

# **MEDICAID THIRD-PARTY LIABILITY LIENS**

## **POST-AHLBORN**

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### **I. Introduction:**

Practitioners who assist Medicaid recipients in the settlement of personal injury claims must understand the rights of state Medicaid agencies to recover from the personal injury settlement. Understanding the limitations in these rights will significantly maximize the net recovery to the client. These materials have been prepared to discuss these limitations and arguments made by State Medicaid agencies against the application of Ahlborn.

### **II. It Is A Simple Concept. The Federal Medicaid Act Requires States To Seek Reimbursement From Liable Third-Parties, But Places Limitations On The State's Recovery Rights In Order To Protect The Medicaid Recipient's Property.**

Medicaid is a cooperative federal-state program providing medical assistance to needy people. See 42 U.S.C. §1396 et. seq. State participation in the program is voluntary, with each participating State afforded latitude in defining the contours of its particular program. See Alexander v. Choate, 105 S.Ct. 712 (U.S. 1985). Still, a State that has elected to participate, must comply with the federal Medicaid statutes and regulations. See Wilder v. Virginia Hosp. Asso., 110 S.Ct. 2510 (U.S. 1990).

#### **A. Seeking Reimbursement By Acquiring The Rights Of The Medicaid Recipient To Recover From Liable Third-Parties**

The federal Medicaid program, Title XIX of the Social Security Act, requires every participating State to implement a “third party liability” provision which requires the State to seek reimbursement from third-parties to the extent of the third-party’s legal liability to pay for care and services provided to a Medicaid recipient through the Medicaid program. See 42 U.S.C. §1396a(A)(25). A State must take all reasonable measures to ascertain the legal liability of a third-party to pay for care and services, and in the event such a legal liability is found to exist after assistance has been provided

through the Medicaid program, the State must seek reimbursement for such assistance to the extent of such legal liability. See 42 U.S.C. §1396a(a)(25)(A) & (B).

To Facilitate this direction, the State must have in effect laws under which, to the extent that payment has been made under the Medicaid program, the “State is considered to have acquired the rights of” the Medicaid recipient to payment by any other party for such health care items or services. See 42 U.S.C. §1396a(a)(25)(H). A State plan must also provide that, as a pre-requisite to Medicaid eligibility, a Medicaid recipient must assign to the State any rights he may have to payment for medical care from a liable third-party. See 42 U.S.C. §1396k(a)(1)(A).

Federal law focuses on the State securing the right of the Medicaid recipient to pursue the liable third-party and the State seeking reimbursement from the liable third-party. There is no provision of federal law that authorizes or sanctions the use of subrogation or lien rights to recover from the Medicaid recipient directly.

**B. Federal Law Protects The Medicaid Recipient’s Property And Restricts The State’s Right To Recover Directly From The Medicaid Recipient’s Property.**

The federal anti-lien and anti-recovery statutes protect the Medicaid recipient’s property from being taken by the State. The federal anti-lien statute at 42 U.S.C. §1396p(a) provides that “no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf” [except in enumerated circumstances not relevant here]. Further, the federal anti-recovery statute at 42 U.S.C. §1396p(b) provides that “no adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made” [except in enumerated circumstances not relevant here].

**C. State Enactment Of Third-Party Liability Provisions**

All States have elected to participate in the Medicaid Program and receive reimbursement for the majority of the expenditures from the federal government. All States have enacted third-party liability statutes or regulations. Prior to the U.S. Supreme Court’s 2006 decision in Ahlborn, the Center for Medicare and Medicaid Services (“CMS”) had interpreted the federal third-party liability provisions to allow a State to seek recovery from a Medicaid recipient’s entire third-party liability judgment, award or settlement and to seek reimbursement up to the full amount of benefits paid by Medicaid. This fact is evident in the CMS Memo issued after Ahlborn (which will be discussed below) which acknowledged that:

“Prior to the Supreme Court’s decision in Ahlborn, CMS had interpreted the Medicaid third party provisions to authorize States to pass laws permitting full

recovery of Medicaid assistance from third party liability settlements, regardless of how the parties allocated the settlement. The Supreme Court rejected this interpretation of the Medicaid statute and held that to the extent the State laws permit recovery over and above what the parties have appropriately designated as payment for medical items and services, the State was in violation of federal Medicaid laws.”

Third-party liability statutes and regulations enacted by the States prior to Ahlborn granted the State Medicaid agencies differing powers. Some States had an absolute right of recovery through subrogation, lien, or assignment. In these States, the Medicaid agency could recover 100% of what it had paid from the entire judgment, award or settlement. Other States enacted statutes and regulations that provided that the Medicaid agency was entitled through subrogation, lien or assignment to either the full payment of its lien or a set percentage of the judgment, award or settlement. Other States, enacted statutes that allowed the Medicaid agency to recover only from the portion of the judgment, award or settlement representing compensation for past medical expenses.

In practice, the Medicaid agencies in States with absolute recovery statutes or statutes that dictated a set percentage of the judgment, award, or settlement to be paid to the State, typically did not negotiate its payment from a Medicaid recipient’s recovery. In the States where there was a less absolute recovery scheme or where the State was limited to recover from only the portion of the settlement representing past medical expenses, the Medicaid agencies would negotiate its payment from a Medicaid recipient’s recovery or the court had the discretion to determine the Medicaid agency’s payment.

If you were a Medicaid recipient and had a choice as to where to live and get injured, it was definitely better to be injured in a State where the Medicaid agency had a limited recovery scheme and was willing to negotiate its recovery.

In States where there was an absolute statutory recovery scheme, there typically was State case law strictly applying the absolute statutory recovery scheme. Usually in these States once there was one or two cases strictly applying the State statute, there was not much case law after that point. This State case law rarely referenced federal law or the argument that federal law limited the State’s recovery.

With limited exception, when a Medicaid recipient challenged the Medicaid agency’s rights based on federal Medicaid law limitations, the court would interpret the federal Medicaid statutes to allow full recovery from the Medicaid recipient’s entire settlement. See for example, Agency for Health Care Admin. v. Estabrook, 711 So.2d161 (Fla. 4DCA 1998); Cricchio v. Pennisi, 90 N.Y.2d 296 (1997); and Link v. Town of Smithtown, 175 Misc. 2d 238 (1997).

One exception however, provided the pathway for the 2006 Ahlborn decision. See Martin ex rel. Hoff v. City of Rochester, 642 N.W.2d 1 (Minn. 2002). In Martin, the Minnesota Supreme Court reviewed the federal assignment and federal anti-lien statutes as it related to Minnesota Medicaid's right to recover from a personal injury settlement. The Court determined that these federal statutes limited Minnesota Medicaid to recover from only the portion of the settlement representing compensation for past medical expenses and remanded the matter back to the trial court for a determination of the portion of the settlement representing compensation for medical expenses. This 2002 decision revealed the argument that was eventually presented to the U.S. Supreme Court in Ahlborn.

### **III. Ark. Dept. of Health & Human Services v. Ahlborn**

The U.S. Supreme Court's decision in Ark. Dept. of Health & Human Services v. Ahlborn, 126 S.Ct. 1752 (U.S. 2006), limits the state's ability to assert their lien against, and collect from, the entire proceeds recovered by a Medicaid recipient from a liable third-party. The decision provides that the Federal law authorizing states to collect Medicaid benefits from liable third-parties does not allow collection from portions of a settlement or judgment that represent compensation for damages other than past medical expenses. Provisions in state statutes that require reimbursement of Medicaid expenditures from the entire Judgment, award or settlement are unenforceable.

The facts and procedural history of the Ahlborn case are as follows. Heidi Ahlborn was severely injured in a car accident. As a result of the accident, Arkansas' Medicaid Program provided Medicaid benefits in the amount of \$215,645.30. Ms. Ahlborn brought a claim for her injuries against liable parties. Arkansas asserted a \$215,645.30 lien against the future proceeds derived from this claim. Ms. Ahlborn settled her claim for a non-specific settlement of \$550,000. Arkansas sought recovery of its \$215,645.30 Medicaid lien from the entire \$550,000 settlement. Ms. Ahlborn refused to pay the Arkansas lien, and sought a declaratory judgment from the Federal District Court. Ms. Ahlborn's declaratory action asserted that Arkansas' Medicaid recovery statute was not authorized by Federal law because it required reimbursement of the lien from the entire settlement.

To avoid an evidentiary hearing and to bring the pure legal issue before the court, Arkansas and Ms. Ahlborn entered into a stipulation in the declaratory action. This stipulation acknowledged that the value of Ms. Ahlborn's damages was \$3,040,708.18, and that the settlement amounted to approximately one-sixth of the value of Ms. Ahlborn's damages. The parties further stipulated that if Ms. Ahlborn's assertion was correct, Arkansas would accept one-sixth of their lien or \$35,581.47. The District Court granted Summary Judgment in favor of Arkansas holding that the Arkansas statute allowed recovery from the entire settlement, and Federal law did not prohibit such a

recovery. This decision was appealed and reversed by the Eighth Circuit. The Eighth Circuit's opinion was affirmed by the U.S. Supreme Court.

The U.S. Supreme Court rejected each and every argument made by Arkansas that supported their assertion that their statutory requirement that the Medicaid lien be paid from Heidi Ahlborn's entire settlement was permitted by Federal law. The opinion addressed Arkansas' basic legal argument and one basic policy issue. Arkansas' basic legal argument was that the Federal statute mandates each of the States to enact laws that require the assignment of a recipient's rights to the State and the assertion of liens to secure the state's rights from the entire third-party benefit. Further, this assignment of rights vested a property interest in the State and the third-party benefit became the property of the State upon assignment. The Court rejected this notion.

In outlining the question presented and the analysis the Court stated:

“We must decide whether Arkansas can lay claim to more than the portion of Ahlborn's settlement that represents medical expenses. The text of the federal third-party liability provisions suggest not; it focuses on recovery of payments for medical care. Medicaid recipients must, as a condition of eligibility, “assign the State any rights ...to payment for medical care from any third party.” 42 U.S.C. §1396k(a)(1)(A), not rights to payment for, for example, lost wages... ADHS points to §1396a(a)(25)(B)'s requirement that States “seek reimbursement for {medical} assistance to the extent of such legal liability” and suggests that this means that the entirety of a recipient's settlement is fair game. In fact, as is evident from the context of the emphasized language, “such legal liability” refers to “the legal liability of third parties ...to pay for care and services available under the plan.” §1396a(a)(25)(A). Here, the tortfeasor has accepted liability for only one-sixth of the recipient's overall damages, and ADHS has stipulated that only \$35,581.47 of that sum represents compensation for medical expenses. Under the circumstances, the relevant “liability” extends no further than that amount...Again, the statute does not sanction an assignment of rights to payment for anything other than medical expenses-not lost wages, not pain and suffering, not an inheritance...At the very least, then, the 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.” See Ahlborn at 1760 – 1761 (emphasis in original).

After determining that under federal law a Medicaid recipient is only required to assign the State their right to recover medical expenses and not their right to recover other damages, the Court reviewed the federal anti-lien statute at 42 U.S.C. §1396p(a) which states that no lien may be imposed against the property of a Medicaid recipient on account of medical assistance provided. The Court noted that read literally the anti-lien statute would prohibit a lien against any portion of Heidi Ahlborn's settlement, but since Heidi Ahlborn had not made this broader assertion The Court would assume in the case

before it that the assignment was a limited exception to the anti-lien statute. Based on the assumption that the required assignment of Ms. Ahlborn's right to recover past medical expenses was a limited exception to the federal anti-lien statute, the Court held that the federal anti-lien statute would affirmatively prohibit a State from asserting a lien against any portion of a settlement not representing compensation for past medical expenses, i.e. the Medicaid recipient's unassigned individual property.

It is important to note that the Court assumed the assignment is a limited exception to the federal anti-lien statute. The Court left open the question of whether the anti-lien statute affirmatively prohibited a State from asserting a lien against any portion of a Medicaid recipient's settlement. Further, the Court acknowledged that the anti-recovery statute was broader than the federal anti-lien statute in that it prevented "adjustment or recovery" and was not limited to only the recovery construct of "lien." The question of whether the anti-lien and anti-recovery statutes would prohibit any lien or recovery from a Medicaid recipient's settlement was not answered by the Ahlborn Court.

Arkansas and the United States made several public policy arguments. The most colorable being that a rule of full reimbursement is needed generally to avoid the risk of settlement manipulation. The Court rejected this argument. The Court noted that this issue was not squarely before the Court because Arkansas had entered into a stipulation designating \$35,581.47 as recovery for medical costs. However, the Court rationalized that: "even in the absence of such a post-settlement agreement, though, the risk that parties to a tort suit will allocate away the state's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision. For just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a countervailing concern that a rule of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others."<sup>1</sup>

It must be noted that the Court in denying the argument by Arkansas and the United States that a rule of full reimbursement was necessary to avoid settlement manipulation, that the Court did not offer or suggest that states can enact statutory provisions that require a mathematically calculated percentage of the settlement be designated as the portion of the settlement representing past medical expenses. Such a statutorily hard coated fixed calculation would likely violate the Constitution and could not fairly take into account the facts of each individual case. The Court instead simply noted that the court is the proper venue for this determination.

For the reasons discussed in the Ahlborn opinion and outlined above, the Court affirmed the Eighth Circuit's decision, effectuating a victory for Heidi Ahlborn and a defeat for the State of Arkansas. The basic holding of the Court provides that the Federal law

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<sup>1</sup> See Ahlborn at 1763.

authorizing States to collect Medicaid benefits from liable third-parties does not allow collection from portions of a settlement or judgment that represents compensation of damages other than past medical expenses. Provisions in state statutes that require reimbursement of Medicaid expenditures from the entire third-party benefits are unenforceable.

#### **IV. The Federal Government's Direction To States Immediately After Ahlborn.**

Immediately after the Ahlborn decision, the federal government through CMS directed all State Medicaid agencies to comply with federal law as interpreted by Ahlborn. See *Memorandum from Gale Arden, Director of CMS's Center for Medicaid and State Operations Disable and Elderly Health Programs Group to all Associate Regional Administrators for Medicaid and State Operations, "State Options for Recovery against Liability Settlements in Light of Ahlborn"*(July 3, 2006)("CMS Memo"). The CMS Memo directed that "it is imperative that States comply with the decision in Ahlborn." *Id.* CMS outlined that Ahlborn "interpreted current federal Medicaid law to preclude the State from enforcing laws which broaden the assigned rights of a Medicaid recipient" and directed that "States may only require assignment of the right to payment from a third party for healthcare (or medical) items and services." *Id.* CMS directed that "State's lien laws must only operate to recover from that portion of a settlement that is allocated to healthcare items or services, **even if it means that Medicaid must forego full recovery of its claim.**" *Id.*

Interestingly, The CMS Memo was not revealed to the legal community until the 2012 U.S. Fourth Circuit Court of Appeals decision in E.M.A. ex rel. Plyler v. Cansler, 674 F.3d 290 (U.S. 4<sup>th</sup> Cir. 2012). The Fourth Circuit found the CMS Memorandum "illuminating" in the Court's determination that "*Ahlborn* is properly understood to prohibit recovery by the state of more than the amount of settlement proceeds representing payment for medical care already received" and that North Carolina's mandatory 1/3 allocation statute was a "violation of *Ahlborn*." Further, the West Virginia Supreme Court noted that the CMS Memo concluded that statutory language similar to that in the West Virginia Medicaid statute required revision post-Ahlborn. See *In re E.B.*, 729 S.E.2d 270, 293 (W.Va. June 21, 2012)(*noting the CMS Memo "concluded that statutory language such as that found in [W.Va.'s Medicaid statute] necessarily requires revision."*)

## V. States' Response To Ahlborn And States' arguments against the application of Ahlborn

### A. State Response

States have had three basic responses to the Ahlborn decision. To begin with, some States' statutory recovery schemes were not affected by the Ahlborn decision. As mentioned above, some States had statutory recovery schemes that provide that the State is only entitled to recover from the portion of the settlement compensating for medical expenses. In these States, the statute often provide an administrative or judicial procedure for the determination of the portion of a settlement representing compensation for medical expenses. In these States, rarely are these procedures used because the State negotiates its payment instead of taking the matter to court. These States have no problem with the Ahlborn decision because their statutes are in compliance with Ahlborn.

Other States have realized that their Medicaid recovery statutes violate Ahlborn. Many of these States began negotiating their recovery from personal injury settlements because they understood the reality if the matter was taken to court. In these States, you will note that there are no published decisions citing Ahlborn because the repayment of the Medicaid lien is settled before it gets to the point of a court decision. The fact remains that in these States the statute violates Ahlborn and the State is more than willing to recover as much as possible, but ultimately if push comes to shove they will settle the lien payment before going to court.

Some of these States where the State has recognized that the statute violates Ahlborn have amended their statutes to bring them into compliance with Ahlborn. These amendments have focused on limiting the Medicaid agency to only the portion of the settlement representing compensation for medical expenses and providing an administrative or judicial procedure for determining the Medicaid payment. Some of these States initially fought the application of Ahlborn, but did not receive favorable results through the Court. In these States you may find one or two published opinions talking about Ahlborn's application to that State's old statutory scheme. Some of the States that have amended their Medicaid recovery statutes include California, Pennsylvania, New Hampshire and Oklahoma.

Finally, there are some States that refuse to recognize the Ahlborn decision and doggedly fight the application of Ahlborn. These States have refused to amend their statutory recovery scheme to bring it into line with Ahlborn. Generally these States have statutes which entitle Medicaid to either full payment of its lien or a percentage of the gross settlement. These States do not typically negotiate their payment and have the most published opinions concerning Ahlborn. These States include North Carolina, Florida, Nebraska and Ohio.

As a side note, most of the States that doggedly fight the application of Ahlborn have outsourced recovery of Medicaid liens to private collections companies. These collections companies are paid a percentage of what they recover and have a monetary interest in fighting the application of Ahlborn. These private collections companies understand that if they fight the application of Ahlborn, it will increase their profit. The thought process is that if we require a Medicaid recipient to take the matter to court and doggedly fight any reduction in the lien, it will discourage the majority of Medicaid recipients from incurring the time and cost of litigating the matter and they will just pay the full lien.

**B. The Main Arguments States Make Against The Application Of Ahlborn.**

**1. Ahlborn applies only to the Arkansas Medicaid recovery statute**

The initial argument is that Ahlborn is inapplicable to the instant State's recovery scheme. States argue that Ahlborn only applied to Arkansas' Medicaid recovery statute and does not apply to all other State's recovery statutes. This is a weak argument, since the federal law used to invalidate Arkansas' recovery statute is applicable to all State Medicaid recovery statutes.

**2. Ahlborn only applies when there is a stipulation between the State and the Medicaid recipient concerning the portion of the settlement representing past medical expenses.**

States argue that Ahlborn is only applicable in cases where the State and the Medicaid recipient have stipulated to the amount of the settlement representing compensation for past medical expenses. If there is no stipulation between the State and the Medicaid recipient, then Ahlborn is inapplicable. This argument should be considered weak because this argument assumes that the Ahlborn Court would have allowed full recovery if Arkansas and Heidi Ahlborn simply had not stipulated to the amount of the unallocated settlement representing compensation for past medical expenses. But this is a flawed assumption. If Arkansas and Heidi Ahlborn had not entered into the stipulation, the Ahlborn Court would have reached the same ruling concerning the law. However, the Ahlborn Court would have remanded the matter back to the trial court for a determination of the portion of the settlement representing compensation for past medical expenses. This is supported by the Ahlborn Court's statement that in the absence of a stipulation the matter can be submitted to "the court for decision." Ahlborn at 1763.

While this argument that Ahlborn only applies when there is a stipulation between the State and the Medicaid recipient is a weak argument, this argument has been persuasive to a couple of courts. See Andrews v. Haygood, 669 S.E.2d 310 (N.C. 2008) and Russell v. Agency for Health Care Admin., 23 So.3d 1266 (Fla. 2DCA 2010).

**3. The Ahlborn Court only faulted the Arkansas statute because there was no limit in Arkansas' recovery.**

States argue that the holding in Ahlborn is that a State cannot seek recovery of the entire settlement. States point out that the Ahlborn Court noted that Arkansas statute could entitle Arkansas to the full settlement if its lien was larger than the settlement amount. States then argue that this was the problem with the Arkansas statute. These States then argue that since their State recovery statute has a cap in the recovery such as 1/3 of the settlement (N.C.'s statute) or half of the net settlement after deducting attorney fees and costs (PA, OH, FL's statutes), then the State could never recover the entire gross settlement. Thus, there will always be funds available from the settlement to compensate the Medicaid recipient for damages other than medical expenses.

This argument misstates and ignores the legal ruling of Ahlborn. The Court did not determine the Arkansas statute unenforceable because it could potentially allow the State to take all the settlement. Instead, the Court held that federal law only allowed a State to assert a lien against, and seek recovery from, the portion of the settlement representing compensation for medical expenses because the remainder of the settlement is the Medicaid recipient's unassigned individual property. Yes, any State statute that allows the State to recover the entire settlement when less than the full settlement amount represents compensation for past medical expenses would violate Ahlborn, but it is also a violation of Ahlborn for a State to take any amount in excess of the amount of the settlement representing compensation for medical expenses.

**4. There is no violation of Ahlborn when a State statute restricts recovery to a percentage of the settlement.**

In conjunction with the argument that Ahlborn only faulted the Arkansas statute because Arkansas could recover the entire settlement, States argue that their particular statute is in compliance because it dictates the amount of a settlement representing medical expenses. These States argue that since their statute limits recovery to a percentage of the gross settlement, this percentage represents the compensation for medical expenses upon which the State can recover.

The States that make this argument point to Footnote 18 of the Ahlborn decision which states:

FN 18 As one amicus observes, some States have adopted special rules and procedures for allocating tort settlements in circumstances where, for example, private insurers' rights to recover are at issue. See *Brief for Association of Trial Lawyers of America* 20-21. Although we express no view on the matter, we leave open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation.” (Emphasis added)

States argue that its statutory percentage recovery is exactly what the Ahlborn Court was discussing in Footnote 18 as a “special rule or procedure” for allocating the settlement. These States argue that Ahlborn in Footnote 18 left open the opportunity for the State to have a hard-coat percentage recovery. However, States that make this argument are misconstruing Footnote 18 into something it is not. Footnote 18 is reference to pages 20-21 of the Amicus Brief of the Association of Trial Lawyers of America. Pages 20-21 of this amicus brief does not reference hard-coat statutory allocation of settlements. Instead, it references rules and procedures “adopted” by courts to determine the portion of a settlement compensating for medical expenses used in the context of workers compensation cases or settlements involving health insurance liens. The Ahlborn Court was not referencing Medicaid statutes that dictate a percentage of a settlement representing medical expenses.

Some courts have agreed with the States argument. These courts have held that the statutory hard-coat percentage is a special rule or procedure allowed under Ahlborn—thus, the State was free to recover the statutory percentage from the settlement regardless of what portion of the settlement actually represented compensation for past medical expenses. These decisions have prohibited the court from limiting the Medicaid lien to only the portion of the settlement representing past medical expenses. See for example Andrews v. Haygood, 669 S.E.2d 310 (N.C. 2008); Armstrong v. Cansler, 722 F.Supp.2d 653 (W.D.NC 2010); Russell v. Agency for Health Care Admin., 23 So.3d 1266 (Fla. 2DCA 2010); Scharba v. Braden. Ltd., 2010 WL 1380121 (M.D.Fla. Mar. 31, 2010); Garcon v. Agency for Health Care Admin., 96 So.3d472 (Fla. 3DCA Sept. 5, 2012); and Mulk v. Ohio Dept. of Job & Family Servs., 969 N.E.2d 1254 (OH App. 10 Dist, 2011). .

Other courts have recognized that Footnote 18 of the Ahlborn decision does not reference hard-coat allocation statutes, but instead reference court procedures for the court to determine the portion of a settlement allocable to medical expenses. See E.M.A. ex rel. Plyler v. Cansler, 674 F.3d 290, 308 (U.S. 4<sup>th</sup> Cir. 2012)(“*The ATLA Brief, rather than advocating full recovery subject only to a statutory cap, discussed procedures in several states to have “mini-hearings” to set allocations from tort settlements where there is no agreement among the interested parties.*”); and In re E.B., 729 S.E.2d 270 (W.Va. 2012).

The growing consensus in both state and federal case law is that a State may have a statutory *default* allocation dictating that the state may recover a set percentage of a settlement, however, there MUST be procedures in place for a Medicaid recipient who is dissatisfied with the default allocation to appeal the results of the statutory *default* allocation administratively or through the courts. Without a method for a court to determine the amount of the settlement representing past medical expenses and limit the State to recover from this amount, the State statutory recovery may result in the State receiving more than the portion of the settlement compensating for past medical expenses. The Medicaid recipient MUST be afforded the chance to go to court to have

the payment of the lien determined based on the facts and circumstances of the case and settlement. See E.M.A., Tristani, and Roberts v. Albertsons, \_\_ So.3d \_\_ 2012 WL 5232182 (Fla. 4DCA Oct. 24, 2012).

## **5. Ahlborn did not mandate a percentage reduction in the Medicaid lien**

States argue that while Ahlborn may limit its recovery to the portion of the settlement representing past medical expenses, it did not mandate the use of the mathematical formula used by the parties in Ahlborn to determine the portion of Heidi Ahlborn's settlement representing past medical expenses. This is actually a valid argument, but States have not been able to articulate a better way to figure out the portion of a settlement representing past medical expenses.

The Ahlborn Court did not mandate that all Medicaid liens be reduced in the same percentage as the settlement bore to the total monetary value of all damages. In Ahlborn, Arkansas and Heidi Ahlborn determined the portion of the settlement representing compensation for past medical expenses by applying the percentage the settlement bore to the total monetary value of all damages to the Medicaid lien amount. This has become known as the "*Ahlborn formula*." The U.S. Supreme Court spent a great deal of time discussing how this math worked and comparing this stipulation to a jury verdict or a judge allocated settlement. However, ultimately, the Ahlborn Court did not state that this *Ahlborn formula* should be used in all cases.

States have argued that the Ahlborn Court did not mandate the use of the *Ahlborn formula* and that the *Ahlborn formula* is problematic. A number of courts have agreed with the States that Ahlborn did not mandate use of the *Ahlborn formula*, and some courts have stated the *Ahlborn formula* is problematic. However, states have been unable to figure out a different way to determine the amount of the settlement representing compensation for past medical expenses. States understand that any legitimate calculation would require inclusion of the value of all damages in the calculation. The inclusion of the value of all damages in the calculation, regardless of how an alternative calculation reasonably works off of that number, typically results in a small amount of the settlement representing past medical expenses. States have not been able to figure out an alternative to the *Ahlborn formula* that doesn't mathematically end up with a similar number as the *Ahlborn formula*.

Ultimately, the courts while acknowledging that Ahlborn does not mandate the use of the *Ahlborn formula*, end up using the *Ahlborn formula* or something similar, to determine the amount of the settlement representing compensation for past medical expenses. The *Ahlborn formula* is a reasonable and rational way to arrive at the number and that is why Arkansas and Heidi Ahlborn used that formula as a basis of their stipulation. See Lugo v. Beth Israel Medical Center, 819 N.Y.S. 2d 892, 13 Misc. 3d 681, 2006 NY Slip Op. 26340 (N.Y. Sup. July 21, 2006); Chambers v. Jain, 15 Misc.3d 1120 (A) 2007 N.Y. Slip

Op. 50776 (April 13, 2007)(“*In Lugo, Justice Schlesinger held that Ahlborn must be read to limit the DSS to the amount of the settlement proceeds allocated to past medical expenses...the court in Lugo acknowledged that the formula utilized in Ahlborn was based on a specific stipulation between the parties, but the court also found that such a formula is rational and noted that nothing in Ahlborn suggested that this formula is in any way improper.”); Lima v. Vous, 94 Cal.Rptr.3d 183 (Cal.App. 2 Dist. 2009); and Bolanos v. Superior Court, 87 Cal.Rptr.3d 174 (Cal.App. 2 Dist. 2008)(“*the fundamental point is that a settlement that does not distinguish between past medical expenses and other damages must be allocated between these two classes of recoveries. Without such an allocation, the principle set forth in Ahlborn, that the state cannot recover for anything other than past medical expenses, cannot be carried into effect... We agree that Ahlborn itself does not require the application of the precise formula used in that case, although we do not think this approach, which has the Supreme Court's approval, should be abandoned lightly. We do not agree, however, that Ahlborn did not ‘consider’ the formula-its decision in the case was based on the results of the formula-nor do we agree that Ahlborn is of no consequence when it comes to a settlement that has not been allocated between past medical expenses and other damages.”); Burtsell v. Toumpas, 2012 WL 1656303 (D.N.H. May 10, 2012); and McKinney v. Philadelphia Housing Authority, 2010 WL 3364400 (E.D.Pa. Aug. 24, 2010).**

The key point is that the portion of the settlement representing past medical expenses must be calculated in a reasonable and rational manner. The valuations presented to the court should be reasonable and the method of calculation presented to the court should be rational based on how a jury would calculate the final award to past medical expenses. The *Ahlborn* formula is a reasonable and rational method of determining the amount of a settlement representing past medical expenses, but there may be other reasonable and rational ways to drive the number.

**6. The State is able to recover from not only the portion of a settlement representing compensation for past medical expenses but also the portion representing compensation for future medical expenses.**

Some States have argued that they can recover from not only the portion of the settlement representing compensation for past medical expenses, but also the portion compensating for future medical expenses. While this argument could be supported by inference and a lazy reading of the text of federal law and the *Ahlborn* decision, ultimately this argument is not supported by federal law, defies logic and is a dead end for the State.

States point out that federal law requires an assignment of the right to recover medical expenses and the *Ahlborn* Court interpreted federal law to allow only recovery from the portion of a settlement representing compensation for “medical expenses.” States argue that “medical expenses” must include not only past medical expenses but also future medical expenses.

This argument was not made in Ahlborn. However, the facts of Ahlborn and the core result of its decision supports the idea that Medicaid agencies can only recover from the portion of the settlement representing past medical expenses. We know from the facts of Ahlborn that Heidi Ahlborn suffered severe injury and her claim for past medical expenses was \$215,000. Given the severity of her injury, her stated permanent disability, the size of her claim for past medical expenses, and her claim for future lost income, we know that Heidi Ahlborn must have had a large claim for future medical expenses. However, this claim for future medical expenses was not part of the calculation of her recovery of \$35,000 in past medical expenses. Arkansas and Heidi Ahlborn stipulated as to her recovery of past medical expenses and did not stipulate to her claim for future medical expenses.

The Ahlborn Court noted that Heidi 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.” Ahlborn at 547 U.S. at 273. The Ahlborn Court did not talk about her claim for future medical expenses. Instead, the Court limited Arkansas to recover from only the \$35,000 representing past medical expenses. The Court could have held Arkansas Medicaid could recover from the \$35,000 in past medical expenses and whatever amount of the settlement compensated for future medical expenses, but it did not. The Court talked in terms of the recovery of “medical expenses” but ultimately limited Arkansas to recover from only the portion of the settlement representing compensation for past medical expenses. So, the result of the Ahlborn decision does not support the idea that a State can recover from both the recovery in past medical expenses and the recovery in future medical expenses.

Additionally, the idea that the State can recover from both the recovery in past medical expenses and future medical expenses defies logic in two ways. First, a Medicaid recipient at trial cannot board the Medicaid lien as an element of past medical expenses and also as an element of future medical expenses. It would be reversible error for the jury to award the Medicaid lien amount as part of the award in past medical expenses and then also as part of the award in future medical expenses. It is impossible for the award in future medical expenses to contain any aspect of a recovery of the Medicaid lien amount.

Second, under normal circumstances, the State will not be responsible for paying for future medical expenses, so the State should not be allowed to take that portion of the settlement. A settlement under normal circumstances, will cause the Medicaid recipient to be financially ineligible for Medicaid and future medical care will be paid by the settlement or other sources. So again, it is not reasonable for the State to expect to recover from the portion of a settlement representing compensation for future medical expenses when the State is not liable for these future services. Some would argue that if

a Special Needs Trust is funded with the settlement and the Medicaid recipient will continue to receive Medicaid benefits, the State should be allowed to recover from the portion of the settlement representing compensation for future medical expenses. But this argument ignores the after death payback of Medicaid required in a Special Needs Trust—the State will be repaid from the recovery of future medical expenses from the SNT after death.

Nearly all Courts when outlining the portion of the settlement a State can recover from under Ahlborn, expressly state the State can only recover from the portion of the settlement representing past medical expenses. Those Courts that do not expressly use the term “past medical expenses” do not make reference to “future medical expenses.”

There has only been one court to accept this argument that the State can recover from both the portion of the settlement compensating for past medical expenses and the portion compensating for future medical expenses. The Idaho Supreme Court initially rejected Idaho Medicaid’s argument that it could recover from both the portion of a settlement compensating for past medical expenses and the portion compensating for future medical expenses, and determined that Idaho can only recover from the portion of the settlement representing compensation for past medical expenses. See Idaho Dept. of Health & Welfare v. Hudelson, 2008 WL 4595251 (Idaho 2008). However, oddly, after Hudelson, the Idaho Supreme Court changed its mind and held that the State could recover from the portion of the settlement representing future medical expenses. See In re Matey, 213 P.3d 389, 394 (Idaho 2009).

Other than the In re Matey case mentioned above, when States claim they can recover from both the recovery in past medical expenses and future medical expenses, the Courts have rejected this idea and rejected the In re Matey decision. See McKinney v. Philadelphia Housing Authority, 2010 WL 3364400 (E.D.Pa. Aug. 24, 2010) and In re E.B., 729 S.E.2d 270 (W.Va. June 21, 2012). Both McKinney and In re E.B. provide detailed analysis of this issue. Ultimately, this argument by the State is not a valid argument.

## **7. Public policy arguments**

States make many public policy arguments in support of full reimbursement or at least a tempering of the Ahlborn holding. These arguments focused on financial strain, limited resources and gratuitous concern about judicial economy. These same public policy arguments were to some extent made in Ahlborn and found unpersuasive.

States argue that Medicaid provides medical care to people with limited resources at their greatest time of need, thus, the State must be repaid in full so the State can help others in need. The States forget that nothing in Ahlborn suggest that the State shouldn’t be repaid what is properly owed. Second, the States forget to mention that about 60% of

whatever is collected is returned to the federal government as the federal government's reimbursement of the federal share. So, these funds cannot be used by the State to help others it must be returned to the federal government.

The States argue that if the Court is allowed to determine the amount of a settlement compensating for past medical expenses, then this will cause an enormous strain on State resources in attending hearings and strain judicial resources. So, States argue the court should not have the authority to limit the payment of a Medicaid lien. This argument ignores two major points. First, the determination of what portion of a settlement represents past medical expenses is a determination of property rights. The right to own and possess property is a fundamental right protected by the Constitution. Courts are the proper venue for the determination of fundamental rights such as property rights. Protection of property rights is the proper use of state and judicial resources.

But most importantly, States forget that they can negotiate their recovery and avoid the strain on state and judicial resources. It is well established that once parties understand the legal realities that may result if a matter is litigated through the court, the parties can negotiate resolution. States are free to negotiate their recovery and avoid the necessity of involving the court. The alleged strain on state and judicial resources is a self-imposed strain created by the State's unwillingness to negotiate.

## **VI. U.S. Circuit Court of Appeals Decisions Of Importance**

### **A. *Tristani ex rel. Kames v. Richman*, 652 F.3d 360 (3<sup>rd</sup> Cir. 2011),**

Several Pennsylvania Medicaid recipients brought a class action to recover monies paid to Pennsylvania Medicaid and to strike unpaid Medicaid liens. The federal trial Court reviewed federal law, the Ahlborn decision and the Pennsylvania Medicaid statute and wrote a long detailed decision. See Tristani v. Richman, 609 F.Supp.2d 423 (WDPA 2009).

The trial court acknowledged that the Ahlborn Court had not answered the question of whether the federal anti-lien and anti-recovery statutes prohibit a State from recovering from any portion of a Medicaid recipient's settlement. The trial court determined that the federal assignment statutes focused on the State acquiring the rights of the Medicaid recipient to pursue the liable third-party and that federal law did not authorize the use of liens to passively recover from the Medicaid recipient post-settlement. The trial court noted that the federal anti-lien statute contained enumerated exceptions, none of which allowed a State to recover from a Medicaid recipient's settlement with a third-party. The trial court determined that the federal anti-lien statute prohibited a State from asserting a lien against any portion of a Medicaid recipient's settlement. If the State wished to

recover, it needed to actively pursue the liable third-party for recovery based on the Medicaid recipient's assignment to the State.

The trial court reviewed the Pennsylvania Medicaid recovery statute. The trial court noted that the statute contained a formula whereby Pennsylvania Medicaid was entitled to half of the net settlement after deducting attorney fees and cost. Court noted that Pennsylvania Medicaid had issued policy statement after Ahlborn that this statutory formula was the method of determining the portion of a settlement representing past medical expenses. The trial court also noted that this statutory formula had been amended in 2008 to allow a Medicaid recipient who was dissatisfied with the statutory allocation to past medical expenses to petition the court or agency for an alternative determination.

The trial court determined that a State can have a statutory formula for determining its payment because this was a "special rule or procedure" the Ahlborn Court in Footnote 18 had referenced. The trial Court ruled that both the old statutory formula (which did not allow for a deviation from the statutory formula) and the new 2008 version of the statute (allowing for the court to deviate from the formula), was in keeping with Ahlborn.

The Third Circuit reviewed the trial courts decision. See Tristani v. Richmond, 652 F.3d 360 (U.S. 3<sup>rd</sup> Cir. 2011). The first point that the Third Circuit reviewed was whether the federal anti-lien and anti-recovery statutes prohibit a State from asserting a lien against a Medicaid recipient's settlement. The Third Circuit extensively reviewed the legislative history of the federal third-party liability provisions. It is difficult to explain how the Third Circuit came to this determination, but the Third Circuit determined that while there was no written exception to the anti-lien and anti-recovery statutes that would allow a State to recover from a Medicaid recipient's settlement, legislative history supported an unwritten exception to allow the State to recover from the portion of a Medicaid recipient's settlement representing compensation for past medical expenses.

After that determination, the Third Circuit turned to the issue of the Pennsylvania statutory formula. The Third Circuit held that the old version of the statutory formula which mandated WITHOUT EXCEPTION the amount of a Medicaid recipient's settlement representing past medical expenses, was a violation of Ahlborn. The new 2008 version of the statutory formula was permissible in light of Ahlborn because it provided the Medicaid recipient with the ability to approach the court for a determination of the amount of the settlement representing past medical expenses. The Court stated:

"The question remains whether the prior scheme, which did not provide a right of appeal from the default allocation, is valid under Ahlborn. The District Court upheld the scheme, but we find it problematic...{Ahlborn} did not give states unfettered discretion to allocate settlements without regard to the actual portion attributable to medical expenses. Indeed, Ahlborn expressed a preference for

resolving allocation disputes “either by obtaining the State’s advanced agreement to an allocation or, if necessary, by submitting the matter to a court for decision.”... We hold merely that in determining what portion of a Medicaid beneficiary’s third-party recovery it may claim in reimbursement for Medicaid expenses, the state must have in place procedures to allow a dissatisfied beneficiary to challenge the default allocation. As the Beneficiary’s point out, without such a rule nothing would prevent states from allocating 75%, 90% or even 100% of a settlement to medical expenses, thereby eviscerating the rule promulgated by Ahlborn.” *Id.* at 378-379

The Third Circuit answered a major question when it determined that it was a violation of Ahlborn for a State to have a mandatory allocation. Unlike Pennsylvania which had amended its statutory formula to allow a dissatisfied Medicaid recipient the opportunity to go to court to challenge the default allocation, a number of states, such as North Carolina, Georgia, Hawaii, and Florida, had not amended their statutes. These States still to this day, have statutes that require either full payment of the lien or a percentage of the gross settlement and do not allow a Medicaid recipient to challenge the statutory allocation through the Court. The Third Circuit revealed that this was a violation of Ahlborn!

**B. E.M.A. ex rel. Plyler v. Cansler, 674 F.3d 290 (U.S. 4<sup>th</sup> Cir. 2012).**

Injured child brought action in federal court to have an allocation to past medical expenses made by the federal court from unallocated settlement in order to limit the payment of the North Carolina Medicaid lien. See Armstrong v. Cansler, 722 F.Supp.2d 653 (W.D.NC 2010). The federal trial court recognized that the North Carolina Supreme Court in Andrews v. Haygood had determined that the North Carolina Medicaid statute provided that North Carolina Medicaid was entitled to 1/3 of a Medicaid recipient’s settlement. Since the Arkansas statute reviewed in Ahlborn did not have such a limitation, North Carolina’s statute was different from the Arkansas statute, and thus, not a violation of Ahlborn. The federal Court agreed with the North Carolina Supreme Court rationalizing that since at least 2/3 of the settlement would be available to compensate a North Carolina Medicaid recipient for damages distinct from medical expenses, it was not a violation of Ahlborn. The federal trial court held that the full Medicaid lien must be paid because the Medicaid lien did not exceed 1/3 of the minor’s settlement.

The Forth Circuit Court of Appeals Over turned the trial court’s decision and wrote a very well-reasoned opinion. See E.M.A. ex rel. Plyler v. Cansler, 674 F.3d 290 (U.S. 4<sup>th</sup> Cir. 2012). The Forth Circuit disagreed with the North Carolina Supreme Court’s holding in Andrews v. Haygood and said “nothing in Justice Stevens’ [Ahlborn] opinion supports such a crabbed application of that decision.” The Fourth Circuit outlined that a statutory formula allocation makes no difference in the Ahlborn analysis if the amount

derived by the formula exceeds the amount recovered in past medical expenses. In this regard, the Court stated:

“Ahlborn is properly understood to prohibit recovery by the state of more than the amount of settlement proceeds representing payment for medical care already received. The North Carolina statute’s one-third cap on the state’s recovery against a Medicaid recipient’s settlement proceeds does not satisfy Ahlborn insofar as it permits DHHS to assert a lien against settlement proceeds intended (or otherwise properly allocable) to compensate the Medicaid recipient for other claims. *Id.* at 308

The Fourth Circuit then proceeded to agree with the Third Circuit’s *Tristani* decision by outlining that under Ahlborn a Medicaid recipient must be allowed to challenge a statutory default allocation judicially or administratively. The Fourth Circuit stated that “[I]n the event of a lump-sum settlement, as in this case, the sum certain allocable to medical expenses must be determined, in the absence of a stipulation by the affected parties, by judicial determination or some similar adversarial process, before the state may recoup its Medicaid outlays.” *Id.*

The Fourth Circuit remanded the case back to the trial court for a determination of the portion of the unallocated settlement representing compensation for past medical expenses.

### **C. North Carolina’s appeal of E.M.A. to the U.S. Supreme Court**

North Carolina appealed the Fourth Circuit’s E.M.A. decision to the U.S. Supreme Court. Surprisingly, while there is no conflict between the U.S. Circuit Courts (the Third and Fourth are in agreement), the U.S. Supreme Court granted cert. See Delia v. E.M.A. ex rel. Johnson, 133 S.Ct. 99 (Mem) (U.S. 2012)

The core question presented to the U.S. Supreme Court is whether under Ahlborn a State can have a statutory allocation of settlement proceeds that does not allow a Medicaid recipient to challenge the allocation through the court.

#### **Amicus Briefs have been filed by the following groups:**

##### **Supporting North Carolina:**

1. Amicus Brief for the National Governors Association, National Conference of State Legislatures, Council of State Governments, National Association of Counties, International City / County Management Association, National League of Cities, United States Conference of Government Finance Officers Association, and City of New York.

2. Amicus Brief of Texas, Alabama, Georgia, Hawaii, Idaho, Indiana, Michigan, Nebraska, New Mexico, Ohio and South Carolina.

**Supporting the Medicaid recipient E.M.A.:**

1. Amicus Brief of the Federation of Defense and Corporate Counsel.
2. Amicus Brief of the American Association for Justice and the North Carolina Advocates for Justice.
3. Amicus Brief of AARP and the Constitutional Accountability Center.
4. AMICUS BRIEF OF THE UNITED STATES!!!!
  - a. The United States through the DOJ / HHS filed an Amicus Brief in support of the Medicaid recipient advocating affirmance of E.M.A. This was a surprise since the United States in 2006 had filed an amicus brief in Ahlborn supporting Arkansas advocating full payment of Medicaid liens. The Amicus Brief filed by the United States in E.M.A. outlines that the federal government believes it is a violation of federal law and Ahlborn for North Carolina to have a hard-coat allocation formula that does not allow the Medicaid recipient to challenge the allocation formula through the court. The United States' amicus brief references the 2006 CMS Memo and reiterates that the CMS Memo was correct and states must comply with federal law as interpreted by Ahlborn. The United States amicus brief is well written and a wonderful move by the federal government. However, it does beg the question, If the United States believes North Carolina is violating federal Medicaid law, why doesn't the federal government withhold Medicaid funding until North Carolina (as well as the other violating States) bring their statutes and practices into compliance with Ahlborn? (probably political pressure from NC would prohibit this move)

Oral Argument was held before the United States Supreme Court on January 8, 2013. An Opinion from the Court is expected soon. This Opinion will likely "shut-down" many of the arguments routinely asserted by State Medicaid agencies against the application of Ahlborn. Next year this presentation will be titled "*Medicaid Third-Party Liability Liens Post-Delia*." Hopefully, there will be only good news to report.