



Calculating Medi-Cal's reimbursement rights under *Ahlborn*

The California Welfare & Institutions Code and Ahlborn make clear that the state's demands for Medi-Cal reimbursement must comply with federal laws



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Introduction

The United States Supreme Court has held that a State cannot claim a lien upon a beneficiary's tort recovery that exceeds that portion of the recovery that is compensation for past medical care paid by the State's medical assistance program. The amount of the State's lien must be reduced in the same proportion that the settlement has to the plaintiff's overall damages. Any attempt to claim more than this proportionate share of a settlement, therefore, is a violation of the federal Medicaid laws and a violation of the United States Constitution.

The Court should, therefore, strike or extinguish a California Department of Health Services lien (Medi-Cal) to the extent it exceeds the proper amount in proportion to the settlement and after reduction for attorneys fees and costs.

The federal Medicaid act and California's participation through the Medi-Cal program

Title 42, section 1396 of the United States Code authorizes annual appropriations from Congress to the States to enable them to create and maintain medical assistance programs. Medi-Cal was enacted in California in response to this federal legislation. (Welf. &

Inst. Code, § 14000 *et seq.* *Olszewski v. Scripps Health* (2003) 30 Cal.4th 798.) Title XIX of the Social Security Act, which created the Medicaid law, authorized the federal government to support states that adopt medical assistance programs. (42 U.S.C., § 1396 *et seq.*) Some of the funds are provided by the federal government; some of the funds are provided by the state. (42 U.S.C., § 1396a(a).)

The Medicaid Act requires participating states to seek reimbursement for Medicaid payments from third-party tortfeasors, such as the defendants in personal injury cases. (42 U.S.C., § 1396a(a)(25).) California Welfare & Institutions Code sections 14124.71 and 14124.72, in turn, authorizes the director of the Department of Health Services to recover payments from third-party tortfeasors. Section 14124.71 authorizes the DHS to file an action directly against the third-party tortfeasor. Welfare & Institutions Code section 14124.728 authorizes Medi-Cal to assert a lien on the injured plaintiff's action.

Limitations on the department's rights: it can assert a lien only on the proportion of a settlement that represents compensation for costs of past medical care

In *Arkansas Dept. of Health and Human Services v. Ahlborn* (2006) 547 U.S. 268, the United States Supreme Court reviewed an Arkansas statutory scheme that was functionally equivalent to the



Lew



FEBRUARY 2008

California statutes. Like California, Arkansas permitted its Department of Health Services (ADHS) to file its own action against a tortfeasor or assert a lien on the beneficiary's action against that tortfeasor. Also, an Arkansas statute made the entire settlement subject to the ADHS's lien.

The plaintiff in *Ahlborn* was involved in an automobile accident and suffered serious injuries. She applied for and received Medicaid benefits, through Arkansas' medical assistance agency, ADHS (Arkansas Department of Health Services). She informed ADHS about the nature of the injuries and that they were caused in an automobile accident.

The plaintiff filed an action against the tortfeasor, seeking damages for past medical expenses, loss of earnings, loss of earning capacity, and pain and suffering. The overall value of the plaintiff's entire damages was reasonably worth \$3 million. (For convenience, the numbers are rounded.) ADHS asserted a lien for \$215,000, the full amount of benefits it paid for medical care on the behalf of the plaintiff. The case eventually settled for \$550,000, approximately one-sixth of the full value of the plaintiff's overall damages. The settlement was not allocated among the categories of damages.

The plaintiff next filed a declaratory relief action in federal court. She sought a declaration that the ADHS lien for the full amount violated federal Medicaid laws. She argued that full satisfaction of the lien would require depletion of compensation for injuries other than past medical expenses. The plaintiff argued that the state was entitled to only \$35,000, which was one-sixth of the settlement — the same proportion of settlement to overall damages — after attorneys' fees and costs.

The question that the United States Supreme Court faced is whether the State "can lay claim to more than the portion of Ahlborn's settlement that represents medical expenses." (547 U.S. at 460 [126 S.Ct. at 1760].) The Supreme

Court said, "No." While Section 1396a(a) requires States, as a condition of receiving Medicaid funds, to enact laws to recover benefits paid as a result of medical care for injuries, Congress did not authorize States to assert liens against a beneficiary's other property, which is what would occur if the State asserted a lien over the entire settlement.

The United States Supreme Court explained that federal Medicaid law requires States receiving Medicaid funds "to take all reasonable measures to ascertain the legal liability of third parties . . . that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service to pay for care and services available under the plan." (42 U.S.C., § 1396a(a)(25)(A).) "[I]n any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability." (42 U.S.C., § 1396a(a)(25)(B).)

As a condition for receiving funds, "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 [must have] 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." (42 U.S.C. § 1396a(a)(25)(H).)

Title 42, section 1396k(a)(1)(A) requires States to establish eligibility requirements for medical assistance recipients. Those eligibility provisions direct the States to require recipients "for the purpose of assisting in the collection

of . . . payments for medical care . . . [&] . . . to assign the State any rights . . . to payment for medical care from any third party."

Congress barred the States from imposing liens against a recipient's property in order to recover benefits paid on his behalf for medical care and services. Section 1396p(a)(1) provides that, "[n]o lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan." (There are two exceptions — a lien created by a judgment against the recipient for benefits incorrectly paid on his behalf, and a beneficiary who is an inpatient at a nursing facility. (42 U.S.C., § 1396p(a)(1)(A), (B).))

Ahlborn explained that the focus of these federal statutes is on the recipient's assignment of rights to receive payment from third parties for medical care that was already paid by medical assistance. Section 1396k(a) required assignment of rights "to payment for medical care from any third party"; the statute does not require assignment of rights to payment for other injuries, such as lost wages. (547 U.S. at 472.)

Section 1396a(a)(25)(B)'s reference to "reimbursement for such [medical] assistance to the extent of such legal liability" applies only to the liability of third parties "to pay for care and services available under the plan." (547 U.S. at 472 (emphasis in original).) "Again, the statute does not sanction an assignment of right to payment for anything other than medical expenses — not lost wages, not pain and suffering, not an inheritance." (547 U.S. at 472 (emphasis added).)

The California Department of Health Services typically attempts to assert an excessive lien in violation of the federal law

- *The overall value of damages*

The value of plaintiff's overall damages is calculated by adding the past



FEBRUARY 2008

medical costs, the intermediate present value of future medical costs, the intermediate present value of loss of earning capacity and the general damages. In moving to extinguish or reduce the lien, admissible evidence of the overall damages, including the use of reports and expert depositions or declarations should be submitted.

• ***Reduction of the department's lien in proportion that the settlement bears to the overall damages***

The Department of Health Services typically asserts a lien in the amount it claims it paid in benefits. By calculating the amount of the settlement divided by the value of plaintiff's overall damages, a ratio is obtained. Using that ratio and under *Ahlborn*, the Department's lien should be reduced proportionately. In addition, there should be a further reduction for the percentage of attorneys fees, as provided by Welfare & Institutions Code section 14124.72(d). The lien should be reduced once more, so that the Department shares in the costs of the litigation.

The department usually does not enter any alternative evidence of the overall damages, leaving plaintiff's evidence uncontradicted. Absent admissible evidence, the department's arguments regarding overall value should be disregarded.

• ***The department cannot defy the federal Medicaid laws or the supreme court's ruling in Ahlborn***

The department may try to defy the federal Medicaid laws – in particular, the Anti-Lien Provisions – by suggesting that plaintiff, her parents or her counsel are trying to manipulate the settlement to avoid paying the lien. The department has raised this very contention in many cases. The Supreme Court rejected such speculation (and baseless insinuation) as a reason to disregard Congress' plain language in the Anti-Lien Provisions. In language that is equally applicable to the present action, the Supreme Court addressed this "manipulation" argument:

[T]he aspersions the United States casts upon *Ahlborn* are entirely unsupported; all the record reveals is that [the State], despite having intervened in the lawsuit and asked to be apprised of any hearings, neither asked to be nor was involved in the settlement negotiations. Whatever the bounds of the duty to cooperate, there is no evidence that it was breached here. (*Ahlborn*, 547 U.S. at 476.)

Another federal court also rejected the suggestion that permitting the State to seize funds – that were intended to compensate for other damages – is necessary to prevent beneficiaries and their lawyers from manipulating settlements. The federal court also explained that allowing a State to overreach would result in a disincentive for injured beneficiaries to pursue their rights at all, thus depriving the State of any recovery. The State's approach would be self-defeating:

Federal Medicare and state Medicaid administrators justify a full reimbursement approach on the ground that "the required apportionment of [settlement proceeds] short of a decision on the merits would [otherwise] allow beneficiaries and personal injury attorneys to reduce or eliminate . . . reimbursements by weighing claims in favor of items of damage other than medical expenses." . . . Yet full reimbursement deprives poor and injured individuals of needed compensation for their pain and suffering, lost wages, and other non-medical damages.

Moreover, although the policy provides Medicare and Medicaid with the maximum possible recovery in individual cases, it could adversely affect the programs' overall ability to obtain repayment of their costs from third party tortfeasors. Because it may deprive them of any compensation for their injuries, the full reimbursement approach gives many beneficiaries little incentive to pursue valid claims or, if they do, to [not] accept otherwise reasonable settlement offers, thereby

tending to push them into uncertain litigation that burdens the courts and may result in little or no recovery for either the beneficiaries or for Medicare or Medicaid. (*In re Zyprexa Products Liability Litigation* (E.D.N.Y. 2006) 451 F.Supp.2d 458,469-470 (citation omitted; footnote added).)

In most actions, the department will assert a lien but will not bother to intervene or file its own action. There will typically be no evidence that it expressed any interest in participating in settlement negotiations. Nor will there usually be any evidence submitted by the department in support of its positions. If the department was actually concerned about possible manipulation of a settlement, it can protect itself by participating in the action. It can file its own action against a tortfeasor or intervene in a pending action. (Welf. & Inst. Code, § 14124.71.) This would mean, however, that it would have to investigate liability and causation, retain experts, and expend time to prepare for trial. This would also require taking risk – both financial and effort – and the department usually fails to express any interest in doing so. To the contrary, it usually asserts a lien and is content to wait for a settlement check. The department cannot reasonably claim that the federal Anti-Lien Provisions should be disregarded, or that it should be entitled to invade funds that are compensation for other damages.

Conclusion

California Welfare & Institutions Code section 14124.76(a) and *Ahlborn* make clear that the department's demands for reimbursement must comply with Congress's Medicaid laws. The department's excessive liens are barred by the anti-lien provisions of the federal statute. Upon timely motion, the Court should strike or extinguish the department's lien to the extent it exceeds the ratio of the settlement to the total value of the damages.



FEBRUARY 2008

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