

ARGUMENT DOCKET

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA **SEP 2 2011**

No. 101537

PATSY HARDY, Secretary
West Virginia Department of Health and Human Resources,
Petitioner/Intevenor Below,

v.

HOLLY GRESS, as next friend of E.B., a minor,
Respondent/Petitioner Below.

The Honorable James Mazzone
Circuit Court of Hancock County, West Virginia
Civil Action No. 09-P-47 M

RESPONDENT'S SUPPLEMENTAL BRIEF

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INTRODUCTION

Respondent Holly Gress, as next friend of E.B., a minor, submits this supplemental brief in response to this Court's letter of August 3, 2011, in which the Court requested that the parties brief two issues addressed by the United States District Court for the District of Colorado in *I.P. v. Henneberry*, --- F. Supp. 2d ---, 2011 WL 2650223 (D. Colo. Apr. 26, 2011): first, "whether the reimbursement of past medical expenses paid by Medicaid agencies may come from medical expenses recovered as past and/or future medical care" and, second, "whether the formula adopted in *Ahlborn* to determine what portion of any recovery is attributable to medical costs should be applied in other cases."

As to the first issue, it is clear that state Medicaid agencies may only be reimbursed for past medical expenses out of that portion of any recovery attributable to past medical care. The United States Supreme Court so held in *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268, 126 S. Ct. 1752 (2006). Relevant provisions of the federal Medicaid Act likewise distinguish between third party liability for past medical expenses and other damages, including future medical expenses. A substantial majority of the courts to have considered the issue have concluded, contrary to *Henneberry*, that a state Medicaid agency may not recover from that portion of a tort judgment or settlement representing damages for future medical expenses.

In addition, Petitioner West Virginia Department of Health and Human Resources (DHHR) has waived any argument that it was entitled to seek reimbursement of medical expenses paid on E.B.'s behalf out of that portion of Respondent's tort settlement representing future medical expenses, because DHHR failed to raise that issue in the Circuit Court.

As to the second issue, Respondent does not contend that the *Ahlborn* decision requires courts to employ the precise formula used in that case to allocate a tort settlement between reimbursement for past medical expenses and other categories of damages. But that is not the issue. Rather, the question is whether it was reasonable for the Circuit Court to employ the formula used in *Ahlborn* to make that allocation, especially where DHHR failed to offer an alternative “rational approach” for making that allocation. *Lima v. Vouis*, 174 Cal. App. 4th 242, 260, 94 Cal. Rptr. 3d 183, 196 (2009).

ARGUMENT

I. DHHR May Not Obtain Reimbursement Out of Respondent’s Recovery for Future Medical Expenses.

A. DHHR has waived any argument that it could obtain reimbursement out of respondent’s recovery for future medical expenses.

Before turning to the substance of the first issue on which the Court requested briefing, it is necessary to address the issue of waiver. In the Circuit Court, DHHR never argued that federal Medicaid law permits a state Medicaid agency to seek reimbursement for medical expenses paid out of that portion of a Medicaid recipient’s recovery from a third party attributable to future medical expenses. Instead, DHHR argued only that the Supreme Court’s decision in *Ahlborn* is limited to cases in which the state Medicaid agency and the Medicaid recipient have stipulated to the portion of the recipient’s tort recovery attributable to past medical expenses, DHHR Mot. for Summ. J. 6-10; that W. Va. Code § 9-5-11—which entitles DHHR to full reimbursement of medical expenses it has paid, less its share of attorneys’ fees and litigation costs—controls under the doctrine of *lex loci contractus*, *id.* at 10; and that W. Va. Code § 9-5-11 is not in conflict with the federal Medicaid Act, because it limits the state’s recovery “to the actual medical expenses paid by the State on behalf of the Medicaid recipient for which a third party is liable to the extent

the Medicaid recipient is reimbursed for them,” *id.* The Circuit Court properly rejected each of these arguments.

Because DHHR did not argue to the Circuit Court that federal Medicaid law permits a state Medicaid agency to be reimbursed out of a Medicaid recipient’s recovery for future medical expenses, it has waived that argument before this Court. This Court has “long held that theories raised for the first time on appeal are not considered.” *Clint Hurt & Assoc. v. Rare Earth Energy, Inc.*, 198 W. Va. 320, 329, 480 S.E.2d 529, 538 (1996); *see also Lin v. Lin*, 224 W. Va. 620, 624-25, 687 S.E.2d 403, 407-08 (2009); *Zaleski v. W. Va. Mut. Ins. Co.*, 224 W. Va. 544, 550, 687 S.E.2d 123, 129 (2009); *Crain v. Lightner*, 178 W. Va. 765, 771, 364 S.E.2d 778, 784 (1987); *Syl. Pt. 1, Mowery v. Hitt*, 155 W. Va. 103, 181 S.E.2d 334 (1971).

B. In *Ahlborn*, the U.S. Supreme Court prohibited state Medicaid agencies from recouping medical expenses from any portion of a settlement or judgment other than past medical expenses.

If this Court nevertheless decides to reach the merits of the issue, it is clear that federal Medicaid law prohibits state Medicaid agencies from being reimbursed out of a Medicaid recipient’s recovery for future medical expenses. That conclusion is at least implicit in the *Ahlborn* decision itself. It is required by the language of the federal Medicaid Act. And, it is the conclusion of a substantial majority of the courts to consider this issue.

In *Ahlborn*, the United States Supreme Court ruled that a state Medicaid agency could seek reimbursement for medical expenses paid only out of that portion of a Medicaid recipient’s recovery attributable to past medical expenses. Any claim for reimbursement from other “heads of damage,” including future medical expenses, would run afoul of the Medicaid Act’s anti-lien provision. A close reading of the decision makes this distinction clear.

Heidi Ahlborn, a Medicaid recipient who had been severely injured in a car accident, sued two tortfeasors for her injuries. She claimed damages “not only for past medical costs, but

also for permanent physical injury; *future medical expenses*; past and future pain, suffering, and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future.” 547 U.S. at 273, 126 S. Ct. at 1757 (emphasis added). The case settled for \$550,000 and the Arkansas Department of Health and Human Services (ADHS) asserted a lien against the settlement for \$215,645.30, the total payments made by ADHS for Ahlborn’s care. *Id.* at 274, 126 S. Ct. at 1757.

Ahlborn then filed an action seeking a declaration “that the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of compensation for injuries *other than past medical expenses.*” *Id.* (emphasis added). The parties stipulated that, “if Ahlborn’s construction of federal law was correct, ADHS would be entitled to only the portion of the settlement (\$35,581.47) that constituted reimbursement for medical payments made.” *Id.*, 126 S. Ct. at 1757-58. The U.S. Supreme Court held that “Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn’s settlement in an amount exceeding \$35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so.” *Id.* at 292, 126 S. Ct. at 1767.

Thus, Ahlborn sought—and presumably recovered—tort damages for both past and future medical expenses, as well as other categories of damages, and the U.S. Supreme Court limited Arkansas’ lien to that portion of the tort settlement that represented past medical expenses. Moreover, the Court determined that federal law “affirmatively prohibit[ed]” the state Medicaid agency from asserting a lien on the remainder of Ahlborn’s recovery, including that portion of the settlement attributable to future medical expenses. *Ahlborn* simply cannot be read

to permit a state to recoup its Medicaid expenditures out of a recipient's recovery for future medical expenses.¹

C. The Federal Medicaid Act limits state Medicaid agencies' claims for reimbursement to third party payments for "health care items or services" for which the agency has already paid, i.e., to payments for past medical expenses.

Ahlborn's conclusion that a state Medicaid agency's lien must be limited to that portion of a recipient's third-party recovery constituting reimbursement of past medical expenses is strongly supported by the language of the federal Medicaid Act itself. As the U.S. Supreme Court explained, the anti-lien and anti-recovery provisions of the statute, 42 U.S.C. §§ 1396p(a) & (b) respectively, place "express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf." 547 U.S. at 283, 126 S. Ct. at 1762. Read literally, the Court noted, those provisions "would appear to ban even a lien on that portion of the settlement proceeds that represents payments for medical care" and "to forestall any attempt by the State to recover benefits paid, at least from the [Medicaid recipient]." *Id.* at 284 & n.13, 126 S. Ct. at 1763 & n.13.

The Court assumed, without deciding, that other provisions of the Medicaid Act, specifically 42 U.S.C. §§ 1396a(a)(25)(A), (B), and (H), created a limited exception to the anti-lien and anti-recovery provisions with regard to that portion of any settlement that represented reimbursement of past medical expenses paid by Medicaid, and it is to the language of those provisions that we now turn.

¹ The decision in *Henneberry*, and the earlier decision by the Idaho Supreme Court in *In re Matey*, 147 Idaho 604, 213 P.3d 389 (2009), on which the Colorado District Court relied, fail to carefully parse the *Ahlborn* decision and therefore misread it. Both courts apparently were misled by the Supreme Court's use of the phrase "payments for medical care" as shorthand for reimbursement of past medical expenses.

42 U.S.C. § 1396a(a)(25)(A) provides, in relevant part, that a state Medicaid agency, such as DHHR, “will take all reasonable measures to ascertain the *legal liability of third parties . . . to pay for care and services* available under the [state Medicaid] plan.” 42 U.S.C. § 1396a(a)(25)(B) adds “that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual . . . , the State or local agency will seek *reimbursement* for such assistance *to the extent of such legal liability*.” Finally, 42 U.S.C. § 1396a(a)(25)(H) requires:

that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for *such* assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party *for such health care items or services*.

42 U.S.C. §§ 1396a(a)(25)(A), (B), and (H) (emphases added).

As the U.S. Supreme Court explained in *Ahlborn*, these provisions limit a state Medicaid agency’s ability to seek reimbursement. 547 U.S. at 280-82, 126 S. Ct. at 1760-62. The state can only seek reimbursement “to the extent of” the third party’s “legal liability” “to pay for care and services” available under Medicaid. 42 U.S.C. §§ 1396a(a)(25)(A), (B). Moreover, the State acquires the Medicaid recipient’s rights only to the third party’s payment “for such health care items or services” for which the state Medicaid agency has already paid. 42 U.S.C. § 1396a(a)(25)(H).

Under these provisions, the only portion of the settlement that DHHR can reach is that portion that represents the tortfeasors’ payment for health care items and services for which DHHR had already paid, *i.e.*, E.B.’s past medical expenses.

D. The majority of courts to consider the issue have rejected the argument that state medicaid agencies may recover out of damages attributable to future medical expenses.

The issue whether a state Medicaid agency may satisfy its lien out of that portion of a settlement representing future medical expenses has now been considered by a number of courts. The vast majority of these courts have concluded that the State's recovery must be limited to that portion of a settlement representing reimbursement of past medical expenses. *See, e.g., Lugo v. Beth Israel Med. Ctr.*, 13 Misc. 3d 681, 819 N.Y.S.2d 892 (N.Y. Sup. Ct. 2006); *Chambers v. Jain*, 15 Misc. 3d 1120(A), 839 N.Y.S.2d 432 (N.Y. Sup. Ct. 2007) (following *Lugo*); *Bolanos v. Super. Ct.*, 169 Cal. App. 4th 744, 87 Cal. Rptr. 3d 174 (2008); *Lima v. Vouis*, 174 Cal. App. 4th 242, 94 Cal. Rptr. 3d 183 (2009); *McKinney v. Phila. Hous. Auth.*, No. 07-4432, 2010 WL 3364400, at *9 (E.D. Pa. Aug. 24, 2010); *see also Southwest Fiduciary, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.*, 226 Ariz. 404, 249 P.3d 1104 (2011) (limiting state Medicaid plan's recovery to that portion of settlement that represents recovery of the plan's payments on behalf of the victim); *but see I.P. v. Henneberry*, 2011 WL 2650223 (D. Colo. Apr. 26, 2011) (Medicaid lien may be satisfied out of future medical damages); *In re Matey*, 147 Idaho 604, 213 P.3d 389 (2009) (same).

The first court to consider the question was *Lugo*, in which the court held that *Ahlborn* barred the New York state Medicaid agency "from recouping its lien from any settlement monies not allocated to past medical expenses." 13 Misc. 3d at 685, 819 N.Y.S.2d at 895. The California Court of Appeals agreed in *Bolanos*: under *Ahlborn*, that court wrote, "the state is entitled only to that portion of the settlement that compensates for past medical expenses." 169 Cal. App. 4th at 752, 87 Cal. Rptr. 3d at 180 (citing *Ahlborn*, 547 U.S. at 280, 126-S. Ct. at 1752, and 42 U.S.C. § 1396k(a)(1)(A)).

The issue was squarely considered in *McKinney*, where the United States District Court expressly rejected the Pennsylvania state Medicaid agency's argument "that *Ahlborn* permits states to encumber settlement monies attributable to *future* medical expenses." 2010 WL 3364400, at *9 (emphasis in original). The district court's analysis is instructive:

Firstly, the Court in *Ahlborn* noted that Ahlborn was seeking damages "not only for past medical costs, but also for permanent physical injury; *future medical expenses*; past and future pain, suffering, and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future." 547 U.S. at 273 (emphasis added). This suggests that the Court, when it spoke of "medical expenses" in the remainder of the opinion, was referring to past medical expenses. Second, the Medicaid statute says that a state must,

to the extent that *payment has been made* under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, [have] in effect laws under which, to the extent that payment has been made under the State plan for medical assistance . . . to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for *such* health care items or services.

42 U.S.C. § 1396a (a)(25)(H) (emphasis added). It is clear from a reading of this statutory language that the italicized word "such" refers to the "payment [that] has been made"-that is, the payments the state made on the beneficiary's behalf *in the past* for medical expenses. Therefore, it would appear that DPW cannot draw on portions of the settlement designed to compensate for future medical expenses in order to reimburse itself for *past* medical expenditures.

Id. (emphases in original).

Finally, in *Southwest Fiduciary, Inc.*, the Arizona Court of Appeals considered a closely related question: whether the state Medicaid agency could recover from that portion of a

settlement that represented past medical damages for which Medicaid had not paid.² The court ruled that the Medicaid agency could not:

we take from [*Ahlborn's*] emphasis on the anti-lien provision the general rule that a state plan may recover from a victim's tort settlement no more than the portion of the settlement attributable to payments the plan has made on behalf of the victim. . . . Given the Court's refusal to permit the state plan in that case to recover from the other components of the settlement, we conclude federal law does not allow a state Medicaid plan to enforce its lien against any portion of a tort settlement not attributable to the plan's actual payments. . . . We take *Ahlborn's* warning that 42 U.S.C. § 1396p(a) bars any lien beyond "proceeds designated as payments for medical care," to mean that a Medicaid lien may be enforced only against the portion of a settlement attributable to payments the state plan has made on behalf of the victim.

226 Ariz. at ___ ¶¶ 17-18, 249 P.3d at 1108-09. *A fortiori*, under the Arizona court's reasoning, the state Medicaid agency could not seek reimbursement out of damages for future medical expenses.

Against this substantial weight of authority, DHHR can point to only two cases: the *Henneberry* decision that prompted the Court's request for further briefing, and the *Matey* decision on which it relied. Neither is persuasive. Both courts rested their opinions on the premise that the *Ahlborn* decision made no distinction between damages for past medical care and those for future medical care. *Henneberry*, 2011 WL 2650223, at *6; *Matey*, 147 Idaho at 609, 213 P.3d at 394. As demonstrated above, that premise is patently incorrect.

Thus, the weight of precedent, the language of relevant provisions of the federal Medicaid Act, and the *Ahlborn* decision itself all point to the same conclusion: DHHR may not

² Under Arizona's collateral source rule, a tort victim may recover the full amount of their billed medical damages caused by the tort, even though they may not have paid that amount (or any amount) of medical expenses. *Southwest Fiduciary, Inc.*, 226 Ariz. at ___, ¶ 12, 249 P.3d at 1107.

seek reimbursement out of that portion of E.B.'s settlement attributable to future medical expenses.

II. It Was Entirely Reasonable and Appropriate for the Circuit Court to Use the Formula Employed in *Ahlborn* to Allocate Respondent's Tort Settlement Between Reimbursement for Past Medical Expenses and Other Categories of Damages.

The second question posed by the Court—"whether the formula adopted in *Ahlborn* to determine what portion of any recovery is attributable to medical costs should be applied in other cases"—can be addressed much more briefly. Respondent does not contend that the *Ahlborn* decision *requires* courts to employ the precise formula used in that case to allocate a tort settlement between reimbursement for past medical expenses and other categories of damages. Numerous cases have recognized that the formula used in *Ahlborn* is a permissible, but not mandatory, method of making that allocation. *See, e.g., Lugo*, 13 Misc. 3d at 687-89, 819 N.Y.S.2d at 897-98; *Bolanos*, 169 Cal. App. 4th at 754, 87 Cal. Rptr. 3d at 181; *McKinney*, 2010 WL 3364400, *6 (collecting cases on this point). What is required is that "past medical expenses are distinguished in the settlement from other damages on the basis of a rational approach." *Bolanos*, 169 Cal. App. 4th at 754, 87 Cal. Rptr. 3d at 181; *see also Lima v. Vouis*, 174 Cal. App. 4th at 260-61, 94 Cal. Rptr. 3d at 196-97 (allocation method must be "rational," "fair and equitable"); *McKinney*, 2010 WL 3364400, *9 ("this Court is intimately familiar with this litigation and can make a fair and reasonable assessment of how much of the settlement should be apportioned to past medical expenses").

The Circuit Court in this case chose to use the *Ahlborn* formula. The question before this Court, therefore, is whether it was reasonable for the Circuit Court to employ that formula to allocate Respondent's settlement. There can be no question that it was reasonable—and not reversible error—for the Circuit Court to do so. *See Southwest Fiduciary, Inc.*, 226 Ariz. at ___,

¶ 28, 249 P.3d at 1111 (concluding that it was not error for the trial court to employ the *Ahlborn* formula under similar circumstances); *Lugo*, 13 Misc. 3d at 687-88, 819 N.Y.S.2d at 897 (noting that *Ahlborn* formula, while not mandatory, had the “sanction” of the Supreme Court); *Bolanos*, 169 Cal. App. 4th at 761, 87 Cal. Rptr. 3d at 186 (“we do not think this approach, which has the Supreme Court’s approval, should be abandoned lightly”).

This is especially so because DHHR failed to offer an acceptable alternative approach for making that allocation. DHHR’s insistence on full reimbursement, reduced only by its share of attorneys’ fees and costs, pursuant to W. Va. Code § 9-5-11 was neither rational nor fair and equitable. *See McKinney*, 2010 WL 3364400, *8 (“states are not unfettered in their ability to statutorily define how much of every settlement is attributable to past medical expenses, lest they dictate that 100% of settlement proceeds are, by force of law, considered compensation for past medical expenses. This would obviously be in tension with the Federal Medicaid statute and would raise serious Supremacy Clause concerns.”); *Tristani v. Richman*, --- F.3d ---, 2011 WL 2557234 (3d Cir. June 29, 2011) (striking down prior Pennsylvania statutory apportionment scheme, because it lacked procedures for a “dissatisfied beneficiary to challenge the default allocation;” without such procedures, a statutory default allocation could “eviscerat[e] the rule promulgated by *Ahlborn*”). Indeed, DHHR’s proposal was identical to that rejected by the United States Supreme Court in *Ahlborn*.

Under these circumstances, the Circuit Court’s decision to use the formula approved by the Supreme Court in *Ahlborn* was entirely justified.

CONCLUSION

For the foregoing reasons, as well as those set forth in Respondent’s Response to Petition for Appeal, Respondent urges this Court to affirm the Order of the Circuit Court of Hancock

County and limit DHHR's entitlement to a reimbursement of \$79,040.82, less its share of attorneys' fees and costs.

Respectfully submitted,



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CERTIFICATE OF SERVICE

I, hereby certify that I have served a true and correct copy of the foregoing Supplemental Brief by United Parcel Service for overnight delivery on this 1st day of September, 2011, in accordance with Rule 37 to the following:

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