No. 97-2029

In the Supreme Court of the United States

OCTOBER TERM, 1997

PARAMOUNT HEALTH SYSTEMS, INC., ET AL.,
PETITIONERS

v.

ROBERT W. WRIGHT, DIRECTOR,
ILLINOIS DEPARTMENT OF PUBLIC AID, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether Section 4714 of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 509-511, clarifies the States' payment obligations to providers of medical services to qualified Medicare beneficiaries, set forth in the prior version of the Medicaid Act, 42 U.S.C. 1396a(n) (1994 & Supp. II 1996).

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases:

Statutes:

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-11) is reported at 138 F.3d 706. The opinion of the district court (Pet. App. 13-21) is unreported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 12) was entered on March 19, 1998. The petition for writ of certiorari was filed on June 17, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. Medicare is a federal program that provides for medical coverage for individuals who are disabled or at least 65 years of age, and who meet certain other eligibility requirements. Those persons are automatically enrolled in Part A of the Medicare program, a federally funded hospital insurance program. See 42 U.S.C. 1395 *et seq.* (1994 & Supp. II 1996). A provider of medical services to beneficiaries under Medicare Part A receives a significant portion of its fee from the federal government, which pays the provider from the Federal Hospital Insurance Trust Fund established by 42 U.S.C. 1395i.[1] The beneficiary is responsible for coinsurance payments and deductible amounts. See 42 U.S.C. 1395e.

Persons who are covered by Medicare Part A (and certain other persons) may also purchase supplementary insurance for additional medical services under Part B of the Medicare program by paying a monthly premium to the Federal Supplementary Medical Insurance Trust Fund, which is established by 42 U.S.C. 1395t. A provider of medical services to beneficiaries under Medicare Part B receives a portion of its fee, typically 80% of the applicable fee schedule amount, from the Supplementary Medical Insurance Trust Fund. The beneficiaries of Part B services pay (in addition to premiums) coinsurance, copayments and deductible amounts. 42 U.S.C. 1395*l*(a)(1) and (b), 1395r.

b. The Medicaid program is a cooperative federal-state public assistance program that provides federal financial assistance (*i.e.*, federal matching funds) to

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[1] We use the term "provider" in this brief "in its colloquial sense rather than in its technical Medicare senses," as did the court of appeals, see Pet. App. 2.

States that elect to pay for medical services on behalf of certain needy individuals. See 42 U.S.C. 1396 *et seq.* (1994 & Supp. II 1996); *Harris* v. *McRae*, 448 U.S. 297, 301 (1980).[2] The Medicaid Act gives participating States discretion in setting the rates they will pay providers, within boundaries set by federal law. See 42 U.S.C. 1396a(a)(30). A participating State must submit a state plan, setting forth the fee schedule or methodology that the State will use in reimbursing providers, to the Secretary of Health and Human Services for approval. See 42 U.S.C. 1396a(b). Providers generally must accept a State's payment for services covered under the Medicaid plan as payment in full, and may not seek to collect other than nominal payments for such services from the beneficiary or elsewhere. See 42 U.S.C. 1396*o*.

c. The Medicare and Medicaid Acts overlap in coverage for needy persons who are also elderly or disabled. Such individuals are often entitled to participate in Medicare Part A, but they may not be able to pay either the premiums needed to enroll in Medicare Part B or the coinsurance, copayments and deductibles for which they would be responsible under Parts A and B. To address that problem, Congress has required States participating in the Medicaid program to enter "buy-in" agreements with the Secretary of Health and Human Services. Under a buy-in agreement, the States use Medicaid funds to pay the Medicare Part B premiums on behalf of individuals who are eligible for both Medicare and Medicaid, and certain other persons who are eligible for Medicare but do not meet the

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[2] Federal financial participation is calculated according to a statutory formula that pays, at a minimum, 50% of the State's costs. 42 U.S.C. 1396b(a)(1), 1396d(b).

general eligibility criteria for Medicaid coverage. See 42 U.S.C. 1395v, 1396d(a). As a result, the State's Medicaid program pays the Medicare premium, rather than the full medical expenses, of the elderly or disabled Medicaid-eligible persons, and those persons are then enrolled in the Medicare B program; the cost of their medical care thus is shifted in large part from the States' Medicaid programs to the federal government under Medicare.

Initially, the only persons eligible for this Medicare "cost-sharing" were those who met the qualifications for both Medicare and Medicaid services ("dual eligibles"). In 1986, Congress extended the class of persons eligible for the buy-in program to include individuals who have incomes below the federal poverty line but who do not meet the income and assets qualifications for Medicaid eligibility. See Omnibus Budget Reconciliation Act of 1986 (OBRA), Pub. L. No. 99-509, § 9403, 100 Stat. 2053-2054. Members of this new class of individuals eligible for the buy-in program were called Qualified Medicare Beneficiaries, or "QMBs." See OBRA § 9403(b), 100 Stat. 2053. In 1988, Congress required States' Medicaid plans to buy-in to Medicare Part B for these individuals (as well as the "dual eligibles" who had been covered by buy-in agreements before 1986). Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 748. Congress also redefined the statutory term "qualified medicare beneficiary" to include both the former group of QMBs (a group often called "pure" QMBs) and dual eligibles. Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8434, 102 Stat. 3805; see 42 U.S.C. 1396d(p)(1).

d. As noted above, Medicare Part B typically leaves individuals responsible for copayments, coinsurance,

and deductible amounts. The elderly poor and disabled poor who are enrolled in Part B under the buy-in process (the QMBs) are often unable to meet such expenses. Congress has therefore required participating States' Medicaid plans to contribute towards those expenses on behalf of QMBs. See 42 U.S.C. 1396a(a)(10)(E)(i), 1396d(p)(3). The *amount* owed by the States to providers of medical services for those expenses is the subject of this dispute.

The Section of the Medicaid Act that governs the "contents" of state plans requires that a state plan for medical assistance "provide * * * for making medical assistance [*i.e.*, Medicaid funds] available for medicare cost-sharing" for QMBs. 42 U.S.C. 1396a(a)(10)(E)(i). The Medicaid Act defines "medicare cost-sharing" to include the specified premiums, coinsurance, copayments and deductibles owed under Medicare. 42 U.S.C. 1396d(p)(3).

Although Section 1396a(a)(10)(E)(i) thus requires States to make medical assistance available for Medicare cost-sharing for QMBs, that Section does not address the *amount* of cost-sharing to be paid by the States. A different section, titled "Payment Amounts," addresses that issue. Before 1997, that Section provided:

> In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan *may provide payment* in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter [*i.e.*, Medicare] with respect to the service or item *exceeding the*

> *amount that is otherwise payable under the State plan* for the item or service for eligible individuals who are not qualified medicare beneficiaries.

42 U.S.C. 1396a(n) (emphasis added).

The Secretary of Health and Human Services read Section 1396a(n) to permit States to limit their cost-sharing payments to the amount (if any) by which the State's Medicaid rate for the service provided exceeded the amount that Medicare has paid, and has approved state plans that impose such a cap.[3] In essence, the Secretary permitted the States to limit their payments to the amount that they would have paid for QMBs' medical services under the Medicaid program, had they not been enrolled in Medicare, less the federal contribution made under Medicare. Providers of medical services argued, however, that the Medicaid and Medicare statutes required the States to pay those expenses in full. Four courts of appeals rejected the Secretary's construction of the Medicaid Act and ruled that the Act required States to pay the cost sharing in full. See *Rehabilitation Ass'n of Virginia, Inc.* v. *Kozlowski*, 42 F.3d 1444 (4th Cir. 1994), cert. denied, 516 U.S. 811 (1995) (*Kozlowski*); *Haynes Ambulance Serv., Inc.* v. *Alabama*, 36 F.3d 1074 (11th Cir. 1994) (per curiam) (*Haynes*); *Pennsylvania Medical Soc'y* v. *Snider*, 29 F.3d 886 (3d Cir. 1994) (*Snider*); *New York City Health & Hosps. Corp.* v. *Perales*, 954 F.2d 854 (2d Cir.), cert. denied, 506 U.S. 972 (1992) (*Perales*).[4]

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[3] It is undisputed that States must pay Part B premiums in full.

[4] The relevant state authorities filed petitions for a writ of certiorari in *Kozlowski* and *Perales*. In the government's responses to the certiorari petitions in those cases, we argued that, although we believed that the courts of appeals' decisions were wrong, the absence of a conflict among the circuits counseled

Although those appellate courts each rejected the Secretary's construction of Section 1396a(n), they disagreed among themselves as to the precise rationale for the result that they had reached, see *Beverly Community Hosp. Ass'n* v. *Belshé*, 132 F.3d 1259, 1263 n.4 (9th Cir. 1997), petitions for cert. pending, Nos. 97-1947, 97-1949, 97-2029; there were dissents from two of the appellate decisions, see *Kozlowski*, 42 F.3d at 1462-1472 (Niemeyer, J., dissenting); *Perales*, 954 F.2d at 863-869 (Cardamone, J., dissenting); and two district courts upheld the Secretary's construction even after *Kozlowski*, the last of the appellate decisions, was issued. See *Dameron Physicians Medical Group, Inc.* v. *Shalala*, 961 F. Supp. 1326 (N.D. Cal. 1997); *Kulkarni* v. *Leean*, No. 96 C 884-S, 1997 WL 527674 (W.D. Wis. June 23, 1997).

e. In 1997, Congress enacted Section 4714 of the Balanced Budget Act, which amended 42 U.S.C. 1396a(n). Section 4714(a) is titled "Clarification Regarding State Liability For Medicare Cost-Sharing." See Balanced Budget Act of 1997 (BBA or 1997 Act), § 4714(a), Pub. L. No. 105-33, 111 Stat. 509. It provides that, in carrying out its cost-sharing obligations under Section 1396a(n), "a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that" such payments would exceed "the payment amount that otherwise would be made under the State [Medicaid] plan." 42 U.S.C. 1396a(n)(1)(B). Section 4714(a) thus expressly continues in effect the Secretary's longstanding position under the applicable Medicaid provisions as they

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against further review. See 94-1912 Gov't Br. in Opp. at 7-12 (July 1995); 92-315 Gov't Br. in Opp. at 7-9 (Oct. 1992).

existed before the enactment of the 1997 Act. As its title states, Section 4714(a) was enacted to "[c]larif[y] that state Medicaid programs may limit Medicare cost-sharing to amounts that, with the Medicare payment, do not exceed what the state's Medicaid program would have paid for such service to a recipient who is not a QMB." H.R. Conf. Rep. No. 217, 105th Cong., 2d Sess. 870-871 (1997).

Congress also provided that the clarification in Section 4714(a) would apply, not only prospectively, but also to payments for items and services rendered before the effective date of the clarification, if such payments were the subject of any lawsuit pending as of, or initiated after, the date of enactment. See BBA § 4714(c), 111 Stat. 510; 97-1947 Pet. App. 38a. The amendment does not apply, however, to payments that were the subject of cases challenging the Secretary's interpretation of the Medicaid Act prior to passage of the 1997 Act that had been litigated to final judgment.

2. Before the 1997 amendments were passed, petitioners, who provide services to QMBs in Illinois, brought this action to compel the Illinois Medicaid program to pay cost-sharing for QMBs in full. Petitioners challenged Illinois' policy, reflected in state regulations and in a state plan approved by the Secretary, of limiting cost-sharing payments to the amount by which the Illinois Medicaid rate exceeds what Medicare pays. Petitioners argued, *inter alia*, that Sections 1396a(a)(10)(E)(i) and 1396d(p)(3) of the Medicaid Act required the State to pay cost-sharing in full.

The district court granted petitioners' motion for summary judgment, following the decisions of the four courts of appeals that had addressed the question, and in particular the Third Circuit's decision in *Snider*. Pet. App. 17. The court thus entered judgment requiring

Illinois to pay cost-sharing for QMBs in full, *id.* at 23-25, but stayed its judgment pending appeal, *id.* at 28.[5]

3. The Secretary appealed the district court's decision. After briefing on appeal was complete, Congress enacted Section 4714. In supplemental briefing, petitioners urged that Section 4714 changes rather than clarifies the prior payment rules, and that the retroactive application of the new payment rules is unconstitutional.[6]

The court of appeals reversed. The court held that Section 4714 clarifies, rather than changes, the law. It therefore did not reach petitioners' constitutional challenges to Section 4714. Pet. App. 1-11.

The court first analyzed the law as it stood before the 1997 amendments. The court explained that Section 1396a(a)(10)(E)(i) required the States to "make medical assistance [i.e., Medicaid funds] available for medicare cost-sharing," and that Section 1396d(p)(3) defines Medicare cost-sharing to include the Part B copayments and deductibles at issue in this case. The court suggested that "[t]he natural inference" of this provision, standing alone, was that the States were required to pay cost-sharing amounts in full. Pet. App. 5-6.

The court acknowledged that Section 1396a(n) provided that States "may" pay cost-sharing in an amount that, together with the Medicare payment, exceeds the amount that is payable under the state plan for Medicaid recipients who are not QMBs. It also noted that the Secretary interpreted this language as making the States' duty of reimbursement at Medicare rates

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[5] The court also certified this action as a class action. Pet. App. 25.

[6] Petitioners did not dispute that the new law could be applied prospectively.

optional. See Pet. App. 6. The court reasoned that, "[i]f this is right, then since section 1396a(a)(10)(E)(i) appears to make such reimbursement mandatory, the Act as a whole (so far as bears on the issue of cost-sharing for [QMBs]) is ambiguous, thus bringing into play the *Chevron*[*U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984)] doctrine of deference to agency interpretations of vague or incomplete statutes." *Ibid.*

The court suggested an "alternative possibility": namely, that "the permissive language [in Section 1396a(n)] is just intended to avoid an ambiguity that would be created by the Medicare cost-sharing language if the statute did not explicitly authorize the state to exceed the Medicaid cost level." Pet. App. 6. The court noted that the Medicaid Act elsewhere forbids the States from reimbursing providers in excess of prescribed levels. *Ibid.* The court suggested that Section 1396a(n) simply "makes clear that the ceiling can be pierced without penalty if necessary to enable the state to comply with the requirement that it reimburse the providers of services to [QMBs] at Medicare rates." *Id.* at 6-7.

The court recognized, however, that "this interpretation is undermined by the fact that if, as [petitioners] must and [do] argue, the statute *clearly* entitles [them] to reimbursement at Medicare rates (if it is not clear, *Chevron* is back in play), the state could hardly be penalized for such reimbursement." Pet. App. 7. As the court explained, "[t]hat would be penalizing it for complying with the statute." *Ibid.* After noting two additional flaws in its "alternative" con-

struction of Section 1396a(n)[7], the court asked: "Is all of this enough to render the statute ambiguous and thus bring the *Chevron* doctrine into play despite the contrary view of the four circuits to have addressed the issue?" *Ibid.*

Rather than answer that question directly, the court turned to the effect of the 1997 amendments. The court noted that the amendments are captioned "Clarification Regarding State Liability for Medicare Cost-Sharing," see Pet. App. 8, and that this Court has held that congressional legislation declaring the meaning of prior law is entitled to great weight. See *id.* at 9 (citing *Loving* v. *United States*, 517 U.S. 748, 769 (1996), and earlier cases). The court nonetheless expressed doubt about this principle, and suggested that it was difficult to reconcile with other decisions of this Court, such as *United States* v. *Philadelphia Nat'l Bank*, 374 U.S. 321 (1963). Pet. App. 8-9. The court felt "constrained by [the *Loving* line] to give *some* weight to Congress's declaration in the Balanced Budget Act that providers of services to [QMBs] are not entitled to reimbursement at full Medicare rates." *Id.* at 10-11. Although the court did not know "how much weight to give it—probably rather little in the circumstances—it [was]

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[7] The court first noted that, although Section 1396a(n) dates back only to 1986, "[p]roviders of services for dual eligibles had for more than twenty years—since the original enactment of the Medicaid and Medicare statutes—been receiving reimbursement at higher than Medicaid rates not only without penalty but also without anyone, so far as we are aware, raising the spectre of possible penalties." Pet. App. 7. The court then explained that the "alternative" construction also would have produced the anomalous historical result of requiring the States to pay more for the relatively affluent "pure" QMBs than for dual-eligibles. See *ibid.*

enough to tip the balance in favor of *Chevron* deference." *Id.* at 11. The court concluded that "[t]he Act is a hopeless muddle so far as [QMB] reimbursement is concerned, and while it seems to us that [petitioners have] the better interpretation, there is sufficient ambiguity to require us to defer to the government." *Ibid.* The court thus reversed the judgment of the district court.

ARGUMENT

As we have explained in our consolidated brief in opposition to the petitions for a writ of certiorari in Nos. 97-1947, 97-1949, and 97-2079, which also raise the issue that is presented in this case, the decision of the court of appeals is correct and does not conflict with any decision of this Court or any other courts of appeals.[8] The court of appeals correctly concluded that Section 4714(a) of the Balanced Budget Act of 1997 clarified rather than changed existing law governing States' obligations under their Medicaid plans to pay for Medicare cost-sharing, and therefore raises no potential constitutional questions of retroactivity. That decision also does not conflict with any decision of any other court of appeals. Furthermore, even if Section 4714(a) changed the law, petitioners' constitutional claims would lack merit. Further review is therefore not warranted.

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[8] We have provided petitioners with a copy of our brief in Nos. 97-1947, 97-1949, and 97-2079, which is being filed contemporaneously with this brief.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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