

GUMEN DOCKET

Supreme Court Docket No. 101537

SEP 22 2011

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

IN Re: E.B., a minor,

Respondent,

v.

**PATSY HARDY,¹ Secretary, West Virginia
Department of Health and Human Resources,**

Petitioner/Intervenor Below.

**(Civil Action No. 09-P-47 M
Circuit Court of Hancock County (J. Mazzone)**

SUPPLEMENTAL BRIEF OF PETITIONER WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

**DARRELL V. McGRAW, JR.
ATTORNEY GENERAL**

**Mary McQuain, Assistant Attorney General
State Bar No. 713
DHHR Division/Bureau For Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301
Telephone: 304-356-4899
Fax: 304-558-1509
Email: Mary.G.McQuain@wv.gov
*Counsel on behalf of Petitioner***

¹ Michael J. Lewis has replaced Patsy Hardy as Secretary of the West Virginia Department of Health and Human Resources.

TABLE OF CONTENTS

TABLE OF AUTHORITIES.....ii

I. SUMMARY OF MATERIAL FACTS.....1

II. ARGUMENT.....2

 A. Whether The Reimbursement Of Past Medical Expenses Paid By Medicaid
 Agencies May Come From Medical Expenses Recovered As Past And/Or Future
 Medical Care.....2

 B. Whether The Formula Adopted In *Ahlborn* To Determine What Portion Of Any
 Recovery Is Attributable To Medical Costs Should Be Applied In Other Cases.....10

CONCLUSION.....21

I.P. ex rel. Canderas v. Henneberry, 2011 WL 1743734 (D.Colo.May 5, 2011), 85
Fed.R.Evid.Serv. 367

CERTIFICATE OF SERVICE AND FILING

TABLE OF AUTHORITIES

CASES

<i>Anderson v. Wood</i> , 204 W.Va. 558, 514 S.E.2d 408 (1999),.....	18
<i>Andrews ex rel. Andrews v. Haygood</i> , 362 N.C. 599, 669 S.E.2d 310 (2008), <i>cert. denied</i> by	
<i>Brown v. North Carolina Dept. of Health and Human Services</i> , 129 S.Ct. 2792, 174 L.Ed.2d 291, USLW 3544 (U.S. Jun 15, 2009) (NO. 08-1146).....	15
<i>Arkansas Dept. of Health and Human Services v. Ahlborn</i> (2006), 547 U.S. 268, 126 S.Ct. 1752; 164 L.Ed.2d 459.....	<i>passim</i>
<i>Cart v. General Electric Company, et al.</i> , 203 W.Va. 59, 506 S.E.2d 96 (1998).....	18
<i>Davis v. Eagle Coal and Dock Co.</i> , 220 W.Va. 18, 640 S.E.2d 81 (2006).....	19
<i>Grayam v. Department of Health and Human Resources</i> , 201 W.Va. 444, 498 S.E.2d 12 (1997).....	9, 14, 15, 17, 18
<i>Kittle v. Icard</i> , 185 W.Va. 126, 405 S.E.2d 456 (1991), <i>overruled</i> by <i>Grayam v. Department of Health and Human Resources</i> , 201 W.Va. 444, 498 S.E.2d 12 (1997).....	17
<i>In re Matey</i> , 147 Idaho 604, 213 P.3d 389, 394 (Idaho 2009).....	3
<i>I.P. ex rel. Canderas v. Henneberry</i> , -- F.Supp. --, 2011 WL 2650223 (D.Colo.Apr. 26, 2011).....	<i>passim</i>
<i>I.P. ex rel. Canderas v. Henneberry</i> , 2011 WL 1743734 (D.Colo.May 5, 2011), 85 Fed.R.Evid.Serv. 367.....	4
<i>National Fruit Product Co., Inc. v. Baltimore and Ohio Railroad Co.</i> , 174 W.Va. 759, 329 S.E.2d 125 (1985).....	19
<i>Porter v. McPherson</i> , 198 W.Va. 158, 479 S.E.2d 668 (1996).....	17
<i>Rehab. Association of Virginia v. Kozlowski</i> , 42 F.3d 1444 (4th Cir. 1994).....	19

Special Needs Trust for K.C.S. v. Folkemer, 2011 WL 1231319 (D.Md. Mar.28,2011).....*passim*

State Dep’t of Health & Welfare v. Hudelson, 146 Idaho 439, 196 P.3d 905 (2008)15

Schweiker v. Gray Panthers, 453 U.S. 34 (1981).....19

Tristani v. Richman, -- F.3d -- 2011 WL 2557234 (3d Cir. (Pa.) June 29, 2011).....*passim*

Wine v. Globe American Casualty Co., 917 S.W.2d 558 (Ky. 1996).....17

STATUTES

42 U.S.C. § 13966, 7

42 U.S.C. § 1396a(a)(25).....7

[(A) requires participating States to "take all reasonable measures to ascertain the legal liability of third parties" for medical expenses paid by Medicaid and (B) to "seek reimbursement for such [medical] assistance to the extent of such legal liability"].

42 U.S.C. § 1396k(a).....7, 8

[Medicaid beneficiaries must "assign the State any rights ... to payment for medical care from any third party." 42 U.S.C. 1396k(a)(1)(A)].

42 U.S.C. § 1396p.....3, 7

[prohibits States from imposing any lien "against the property of any individual prior to his death on account of medical assistance paid." 42 U.S.C. 1396p(a)(1)].

Colorado Revised Statute (“CRS”) §25.5-4-301(5)(a)(2009)..... 15

Ohio Revised Code § 2315.18 (b)(2)(2004).....8

62 PA. STAT. ANN. §1409(b)(11)(2008) [62 P.S. § 1409(b)(11)].....16

W.Va. Code § 9-5-11 (2009).....*passim*

W.Va. Code § 23-2A-1 (1990).....18

West Virginia Code § 44-10-14(g)(2002).....1, 11

RULES

Rule 22, West Virginia Rules of Civil Procedure.....13, 14

**SUPPLEMENTAL BRIEF OF PETITIONER
WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES**

This Supplemental Brief is filed at the request of this Court pursuant to the letter of Chief Counsel Bruce Kayuha, dated August 3, 2011 and Order entered August 30, 2011. The argument in this brief is addressed by way of two subdivisions consistent with the letter and Order.

I. SUMMARY OF MATERIAL FACTS

This case arises from the West Virginia Department of Health and Human Resources' ("DHHR") interest in seeking statutorily-mandated reimbursement from Appellees for funds that the DHHR expended during Appellee E.B.'s enrollment in the West Virginia Medicaid Program. E.B. suffered multiple injuries during his birth on May 5, 2005. Ohio Medicaid spent \$698,225.94 from May 5, 2005 to March 2007 and DHHR spent \$557,104.71 for E.B.'s medical care from March 2007 to December 9, 2009. E.B. is still enrolled in the West Virginia Medicaid program. Respondent Gress has indicated that she intends that E.B. remain on West Virginia Medicaid indefinitely.

Acting as E.B.'s guardian, Ms. Gress filed a medical malpractice action in the United States District Court for the Southern District of Ohio. The case was subsequently settled and Appellees recovered \$3.6 million in settlement proceeds. The proceeds were not allocated between medical and other items of damages. DHHR notified Appellee that it intended to assert a subrogation claim for \$289,075.44 against the settlement proceeds pursuant to W.Va. Code § 9-5-11 (2009).¹ Ohio Medicaid asserted a similar claim regarding its subrogation interest. Pursuant to W.Va. Code §44-10-14 (2002), Gress petitioned the Circuit Court of Hancock County, West Virginia, for approval of the infant settlement and challenged the subrogation claims made by Ohio Medicaid and DHHR in that proceeding. The Circuit Court ruled that the

¹ This amount includes a *pro rata* reduction for attorney's fees based upon Appellees' 40% contingency fee arrangement with their attorneys and a reduction for a proportionate share of the costs.

West Virginia recovery statute was in conflict with the United States Supreme Court decision in *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006) and that based on the Circuit Court's findings of fact, under the formula used in *Ahlborn*,² DHHR was only entitled to recover \$79,053.16.³ The Circuit Court found that the "full value" of the case was \$25,373,937.95; that past medical expenses totaled \$1,255,329.95; that future medical expenses totaled \$19,118,608.00; that damages for pain and suffering totaled \$5,000,000.00. See July 12, 2010 Order. The Circuit Court's conclusion is based on the premises that (1) W.Va. Code § 9-5-11 (2009) is in conflict with federal law; (2) that the State is limited to seeking its reimbursement from the portion of the settlement that is allocated to past medical expenses; and (3) that the formula applied in *Ahlborn* establishes as a rule of law the method to be used in all other cases to determine what portion of the settlement is attributable to medical expenses versus other categories of damages. *Id.* Each of these premises and the conclusions drawn from them by the Circuit Court are clearly erroneous. This brief supplements DHHR's argument on the latter two issues.

II. ARGUMENT

A. WHETHER THE STATE'S REIMBURSEMENT OF PAST MEDICAL EXPENSES PAID BY MEDICAID AGENCIES MAY COME FROM MEDICAL EXPENSES RECOVERED AS PAST AND/OR FUTURE MEDICAL EXPENSES.

Yes. The State may seek reimbursement of medical expenses it paid on behalf of a Medicaid recipient from medical expenses recovered by the Medicaid recipient as past and future medical expenses. See *I.P. rel. Canderas v. Henneberry*, -- F.Supp. --, 2011 WL 2650223 (D.Colo.Apr.26,2011); *Special Needs Trust for K.C.S. v. Folkemer*, 2011 WL 1231319 (D.Md. Mar.28, 2011); *Tristani v. Richman*,-- F.3d -- 2011 WL 2557234 (3d Cir. (Pa.) June 29, 2011).

² By applying the ratio of the "full value" of the case to the actual settlement amount to the medical expense portion.

³ The Court likewise ruled that Ohio Medicaid could only recover \$99,062.70 (14.7% of its expenditure).

6 - 4

In *I.P. v. Henneberry*, the federal Court ruled, *as a matter of law*, that the Colorado Medicaid Agency could seek reimbursement from the portion of Plaintiff's settlement proceeds that represents medical expenses--past and future--up to the total amount it spent on Plaintiff's behalf as of the date [of plaintiff's settlement with the hospital]." 2011 WL 2650223 at 8. The Court rebuffed plaintiff's argument that the Department, in seeking reimbursement for past medical expenses it paid on I.P.'s behalf, was limited to seeking reimbursement from funds allocated to past medical expenses:

Ahlborn does not require, as Plaintiff suggests, that—in seeking this reimbursement—the Department is limited to funds allocated to past medical expenses. The *Ahlborn* Court made no such distinction. It stated instead, “that the federal third-party provisions require an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care.” *Id.* at 282. *See also In re Matey*, 147 Idaho 604 213 P.3d 389, 394 (Idaho 2009)(“The *Ahlborn* Court made no distinction between damages for past care and those for future medical care. Nothing in 42 U.S.C. § 1396p indicates that the State may not seek recovery of its payments from a Medicaid recipient's total award of damages for medical care whether for past, present or future care.”).

Because Plaintiff intends on staying on Medicaid, any funds allocated for future medical expenses should rightfully be exposed to the state's lien so that the state can be reimbursed for its past medical payments. Accordingly, the Court concludes that the Department may seek reimbursement for past medical expenses from funds allocated to “medical expenses,” regardless of whether those funds are allocated for past or future medical expenses.

See also, Special Needs Trust for K.C.S. v. Folkemer, 2011 WL 1231319 at 14 (D.Md.) (finding the observation made by the Idaho Supreme Court in *In re Matey* “persuasive,” that the Department may satisfy its reimbursement from settlement proceeds allocable as past and future medical expenses, and concluding that the anti-lien and anti-recovery provisions of the Social Security Act do not prohibit the State from recouping expenses it paid on behalf of the Medicaid recipient “from settlements that contain unstipulated damage amounts”).

In *I.P. v. Henneberry*, I.P. suffered a brain injury during birth and is permanently disabled. I.P. had been receiving Medicaid since birth. I.P.'s mother and guardian indicated that

she intended that I.P. remain enrolled in the Medicaid Program. The Colorado Medicaid program spent a total of \$836,673.00 in medical assistance on I.P.'s behalf between 2004 and 2009, when she received an undisclosed amount in a settlement with the hospital. The Colorado Medicaid Agency placed a lien on these proceeds in the amount \$736,673.71⁴. Instead of paying Colorado Medicaid, the state court, after approving the settlement, established the I.P. Qualified Settlement Fund and funded it with \$785,000.00 of the settlement. I.P.'s guardian then filed a declaratory judgment action in federal court, seeking a declaration that Colorado's recovery scheme was in violation of the Medicaid Act. She also sought a declaration that, to the extent Colorado's statute was consistent with federal law, the formula used in the *Ahlborn* case applied to allocate the settlement proceeds between medical and other categories of damages and that the Department, in seeking its reimbursement, was limited to funds allocated to past medical expenses. After the Court ruled that Colorado's recovery scheme was consistent with federal law, that Colorado Medicaid could satisfy its subrogation claim for past medical expenses from settlement proceeds allocated to past and future medical expenses, declined to apply the formula used in *Ahlborn* to determine the amount of proceeds allocable to medical expenses, and ruled on evidentiary matters related to this ruling, the case settled. *Id.*; *See also I.P. ex rel. Canderas v. Henneberry*, 2011 WL 1743734 (D.Colo.May 5, 2011); *see also* docket sheet, C.A. No. 09-CV-01681.

In *Special Needs Trust for K.C.S. v. Folkemer*, the United States District Court in Maryland ruled, *as a matter of law*, that the State Medicaid Agency was entitled to full reimbursement from a Medicaid recipient's settlement that had been placed in a "special needs trust" and that the State was not required to pay a *pro rata* share of the Medicaid recipient's attorneys' fees and litigation costs.

⁴ This reflects that the State had recovered \$100,000 in an earlier settlement with the physician.

K.C.S. suffered multiple injuries during birth and requires 24-hour medical care. Maryland Medicaid spent \$298,585.75 on K.C.S.'s care between 2004 and 2009, when she recovered a global settlement of \$3 million from a personal injury settlement with her physicians. Although plaintiff was aware of the State's subrogation interest, she did not notify Maryland Medicaid of the settlement, paid \$1 million to K.C.S.' attorney, and then transferred the entire net recovery of \$2 million to K.C.S.'s trust. Upon learning of the settlement, the Maryland Medicaid Agency sought recovery for the full amount of medical expenses the State had paid on behalf of K.C.S. to the date of settlement. In response, K.C.S, through her guardian, sought a declaratory judgment preventing the recovery from the trust.

K.C.S. alleged that the Maryland Medicaid recovery statute violates federal law (i.e. *Ahlborn* decision) because it allows the Department to seek recovery from her entire settlement instead of from the tortfeasor directly. The Department argued that K.C.S. had assigned her rights to recovery to the Department when she accepted medical assistance and therefore the portion of the settlement that represented past medical expenses actually belonged to the Department and not to K.C.S. Plaintiff also argued that even if the Department was allowed to recover its expenses from her settlement, the recovery should come only from the portion of the settlement that represents past medical expenses and that there should be a *pro rata* set-off for the share of attorneys' fees that were attributable to the Department's recovery. Plaintiff conceded that if the Court ruled in favor of the Department on these "purely legal" issues, "the Department is entitled to reimbursement for the full amount of its claimed subrogation interest (\$298,585.75), and this is regardless of how the [\$3 million] recovery is allocated among the various damages claims." 2011 WL 1231319 at 3, n.3 and at 18, n. 19.

The United States District Court granted the Department's motion for summary judgment on all counts. First, it ruled that Maryland's recovery scheme was consistent with federal law to the extent that Maryland only sought reimbursement for past medical care and that § 1396 does not require the State to directly seek reimbursement from responsible third parties by means of intervening in a lawsuit. *Id.* at 9. Second, the Court ruled that the State can satisfy its reimbursement for past medical expenses from K.C.S.' settlement award for future medical expenses. *Id.* at 18. The Court, citing *Ahlborn*, ruled that because the global settlement failed to stipulate an amount for medical care, the court was authorized to determine the amount that represents past medical care. *Id.* at 13. That was the amount spent by Medicaid (\$298,505.75). *Id.* at 14. The Court concluded that the Department is entitled to a "full recovery," stating that

It was inevitable that the damage award represented payments for both past and future medical costs. The fact that these two compensation categories were placed in the same award should not result in the Department being prohibited from recouping amounts for past awards. Again, there is no indication from the record that [the Department is] attempting to recover anything more than expenses for past medical care. *Id.* at 14.

Tristani v. Richman (3d Cir. Pa. 2011) is cited because it reversed the anomalous holding of the district court, *Tristani v. Richman*, 609 F.Supp.2d 423 (W.D. Pa. 2009), that *Ahlborn* prohibits *any* lien at all against a personal injury recovery. In doing so, the federal appeals court upheld Pennsylvania's long-standing practice (30 years) of placing Medicaid liens on future judgments or settlements. The federal appeals court also ruled that Pennsylvania's current statutory framework--a 50% allocation rule, which affords Medicaid recipients a right of appeal from the statutory allocation, is consistent with federal law. (discussed in next heading.)

The federal appeals court, in *Tristani*, said that "the Supreme Court [in *Ahlborn*] assumed without deciding that [Medicaid] liens, when limited to a portion of the settlement or judgment constituting reimbursement for medical costs, are an 'implied exception to the federal law

prohibiting states from imposing liens on the property of Medicaid beneficiaries.” 2011 WL 2557234 at 3. The appeals court then analyzed the forced assignment and reimbursement provisions of the Social Security Act (42 U.S.C. §§1396k(a)(1)(A), 1396a(a)(25)) with the Act’s anti-lien and anti-recovery provisions (§ 1396p(a)(1)), reviewed their Congressional history, and concluded that Medicaid liens, when limited to the portion of the settlement or judgment constituting reimbursement for medical costs, are *in fact* an implied exception to the federal law prohibiting states from imposing liens on the property of Medicaid beneficiaries:

The text of the Social Security Act, when combined with its structure, purpose, and legislative history, reveals that Congress sought to accomplish different goals in enacting the anti-lien and anti-recovery provisions on the one hand, and the reimbursement and forced assignment provisions on the other hand. While the anti-lien and anti-recovery provisions were intended to protect the assets of Medicaid recipients, the subsequently-enacted forced assignment and reimbursement provisions were intended to limit the financial burden of Medicaid on the states and ensure that Medicaid beneficiaries did not receive a windfall by recovering medical costs they did not pay.⁵ In this context, the forced assignment and reimbursement provisions are best viewed as creating an implied exception to the anti-lien and anti-recovery provisions of the Act. Our conclusion is bolstered by the fact that the statutory mechanism created by Congress for beneficiaries to relinquish their right to recover medical assistance payments to the state—a partial assignment—itself creates a lien [under Pennsylvania law].⁶ Consequently, we hold that liens on settlements or judgments limited to medical costs are not prohibited by the anti-lien and anti-recovery provisions of the Social Security Act. *Id.* at 12.

Thus, the above-cited federal court decisions make it clear that—whether the State asserts its subrogation claim as an “assignment” or a “lien”—federal law allows States to seek recovery for their subrogated interests from the portion of the settlement proceeds intended to compensate the Medicaid recipient for his past and future medical expenses. These decisions also give effect to the Supreme Court’s statement, in *Ahlborn*, that 42 U.S.C. § 1396k(a) “requires” that “the

⁵ In response to the Dissent’s argument that any windfall to Medicaid beneficiaries can be avoided by precluding beneficiaries from claiming amounts paid by Medicaid in their suits against third parties, the Court replied that it was “unpersuaded by this approach because it would result in a windfall to tortfeasors.” *Id.* at FN 16.

⁶ The Court reasoned that “[t]he more logical conclusion is that Congress understood the legal effect of the forced assignment provision would be to provide the states with a lien on recoveries of medical costs.”

State be paid first out of *any* damages representing payments for medical care *before* the recipient can recover any of her own costs for medical care.” *Ahlborn*, 547 U.S. at 282 (emphasis added). In *I.P.* and *K.C.S.*, the federal district courts also made it clear that the Medicaid recipient could not circumvent the law by placing the settlement proceeds in a trust.

In the present case, there is no *Ahlborn* violation because the DHHR is only attempting to recover expenses for past medical care from the medical expense portion of the settlement. It is evident that the damage award represents payments for both past and future medical costs. The fact that these two compensation categories were placed in the same award does not result in the DHHR being prohibited from recouping amounts for past awards. *I.P.*; *supra*; *K.C.S.*, *supra*. Because E.B. intends on staying on Medicaid, any funds allocated for future medical expenses should rightfully be exposed to DHHR’s subrogation claim so that the DHHR can be reimbursed for its past medical expenses. Because DHHR can seek reimbursement from the portion of Appellees’ settlement proceeds that represents E.B.’s medical expenses—past and future--up to the total amount DHHR spent on E.B.’s behalf as of December 9, 2009, DHHR is entitled to its full reimbursement, less its *pro rata* share of attorney's fees and costs (\$289,075.44). This is regardless of whether the medical expense portion of the settlement is determined under W.Va. Code § 9-5-11 (2009) or by using the formula applied in *Ahlborn*. And this is regardless of whether the economic cap on non-economic damages⁷ is properly applied to the calculation under the formula in *Ahlborn*.

Under the formula applied in *Ahlborn*, using the Circuit Court’s factual findings, 80.29% of the \$3.6 million settlement, or \$2,890,440.00, is allocable to medical care;⁸ if the statutory cap

⁷ The cap for non-economic damages in Ohio is \$350,000. *See* Ohio Revised Code § 2315.18 (b)(2)(2004).

⁸ Amount of settlement: \$3,600,000.00. Assuming “full value” of the case = \$25,373,937.95.
Medical costs paid by DHHR to 12-9-09: \$557,104.71; Medical costs paid by Ohio Medicaid: \$698,225.94.

is applied, then 98.31% of the settlement proceeds, or \$3,539,160.00, is allocable to medical care.⁹ If the “full” value of the case is the actual amount of the settlement, then \$3,250,000.00 is allocable to medical care.¹⁰ Since the portion of the settlement allocable to medical care is greater than the total past medical expenses paid by the Medicaid Agencies on behalf of E.B. under any of these methodologies, the Medicaid Agencies are entitled to full reimbursement of their subrogation claims. *I.P.*, *supra*; *K.C.S.*, *supra*; *Tristani*, *supra*.

Accordingly, the DHHR is entitled to its full recovery, less its *pro rata* share of attorney’s fees and costs – i.e., \$289,075.44 – and to be paid before the funds recovered for medical care are placed in a trust account. *Id.*; *Ahlborn*, 547 U.S. at 284; 42 U.S.C. § 1396k(a); *Grayam v. Department of Health and Human Resources*, 201 W.Va. 444, 498 S.E.2d 12 (1997); W.Va. Code § 9-5-11 (2009). The Circuit Court of Hancock County erred in holding otherwise.

B. WHETHER THE FORMULA ADOPTED IN *AHLBORN* SHOULD BE APPLIED IN OTHER CASES TO DETERMINE WHAT PORTION OF A MEDICAID RECIPIENT’S SETTLEMENT IS ATTRIBUTABLE TO MEDICAL COSTS.

No. The *Ahlborn* decision did not establish as a rule of law a formula to calculate the allocation of settlement proceeds in all other cases. *Ahlborn* merely decided that the State’s Medicaid reimbursement extends no further than the portion of the settlement representing medical expenses (in that case, the precise amount stipulated by the parties). W.Va. Code § 9-5-11 (2009) is consistent with federal law. Specifically, W.Va. Code § 9-5-11 states that the State’s assigned right extends no further than the right to recover to “the extent of the reasonable

Total past medical costs (as of 12-9-09): \$1,255,329.95.
Future medical costs: \$19,118,608.
Total medical costs: \$1,255,329.95 + \$19,118,608 = \$20,373,937.95.
Ratio of medical costs to full value of the case: \$20,373,937.95 ÷ \$25,373,937.95 = .8029, or 80.29%.
Portion of the settlement allocated to medical costs: .8029 x 3,600,000 = \$2,890,440.

⁹ If the Statutory Cap on non-economic damages applies, the “full value” of the case is \$20,723,967.95 [\$20,373,937.95 + \$350,000.00]. Percentage allocable to medical care is 98.31% [\$20,373,937.95 (total medicals) ÷ \$20,723,967.95 (“full value”)]. Portion allocable to medical care is .9831 x \$3.6 million = \$3,539,160.00.

¹⁰ \$3.6 million - \$350,000 (statutory cap non-economic damages) = \$3,250,000 (medical expense portion).

value of the medical assistance paid and attributable to the sickness, injury, disease or disability for which the recipient has received damages.” *I.P. ex rel. Canderas v. Henneberry, supra; Special Needs Trust for K.C.S. v. Folkemer, supra; Tristani v. Richman, supra*. The West Virginia Legislature validly adopted a procedure to divide settlements between medical costs and other expenses that is consistent with federal law (i.e., W.Va. Code § 9-5-11(b) (2009)). Courts in West Virginia “must follow the legislative mandate.” *Grayam v. Department of Health and Human Resources*, 201 W.Va. at 454, 498 S.E.2d at 22.

In *Ahlborn*, the parties stipulated to an amount representing total recovery for medical expenses and applied the ratio of the settlement to the full value of the case. The Court simply accepted the stipulation and then applied the same ratio to the portion allocated for medical expenses (“the so-called *Ahlborn* formula”):

...as is evident from the context of the emphasized language, “such legal liability” refers to “the legal liability of third parties ... *to pay for care and services available under the plan.*” § 1396a(a)(25)(A) (emphasis added). Here the tortfeasor has accepted liability for only one-sixth of the recipient’s overall damages, and ADHS has stipulated that only \$35,581.47 of that sum represents compensation for medical expenses. Under the circumstances, the relevant liability extends no further than that amount. 457 U.S. at 280-81.

See also 457 U.S. at 282, n. 12 (“Given 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...”). Thus, the formula used by the *Ahlborn* Court was a product of the parties’ stipulation; the Supreme Court did not create a formula for use in other cases. *See, I.P.* at 6 (“The *Ahlborn* formula was strictly the product of the parties’ stipulation...In the absence of a similar stipulation here, the Court will not dictate how the parties should allocate the proceeds in the settlement”); *K.C.S.* at 13 (“It is critical to note that in *Ahlborn* the settlement amount for past medical care was stipulated in the settlement”). *See also, Tristani*, 2011 WL 2557234 at 14

(agreeing with the district court that *Ahlborn* permitted States to adopt “special rules and procedures” as an alternative to judicial allocation).

In the present case, there is no such stipulation and the facts are materially different from *Ahlborn*. Also, no party here urges a construction of West Virginia law that would violate the pronouncement in *Ahlborn* because the parties agree that DHHR’s subrogation claim extends no further than the portion of the recovery representing medical costs.¹¹

State tort and insurance law, tort rights of action, subrogation, judicial procedures and settlement standards, are matters of State law. *Ahlborn* does not prohibit States from implementing procedures to allocate unallocated settlements or to give priority to payment of economic expenses (such as medical expenses) from judgments or settlements before distribution of the settlement proceeds for noneconomic damages.¹² *Tristani*, at 14. In fact, *Ahlborn* specifically references the possibility that States may have rules and procedures in place for allocating tort settlements and giving such preference. *Id.* The Supreme Court, in *Ahlborn*, recognized the possibility that plaintiffs would manipulate settlement agreements to artificially depress the portion attributable to medical expenses. In *Ahlborn*, the Court suggested that this risk could be avoided either by obtaining the State’s advance agreement to an allocation or, if

¹¹ Appellee testified that “more than half” of the recovery constituted medical expenses and argued that 80.29% of the damages, based on the “full value” of the case, was attributable to past and future medical expenses.

¹² It is noted that West Virginia Code § 44-10-14(g), governing minor settlement proceedings, expressly directs the Court to order payment of medical expenses *before* distribution of the net settlement proceeds to the minor:

...the court *shall* provide by order that an attorney appearing in the proceeding shall negotiate, satisfy and pay initial expense payments from settlement proceeds, the costs and fees incurred for the settlement, and any bond required therefore; *expenses for treatment of the minor related to the injury at issue*, payments to satisfy any liens on settlement proceeds, if any, and such other directives as the court finds appropriate to complete the settlement and secure the proceeds for the minor.

necessary, by submitting the matter to a court for decision.” 547 U.S. at 288. In a footnote the Court stated:

[some States have adopted special rules and procedures for allocating tort settlements in circumstances where, for example, private insurers’ rights to recovery are at issue. Although we express no view on the matter, we leave open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulations. *Id.* at n.18.

The West Virginia Legislature, in enacting W.Va. Code § 9-5-11, expressed its concern that parties would manipulate settlement agreements to artificially depress the portion attributable to medical expenses:

....The right of subrogation created in this section includes all portions of the cause of action, by settlement, compromise, judgment or award, notwithstanding any settlement allocation or apportionment that purports to dispose of portions of the cause of action not subject to the subrogation. Any settlement, compromise, judgment or award that excludes or limits the costs of medical services or care shall not preclude the Department of Health and Human Resources from enforcing its rights under this section. The [S]ecretary may compromise, settle and execute a release of any such claim, in whole or in part. W.Va. Code § 9-5-11(a).

W.Va. Code § 9-5-11 provides for “special rules and procedures” of the kind that are consistent with the federal requirement that the State recovery not exceed the portion of the third party recovery attributable to Medicaid-paid expenses. Specifically, it provides for a *pro rata* reduction for attorney’s fees and procurement costs “irrespective of whether the case be terminated by judgment or by settlement without trial”¹³ and sets forth the following settlement standards and procedures, consequences of non-compliance and procedure for judicial review:

Nothing in this section shall preclude any person who has received medical assistance from settling any cause of action which he or she may have against another person and delivering to the Department of Health and Human Resources, from the proceeds of such settlement, the sums received by him or her from the department or paid by the Department of Health and Human Resources in the matter. If such other person is aware of or has been informed of the interest of the

¹³ Federal law does not require a *pro rata* reduction for attorney’s fees and costs. *See K.C.S.* at 17.

Department of Health and Human Resources in the matter, it *shall* be the duty of the person to whose benefit the release inures to withhold so much of the settlement as may be necessary to reimburse the department to the extent of its interest in the settlement. No judgment, award of or settlement in any action or claim by a medical assistance recipient to recover damages for injuries, disease or disability, in which the Department of Health and Human Resources has interest, shall be satisfied without first giving the department *notice and reasonable opportunity to establish its interest*. The department shall have sixty days from receipt of such written notice to advise the recipient or his or her representative in writing of the department's desire to establish its interest through the assignment. If no such written intent is received within the sixty-day period, then the recipient may proceed and *in the event of full recovery* forward to the department the portion of the recovery proceeds less the department's share of attorney's fees and costs expended in the matter. *In the event of less than full recovery* the recipient and the department *shall agree* as to the amount to be paid to the department for its claim. If there is no recovery, the department shall under no circumstances be liable for any costs or attorney's fees expended in the matter. (emphasis added).

If, after being notified in writing of a subrogation claim and possible liability of the recipient, guardian or attorney or personal representative for failure to subrogate the department, a recipient, his guardian, attorney or personal representative disposes of the funds representing the judgment, settlement or award, *without the written approval of the department*, that person *shall be liable* to the department for any amount that, as a result of the disposition of the funds, is not recoverable by the department. (emphasis added)

In the event that a controversy arises concerning the subrogation claims by the department, an attorney *shall interplead*, pursuant to rule twenty-two of the Rules of Civil Procedure, the portion of the recipient's settlement that will satisfy the department exclusive of attorney's fees and costs regardless of any contractual arrangement between the client and the attorney. (emphasis added)

W.Va. Code § 9-5-11(b) operates as a "notice and hold" provision.¹⁴ It puts the Medicaid recipient on notice that he owes the DHHR a sum of money and that the DHHR has a right to file a claim to collect that money. The "notice and hold" provision serves as an agreement with the Medicaid recipient, enabling the State to assert its rights to reimbursement of the cost of medical care, without directly intervening in the tort suit. *See K.C.S.*, 2011 WL 1231319 at 12 (construing a similar provision in Maryland's statute). This provision ensures that the recipient has the

¹⁴ The word "lien" does not appear anywhere in W.Va. Code § 9-5-11(2009).

opportunity to fully recover damages resulting from his injury and that the DHHR will have the opportunity to recover its reimbursement to the full extent of medical costs recovered.¹⁵

Subdivision (b) creates a procedure whereby, in the event of full recovery, an unallocated settlement will be allocated first to medical expenses, from which the DHHR can satisfy its reimbursement up to the full amount of the expenses paid by the DHHR, reduced by a *pro rata* share of attorney's fees and costs. In the event of less than full recovery, the Statute directs the recipient to contact the DHHR and attempt to negotiate an agreement. "The Secretary has the sole discretion to 'compromise, settle, and execute a release of any ... claim...'" *Grayam v. Department of Health & Human Resources*, 201 W.Va. at 453, 498 S.E.2d at 21. In the case of no agreement, the liable third party, the third party liability insurer, or an unhappy recipient can challenge the statutory allocation, or the Secretary's refusal to a lesser amount than that proposed by the Medicaid recipient, by interpleading, pursuant to Rule 22 of the West Virginia Rules of Civil Procedure, "the portion of the recipient's settlement that will satisfy the Department's [subrogation claim] exclusive of attorneys fees and costs" for resolution by the court.

In the event of interpleader, the circuit court will ultimately have to make factual findings; e.g., as to the amount of past medical expenses and as to how the settlement proceeds should be allocated between medical expenses (past and future) and other categories of damages. However, the circuit court's review must be against the backdrop of W.Va. Code § 9-5-11 – i.e., the circuit court must consider that W.Va. Code § 9-5-11 gives DHHR a priority right to collect on its assigned claim "to the extent of the reasonable value of the medical assistance paid" from the Medicaid recipient's recovery for medical expenses. *See, I.P.*, 2011 WL 1743734 at 2 (ruling that, in making a factual finding as to how the settlement proceeds should be allocated between medical and other categories of damages, "the Court will have to consider that the Colorado

¹⁵ Many settlements are driven by past medical expenses, which provide "hard" numbers for negotiation.

statute allows Defendants to collect on their lien to the fullest extent allowed by federal law,” citing CRS §25.5-4-301(5)(a)). *Accord, Grayam v. Department of Health and Human Resources*, 201 W.Va. at 454, 498 S.E.2d at 22 (“The Court must follow the legislative mandate”).¹⁶

In *Tristani*, the Third Circuit Court of Appeals ruled that Pennsylvania’s current statutory framework, which provides for a 50% allocation rule, including the right to appeal the statutory allocation, “is consistent with the Supreme Court’s holding in *Ahlborn* and comports with the practice of other states.”¹⁷ 2011 WL 2557234 at 14. The appeals court affirmed the district court’s ruling that Pennsylvania’s 50% allocation rule¹⁸ and agency appeal provisions are “special rules and procedures” of the kind suggested by *Ahlborn* as an alternative procedure to judicial allocation. *Id.*

The federal appeals court in *Tristani* expressed “no view as to whether allocation disputes of this type must be adjudicated by a court, or may instead be resolved through other ‘special rules and procedures.’” *Ahlborn* at 288, n.18. “We hold merely that in determining what portion of a Medicaid beneficiary’s third-party recovery it may claim in reimbursement for medical expenses, the state must have in place procedures that allow a dissatisfied beneficiary to challenge the default allocation.” *Id.* at 15. Likewise, the federal district courts in *I.P.* and *K.C.S.* expressed no view on this issue. Those courts merely reflect that *Ahlborn* permits judicial allocation. The Court, in *I.P.*, did rule that judicial allocation in Colorado must be against the backdrop of the Colorado recovery statute. 2011 WL 1743734 (May 5, 2011) (“the Court will

¹⁶ The Medicaid recipient should have to first come forward with sufficient evidence that the amount recovered for medical care expenses (past and future) is less than the amount claimed by the DHHR to satisfy its subrogation interest. *I.P.*, *supra*; *K.C.S.*, *supra*.

¹⁷ Reference was made to decisions of the North Carolina and Idaho Supreme Courts. *Andrews ex rel. Andrews v. Haygood*, 362 N.C. 599, 669 S.E.2d 310, 314 (2008); *State Dep’t of Health & Welfare v. Hudelson*, 146 Idaho 439, 196 P.3d 905, 911 (2008).

¹⁸ In the absence of a judicial allocation of damages, the Pennsylvania Department of Public Welfare is entitled to recover the lesser of its actual expenditures on medical costs or one half of the beneficiary’s recovery after expenses. 2011 WL 2557234 at 13, interpreting 62 PA. STAT. ANN. §1409(b)(11)(2008).

have to consider that the Colorado statute allows Defendants to collect on their lien to “the fullest extent allowed by federal law”).

In West Virginia, the *pro rata* reduction for attorney’s fees and costs is roughly equivalent to a 50 – 60 % allocation rule, depending on the recipient’s fee arrangement with her attorney and her litigation costs in procuring the settlement.¹⁹ In the present case, application of W.Va. Code § 9-5-11 reduced DHHR’s claim 49%. In addition, the Secretary of the DHHR has discretion to compromise the claim. For example, when the past medical expenses exceed the recovery, the Secretary can authorize DHHR to allocate one-third of the settlement to medical expenses, one-third to the Medicaid recipient’s attorney and one-third to the Medicaid recipient. Thus, the provision for a reduction for attorney’s fees and costs and the provision authorizing the Secretary to exercise discretion and the provision for a judicial review *via* interpleader,²⁰ prevents the State from eviscerating the rule, in *Ahlborn*, that the State’s reimbursement extends no further than the portion of the settlement representing medical expenses. *Tristani, supra*.

When allocating medical and non-medical damages in an otherwise unallocated settlement, what matters is that medical expenses are distinguished in the settlement from other damages on the basis of a rational approach. *Ahlborn*, 547 U.S. at 280-82; *I.P. v. Henneberry*, 2011 WL 2650223 at 6 (“The Department’s recovery will be limited to those funds allocated to compensation for medical costs, regardless of the method used to make that allocation”). Absent a stipulation, and facts similar to the *Ahlborn* case, the formula used in *Ahlborn* may not provide a rational approach to resolving this problem. *I.P., supra*; *K.C.S., supra*; *Tristani*.

¹⁹ As noted, under the Medicaid Act, the State is not required to reduce its subrogation claim by a *pro rata* reduction of attorney’s fees and costs. *K.C.S., supra*.

²⁰ The judicial review proscribed by W.Va. Code § 9-5-11 (2009) is comparable to the judicial review provided for an administrative “appeal” in Pennsylvania, North Carolina and Idaho.

Importantly, whether or not to adopt the *Ahlborn* formula as a rule of law in other cases raises serious public policy considerations and a balancing of the public interest with the interests of Medicaid beneficiaries, third parties and their insurers. For example, whether allocation hearings would substantially curtail the State's federally mandated recovery under the Medicaid Act and increase the burden of Medicaid on the States; the logistical problems associated with a theory (like the one advanced in this case) that requires a judicial ascertainment of the platonic "true value" of a plaintiffs' claims;²¹ whether mini trials replete with competing damages experts and witnesses testifying as to issues like humiliation, pain and suffering, loss of enjoyment of life, would undermine the economy of settlement;²² the strain on resources to send State employees across the State of West Virginia to participate in evidentiary allocation hearings each time a Medicaid recipient recovers from a third party; that case by case determination of the medical portion of settlements could lead to variable results and increased litigation due to inconsistency in outcomes.

The Supreme Court of Appeals of West Virginia has consistently recognized that Medicaid is purely a creature of statute. It has consistently deferred to the Legislature in the formulation of the intricacies of the Medicaid recovery scheme. For example, in *Kittle v. Icard*, 185 W.Va. 126, 405 S.E.2d 456 (1991), *overruled by Grayam v. DHHR*, 201 W.Va. 444, 498 S.E.2d 12 (1997), the Court addressed the issue of whether the equitable "made-whole" rule²³

²¹ This is especially problematic when the court ruling on the subrogation issue is not the court that tried the underlying action.

²² See *I.P. v. Henneberry*, 2011 WL 1743734, Rules of admissibility of evidence apply to such hearings.

²³ The made-whole rule has been interpreted in insurance cases to mean that "[u]nder general principles of equity, in the absence of statutory law or valid contractual obligations to the contrary, an insured must be fully compensated for injuries or losses sustained (made whole) before the subrogation rights of an insurance carrier arise." *Grayam* at 16-17, 448-449, citing, *Wine v. Globe American Casualty Co.*, 917 S.W.2d 558, 562 (Ky. 1996). "The equitable principle underlying the made-whole rule in insurance subrogation cases is that the burden of loss should rest on the party paid to assume the risk (the insurer) and not on the party least able to shoulder the loss (the inadequately compensated insured)." *Grayam* at 17, 449, citing *Porter v. McPherson*, 198 W.Va. 158, 163, 479 S.E.2d 668, 673 (1996) (citing *Wine*, 917 S.W.2d at 562). Medicaid is not insurance. It is entirely funded by the taxpayers.

applies in a subrogation claim made pursuant to the original version of W.Va. Code § 9-5-11 (1990). In resolving this issue, the Court held that “the usual and ordinary definition of subrogation should be applied unless the legislature clearly expresses an intent within the statute to give subrogation a different meaning.” *Kittle*, 185 W.Va. at 130, 405 S.E.2d at 460. Finding no intent by the legislature that the usual and ordinary definition of subrogation should not apply, and in light of the equitable principles underlying the doctrine of subrogation, the *Kittle* Court concluded that the right to subrogation may be limited by the “made-whole rule” to deny DHHR full reimbursement for medical assistance payments from proceeds of the settlement obtained by the Medicaid recipient. *Id.* at 133-34, 405 S.E.2d at 463-64. *Kittle* was superseded by statute, as explained in Syllabus Point 2 of *Grayam v. Department of Health and Human Resources*, 201 W.Va. 444, 498 S.E.2d 12 (1997), as follows:

In both the 1993 and 1995 amendments to West Virginia Code § 9-5-11 (Supp. 1993 & Supp. 1995), the legislature rendered the made whole rule inapplicable by clearly and unambiguously modifying the usual and ordinary meaning of subrogation as it is used in that statute. Pursuant to these amendments, if another person is legally liable to pay for medical assistance provided by the Department of Health and Human Resources, the Department possesses a priority right to recover full reimbursement from any settlement, compromise, judgment, or award obtained from other person or from the recipient of such assistance if he or she has been reimbursed by the other person.

In *Anderson v. Wood*, 204 W.Va. 558, 514 S.E.2d 408 (1999), the Court reiterated that *Grayam*'s recognition of DHHR's right of full subrogation for medical expenses was based upon this court's finding that W.Va. Code § 9-5-11(a) authorized subrogation.

In *Cart v. General Electric Company, et al.*, 203 W.Va. 59, 506 S.E.2d 96, 100 (1998), this Court, in refusing to apply the “made whole” rule to the State's statutory subrogation rights under the workers compensation system, W.Va. Code § 23-2A-1 (1990), proclaimed:

We have traditionally stated that our workers' compensation system is entirely a statutory creature and for this reason we feel that judicial intrusion into the statutory framework, particularly on so complex an issue, is unwarranted. *Id.*, citing *National Fruit Product Co., Inc. v. Baltimore and Ohio Railroad Co.*, 174 W.Va. 759, 765, 329 S.E.2d 125, 132 (1985); 2A Arthur Larson § 74.31(b) (1996) (Analyzes the various state workers' compensation statutes and concludes that "[r]eimbursement of the compensation payor according to the terms of the statute is mandatory, and cannot be modified by courts.")

The same reasoning should be applied--but with greater force--to Medicaid subrogation. Not only is Medicaid purely statutory, it is extremely complex. The United States Supreme Court has called the Medicaid laws "an aggravated assault on the English language, resistant to attempts to understand it." *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981). The United States Court of Appeals for our own Fourth Circuit has called the Medicaid Act one of the "most completely impenetrable texts within human experience" and "dense reading of the most tortuous kind." *Rehab. Association of Virginia v. Kozlowski*, 42 F.3d 1444, 1450 (4th Cir. 1994). To the extent that Medicaid subrogation statutes are consistent with federal law, reimbursement of the State Medicaid Agency according to the terms of the statute is mandatory. *I.P., supra*; *K.C.S., supra*; *Tristani, supra*. Accord, *Grayam v. DHHR, supra*.

"Preemption is disfavored in the absence of convincing evidence warranting its application." *Davis v. Eagle Coal and Dock Co.*, 220 W.Va. 18, 23, 640 S.E.2d 81, 86 (2006), quoting *Hartley Marine Corp. Mierke*, 196 W.Va. 669, 673, 474 S.E.2d 599, 603 (1996).

Accordingly, the formula used in *Ahlborn* should not be adopted as a rule of law in this or other cases absent a stipulation and agreement with the DHHR.

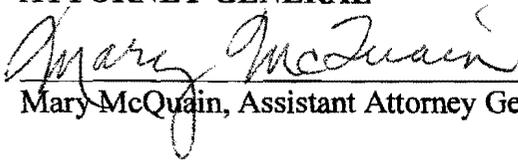
CONCLUSION

The recent decisions from federal courts in Colorado, Maryland and Pennsylvania make it clear that a State may seek reimbursement for its past medical expenses from settlement proceeds intended to compensate a Medicaid recipient for his past and future medical expenses.

Thus, in the present case, the DHHR is entitled to its full reimbursement, less a *pro rata* reduction for attorney's fees and costs, regardless of whether the allocation for the medical expense portion of the settlement is determined pursuant to W.Va. Code § 9-5-11 or by the formula applied in *Ahlborn*. The Circuit Court erred in holding otherwise. The formula in *Ahlborn* should not be applied in other cases absent a stipulation and facts similar to that case. In the present case, there was no such stipulation and the facts are materially different. West Virginia's current statutory framework is consistent with the Supreme Court's holding in *Ahlborn* and comports with the practice of other states. Because Medicaid is purely statutory and Medicaid subrogation involves consideration of complex issues of public policy, this Court should defer to the Legislature whose province it is to formulate rules and standards concerning the intricacies of the Medicaid recovery scheme. Accordingly, this case should be reversed and remanded to the Circuit Court with instructions to forthwith pay over, from the escrow account, the amount of \$289,075.44, plus interest, to the West Virginia Department of Health and Human Resources, and provide the DHHR such further relief as this Court deems appropriate.

**MICHAEL J. LEWIS, Secretary, West Virginia
Department of Health and Human Resources,
Petitioner By Counsel**

**DARRELL V. MCGRAW, JR.
ATTORNEY GENERAL**



Mary McQuain, Assistant Attorney General (W.Va. Bar #713)

EXHIBITS

ON

FILE IN THE

CLERK'S OFFICE