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Kicking Ohio Medicaid Recipients When They are Down: How Ohio's Third Party Liability Medicaid Statute Violates Federal Law as Interpreted by Ahlborn

Kelly Voyles

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**KICKING OHIO MEDICAID RECIPIENTS WHEN
THEY ARE DOWN: HOW OHIO’S THIRD PARTY
LIABILITY MEDICAID STATUTE VIOLATES
FEDERAL LAW AS INTERPRETED BY *AHLBORN***

KELLY VOYLES*

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I. INTRODUCTION

On January 12, 2008, Brian K. Bates, an Ohio citizen, was seriously injured in a car accident due to the negligence of another driver.¹ Because Bates was unable to pay all of the \$185,000 worth of his medical expenses, he relied upon Medicaid to pay about \$67,245.37 on his behalf.² Following his accident, Bates filed a claim with a value of over \$500,000 against the negligent driver.³ The parties, however,

¹ Encompass Indem. Co. v. Bates, No. 11AP-1010, 2012 Ohio App. LEXIS 3946, at *1 (Ohio Ct. App. Sept. 28, 2012).

² *Id.*

³ *Id.* at *6.

eventually agreed to settle Bates' claim for \$100,000—twenty percent of the claim's true value.⁴ After attorney's fees, costs, and expenses were deducted from Bates' settlement, only \$62,000 remained, and from this remaining \$62,000, Ohio's Medicaid agency, the Ohio Department of Job and Family Services (ODJFS), then sought reimbursement for the medical payments it made on Bates' behalf.⁵

Pursuant to Ohio's Medicaid third party liability statute, which requires ODJFS to recover from a Medicaid recipient's tort settlement with a liable third party the lesser of all that it paid on the recipient's behalf or fifty percent of the recipient's total settlement value,⁶ ODJFS claimed fifty percent⁷ (\$31,000) of Bates' remaining \$62,000 settlement.⁸ Bates, however, argued that pursuant to a recent Supreme Court decision, *Arkansas Department of Health and Human Services v. Ahlborn*,⁹ ODJFS should only have been entitled to recover twenty percent of his remaining settlement (\$13,449.07)¹⁰ because he settled his claim for twenty percent of its true value.¹¹

If Bates' settlement was specifically allocated for medical expenses, his argument would have been upheld under the *Ahlborn* ruling, leaving him with a remaining settlement of \$48,550.93.¹² Because his settlement was not specifically allocated for medical expenses, however, the Ohio Tenth District Court of Appeals affirmed ODJFS' recovery under the Ohio Medicaid reimbursement statute, leaving Bates with a remaining settlement of only \$31,000 from a claim worth over \$500,000.¹³ As Bates received a full \$17,550.93 less than he would have if his settlement was allocated for medical expenses, this result is fundamentally unfair.

However, not only is this result unfair to Bates, it is also fundamentally unfair to many other Ohio Medicaid recipients whose settlements are likewise not allocated for medical expenses. This inequity is even more apparent when considering the fact that there are many reasons why settlements often are not allocated. For instance, parties may wish to forgo allocation in an attempt to settle their cases as fast as possible so that the injured party can have access to money for his care and rehabilitation, or alternatively, parties may not be able or willing to come to an allocation agreement that is palatable to all involved. Thus, the tendency has been for

⁴ *Id.* at *2, *6.

⁵ *Id.* at *2. ODJFS sought reimbursement pursuant to the federal Medicaid third party liability laws discussed *infra* Part II.A.

⁶ Statutory schemes that limit state Medicaid agencies' recovery to a certain percentage of Medicaid recipients' settlements are referred to as statutory caps throughout this Note.

⁷ ODJFS claimed fifty percent of the settlement because fifty percent (\$31,000) was less than the total amount ODJFS paid on Bates' behalf (\$67,245.37).

⁸ *Bates*, 2012 Ohio App. LEXIS 3946, at *2.

⁹ *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006).

¹⁰ Twenty percent of \$67,245.37, the total amount ODJFS paid on Bates' behalf, is \$13,449.07.

¹¹ *Bates*, 2012 Ohio App. LEXIS 3946, at *6.

¹² The *Ahlborn* ruling is discussed in great detail in *infra* Part II.B.

¹³ *Bates*, 2012 Ohio App. LEXIS 3946, at *2-3.

parties to come to a settlement agreement that is unallocated,¹⁴ which ultimately results in injured parties receiving significantly less than that to which they would have received if their settlements were allocated.

Not only is this statutory scheme fundamentally unfair to Ohio Medicaid recipients, it also creates a situation in which compliance with the Supreme Court's ruling in *Ahlborn* is impossible to ensure.¹⁵ Accordingly, this Note argues that Ohio's Medicaid third party liability statute must either be invalidated by the Ohio Supreme Court or repealed by the Ohio General Assembly. This Note then goes on to argue that the Ohio General Assembly must amend its Medicaid third party liability statute to require settlement allocation before ODJFS can recover the medical payments it made on behalf of Ohio Medicaid recipients. Finally, this Note argues that Ohio should also amend its Medicaid third party liability statute to require that the parties come to an allocation agreement themselves or, if that proves impossible, to require a judicial allocation hearing to so allocate.

Part II of this Note discusses the federal Medicaid program and state Medicaid programs' right to recover medical expenses paid on behalf of Medicaid recipients when those recipients receive settlements from liable third parties. Part II also discusses the Supreme Court's decision in *Ahlborn* and how it affects states' recovery rights under federal Medicaid and anti-lien law. Finally, Part II discusses Ohio's Medicaid third party liability statute and its treatment by the Ohio Tenth District Court of Appeals.

Part III of this Note argues that the Ohio Tenth District Court of Appeals wrongly upheld Ohio's Medicaid third party liability statute and offers reasons for that contention. Part III also argues that to ensure compliance with the federal anti-lien provisions as interpreted by *Ahlborn*, the Ohio Medicaid third party liability statute must be amended to require allocation of unallocated settlements before ODJFS can claim the right to any portion of Ohio Medicaid recipients' settlements. Finally, Part III provides case law, statutory, and policy support for the contention that such allocation is necessary.

Part IV outlines the various ways by which ODJFS' interests can be protected in the settlement process, as well as the various ways by which Medicaid recipients' settlements can be allocated. This Note then concludes by arguing that the best way to allocate Ohio Medicaid recipients' settlements in light of *Ahlborn* is to require the parties to come to an allocation agreement on their own, and if such allocation proves impossible, to have the court so allocate following a hearing where all interested parties have a chance to present their ideas of a fair allocation.

II. MEDICAID REIMBURSEMENT LAW POST-AHLBORN

The federal Medicaid program was created to ensure that all Americans, even the poor, receive medical care. This section examines the federal and state Medicaid programs and discusses how these programs are entitled to reimbursement for medical expenses paid on behalf of Medicaid recipients when a third party is held liable for those medical expenses. This section further discusses the Supreme Court's decision in *Ahlborn* and how this decision has shaped state Medicaid reimbursement

¹⁴ Robert B. Pearlman, *Ahlborn, Jackson and the Three Most Important Words in Personal Injury Practice*, S.C. LAWYER, Jan. 21, 2010, at 18, 20.

¹⁵ This contention will be further discussed *infra* Part III.

law. Finally, this section focuses on Ohio's Medicaid third party liability law, as well as the Ohio Tenth District Court of Appeals' interpretation of that law.

A. The Federal Medicaid Program

The federal Medicaid program was created in 1965 with the enactment of Title XIX of the Social Security Act.¹⁶ This program, which is jointly financed and administered by the federal government¹⁷ and the states,¹⁸ is the largest source of funding for medical and health-related services in America.¹⁹ State participation in the federal Medicaid program is not mandatory; however, because the federal Government pays between 50% and 83%²⁰ of the costs that states incur for patient care, every state has opted to participate.²¹ To receive this federal funding, each state must establish a single agency to administer the plan²² and comply with federal statutory requirements governing Medicaid administration.²³

1. Third Party Liability Recovery Provisions

While Medicaid was intended “to provide for the medical needs of the poorest Americans,”²⁴ Congress did not intend for the Program to act as an insurance

¹⁶ 42 U.S.C.A. §§ 1396-1396v (West 2013).

¹⁷ The program is administered on the federal level by the Centers for Medicare and Medicaid Services. *The Centers for Medicare & Medicaid Services (CMS): Overview*, ALLGOV.COM (2012), <http://www.allgov.com/departments/department-of-health-and-human-services/centers-for-medicare-medicoid-services-cms?agencyid=7395>.

¹⁸ See *Ohio Medicaid Statistics*, MEDICAID.GOV, <http://www.medicoid.gov/Medicaid-CHIP-Program-Information/By-State/ohio.html> (last visited Nov. 20, 2012) (“Each state establishes and administers its own Medicaid program and determines the type, amount, duration, and scope of services covered within broad Federal guidelines.”).

¹⁹ Kathleen Sebelius, *HHS: What We Do*, U.S. DEP'T. OF HEALTH & HUMAN SERVS, <http://www.hhs.gov/about/whatwedo.html> (last visited Jan. 28, 2013). Medicaid provides for over fifty million Americans. *Id.*

²⁰ See *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275 n.4 (2006) (“The exact percentage of the federal contribution is calculated pursuant to a formula keyed to each State's per capita income.”).

²¹ *Id.* at 275.

²² 42 U.S.C.A § 1396a(5) (West 2012) (“A state plan for medical assistance must—either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan.”).

²³ See *Ohio Medicaid Basics 2011*, HEALTH POLICY INST. OF OHIO, (May 2011), <http://a5e8c023c8899218225edfa4b02e4d9734e01a28.gripelements.com/pdf/publications/basics2011.pdf> (“Ohio's Medicaid program includes services mandated by the federal government plus optional services the state chooses to provide. Ohio has some discretion to vary the services it covers but, in all cases, the services must be ‘sufficient in amount, duration, and scope to reasonably achieve its purpose,’ according to federal regulations (42 C.F.R. § 440.230).”).

²⁴ Suzanne G. Clark, Case Note, *An Accident Waiting to Happen: Arkansas Department of Health and Human Services v. Ahlborn Exposes Inequities in Medical Benefits Legislation*, 60 ARK. L. REV. 533, 539 (2007). In Ohio, “Medicaid covers several categories of low-income

provider.²⁵ Rather, Congress intended for Medicaid to be the payer of last resort of recipients' medical expenses.²⁶ Accordingly, as a condition for participation in the federal Medicaid program, § 1396a(25)(A) of the Social Security Act requires states to "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan."²⁷ Section 1396a(25)(B) then requires states to seek reimbursement from such liable third parties.²⁸

2. Third Party Liability Assignment Provisions

Pursuant to this reimbursement requirement, if a third party is found liable for Medicaid recipients' medical expenses, § 1396a(25)(H) stipulates that states must enact laws under which they are considered to have acquired the recipients' rights to any settlements between the recipients and the liable third parties as reimbursement for medical payments the states made on the recipients' behalf.²⁹ Similarly, § 1396k(a)(1) requires recipients, "as a condition of eligibility for medical assistance," to assign to their state all of their rights to such settlements.³⁰

Americans, including children, parents, pregnant women, seniors, and certain people with disabilities." HEALTH POLICY INST. OF OHIO, OHIO MEDICAID BASICS 2011 (May 2011), available at http://a5e8c023c8899218225edfa4b02e4d9734e01a28.gripelements.com/pdf/publications/basics2011_execsummary.pdf.

²⁵ See Allen N. Trask, III, Comment, *Orders from on High: The Current Struggle over Medicaid Third Party Recovery Between North Carolina and the Supreme Court of the United States*, 30 CAMPBELL L. REV. 471, 473 (2008) ("Medicaid was intended to provide assistance to the poor, but it was not intended to act as an insurance policy.").

²⁶ Trask, *supra* note 25, at 473.

²⁷ 42 U.S.C.A. § 1396a(a)(25)(A) (West 2012).

²⁸ 42 U.S.C.A. § 1396a(a)(25)(B) (West 2012) ("A State plan for medical assistance must provide that in 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.").

²⁹ 42 U.S.C.A. § 1396a(a)(25)(H) (West 2012) ("A State plan for medical assistance must provide, that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services.").

³⁰ 42 U.S.C.A. § 1396k(a)(1)(A) (West 2012) ("For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under [42 U.S.C. §§ 1396 et seq.], a State plan for medical assistance shall (1) provide that, as a condition of eligibility for medical assistance under the State plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under [42 U.S.C. §§ 1396 et seq.] and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party.").

B. The Effect of Ahlborn on State Medicaid Reimbursement Statutes

Initially, the Centers for Medicare and Medicaid Services (CMS) “interpreted the[se] Medicaid third party liability provisions to authorize [s]tates to pass laws permitting full recovery of Medicaid assistance payments from third party liability settlements, regardless of how [or if] the parties allocated the settlement.”³¹ However, in *Ahlborn*, the seminal decision on these Medicaid third party liability provisions, the Supreme Court unanimously rejected CMS’ interpretation and held that state Medicaid agencies may only recover the limited portion of the settlement that actually represents medical expenses.³²

This unanimous decision arose out of a 1996 car accident in which Heidi Ahlborn, “then a 19 year old college student and aspiring teacher, suffered severe and permanent injuries”³³ due to the negligence of two tortfeasors.³⁴ Because her “liquid assets were insufficient to pay for her medical care,” Ahlborn was forced to rely on Arkansas’ Medicaid program, the Arkansas Department of Human Services (ADHS),³⁵ to pay \$215,645.30 worth of her medical expenses.³⁶

In 1997, Ahlborn filed suit against the tortfeasors seeking damages for those medical expenses, as well as for “permanent physical injury; future medical expenses; past and future pain, suffering, and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future.”³⁷ Rather than taking her case to trial, however, Ahlborn settled with the tortfeasors for \$550,000, one sixth of her original \$3,040,708.12 claim.³⁸ Then, pursuant to the Arkansas Medicaid third party liability statute, ADHS claimed its right to reimbursement from this settlement.³⁹ Accordingly, ADHS asserted a lien⁴⁰ against Ahlborn’s settlement in the amount of \$215,645.30—the total amount of medical expenses ADHS paid on Ahlborn’s behalf.⁴¹

³¹ Memorandum from Gale Arden, Dir., Ctr. for Medicaid & State Operations: Disabled & Elderly Health Programs Grp., on State Options for Recovery Against Liab. Settlements in light of *Ark. Dep’t of Human Servs. v. Ahlborn*, to All Assoc. Reg’l Adm’rs for Medicaid & State Operations (July 3, 2006), available at <http://www.specialneedsnj.com/article.php?id=20> [hereinafter Arden, Memorandum].

³² *Ark. Dep’t of Human Servs. v. Ahlborn*, 547 U.S. 268, 282 (2006).

³³ *Id.* at 273. Ahlborn “was left brain damaged, unable to complete her college education, and incapable of pursuing her chosen career.” *Id.*

³⁴ *Id.* at 272-73.

³⁵ *What is Medicaid?*, ARK. MEDICAID, <https://www.medicaid.state.ar.us/InternetSolution/General/whatis.aspx> (last visited Nov. 20, 2012).

³⁶ *Ahlborn*, 547 U.S. at 273.

³⁷ *Id.* ADHS was not named as a party in this suit. *Id.*

³⁸ *Id.* at 274.

³⁹ *Id.*

⁴⁰ Justice Stevens acknowledged that a state’s recovery for medical expenses paid on behalf of a Medicaid recipient amounts to a lien on the beneficiary’s settlement. *Id.* at 286 (“A lien is typically imposed on the property of another for payment of a debt owed by that other. . . . That the lien is also called an ‘assignment’ does not alter the analysis.”).

⁴¹ *Id.* at 274.

In reaction to ADHS' lien against her settlement, Ahlborn filed suit against ADHS in 2002, claiming Arkansas' Medicaid third party liability statute, which allowed ADHS to claim the rights to her settlement for the full amount of medical expenses paid on her behalf,⁴² violated the anti-lien provisions of the Social Security Act: §§ 1396p(a)(1) and 1396(a)(18).⁴³ Section 1396p(a)(1) prohibits states from imposing liens "against the property"⁴⁴ of any individual prior to [her] death on account of medical assistance paid on [her] behalf under the State [Medicaid program],⁴⁵ and § 1396(a)(18) requires states to comply with § 1396p(a)(1).⁴⁶

Ahlborn argued that because the parties stipulated⁴⁷ that only \$35,581.47⁴⁸ of her settlement was designated for medical expenses, ADHS' claim to the full amount of medical expenses paid on her behalf (\$215,645.30) violated the anti-lien provisions insofar as such a claim "would require depletion of compensation for injuries other than past medical expenses."⁴⁹ In other words, Ahlborn argued that if ADHS claimed the right to more than \$35,581.47 of her settlement, it would claim the right to funds that were not designated for medical expenses,⁵⁰ thereby asserting a lien on her

⁴² *Id.* at 277-78 ("As a condition of eligibility' for Medicaid, an applicant 'shall automatically assign his or her right to any settlement, judgment or award which may be obtained against any third party to [ADHS] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.'" (quoting ARK. CODE ANN. § 20-77-309(a) (2001) (repealed 2006)).

⁴³ *Id.* at 274.

⁴⁴ Any assignment to a state of the right to an individual's settlement funds would be considered a lien on the personal property of an individual because settlement funds are considered personal property and state assignments of rights to such settlements are considered liens. *See* *Martin v. City of Rochester*, 642 N.W.2d 1, 14 (Minn. 2002) ("Essentially, at the time of an accident, the injured party acquires in tort one or more [property] rights of action or claims against those responsible for injuries. These rights of action or claims can be likened to a 'bundle of sticks.'" (quoting *United States v. Ben-Hur*, 2 F.3d 313, 317-18 (7th Cir. 1994))); *see also supra* text accompanying note 40.

⁴⁵ 42 U.S.C.A. § 1396p(a)(1) (West 2013).

⁴⁶ 42 U.S.C.A. § 1396a(a)(18) (West 2013) ("A State plan for medical assistance must comply with the provisions of 42 U.S.C. § 1396p with respect to liens, adjustments and recoveries of medical assistance correctly paid.").

⁴⁷ Originally, Ahlborn's settlement was unallocated; however, "to facilitate the District Court's resolution of the legal questions presented," the parties stipulated to the amount in the settlement that represented the medical payments ADHS made on Ahlborn's behalf. *Ahlborn*, 547 U.S. at 274.

⁴⁸ Since Ahlborn settled her claim for one-sixth of its true value, the parties stipulated that medical expenses in the settlement should be reduced pro rata to \$35,581.47, because the amount was one-sixth of the \$215,645.30 that ADHS paid on Ahlborn's behalf for medical expenses. *Id.*

⁴⁹ *Id.*

⁵⁰ Funds not designated for medical expenses in Ahlborn's settlement included those for "permanent physical injury; future medical expenses; past and future pain, suffering, and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future." *Id.* at 273.

personal property “on account of medical assistance paid on [her] behalf”⁵¹ that was not excepted by the assignment provisions.⁵² ADHS, however, argued that the Medicaid third party assignment provisions permitted such a claim.⁵³

Upon review of both arguments, the Supreme Court acknowledged that the assignment provisions create an exception to the absolute prohibition of placing liens on Medicaid recipients’ settlements on account of medical assistance paid on their behalf when third parties are liable for such assistance;⁵⁴ however, the Court made clear that “the exception carved out by [the anti-lien provisions] is limited to payments for *medical care*. Beyond that, the anti-lien provision[s] appl[y].”⁵⁵

The Supreme Court then went on to hold that state Medicaid agencies may only recover that limited portion of Medicaid recipients’ settlements that actually represents payments for medical care,⁵⁶ which in *Ahlborn*’s case, was the portion of her settlement that the parties stipulated to representing medical care.⁵⁷ To hold otherwise, the Court reasoned, would violate the anti-lien provisions because the state would then be permitted to take from other categories of damages that are the personal property of Medicaid recipients and are not excepted by the assignment

⁵¹ 42 U.S.C.A. § 1396p(a)(1) (West 2013).

⁵² *Ahlborn*, 547 U.S. at 274; *see also* *Martin v. City of Rochester*, 642 N.W.2d 1, 15 (Minn. 2002) (“As a condition of receiving medical assistance from a state, a medical assistance recipient assigns to the state one stick from that bundle [of sticks]—the specific claim to recover medical expenses from those responsible for the injuries. . . . But the recipient retains ownership of the remaining sticks in the bundle. . . . To the extent that any settlement with the responsible third parties is for this large bundle of sticks (the original tort action minus the claim for medical care), the settlement proceeds are the recipient’s personal property, and as such are protected by the federal anti-lien provision[s].”).

⁵³ *Ahlborn*, 547 U.S. at 285-86.

⁵⁴ *Id.* at 284 (“To the extent that the forced assignment is expressly authorized by the terms of §§ 1396a(a)(25) [sic] and 1396k(a), it is an exception to the anti-lien provision.”).

⁵⁵ *Id.* at 284-85.

⁵⁶ *Id.* at 282 (“[The 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.”). The Supreme Court came to this conclusion after a thorough examination of the federal Medicaid and anti-lien provisions, emphasizing the language in those provisions that supports the contention that the assignment provisions only authorize assignment of rights to damages that represent *medical care*. *Id.* at 280 (“Medicaid recipients must, as a condition of eligibility, ‘assign the State any rights . . . to payment for medical care from any third party.’” (quoting 42 U.S.C. § 1396k(a)(1)(A) (2006))); *Id.* (“[Section] 1396a(a)(25)(B)’s requirement that states ‘seek reimbursement for [medical assistance] to the extent of such legal liability’ (emphasis added) . . . [refers to], as is evident from the context of the emphasized language, ‘such legal liability of third parties . . . to pay for care and services available under the plan.’” (quoting § 1396a(a)(25)(B) and § 1396a(25)(A), respectively)); *Id.* at 281 (“[Section 1396a(a)(25)(H)] makes clear that the State must be assigned ‘the rights of [the recipient] to payment by any other party for such health care items or services.’” (quoting § 1396a(a)(25)(H))).

⁵⁷ In settlements that are allocated, state Medicaid agencies would only be entitled to the portion allocated for medical expenses.

provisions.⁵⁸ Therefore, in *Ahlborn's* case, because the parties stipulated that \$35,581.47 was the portion of her settlement that represented medical care, the Supreme Court ruled that ADHS could only recover \$35,581.47 from her settlement as reimbursement for medical payments made on her behalf.⁵⁹

While the Supreme Court explicitly ruled that states may recover only the portion of a Medicaid recipient's settlement that represents medical care, the Court was silent as to how states should determine that portion when the settlement is unallocated and the parties do not stipulate to the amount of that unallocated settlement that represents medical care. As such, states have been left on their own to create methods of calculating the appropriate amount of reimbursement to which they are entitled from unallocated settlements and have accordingly established a multitude of varying rules and procedures for that calculation.⁶⁰

C. *The Ohio Medicaid Third Party Liability Statute*

In Ohio, Revised Code § 5101.58 governs ODJFS' right to reimbursement, and specifically, subdivision (G)(2) establishes the Ohio rule for seeking that reimbursement from unallocated settlements. Section 5101.58(A) stipulates that "[t]he acceptance of public assistance gives an automatic right of recovery to [ODJFS] . . . against the liability of a third party for the cost of medical assistance paid on behalf of the [the Medicaid recipient]."⁶¹ This statute also entitles ODJFS to recover from a Medicaid recipient's settlement with a liable third party the medical payments it made on the recipient's behalf.⁶²

⁵⁸ *Ahlborn*, 547 U.S. at 285; see also *Martin v. City of Rochester*, 642 N.W.2d 1, 15 (Minn. 2002) ("As a condition of receiving medical assistance from a state, a medical assistance recipient assigns to the state one stick from that bundle [of sticks]—the specific claim to recover medical expenses from those responsible for the injuries. . . . But the recipient retains ownership of the remaining sticks in the bundle. . . . To the extent that any settlement with the responsible third parties is for this large bundle of sticks (the original tort action minus the claim for medical care), the settlement proceeds are the recipient's personal property, and as such are protected by the federal anti-lien provision.").

⁵⁹ *Ahlborn*, 547 U.S. at 285.

⁶⁰ See Joseph D. Juenger, *In Light of Ahlborn—Designing State Legislation to Protect the Recovery of Medicaid Expenses from Personal Injury Settlements*, 35 N. KY. L. REV. 103, 122 (2008) ("[W]here no allocation of damages is expressly set forth, the States must establish rules and procedures in order to 'seek reimbursement.'" (quoting 42 U.S.C. § 1396a(a)(25)(B))). See generally *Petition for Writ of Certiorari, Brown v. N.C. Dep't. of Health & Human Servs.*, 129 S. Ct. 2792 (March 12, 2009) (No. 08-1146), 2009 WL 698514 [hereinafter *Brown Writ*].

⁶¹ OHIO REV. CODE ANN. § 5101.58(A) (LexisNexis 2013). This section is in compliance with 42 U.S.C. §§ 1396a(25)(A)-(B) (2013) of the federal Medicaid statute discussed *supra* Part II.A.1.

⁶² *Id.* ("When an action or claim is brought against a third party by a public assistance recipient or participant, any payment, settlement or compromise of the action or claim, or any court award or judgment, is subject to the recovery right of the department of job and family services or county department of job and family services."). This section was written to comply with 42 U.S.C. §§ 1396a(25)(H) and 1396k(a) of the federal Medicaid statute discussed *supra* Part II.A.2.

In response to the *Ahlborn* decision, the Ohio General Assembly amended § 5101.58 in 2007 with the addition of subdivision (G)(2).⁶³ Section 5101.58(G)(2) permits ODJFS to recover from a Medicaid recipient's *unallocated* settlement the less all of the medical expenses it paid on the recipient's behalf or fifty percent of the recipient's total settlement after deducting reasonable attorney's fees, costs, and expenses.⁶⁴

D. The Ohio Tenth District Court of Appeals' Interpretation of § 5101.58(G)(2) in Encompass Indemnity Co. v. Bates

Section 5101.58(G)(2)'s fifty percent statutory cap formulation was challenged as a violation of the federal anti-lien provisions per *Ahlborn* in *Encompass Indemnity Co. v. Bates*,⁶⁵ the case whose factual background was discussed in the Introduction of this Note. In *Bates*, appellant Brian K. Bates' settlement with the liable driver was not specifically allocated for medical expenses; however, because he settled his claim for twenty percent of its true value, Bates nonetheless argued that only \$13,449.07 (twenty percent of the \$67,245.37 ODJFS paid on Bates' behalf) of his settlement represented medical expenses.⁶⁶ As such, Bates argued that "ODJFS may not be reimbursed more than 20 percent of the amount it paid towards [his] medical bills" without violating the federal anti-lien provisions as interpreted by the Supreme Court in *Ahlborn*.⁶⁷

Despite Bates' argument, the Ohio Tenth District Court of Appeals affirmed the decision of the lower court and decided that compliance with *Ahlborn* did not require such a pro rata reduction in ODJFS' recovery.⁶⁸ In so deciding, the court relied upon an earlier Medicaid third party liability case, *Mulk v. Ohio Department of Job & Family Services*,⁶⁹ and held that

⁶³ *Mulk v. Ohio Dep't of Job & Family Servs.*, 969 N.E.2d 1254, 1261 (Ohio Ct. App. 2011).

⁶⁴ OHIO REV. CODE ANN. § 5101.58(G)(2) (LexisNexis 2013) ("Reasonable attorneys' fees, not to exceed one-third of the total judgment, award, settlement, or compromise, plus costs and other expenses incurred by the recipient or participant in securing the judgment, award, settlement, or compromise, shall first be deducted from the total judgment, award, settlement, or compromise. After fees, costs, and other expenses are deducted from the total judgment, award, settlement, or compromise, the department of job and family services or appropriate county department of job and family services shall receive no less than one-half of the remaining amount, or the actual amount of medical assistance paid, whichever is less.").

⁶⁵ *Encompass Indem. Co. v. Bates*, No. 11AP-1010, 2012 Ohio App. LEXIS 3946 (Ohio Ct. App. Sept. 28, 2012).

⁶⁶ *Id.* at *6.

⁶⁷ *Id.*

⁶⁸ *Id.* at *6-7.

⁶⁹ *Mulk v. Ohio Dep't of Job & Family Servs.*, 969 N.E.2d 1254, 1261 (Ohio Ct. App. 2011). In *Mulk*, after multiple appellants required Medicaid to pay for medical care they received as a result of injuries sustained due to the tortious conduct of third parties, appellants argued "that the principles established in *Ahlborn* require[d] a pro rata reduction of [ODJFS'] recovery from any judgment or settlement for medical expenses paid to account for attorney's fees and costs." *Id.* at 1258-59. Thus, because appellants had a one-third contingency fee agreement, which would reduce their settlement by 33%, appellants argued that ODJFS' recovery for medical expenses must be reduced by 33%. *Id.* at 1259. Appellants argued that if

by limiting ODJFS to one-half of the settlement amount remaining after deducting attorney's fees, costs and expenses, or the full amount of the medical expenses paid by ODJFS, whichever is less, [§ 5101.58(G)(2)] address[es] the concern raised in *Ahlborn*—that reimbursement not go beyond an amount representing payments for medical care.⁷⁰

The Tenth District justified this holding based on the fact that “[§ 5101.58(G)(2)] is structured to ensure that [ODJFS] will take no more than half of the remaining recovery, thereby ensuring that the injured party will retain a portion of the judgment or settlement to compensate for other categories of damages.”⁷¹ Thus, the court determined that “[t]he General Assembly [] created a valid method to fulfill its obligations under [*Ahlborn*] and to preserve an injured party's recovery of other categories of damages.”⁷²

As of today, no appeal has yet been made in *Bates*, and the Supreme Courts of the United States and Ohio have refused to hear further appeals in *Mulk*.⁷³ Despite its being challenged, therefore, § 5101.58(G)(2) remains the current Medicaid third party liability law in the State of Ohio.

III. TO ENSURE COMPLIANCE WITH *AHLBORN*, § 5101.58(G)(2) MUST BE INVALIDATED OR REPEALED AND § 5101.58 MUST BE AMENDED TO REQUIRE ALLOCATION OF UNALLOCATED SETTLEMENTS BEFORE ODJFS MAY RECOVER

Though § 5101.58(G)(2) remains the third party liability law in the State of Ohio, this section will argue that either the Ohio Supreme Court must invalidate it or, in the alternative, the Ohio General Assembly must repeal it. This section further discusses how *Bates* was wrongly decided and argues that to ensure compliance with *Ahlborn*, § 5101.58 must be amended to require the allocation of unallocated settlements before ODJFS may recover the medical expenses it paid on behalf of Medicaid recipients. Finally, this section provides case law, statutory, and policy support for the contention that allocation is necessary.

the recovery was not so reduced, it would “‘dip into’ the portion of the judgment or settlement compensating for other forms of damages, such as lost wages or pain and suffering, in order to satisfy their attorney’s fees and costs,” and would therefore violate the anti-lien provisions. *Id.* The court, however, determined that because the recipients’ settlements were not allocated, § 5101.58(G)(2) created a valid method of reimbursement that complied with *Ahlborn*. *Id.* The court reasoned that § 5101.58(G)(2) complied with *Ahlborn* because it provided for the payment of attorney’s fees, while ensuring that “the injured party w[ould] retain a portion of the . . . settlement to compensate for other categories of damages,” as it ensured that ODJFS would take no more than half of the entire settlement. *Id.*

⁷⁰ *Bates*, 2012 Ohio App. LEXIS 3946, at *12-13.

⁷¹ *Id.* at *13 (quoting *Mulk*, 969 N.E.2d at 1259).

⁷² *Id.* (quoting *Mulk*, 969 N.E.2d at 1264).

⁷³ The Ohio Supreme Court refused to hear a discretionary appeal for *Mulk*. *Mulk*, 963 N.E.2d 824 (Ohio 2011). The United States Supreme Court also denied certiorari. *Mulk*, 133 S. Ct. 242 (2012).

A. The Ohio Tenth District Court of Appeals' Decision in Mulk and Bates are Contrary to the Principles Established in Ahlborn and to Principles of Justice

While the Ohio Tenth District Court of Appeals refused to invalidate § 5101.58(G)(2), this sub-section demonstrates that the court should have done so for multiple reasons. First of all, under § 5101.58(G)(2), compliance with the anti-lien provisions as interpreted by *Ahlborn* is impossible to ensure and creates the likely possibility that a recovery by ODJFS will in fact violate the federal anti-lien provisions. Furthermore, the Supreme Court's reasoning in *Ahlborn* simply does not support the Tenth District's justification for upholding § 5101.58(G)(2).

1. Compliance With the Federal Anti-Lien Provisions as Interpreted by *Ahlborn* is Impossible to Ensure Under § 5101.58(G)(2)'s Statutory Scheme

In *Ahlborn*, the Supreme Court was abundantly clear that “the federal third-party liability provisions *require* an assignment of no more than the right to recover the portion of a settlement that represents payments for *medical care*.”⁷⁴ Under § 5101.58(G)(2), however, compliance with this rule is impossible to ensure because no consideration is actually given to the amount in the settlement that actually represents payments for medical care. Rather, the fifty percent cap creates an unjustified and unverified presumption that the parties intended either the full value of the amount ODJFS paid on the recipient's behalf or fifty percent of the recipient's total settlement minus fees and costs to represent payments for medical care.⁷⁵ As is evident from the plight of Bates, as well as the plights of the appellants in *Mulk*, however, this presumption does not always reflect the true intentions of Medicaid recipients, many of whom believe the medical expenses reflected in their settlements are limited pro rata by the percent by which they settled their claim.⁷⁶ Therefore, because § 5101.58(G)(2) fails to ensure, as *Ahlborn* requires, that ODJFS' recovery is properly limited to the portion of a settlement that actually represents payments for medical care, the Ohio Tenth District Court of Appeals should have invalidated it.

2. Section 5101.58(G)(2) Creates the Likely Possibility that ODJFS' Recovery Will Violate the Federal Anti-Lien Provisions

The Ohio Tenth District Court of Appeals should not only have invalidated § 5101.58(G)(2) because it fails to ensure that ODJFS' recovery is properly limited to medical expenses, but it also should have invalidated § 5101.58(G)(2) because it creates the likely possibility that an ODJFS recovery will actually violate federal anti-lien provisions. In *Ahlborn*, the Supreme Court determined that “the federal Medicaid anti-lien [provisions] allow a narrow exception for liens that are limited to

⁷⁴ Ark. Dep't of Human Servs. v. Ahlborn, 547 U.S. 268, 282 (2006) (emphasis added).

⁷⁵ See *Wos v. E.M.A.*, 133 S. Ct. 1391, 1399 (2013) (In discussing North Carolina's non-rebuttable one-third statutory cap formulation, the Court noted, “[t]he problem is not that it is an unreasonable approximation in all cases. In some cases, it may well be a fair estimate. But the State provides no evidence to substantiate its claim that the one-third allocation is reasonable in the mine run of cases. Nor does the law provide a mechanism for determining whether it is a reasonable approximation in any particular case.”).

⁷⁶ See *supra* text accompanying notes 68-69, 71.

recoveries only for medical expenses.”⁷⁷ A state statute that authorizes recovery of more than medical expenses thus violates the anti-lien provisions because that recovery would be a lien on the personal property⁷⁸ of a Medicaid recipient that was not excepted by the third party assignment provisions.⁷⁹

Under § 5101.58(G)(2), the likelihood of such a violation of the federal anti-lien provisions arises.⁸⁰ In fact, § 5101.58(G)(2) will always violate the anti-lien provisions when, as was the case in *Bates* and *Mulk*, the amount paid by ODJFS for medical services exceeds the amount in the settlement that the parties believed to represent medical expenses, but is less than one half of the total settlement.⁸¹ In such a case, ODJFS’ recovery encroaches upon other categories of damages, which *Ahlborn* specifically forbids.⁸²

Moreover, such a case likely violates the Supremacy Clause of the United States Constitution as well. Under the Supremacy Clause, “[w]here a state and federal law ‘directly conflict,’ state law must give way.”⁸³ Because the State of Ohio’s § 5101.58(G)(2) creates the likelihood of directly conflicting with the anti-lien provisions of the federal Social Security statute, the Tenth District Court of Appeals should have invalidated because it likely violates the Supremacy Clause as well.

3. The Supreme Court’s Reasoning in *Ahlborn* does not support the Ohio Tenth District Court of Appeals’ Justification for Upholding § 5101.58(G)(2)

The Ohio Tenth District Court of Appeals’ justification for upholding § 5101.58(G)(2)—that it comports with *Ahlborn* because it guarantees that Medicaid recipients will receive at least some portion of the settlement as compensation for other categories of damages—is also not supported by the Supreme Court’s decision in *Ahlborn*. In *Ahlborn*, the Supreme Court’s held not that Medicaid recipients must maintain some compensation for other categories of damages when state Medicaid agencies seek reimbursement for medical payments. Rather, the Supreme Court’s holding was that a state Medicaid agency’s recovery violates the federal anti-lien

⁷⁷ *In re E.B.*, 729 S.E.2d 270, 289 (W. Va. 2012). This exception is the Medicaid third party assignment provisions. *See supra* text accompanying notes 55-57.

⁷⁸ *See Martin v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002).

⁷⁹ *Supra* text accompanying notes 55-57.

⁸⁰ *Cf. Elizabeth A. Grymes, Note, A Post-Ahlborn Analysis of the Supreme Court of North Carolina’s Decision in Andrews v. Haygood*, 2 CHARLOTTE L. REV. 525, 539 (2010).

⁸¹ *Cf. Andrews v. Haygood*, 669 S.E.2d 310, 317 (N.C. 2008) (Hudson, J., dissenting) (“Application of the [one-third statutory cap formulation] in a case like this one, in which there has been no allocation, could allow precisely the result that is explicitly barred by *Ahlborn*. In fact, this would be the outcome with any settlement in which the amount actually paid by [the state Medicaid agency] is greater than the amount of the settlement designated for medical expenses, but less than the one-third cap.”).

⁸² *Ark. Dep’t of Human Servs. v. Ahlborn*, 547 U.S. 268, 281 (2006) (“The [Medicaid] statute does not sanction an assignment of rights to payment for anything other than medical expenses—not lost wages, not pain and suffering, not an inheritance.”).

⁸³ *PLIVA, Inc. v. Mensing*, 131 S. Ct. 2567, 2577 (2011).

provisions unless that recovery is narrowly tailored to the portion of a settlement that represents medical expenses.⁸⁴

Thus, the Supreme Court was concerned with ensuring that state Medicaid agencies recover no more than that to which they are legally entitled from Medicaid recipients' settlements; it was not concerned with ensuring those recipients had at least some compensation for damages other than medical expenses. The Ohio Tenth District Court of Appeals' justification for upholding § 5101.58(G)(2), therefore, has no merit under *Ahlborn*.

B. Section 5101.58(G)(2) Should be Amended to Require the Allocation of Unallocated Settlements Before ODJFS May Recover for Medical Expenses

As discussed above, the Tenth District's justification for upholding § 5101.58(G)(2) is without merit; under § 5101.58(G)(2) there is no way to ensure compliance with *Ahlborn*; and in fact, § 5101.58(G)(2) creates the likely possibility that the anti-lien provisions and United States Supremacy Clause will in fact be violated. Accordingly, § 5101.58(G)(2) must either be invalidated by the Ohio Supreme Court upon appeal of *Bates*,⁸⁵ or in the alternative, be repealed by the Ohio General Assembly.

Additionally, the General Assembly must amend § 5101.58 to require allocation of unallocated settlements before ODJFS can claim the right to any portion of Ohio Medicaid recipients' settlements. Requiring such an allocation will ensure compliance with the anti-lien provisions as interpreted by *Ahlborn* by ensuring that ODJFS' recovery will be properly limited to the portion of a settlement that the parties actually intended to represent medical expenses. This sub-section provides case law, other states' statutory law, and considerations of fairness and the justice system to support the contention that allocation should be required.

1. Case Law Supports the Contention that § 5101.58 Should be Amended to Require Allocation

The contention that under § 5101.58(G)(2) compliance with *Ahlborn* is impossible to ensure and should therefore be amended to require allocation is supported by the fact that the United States Supreme Court, federal courts, and various state courts have all invalidated statutory cap formulations both exactly like and similar to Ohio's § 5101.58(G)(2). These courts have held that to ensure compliance with *Ahlborn*, allocation of unallocated settlements should be mandated before state Medicaid agencies may recover for medical expenses.

The Supreme Court so decided in its 2013 decision, *Wos vs. E.M.A. ex rel. Johnson*.⁸⁶ In *Wos*, the Supreme Court was called to determine whether North Carolina's one-third statutory cap formulation was compatible with *Ahlborn* and the anti-lien provisions.⁸⁷ The case came to the Court after a series of state and federal opinions relating to the North Carolina statute came into conflict.

⁸⁴ *Ahlborn*, 547 U.S. at 292 ("Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding [that which represents medical expenses], and the federal anti-lien provision affirmatively prohibits it from doing so.").

⁸⁵ Because, as discussed in *supra* note 73, appellants have exhausted their appeals in *Mulk*.

⁸⁶ *Wos v. E.M.A.*, 133 S. Ct. 1391 (2013).

⁸⁷ *Id.* at 1395.

The first of these opinions was the North Carolina Supreme Court's: *Andrews v. Haygood*.⁸⁸ In *Andrews*, the court held that North Carolina's one-third statutory cap formulation was "a reasonable method for determining the State's medical reimbursements" when a settlement was not specifically allocated for medical reimbursements.⁸⁹ The United States District Court for the Western District of North Carolina, in *Armstrong v. Cansler*,⁹⁰ agreed with the North Carolina Supreme Court's decision in *Andrews*.⁹¹ Upon appeal, however, the Fourth Circuit held in *E.M.A. ex rel. Plyler v. Cansler* that North Carolina's one-third statutory cap "fail[s] to comply with federal Medicaid law as interpreted by the Supreme Court in *Ahlborn*,"⁹² stating, "[w]e are not persuaded that a mere 'reasonable cap' on a settlement satisfies the federal anti-lien law as required by *Ahlborn*."⁹³

Ultimately, the Supreme Court agreed with the Fourth Circuit, holding that "[a]n irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act's clear mandate that a State may not demand any portion of a beneficiary's tort recovery except the share that is attributable to medical expenses."⁹⁴ Thus, the Court noted, that in cases where medical expenses were neither allocated in the settlement nor stipulated to by the parties,⁹⁵ an allocation must be made to protect "from state demand the portion of a [Medicaid recipient's] tort recovery that the . . . judgment does not attribute to medical expenses."⁹⁶

The Supreme Court of West Virginia likewise determined that West Virginia's one-third statutory cap on recovery violated the anti-lien provisions as interpreted by *Ahlborn*.⁹⁷ That court held that "the only way for the State to ensure compliance with

⁸⁸ *Andrews v. Haygood*, 669 S.E.2d 310 (N.C. 2008).

⁸⁹ *Id.* at 314.

⁹⁰ *Armstrong v. Cansler*, 722 F. Supp. 2d 653 (W.D.N.C. 2013).

⁹¹ *Id.*

⁹² *E.M.A. v. Cansler*, 674 F.3d 290, 312 (4th Cir. 2012).

⁹³ *Id.* at 308. The court determined that allocation of unallocated settlements is required so a Medicaid recipient can have an opportunity to rebut the one-third statutory presumption.

⁹⁴ *Wos v. E.M.A.*, 133 S. Ct. 1391, 1399 (2013).

⁹⁵ *Id.* ("When there has been a judicial finding or approval of an allocation between medical and nonmedical damages—in the form of either a jury verdict, court decree, or stipulation binding on all parties—that is the end of the matter.")

⁹⁶ *Id.* While the court seemed to favor a judge or jury determining such an allocation through a mini-trial based on which party would have been "most likely to prevail on the claims at trial and how much they reasonably could have expected to receive on each claim if successful, in view of damages awarded in comparable tort cases," the court did note that "States have considerable latitude to design administrative and judicial procedures to ensure a prompt and fair allocation of damages." *Id.* at 1401.

⁹⁷ *In re E.B.*, 729 S.E.2d 270, 291 (W. Va. 2012) ("We are not persuaded by those decisions relied upon by [the state Medicaid agency] holding that state Medicaid reimbursement statutes comply with *Ahlborn* simply because they contain 'reasonable statutory caps' on recovery from unallocated lump sum settlements. These decisions fail to require a determination of what portion of a settlement is attributable to medical expenses as required by *Ahlborn*.").

Ahlborn is to provide for a specific allocation of damages in a settlement . . . obtained by a recipient of Medicaid assistance.”⁹⁸ Similarly, in *McKinney ex rel. Gage v. Philadelphia Housing Authority*, the district court purposefully decided to forgo applying a fifty percent statutory cap when it was asked to determine the portion of an unallocated settlement that was attributable to reimbursement for medical expenses.⁹⁹ The majority of other courts that have interpreted *Ahlborn* have likewise held that allocation of unallocated settlements is required before state Medicaid agencies may recover medical expenses paid on behalf of Medicaid recipients.¹⁰⁰

Some of the courts that have not mandated allocation of unallocated settlements have nonetheless required states to allow Medicaid recipients an opportunity to challenge state Medicaid third party liability statutes that provide either for full recovery or full recovery subject to some form of a statutory cap. For example, the courts in *State Department of Health and Welfare v. Hudelson* and *Price v. Wolford* held that Medicaid recipients must be given an opportunity to rebut a presumption of full recovery upon a showing of evidence that a more limited allocation of damages for medical expenses is justified.¹⁰¹ Similarly, the Third Circuit Court of Appeals

⁹⁸ *Id.* at 295.

⁹⁹ *McKinney ex rel. Gage v. Phila. Hous. Auth.*, No. 07 Civ. 4432, 2010 WL 3364400, at *12 (E.D. Pa. 2010).

¹⁰⁰ *In re E.B.*, 229 S.E.2d at 290; *see also Bolanos v. Super. Ct.*, 87 Cal. Rptr. 3d 174, 180 (Ct. App. 2008) (“The fundamental point is that a settlement that does not distinguish between past medical expenses and other damages must be allocated between these two classes of recoveries. Without such an allocation, the principle set forth in *Ahlborn*, that the state cannot recover for anything other than past medical expenses, cannot be carried into effect.”); *Lugo v. Beth Israel Med. Ctr.*, 819 N.Y.S.2d 892, 896 (App. Div. 2006) (holding that “*Ahlborn* must be read to limit the [state Medicaid agency’s] recoupment to the amount of the settlement proceeds allocated to past medical expenses” and that “[t]his Court is [e]mpowered to [a]llocate the [s]ettlement [p]roceeds”); *Harris v. City of New York*, 837 N.Y.S.2d 486, 489 (App. Div. 2007); *Wright v. N.Y. Hosp. Med. Ctr. of Queens*, No. 0017444/2001, 2007 WL 4229216 (N.Y. App. Div. 2007); *Sw. Fiduciary, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.*, 249 P.3d 1104, 1111 (Ariz. Ct. App. 2011) (“When the proper allocation of the settlement amount to the damage component represented by [the state Medicaid agency] payments is disputed, the better course is to seek the intervention of the court.”); *I.P. ex rel. Cardenas v. Henneberry*, 795 F. Supp. 2d 1189, 1193-94, 1198 (D. Colo. 2011) (holding that Colorado’s Medicaid statute comports with *Ahlborn* because it allows for state reimbursement to “the fullest extent allowed by federal law,” which the court determined was the “federal Medicaid laws . . . as interpreted by *Ahlborn*,” and directed the case to trial to determine the portion of the settlement that represents medical expenses (quoting COLO. REV. STAT. § 25.5-4-301(5)(a) (2013))).

¹⁰¹ *See State Dept. of Health & Welfare v. Hudelson*, 196 P.3d 905, 912 (Idaho 2008), *abrogated by Verska v. St. Alphonsus Reg’l Med. Ctr.*, 265 P.3d 502 (Idaho 2011) (“If no [allocation agreement] is reached, [the state Medicaid statute] presumes that the Department is entitled to recoup amounts it has paid in benefits on behalf of the recipient up to the amount of the settlement or judgment. However, this presumption is subject to being rebutted. The Medicaid recipient may present evidence directed toward rebutting the presumption.”); *Price v. Wolford*, 608 F.3d 698, 707 (10th Cir. 2010) (upholding Oklahoma’s Medicaid statute that allows for full recovery “unless a more limited allocation of damages to medical expenses is shown by clear and convincing evidence.” (quoting OKLA. STAT. ANN. tit. 63, § 5051.1(D)(1)(d) (West 2012))).

upheld Pennsylvania's former one-third statutory cap¹⁰² because, "[p]ursuant to the current statutory framework, beneficiaries unhappy with its results may appeal the default allocation."¹⁰³ After the Supreme Court's ruling in *Wos*, a Florida appellate court in *Agency for Health Care Administration v. Riley* likewise held that "a plaintiff should be afforded an opportunity to seek the reduction of a Medicaid lien amount established by [Florida's irrebuttable fifty percent statutory cap], with evidence, that the lien exceeds the amount recovered for medical expenses."¹⁰⁴

All of the above cases support the contention that to ensure compliance with *Ahlborn*, state Medicaid third party liability statutes must either provide for the allocation of unallocated settlements or provide an opportunity for Medicaid beneficiaries to rebut a statutory cap presumption. The Supreme Court's *Wos* decision and the Florida appellate court's *Riley* decision, however, are exceedingly persuasive.

The *Wos* Court explicitly held that "[a]n irrebuttable, one-size-fits-all statutory presumption," like the irrebuttable fifty percent statutory cap in Ohio, "is incompatible with the Medicaid Act's clear mandate that a State may not demand any portion of a beneficiary's tort recovery except the share that is attributable to medical expenses."¹⁰⁵ In that case, the Supreme Court invalidated an irrebuttable one-third statutory cap, noting that "[i]f a State arbitrarily may designate one-third of any recovery as payment for medical expenses, there is no logical reason why it could not designate *half*, three quarters, or all of a tort recovery in the same way."¹⁰⁶ Thus, in invalidating North Carolina's one-third statutory cap, the Supreme Court explicitly noted that an irrebuttable fifty percent statutory cap, like Ohio's § 5101.58(G)(2), would be a more egregious violation of the federal anti-lien provisions. As mentioned above, the *Riley* stated noted that because of this *Wos* decision, its reasoning in its earlier decision upholding Florida's irrebuttable fifty percent statutory cap¹⁰⁷ was "severely undermined,"¹⁰⁸ and as such, mandated that Florida Medicaid recipients be given the opportunity to rebut that statutory presumption.¹⁰⁹

As Ohio's § 5101.58(G)(2) provides Ohio Medicaid recipients with an irrebuttable, one-size-fits-all statutory presumption exactly like Florida's Medicaid third party liability statute that was invalidated under *Wos*, § 5101.58(G)(2) must be amended to ensure compliance with the anti-lien provisions as interpreted by

¹⁰² See *infra* text accompanying notes 112-13.

¹⁰³ *Tristani ex rel. Karnes v. Richman*, 652 F.3d 360, 378 (3d Cir. 2011). The court held that "in determining what portion of a Medicaid beneficiary's third-party recovery it may claim in reimbursement for Medicaid expenses, the state must have in place procedures that allow a dissatisfied beneficiary to challenge the default allocation." *Id.*

¹⁰⁴ *Agency for Health Care Admin. v. Riley*, 119 So. 3d 514, 516 (Fla. Dist. Ct. App. 2013).

¹⁰⁵ *Wos v. E.M.A.*, 133 S. Ct. 1391, 1399 (2013).

¹⁰⁶ *Id.* at 1398 (emphasis added).

¹⁰⁷ *Russell v. Agency for Health Care Admin.*, 23 So. 3d 1266 (Fla. Dist. Ct. App. 2010), *abrogated by Riley*, 119 So.3d 514.

¹⁰⁸ *Riley*, 119 So.3d at 515.

¹⁰⁹ *Id.* at 516.

Ahlborn and *Wos*. Section 5101.58(G)(2) can be amended to provide a rebuttable presumption or to mandate allocation of unallocated settlements; however, the best solution is to amend § 5101.58 to require allocation before ODJFS can recover any portion of an Ohio Medicaid recipient's settlement.

2. Statutory Support for the Contention that § 5101.58 Should be Amended to Require Allocation

The contention that allocation of unallocated settlements is necessary to ensure compliance with the *Ahlborn* principles is also supported by the fact that “[i]n reaction to the Court’s ruling in *Ahlborn*, many states that previously imposed statutory caps on Medicaid reimbursement amounts [have since] changed their laws.”¹¹⁰ For example, prior to *Ahlborn*, California law, like § 5101.58(G)(2), provided for state recovery of all of the medical expenses paid on a Medicaid recipient’s behalf unless those expenses exceeded half the total settlement after deducting attorney’s fees.¹¹¹ The California legislature, however, “quickly recognized that a [fifty percent] cap was not in compliance with [the] Court’s ruling in *Ahlborn*, and took prompt steps to amend the statute to eliminate the cap and provide for an allocation method.”¹¹² Likewise, Pennsylvania law prior to *Ahlborn* imposed a fifty percent cap on the state’s recovery;¹¹³ however, in response to the *Ahlborn* decision, the Pennsylvania legislature amended its Medicaid third party liability statute to stipulate that in the case of an unallocated settlement, “the court or agency shall allocate the judgment or award between the medical portion and other damages.”¹¹⁴

As the Supreme Court in *Wos* noted, as of 2013, sixteen States and the District of Columbia provide for some type of judicial hearing to allocate unallocated settlements before state Medicaid agencies are entitled to recover from any portion of a Medicaid recipient’s settlement with a liable third party.¹¹⁵ Of these sixteen states, some “have established rebuttable presumptions and adjusted burdens of proof to ensure that speculative assessments of a plaintiff’s likely recovery do not defeat the State’s right to recover medical costs.”¹¹⁶

¹¹⁰ Grymes, *supra* note 80, at 533.

¹¹¹ CAL. WELF. & INST. CODE § 14124.78 (West 2005).

¹¹² *Brown Writ*, *supra* note 62, at 23. The amended § 14124.78 provides for recovery only of “that portion of a settlement . . . that represents payment for medical expenses . . . provided on behalf of the beneficiary” and stipulates that “all reasonable efforts shall be made to obtain the director’s advance agreement to a determination as to what portion of the settlement . . . represents payment for medical expenses . . . provided on behalf of the beneficiary.” CAL. WELF. & INST. CODE § 14124.78 (West 2005).

¹¹³ *E.M.A v. Cansler*, 674 F.3d 290, 309 (4th Cir. 2012).

¹¹⁴ 62 PA. CONS. STAT. § 1409.1(b)(1)-(2) (West 2012).

¹¹⁵ *Wos v. E.M.A.*, 133 S. Ct. 1391, 1401 (2013); see, e.g., D.C. CODE § 4-604(b) (2011); 305 ILL. COMP. STAT. ANN. 5/11-22 (West 2008); MISS. CODE ANN. § 43-13-125(2) (West 2008); MO. ANN. STAT. § 208.215.9 (West 2010); N.H. REV. STAT. ANN. § 167:14-a(IV) (LexisNexis 2010); VA. CODE ANN. § 8.01-66.9 (West 2012).

¹¹⁶ *Wos*, 133 S. Ct. at 1401.

For example, the Oklahoma legislature amended its Medicaid third party liability statute, which provided for full recovery of medical expenses paid, to allow recipients to show “by clear and convincing evidence” that a “more limited allocation of damages to medical expenses” is justified.¹¹⁷ Massachusetts likewise provides a rebuttable presumption of full reimbursement,¹¹⁸ whereas Hawaii provides a rebuttable one-third presumption,¹¹⁹

These statutes support the proposition that to ensure compliance with the Supreme Court’s decision in *Ahlborn* Ohio’s § 5101.58 should be amended to require allocation of unallocated settlements. Alternatively, these statutes at the very least support the proposition that Ohio Medicaid recipients should be allowed an opportunity to rebut § 5101.58(G)(2)’s fifty percent presumption by demonstrating that a more limited allocation of damages to medical expenses is justified.

3. Section 5101.58 Should be Amended Because § 5101.58(G)(2) is Fundamentally Unfair to Ohio Medicaid Recipients

Not only should § 5101.58 be amended because it runs contrary to case and statutory law, it should also be amended because, as it currently stands, it is fundamentally unfair to Ohio Medicaid recipients whose settlements with liable third parties are not allocated. Section 5101.58(G)(2) is unfair to such Medicaid recipients because it entitles ODJFS to recover much more from their settlements than it would be entitled to recover if their settlements were allocated without any justifiable reason for the distinction. This unfairness is evident in *Bates*’ case, as he received a full \$17,550.93 less than he would have if his settlement was allocated. Such a law, which bases the amount that a Medicaid recipient can ultimately recover from a settlement on an arbitrary technicality like allocation, so to speak kicks Ohio Medicaid recipients with unallocated settlements when they are down: they are already “the poorest Americans;”¹²⁰ are injured; take settlements for significantly less than the true value of their claims; and then, for no justifiable reason, are forced to give more of that significantly reduced settlement to ODJFS than they would have if their settlements were allocated. This injustice is even more apparent considering that the current legal climate favors non-allocation.¹²¹

Whether to facilitate “hyper-efficiency in practice” or to avoid confrontation with the opposing side based on the value of damages associated with each specific claim in the settlement, the tendency of personal injury lawyers today is “to plead damages in a general sense, frequently putting forward a laundry list of claims for relief”

¹¹⁷ OKL. STAT. ANN. tit. 63, § 5051.1(D)(1)(d) (West 2012).

¹¹⁸ MASS. ANN. LAWS ch. 118E, § 22(c)-(d) (LexisNexis 2012).

¹¹⁹ HAW. REV. STAT. § 346-37(h).

¹²⁰ See *supra* text accompanying note 24. Some Medicaid recipients, however, are not the poorest Americans to begin with, but, after having to pay their medical bills associated with their injuries, become so poor that they have to rely on Medicaid. Such was the case for both *Ahlborn* and *Bates*. Ark. Dep’t of Human Servs. v. *Ahlborn*, 547 U.S. 268, 273 (2006); *Encompass Indem. Co. v. Bates*, No. 11AP-1010, 2012 Ohio App. LEXIS 3946, at *1 (Ohio Ct. App. Sept. 28, 2012). Nevertheless, the fact that they were not poor until their injuries does not take away from the argument that § 5101.58(G)(2) is fundamentally unfair.

¹²¹ Pearlman, *supra* note 14.

without actually allocating.¹²² Given this tendency, as well as the fact that § 5101.58 does not require parties to allocate their settlements, a great deal of Ohio Medicaid recipients' settlements will go unallocated, thereby forcing those recipients to assign to ODJFS much more of their settlement than they would have if their settlements were allocated for no justifiable reason. To avoid this injustice § 5101.58 must be amended to require the allocation of unallocated settlements before ODJFS may recover for medical expenses paid on behalf of Ohio Medicaid recipients.

4. Amending § 5101.58 Would Be Consistent with the Public Policy in Favor of Settlements

In addition to being highly unfair to Ohio Medicaid recipients with unallocated settlements, § 5101.58(G)(2) will also have the negative effect of deterring parties from settling their cases. Parties decide whether to settle or litigate by balancing the value of the settlement offer against the costs and risks of litigation.¹²³ If the value of the settlement is greater than the costs and risks of litigation, parties will typically agree to settle.¹²⁴ This balancing equation, however, is more difficult to apply in Medicaid third party liability cases because plaintiffs not only have to weigh the value of the settlement against the costs and risks of litigation, but they also have to take into consideration the fact that state Medicaid agencies will claim the right to a portion of their settlements as reimbursement for medical payments made on their behalf.

Because § 5101.58(G)(2) gives ODJFS the right to either the entire amount of medical expenses it paid on behalf of Ohio Medicaid recipients or to half of recipients' total settlement minus attorney's fees and costs, the value of recipients' settlements likely becomes significantly less than that to which they, like Bates and the appellants in *Mulk*, believe they are entitled. Once recipients are apprised of the possibility receiving such a significantly reduced settlement under § 5101.58(G)(2), they are likely to decide that the value of their settlement is no longer greater than the costs and risks associated with litigation, thereby having the effect of many cases resulting in trial rather than settlement. Thus, as it currently stands, Ohio's Medicaid third party liability statute has the effect of disincentivizing Ohio Medicaid recipients from settling their cases.¹²⁵

This outcome, however, is contrary to the strong public policy in favor of settlements.¹²⁶ Public policy favors settlements over litigation for a number of

¹²² *Id.* at 18-20, 22.

¹²³ Stephen Mcg. Bundy, *The Policy in Favor of Settlement in an Adversary System*, 44 HASTINGS L.J. 1, 12 (1992).

¹²⁴ *Id.*

¹²⁵ *Cf.* Brief for Ass'n of Trial Lawyers of Am. as Amicus Curiae Supporting Respondents, *Ahlborn*, 547 U.S. 268 (No. 04-1506) [hereinafter Trial Lawyers' Brief] ("If this Court were to rule for petitioner, an injured plaintiff who had received medical treatment funded by Medicaid would have little incentive to settle her personal injury lawsuit for an amount that fell far short of her total claim for damages, because any settlement award immediately would be reduced by the total amount claimed by the state Medicaid agency for reimbursement of medical expenses paid. . . . Where the cost of treatment funded by Medicaid was substantial, there would be relatively little, if any money left to compensate plaintiff for her injuries.").

¹²⁶ *Id.* at 10 ("[The Supreme] Court has long recognized a strong public interest in the expeditious resolution of lawsuits through settlement."); *see also* Margaret Meriwether

reasons;¹²⁷ however, some of the most important reasons are ensuring the efficient resolution of lawsuits, easing the burden on the courts,¹²⁸ and preserving limited judicial resources.¹²⁹ To comply with this public policy and to meet these goals, therefore, § 5101.58 must be amended so that Ohio Medicaid recipients are not disincentivized from settling due to the law's effect of significantly reducing the value of their settlements.

Amending § 5101.58 to require allocation of unallocated settlements would eliminate that significant reduction in the value of Medicaid recipients' settlements because if the recipients' claims were allocated, ODJFS would only be able to recover from them that significantly limited amount that was intended to represent medical expenses. Therefore, by requiring allocation, Ohio Medicaid recipients will no longer be incentivized to forgo settlement based on the possibility that ODJFS will claim a significantly larger portion of their settlement than that to which they believe it is entitled. Thus, allocation would remedy the disincentivizing effect of the current law.

IV. VARIOUS WAYS BY WHICH BOTH THE INTERESTS OF ODJFS AND OHIO MEDICAID RECIPIENTS CAN BE PROTECTED IN THE ALLOCATION PROCESS

As discussed in Part III of this Note, to ensure compliance with *Ahlborn*, § 5101.58(G)(2) must either be invalidated by the Ohio Supreme Court or repealed by the Ohio General Assembly. Part III of this Note also argued that § 5101.58 must be amended to require the allocation of unallocated settlements before ODJFS may recover any portion of Ohio Medicaid recipients' settlements.

This Section will address concerns that ODJFS may have with regard to such a statutory amendment and identify how those concerns can be mitigated. Additionally, this Section will discuss various ways by which Medicaid recipients' settlements can be allocated and will argue that the best allocation method would be to require parties to negotiate an appropriate allocation themselves or if the parties reach an impasse, to have a court determine the allocation following an impartial hearing.

Cordray, *Settlement Agreements and the Supreme Court*, 48 HASTINGS L.J. 9, 36, 38 (1996) (noting that the Supreme Court has endorsed the policy favoring settlements since the turn of the century by declaring that "settlements of matters in litigation, or in dispute, without recourse to litigation, are generally favored" (quoting *St. Louis Mining & Milling Co. v. Mont. Mining Co.*, 171 U.S. 650, 656 (1898))).

¹²⁷ Cordray, *supra* note 126, at 36-37.

¹²⁸ Trial Lawyers' Brief, *supra* note 125, at 10 ("Our state and federal judicial systems would cease to function if all, or even a substantial portion, of cases were litigated to trial.").

¹²⁹ Cordray, *supra* note 126, at 36 ("When parties resolve their dispute through settlement rather than full litigation, the growing pressure on court dockets is relieved. Settlement thus enables courts to conserve scarce judicial resources and to reduce their considerable backlog. Settlement is, as a result, 'indispensable to judicial administration.'" (quoting *Jannah v. GAF Corp.*, 887 F.2d 432, 435 (2d Cir. 1989))); *see also* Anne Knickerbocker, Annotation, *Policy Encouraging and Favoring Compromise*, 15B Am. Jur. 2d *Compromise and Settlement* § 3 (2012) ("Generally, the law and public policy favor and encourage compromises and settlements as a means of resolving uncertainties and discouraging lawsuits. Settlement agreements simplify litigation without taking up valuable court resources, and reduce the burden on the courts. Accordingly, there is a strong judicial policy in favor of settlements.").

A. Methods by Which ODJFS' Interests Can be Protected in the Settlement Allocation Process

Although Ohio Medicaid recipients, who will be able to retain more of their settlements than they would under § 5101.58(G)(2)'s current statutory cap formulation, will argue that an amendment to § 5101.58 is in their best interests, ODJFS will likely argue against the amendment for fear that Medicaid recipients will allocate only a small amount of damages to medical expenses, thereby "allocating away" most of ODJFS' interest in the settlement. As discussed in Part III, such an allocation is necessary to ensure compliance with the federal anti-lien provision as interpreted by the Supreme Court in *Ahlborn*; however, ODJFS's interests in the allocation process can still be protected through the employment of various mitigation methods. In each of these methods, ODJFS must become intimately involved in the settlement allocation process.¹³⁰

ODJFS' involvement in the settlement allocation process can be ensured through a variety of ways. One such way is to amend § 5101.58 to require the mandatory joinder of ODJFS to any claim in which a Medicaid lien is at issue.¹³¹ Alternatively, instead of making the joinder mandatory, § 5101.58 could be amended to require Medicaid recipients' attorneys to notify ODJFS of any settlement negotiations, giving ODJFS the option to intervene and participate in the settlement negotiations if it so desires.¹³² Section 5101.58 could also be amended to require ODJFS' consent before any allocation of damages is finalized by the parties.¹³³ By requiring or allowing ODJFS to join the Medicaid recipients' claims, or by requiring ODJFS to give its consent to any allocation by Medicaid recipients, ODJFS will be able to prevent Medicaid recipients from completely allocating away its interest.

There are also more drastic ways in which ODJFS' interest can be protected in the settlement allocation process. One such approach is to take the allocation decision away from all interested parties altogether, leaving the allocation decision solely within the discretion of the court.¹³⁴ This approach would then ensure an impartial allocation for both parties. An even more drastic approach would be to eliminate the need for allocation altogether. This can be achieved by statutorily excluding medical expenses from Medicaid recipients' personal injury settlements, thereby forcing ODJFS to initiate its own law suits against third parties liable for the

¹³⁰ See Arden, Memorandum, *supra* note 31 ("In order to protect the Medicaid program's interest in the allocation of settlement monies to medical items and services it is extremely important for States to be involved in the litigation and settlement process.").

¹³¹ See *id.* ("States may pass laws which require mandatory joinder of a State when a Medicaid lien is at issue."). Such a requirement is consistent with 42 U.S.C. § 2651(d), which gives the United States the right to join in any action that a Medicaid recipient has against a liable third party to enforce the state's right to recovery of medical expenses paid on the recipient's behalf. 42 U.S.C.A. § 2651(d) (West 2013).

¹³² Arden, Memorandum, *supra* note 31.

¹³³ See *Ark. Dep't of Human Servs. v. Ahlborn*, 547 U.S. 268, 288 (2006) ("[T]he risk that parties to a tort suit will allocate away the State's interest can be avoided . . . by obtaining the State's advance agreement to an allocation.").

¹³⁴ *Id.*

medical expenses paid on behalf of Medicaid recipients.¹³⁵ ODJFS would therefore completely avoid the risk of settlement manipulation by Medicaid recipients.

B. Methods by Which Medicaid Recipients' Settlements can be Allocated

As the above discussion demonstrates, ODJFS' interests in the settlement allocation process can be protected through a variety of mitigation methods. Therefore, this Note will now discuss the variety of ways in which Ohio Medicaid recipients' settlements with liable third parties can be allocated.

On one end of the spectrum, the Ohio General Assembly could amend § 5101.58 to require that *courts* allocate unallocated settlements through an allocation hearing. Under this method, all interested parties, including ODJFS, would have the opportunity to be heard and then the court would use its discretion to make an objective determination of what would constitute a fair allocation based on the totality of the circumstances.¹³⁶ This method would ensure that allocation is equitable for both Medicaid recipients and ODJFS.¹³⁷ However, this method would also entail a considerable amount of time and expense, as courts would basically have to engage in mini-trials to determine appropriate allocations, thereby consuming already limited judicial resources and prolonging the final settlements.¹³⁸

On the other end of the spectrum, § 5101.58 could be amended to require the *parties* to allocate for medical expenses before the court would approve of any settlement. Such a pre-settlement allocation requirement would eliminate the waste of time and expense associated with post-settlement allocation hearings, as well as the reduce the potential for post-settlement appeals. This approach, however, could

¹³⁵ See J. Michael Hayes, *Are Medicare, Medicaid, and ERISA Liens?*, 79 N.Y. St. B.J. 28, 29-31 (2007).

¹³⁶ See *Wos v. E.M.A.*, 133 S. Ct. 1391, 1399 (2013) (holding that when an allocation cannot be reached by settlement agreement or stipulation, a judge or jury should make the allocation decision in a mini-trial); Trial Lawyers' Brief, *supra* note 125, at 19-20; Henning v. Wineman, 306 N.W.2d 550, 553 (Minn. 1981) (deciding that the district court had the authority to allocate settlement proceeds among recoverable and non-recoverable damages); *Rimes v. State Farm Mut. Auto. Ins. Co.*, 316 N.W.2d 348 (Wis. 1982) (upholding the trial court's use of a post-settlement mini-trial to allocate proceeds); *Sw. Fiduciary, Inc. v. Ariz. Health Care Cost Containment Sys. Admin.*, 249 P.3d 1104, 1111 (Ariz. Ct. App. 2011) ("When the proper allocation of the settlement amount to the damage component represented by [the state Medicaid agency] payments is disputed, the better course is to seek the intervention of the court."); *E.M.A v. Cansler*, 674 F.3d 290, 312 (4th Cir. 2012) ("In the event of an unallocated lump-sum settlement exceeding the amount of the state's Medicaid expenditures, as in this case, the sum certain allocable to medical expenses must be determined by way of a fair and impartial adversarial procedure.").

¹³⁷ See *Harris v. City of New York*, 837 N.Y.S.2d 486 (App. Div. 2007) (holding a hearing was necessary to determine the percentage of the settlement that should be allocated for medical expenses despite the fact that the plaintiff alleged the entire settlement award was for pain and suffering).

¹³⁸ *But see Wos*, 133 S. Ct. at 1401 (In response to North Carolina's argument that holding mini-trials would be "wasteful, time consuming, and costly," the Court stated that "[e]ven if that were true, it would not relieve the State of its obligation to comply with the terms of the Medicaid anti-lien provision. And it is not true as a general proposition. . . . Sixteen States and the District of Columbia provide for hearings of this sort, and there is no indication that they have proved burdensome.").

also prove problematic if parties cannot agree upon an appropriate allocation. If the parties are required to allocate before the court can approve a settlement and the parties cannot come to an allocation agreement, the case will be forced to proceed to trial, thereby violating the strong public policy favoring settlement.¹³⁹

Alternatively, and as Bates argued, § 5101.58 could be amended to require that the allocation decision be based solely on the *Ahlborn* formula. The *Ahlborn* formula divides the settlement amount by the alleged total original value of the claim and then multiplies that fraction by the total amount that ODJFS paid on behalf of the Medicaid recipient. The resulting value would be the appropriate amount allocated for medical expenses.¹⁴⁰ Such an amendment would eliminate the time and expense associated with a mini trial, would eliminate the possibility of being forced to litigate if the parties cannot agree upon an appropriate allocation in the mandatory pre-settlement allocation context, and would ensure an efficient resolution of the lawsuit. Such an amendment does, however, present a major drawback: Since the *Ahlborn* formula requires some determination of the original value of the claim, if the parties cannot agree upon this value, then they will be forced to turn to the court, which would then be forced to use its scarce resources and hold a mini trial to determine that value.¹⁴¹

As this discussion illustrates, each of the above-proposed methods has both positive and negative characteristics. As such, some courts have instituted middle-ground allocation methods in an attempt to capitalize on the positive characteristics and reduce the negative ones. Such courts have required that parties first attempt to allocate for medical expenses on their own, and then, if the parties cannot agree upon an appropriate allocation, these courts would either apply the *Ahlborn* formula¹⁴² or hold an allocation hearing¹⁴³ to determine the appropriate allocation.

C. Section 5101.58 Should be Amended to Require All Interested Parties to Attempt to Allocate, and if this Proves Impossible, Allocation Should be Court-Determined

Keeping in mind that any allocation determination must consider both the interests of both Ohio Medicaid recipients and ODJFS, the best allocation method

¹³⁹ See *supra* Part III.B.4.

¹⁴⁰ For example, in Bates' case, \$100,000 (his settlement value) would be divided by \$500,000 (the alleged total value of his original claim), resulting in a fraction of one-fifth, which would then be multiplied by \$67,245.37 (the amount ODJFS paid on his behalf). The resulting value, \$13,449.07, would then be the appropriate allocation value. See also *State Dept. of Health & Welfare v. Hudelson*, 196 P.3d 905, 912 (Idaho 2008), *abrogated by* *Verska v. St. Alphonsus Reg'l Med. Ctr.*, 265 P.3d 502 (Idaho 2011).

¹⁴¹ See *McKinney ex rel. Gage v. Phila. Hous. Auth.*, No. 07 Civ. 4432, 2010 WL 3364400, at *7 (E.D. Pa. 2010).

¹⁴² See *Hudelson*, 196 P.3d at 912.

¹⁴³ See *In re E.B.*, 729 S.E.2d 270, 297 (W. Va. 2012) (“[A]ll reasonable efforts should be made to obtain the agreement of [the state Medicaid agency] regarding the allocation of the Medicaid recipient’s past medical expenses after a settlement has been obtained. However, if judicial allocation becomes necessary, the trial court is required to hold an evidentiary damages hearing.”); *Bolanos v. Super. Ct.*, 87 Cal. Rptr. 3d 174, 180 (Ct. App. 2008) (“If there is no settlement allocation, as in a settlement, the parties must attempt to allocate; if they cannot agree, they must turn to the court.”).

for the State of Ohio is the middle-ground approach advocated in *In re E.B.* and *Bolanos*.¹⁴⁴ Thus, the legislature should amend § 5101.58 to require that parties first attempt to agree upon an appropriate allocation of the settlement, and if agreement is impossible to achieve, the court should then hold an allocation hearing in which all interested parties can produce evidence to establish the value that they believe appropriately represents medical damages.

In such allocation hearings, courts should use the *Ahlborn* formula as a starting point, but should also consider all of the evidence proffered by the interested parties before making a final allocation decision. For example, courts should hear the evidence proffered by the parties to confirm the true value of recipients' original claims before they apply that value to the *Ahlborn* formula. Such a confirmation would ensure that recipients are not exaggerating the true value of their claims, thereby ensuring an equitable allocation for ODJFS. Courts should also consider recipients' injuries¹⁴⁵ and how they compare to verdicts in similar cases.¹⁴⁶ Finally, courts should consider the likelihood that recipients would prevail on their claims, as well as how much they would reasonably expect to recover if they were to prevail to ensure that the final allocation of medical damages is objectively reasonable for both recipients and ODJFS.¹⁴⁷

To further ensure a fair allocation, and to mitigate any potential negative consequences associated with mandatory allocation, § 5101.58 must be amended to require the mandatory joinder of ODJFS to Medicaid recipients' actions. Such a mandatory joinder will ensure that recipients and liable third parties will not allocate away ODJFS' interest in the settlement, and if the parties cannot agree on an allocation on their own, will ensure that ODJFS' interests are properly represented in any judicial allocation hearing.

In sum, amending § 5101.58 to require allocation of unallocated settlements ensures that ODJFS' recovery will be limited to the portion of Ohio Medicaid recipients' settlements that was intended to represent medical expenses, thereby allowing the recipients to keep a greater portion of their settlements than they would

¹⁴⁴ See *In re E.B.*, 729 S.E.2d at 297; see *Bolanos*, 87 Cal. Rptr. 3d at 180.

¹⁴⁵ Based on the recipient's injuries, the court might even determine that the *Ahlborn* formula would not be appropriate to use at all. See *Bolanos*, 87 Cal. Rptr. 3d at 181 ("[T]here are cases when the assumption of the *Ahlborn* formula may not apply, i.e., the settlement may not be driven primarily by past medical expenses. Such cases are those involving catastrophic injuries to children, where the cost of future medical care, perhaps extending over a lifetime, is the largest factor in the settlement.").

¹⁴⁶ See *Lugo v. Beth Israel Med. Ctr.*, 819 N.Y.S.2d 892, 897-98 (App. Div. 2006) ("A court determination is necessary to confirm the full value of the case and the value of the various items of damages, including the plaintiff's injuries and how they compare to verdicts awarded in other cases.").

¹⁴⁷ See *Wos v. E.M.A.*, 133 S. Ct. 1400 (2013) ("What portion of [the] lump sum settlement constitutes 'fair and just compensation' for each individual claim will depend both on how likely [the Medicaid recipient] would have been to prevail on the claims at trial and how much they reasonably could have expected to receive on each claim if successful, in view of damages awarded in comparable tort cases."); *McKinney ex rel. Gage v. Phila. Hous. Auth.*, No. 07 Civ. 4432, 2010 WL 3364400, at *12 (E.D. Pa. 2010) ("[T]he court has considered the risks and uncertainties Plaintiffs faced in prevailing on their underlying claim and their probability of recovering past medical expenses in particular.").

under the current § 5101.58(G)(2). Amending § 5101.58 to require the mandatory joinder of ODJFS to Medicaid recipients' actions against liable third parties will also ensure that ODJFS' interests in the allocation process are protected. Amending § 5101.58 to require that ODJFS, the recipient, and the third party attempt to come to an agreement on an appropriate allocation will furthermore ensure a swift resolution of the lawsuit, as well as ensure that scarce judicial resources are not unnecessarily consumed.¹⁴⁸ Finally, by amending § 5101.58 to allow for a judicial allocation hearing if parties fail to agree on an appropriate allocation, the parties will avoid having to proceed to a full trial and will be assured of an objective and fair allocation. Such amendments would therefore ensure that the interests of all the parties, as well as the interest of the judicial system, are considered and safeguarded.

V. CONCLUSION

In *Ahlborn*, the unanimous Supreme Court was exceedingly clear in that the language of the federal Medicaid third party liability provisions stipulates that state Medicaid agencies may only be assigned the right to the portion of a Medicaid recipient's settlement that represents damages for medical expenses. While the Ohio Tenth District Court of Appeals held that § 5101.58(G)(2) satisfies this standard, the court's reasoning is flawed in multiple respects.

First of all, § 5101.58(G)(2) fails to ensure, as *Ahlborn* requires, that ODJFS' recovery is properly limited to the portion of Medicaid recipients' settlements that actually represents medical damages. Secondly, § 5101.58(G)(2) creates the likely possibility that any ODJFS recovery will in fact violate the federal anti-lien provisions, which would therefore violate the Supremacy Clause of the United States Constitution. Finally, the Supreme Court's reasoning in *Ahlborn* simply does not support the Tenth District's justification for upholding § 5101.58(G)(2). The Ohio Supreme Court must therefore invalidate § 5101.58(G)(2) upon appeal of *Bates* or, if no appeal is made or granted, the Ohio General Assembly must repeal it.

Furthermore, to ensure compliance with *Ahlborn* and the federal anti-lien provisions, § 5101.58 must be amended to require the allocation of unallocated settlements before ODJFS may recover for medical expenses paid on behalf of Medicaid recipients. Such an amendment is supported by the fact that the majority of courts, and in particular the United States Supreme Court in *Wos*, that have heard cases pertaining to statutory caps post-*Ahlborn* have invalidated the caps and have required settlement allocation, or at the very least required that Medicaid recipients be given the opportunity to rebut statutory cap presumptions. Amending § 5101.58 to require allocation is further supported by the actions of the multiple state legislatures that amended their Medicaid third party liability statutes to require settlement allocation post-*Ahlborn*, as well as supported by principles of fairness to the Medicaid recipient and the strong public policy in favor of settlements.

As the interests of both Ohio Medicaid recipients and ODJFS must be protected in such mandatory allocations, § 5101.58 must be amended to require that ODJFS join any action in which a Medicaid lien is at issue. Then, to ensure a swift

¹⁴⁸ As the Trial Lawyers' Brief noted, once a procedure for an allocation hearing is established, it is rarely used and parties are typically able to agree to an allocation without the need for the time and expense of an allocation hearing. Therefore, requiring parties to negotiate an allocation at first will likely save vast amounts of judicial resources. Trial Lawyer's Brief, *supra*, note 125, at 21.

resolution of the lawsuit and to ensure that judicial resources are not unnecessarily wasted, § 5101.58 must also be amended to require that the parties attempt to agree upon an appropriate allocation themselves. To avoid having to resort to litigation if the parties fail to agree upon a proper allocation, however, § 5101.58 must allow the court to hold an allocation hearing where the *Ahlborn* formula and all of the evidence proffered by the parties would be considered to determine an allocation that would be fair to both Ohio Medicaid recipients and ODJFS.

Such amendments to § 5101.58 will ensure ODJFS' compliance with the federal anti-lien provisions as interpreted by the Supreme Court in *Ahlborn*, as well as ensure that liable third parties will appropriately compensate both Ohio Medicaid recipients and ODJFS. Accordingly, to prevent violations of the federal anti-lien provisions, and to protect the interests of Ohio Medicaid recipients and ODJFS, the Ohio General Assembly must implement these amendments as soon as possible.

