

Medicaid Lien Resolution Fundamentals

By Jason D. Lazarus, Esq.

Introduction to Medicaid Third Party Laws & Anti-Lien Provisions

For clients who are on Medicaid, they will most likely have a Medicaid lien when their case is settled. When Medicaid has made payments for medical expenses related to an injury, it may assert a lien against the beneficiary's recovery under state Medicaid third party recovery laws. Every state must comply with federal Medicaid statutes and regulations to participate in the joint federal-state Medicaid program. Pursuant to Title XIX of the Social Security Act, the federal Medicaid program requires every participating State to enact a "third party liability" provision which empowers a State to seek reimbursement from liable third parties for injury-related medical expenditures paid on behalf of a Medicaid recipient.¹ In order to comply with this requirement, a State Medicaid program must have statutory provisions under which the Medicaid recipient is considered to have assigned to the State his or her right to recover from liable third parties medical expenses paid by Medicaid. Federal law codifies this stating²:

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

Despite the mandate in federal law for state Medicaid agencies to seek reimbursement from liable third parties by "acquiring the rights of such individual to payment by any other party for such health care items or services," there are important limitations on a State's recovery

¹ See 42 U.S.C. §1396a(a)(25).

² 42 U.S.C. §1396a(a)(25)(H).

rights which protect the Medicaid recipient's property. The limitation comes from the federal anti-lien statute which proclaims "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid," and the federal anti-recovery statute at §1396p(b)(1) states "[n]o adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made."³

KEY TAKEAWAY: While states participating in the joint federal-state Medicaid program are mandated under Title XIX of the Social Security Act to have "third party liability" provisions that enable them to seek reimbursement from third parties for injury-related medical costs covered by Medicaid, there are significant restrictions to ensure the protection of Medicaid recipients. Federal law dictates that once the State provides medical assistance, it assumes the rights of the individual to receive payment from any liable third party for such health care items or services. However, the federal anti-lien statute prevents a lien from being placed against an individual's property due to medical assistance provided before their death. Additionally, the federal anti-recovery statute ensures that no adjustments or recoveries can be made on medical assistance correctly paid on behalf of an individual. These protections ensure that while the state can recoup costs, the rights and property of Medicaid recipients remain safeguarded.

The Ahlborn SCOTUS Decision

The tension between these provisions in federal law and state law recovery statutes has become the source of litigation in federal as well as State courts. When these cases reached the top court in the land, the Supreme Court held that federal provisions preempt and limit a State's right to seek reimbursement from a Medicaid recipient's settlement to the extent that it reaches

³ 42 U.S.C. §1396p(a)(1).

elements of damages beyond medical expenses. The United States Supreme Court first weighed in on the rights of a State Medicaid agency to recover from personal injury settlements via State third party liability recovery statutes in 2006. The Supreme Court’s decision in *Arkansas Department of Health and Human Services v. Heidi Ahlborn*⁴ limited a State Medicaid program’s ability to assert a lien against the entire recovery from a third-party tortfeasor. The United States Supreme Court interpreted federal law authorizing States to recover Medicaid payments in a tort action to be limited to medical payments.⁵ Stated a different way, the *Ahlborn* decision forbids recovery by Medicaid state agencies against the non-medical portion of the settlement or judgment.⁶ Non-medical portions of a settlement or judgment are damages such as pain and suffering or lost wages. According to the Court in *Ahlborn*:

. . . [t]here 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.⁷

The holding of *Ahlborn* was a surprising result and has had a significant impact on personal injury litigation. In some instances, it has resulted in a much larger net amount being available to the injury victim at the “expense of the States’ ability to recover Medicaid expenditures.”⁸

⁴ 547 U.S. 268 (2006).

⁵ See *Ahlborn* 547 U.S. at 290.

⁶ *Id.*

⁷ *Id.* at 284.

⁸ Joseph D. Juenger, *In Light of Ahlborn – Designing State Legislation to Protect the Recovery of Medicaid Expenses from Personal Injury Settlements*, 35 N. KY. L. REV. 103 (2008).

When the *Ahlborn* decision was published, it was hailed by the Center for Constitutional Litigation (hereinafter “CCL”), associated with the American Trial Lawyers Association (now “American Association for Justice”), as a “significant victory” for injury victims.⁹ Other commentators have agreed with the CCL that it represents a major victory for injury victims.¹⁰ State courts have limited its application in some instances or found it wholly inapplicable.

Ahlborn by the Facts

Heidi Ahlborn was injured in a very serious car accident in January of 1996.¹¹ At the time, she was a nineteen year old college student pursuing a degree in teaching.¹² She suffered a catastrophic brain injury that left her incapable of finishing college and unable to care for or support herself in the future.¹³ Due to her injuries and lack of assets, Ahlborn qualified for Medicaid coverage in Arkansas.¹⁴ Medicaid paid Arkansas healthcare providers \$215,645.30 for injury-related care on her behalf.¹⁵

After the accident, a personal injury action was filed on behalf of Heidi in April of 1997.¹⁶ The damages sought included not only past medical costs but also for her “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.”¹⁷ During the pendency of the litigation, the Arkansas Department of Health Services

⁹ Lou Bograd, Center for Constitutional Litigation, P.C., Memorandum to Interested Parties, *Possible Extension of Ahlborn Ruling to Medicare and Guidance to Plaintiff’s Counsel Regarding the Decision* (May 16, 2006).

¹⁰ Juenger, *supra* note 6 at 103.

¹¹ *Ahlborn*, 547 U.S. at 273.

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

(hereinafter “ADHS”) sent Ahlborn’s personal injury attorneys periodic notices regarding the outlays by Medicaid on behalf of Ms. Ahlborn.¹⁸ The letters indicated that Arkansas law provided ADHS with a claim for reimbursement from “any settlement, judgment or award” that was obtained from “a third party who may be liable” for Heidi Ahlborn’s injuries and no settlement “shall be satisfied without first giving [ADHS] notice and a reasonable opportunity to establish its interest.”¹⁹

When suit was filed, ADHS wasn’t notified of the suit, as requested. Plaintiff’s counsel did inform ADHS of the available insurance coverage in the suit.²⁰ ADHS intervened in the personal injury action in February of 1998 to assert a lien against any proceeds from a settlement or judgment.²¹ The case was ultimately settled in 2002 without, per customary practice, any allocation of the settlement proceeds between categories of damages.²² ADHS asserted a lien against the settlement for the total amount of the payments made by ADHS for Ahlborn’s care which totaled \$215,645.30.²³

In September of 2002, Ahlborn filed suit in the United States District Court for the Eastern District of Arkansas seeking a declaratory judgment that “the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of compensation for injuries other than past medical expenses.”²⁴ Certain stipulations were entered into by the parties in the litigation in the US District Court. Firstly, ADHS and Ahlborn stipulated that Heidi Ahlborn’s total claim “was reasonably valued at \$3,040,708.18.”²⁵ Secondly, the parties agreed that the out

¹⁸ *Id.* at 274.

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

of court settlement reached represented “one-sixth of that sum.”²⁶ Thirdly, the parties stipulated that if the plaintiff’s “construction of federal law was correct, ADHS would be entitled to only the portion of the settlement (\$35,581.47) that constituted reimbursement for medical payments made.”²⁷

On cross motions for summary judgment, the Federal District Court found that Ahlborn, under Arkansas law, assigned to ADHS her right to any tort recovery from third parties to the “full extent of Medicaid’s payments for her benefit.”²⁸ The Court held accordingly that ADHS was entitled to its full lien amount of \$215,645.30.²⁹ The ruling was appealed to the Eighth Circuit and the judgment of the District Court was reversed.³⁰ The Eighth Circuit held that ADHS was only entitled to the portion of the settlement attributable to payments for medical care.³¹ ADHS appealed to the United States Supreme Court which affirmed the Eighth Circuit’s decision.³²

Ahlborn Legal Analysis

The heart of the controversy before the Supreme Court was the interpretation of federal law requiring state Medicaid programs to recover from third party tortfeasors amounts paid on behalf of an injury victim.³³ State Medicaid agencies must “take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan.”³⁴ Federal law also requires state Medicaid agencies to seek recovery from third parties

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.* at 275.

³¹ *Id.*

³² *Id.*

³³ *Id.*

³⁴ *Id.* (quoting 42 U.S.C. §1396a(a)(25)(A)).

where the reimbursement the State will receive exceeds the costs of recovery.³⁵ States are required to enact State statutes to facilitate recovery of such claims by providing an assignment from the injury victim to the State Medicaid agency for recovery of third party medical care payments.³⁶ Finally, the amount collected by the State Medicaid agency “shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of” the Medicaid recipient.³⁷

Arkansas had complied with federal law and enacted statutes providing ADHS with the right to recover “the cost of benefits” from third parties.³⁸ Arkansas law provided that as a “condition of eligibility”, Medicaid applicants “shall automatically assign his or her right to any settlement, judgment or award which may be obtained against any third party to [ADHS] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.”³⁹ Further, the Arkansas statute provided that ADHS “shall have a right to recover” when medical assistance is provided to the Medicaid recipient due to “injury, disease, or disability for which another person is liable.”⁴⁰ It was pursuant to this statute that the ADHS claimed an entitlement to recover all of the costs expended on Ahlborn’s behalf even though it would be recovered from portions of a settlement that didn’t represent medical expenses.⁴¹

The question squarely before the United States Supreme Court was whether the ADHS could “lay claim to more than the portion of Ahlborn’s settlement that represents medical expenses.”⁴² Justice Stevens said in the opinion that the “text of the federal third-party liability

³⁵ 42 U.S.C. §1396a(a)(25)(B).

³⁶ 42 U.S.C. §1396a(a)(25)(H); *see also* 42 U.S.C. §1396k(a).

³⁷ 42 U.S.C. §1396k(a).

³⁸ *Ahlborn*, 547 U.S. at 277 (citing Ark. Code Ann. §§20-77-301 through 20-77-309 (2001)).

³⁹ *Id.* at 277.

⁴⁰ *Id.*

⁴¹ *Id.* at 278.

⁴² *Id.* at 280.

provisions suggests not; it focuses on recovery of payments for medical care.”⁴³ While the State of Arkansas made many legal arguments to the Supreme Court as to why ADHS’s lien attached to Ahlborn’s entire settlement, each was rejected by the Court. Arkansas’ primary legal argument was that the federal statute mandated every State to pass laws that require the assignment of a Medicaid beneficiary’s rights to the State and assertion of liens to collect from the entire third-party recovery.⁴⁴ Justice Stevens addressed this argument by pointing to federal law which says the “State must be assigned ‘the rights of [the recipient] to payment by any other part for such health care items or services.’”⁴⁵ According to the Court, federal law didn’t sanction “an assignment of rights to payment for anything other than medical expenses –not lost wages, not pain and suffering, not an inheritance.”⁴⁶ This was not the basis of the Court’s decision in favor of Ahlborn though.

Instead, the Court’s decision rested on its interpretation of the “anti-lien”⁴⁷ statute in the United States Code.⁴⁸ The anti-lien statute prohibits States from exerting liens against a Medicaid recipient’s property prior to death for medical assistance paid on their behalf except in specifically enumerated situations.⁴⁹ While the Court found one of the anti-lien statute’s enumerated exceptions was relevant to Ahlborn’s situation, it was the assignment of a Medicaid beneficiary’s rights to the State and assertion of liens to collect from a third-party recovery which it found was limited only to medical care.⁵⁰ Accordingly, because the exception that was

⁴³ *Id.*

⁴⁴ *Id.* at 281.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ 42 U.S.C. §1396p.

⁴⁸ *Ahlborn*, 547 U.S. at 284.

⁴⁹ *Id.*

⁵⁰ *Id.*

carved out was limited to payments for medical care, the anti-lien provision bars recovery by ADHS against the portion of Ahlborn's settlement that was non-medical.⁵¹

Arkansas made several public policy arguments as to why a rule of full reimbursement was needed. The most "colorable" argument was that there was an "inherent danger of manipulation in cases where the parties to a tort case settle without judicial oversight or input from the State."⁵² The Court found that this issue was not before them because the ADHS had stipulated that only \$35,581.47 of Ahlborn's settlement proceeds were attributable to payment for medical costs.⁵³ Nevertheless, Justice Stevens pointed out that "[e]ven 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."⁵⁴ He went on to say "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."⁵⁵

KEY TAKEAWAY: The U.S. Supreme Court's ruling in *Arkansas Department of Health and Human Services v. Heidi Ahlborn* set a pivotal precedent regarding Medicaid liens in personal injury settlements. While states are obligated to seek reimbursement for Medicaid expenditures under the "third party liability" provisions, the Supreme Court in the Ahlborn case emphasized that federal law limits a state's claim to only the portion of a settlement or judgment that corresponds to past medical expenses. This distinction ensures

⁵¹ *Id.*

⁵² *Id.* at 288.

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*

that Medicaid cannot recover from elements of a settlement like pain and suffering or lost wages, which are deemed non-medical. The ruling highlights the interplay between federal statutes and state law and emphasizes the balance between a state’s reimbursement rights and a Medicaid recipient’s property rights. The decision is significant for personal injury litigation, ensuring that Medicaid recipients retain larger portions of their settlements by limiting the reach of state recovery.

A Word About Pro-Rata

The United States Supreme Court noted in *Ahlborn*, while discussing the stipulation that led to the ratio formula, that its effect “is the same as if a trial judge had found that Ahlborn’s damages amounted to \$3,040,708.12 (of which \$215,645.30 were for medical expenses), but because of her contributory negligence, she should recover only one-sixth of those damages.”⁵⁶ The pro-rata methodology of reducing Medicaid liens, as it has been termed since *Ahlborn*, is in essence a way of reducing a lien based upon equitable principles of the plaintiff not recovering his or her full measure of damages.

A 2008 decision by the California Supreme Court explained the pro-rata methodology succinctly.⁵⁷ In *Bolanos*, the court said “we come now to the aspect of *Ahlborn* that addresses how to allocate medical and nonmedical damages in an otherwise unallocated settlement. We have already set forth how the parties went about this task in *Ahlborn*; the ratio of the settlement to the total claim, when applied to the benefits provided by ADHS, yielded \$35,581.[9] (See p. 752, *ante*.) One very direct indication of the court's approval of the approach followed by the parties in *Ahlborn* is the court's unequivocal conclusion that ADHS was entitled to no more than \$35,581. (*Ahlborn*, *supra*, 547 U.S. at p. 292.)” And further said, “[w]hile it is perfectly correct

⁵⁶ *Ahlborn*, 547 U.S. at n 9.

⁵⁷ *Bolanos v. Superior Court of the State of California*, 87 Cal. Rptr. 3d 744 (2008).

to speak of the ratio of the settlement to the total claim, it may be both easier and more accurate to determine what percentage the settlement is of the total claim, and then to apply that percentage to the sum paid by the director to the beneficiary. Thus, taking the facts of *Ahlborn*, \$550,000 is 18.08 percent of \$3,040,708; 18.08 percent of \$215,645 is \$38,988. (The difference between the latter sum and the stipulated amount of \$35,581 is, in all likelihood, the proportionate share of litigation costs to be borne by ADHS.)” Lastly, the court pointed out “one cannot take lightly the fact that the Supreme Court, expounding federal law governing a federal program, concluded that the formula devised by the parties in *Ahlborn* produced a reliable result.”

KEY TAKEAWAY: The U.S. Supreme Court's decision in *Ahlborn* set a precedent by using a clear methodology, known as the pro-rata method, for reducing Medicaid liens when a plaintiff does not recover their full damages in a settlement. This approach is anchored in equitable principles, suggesting that if a plaintiff recovers only a fraction of their total damages in a settlement, then Medicaid should be reimbursed equivalently — only a fraction of its claim. The California Supreme Court's 2008 decision in *Bolanos v. Superior Court* further elucidated this methodology, emphasizing that the pro-rata approach produces a reliable result and aligns with the intentions of federal law governing Medicaid. The decisions from both courts underscore the importance of ensuring that Medicaid liens are equitable and proportionate to the actual recovery in a settlement.

Post *Ahlborn* - The *Wos* SCOTUS Decision

Since the primary holding in *Ahlborn* is that federal laws that authorize States to assert recoveries against third parties who have provided payments for medical care for Medicaid beneficiaries only applies to the portions of a settlement that represent compensation for medical

expenses, it appeared to invalidate state statutes that require full reimbursement of Medicaid expenditures from a third-party recovery. After the *Ahlborn* decision, States began to revise their third-party liability statutes with inconsistent results in the courts. In 2012, a challenge of the North Carolina Medicaid's third-party liability recovery statute would lead the United States Supreme Court to again weigh in on state Medicaid agencies' rights to recover.

In *E.M.A. v. Cansler*⁵⁸, the Fourth Circuit Court of Appeal agreed with the Third Circuit that in determining what portion of a Medicaid beneficiary's third-party recovery a State Medicaid agency may claim as reimbursement for Medicaid expenses, the state must have in place procedures that allow a dissatisfied beneficiary to challenge a statutory default allocation. In reaching its conclusion, the Fourth Circuit also held that the North Carolina Supreme Court wrongly interpreted *Ahlborn* in upholding the validity of North Carolina's statutory default allocation in a previous decision.

According to the *E.M.A.* decision, the United States Supreme Court's unanimous decision in *Ahlborn* makes clear, "federal Medicaid law limits a state's recovery to settlement proceeds that are shown to be properly allocable to past medical expenses. In the event of an unallocated lump-sum settlement exceeding the amount of the state's Medicaid expenditures, as in this case, the sum certain allocable to medical expenses must be determined by way of a fair and impartial adversarial procedure that affords the Medicaid beneficiary an opportunity to rebut the statutory presumption in favor of the state that allocation of one-third of a lump sum settlement is consistent with the anti-lien provision in federal law."⁵⁹

⁵⁸ 674 F.3d 290 (4th Cir. 2012), *cert. granted sub nom. Delia v. E.M.A.*, 567 U.S. ____ (Sept. 25, 2012)

⁵⁹ *Id.* at 312 (emphasis added).

The Fourth Circuit went on to say “The Supreme Court has characterized the third-party liability provisions in federal Medicaid law as an exception to the anti-lien provisions, stating that “[t]o the extent that the forced assignment [of payments that constitute reimbursement for medical expenses] is expressly authorized in §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision.”⁶⁰ At the same time, the Supreme Court has emphasized that this exception is strictly limited—a State cannot force assignment of, or place a lien on, any property that does not constitute reimbursement for medical expenses.⁶¹

The Fourth Circuit did not agree with North Carolina's argument that its statute set a "reasonable cap" on the State's recovery and therefore satisfied the federal anti-lien law.⁶² Instead, the court concluded that North Carolina's one-third cap on a Medicaid recipient's settlement proceeds does not satisfy *Ahlborn* insofar as it permits North Carolina to assert a lien against settlement proceeds intended to compensate the Medicaid recipient for other claims, such as pain and suffering or lost wages.⁶³ The court declined to express a view as to whether allocation disputes must be adjudicated by a court, or may instead be resolved through other "special rules and procedures" alluded to in *Ahlborn*. However, the court held that in determining what portion of a Medicaid beneficiary's third-party recovery the State may claim in reimbursement for Medicaid expenses, it must have in place procedures that allow a dissatisfied beneficiary to challenge the default allocation.⁶⁴ As the North Carolina statute had no such provision, the court remanded the case back to the district court to make the allocation.

⁶⁰ *Id.* citing *Ahlborn*, 547 U.S. at 284, 126 S.Ct. 1752 (citing *Wash. State Dep't of Soc. & Health Servs. v. Guardianship Estate of Keffeler*, 537 U.S. 371, 383-85, & n. 7, 123 S.Ct. 1017, 154 L.Ed.2d 972 (2003)).

⁶¹ *Ahlborn*, at 284-85, 126 S.Ct. 1752 (“[T]he exception carved out by §§ 1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.”).

⁶² *Id.* at 308.

⁶³ *Id.* at 307.

⁶⁴ *Id.* at 311.

The United States Supreme Court granted certiorari on September 25, 2012. Oral arguments occurred on January 8, 2013. The Court rendered its opinion on March 20, 2013 upholding the Fourth Circuit’s judgment in a 6-3 decision.⁶⁵ In *Wos v. EMA*, the Supreme Court was asked to review North Carolina’s Medicaid Third-Party Liability Recovery statute. North Carolina’s statute required that up to one-third of any damages recovered by a beneficiary for their injuries must be paid to Medicaid to reimburse it for payments it made on account of the injury. The Supreme Court found that this statute was not compatible with the federal anti-lien provision and violated the holding of *Ahlborn* which “precludes attachment or encumbrance” of any portion of a settlement not “designated as payments for medical care”.⁶⁶

The *Wos* decision discussed the tension between the mandate under federal law requiring an assignment to the State of “the right to recover that portion of a settlement that represents payments for medical care,” and the preclusion of “attachment or encumbrance of the remainder of the settlement.” The *Ahlborn* opinion held that the federal Medicaid statute sets both a floor and a ceiling on a State’s potential share of a beneficiary’s tort recovery. The *Wos* court pointed out that an injury victim has a property right in the proceeds of a settlement “bringing it within the ambit of the anti-lien provision.”⁶⁷ “That property right is subject to the specific statutory exception requiring a State to seek reimbursement for medical expenses paid on the beneficiary’s behalf, but the anti-lien provision protects the beneficiary’s interest in the remainder of the settlement.”⁶⁸

North Carolina’s statute as applied ran afoul of the holding in *Ahlborn* because it set “forth no process for determining what portion of a beneficiary’s tort recovery is attributable to

⁶⁵ *Wos v. E.M.A.*, 133 S. Ct. 1391, 185 L. Ed. 2d 471(2013).

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.*

medical expenses.” Instead, the statute applies an arbitrary figure (one-third) and mandates that amount be the payment for medical care out of the tort recovery. As applied, this violates the federal anti-lien law and is therefore pre-empted. The *Wos* Court pointed out that if “a State arbitrarily may designate one-third of any recovery as payment for medical expenses, there is no logical reason why it could not designate half, three-quarters, or all of a tort recovery in the same way.”⁶⁹ Since North Carolina could provide no evidence to substantiate the claim it made that the one-third allocation was reasonable and provided no mechanism for determining whether it was a reasonable approximation in any particular case, the Court rejected its application.

In a very important part of the decision, the *Wos* Court discusses when the state may not demand recovery from a portion of the settlement allocated to non-medical damages. The court stated that when “there has been a judicial finding or approval of an allocation between medical and nonmedical damages—in the form of either a jury verdict, court decree, or stipulation binding on all parties—that is the end of the matter.”⁷⁰ “With a stipulation or judgment under this procedure, the anti-lien provision protects from state demand the portion of a beneficiary’s tort recovery that the stipulation or judgment does not attribute to medical expenses.”⁷¹

In applying all of the foregoing to the facts of the case, the *Wos* Court pointed out the flaws of the North Carolina statute which didn’t allow for an allocation. The Court found that a substantial share of the damages in the settlement must be allocated to skilled home care in the future. This would not be reachable by the state Medicaid agency to satisfy their lien. In addition, the *Wos* Court noted that it may also be necessary to consider how much E.M.A. and her parents could have expected to receive in terms of compensation for the other tort claims made in the suit

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.*

had it gone to trial. “An irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act’s clear mandate that a State may not demand any portion of a beneficiary’s tort recovery except the share that is attributable to medical expenses.”⁷²

KEY TAKEAWAY: The U.S. Supreme Court, through the *Ahlborn* and *Wos* decisions, emphasized that state recovery from Medicaid beneficiaries' settlements should be strictly limited to the portion representing medical expenses. The Court rejected state provisions that attempted to set fixed percentages or arbitrary allocations, insisting that any such claim by the state should be supported by evidence or a proper adjudicative procedure. State statutes allowing blanket claims on a set percentage of settlements, without provisions for individual case evaluations or challenges, were deemed incompatible with federal Medicaid law. Furthermore, if a settlement or judgment specifies allocations for damages, these allocations should guide states in determining recoverable amounts. This ensures that portions of settlements meant for non-medical damages, such as pain and suffering or lost wages, remain protected and outside the reach of state Medicaid recovery efforts.

The Gallardo SCOTUS Decision

After *Wos*, the Supreme Court did not address Medicaid liens again until June of 2022. The United States Supreme Court decided in *Gallardo v. Marstiller*,⁷³ a 7-2 decision, to allow Florida Medicaid to recover its lien from all medical damages past and future, pursuant to Section 409.910 of the Florida Statutes. This decision has nothing to do with future eligibility for Medicaid post settlement, which is still protected by special needs trusts, instead it allows a state Medicaid agency to pursue its lien against all medical damages in the case. This is a departure from the

⁷² *Id.*

⁷³ *Gallardo v. Marstiller*, 596 U.S. ____ (2022).

dictates of *Ahlborn* which protected a Medicaid recipient's property right in their settlement as prescribed by the federal anti-lien provisions.

Gallardo argued that the anti-lien provisions in the Medicaid Act prohibited Florida Medicaid from attempting to recover its lien from anything other than the amounts properly allocable to past medical expenses. The Supreme Court held otherwise finding that it falls within an exception to the anti-lien provisions that served as the pillars of the *Ahlborn* decision. Further, the court held that the assignment provisions in the Medicaid Act require a Medicaid beneficiary, as a condition of eligibility, to assign all rights to payments for medical care from a third party back to the state Medicaid agency. States must also enact recovery provisions that allow for the state to recover from liability third parties when a Medicaid beneficiary is injured, and Medicaid pays for that care. While the court upheld the property right and anti-lien prohibitions against recovery from non-medical damages, it held it didn't protect damages that were for medical care.

The bottom line of the holding is as follows:

“Under §1396k(a)(1)(A), Florida may seek reimbursement from settlement amounts representing “payment for medical care,” past or future. Thus, because Florida’s assignment statute “is expressly authorized by the terms of . . . [§]1396k(a),” it falls squarely within the “exception to the anti-lien provision” that this Court has recognized. *Ahlborn*, 547 U. S., at 284.”

Justice Sotomayor's dissent in *Gallardo* is right on point about the inequity of the majority's opinion related to Medicaid liens and from what elements of damages a state agency can recover from: “It holds that States may reimburse themselves for medical care furnished on behalf of a beneficiary not only from the portions of the beneficiary's settlement representing compensation for Medicaid-furnished care, but also from settlement funds that compensate the Medicaid beneficiary for future medical care for which Medicaid has not paid and might never pay. The Court does so by reading one statutory provision in isolation while giving short shrift to

the statutory context, the relationships between the provisions at issue, and the framework set forth in precedent. The Court's holding is inconsistent with the structure of the Medicaid program and will cause needless unfairness and disruption." Justice Sotomayor also recognized that due to the majority's ruling, many injury victims would have fewer dollars from their settlement to place into federally authorized special needs trusts that protect their ability to pay for important expenses Medicaid will not cover. This is exactly what had been done for the benefit of Gallardo when her case was settled but now, she will have less go into that trust since more money will have to go to reimburse Florida Medicaid.

So, what does *Gallardo* mean for injury victims? A state Medicaid agency or its recovery contractor can now take the position that the recovery right applies to past and future medicals so when you do an *Ahlborn* analysis, it would be the appropriate reduction percentage (using a pro-rata formula) applied to the entire value of medical damages to see if there is a reduction in the lien. Pre-*Gallardo*, some states were already taking that position as well as some recovery contractors. From a practical perspective, in cases with a large life care plan or a lot of future medicals, there may not be a reduction at all in the lien. It is going to be important that the non-economic damages get properly valued with some multiplier times specials to make strong arguments for a reduction.

KEY TAKEAWAY: The Supreme Court's decision in *Gallardo v. Marstiller* marked a significant shift in the landscape of Medicaid lien recovery. In contrast to the prior precedent set by *Ahlborn*, the *Gallardo* decision permits state Medicaid agencies to recover liens from both past and future medical damages contained in a settlement, not just those related to past medical expenses. The Court anchored its reasoning on the Medicaid Act's assignment provisions, emphasizing that beneficiaries, as part of their Medicaid eligibility

conditions, assign all rights to third-party payments for medical care back to the state. This expansive interpretation means that amounts designated in settlements for future medical expenses are now accessible to state Medicaid agencies for reimbursement. Justice Sotomayor's dissent underscores the potential consequences of the majority's decision, highlighting that it could inadvertently burden injured individuals by diminishing funds allocated to special needs trusts, thus compromising their ability to afford necessary services not covered by Medicaid. For practitioners, the ruling emphasizes the importance of meticulous damage valuation, especially concerning non-economic damages, to advocate for reduced Medicaid claims.

Conclusion

As a trial lawyer, it is important to understand the underpinnings of the *Ahlborn* and *Wos* and *Gallardo* decisions so you can apply them to your State's third-party liability recovery provisions. The important thing to remember is that these cases limit a State Medicaid agency's recovery rights related to a third-party liability settlement. In order to reduce a Medicaid lien, State-specific statutes must be followed, but arguments to reduce should be based on the principles espoused in *Ahlborn*, *Wos* and *Gallardo* so that the lien is reduced in proportion to the full value of damages versus what was received.

Another critical area of focus is ERISA liens, which involve employer-sponsored health plans governed by federal law. These liens present their own set of complexities and require specific resolution strategies. The next section focuses on how to effectively resolve ERISA liens.

Medicaid Lien Resolution Practice Tip:

Given the importance of *Gallardo* and its impact on Medicaid lien resolution, the following are some strategies to deal with some of the issues created by the decision (depending on your state law):

Strategize Around Medical Expenses: Consider disclaiming medical expenses as part of the settlement. Before finalizing a settlement, consider amending the complaint to dismiss claims related to these expenses. Remember, you may need to provide notice to the Medicaid agency when making such changes.

Maximize Pro-Rata (Ratio) Strategies:

- **Value Non-Economic Damages Robustly:** Be assertive and ensure non-economic damages are not undervalued. Leverage high-end jury verdicts to advocate for higher pain and suffering awards.
- **Substantiate Damages:** Consider using a mock jury post-resolution. This strategy can help in affirming the value of damages claimed and can add weight to your negotiations.

Optimize Future Medical Expense Calculations:

- **Categorize Non-Medical Expenses Carefully:** Remove items that aren't strictly "medical" from the Life Care Plan (LCP). This can include vehicles, durable medical equipment, home renovations, etc.
- **Dual Eligible Beneficiaries:** If a person is eligible for both Medicare and Medicaid, note that Medicare Set-Asides (MSAs) are arguably off-limits for Medicaid claims.
- **Use Medicaid Rates for Future Medical Valuation:** If the injured party will require Medicaid in the future and will utilize a Special Needs Trust (SNT), then value future

medical expenses at Medicaid rates. Since Medicaid rates are often lower than private or out-of-pocket rates, this can decrease the potential lien amount.