

## The United States Supreme Court Reduces the Medicaid Lien

Karen E. Dunivan  
ThompsonMcMullan, P.C.

On May 1, 2006, the United States Supreme Court issued a landmark decision (*Arkansas Dept. of Health and Human Servs. v. Ahlborn*, 126 S.Ct. 1752) which should change the way practitioners handle the Medicaid lien and, quite possibly, the way one files suit and settles personal injury cases in which Medicaid payments represent a portion of the potential recovery.

Heidi Ahlborn, an Arkansas Medicaid recipient, sought a declaration from the federal district court that the Arkansas Department of Health and Human Services (“ADHS”) had violated federal law by imposing a lien against the settlement proceeds she recovered from the third-party tortfeasor which caused the injuries entitling her to receive Medicaid payments. The district court held in her favor, while the Eighth Circuit reversed. A conflict has existed amongst several circuits, although Virginia’s lien statute has remained in tact. The United States Supreme Court issued this opinion in favor of Ms. Ahlborn thereby changing the way the Virginia Department of Medical Assistance Services (“DMAS”) will be allowed to seek reimbursement from Virginia Medicaid recipients.

Federal statutes, 42 U.S.C. 1396 *et seq.*, impose a certain structure on the States’ plans for medical assistance which are funded, in part, by federal dollars. While federal statutes govern the medical assistance program, each State can implement its own Medicaid plan in accordance with the federal law. The federal statutes require, *inter alia*, that the States seek reimbursement from third parties who are liable for the medical care and services of a Medicaid recipient. Important to the decision in the *Ahlborn* case is the fact that these statutes also prohibit the placement of a lien on the property of a Medicaid recipient except under very defined circumstances. One exception to the “anti-lien rule” is a lien imposed pursuant to an assignment of interest for a chose in action as a condition precedent for Medicaid eligibility. Many States’ lien statutes impose such a lien against the entire recovery up to the amount of the medical assistance received by the plaintiff. Ahlborn argued that Arkansas’ lien statute violated federal law by imposing a lien on her property in violation of the federal statutes.

The Arkansas statute which allows ADHS to place a lien against personal injury proceeds is consistent with Virginia’s lien statute, Virginia Code § 8.01-66.9. Both seek reimbursement for all Medicaid payments from the recovery received by the plaintiff, and both statutes impose a lien on these recoveries. In Virginia, this lien is subject only to reasonable attorneys’ fees and makes no provision for non-economic damages and lost wages and future earnings. The Virginia statute does provide an opportunity to negotiate with DMAS and the Attorney General to reduce the lien in cases decided at the discretion of DMAS and the Attorney General. As many practitioners know, however, DMAS and the Attorney General’s Office are slow to reduce their lien and often, if not always, suggest that the attorneys’ fees should be reduced as well. Therefore, the rationale used

to determine the *Ahlborn* case holds true in Virginia and should cause DMAS and the Attorney General's Office to change the way in which Medicaid liens are imposed.

This rationale turns on two points: (1) whether DMAS is entitled to reimbursement from the portion of the plaintiff's recovery not allocated to medical payments, such as pain and suffering, lost wages and future earnings; and (2) whether the States can impose a lien on the Medicaid recipient's property. Under the provisions of the federal statutes, "to the extent that payment has been made under the State plan for medical assistance for *health care items or services* furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party *for such health care items or services.*" 42 U.S.C. § 1396a(a)(25)(H) (emphasis added). Notably, however, *Ahlborn* argued that nothing in this statute extends to payments for lost wages, future earnings, and pain and suffering, and the United States Supreme Court agrees. The Supreme Court held that the imposition of a lien was valid because it fell into one of the exceptions to the "anti-lien rule," but the lien was only valid to the extent of the recovery that was for health care items and services. Any lien in excess of that percentage violates the federal statutes because such a lien would attach to non-economic damages, lost wages and/or future earnings.

How then, will the percentage of the recovery attributed to medical costs be determined, and who will do so? In the *Ahlborn* case, the parties stipulated to the true value of the damages irrespective of coverage and liability issues. They agreed that the value of the case was \$3,040,708, but because of coverage issues, the case settled for \$550,000 or approximately one-sixth of the real value of her case. ADHS had made payments in the amount of \$215,645 on behalf of Ahlborn. Thus, the percentage of the gross amount of medical payments which should be reimbursed by the recipient could be determined by simple math. The parties stipulated that if Ahlborn's interpretation of the law was correct, ADHS should be reimbursed \$35,581, or one-sixth of its original lien.

By way of further example, assume the plaintiff has \$75,000 in past medical expenses as a result of the accident, but the case settles for \$100,000 due to the amount of coverage or because of questionable liability. Under the current Virginia statute, DMAS would claim \$75,000, or the amount of the medical payments made by DMAS. After *Ahlborn* however, DMAS is only entitled to reimbursement in the proportionate amount representing the percentage of recovery to the whole value of the case. Continuing with the example above, if the total value of the case were \$375,000, then the recovery is only twenty-seven percent of the total value (\$100,000 divided by \$375,000); and, therefore DMAS would only be entitled to be reimbursed twenty-seven percent of its claim or in this example, \$20,250. The remaining balance compensates the plaintiff for other damages such as pain and suffering and lost wages and future earnings. This ruling also allows practitioners to take cases that otherwise might be impractical or economically unfeasible to prosecute, ultimately inuring to the benefit of injured people *and* DMAS.

We return to the question: How will the true value of the case be determined and how will an allocation between differing types of damages occur? Unlike in *Ahlborn*, DMAS will most likely not stipulate to values upon which all parties will agree.

However, armed with an understanding of this new opinion, practitioners will certainly have a greater opportunity to aggressively negotiate with DMAS and the Attorney General's Office. With the exception of the cases wherein the plaintiff is made whole, it seems that all cases should be adjusted in light of this new opinion. In other words, if the case settled for less than its true value, DMAS should be repaid proportionately less than its full claim.

In anticipation of cases where the facts warrant special attention to the Medicaid lien, practitioners might give some consideration to filing suit for non-economic damages only or for lost wages and future earnings only. Certainly some discussion of the true value of the case should factor into settlement negotiations and settlement agreements. Life care planners may become useful in cases which will never go to trial and in the past would not warrant such an expense. There is also the option for pre-settlement negotiations with DMAS to set the percentage of the claim for reimbursement. In the absence of an agreement, "mini-trials" may be appropriately tried before a judge to determine the true value of the case and thereby the percentage of the recovery DMAS should be reimbursed for medical care and services.