WHAT DOES THE AHLBORN DECISION REALLY MEAN?
MEDICAID REIMBURSEMENT IN PERSONAL INJURY CASES AFTER
ARKANSAS DEP’T OF HEALTH & HUMAN SERVICES V. AHLBORN

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You have a catastrophically injured client who receives Medicaid benefits. You have settled the case. Due to liability issues or policy limit issues, you believe you’ve gotten your client about 20 cents on the dollar for his true damages. Medicaid wants the entire settlement because it has paid $100,000 more for the client’s medical expenses than you recovered. What now? Ahlborn is a decision capable of creating more confusion and pitfalls—for all involved—than any case in recent history. This article will help you decipher and apply the Ahlborn decision.

It appears that Monday, May 1, 2006, was a landmark day for plaintiffs’ rights in personal injury settlements. On that day the United States Supreme Court unanimously affirmed the Eighth Circuit’s decision in Arkansas Dep’t of Health & Human Services v. Ahlborn.² With this holding, a state’s Medicaid department will be limited to reimbursement from only that portion of a judgment or settlement that represents payment for medical expenses - states are now prohibited from seeking reimbursement for Medicaid costs from settlement proceeds that were intended to cover items other than medical expenses, such as pain and suffering and wage loss. The United States Supreme Court held that the federal anti-lien statute prevents states from attaching or encumbering the non-medical portion of the settlement or judgment.

In the slip opinion released May 1, 2006, the Court reasoned:

There is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care. So much is expressly provided for by §§1396a(a)(25) and 1396k(a). And we assume, as do the parties, that the State can also demand as a condition of Medicaid eligibility that the recipient “assign” in advance any payments that may constitute reimbursement for medical costs. To the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision. See Washington State Dept. of Social and Health Servs. v. Guardianship Estate of Keffeler, 537 U.S. 371, 383–385, and n. 7 (2003). But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn’s property. As explained above, the exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.”

(Emphasis added.)
So Where Are We Now?

In the United States Supreme Court’s own words, states may not demand reimbursement from portions of the settlement allocated or allocable to nonmedical damages; instead, states are given only a priority disbursement from the medical expenses portion alone. Prior to this ruling, for example, if an Arkansas Medicaid recipient settled his or her entire action against a third party for $20,000 and the state (Medicaid Department) paid that amount or more to medical providers on his or her behalf, nothing in the state statutes would preclude the state from receiving the entire settlement, leaving the recipient with nothing.

Because of the uncompromising collection/reimbursement practices in many states prior to Ahlborn, many plaintiffs’ attorneys may now—with Ahlborn in their quiver—be looking for, well, let’s just be honest and call it revenge. Perhaps the correct path forward, however, is to pause for a few moments, quietly reflect, and then tread carefully when trying to apply Ahlborn. I look at it like this—the atom has been split, but the plaintiffs’ bar has not yet built a stable weapon. If the plaintiffs’ bar becomes overly aggressive without a solid strategy, the Ahlborn decision leaves open the door for states to seek a political solution, including, a change in the state statutory framework that may force a favorable allocation for the state. Several state Medicaid Departments already have heeded the Supreme Court’s advice and the advice of The Centers for Medicare and Medicaid Services (a federal partner in the funding of state Medicaid programs) and turned to their state’s legislative branch to prevent their interest in a third party recovery from being, as they fear, “allocated away.”³ The Ahlborn victory could be short-lived.

I. Defining the Issues

Following a motor vehicle accident in which Ahlborn was seriously and permanently disabled, she applied and qualified for Medicaid benefits in the State of Arkansas. As a result of the accident, Medicaid paid approximately $215,645 for her care. Ahlborn received $550,000 as a result of her settlement with the third-party tortfeasor.

In order to receive Medicaid benefits, Arkansas law (like in other states) required Ahlborn to assign to the Arkansas Department of Human Services (ADHS) her “right to any settlement, judgment, or award” she might receive from third parties, “to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.” ARK. CODE ANN. § 20-77-307(a). Note the emphasis on the word “any”—Arkansas, like most states, takes the position that it gets the first bite of the apple regardless of the type of damages being paid by the tortfeasor. Accordingly, ADHS attempted to recover the total $215,645.30 it paid on her behalf based on the assumption that the settlement award ($550,000) was its property to begin with, and not Ahlborn’s.

In contrast to the overbroad state statute, the Eighth Circuit found that where a third party is liable for the cost of a Medicaid recipient’s health care, federal law assigns to the state plan “the rights of such individual to payment by any other party for such health care items or services.”⁴ As the emphasized language denotes, federal law narrowly defines (and limits) the assignment to the state as the right “to payment for medical care from any third party.”⁵ Thus, the Court found conflict between the Arkansas state law and the federal law.

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In resolving the conflict, the Eighth Circuit agreed with Ahlborn’s argument that 42 U.S.C. §1396p(a)(1) prohibited (with certain exceptions not applicable here) the imposition of a lien “against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan[.]” Under the statute’s implementing regulation, “property” is defined as “the homestead and all other personal and real property in which the recipient has a legal interest.” It is basic property law that a chose in action is personal property,” and that “the right to sue for damages is property.” Consequently, because Ahlborn had a legal interest in her right to sue, the court held that Ahlborn’s right to a settlement that may be received from a third-party tortfeasor (which, again, the Arkansas statute required her to assign to the state) was Ahlborn’s “property” and not that of ADHS. Thus, ADHS could only impose its lien on payments for medical care from any third party and could not enforce its lien on the entire settlement.

As a matter of law, the court found that federal law trumped the Arkansas state law in that: (1) an individual’s right to sue and subsequent settlement is the individual’s property and not that of the state Medicaid Department; and (2) that federal law only allows Medicaid to recover third-party payments made to compensate the beneficiary for medical care. In Ahlborn, ADHS was only able to enforce its lien upon $35,581.47, or one-sixth of the total amount that ADHS paid in medical expenses on Heidi Ahlborn’s behalf. As noted previously, Ahlborn had been seriously injured in an automobile accident. Medicaid paid $215,645 of her medical bills. She later settled her case for $550,000. Medicaid thereafter claimed that it was entitled to repayment of the $215,645 that it had paid out on her behalf. It was stipulated that Ahlborn’s claim was worth more than $3,000,000 and that her settlement constituted about one-sixth of that amount. The Eighth Circuit Court of Appeals, affirmed by the United States Supreme Court, held that Medicaid was entitled to only $35,581.47, and was ineligible to receive any part of the award that was to compensate Ahlborn for pain and suffering, lost wages, or loss of future earnings. The remaining portion of the $550,000 settlement was Ahlborn’s property.

Although the Eighth Circuit found in favor of the plaintiff, such a decision has not been uniformly accepted among all the circuits. For example, the Second Circuit held in the 1999 case of Sullivan v. County of Suffolk that:

As a Medicaid recipient, Sullivan assigned his right to recover from a third party to Department of Social Services [DSS], up to the amount of medical assistance provided. DSS was entitled to any rights that Sullivan had to the third-party reimbursement. DSS pursued its right to recover from a responsible third party by placing a lien on Sullivan’s lawsuit against that party. Because the lien attached directly to the tort settlement proceeds, the tortfeasor owes that money to DSS.

Essentially the court stated that Sullivan had no right to the proceeds prior to the DSS recovery of its lien, thus allowing the DSS to collect the entire value of its lien prior to Sullivan taking possession of any settlement funds.

The apparent split among the circuits forced the Supreme Court to hear the Ahlborn case and rectify any discrepancies in the law.
II. Does Ahlborn Apply to Medicare?

Arguments both for and against Ahlborn controlling similar cases involving Medicare reimbursement claims can be advanced.

Arguments Against Applying Ahlborn to Medicare—Differing Statutory Language

It can be argued that because Medicaid third-party liability provisions differ greatly from Medicare third-party liability provisions, Ahlborn should not apply to cases involving Medicare. Unlike Medicaid, the Medicare statute is not based on an assignment of rights—payments are made conditionally, and are subject to full recovery when a third-party payer is held to be responsible for Medicare-related services and items. In addition, Medicare is not limited to recovering only from the portion of a settlement that is allocated to health care items and services, nor does the Medicare statute contain an anti-lien provision. Glibly stated, the intent behind the Medicare Secondary Payer (MSP) legislation was not to protect Medicare beneficiaries from having to repay certain conditional payments made on their behalf.

When third-party liability is alleged, Medicare makes a payment conditioned on being reimbursed from any recovery from an insurance policy (including a self-insured plan) covering the liable third party. The MSP legislation does not limit The Centers for Medicare and Medicaid Services’ (CMS’s) right of reimbursement to its right of subrogation. The statutory framework provides CMS with an independent right of recovery against any entity that is responsible for the payment of, or that has received payment for, Medicare-related items or services. This independent right of recovery is separate and distinct from CMS’s right of subrogation and is not limited by the equitable principle of apportionment (from which the benefits of Ahlborn flow) stemming from the subrogation right. See Zinman v. Shalala, 67 F.3d 841 (9th Cir. 1995).

In Zinman, certain Medicare beneficiaries argued that because CMS is a subrogee, its recovery must be limited to the pro-rata share of an insurance settlement that includes payment for medical expenses. However, the right of Medicare to receive full reimbursement was upheld (even though a beneficiary receives a discounted settlement from a third party).

Holding that the right of Medicare to recover is not limited by the equitable principle of apportionment, the Ninth Circuit Court of Appeals reasoned:

It is clear from the statute that the references to “item or service” are intended to define the payments for which Medicare has a right to reimbursement. Nothing in this language, however, compels the conclusion that Congress intended to limit the amount of recovery for a conditionally paid “item or service” to a proportionate share of a discounted settlement. The beneficiaries’ reliance on 42 U.S.C. §§ 1395y(b)(2)(B)(i) and (ii) is misplaced.

The Ninth Circuit further stated:

[T]o define Medicare’s right to recover its conditional payments solely by reference to its right of subrogation would render superfluous the alternative remedy of the independent right of recovery contained in section 1395y(b)(2)(B)(ii). We decline to construe the statute in a way that would render clear statutory language superfluous.
In sum, the Ninth Circuit confirmed CMS’s position that MSP legislation allowed for the full reimbursement of conditional Medicare payments.

The only situation in which Medicare may recognize allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case. If the court or other adjudicator of the merits specifically designates amounts that are for payment of pain and suffering or other amounts not related to medical services, Medicare will accept the court’s designation. Medicare does not seek recovery from portions of court awards that are designated as payment for losses other than medical services—that has always been the rule. However, the allocation must be supported by a court order. As the court reasoned in Zinman:

[T]he injured victim alleged a variety of damages, some capable of precise computation, some not. Such allegations are not uncommon. [CMS’s] ability to recover the full amount of its conditional payments, regardless of a victim’s allegations of damages, avoids the commitment of federal resources to the task of ascertaining the dollar amount of each element of a victim’s alleged damages. . . . Apportionment of Medicare’s recovery in tort cases would either require a factfinding process to determine actual damages or would place Medicare at the mercy of a victim’s or personal injury attorney’s estimate of damages.

Because liability payments are usually based on the injured or deceased person’s medical expenses, liability payments are assumed/considered to have been made “with respect to” medical services related to the injury even when the settlement: (1) does not expressly include an amount for medical expenses; or conversely, (2) when the allocation is done by the parties absent an order or other adjudication on the merits. Absent a court order, any intellectual or legal arguments directed to the lead recovery contractor for Medicare might be met with the classic “huh?” or “what?” response. The Medicare Secondary Payer Recovery Contractor (MSPRC) holds the majority of the deck and, some would argue, display indifference because they are governed by a clear statutory framework. If thrown a curveball, the MSPRC might simply move your client’s file to the bottom of the stack and defer the matter until later. Thus, trying to use Ahlborn to assist in determining the amount of Medicare’s reimbursement is likely a dead end.

Arguments in Favor of Applying Ahlborn to Medicare—Similar Statutory Obligation and Purpose

Arguments in favor of applying Ahlborn to Medicare present the flip side of the statutory difference position noted above: Ahlborn should apply to repayment claims made by Medicare even though the statutory language differs from the Medicaid statute, because the basic elements of the reimbursement obligation are the same under all of the major government-funded health care programs. Medicaid, the Medical Care Recovery Act (MCRA), and the Medicare Secondary Payer Act (MSP) share a common legislative purpose—specifically, to ensure that the obligation to pay is secondary to the obligation of another plan of insurance when both are responsible for payment for medical care. All three provide their respective health care program with similar reimbursement rights to meet that purpose.
The MSP third-party liability provisions contain language that is similar to the language of the Medicaid Act that was interpreted in *Ahlborn* and the MSP repayment and enforcement provisions are similar to those of Medicaid:

A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this subchapter with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means...

Tort litigation has seen the application of MSP because in many situations a defendant has liability insurance to compensate victims for injuries that the defendant may have caused. When the primary insurance plan (i.e., the defendant’s liability policy) is not expected to be able to pay promptly (possibly because liability has not been established), Medicare may pay for the medical items and services for the victim, subject to a right of reimbursement. MSP allows the government to waive any provision of the Act when it is determined that “waiver is in the best interests of the program.”

In addition, under both statutes—Medicaid and MSP—the government’s repayment rights are limited to medical costs, while the injured party’s right to recover for other damages remains intact:

1. Medicaid: State assigned “rights . . . to payment for medical care from any third party”
2. MSP: Reimbursement from primary plans having “responsibility to make payment with respect to such item or service”

Thus, while the common goal of both statutes—having the government be the payer of last resort (to keep government health care costs as low as possible) rather than the primary payer—should be noted, it can be argued that these statutes construe the reimbursement obligation narrowly to just the medical costs recovered by the plaintiff.

III. Does *Ahlborn* Apply to Private Health Insurance / ERISA Liens?

The reasoning applied by the Supreme Court in *Ahlborn* was based primarily upon the Social Security Act’s anti-lien provision. Because that body of law applies only to governmental healthcare, and not employee health plans or private insurance, the decision likely cannot be directly applied to other forms of subrogation. This is the position of several recent federal court rulings, including one from the Eighth Circuit in the case of *Administrative Committee of Wal-Mart Stores v. Shank*. In that case, Wal-Mart’s ERISA plan demanded an injured employee’s entire net personal injury settlement to satisfy its lien. The lien in question satisfied all other enforceability requirements, leaving only the argument that the principles of *Ahlborn* should be applied to reduce Wal-Mart’s lien and leave Shank with the remainder of the settlement as compensation. Unfortunately, the Court disagreed and found that because *Ahlborn* was specific to Medicaid and the Social Security Act, it had no application to ERISA. The Court did not believe that ERISA contained a provision requiring the application of *Ahlborn*’s principles to ERISA liens. The Court therefore ruled that the lien must be enforced in full – awarding the entire net settlement to the Wal-Mart ERISA plan. Similar conclusions have recently been reached in the Western District of

This result does not necessarily mean that ERISA liens should not be subject to pro rata reduction. ERISA recovery must, by the Act’s own language, be founded upon “appropriate equitable relief” (29 USC 1132(a)(3)). The meaning of that phrase and whether it may entail equitable reduction of ERISA liens where appropriate is still a relatively new and open question among the courts. However, it appears that the Ahlborn decision will likely not play a role in that discussion, as its basis lies too heavily in interpretation of the Social Security Act. If pro rata reductions are going to be universally applied to ERISA as they are now to Medicaid, it will have to be the result of precedent that is more specific to ERISA itself.

IV. Practical Considerations In Applying Ahlborn

While attempts to apply Ahlborn to Medicare reimbursement claims and private health insurance / ERISA liens might result in a dead end, the Ahlborn decision absolutely requires the state Medicaid tort recovery departments to change their practices. This isn’t news to them - the agencies are aware that a change is necessary and they have received guidance from The Centers for Medicare and Medicaid Services (CMS), their federal partner in Medicaid funding, accordingly. As the memo makes clear, “A State’s lien laws may 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”. In its Ahlborn decision, the U.S. Supreme Court went so far as to direct the states to “get involved” to avoid having their interest allocated away.

Agencies, unfortunately, do not yet have the resources available to make the requisite changes and have struggled to find a standardized approach that conforms to the Supreme Court’s May 2006 mandate. The struggle is largely due to the fact that, to some extent, Ahlborn is an anomaly – How often have you seen the defendant voluntarily stipulate to the full value of damages? Further, do you think any defendant will readily do so again? The lack of a “stipulation” of damages in your cases makes it difficult to apply the Ahlborn decision: 1) In footnote 9 of its decision, The Supreme Court acknowledged that the effect of the stipulation is the same as if a trial judge had found that Ahlborn’s damages amounted to $3,000,000, but because of her contributory negligence she could only recover 1/6 of the damages (emphasis added); and 2) In footnote 11, the Court noted that “[g]iven the stipulation between ADHS and Ahlborn, there is no textual basis for treating the settlement here differently from a judge-allocated settlement or even a jury award” (emphasis added). These emphasized points are important and are the cause of many problems between the state / territory Medicaid agencies and plaintiffs’ attorneys. Without clear guidance on ‘how to get there’ by voluntarily agreement, the agencies and plaintiffs bar have struggled to get their heads around how to apply the decision in a factual and rational manner without involving the court. In this regard, the plaintiff bar must help. The balance of this article shares this author’s experience in working to resolve Medicaid liens, post Ahlborn, in all 50 states and the territories. The Garretson Law Firm has a practice group solely dedicated to assisting the plaintiff bar in evaluating and resolving Medicare and Medicaid reimbursement claims / liens in personal injury and mass tort settlements.
In the introduction to these materials, I encouraged the reader to be cautious before implementing any strategy. As practitioners form their game plans, several fundamental tenets must be embraced: (1) states are not going to sit idly by and allow parties to negotiate away their interest; (2) defendants are not likely to cooperate in allocating damages; (3) the courts are not any better prepared to “do the math” and, let’s face it, they are already over burdened; and, (4) you must show them all a reasonable path forward. In light of these realities, plaintiff’s counsel should consider the following.

1. Decide whether you are going to seek recovery for medical costs that are/have been paid by Medicaid and make this known in your pleadings. Simply trying to wordsmith away Medicaid’s interest is a slippery slope at best — According to this author’s analysis, 34 states already require plaintiffs’ counsel to notify the state of the recipient’s personal injury claim after being retained and/or before settling the claim. Many of these statutes create a duty in the attorney to determine if the state is paying the client’s medical bills. So, if you have that knowledge, it does not take a whole lot of creativity to imagine a scenario under which the state can take action against you and/or your client. Further, legislative changes post **Ahlborn**, like the recent change in the Pennsylvania Code, go so far as to proclaim the “beneficiary generally recovers the Department’s expenses as part of his tort claim unless the Department chooses to intervene in an action to sue separately.”

2. Notify the Medicaid agency involved that you will be attempting to recover the full array of tort-related damages, which may include past medical expenses. Request a summary of the agency’s injury-related expenses, noting that all tort-related damages will be fairly allocated, consistent with the **Ahlborn** decision, between the injured party and the Medicaid agency.

3. Before trying to apply **Ahlborn**, first try to demonstrate to the state that it is not cost effective for them to pursue the full value of their lien. According to the memorandum from CMS referenced above, “[t]he States may use the “Cost Effectiveness” criteria set forth in Section 1902(a)(25)(B) of the Social Security Act to determine that it is not “cost-effective” to pursue its direct right of recovery against the potentially liable party”. As such, the state may determine that it is more cost-effective to pursue a lesser amount than the full cost of care in order to avoid litigation. Before **Ahlborn**, the Medicaid claim had priority to all proceeds; therefore it was insulated, in some degree, to the risks involved in a trial/hearing vs. settlement analysis. Now it does matter. Thus, according to CMS, the State may “pursue a reduced claim to the extent that it is cost-effective to do so.”

4. If a satisfactory result cannot be achieved through the cost-effectiveness analysis, attempt to reach an agreement with Medicaid regarding the allocation of the settlement. To get off home plate, you must start with the assumption that medical payments are part of the client’s recovery and attempt to agree on one of the allocation methodologies articulated below. (While at first blush there could be as many interpretations of **Ahlborn** as there are state and territory Medicaid tort recovery units, this author, as discussed below, has begun to recognize a few consistently successful methodologies).

Prior to diving into the methodologies, recall the key points from the **Ahlborn** decision: a) only the portion of the personal injury settlement or award specifically allocated to compensate the plaintiff (Medicaid recipient) for past medical expenses arising out of the injury is available to satisfy a lien; b) any portion allocated to compensate the plaintiff Medicaid recipient for pain and
suffering, lost wages, and other non-medical damages is not available to satisfy a lien; and, c) to the extent that the claimed lien amount exceeds the portion of the personal injury settlement or award specifically allocated to past medical expenses, Medicaid’s recovery of the lien consequently will be limited to this “cap”.

**Allocation Methodologies**

To no one’s surprise, attempts to apply this monumental decision have resulted in significant chaos and backlogs at the Medicaid tort recovery departments throughout the country. Arguably the state (and territory) agencies, plaintiff bar and court systems did not have the resources or direction necessary to react efficiently, uniformly and/or productively to *Ahlborn*.

During the nine months of turmoil immediately following the *Ahlborn* decision, this author’s firm (through interaction with the various state agencies) has observed and recorded dozens of distinctive attempts - some successful, some not - to apply the decision to settled cases. In this author’s opinion, all of the successful approaches appear to fit into one of three broad categories. To foster uniformity and consistency, The Garretson Law Firm coined some nomenclature for these emerging methodologies: Proportionate Value / Adjusted Allocation™ (PVAA), Proportionate Value / Adjusted Lien™ (PVAL), and Equitable Apportionment (EA).27 The Garretson Law Firm also is working to refine and promote an additional methodology that better recognizes the “weighting” in favor of non economic damages (as opposed to economic damages) in settlements where the actual recovery has been limited due to policy limits rather than comparative fault and / or contributory negligence.

a. **Proportionate Value / Adjusted Allocation™ (PVAA)**

- **Step 1:** Total Damages – The first step is to determine the total damages that could be black-boarded at trial. In making this calculation, do so as if causation and liability were not a factor. **Example:** There is a $350,000 settlement. After identifying all damages based on economic reports and/or life care plans (all the typical tools that attorneys use to show defendants what the full measure of harm is/was), the plaintiff’s attorney can black-board that a reasonable full value of damages is $1,000,000. (In determining full value, it is critical that you substantiate the number with a rationale relationship to similar cases and that it is consistent with your pleadings, demand package and other correspondence with the defendant). However, due to policy limits and/or comparative fault/contributory negligence, the parties settled for $350,000.

- **Step 2:** What Percentage are past medical expenses of the total damages? Determine the percentage of the total damages which are comprised of past medical losses (as opposed to other losses such as pain and suffering, disfigurement, future medical expenses, lost wages, derivative losses, and so on). In completing this step, determine whether in your state you could claim at trial the actual medical expenses billed by the providers of care instead of the actual medical expense paid by Medicaid to the providers (the paid amount is often 30% to 50% of the amount billed by the providers). Utilizing actual expenses paid by Medicaid to providers as opposed to actual medical expenses billed by providers would greatly reduce the ratio of past medical expenses to the total black-board damages. Medicaid will want you to use the same “rates” (i.e., what providers billed versus what providers were paid) in both your calculation of total damages (if using billed rates is allowed in your state to prove damages at trial) and your calculation of the percentage of past medical expenses. **Example:** The medical providers billed Medicaid a total expense
of $200,000 for the injury-related care, or 20% of Total Damages. The payments to medical providers by Medicaid were $100,000, or 10% of Total Damages.

- Step 3: Determine the initial allocation. Next, apply the appropriate past medical expenses percentage from Step 2 to the actual recovery by your client to determine the initial allocation to past medical expenses in your settlement. Example (using paid rate): Under Step 3, the initial allocation, based upon the “Paid Rate”, is 10% of $350,000 (i.e. $35,000).

- Step 4: Adjust initial allocation to account for state’s proportionate share of attorney fees and case costs. After calculating the actual attorney fees and case costs, multiply that sum by the appropriate past medical expenses percentage from Step 2. Deduct that quotient from the initial allocation in Step 3 to yield the adjusted past medical expense allocation. This further offset is done to recognize the proportionate sharing of fees and case costs (“procurement costs”) if your applicable state Medicaid recovery statute allows for such offset to be made to a claimed Medicaid lien. Such statutes vary from state to state with some states allowing a full offset, some allowing a partial offset and some allowing no offset at all. Example: Attorney fees and case costs totaled $150,000 (of the $350,000 settlement). If we multiply that amount by 10% (from Step 2, using “paid rate”), we yield $15,000. If that amount is now deducted from the corresponding initial allocation of $35,000 (from Step 3), we yield $20,000 for the adjusted allocation.

- Step 5: Satisfy lien within the adjusted medical expense allocation. The state only can satisfy its claimed lien (i.e. injury-related expenditures) from the adjusted allocation determined in Step 4. To the extent that the claimed lien amount exceeds the adjusted allocation from Step 4, the Medicaid department’s recovery of the lien consequently will be reduced (i.e. they only can get up to the adjusted allocation amount from Step 4). Example: While the state’s lien is for $100,000, their recovery is capped at $20,000.

b. Proportionate Value / Adjusted Lien™ (PVAL). The primary difference between this second methodology and the first methodology is the manner (and timing) in which attorney fees and case costs (“procurement” expenses) impact the claimed lien.

- Steps 1 thru 3 are identical to the first methodology (Proportionate Value / Adjusted Allocation (PVAA)). There is a $350,000 settlement. After identifying all damages based on economic reports and/or life care plans, the plaintiff’s attorney can black-board that reasonable full damages are $1,000,000 (Step 1). (As stated above, it is critical that you substantiate the “full value” number with a rationale relationship to similar cases and that it is consistent with your pleadings, demand package and other correspondence with the defendant). However, due to policy limits and/or comparative fault/contributory negligence, the parties settled for $350,000. Example (using paid rate): The payments to medical providers by Medicaid were $100,000, or 10% of Total Damages. Under Step 3, therefore, the initial allocation, based upon the “Paid Rate”, is 10% of $350,000 (i.e. $35,000).

- Step 4: Adjust the claimed lien by the percentage allowed by your state Medicaid recovery statute to account for state’s proportionate share of attorney fees and case costs (i.e. determine the amount of attorney fees and case costs – What percentage is that amount of the actual gross settlement recovered by your client?). Example: Attorney fees and case costs totaled $150,000. The actual gross settlement recovered by the client is $350,000. The state’s claimed lien is $100,000. Assume your state statute allows the
claimed lien to be fully offset by procurement costs. $150,000 (fees/costs) is 43% of $350,000 (gross settlement). The claim lien of $100,000 is therefore reduced by 43%, yielding an adjusted lien of $57,000 (i.e. $57,000 is the claimed lien amount adjusted by cost of procurement).

- **Step 5**: Satisfy adjusted lien within the medical expense allocation. The state only can satisfy its “adjusted” claimed lien (i.e. injury-related expenditures reduced proportionally by procurement expenses) from the appropriate initial allocation determined in Step 3 (recall discussion regarding “billed rates” vs. “paid rates”). To the extent that the adjusted claimed lien amount (Step 4) exceeds the initial allocation from Step 3, the Medicaid department’s recovery of the lien consequently will be reduced or capped (i.e. they only can get up to the initial allocation from Step 3). **Example**: While the state’s adjusted lien is for $57,000, their recovery is capped at $35,000.

c. **Equitable Apportionment (EA)**. This third methodology is a fallback when the plaintiff and the state cannot agree on the allocation of the damages (between past medical expenses and other damages) pursuant to the first or second methodology above. For instance, in *Ahlborn* the parties stipulated to the full value of the case, but never engaged in substantive discussion concerning the true allocation or proportion of past medical expenses.

- **Steps 1 and 2** are identical to the methodologies listed above. **Example**: There is a $350,000 settlement. After identifying all damages based on economic reports and/or life care plans, the plaintiff’s attorney can black-board that reasonable full damages are $1,000,000 (Step 1). (As stated above, it is critical that you substantiate the “full value” number with a rationale relationship to similar cases and that it is consistent with your pleadings, demand package and other correspondence with the defendant). However, due to policy limits and/or comparative fault/contributory negligence, the parties settled for $350,000.

- **Step 3**: Determine equitable apportionment. Next, determine what percentage the actual recovery is of the total damages. Alternatively stated – What percentage of the full value of the case did plaintiff actually recover? **Example**: Plaintiff actually recovered $350,000.00. The full value of the case is $1,000,000. Plaintiff recovered 35% of the full value of the case.

- **Step 4**: Adjust the claimed lien by the equitable apportionment percentage. **Example**: The payments to medical providers by Medicaid were $100,000. The lien should be reduced by the equitable apportionment percentage calculated in Step 3. The adjusted lien amount therefore is now $35,000.

- **Step 5**: Satisfy lien within the “claimed lien adjusted by equitable apportionment percentage”. The state only may get the claimed lien adjusted by the equitable apportionment percentage (determined in Step 4). To the extent that the actual lien amount exceeds this adjusted lien number (Step 4) the Medicaid department’s recovery of the lien consequently will be reduced or capped.
5. If the parties are unable to come to an agreement, you may be left to seek a court order allocating the settlement among the different categories of damages.\textsuperscript{28} Perhaps the threat of a court hearing alone will provide the impetus to successfully reaching a negotiated allocation. This author believes that states are loath to participate in post-settlement allocation hearings because those hearings are not in the state’s best interest. Participating as the state in a hearing in front of a judge where you (the state) appear adverse to a brain-injured child in a wheelchair is a loser’s game. Most judges will be more sympathetic to the injured party in that context. Furthermore, the states fear establishing adverse precedence. Further, litigation requires a state to exhaust even more of its scarce resources. The costs and risks of leaving its fate in the hands of the court may bring the Medicaid agency to the table to discuss allocation along the lines of the methodologies outlined above.

\textbf{Consider the Counter Points} – From the states’ perspective, they are not going to ask the same questions every time. In this author’s experience, many states will first try to examine the third party’s liability for the medical costs instead of whether the settlement amount covers all damages. In some cases, liability and causation may not be disputed but the amount of future damages is disputed. In those cases, the state’s position may be that it is entitled to full reimbursement of its past medical expenses. In other cases, where comparative negligence is at issue, some states have been more willing to reduce their claim in proportion to the recipient’s negligence on the basis that the reimbursement is based on the third party’s liability for the medical costs. In this respect, from the states’ perspective, the controlling language in \textit{Ahlborn} is “interpretation of the text of these statutes demonstrates that the federal statutory scheme requires only that the State recover payments from third parties to the extent of their legal liability to compensate the beneficiary for medical care and services incurred by the beneficiary.”

If the only alternative is a court hearing, the procedural mechanism is already in place in cases involving minors or incompetents. But what do you do about cases involving a competent adult that are not in litigation? The best recommendation this author has is:

\begin{itemize}
\item a. Ask the appropriate court (e.g. the court in which you would have filed a complaint against the defendant) for a hearing on the allocation of damages; or,
\item b. The plaintiff (ex parte) or parties (by joint stipulation) could move the court, prior to finalizing the settlement agreement, to establish a 468B Qualified Settlement Fund (QSF)\textsuperscript{29} and ask the court to appoint a neutral fund administrator (perhaps even the mediator from the case or a respected member of the bar) to make a reasonable allocation of damages.
\item c. Ask the court or fund administrator to apply one of the three allocation methodologies articulated above.
\end{itemize}

The suggestions outlined above appear to be supported by the Supreme Court’s opinion in \textit{Ahlborn}. The Court addressed the “risk-of-settlement-manipulation” argument raised by the Arkansas Department of Human Services (as well as by ADHS’ amicus in support) by reasoning that, “the risk that parties to a tort suit will allocate away the state’s interest can be avoided by either obtaining the state’s advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision.”\textsuperscript{30}
If counsel and Medicaid departments are able to establish rapport and dialogue, and if they both accept the rationale of the United States Supreme Court in *Ahlborn*, including the adoption of one of the three methodologies articulated above or another fact-driven alternative, then court orders may not be needed. But let’s not be overly Pollyanna-ish—both sides are called to advocate fiercely for their clients in any context in which they engage in allocation discussions. In this regard, there may be instances where the only solution is to seek guidance from the court.

V. Conclusion

I introduced this article with the rather alarming statement that “*Ahlborn is a decision capable of creating more confusion and pitfalls than any case in recent history.*” I base that proposition on the fact that every effort to build damages on the front-end of a Medicaid beneficiary’s case may negatively impact the client’s net recovery on the back-end. Plaintiffs’ counsel must be prepared to deal with the following, as the department likely will not roll over on your construction of the “allocation” at the time of settlement.

1. Medicaid will place the onus on you to prove up your numbers. Keep in mind that the state clearly knows what its damages are. States will want to see your complaint, your life care plan, economist’s report, and other medical records to see whether your allocation analysis on the back-end of the case is in line with what you have tried to plead and prove from the beginning. The state is looking for something other than your own experience to support an unusual general damage proportion.

2. The state may be more proactive in pursuing a recovery directly from the third party, as many state statutes allow. If so, the state is likely to obtain all your correspondence with the defendant about your client’s case.

3. In light of the above possibilities, crafty defense attorneys may begin playing Medicaid, you (the plaintiff counsel) and the Medicaid recipient (your client) off of each other, ultimately creating a rift between plaintiff’s counsel and Medicaid that will hinder the ability to have a meaningful discussion regarding allocation on the back-end of the case.

4. Defendants have little incentive to cooperate with you on the back-end of the case. If they are perceived by the state as participating in a process that “allocates away” the state’s interests, the state likely will become more aggressive in chasing defendants directly.

5. As is typical in disputes with the government, the states may soon reacquire the upper hand through legislation. Many state Medicaid departments have sought or currently are seeking to ensure that their respective statutory framework dictates that no settlements occur without Medicaid’s official “signoff.” In Utah, for instance:

   A recipient may not file a claim, commence an action, or settle, compromise, release, or waive a claim against a third party for recovery of medical costs for an injury, disease, or disability for which the department has provided or has become obligated to provide medical assistance, *without the department’s [of Health] written consent . . . .* 32
The instructional memorandum from CMS to the states referenced above certainly directs all states to consider adopting such legislation that defines judicial procedures and settlement standards in state courts. For example, the memo suggests that states could enact laws which give priority to the repayment of medical expenses, which provide for a specific allocation amongst damages (i.e. pain and suffering, lost wages, and medical claims) and only permitting the compromising of a claim with the State’s consent.\textsuperscript{33} To this end, the 2007 amendments in Oklahoma, for instance, are telling – They read “\textit{Damages for medical costs are considered a priority over all other damages and should be paid by the tortfeasor prior to other damages being allocated or paid.”}\textsuperscript{34}

The United States Supreme Court has clarified to whom the pot of settlement money belongs. Now, it is up to plaintiff’s counsel to focus on a stable allocation strategy. Certainly you should advocate as zealously as possible for your client. Further, ABA Model Rule 1.1 addresses the cause-and-effect issues articulated above (i.e., the impact that your pleading on the front-end of cases will have upon the net benefit to the Medicaid client on the back-end), stating that a lawyer “\textit{shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness and preparation reasonably necessary for the representation.”} Against this benchmark, clients who are Medicaid recipients reasonably will expect counsel not only to advocate for the substance (the dollar amount) but the “form-of-settlement” (the allocation) as well.

In this endeavor, I believe we do not want to implement a process that benefits our current clients while the states are reeling to figure out how to equalize the balance of power—which they will—and leaves such discord in the wake that states will be difficult to work with when they level the field (if not obtain the upper hand). With the risk of being histrionic, I analogize the path forward to the “Mutually Assured Destruction” game theory I recall from the cold war era: Certain behaviors or choices are deterred because they will lead to the imposition by others of overwhelming punitive consequences. At times, rational self-interest hurts everyone.

\begin{flushleft}
\textsuperscript{1}Matt Garretson, B.A., Yale University; J.D, Northern Kentucky University’s Salmon P. Chase College of Law, founded The Garretson Law Firm (Cincinnati, Ohio), which provides mass tort/class action settlement allocation and fund administration services. His firm also assists lawyer-clients with a variety of Medicare & Medicaid issues, including resolving reimbursement claims, preserving benefits and managing custodial accounts. Mr. Garretson is the President of The Settlement Services Group, which provides structured settlement and settlement-related trust services. He is a frequent speaker at CLE seminars about lawyers’ professional responsibilities in individual and mass tort settlements and has recently authored a legal text book published by ATLA/West Publishing entitled Negotiating and Settling Tort Cases. In addition, he has published several articles and law journals on this topic. He is an adjunct professor at Salmon P. Chase College of Law, where he teaches law practice management and emphasizes how to avoid professional liability claims. He is the special master and/or administrator of settlement funds throughout the country. His role in numerous high profile church-related sexual abuse and civil rights settlements contributed to his selection by Lawyers Weekly as 1 of 5 “Lawyers of the Year” in Ohio for 2003 and 2006. He is a member of ATLA’s Leaders Forum.


\textsuperscript{3}At the time of revising this article (October 1, 2007), the author is aware of legislative changes or attempts at such change, in CA, KY, OK and PA. Pennsylvania’s policy statement appears to be the most
\end{flushleft}
comprehensive Medicaid effort. They have issued a policy statement which amends Title 55 of the Pennsylvania Code, Chapter 259. The statement explains how the Department will interpret and apply the requirements of 62 P.S. §1409(b) to be consistent with the *Ahlborn* decision. Pennsylvania believes their existing law is facially consistent with *Ahlborn*. Therefore, the statement of policy is to formally document the Department’s interpretation and establish procedures. The policy announces that §1409(b)(11), which limits the Department’s reimbursement to one-half of the beneficiary’s net recovery, is consistent with *Ahlborn*. Other parts of the statement seem to be directed at arguments presumably presented by attorneys to the Department in the aftermath of *Ahlborn*. Specifically, that the Medicaid “beneficiary generally recovers the Department’s expenses as part of his tort claim unless the Department chooses to intervene in an action of sue separately.” This statement precludes attorneys from arguing that medical expenses were not considered in the settlement, therefore, barring the Department’s recovery under *Ahlborn*. Additionally, the state has effectively inhibited “equitable apportionment” arguments. The policy asserts that under Pennsylvania law a settlement conclusively establishes the settlement as full compensation for damages. Other state efforts have been aimed at ensuring that the Medicaid Department is included in settlement negotiations involving Medicaid beneficiaries. On October 1, 2007, Oklahoma amended §5051.1 “Recovery from Tortfeasors of amounts paid for medical expenses of injured and diseased persons – Liens or other legal actions” in pertinent part (A.1) to read “Damages for medical costs are considered a priority over all other damages and should be paid by the tortfeasor prior to other damages being allocated or paid . . . .” and (D.1.d) to say that the lien authorized by this subsection shall “be applied and considered valid as to the entire settlement, after the claim of the attorney or attorneys for fees and costs, unless a more limited allocation of damages to medical expenses is shown by clear and convincing evidence.” Earlier this year, Kentucky unsuccessfully attempted to pass a law requiring the Department to approve settlements involving Medicaid beneficiaries. And, California has proposed adding a trailer to §14124.72(d) to avoid settlement manipulation.


5Id. § 1396k(a)(1)(A) (emphasis added).

6Id. § 1396a(a)(25)(H).


9Sullivan v. County of Suffolk, 174 F.3d 282, 286 (2d Cir. 1999).


11This conditional payment and Medicare’s right to reimbursement from the beneficiary’s settlement proceeds can be found at 42 U.S.C. § 1395y(b)(2).

12The rules that govern how this statute operates can be found in Title 42 C.F.R. § 411.20. The Centers for Medicare and Medicaid Services (CMS) has a right of action to recover its payment from any entity, including a beneficiary, provider, supplier, physician, attorney, State Agency, or private insurer that has received a third-party payment. 42 C.F.R. § 411.24(g). If the beneficiary or other party received a third-party payment, the beneficiary or other party must reimburse Medicare within 60 days. *Id.* § 411.24(h). If Medicare is not reimbursed as required by Section 411.24(h), the third-party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party. *Id.* § 411.24. If a third-
party payer learns that the CMS has made a Medicare primary payment for services for which the third-party payer has made or should have made primary payment, it must give the CMS notice to that effect. \textit{Id.} § 411.25.


\footnote{The \textit{Ahlborn} decision essentially reinforced the notion that the right of subrogation is equitable in nature and generally requires application of the equitable principle of apportionment. Under this equitable principle, a subrogated right holder is limited to recovery of the proportion of its loss for which third-party reimbursement is actually received. \textit{See} Zinman v. Shalala, 67 F.3d 841, 844 (1995) (referring to APPLEMAN’S \textit{INSURANCE LAW & PRACTICE} § 4054 (1990)).}

\footnote{\textit{Id.} at 845.}

\footnote{Or perhaps an order by the administrator of a Qualified Settlement Fund.}

\footnote{\textit{Ahlborn}, 126 S. Ct. at 1756.}

\footnote{Applicable where the United States has paid for the medical care of persons in the military, their dependents, or retired veterans. MCRA § 2651(a) states:}

\begin{quote}
In any case in which the United States is authorized or required by law to furnish or pay for hospital, medical, surgical, or dental care and treatment . . . to a person who is injured or suffers a disease . . . under circumstances creating a tort liability upon some third person . . . to pay damages therefore, the United States shall have a right to recover (independent of the rights of the insured or diseased person) from said third person, or that person’s insurer, the reasonable value of the care and treatment . . . and shall as to this right be subrogated to any right or claim that the injured or diseased person . . . has against such third person to the extent of the reasonable value of the care and treatment . . . The head of the department or agency of the United States furnishing such care or treatment may also require the injured or diseased person . . . to assign his [or her] claim or cause of action against the third person to the extent of that right or claim.
\end{quote}

In order to recover under the MCRA, the government may intervene or join in any action brought by an injured person, or may bring its own action against a responsible third party. 42 U.S.C. § 2651(d). The statute also authorizes the government to “compromise or settle and execute a release of any claim that the United State has by virtue of the right to established by § 2651” or to “waive any such claim, in whole or in part, for the convenience of the Government, or if [it is determined] that collection would result in undue hardship upon the person who suffered the injury or disease resulting in care or treatment.” \textit{Id.} § 2652(b).

MCRA also shields the injured individual, expressly stating: “No action taken by the United States in connection with the rights afforded under this legislation shall operate to deny to the injured person the recovery for that portion of his [or her] damage not covered hereunder.” \textit{Id.} § 2652(c).

\footnote{\textit{Id.} § 1395y(b)(2)(B)(ii).}
21Similarly, MCRA: “Right to recover . . . the reasonable value of the care and treatment.”

222007 WL 2457664 (8th Cir. Aug. 31, 2007)

23Memorandum from Gale Arden, Director of CMS's Center for Medicaid and State Operations Disable and Elderly Health Programs Group (DEHPG), to all Associate Regional Administrators for Medicaid and State Operations, "State Options for Recovery Against Liability Settlements in Light of U.S. Supreme Court Decision in Arkansas Department of Human Services v. Ahlborn" (July 3, 2006),

24Ahlborn, 126 S. Ct. at 1765.

25Policy statement amending Title 55 of the Pennsylvania Code, Chapter 259. The statement explains how the Department will interpret and apply the requirements of 62 P.S. §1409(b) to be consistent with the Ahlborn decision. Pennsylvania believes their existing law is facially consistent with Ahlborn. Therefore, the statement of policy is to formally document the Department’s interpretation and establish procedures.

26Arden Memorandum at p. 5.

27In order to help create and promote standardized protocols and nomenclature, The Garretson Law Firm has “trademarked” the first two of these methodologies. The intent is not to preclude attorneys from employing these lien resolution methods, but rather to allow our firm to be the “keeper of the math” associated with the protected name. In this regard, all parties involved can have confidence that an agreement with the state to use any of these methods will produce consistent results.

28Should the government claim a right of priority reimbursement and ignore the notion of allocation, be prepared to argue that such a position is inconsistent with the Supreme Court’s holding in Ahlborn

29Designated Settlement Funds (DSFs) came into existence when the United States Tax Reform Act of 1986 inserted § 468B into the Internal Revenue Code. This section established a safe harbor by spelling out terms under which the defendant in a tort claim may make qualified payments into a designated settlement fund and be certain that the Internal Revenue Service will deem economic performance to have occurred. This is important to the defendant and his or her insurers because the payment cannot be deducted until there has been economic performance. I.R.C. § 461(h). QSFs were created by regulations relating to § 468B, which became effective on January 1, 1993. Treas. Reg. § 1.468B-1. Comparing the requirements of a DSF and a QSF reveals that a QSF is not restricted to tort claims. Neither a DSF nor a QSF can be used in relation to Workers’ Compensation claims. Although there are some additional differences between a DSF and a QSF, they actually operate very similarly. Generally speaking, the regulations issued under § 468B apply the § 468B statute to a broader range of settlement funds. Henceforth, these materials will refer generically to a “468B Fund.” QSFs can introduce a degree of “breathing space” to a settlement that can prove uniquely valuable in the following ways: i) allocating the settlement proceeds among the types of damages and/or claimants; ii) verifying and negotiating liens and/or subrogation claims; iii) determining the appropriate role and underwriting of a structured settlement annuity; iv) evaluating the need to preserve governmental entitlement benefits (e.g., the need for the establishment of a special needs trust); and v) a host of other decisions which can best be made without the pressure associated with the litigation itself. (This breathing space is made available because,
while temporarily parked in the 468B, the assets are not “constructively received” by any claimant, as that doctrine is set forth in Treasury Regulation §1.451.2).

30 Ahlborn, 126 S. Ct. at 1756.

31 UTAH CODE ANN. § 26-19-5(1)(a), for instance, states that “When the department provides or becomes obligated to provide medical assistance to a recipient that a third party is obligated to pay for, the department may recover the medical assistance from the third party.” As such, the state can either wait until the plaintiff recovers and assert its traditional right of subrogation (subject, of course, to the Ahlborn limitations), or the state can pursue the action directly against the tortfeasor.

32 UTAH CODE ANN. § 26-19-7(1)(a) (emphasis added).

33 Arden Memorandum at p. 3.

34 See Oklahoma amended §5051.1 (A.1)