Nos. 97-1947, 97-1949 and 97-2079

# In the Supreme Court of the United States

OCTOBER TERM, 1997

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, DBA BEVERLY HOSPITAL, ET AL., PETITIONERS

*v.*

S. KIMBERLY BELSHÉ, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES

RICHARD GILMORE, M.D., ET AL., PETITIONERS

*v.*

DONNA E. SHALALA, ET AL.

CALIFORNIA AMBULANCE ASSOCIATION, ET AL., PETITIONERS

*v.*

DONNA E. SHALALA, ET AL.

*ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT*

**BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION IN NOS. 97-1949 AND 97-2079 AND BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENT IN NO. 97-1947**

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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:

Cases—Continued: Page

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## OPINIONS BELOW

This brief is submitted by the Secretary of Health and Human Services in opposition to three petitions for

a writ of certiorari that seek review of the same judgment of the United States Court of Appeals for Ninth Circuit. The Secretary was named as a defendant in No. 97-1949 and No. 97-2079, but participated only as *amicus curiae* in No. 97-1947. The opinion of the court of appeals (97-1947 Pet. App. 1a-23a) is reported at 132 F.3d 1259. The opinions of the district court (97-1947 Pet. App. 24a-29a; 97-1949 Pet. App. 23a-31a; 97-2079 Pet. App. 26-28) are unreported.

**JURISDICTION**

The judgment of the court of appeals was entered on December 2, 1997. 97-1947 Pet. App. 30a-32a. A petition for rehearing was denied on March 3, 1998. The petitions for a writ of certiorari were filed on June 1, 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 coin-

[1] We use the term "provider" in this brief "in its colloquial sense rather than in its technical Medicare senses," as did the Seventh Circuit in the related case of *Paramount Health Systems*,

surance 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 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 ap-

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*Inc.* v. *Wright*, 138 F.3d 706, 706 (1998), petition for cert. pending, No. 97-2029.

[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).

proval. 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 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 these 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 must "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'

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

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. *State of Alabama*, 36 F.3d 1074 (11th Cir. 1994) (per curiam) (*Haynes*); *Pennsylvania Med. 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]

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 97-1947 Pet. App. 20a, 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 Med. Group* v. *Shalala*, 961 F. Supp. 1326

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

(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 would otherwise 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 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. 511; 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. a. Before the 1997 amendments were passed, petitioners, who provide medical services to QMBs in California, brought these actions to compel the California Medicaid program to pay cost-sharing for QMBs in full. Petitioners challenged California's policy, reflected in state regulations and in a state plan approved by the Secretary, of limiting cost-sharing payments to the amount (if any) by which the California Medicaid rate exceeds what Medicare pays. Petitioners argued, *inter alia*, that the Medicaid Act required the State to pay cost-sharing in full.

The same district judge presided in each case. The district court granted petitioners' motions for summary judgment, following the Second, Third, and Eleventh Circuit decisions that had rejected the Secretary's construction of the Medicaid Act, and also adopting the "similar reasoning" of the Fourth Circuit, except in part. See 97-2079 Pet. App. 26-28; see also 97-1947 Pet. App. 27a-29a; 97-1949 Pet. App. 20a-23a.

b. The Secretary appealed the district court's decisions. After briefing on appeal was complete, Congress enacted Section 4714 of the Balanced Budget Act of 1997. In supplemental briefing, petitioners urged that Section 4714 changed rather than clarified the prior payment rules, and that the retroactive application of the new payment rules was unconstitutional.[5] The court of appeals reversed. It held that Section 4714 clarified the law, and that it therefore has no retro-

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[5] Petitioners did not dispute that the new law could be applied prospectively. See 97-1947 Pet. App. 18a.

active effect that might be called into constitutional question. 97-1947 Pet. App. 1a-23a.[6]

The court emphasized that "Congress expressly (and formally) stated as its intention that the new provision in [BBA] § 4714 was a 'clarification' of the payment rules contained in Section 1396a(n). It has been established law since nearly the beginning of the republic * * * that congressional legislation that thus expresses the intent of an earlier statute must be accorded great weight." 97-1947 Pet. App. 18a. The court remarked that some of this Court's decisions have "question[ed] the competence of a later Congress to opine on the intended meaning of an earlier statute," but it observed that those decisions "involved attempts to use less formal types of subsequent legislative history, particularly Senate and House Committee Reports, to infer the meaning of prior enactments." *Ibid.* "By contrast, here Congress has formally declared [BBA] § 4714 to be a clarification of Section 1396a(n) in the title of the Act as well as in the Committee Reports." *Id.* at 19a.

The court rejected petitioners' argument that Section 4714(a) could not be a clarification of the law because it effected a substantial change in the law. That argument, the court held, failed to take account of the differences in rationales among the decisions construing Section 1396a(n); it also ignored the fact that "any quality of crystal clarity is uniformly recognized as

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[6] The court of appeals rejected petitioners' argument that Section 4714 does not apply to these cases because they were already on appeal when the Balanced Budget Act of 1997 was enacted, and therefore the cases were not "pending" within the meaning of Section 4714(c). See 97-1947 Pet. App. 16a-17a. That argument has not been renewed in this Court.

totally absent from the Medicaid and Medicare statutes," which have been characterized as "among the most completely impenetrable texts within human experience." 97-1947 Pet. App. 19a-20a. The court found Section 1396a(n) itself to be "a superb example of the baffling nature of the statute." *Id.* at 20a. "Given the extraordinary difficulty that the courts have found in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of Section 1396a(n) is worthy of real deference," and petitioners' arguments that the law changed rather than clarified the law "incorrectly presume a clearly established meaning for Section 1396a(n)—something that simply did not exist before [BBA] § 4714 was adopted." *Id.* at 20a-21a.

The court therefore "honor[ed]" Congress's express description of Section 4714(a) as a clarification of the law. 97-1947 Pet. App. 21a. That decision, observed the court, "moots all of [petitioners'] constitutional objections to the new legislation, because those objections rest entirely on the assertedly retroactive, rather than declaratory, nature of [BBA] § 4714." *Ibid.*

**ARGUMENT**

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 does not conflict with any decision of any other court of appeals, and it presents no issue of continuing importance. Furthermore, even if Section 4714(a) changed the law, petitioners' constitutional claims

would lack merit. Further review is therefore not warranted.

1. In enacting Section 4714(a), Congress ratified the Secretary's longstanding position that a State may limit its cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare pays for a given service. Because the Secretary's construction of prior law was correct and reasonable, Section 4714 did not change the law and therefore raises no questions of retroactivity.

"The power of an administrative agency to administer a congressionally created * * * program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress." *Morton* v. *Ruiz*, 415 U.S. 199, 231 (1974). Accordingly, as this Court held in *Chevron U.S.A. Inc.* v. *National Resources Defense Council, Inc.*, 467 U.S. 837 (1984), where Congress has not expressed its intention on a precise question at issue, courts should defer to a reasonable interpretation of the statute in question by the agency charged with administering the program under that statute. *Id.* at 844.

The Secretary's position on the extent of the States' cost-sharing obligations was reasonable. Section 1396a(a)(10)(E)(i) imposed upon the States the obligation to provide "for making medical assistance available for cost-sharing * * * for qualified medicare beneficiaries." That provision, however, did not specify any particular *amount* that States must make available for cost-sharing. Section 1396a(n), titled "Payment Amounts," did address the issue of amount, and provided that a State "may" pay cost-sharing even if the sum of the federal Medicare payment and the state payment exceeded the amount otherwise payable under

the state Medicaid plan to eligible individuals who are not QMBs. The Secretary reasonably construed Section 1396a(n) to permit, but not to require, States to pay cost-sharing in excess of the State's Medicaid rate. The Secretary's construction flowed naturally from the language of the Medicaid Act, since there was no other apparent reason for Congress to have provided in the Medicaid Act that a State "may" pay more cost-sharing than the difference between the State's Medicaid rate and the amount that Medicare pays.

Petitioners emphasize that three of the four courts of appeals that rejected the Secretary's construction of Section 1396a(n) read that provision as providing only that providers (or States) would not be penalized for accepting (or making) payments that, with the Medicare payment, exceeded the Medicaid rate. See *Perales*, 954 F.2d at 859; *Snider*, 29 F.3d at 895; *Haynes*, 36 F.3d at 1076. As the Seventh Circuit recently explained, however, those readings of the Medicaid Act are "undermined by the fact that if [as petitioners argue] * * * the statute *clearly* entitle[d] [petitioners] to reimbursement at Medicare rates, * * * the state [or provider] could hardly be penalized for such reimbursement. That would be penalizing it for complying with the statute." *Paramount Health Sys.* v. *Wright*, 138 F.3d 706, 709 (7th Cir. 1998), petition for cert. pending, No. 97-2029.[7] As Judge Niemeyer pointed out in his dissent in *Kozlowski*, "[i]t is utterly implausible * * * to believe that Congress would create a new section in the Act solely to acknowledge that it is permissible for states to do what

[7] The petition pending in *Paramount* raises the same question as that presented here, and our response to that petition is being filed contemporaneously with this brief.

Congress *requires* them to do in other sections." 42 F.3d at 1469.

The Secretary's construction, moreover, comports with the purpose of the buy-in provisions, which is to relieve the States from the financial obligations that they would have to shoulder under their Medicaid plans if QMBs were not able to participate in the Medicare Part B program. Specifically, the Secretary's construction recognizes that, if the States did not buy QMBs into Medicare, the States would be required to pay for the medical care of at least those QMBs who are eligible for Medicaid, at whatever their Medicaid rates would allow. It is therefore reasonable to conclude that the States should not have to pay for medical services at a rate that is higher than the rate at which their own Medicaid plans would otherwise have required payment.

The legislative development of the provisions at issue further supports the reasonableness of the Secretary's construction. When Congress made buy-in coverage of all QMBs mandatory in 1988, the House Report accompanying the legislation specifically stated that States would not be required to make payments in excess of their Medicaid ceilings. See H.R. Rep. No. 105(II), 100th Cong., 2d Sess. 61 (1988). In 1989, Congress again amended the QMB provisions to "codif[y] the current practice with respect to dual eligibles and extend[] it to qualified Medicare beneficiaries." H.R. Rep. No. 247, 101st Cong., 1st Sess. 429 (1989). It did so, *inter alia*, by requiring physicians to accept assignments of claims from QMBs for the specific purpose of preventing physicians from exceeding the Medicaid ceilings by billing QMB patients directly for such additional amounts. *Ibid.*; see 42 U.S.C. 1395w-4(g)(3); Omnibus Budget Reconciliation Act of 1989, Pub. L. No.

101-239, § 6102(a), 103 Stat. 2169. Thus, Congress has treated QMBs principally as persons eligible for Medicaid benefits, but whose medical expenses are paid in large part by Medicare.

Even if the Medicaid Act is less than crystal clear on the extent of state Medicaid plans' obligations to pay for cost-sharing, it cannot be reasonably contended that the law was so clear and firmly settled against the Secretary's construction that Section 4714(a) must be viewed as a change in the law, despite Congress's express designation of it as a clarification. This Court, of course, had never considered the statutory question at issue. Although four circuits had rejected the Secretary's construction, they had not read the statutes in the same way, and neither the Seventh Circuit nor the Ninth Circuit—where the constitutional challenges to Section 4714(a) have been brought—addressed the statutory question. Two district courts had disagreed with the four circuits' construction of the Medicaid Act and had upheld the Secretary's position.

At a minimum, therefore, the Medicaid Act was "a hopeless muddle so far as [QMB] reimbursement [was] concerned." *Paramount*, 138 F.3d at 711; see also *Kozlowski*, 42 F.3d at 1450 (describing provisions governing Medicaid and Medicare financing as "among the most impenetrable texts within human experience"); 97-1947 Pet. App. 19a-20a (decision below; same). "[T]he fact that well-intentioned and intelligent experts at legal exegesis have arrived at three or four seemingly plausible readings of a particular text may be the best evidence that this interpretive puzzle has no definitive answer." *Kozlowski*, 42 F.3d at 1462-1463 (Niemeyer, J., dissenting). Under these circumstances, Congress's designation of Section 4714(a) as a clarifi-

cation, rather than a change, of the States' obligations under the Medicaid Act, deserves deference.

2. Petitioners urge the Court to grant certiorari to clarify how much weight should be given to a congressional interpretation of prior law, as reflected in a statutory amendment. Petitioners argue that there is tension in this Court's precedents addressing the issue. See 97-1947 Pet. 12-17; 97-1949 Pet. 18-21; 97-2079 Pet. 18-23. That issue is not presented in this case, however, because the Secretary reasonably construed the prior law to arrive at the result that Congress subsequently directed in Section 4714(a). Accordingly, the question of the weight owed to Congress's view, as expressed in Section 4714(a), that the new statute is a "clarification," is academic. At the least, this Court could not reject Congress's view that Section 4714 clarifies prior law without first analyzing the complex and now-superseded pre-1997 framework governing state payment of cost-sharing for QMBs, and determining whether the Secretary's construction of those provisions would have been owed deference under *Chevron*. That antecedent question of statutory interpretation, however, is of no continuing importance.

Moreover, the asserted tension in this Court's decisions is illusory. This Court has stated that express congressional declarations in *legislation* about the meaning of an earlier statute are given great weight, but that statements in "subsequent legislative history" such as committee reports about the meaning of earlier legislation are not. Compare, *e.g.*, *Loving* v. *United States*, 517 U.S. 748, 769-770 (1996) (legislation), and *Red Lion Broad. Co.* v. *FCC*, 395 U.S. 367, 380-381 (1969) (same); with, *e.g.*, *Public Employees Retirement Sys.* v. *Betts*, 492 U.S. 158, 167-168 (1989) (legislative history); *Gwaltney of Smithfield, Ltd.* v. *Chesapeake*

*Bay Found.*, 484 U.S. 49, 63 n.4 (1987) (same); *Consumer Prod. Safety Comm'n* v. *GTE Sylvania*, 447 U.S. 102, 116-118 & n.13 (1980) (same); *United States* v. *Philadelphia Nat'l Bank*, 374 U.S. 321, 348-349 (1963) (same); and *United States* v. *United Mine Workers*, 330 U.S. 258, 281-282 (1947) (same).

In its *Paramount* decision, the Seventh Circuit identified two cases, *South Dakota* v. *Yankton Sioux Tribe*, 118 S. Ct. 789 (1998), and *Rainwater* v. *United States*, 356 U.S. 590 (1958), in which this Court declined to give weight to subsequent legislation in construing earlier enactments. See *Paramount*, 138 F.3d at 711. These cases are readily reconciled with the *Loving* line of authority. In *Yankton Sioux Tribe*, the subsequent legislative materials made contradictory statements about the effect of the prior law at issue, and the Court therefore declined to give those materials significant weight. See 118 S. Ct. at 804 (emphasizing that legislative record "reveals no consistent, or even dominant, approach to the territory in question, and it carries but little force in light of the strong textual and contemporaneous evidence of diminishment") (internal quotation marks omitted). Although the Court did state in that case that "the views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one," see *id.* at 803 (quoting *Philadelphia Nat'l Bank*, 374 U.S. at 348-349), it did not suggest that subsequent legislation should never be given heed in determining the scope of an earlier law passed by Congress.

*Rainwater* involved the applicability of the False Claims Act to civil claims against a wholly owned government corporation. It was argued in that case that Congress's amendment of the criminal (but not the civil) provisions of the Act in 1918, to cover "any corporation in which the United States of America is a

stockholder," suggested that the 1863 Congress that enacted the False Claims Act did not intend it to apply to any government corporations. The Court found the 1918 legislation not probative of the scope of the original Act because the amendment was evidently concerned with different kinds of corporations, in which the government might have an ownership interest, and not wholly owned government corporations. See *Rainwater*, 356 U.S. at 593-594. The Court did not suggest that subsequent legislation is *per se* irrelevant to the scope of an earlier statute; rather, it simply found the subsequent legislation in that case not probative.

This case is readily distinguishable from *Rainwater* and *Yankton*. In this case, Congress has unmistakably addressed the precise statutory question at hand in legislation. Petitioners therefore do not dispute that, prospectively at least, the amendments made by Section 4714(a) definitively define the scope of States' cost-sharing obligations. Under these circumstances, the lower court correctly concluded that Congress's clarification of Section 1396a(n) in 1997 deserved great deference in defining the earlier scope of that law.[8]

3. Petitioners argue that Section 4714 effects an unconstitutionally retroactive change in the law gov-

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[8] The Seventh Circuit expressed concern that the *Loving* line of cases would permit an unsuccessful litigant to obtain a "'clarifying' amendment that would reverse the interpretation that the district court had given to [a] statute, *even if that meaning was crystal clear*" before the amendment. *Paramount*, 138 F.3d at 710 (emphasis added). That concern was misplaced, because nothing in the *Loving* line suggests that Congress could in that way alter the meaning of a "crystal clear" statute. Nor is that concern presented here: by the Seventh Circuit's own characterization, the prior rules governing QMB reimbursement were not "crystal clear" but a "hopeless muddle." *Id.* at 711.

erning the States' cost-sharing obligations to providers under the Medicaid Act. That contention, however, necessarily depends on petitioners' characterization of Section 4714(a) as a change in the law rather than a clarification. Because, as we have explained, Section 4714(a) did clarify prior law, petitioners' constitutional arguments are not properly presented. For the same reason, the court of appeals had no occasion to address petitioners' constitutional arguments.

Even if petitioners' constitutional challenges were properly presented, they would lack merit. Petitioners first argue that the application of Section 4714 to their cases would violate the separation of powers principle set forth in *United States* v. *Klein*, 80 U.S. (13 Wall.) 128 (1872), by directing the outcomes of their cases. See 97-1947 Pet. 17-24; 97-1949 Pet. 21-25. This Court has made clear, however, that "[w]hatever the precise scope of *Klein*, * * * its prohibition does not take hold when Congress 'amend[s] applicable law.'" *Plaut* v. *Spendthrift Farm, Inc.*, 514 U.S. 211, 218 (1995) (quoting *Robertson* v. *Seattle Audubon Soc'y*, 503 U.S. 429, 441 (1992)). Without question, Section 4714(a) amended the law applicable to States' cost-sharing obligations to providers of medical services, and did not simply direct the outcomes of these particular cases. That point is underscored by the fact that Section 4714's amendment to Section 1396a(n) applies prospectively as well as to pending cases. Section 4714 therefore "*did* amend applicable law," *Seattle Audubon Soc'y*, 503 U.S. at 441, and *Klein* has no relevance to this case.

Petitioners' takings and due process challenges to Section 4714 under the Fifth Amendment are also without merit. As explained above, under Medicaid, the States, with the financial assistance of the federal government's matching funds, provide medical assis-

tance to the needy. The Secretary read the pre-1997 Medicaid Act to permit States to limit their cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare would pay for a given service. California had chosen to exercise that option in its state plan. Even if Section 4714 changed the law, the change simply ratified the payment rules already set forth in California law; it did not change the amount that the *federal government* would pay providers. Because Section 4714 did not affect any contractual obligation of the federal government to petitioners, the cases on which they principally rely concerning contractual obligations of the federal government to private parties, *United States* v. *Winstar Corp.*, 518 U.S. 839 (1996), *Perry* v. *United States*, 294 U.S. 330 (1935), and *Lynch* v. *United States*, 292 U.S. 571 (1934), are inapposite.[9]

Thus, the only question is whether Section 4714 effected an unconstitutional taking or violated due process if (by hypothesis) it reduced the amount of cost-sharing that the States legally owed providers for services already rendered. As this Court recently reaffirmed, "a party challenging governmental action as an unconstitutional taking bears a substantial burden." *Eastern Enterprises* v. *Apfel*, 118 S. Ct. 2131, 2146

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[9] Petitioners' assertion that Congress made Section 4714 retroactive to save matching funds is both irrelevant and unsupported. Matching funds are owed to States, not to providers (see 42 U.S.C. 1396b (1994 & Supp. II 1996)); they do not affect the amount of compensation that providers receive for their services from the States. Moreover, Section 4714(a) is permissive. If all the States choose to pay cost-sharing in full, the federal government would still match those payments. Thus, any savings of matching funds would be, at most, "merely incidental" to Congress's regulatory objectives. See *Winstar*, 518 U.S. at 898.

(1998) (plurality opinion); see *id.* at 2156-2157 (Kennedy, J., concurring in the judgment and dissenting in part). Although a plurality of the Court in *Eastern Enterprises* held that the statute under review there effected an unconstitutional taking without just compensation, five members of the Court explicitly disagreed with that conclusion. In any event, the plurality did not disavow any of the Court's earlier takings cases reaffirming that Congress has "considerable leeway" (*id.* at 2149) in enacting social and economic legislation, even if that legislation has a retroactive effect. See *id.* at 2147-2149 (discussing *Connolly* v. *Pension Benefit Guar. Corp.*, 475 U.S. 211 (1986), and *Concrete Pipe & Prods. of Cal.* v. *Construction Laborers Pension Trust for Southern Cal.*, 508 U.S. 602 (1993)).

Application of that settled jurisprudence leads to the conclusion that Section 4714 is constitutional. In determining whether governmental regulation amounts to a taking, this Court considers the economic impact of the regulation, its interference with investment-backed expectations, and the character of the governmental action. See, *e.g.*, *Eastern Enterprises*, 118 S. Ct. at 2146 (plurality opinion); *Connolly*, 475 U.S. at 224-225. All three factors point to a conclusion that Section 4714(a) did not effect a taking. As for the economic impact of the legislation, whereas one plaintiff in *Connolly* had been assessed nearly 25% of that firm's net worth, see 475 U.S. at 222, petitioners have made no effort to show that Section 4714 would have a comparable economic impact on them. On the issue of investment-backed expectations, the law challenged in *Connolly* expanded the employers' obligation to pay benefits, even though those employers had contracts expressly limiting their obligations to pay benefits. See *id.* at 218. In contrast, the California Medicaid plan put petitioners on notice

that payment would be limited to the amount by which California's Medicaid rate exceeded what Medicare pays. See *California Med. Ass'n* v. *Lackner*, 172 Cal. Rptr. 815, 819 (Ct. App. 1981) (California Medicaid rules constitute a promise to pay providers "*at the rates set forth therein*") (emphasis added). Thus, at the time petitioners provided medical services, they had only their hope that their contested reading of the Medicaid Act would ultimately prevail and supersede their contracts with the State. Finally, as for the character of the government regulation at stake, Section 4714, like the statute upheld in *Connolly*, does not permit the government to "physically invade or permanently appropriate any of the [petitioners'] assets for its own use," *Connolly*, 475 U.S. at 225, nor does it have a severely retroactive effect out of proportion to petitioners' own experience, cf. *Eastern Enterprises*, 118 S. Ct. at 2149-2150 (plurality opinion). Petitioners' takings claim is therefore without basis.

Petitioners' due process challenge is similarly without merit. That argument ignores Congress's broad power to enact legislation "adjusting the benefits and burdens of economic life" and to make such legislation retroactive. *Usery* v. *Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976). Such legislation comes to a court "with a presumption of constitutionality, and * * * the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way." *Ibid.* Retroactive economic legislation passes due process scrutiny as long as "the retroactive application of the legislation is itself justified by a rational legislative purpose." *Pension Benefit Guar. Corp.* v. *R.A. Gray & Co.*, 467 U.S. 717, 730 (1984).

Congress plainly had rational bases for making Section 4714 retroactive. First, Section 4714 conformed federal law to the state-law contract between providers and those States (like California) that had limited their cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare paid. Second, Section 4714 conformed the law to the States' expectations, which were formed by the Secretary's longstanding construction of the Medicaid Act and by the Secretary's approval of state plans adhering to that construction. Finally, it was rational for Congress simply to "correct the unexpected results" of the decisions that rejected the Secretary's construction of Section 1396a(n). *General Motors Corp.* v. *Romein*, 503 U.S. 181, 191 (1992). Petitioners' due process challenge thus lacks merit.[10]

**CONCLUSION**

The petitions for a writ of certiorari should be denied.

Respectfully submitted.

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SEPTEMBER 1998

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[10] Petitioner Gilmore asserts that retroactive application of Section 4714 violates the Contract Clause. See 97-1949 Pet. 25-28. It is well established, however, that Congress is not subject to the requirements of the Contract Clause. See, *e.g.*, *R.A. Gray*, 467 U.S. at 732-733.