The *Ahlborn* Case and What it Means to Recoveries

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Heidi Ahlborn, who had hoped to be a teacher, has taught us a lesson. Despite her horrific injuries she is still doing so as we continue to work out the meaning and effect of the Ahlborn case.[1] Ms. Ahlborn's case involved how to allocate the ultimate responsibility of paying for an injured party's damages when there is more than one source available, including the State's Medicaid agency.[2] Medicaid is designed to provide secondary coverage—that is, paying for covered expenses after all other sources are exhausted.

Medicaid (a benefits program funded partly from Federal and partly from State resources) is intended to be the payor of last resort. Other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program.[3]

On the other hand, no lien may be imposed against any individual prior to death because of Medicaid payments.[4] In Ahlborn, the United States Supreme Court determined the appropriate method of implementing Medicaid's secondary payor status described above consistently with Medicaid's anti-lien Statute.

Heidi Ahlborn was a 19-year-old college student when she was involved in a serious automobile accident on January 2, 1996, that left her severely and permanently disabled. As a result, her brain was damaged, she was unable to complete her college education, and she found herself incapable of pursuing her chosen career.[5] The accident was not her fault, and she eventually filed a State court suit against the driver. In the meantime, she applied for and was given financial assistance under the Arkansas Medicaid program, and Medicaid had paid $216,645.30 for her care as of the date of her personal injury settlement.[6]

In the lawsuit she claimed a number of items of unliquidated damage compensable in a personal injury suit under local law: (a) permanent injury; (b) past and future medical expenses; (c) past and future pain, suffering and mental anguish; (d) past loss of earnings and working time; and (e) permanent impairment of ability to earn in the future.[7] The case eventually settled out of court with the defendant insurer paying $525,000 and her own underinsured motorist carrier paying $25,000.[8] In the settlement, there was no allocation between the various elements of damage claimed in her suit.

The State's Medicaid program asserted a "lien or claim" on $215,645.30 of the settlement proceeds, "The slight discrepancy in the numbers reflects adjustments made to eliminate Medicaid payments made on Ms. Ahlborn's behalf for medical care unrelated to injuries sustained in the car accident."[9] The position of the State Medicaid agency was that it was entitled to be reimbursed the full amount of its claim from the settlement. Ms. Ahlborn's position was that the settlement was less than the full amount of her damages and that the State's reimbursement should be limited to the proportion based on the value of its claim to the whole of the recovery.

Both parties confirmed the underinsured carrier's conclusion that Ms. Ahlborn had suffered damages well in excess of the settlement total, stipulating that an estimate of the true value of her claim as liquidated would be roughly $3,040,708.12. Thus, her recovery was approximately one-sixth of her actual damages, and the U. S. Supreme Court held that the State Medicaid agency would be limited to recovering a similar fraction of its claim, or $35,581.47.[10]

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Special needs require special attorneys.

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The opinions at the trial, appellate and Supreme court levels made no distinction as to the source of her recovery, whether from her own car's underinsured carrier or from the other driver's carrier.

The Court was required to navigate between several apparently conflicting statutory provisions. In the author's opinion, the Court used the twin guide of fundamental fairness and plain language statutory construction to reach the conclusion described here.

Federal Medicaid law requires that participating States "ascertain the legal liability of third parties ... to pay for [a beneficiary's] care and services available under the [State's] plan,"[11] to "seek reimbursement for [medical] assistance to the extent of such legal liability,"[12] to enact "laws under which, to the extent that payment has been made ... 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,"[13] and to "provide that, as a condition of [Medicaid] eligibility ..., the individual is required ... (A) to assign the State any rights ... to payment for medical care from any third party; ... (B) to cooperate with the State ... in obtaining [such] payments ... and ... (C) ... in identifying, and providing information to assist the State in pursuing, any third party who may be liable".[14] In an effort to carry out its understanding of this requirement, the state of Arkansas passed legislation providing that a Medicaid recipient's third party recovery was automatically subject to a lien for the full amount of Medicaid benefits paid on account of the injuries giving rise to the recovery, without any adjustment for other items of damage included in the award (or, presumably for any reduction in the award based on comparative negligence).[15]

The statute provided:

(a) As a condition of eligibility, every Medicaid applicant shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to the Department of Human Services to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.

(b) The application for Medicaid benefits shall, in itself, constitute an assignment by operation of law.[16]

Thus, under the local law before the courts decision, the Medicaid agency would be entitled to full reimbursement out of any damage award to the detriment of compensating the beneficiary for her other injuries, even though those other injuries might have been a component of the liquidated amount. The Court found that under the facts of Ahlborn, this position conflicted with the Medicaid law's anti-lien provision which prohibits states from imposing liens "against the property of any individual prior to his death on account of medical assistance paid ... on his behalf under the State plan."[17]

The Court held that federal third-party liability provisions require an assignment of no more than the right to recover that portion of a settlement that represents payments for medical care.[18]

There is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care. So much is expressly provided for by §§ 1396a(a)(25) and 1396k(a). And we assume, as do the parties, that the State can also demand as a condition of Medicaid eligibility that the recipient "assign" in advance any payments that may constitute reimbursement for medical costs. To the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) and 1396k(a), it is an exception to the anti-lien provision. See Washington State Dept. of Social and Health Servs. v. Guardianship Estate of Keffeler, 537 U.S. 371, 383-385, and n. 7, 123 S.Ct. 1017, 154 L.Ed.2d 972 (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.[19]

The Court thus determined that a Medicaid agency would be entitled to proportional reimbursement for the benefits it paid. The agency's claim for full reimbursement was denied.

The decision in the Ahlborn case, while consistent with at least one State's holding,[20] came as a surprise to the Federal Department of Health and Human Services which had previously interpreted the statute to allow full recovery.[21] Although the Court generally accords deference to a Federal agency's construction of a statute which it administers,[22] the Court declined to do so because it found that the Agency's "reasoning couples internal inconsistency with a conscious disregard for the statutory text."[23]

Prior to Ahlborn, the Disability Appeals Board of the Department of Health and Human Services had upheld a full reimbursement plan.[24] Since this decision marked a change in current wisdom at least among Medicaid agencies including the Centers for Medicare and Medicaid Services, it should be no surprise to learn that while this decision drew acclaim from some commentators, it drew criticism from others. The titles of three articles, published in 2007, illustrate the divergence of opinions.

Keeping the Government Away From Medicaid Recipients' Pocketbook: Protecting Medicaid Recipients'

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Rights to Proceeds of Third-Party Settlements in Arkansas Department of Health & Human Services v. Ahlborn[25]

An Accident Waiting to Happen: Arkansas Department of Health & Human Services v. Ahlborn Exposes Inequities in Medical Benefits Legislation[26]

Supreme Court Redefines Personal Injury Playing Field.[27]

These articles view the decision from different perspectives. Perhaps the most cogent of the three is the third, written by a Maryland attorney practicing on the defense side of product liability and professional malpractice litigation, who pointed out that the effect of Ahlborn was to give Medicaid agencies the same rights that have applied to private parties "under well-established rules of subrogation."[28]

Medical Assistance is limited in its recovery not just by the amount it pays, but by the category of damages for which it has paid. . . .

Following these principles, Medical Assistance can only recoup amounts earmarked or determined to be "past medical expenses," and then only in an amount commensurate with the overall settlement. This is the same result (albeit via slightly different reasoning) as the Court reached in Ahlborn.

How then to establish the "true value" of the case so as to arrive at the proportional reduction via settlement as contemplated by Ahlborn? The easiest and most direct route would be by stipulation with Medical Assistance. Given that §15-120 [applicable Maryland law] obligates a recipient's attorney to notify Medical Assistance of the existence of the claim prior to negotiating a settlement and imposes a three-day grace period prior to resolution of a cause of action for Medical Assistance to "establish its subrogated interest," this would be an ideal opportunity to negotiate such a proportion (especially with Ahlborn in your back pocket). In the absence of that, one might enlist the help of a mediator to give Medical Assistance a higher level of comfort as to the true value of the case and the reasonableness of the settlement number. Failing that, a court hearing on allocation will be necessary. Such hearings are routine in many jurisdictions regarding private insurer subrogation rights. See, e.g., Henning v. Wineman, 306 N.W.2d 550 (Minn. 1981); Rimes v. State Farm Mut. Auto Ins. Co., 316 N.W.2d 348 (Wisc. 1982).

Evidence to be presented at such a hearing might include reports from the damages experts on both sides of the case to establish the nature and extent of injury (and associated costs), as well as reports of jury verdicts or settlement in similar cases. Allocation agreements simply between plaintiff's counsel and the alleged tortfeasor's counsel will likely not be sufficient and might very well run afoul of "the risk that parties to a tort suit will allocate away the State's interest. …" Ahlborn at 1765.[29]

Roughly two months after the Supreme Court's Ahlborn decision was announced, the Centers for Medicare and Medicaid Services published a memorandum "to clarify third party rules and options for States in the context" of Ahlborn.[30] It characterized Ahlborn as: "A State's lien laws may only operate to recover from that portion of a settlement that is allocated to healthcare items or services, even if it means that Medicaid must forego full recovery of its claim."[31]

The memorandum suggested two political strategies to avoid Ahlborn's requirement of proportional reimbursement. First, states could enact laws which provide for a specific allocation among damage items, i.e., pain and suffering, lost wages, and medical claims. Second, "[a]ccording to Ahlborn, federal Medicaid anti-lien law precludes the State from passing lien laws which broaden the recovery rights of the state Medicaid agency. Note however, that the State may pass other laws which give it a priority right of recovery in tort actions."[32]

In addition to advising the States how to avoid the limitations on reimbursement to their programs under Ahlborn, the Agency also recommended process to mitigate the adverse consequences of Ahlborn. These includes measures designed to involve the State in the litigation process itself, presumably to maximize the "past medical expense" component of any damage award, such as laws which mandate formal joinder of a state when a Medicaid lien is at issue, requiring notice and cooperation from personal injury attorneys, requiring state consent to any compromise involving medical expenses.[33]

Finally, the memorandum ends with a vague but unmistakable threat to the States:

The Federal government is to be made "whole" to the extent of its share of the amount recovered by the State. To the extent that a State wishes to give part or all of its portion of the Medicaid recovery to the beneficiary, nothing prevents the State from doing so as long as it does not impinge upon the Federal share of the amount recovered by Medicaid.[34]

Interestingly, despite commentators' predictions[35] the two years since Ahlborn was handed down have not seen wholesale slaughter of the States' rights of recovery. In a study published to the 2008 National COB/PTL Conference of the National Association of State Medicaid Directors, Andy Renggli, Chief of Coordination of Benefits of the Washington State Department of Social and Health Services reported that in his State, the median recovery pre- and post Ahlborn dropped less than $1,400 per case.[36] California actually reported a nearly $3,000 increase.[37] Oregon reported a more significant reduction in its median recovery experience, roughly

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$52,000, for the smaller number of cases resolved in Oregon.[38]

In interpreting Ahlborn, several States have, by statute, determined that full recovery with a "cap" complied with the Supreme Court's requirements, based apparently on a majority footnote in the decision. In the opinion of the Court, Justice Stevens was addressing a danger suggested by full reimbursement proponents that parties would manipulate settlements reducing the allocation to the medical expense component and thereby affect the proportional reimbursement. He pointed out that the risk could be avoided either by obtaining the State's advance consent to the allocation or by requiring that the allocation be submitted to the Court. In footnote 18, Justice Stevens notes that "As one amicus observes, some States have adopted special rules and procedures for allocating tort settlements . . .", citing to the brief of the Association of Trial Lawyers of America[39] at 20-21 (hereinafter "ATLA brief"). The ATLA brief, however, rather than advocating full recovery subject only to limiting caps, was discussing procedures in several States to have "mini-hearings" to set allocations of damage settlements where there is not agreement among the interested parties.[40] Nevertheless, as discussed infra, at least the Supreme Court of North Carolina has squarely found that this footnote authorizes the States to mandate full recovery up to a legislatively-determined, across-the-board limit or cap.[41]

One wonders what the "cap" States will do in a situation when the "cap" causes them to give up the portion of a recovery that should have gone to the Federal government's share, if the Department of Health and Human Services finds that the "cap" has "impinged" on its share, given the "threat" discussed, supra.

In Pennsylvania, for example, the statute originally provided for full recovery with a cap of 50%:

Except as otherwise provided in this act, notwithstanding any other provision of law, the entire amount of any settlement of the injured beneficiary's action or claim, with or without suit, is subject to the department's claim for reimbursement of the benefits provided any lien filed pursuant thereto, but in no event shall the department's claim exceed one-half of the beneficiary's recovery after deducting for attorney's fees, litigation costs, and medical expenses relating to the injury paid for by the beneficiary.[42]

The Department of Public Welfare issued a memorandum indicating it believed that this complied with Ahlborn's mandate:

In § 259.2(b)(2), the Department interprets section 1409(b)(11) of the code to establish a statutory default rule of allocation for tort recoveries consistent with Ahlborn. Section 1409(b)(11) of the code limits the Department's reimbursement to ½ of a beneficiary's recovery after deducting attorney's fees, litigation costs and medical expenses regarding the injury paid by the beneficiary. The Department interprets section 1409(b)(11) of the code to mean that the Legislature has by law set aside a portion of a tort recovery for reimbursement of MA and a portion for other damages and expenses. After payment of the expenses and attorney fees, the court or agency shall allocate the judgment or award between the medical portion and other damages and shall allow the department a first lien against the medical portion of the judgment or award, the amount of the expenditures for the benefit of the beneficiary under the medical assistance program.

Ahlborn does not affect state laws governing the allocation of tort proceeds.[43]

However since September, 2008, Pennsylvania law has been changed to provide that after payment of expenses and fees of suit, an otherwise unspecified judgment or award should be allocated between the medical portion and other damages, giving the Medicaid agency a first lien against the medical portion up to the amount of its expenditures.[44] This is considered the default rule of allocation for tort recoveries consistent with Ahlborn".[45] In addition, if the injured party intends to obtain a Court order providing for a different allocation, the Commonwealth should be provided with notice and the opportunity to protect its interests.[46]

Pennsylvania's entire allocation-reimbursement scheme has-at the trial court level-been found to violate the Medicaid anti-lien provision in 42 U.S.C.A. §1396p(a)(1).[47] The Court examined the federal requirement that a state Medicaid plan provide a process for a beneficiary to assign rights against a third party as a condition of eligibility and the requirement that beneficiaries cooperate with state agencies in pursuing third parties[48] and concluded that Medicaid would have no claim on any proceeds it had not actively obtained.

Congress contemplated the commencement of direct actions by state entities against liable third parties for the cost of medical assistance furnished to Medicaid recipients.

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. . . The reimbursement provision envisions an active role in litigation by state entities, not the passive role played by the [state Medicaid agency] in the cases involving [injured parties who became Medicaid beneficiaries].[49]

North Carolina's Supreme Court, where there is a statute providing for full recovery with a cap of one-third of damages, recently upheld the validity of its statute.[50] The Court found that limiting recovery to the lesser of Medicaid's full expenditure or one third complied with Ahlborn, as the Court read the

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opinion, pointing to footnote 18 which is summarized above.[51] The Court found that efficiency and expediency justified this position.

This statutory scheme protects plaintiffs' interests while promoting efficiency in Medicaid reimbursement cases throughout North Carolina. In enacting our statute, the General Assembly may have considered factors such as the strain on resources to send State employees across North Carolina to participate in evidentiary allocation hearings each time a Medicaid recipient recovers from a third party. Likewise, the legislature may have found it important that a case-by-case determination of the medical expense portion of settlements could lead to variable results and increased litigation due to inconsistency in outcomes.[52]

A petition for a Writ of Certiorari with respect to this decision has recently been filed with the United States Supreme Court.[53]

An intermediate appellate court in California has implemented Ahlborn in at least one reported decision, Bolanos v. Superior Court.[54] In this case, Rebecca Bolanos, after being the victim of medical malpractice, was reduced to an irreversible coma, requiring life support and nursing care around the clock. The Medicaid agency paid $746,017 toward her care; the case ultimately settled at $1.5 million. The agency asserted a claim against the proceeds for $546,651, which represented the full amount of its claim net of attorney fees and litigation costs. The Court pointed out that in the event the settlement or verdict is not broken down into its various components, the "Ahlborn formula" takes the ratio of the settlement to the total net loss and then applies the resulting percentage to the Medicaid reimbursement claim.[55] The Court found that the process in Ahlborn, namely: (a) determining the total value of the injured party's claim, (b) allocating the medical expense component of the settlement or award, and then the appropriate standard to be applied to these facts was set by statute:

In determining what portion of a settlement, judgment, or award represents payment for medical expenses, or medical care, provided on behalf of the beneficiary and as to what the appropriate reimbursement amount to the director should be, the court shall be guided by the United States Supreme Court decision in Arkansas Department of Health and Human Services v. Ahlborn (2006) 547 U.S. 268 and other relevant statutory and case law.[56]

What will the future hold for injured parties and attorneys advising them? Although Edmund Burke once wrote "You can never plan the future by the past",[57] it can reliably be predicted that States will attempt to fashion recovery plans that maximize their perceived share of injured parties' recoveries. These methods include the "cap" approach outlined supra. Oklahoma has legislatively established a presumption that full reimbursement applies to any settlement, "unless a more limited allocation is shown by clear and convincing evidence."[58] In Pennsylvania, no judgment against a tortfeasor acts a final judgment adjudicating the Commonwealth's right to reimbursement unless the Commonwealth has been provided notice of the action and an opportunity to be heard on the allocation of damages[59]. A number of states have or have established the "mini" hearing process reported in the ATLA brief described supra.[60] In addition to notice, Colorado has identified a process for the Medicaid agency to identify and track of likely reimbursement cases based on eligibility intake reports, data matches, trauma code reports, among other indicators.[61]

If the Supreme Court acts on the Certiorari Petition in the Bolanos case, it may resolve the question whether full reimbursement with a cap satisfies the Ahlborn analysis. Otherwise, states will continue to prod at and probe the law, with a view towards funding their agencies' expenditures out of as much of the pocketbooks of injured parties as they can. Given the perceptions of a funding crisis for medical providers as well as the general condition of the economy, the interests of sick, injured tort victims may take second place to the government's need for more resources.[62]

Endnotes

1. Arkansas Department of Health and Human Services v. Ahlborn, 547 U.S. 268, 284-285 126 S.Ct. 1752, 164 L.Ed.2d 459.
2. When an injured party has received benefits from an entity apart from a tortfeasor and then received compensation for injuries from the tortfeasor, there are at least three theories. For purposes of this paper, the following definitions will be used. Full reimbursement: dollar for dollar to the entity from the tortfeasor's payment, no reimbursement: the injured party retained both the benefits and the recovery, and proportional reimbursement (the injured party reimbursed the entity for the proportion that the benefit bore to the entire loss). An example of "no reimbursement" can be found in Pennsylvania's original enactment of its no-fault motor vehicle insurance statute. A vehicle owner's carrier was required to provide for medical benefits under the statute. Recognizing that many vehicle owners already had medical insurance, the statute permitted vehicle insurance companies to offer a discount for a driver who elected to have their health insurance be primary and the vehicle medical benefits insurance be secondary. 40 P.S. 1009.203(b). Where the driver did not make the election, then the driver paid a higher premium, but was entitled to retain recoveries for the same injury from both insurance companies. Steppling v. Pennsylvania Manufacturer's Association Insurance Company, 24 D. & C. 3d 618, 1982 WL 762 (Erie Co. Com.Pl. 1982).

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3. S. Rep. No. 99-146, at 312 (1985).
4. 42 U.S.C.A. §1396p(1)(a).
5. Arkansas Department of Health and Human Services v. Ahlborn, supra, 547 U.S. 268, 272-73.
6. The facts in this case were found to be undisputed, beginning at the federal trial court level. Ahlborn v. Arkansas Dept. of Human Services, 280 F. Supp.2d 881, 882 (E.D.Ark.,2003).
7. Ibid. Although every personal injury action probably involves at least one of these components, not every case involves all, and in each case, each element can be computed differently, based on the facts of the particular case. "There's the rub." William Shakespeare, Hamlet (1603).
8. Ibid. at 882 n.1.
9. Ibid. at 883 n. 2
10. The math does not quite compute. $550,000÷3,040708. 12=18.09%. $215,645.30 × 18.09%=$39,010.23. None of the opinions acknowledges this apparent discrepancy, and all opinions refer to the ratio as "one-sixth", the rough equivalent of 18.09. However, one-sixth of $215,645.30 is $35,940.88, which is closer, but still not on the mark.
11. 42 U.S.C.A. § 1396a(a)(25)(A).
12. 42 U.S.C.A. §1396a(a)(25)(B).
13. 42 U.S.C.A. § 1396a(a)(25)(H).
14. 42 U.S.C.A. §1396k(a)(1).
15. Ark.Code Ann. §§ 20-77-301 through 20-77-309
16. Ark.Code.Ann. § 20-77-307. Interestingly, the plain language of this section would seem to apply even to personal injuries a person might have unrelated to their Medicaid claim, so that a damage award to a young person who happened to be receiving Medicaid benefits who was killed instantly in an automobile accident would be subject to a right of Medicaid to be repaid for all Medicaid benefits previously paid to the young person even though they were unrelated to the accident. Although there are no reported decisions construing this provision, this harsh effect may be ameliorated elsewhere in the law: "When medical assistance benefits are provided or will be provided to a medical assistance recipient because of injury, disease, or disability for which another person is liable, the appropriate division of the Department of Human Services shall have a right to recover from the person the cost of benefits so provided." Ark.Code.Ann. § 20-77-301.
17. 42 U.S.C.A. §1396p(a)(1).
18. Arkansas Department of Health and Human Services v. Ahlborn, 547 U.S. 268, 284-285 126 S.Ct. 1752, 164 L.Ed.2d 459.
19. Ibid., 547 U.S. 268, 284-285.
20. Martin v. City of Rochester, 642 N.W. 2d 1 (Minn. 2002), cert. denied, 539 U.S. 957 (2003); contra, Houghton v. Department of Health, 2002 UT 101, 57 P.3d 1067 (2002); Wilson v. Washington, 142 Wash. 2d 40, 10 P. 3d 1061 (2000).
21. California Department of Health Services, DAB No. 1504, 1995 HHSDAB Lexis 1561 (California's recovery system allowing recipients to retain 50% of their tort recoveries was invalid and in violation of 42 U.S.C.A.§1902(a)(25)(B)).
22. Chevron USA, Inc. V. National Resources Defense Council, Inc., 467 U.S. 837, 842, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984)
23. Arkansas Department of Health and Human Services v. Ahlborn, 547 U.S. 268, 292.
24. California Department of Health Services, supra. Washington State Department of Health and Human Services, DAB 1561, 1666 HHSDAB Lexis 717 (Washington's system of allowing the third party liability agency to negotiate compromises to its claim as a part of overall compromise of tort settlement was invalid and in violation of Act based on same logic as California.).
25. Sean Sandison, 58 Mercer L. Rev. 799 (2007).
26. Suzanne G. Clark, 60 Ark. L.Rev. 533 (2007). This article discusses an inconsistency between the potential rights of recovery of ERISA–which has no anti-lien provision. Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Scott, 27 F.Supp.2d 1166, 1174 (W.D.Ark.,1998). Providers whose plans call for full recovery will be entitled to dollar for dollar reimbursement, while Medicaid agencies will be limited to proportional reimbursement. 60 Ark. L.Rev. at 551
27. J. Mark Coulson, 40-Jun Md. B. J. 65 (2007).
28. Ibid. at 66.
29. Ibid. at 66.
30. Gale Arden, Director, Memorandum of Center for Medicare and State Operations Disabled and Elderly Health Programs Group, July 3, 2006. http://www.nasmd.org/issues/CPBTPL_resources.asp (Last visited March 29, 2009).
31. Ibid.
32. Ibid.
33. Ibid.
34. Ibid.
35. "Unfortunately, the Ahlborn decision will ultimately have a negative impact on Medicaid beneficiaries. The decision will result in reducing the funds available to help categorically and medically needy individuals requiring government assistance." Suzanne G. Clark, op. cit. 60 Ark. L.Rev. 533 at 553.
36. Effect of Ahlborn decision on States' Medicaid Tort Recoveries (July 24, 2008) http://www.nasmd.org/resources/docs/AhlbornEffects2008.doc (Last visited Mar 29, 2009).
37. Joy Cheah, Effect of Ahlborn decision on States' Medicaid Tort Recoveries (July 24, 2008) http://www.nasmd.org/resources/docs/TemplateCalifornia.doc (Last visited Mar 29, 2009).
38. Roy Fredericks, Effect of Ahlborn decision on States' Medicaid Tort Recoveries (July 24, 2008) http://www.nasmd.org/resources/docs/TemplateCalifornia.dochttp://www.nasmd.org/resources/docs/TemplateOregon.doc (Last visited Mar 29, 2009). The median award among the 309 cases settled in Oregon post Ahlborn is $195,000.
39. The Association of Trial Lawyers of America has recently changed its name to the American Association for Justice. Since the organization is referred to by its historic name in the Ahlborn opinion, that will continue to be used for this paper.
40. Ahlborn, supra, Br. of ATLA at 20-21, 2006 WL 139217 (2006).
41. Andrews ex rel. Andrews v. Haygood, 362 N.C. 599, 669 S.E.2d 310, (N.C.,2008).
42. 62 PS §1409 (b)(11).
43. Pennsylvania Department of Public Welfare, Statement of Policy, 37 Pa.B. 4881 (Sept. 8, 2007), explaining how it believed Section 1409 should be interpreted. DPW was not completely sanguine about its position. "[T]he

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Department recognizes that there may be specific factual situations when application of section 1409 of the code might violate Ahlborn. Accordingly, the Department establishes a procedure for notifying the Department that the beneficiary intends to make an assertion and seek a court order limiting the availability of tort proceeds to reimburse the MA program." Ibid.

44. 62 P.S. §1409.1.
45. 37 Pa. Bull. 4881, 4881 (September 8, 2007).
46. Id. at 4884.
47. Tristani v. Richmon, 2009 WL 799747 (March 25, 2009) (NO. CIV.A 06-694).
48. 42 U.S.C.A. §1396k(a)(1)(C)
49. Tristani v. Richmon, supra, 2009 WL 799747 at 35.
50. Andrews ex rel. Andrews v. Haygood, 362 N.C. 599, 669 S.E.2d 310, (N.C.,2008)
51. Ibid.
52. Ibid. 362 N.C. at 604, 669 S.E .2d at 314.
53. Guy Loranger "U.S. Supreme Court Asked to Review Ruling on Medicaid Reimbursement", N.C. Lawyers Weekly (March 23, 2009).
54. 169 Cal. App. 4th 744, 87 Cal. Rptr 3d 174 (2nd Dist. Ct. of Appeal 2008).
55. Ibid., 169 Cal. App. 4th at 754, 87 Cal. Rptr 3d at 181.
56. West's Ann Cal.Welf .& Inst.Code § 14124.76, Bolanos, supra, 169 Cal. App. 4th at 761, 87 Cal. Rptr 3d at 186.
57. Letter to a Member of the National Assembly. Vol. iv. p. 55, (1791)
58. 2007 Okla Session Laws 74, 63 Okla St. §5051.1(d).
59. 62 P.S. §1409(a)(4)(ii).
60. E.g., Lugo v. Beth Israel Medical Center, 123 Misc. 3d 681, 819 NYS 2d 892 (1st Jud. Dist. 2006).
61. "Ahlborn--The Colorado Experience", 2008 National COB/TPL Conference, COB/TPL Basics Training (Sept. 28, 2008) at slide 15-16.
62. "It is the merit of the common law," Oliver Wendell Holmes observed, "that it decides the case first and determines the principle afterwards." Oliver Wendell Holmes, Codes, and the Arrangement of the Law, 5 Am L Rev 1 (1870), reprinted in Sheldon M. Novick, ed, 1 The Collected Works of Justice Holmes 212 (Chicago 1995).