Cincinnati Law Library News

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What Does the *Ahlborn* Decision Really Mean?

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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.*

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,* holding that 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.[1] States are now prohibited from seeking reimbursement for Medicaid costs from settlement proceeds that were intended to cover items other than medical expenses.

The 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 Court's own words, states may not demand reimbursement from portions of the settlement allocated or allocable to non-medical damages. Instead, states are given only a priority disbursement from the *medical expenses* portion alone. Prior to *Ahlborn*, 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.

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March 1 Renewal

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Tech Tip: Saving a Lexisnexis Case in PDF

Julie Koehne, Assistant Law Librarian

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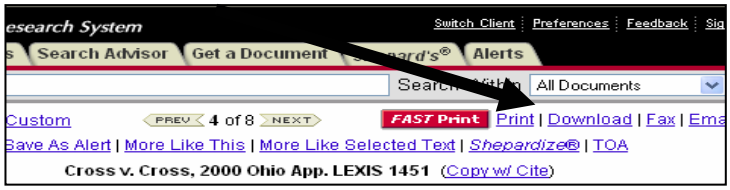

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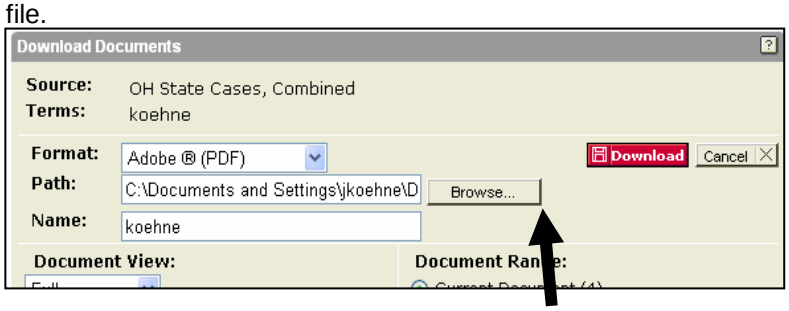

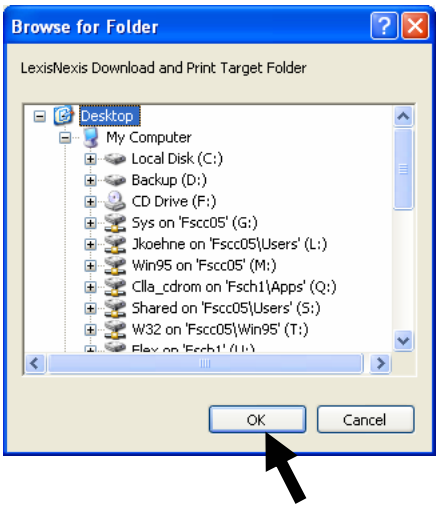

To save the file to a specific place, click on the Browse... button. This allows you to set the **Path** in order to save it to your flash drive (often **E:**) or on the computer. When using the computers in the Law Library, we recommend saving the file to the **Desktop** to make locating and attaching your file to an e-mail easier.

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Spotlight On: Wireless Resources

David Whelan, Law Librarian

The Law Library has offered free "wi fi" wireless access to its members since 2004. We now have members using laptops, wireless PDAs, and even Sony Playstations on the wireless network.

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Figure 1: Sony Playstation Portable (PSP)

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Got wireless? Get on the network and get more out of your membership, and your time spent at the courthouse!

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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,* I believe the *Ahlborn* decision leaves open the door for states to seek a political solution, including, perhaps, a change in the state statutory framework that may force a favorable allocation for the state. 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."[2] 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 the tortfeasor paid. Accordingly, ADHS attempted to recover the total paid on her behalf, based on the assumption that the settlement award 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*."[3] 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."[4] Thus, the Court found the Arkansas state and federal laws conflicted.

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."[5] It is basic property law that a "chose in action is personal property," and that "the right to sue for damages is property."[6] Consequently, because Ahlborn had a legal interest in her right to sue, the court held that Ahlborn's right to a settlement received from a third-party tortfeasor 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. [7]

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. 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, 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, not all the circuits accept uniformly such a decision. For example, the Second Circuit held in the 1999 case of *Sullivan v. County of Suffolk* that "[a]s 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."[8] 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 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 allocated to health care items and services, nor does the Medicare statute contain an anti-lien provision.[9] 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 reimbursement 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.[10] 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.[11] This independent right of recovery is separate and distinct from CMS's right of subrogation[12] and is not

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limited by the equitable principle of apportionment[13] (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 Ninth Circuit upheld the right of Medicare to receive full reimbursement (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 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.[14]

In sum, the Ninth Circuit confirmed CMS's position that MSP legislation allowed for full reimbursement of conditional Medicare payments.

The only situation in which Medicare may recognize allocations of liability payments to non-medical 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 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.[15] 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.[16]

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 a lead contractor for Medicare might be met with the classic "huh?" or "what?" response. Those contractors hold the majority of the deck and, some would argue, display indifference because they are governed by a clear statutory framework. If thrown a curveball, some contractors 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 flipside 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),[17] and the

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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 similar to the language of the Medicaid Act that was interpreted in *Ahlborn* and the MSP repayment and enforcement provisions[18] 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." [19]

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:

- Medicaid: State assigned "rights . . . to payment for medical care from any third party"
- 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. [20]

III. Practical Considerations

I encourage you to be cautious before implementing any strategy. As you form your game plans, two fundamental tenets must be embraced: (1) states are not going to sit idly by and allow parties to negotiate away their interest; and (2) defendants are not likely to cooperate in allocating damages.

In light of this reality, plaintiff's counsel should consider the following: [21]

1. Notify the government agency involved (Medicaid / Medicare) that you will be attempting to recover the full array of tort-related damages, which may include repayment of government medical expenses. Request an accounting of these expenses, noting that all tort-related damages will be equitably allocated between the injured party and the government.

2. Decide whether you are going to seek recovery for medical costs that are / have been paid by the government and make this known in your pleadings.

3. Attempt to reach an agreement with the government regarding the equitable allocation of the settlement. You might consider providing the agency with an average of the highest and lowest damage estimates calculated by economists.

4. If you do not prevail on the steps above, you may have to seek a court order allocating the settlement among different categories of damages. In cases involving minors or incompetents, the procedural mechanism is already in place. But what about cases involving a competent adult? The best recommendation this author has is:

   a. Ask the court for a hearing on the allocation of damages, providing notice to Medicaid; or,

   b. The plaintiff (ex parte) or parties (by joint stipulation) could move the trial court, prior to finalizing the settlement agreement, to establish a qualified settlement fund and to appoint a neutral fund administrator to make a reasonable allocation of damages that includes the medical expense reimbursement amount; and

   c. Ask the court or fund administrator to answer - based upon the demand packages or competing life care plans and economist's reports - one of the following questions:

      i. If causation and liability were not a factor, what percentage of the total damages would be for medical losses and what percentage would be for non-medical losses (pain and suffering, disfigurement, lost wages, derivative losses, and so on), and

      ii. What percentage of the full value of the case did plaintiff recover (taking into account proof in the present case or similar damage cases without same liability or coverage limitations)?

   Medicaid should only recover the same percentage of its claimed lien.

5. Should the government claim a right of priority reimbursement and ignore the notion of equitable allocation, be prepared to argue that such a position is inconsistent with the Supreme Court's holding in Ahlborn and/or that the taking of the other non-medical elements of plaintiff's damages creates an undue hardship.[22]

Example: There is a $350,000 settlement. After identifying all damages using all the typical tools that plaintiffs' attorneys use to show defendants the measure of harm, the attorney shows that reasonable damages are $1,000,000. However, due to policy limits and/or comparative fault / contributory negligence, the parties settled for $350,000. Let's say there was $100,000 in medical provider payments by Medicaid. *Ahlborn* suggests that, under equitable allocation theory, 35 percent of the $100,000 paid by Medicaid might be allocable to medical

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expenses as part of the settlement dollars. This brings the recovery amount to $35,000.

Although the state is not necessarily forced (by *Ahlborn*) to accept "black-board" damages claims, *Ahlborn* does require them to "do equity". If a defendant and/or the state is unlikely to cooperate in making a good-faith classification of damages, the use of a 468B Qualified Settlement Fund (QSF)[23] may become important as an alternate approach to getting a court order on the merits of the case. QSFs can introduce a degree of "breathing space" to a settlement that can prove uniquely valuable in the following ways:

1. Allocating the settlement proceeds among the types of damages and/or claimants;

2. Verifying and negotiating liens and/or subrogation claims;

3. Determining the appropriate role and underwriting of a structured settlement annuity;

4. Evaluating the need to preserve governmental entitlement benefits (e.g., the need for the establishment of a special needs trust); and

5. A host of other decisions which can best be made without the pressure associated with the litigation itself.[24]

In smaller cases, however, the expense and administrative burden of establishing a QSF may be prohibitive. In those instances, the plaintiff's counsel might obtain a court order on allocation of damages by asking for a post-settlement allocation via motion to the court (Minnesota and Wisconsin have a mechanism for a post-settlement allocation hearing, via state supreme court cases).

States are loath to participate in post-settlement allocation hearings because they are not in the state's best interest. It is a loser's game for the state to appear in a hearing in front of a judge adverse to a brain-injured child in a wheelchair. Most judges will be more sympathetic to the injured party in that context. Furthermore, the states will fear establishing adverse precedence that may paint them in a corner on future settlements.

If counsel and Medicaid departments are able to establish rapport, and if they both accept the "equitable allocation" rationale of the United States Supreme Court in *Ahlborn*, 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. And, if these discussions take place outside the court setting, the states may soon have the upper hand.

I believe — after much discussion with Medicaid-related officials in various states — that state Medicaid departments will seek to ensure that their respective statutory framework dictates that no settlements occur without a Medicaid official's "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[of Health]'s written consent . . . ."**[25]

IV. 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 "equitable allocation" at the time of settlement:

1. Medicaid will place the onus on you to prove up your numbers.

2. The state may be more proactive in pursuing a recovery directly from the third party, as many state statutes allow.

3. Defense attorneys may seek to create a rift between plaintiff's counsel and Medicaid, hindering the ability to have a meaningful discussion regarding equitable allocation on the back-end of the case.

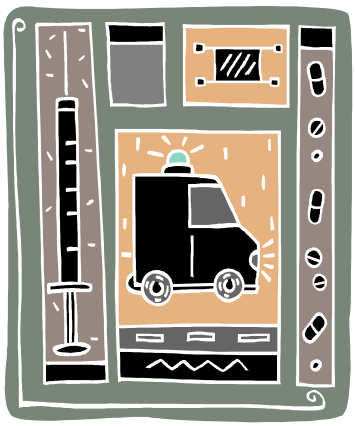
4. That defendants have little incentive to cooperate with you on the back-end of the case, in case it is perceived as helping to allocate away the state's interests.

The suggestions outlined above appear to be supported by the Supreme Court's opinion in *Ahlborn*. The Court addressed the "risk-of-settlement-manipulation" argument 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."[26]

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 *"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.

[Mr. Garrettson's footnotes were omitted due to space. Please contact the Library for a specific reference.]



OSBA Paralegal Certification Program

David Whelan, Law Librarian

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The OSBA certification program adds an option to the other certifications already available to paralegals, including those of the National Association of Legal Assistants and the National Federation of Paralegal Associations. The Cincinnati Paralegal Association has a list of other credentials, as well as their members who have received any particular credential.

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OSBA Paralegal Certification Site
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The Cincinnati Paralegal Association Credential Listing
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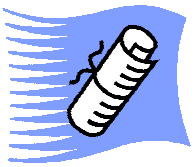

February 2007 Law Library Newsletter

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