnished" and "to be paid"—expressly indicates that Congress intended Medicare to be compensated for future medical expenses. *See* § 2651(a).

In contrast, Medicaid's anti-lien provision expressly prohibits any lien based on "medical assistance *to be paid*" in the future. § 1396p(a)(1) (emphasis added). The Medicare statute shows Congress knows how to write a statute permitting a government payor to seek reimbursement from portions of a tort recovery compensating for future medical expenses. Congress has not enacted such a statute for Medicaid—except for the 2013 statute that Congress nullified in 2018. *See* Pet. Br. 12-13.

VI. Florida's § 1396a(a)(25)(H) arguments lack merit.

A. Florida's attempt to match its broad reading of § 1396k to § 1396a(a)(25)(H) makes no sense.

With one exception, Florida and its amici exclusively argue that there is a mismatch between the State's reimbursement pools under § 1396k and § 1396a(a)(25)(H). The exception is a single paragraph where Florida attempts to conform § 1396a(a)(25)(H) to its broad reading of § 1396k. Resp. Br. 30-31. Florida postulates that subparagraph (H)'s reference to a

third-party liability to pay "for" health care items or services *paid for* by the State plan could also refer to a third-party liability to pay "for" future health care items or services *not paid for* by the State plan. *Id.* 30-31 & n.12. The argument advances the untenable supposition that the statute's language could be read to mean the opposite of what it says. In short, it makes no sense.

B. Florida's argument that § 1396a(a)(25)(H) "most naturally applies" to insurers contravenes the provision's text and rests on mistaken premises.

Florida argues § 1396a(a)(25)(H) "most naturally applies to insurers, not tortfeasors." Resp. Br. 34-35. Florida is wrong. According to *Black's Law Dictionary*, Medicaid regulations, and *Ahlborn,* subparagraph (H)'s reference to a "third party" with a "legal liability" clearly includes a tortfeasor. Pet. Br. 39.

Florida posits that only insurance—and not tort recoveries—"covers specific 'items or services furnished to an individual.'" Resp. Br. 35 (quoting § 1396a(a)(25)(H)). Florida misapprehends tort law. Like an insurer, a tortfeasor is liable only for specific medical expenses: those necessarily incurred to treat the specific injuries caused by its tort. *See* Dan B. Dobbs, *et al.*, *The Law of Torts* § 479 (2d ed. updated 2021); *see, e.g., Albertson's, Inc. v. Brady*, 475 So. 2d 986, 988 (Fla. Dist. Ct. App. 1985) (requiring a tort plaintiff to present evidence "associat[ing] each medical bill with injuries resulting from the accident").

Florida also argues that Congress's motive for enacting § 1396a(a)(25)(H) was to allow recoveries against insurers not available under § 1396k. Resp. Br. 33-34. Petitioner and the United States

acknowledge that the 1993 enactment of § 1396a(a)(25)(H) was intended to enhance the States' recovery toolkit. U.S. Br. 28-29; s*ee, e.g.,* Pet. Br. 50 (§ 1396a(a)(25)(H) "clarified" that state Medicaid subrogation statutes were authorized). But this congressional motive does not explain Florida's position that § 1396a(a)(25)(H) provides a different and smaller pool of reimbursement than § 1396k. Nor does this motive justify limiting subparagraph (H)—contrary to its text—to recoveries against insurers.

Furthermore, that settlements and judgments embody a "one time allocation of liability," Resp. Br. 35, does not mean they cannot be further allocated into different heads of damages. In *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627, 640 (2013), this Court rejected the unfounded assumption that such allocations were arbitrary or impractical. Pet. Br. 11-12. Before *Wos*, the States had procedures to allocate settlements. AAJ Br. 9. Since *Wos*, judges and lawyers have—just as *Wos* predicted[2]—continued to develop rational methods for allocating settlements. *See, e.g., id.* 8-14 (discussing Florida administrative procedure).

The concern of Florida's amici—that "zealous advocates" could structure settlements "to be heavily weighted to future care," 14 States Br. 12-13—ignores that, here, an administrative law judge (not Petitioner's counsel) allocates the settlement. *See* Fla. Stat. § 409.910(17)(b); Pet. Br. 19. Florida's amici also belittle determinations of "future care," labeling them "inherently speculative." 14 States Br. 13. But regardless of how this Court rules, factfinders will have to

---

[2] "Trial judges and trial lawyers … can find objective benchmarks to make projections of the damages the plaintiff likely could have proved had the case gone to trial." 568 U.S. at 640.

determine the amount of a recovery attributable to future medical expenses, Pet. Br. 37-38 n.6, and with the aid of life care planners, they can do so based on reliable, scientific methods and objective benchmarks, AAPLCP Br. 2-11.

VII. Even if Florida's isolated reading of § 1396k were permissible, it is flawed.

Florida and its amici read § 1396k(a)(1)(A)'s assignment of "any rights … to payment for medical care from any third party" out of context. They miss not only clear contextual signs in the Medicaid statutes as a whole, but also overlook the phrases "under the State plan" and "available under the plan" in the assignment/cooperation provision itself. These phrases signify that the assigned rights to "payments for medical care" refer to liabilities for medical care "under the plan"—that is, liabilities for *medical care paid by Medicaid*. *See* U.S. Br. 19-20.

A. Section 1396k(a)'s introductory clause limits third-party payments to those for "medical care … owed under the State plan."

In criticizing Petitioner's focus on "owed" in § 1396k(a)'s introductory clause, Resp. Br. 17-18; 14 States Br. 14, Florida and its amici overlook other words—"medical care" and "under the State plan"—that are equally critical to understanding the text.

Section 1396k(a) undoubtedly signifies the State may collect "payments for medical care." But what medical care? "[M]edical care owed to the recipient of medical assistance *under the State plan*." § 1396k(a) (emphasis added). In this context, "under the State plan" is best understood as modifying both "medical

assistance" and "medical care." Clearly, the medical care is owed "*to* the recipient," but who or what owes the medical care? The Medicaid plan does. And thus the State may collect payments from any third party who also is obligated to pay for this same medical care paid by Medicaid.

Medicaid does not pay for all medical care, items, or services; to the contrary, Medicaid "has the most restrictive guidelines of any third-party payor." AAJ Br. 7-8. Tortfeasors commonly must pay for medical care *not* "owed … under the State plan." *See id.* 2 ("Medicaid does not cover many of the medical care expenses that are recovered in litigation."). The assignment/cooperation provision's purpose—as stated in the statute, not a committee report—is to enable the State to collect "payments for medical care owed … under the State plan," § 1396k(a), rather than those for care not owed under the State plan.

The 14 States twist Petitioner's argument to make it purportedly "incoherent," and then literally re-write the introductory clause to fit their desired meaning. 14 States Br. 14. Of course, the "payments for medical care" being collected are not a State's payments for medical care; they are third-party payments for medical care. But the question to be answered—which Florida and its amici ignore—is *what* medical care? Payments for *any* medical care owed under *any* insurance plan or by *any* tortfeasor or other third party in the past, present, or future for the recipient's lifetime? No. The introductory clause limits the third-party payments to those for "medical care owed … under the State plan"; this limitation applies to the phrase "medical care" as used throughout § 1396k. Even if there were ambiguity on this point, the Secretary's construction limiting the assignment to third-party

liabilities for expenses paid under Medicaid would resolve it. U.S. Br. 23-25.

B. Section 1396k(a)'s cooperation clause addresses care available under the plan.

Florida argues the cooperation clause "draws no … *temporal* distinction" between past and future medical expenses. Resp. Br. 18 (emphasis added). True, but irrelevant.

The clause's text requires the recipient to cooperate in the State's pursuit of third parties "who may be liable to pay *for care and services available under the plan*." § 1396k(a)(1)(C) (emphasis added). Thus, the non-temporal—but controlling—distinction drawn by the cooperation clause is between care and services that were available under the plan and those that were not.

Payment for future medical care and services—which have not been provided—is not "available under the plan," and thus the State may not pursue third-party liability for future medical expenses. In contrast, payment for past medical care may or may not be "available under the plan." If payment for such care was available under the plan, the State may pursue third parties who are also liable for such care. But if payment was not available under the plan, then the State may not pursue third parties to the extent they are liable for care not covered by Medicaid.

C. Section 1396k(a)'s paternity clause does not undermine Petitioner's and the United States' reading.

Florida's emphasis on the paternity clause is misplaced. Resp. Br. 14-15, 39. This clause provides no contextual clues because of critical distinctions

between tortfeasors' and parents' obligations to pay for medical care.

A parent is obligated to pay for *all* categories of medical care a child needs—past, present, and future, as well as both preventive and curative care. *Cf.* 59 Am. Jur. 2d Parent and Child § 65 ("Parents are responsible for the necessary medical expenses of the minor child."). In contrast, a tortfeasor is obligated to pay for "reasonable medical and other expenses proximately resulting from tortious injury and expenses that will probably result in the future." Dobbs, *supra* § 479. A tortfeasor is not similarly situated to a parent, but is more like a health insurer that is obligated to pay for only the medical care covered by its policy. *See Couch on Insurance* § 1:46 ("[I]t was common for policies to narrowly provide coverage of only one type of health care expense.").

A parent providing child support is also generally required to make periodic payments until the child reaches the age of majority or some other milestone. *Cf.* American Law Institute, *Principles of the Law of Family Dissolution* §§ 3:12, 3:24 (updated 2021). In contrast, the "normal remedy" in the tort system "is compensatory damages, awarded in a lump sum, for all losses that have proximately resulted from the tort and all losses that will so result in the future." Dobbs, *supra* § 479. Thus, although a State may be able to require a parent—via court order—to transmit future medical support payments directly to the agency once it has made payments on behalf of the beneficiary, it cannot do the same where a tortfeasor has satisfied its liability to a beneficiary by paying a judgment or settlement. Once a tortfeasor's payment for future medical expenses is made to the beneficiary, the payment becomes the beneficiary's property and subject to the

protection of the anti-lien and anti-recovery provisions.

D. Section 1396k(b)'s remainder clause is not superfluous.

Florida asserts that, if the State may seek reimbursement only for care it has paid for, then § 1396k(b)'s "remainder" clause will do no work. Resp. Br. 22-24. Not so. The remainder clause will do work in at least two sets of circumstances: (i) non-tort settings involving potential third-party liabilities of health insurers and (ii) tort settings where the collateral source rule applies.

1. The remainder clause does work in non-tort settings involving health insurers.

Medicaid agencies may require beneficiaries to make co-payments for many medical services. *See, e.g.,* 42 C.F.R. §§ 447.50-447.54. Florida, for instance, requires co-payments on a variety of services, ranging normally from $1 to $3 and up to 5% (capped at $15) for non-emergency care provided in a hospital's emergency room. *See* Fla. Stat. § 409.9081.

Suppose, for example, that a beneficiary's ER visit costs $100, with the beneficiary making a $5 co-payment and the State paying the remainder ($95). Further suppose that it is later discovered that a private insurer was obligated to pay for 80% of the costs of the ER visit. Under the plain text of § 1396k(b), the State would retain the entire $80 collected from the insurer, and the beneficiary would not receive any reimbursement for her co-payment. If, however, the insurer instead covered 100% of the ER visit, the remainder clause would do its work: The State would retain $95

of the $100 collected from the insurer, and then pay the remaining $5 to the beneficiary. But the assignment and other third-party provisions would allow Medicaid to collect the full amount in the first instance, because the claim was for specific services for which Medicaid had made payment (even though the beneficiary also had made a payment).

2. The remainder clause does work in tort settings where the collateral source rule applies.

About half the States—including Florida[3]—have abolished or limited the collateral source rule. Dobbs, *supra* § 482. But many States still apply it. Resp. Br. 43-44 & n.19.

Under this rule, "a plaintiff's recovery may not be reduced because a source collateral to the defendant … paid the plaintiff's expenses. Rather, an injured plaintiff is entitled to recovery for reasonable medical, hospital, or nursing services rendered to the plaintiff." *Couch on Insurance* § 223:111. For example, "if the plaintiff has an injury causing loss of $100,000 and $50,000 of that injury is covered by the plaintiff's own insurance, the defendant must still pay the full $100,000." Dobbs, *supra* § 482.

Third-party payors—private insurers, Medicaid, and Medicare—"frequently pay less than the total medical bills incurred by a tort victim." *Id.* For example, a provider may bill the plaintiff $150,000 in reasonable charges but accept $50,000 as full payment. *Id.* In such circumstances, most courts that apply the

---

[3] *Joerg v. State Farm Mut. Auto. Ins. Co.*, 176 So. 3d 1247, 1249 (Fla. 2015) (citing Fla. Stat. § 768.76(1)).

collateral source rule would allow the plaintiff to recover the full amount billed ($150,000). *Id.* n.29.

In this regard, the "curious result" of which Florida complains in its own hypothetical is, in fact, *not* the consequence of Petitioner's and the United States' position. Resp. Br. 44. Florida's hypothetical suggests the State's recovery would be subject to a pro-rata reduction tied to the beneficiary's settlement. *Id.* In fact, the State would receive the full $20,000—not merely $10,000. Why? The State's assignment under § 1396k(a)(1)(A) would reach any "payment for medical care" covered by Medicaid, and because the $20,000 compensated for the medical care for which Medicaid *paid* $50,000, the State could retain the full $20,000 per § 1396k(b).

Modifying Florida's hypothetical, suppose the tortfeasor instead paid $75,000 to settle the $150,000 claim for medical care in a State with the collateral source rule. Properly applied, § 1396k(b)'s remainder clause would allow the State to receive full reimbursement ($50,000), while the remainder of the settlement ($25,000) would be paid to the beneficiary. As this example illustrates, Medicaid will be paid *first* and *in full* under §1396k(b) when a beneficiary recovers reasonable medical expenses from a tortfeasor that are *for medical care paid for by Medicaid* and exceed the *amount* paid by Medicaid.

E. Section 1396a(a)(45) is inconsequential.

Although Florida and its amici now place great weight on § 1396a(a)(45), the provision was cited only *once* before in the lower courts. Fla. 11th Cir. Br. 13 (filed Nov. 29, 2017). For good reason: it has no impact on the analysis.

Section 1396a(a)(45) is commensurate with § 1396k and incorporates it by reference. It was enacted alongside the same amendment that made the assignment/cooperation provision mandatory. Resp. Br. 27. The provision says nothing about § 1396k's scope; it establishes only that compliance with § 1396k is a condition of a State's Medicaid eligibility. Thus, Petitioner's and the United States' § 1396k arguments apply equally to § 1396a(a)(45)—to the extent the latter provision has any relevance.

The 14 States seize on the third-party provisions' status as funding conditions to suggest that they should not be judicially enforceable by Medicaid recipients. *See* 14 States Br. 22-30. As the 14 States admit, Florida has forfeited this argument.[4] *Id*. 1, 6, 22. Even if it had not, the argument that recipients cannot enforce the anti-lien provision—to which the third-party provisions provide an implicit exception—is meritless. *See* Dylan Scot Young, *A Judicial Solution to the Medicaid Gap: Using Section 1983 to Do What the Federal Government Cannot*, 84 Geo. Wash. L. Rev. 511, 530 & nn.154-55 (2016) ("A clear consensus has developed that § 1983 actions are available" for Medicaid beneficiaries.); *see also Wos*, 568 U.S. at 632.

VIII. Florida misstates insurance law.

"It is natural for Congress to have followed [an insurance] model in designing Medicaid, which is a form of state-operated insurance." U.S. Br. 22 (internal quotations omitted). Florida implies the United States has misstated insurance law. Resp. Br. 42-43. In fact, Florida has.

---

[4] Florida also has forfeited the 14 States' constitutional avoidance argument. *See* 14 States Br. 17.

Florida claims "[t]he general rule … is that the insurer is entitled to full recovery of its costs—not recovery of only certain portions of damages." *Id.* 43. But the treatise Florida cites tells a different story:

> In many instances, the payment made to an insured by the insurer compensates only some of the loss or damage the insured sustained, such as when some elements of loss are not within the risks covered by the policy. Therefore, the mere fact that an insured receives a recovery from another source may not establish that the amounts recovered correspond to the same elements of loss for which the insured has already recovered from the insurer.

Couch on Insurance § 226:36.

The treatise discusses solutions for such a mismatch: (1) a jury may set a dollar amount for different heads of damages; (2) a reimbursement agreement or policy clause may explicitly require "an itemized settlement or judgment against a tortfeasor"; or (3) "[a] 'mini trial' or separate proceeding" may be required in "which the court could determine how much of a given recovery was attributable to the different elements of the insured's loss." *Id.* In any event, "where the insurer is bringing the action against the third party, or is participating in the insured's action against the third party, *recovery by the insurer is generally limited to the same elements as those for which it has made payment*." *Id.* (emphasis added).

The Medicaid statutes' plain text parallels this general rule of insurance law. Medicaid's recovery is limited to the same elements of loss as those for which it has made payment.

IX. The presumption against preemption is inapplicable.

Florida concedes the third-party provisions impose both a ceiling and a floor on Medicaid lien recoveries, so that if the Court were to rule it is *permitted* to take Petitioner's recovery for future medical expenses, other States would be *required* to do so to maintain Medicaid eligibility. Resp. Br. 5. Indeed, Florida asserts that California's and West Virginia's Medicaid eligibility should be terminated because their laws do not provide for such liens. *Id.* 47. Nonetheless, Florida asserts that the presumption against preemption favors its position because the anti-lien provision affirmatively preempts state laws that take too much of a beneficiary's recovery, while the only consequence for States whose laws take too little is loss of Medicaid eligibility. *Id.* 47-48.

This Court has rejected Florida's premise that a threat to terminate a State's Medicaid eligibility is meaningfully distinguishable from a federal mandate. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 581-82 (2012) (plurality). Whichever way the Court resolves this case, all States must conform their laws and comply. Florida's argument only underscores that the state law at issue does not involve a traditional area of state regulation: It concerns *only* management of a federally funded program and was enacted to comply with that program's requirements. *See Wos*, 568 U.S. at 640. The subject of such a law "is inherently federal in character because the relationship [it concerns] originates from, is governed by, and terminates according to federal law." *Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341, 347 (2001). The

presumption against preemption places no thumb on the scales on either side of the issue.[5]

X. Petitioner's whole-text interpretation of the Medicaid statutes has no dire financial consequences.

Allowing beneficiaries to retain their future-medical-expense awards enables most of them to exit the Medicaid program,[6] saving costs for Medicaid. Pet. Br. 31; AAJ Br. 3-4, 14-16.[7] Neither Florida nor its amici contest this proposition.

The 14 States instead question whether settlements obtained by beneficiaries maximize the States' recovery of past medical expenses. 14 States Br. 21. But the only practical way for States to maximize recoveries is to incentivize beneficiaries to sue tortfeasors, bear (and risk the loss of) the attendant costs and fees, and obtain a settlement or judgment. As the share of damages taken by the State gets larger and larger, the beneficiary's incentive to bring suit gets smaller and smaller. *See* AAJ Br. 18. Thus, shifting

---

[5] Florida's passing mention of the Spending Clause's clear-statement rule, Resp. Br. 46, is irrelevant for essentially the same reason the presumption against preemption is inapplicable: Both Florida's and Petitioner's interpretations impose a funding condition that some States' laws will not satisfy, regardless of which interpretation the Court adopts. The anti-lien, anti-recovery, and third-party provisions give more than adequate notice of the limits on States' recoveries from beneficiaries.

[6] Florida's "understanding" of Ms. Gallardo's continued eligibility for Medicaid is correct. Resp. Br. 21 n.6. Ms. Gallardo's situation falls under the "second," "uncommon" circumstance described in AAJ's amicus brief concerning congressionally authorized Special Needs Trusts. AAJ Br. 4-7.

[7] The regulation governing Medicaid eligibility is 20 C.F.R. § 416.1205, which is miscited in the AAJ brief (at 4).

future medical expenses from the beneficiary's side of the ledger to the State's disincentivizes the beneficiary from bringing suit. And if no suit is brought, there is no recovery. States, of course, can sue tortfeasors directly. § 1396k(a)(1)(A), (C). But States have little appetite for such actions. AAJ Br. 17.

To maximize reimbursements from tort recoveries, States—rather than taking money from tort *victims*—could stop granting windfalls to third-party *tortfeasors*. States like Florida that have no collateral source rule effectively pass on to tortfeasors the lucrative discounts Medicaid leverages from medical providers. *Cf.* Dobbs, *supra* § 482 n.15.50 (citing sources explaining that the collateral source rule prevents a "windfall" by tortfeasors). Beneficiaries in such States—unlike those with a robust collateral source rule—never can obtain a tort recovery for past medical care exceeding the amount paid. Under the collateral source rule, by contrast, beneficiaries and Medicaid agencies possess the bargaining power to obtain more favorable settlements. *See supra* p. 17-18.

Finally, while governments undoubtedly "spend massive amounts … funding Medicaid services," 14 States Br. 18, any financial consequences of Petitioner's and the United States' reading of the Medicaid statutes already have occurred, as the vast majority of courts have agreed with that reading, Pet. App. 47-48. Florida and its amici provide no evidence of whether, or to what degree, the present majority rule has increased Medicaid spending.

CONCLUSION

The court of appeals' judgment should be reversed.

Respectfully submitted,

SCOTT L. NELSON
PUBLIC CITIZEN
LITIGATION GROUP
1600 20th Street NW
Washington, DC 20009
(202) 588-1000

FLOYD FAGLIE
STAUNTON & FAGLIE, PL
189 E. Walnut Street
Monticello, FL 32344
(850) 997-6300

BRYAN S. GOWDY
Counsel of Record
MEREDITH A. ROSS
CREED & GOWDY, P.A.
865 May Street
Jacksonville, FL 32204
(904) 350-0075
bgowdy@appellate-firm.com

Attorneys for Petitioner

December 2021