SOCIAL SERVICES LAW BULLETIN

Number 41 July 2006

MEDICAID "LIENS" ON PERSONAL INJURY JUDGMENTS AND SETTLEMENTS: THE *AHLBORN* AND *EZELL* DECISIONS

■ John L. Saxon*

This *Social Services Law Bulletin* discusses the federal and state laws that govern Medicaid "liens" on personal injury judgments and settlements payable to Medicaid recipients, the North Carolina Supreme Court's June 30, 2006 decision in *Ezell v Grace Hospital*, and the U.S. Supreme Court's May 1, 2006, decision in *Arkansas Department of Health and Human Services v. Ahlborn*.

A Brief Overview of the Medicaid Program

Medicaid is a federal-state public assistance program that pays hospitals, nursing homes, doctors, and other health care providers for medical care they provide to children, pregnant women, and elderly or disabled persons who cannot afford to pay for their own health care.[1]

Although states are not required to participate in the Medicaid program, all of them do.[2] North Carolina's Medicaid program was established in 1969 and began operating on January 1, 1970.[3] The North Carolina Medicaid program is administered by the North Carolina Department of Health and Human Services' Division of Medical Assistance and by county departments of social services.[4]

* Mr. Saxon is an Institute of Government faculty member. His areas of responsibility include social services law and policy. He may be reached at 919-966-4289 or saxon@sog.unc.edu.

[1] The federal Medicaid program was created by Congress in 1965 as Title XIX of the federal Social Security Act. *See* U.S. House of Representatives, Committee on Ways and Means, *2004 Green Book: Medicaid* (http://waysandmeans.house.gov/media/pdf/greenbook2003/MEDICAID.pdf).

[2] As a condition of receiving federal funding for Medicaid, states are required to comply with federal statutory requirements governing administration of the Medicaid program. *See* 42 U.S.C. §1396a.

[3] *See* North Carolina Division of Medical Assistance, "History of [the] North Carolina Medicaid Program" (www.dhhs.state.nc.us/dma/historyofmedicaid.pdf).

[4] *See* North Carolina General Statutes [hereafter G.S.], Chapter 108A, Article 2, Part 6 (G.S. 108A-54 *et seq.*).

UNC SCHOOL OF GOVERNMENT

The University *of* North Carolina *at* Chapel Hill
Institute of Government
Master of Public Administration Program

In state fiscal year 2003-04, North Carolina's Medicaid program paid approximately $7.4 billion for medical care for 1.5 million Medicaid beneficiaries.[5] The federal government paid approximately 66 percent of this cost; North Carolina counties and state General Fund revenues respectively paid about 5 percent and 29 percent of the cost of Medicaid services.[6]

Recovering Medicaid Costs from Beneficiaries

Federal law generally prohibits state Medicaid programs from recovering the cost of Medicaid services from eligible Medicaid beneficiaries.[7]

Federal law specifically prohibits state Medicaid programs from imposing a lien for Medicaid payments made on behalf of a Medicaid beneficiary against the beneficiary's property during the beneficiary's life, unless (1) a court has entered a judgment determining that the benefits were incorrectly paid, or (2) the lien is imposed against the real property of a beneficiary who (a) is a patient in a nursing facility or other medical institution, (b) is required to pay all but a minimal amount of her income for the cost of her care, and (c) is not reasonably expected to be discharged and return home.[8]

Federal law, though, generally requires state Medicaid programs to recover the cost of Medicaid services from the estate of a deceased Medicaid beneficiary if the beneficiary was institutionalized or was at least 55 years old when the services were provided.[9] Federal law also requires that the cost of Medicaid services provided to a beneficiary be reimbursed after the beneficiary's death from the remaining assets of a "special needs trust" established for the beneficiary.[10]

Recovering Medicaid Costs from Third Parties

Medicaid is generally the "payer of last resort."[11] This means that, with certain exceptions, Medicaid's responsibility for paying the cost of covered medical services for an eligible Medicaid beneficiary is secondary to that of any "third party" (for example, Medicare, private health or liability insurance policies, or a tortfeasor who injures a Medicaid beneficiary) who is or may be liable for paying the cost of medical care that is covered under a state Medicaid program.[12]

Federal law includes several provisions that are intended to protect Medicaid's status as "payer of last resort." These provisions, which are summarized in the following section of this bulletin, are referred to as Medicaid's third party liability rules and focus on both "cost avoidance" (ensuring that liable third parties pay the cost of medical care *before* Medicaid pays for the care) and payment recovery or "pay and chase" (obtaining reimbursement from liable third parties *after* Medicaid has paid for medical care).[13]

---

[5] North Carolina Division of Medical Assistance, "Medicaid in North Carolina: Annual Report 2004" (www.dhhs.state.nc.us/dma/2004report/MedicaidTables_Web.pdf).

[6] *Id*.

[7] *See* 42 U.S.C. §§1396a(a)(18), 1396p(b)(1). Federal law allows state Medicaid programs to impose cost-sharing requirements (nominal co-payments, deductibles, etc.) on some Medicaid beneficiaries. *See* 42 U.S.C. §§1396a(a)(14), 1396o. Medical providers who participate in the Medicaid program, however, are required to accept Medicaid payments as full payment for covered services and are prohibited from collecting additional moneys (beyond allowable cost-sharing) from eligible Medicaid beneficiaries. *See* 42 U.S.C. §1396a(a)(25)(C).

[8] 42 U.S.C. §1396p(a)(1). A state Medicaid program may not impose a lien against a Medicaid beneficiary's home to recover the cost of correctly-paid Medicaid benefits if the home is occupied (a) by the beneficiary's spouse, (b) by a child of the beneficiary who is under the age of twenty-one years, (c) by the beneficiary's blind or disabled child, or (d) by a sibling of the beneficiary who has an equity interest in the home and has lived in the home for at least one year immediately before the date of the beneficiary's admission to the nursing home or other medical institution. 42 U.S.C. §1396p(a)(2). A Medicaid lien (other than a lien for incorrectly-paid Medicaid benefits) dissolves if the beneficiary is discharged from the nursing home or other medical institution and returns home. 42 U.S.C. §1396p(a)(3). North Carolina's legislation implementing the federal Medicaid lien provisions is codified in G.S. 108A-70.5. *See* S.L. 2005-276, §10.21C(a).

[9] 42 U.S.C. §1396p(b). North Carolina's Medicaid estate recovery rules are codified in G.S. 108A-70.5 through 108A-70.9. *See* S.L. 2005-276, §10.21C(a), (b).

[10] 42 U.S.C. §1396p(d)(4). *See also* 42 U.S.C. §§1396c(1)(F) and 1396p(e)(2) (requiring reimbursement for Medicaid services from the remaining assets of certain annuities). Pub. Law 109-171, §6012, 120 Stat. 63 (Feb. 8, 2006).

[11] *See* S. Rep. No. 99-146 (1985), 1986 U.S. Code, Congr. & Admin. News 279-280.

[12] *See* 42 C.F.R. §433.136.

[13] State Medicaid programs realize significant savings through "cost avoidance," particularly in connection with

So, if a Medicaid beneficiary, Bob Black, is injured in an automobile accident due to the fault of another driver (Wayne White) and Medicaid pays for medical care related to Mr. Black's injuries, the state Medicaid program might attempt to recover all or part of the Medicaid payments made on Mr. Black's behalf by asserting a Medicaid "lien"[14] against (a) insurance benefits payable to Mr. Black under Mr. Black's auto insurance policy, (b) insurance benefits payable to Mr. Black under Mr. White's auto insurance policy, (c) the settlement of Mr. Black's personal injury claim against Mr. White, or (d) the payment of a judgment in a lawsuit against Mr. White.[15]

beneficiaries who are eligible for Medicare as well as Medicaid. The exact amounts saved or recovered through Medicaid's third party liability rules, however, are hard to determine. The U.S. Solicitor General's *amicus* brief in *Arkansas Department of Health and Human Services v. Ahlborn* claimed that state Medicaid programs recovered approximately $1.6 billion in Medicaid payments through third party liability claims in 2004 (or about one-half of one percent of total Medicaid expenditures). Other data posted on the federal Medicaid web site, however, seem to indicate that Medicaid third party collections in 2004 (not including recoveries from the estates of deceased Medicaid beneficiaries) totaled approximately $1.1 billion, including $392.4 million in recoveries from "casualty" claims such as personal injury settlements payable to Medicaid beneficiaries. Centers for Medicare and Medicaid Services (http://www.cms.hhs.gov/ThirdPartyLiability/).

[14] Although a Medicaid claim against the proceeds of a settlement or judgment for a personal injury claim is sometimes referred to as a Medicaid "lien," it is more properly characterized as a claim based on assignment or subrogation. *See* note 19.

[15] North Carolina's "collateral source" rule allows an injured party to recover, in a tort action against a third party who is liable for the party's injuries, medical expenses she has incurred as a result of the third party's negligence even if the cost of the injured party's medical care has been paid by an insurance company, a third party other than the liable tortfeasor, or a government health care program such as Medicaid. *See* Cates v. Wilson, 321 N.C. 1, 6, 361 S.E.2d 734, 738 (1987). The insurance company, nonliable third party, or government, however, *may* have a right of subrogation that would enable it to recover from the injured party's judgment or settlement the amount it has paid for the injured party's care resulting from the tortfeasor's negligence.

Medicaid's Third Party Liability Rules

Federal Law

Medicaid's third party liability (or TPL) rules are set forth in several provisions of the federal Medicaid statute.

One of these provisions requires state Medicaid programs to "ascertain the legal liability of third parties … to pay for [medical] care and services" provided under their Medicaid plans and to "seek reimbursement" from third parties with respect to such care and services if their "legal liability is found to exist after medical assistance has been made available on behalf of [an eligible Medicaid beneficiary] and … the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery …."[16]

To facilitate recovery from liable third parties, the federal Medicaid statute requires a participating state to have "in effect laws under which, to the extent that payment has been made under the [state Medicaid plan] for … health care … furnished to [an eligible Medicaid beneficiary], the State is considered to have acquired the right of [the Medicaid beneficiary] to payment by [a liable third party] for such health care …."[17]

In addition, federal law requires a state's Medicaid program to require a Medicaid beneficiary, as a condition of Medicaid eligibility, "to assign [to] the State [the beneficiary's] rights … to payment for medical care from any third party" and "to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services" provided under the state Medicaid plan.[18]

The federal Medicaid statute, however, does not, as one might expect, provide for the imposition of a Medicaid "lien" on moneys payable by third parties to a Medicaid beneficiary for medical care or services provided under a state Medicaid program.[19] In fact, it

[16] 42 U.S.C. §1396a(a)(25)(A), (B).

[17] 42 U.S.C. §1396a(a)(25)(H).

[18] 42 U.S.C. §1396k(a).

[19] It is not legally correct to characterize Medicaid's claim against the personal injury settlement of a Medicaid recipient as a "lien" when all or part of the settlement has been "assigned" to the state Medicaid program pursuant to 42 U.S.C. §§1396a(a)(25) and 1396k. The *assignment* of property involves a transfer of a legal or equitable interest in the property from one person (usually the property owner) to another. If a Medicaid beneficiary assigns her right to payment for medical expenses that have been paid by Medicaid to the state Medicaid program, that right *belongs* to

expressly prohibits participating states from imposing a lien against the personal property of an eligible Medicaid beneficiary with respect to Medicaid payments that were correctly made on behalf of the beneficiary.[20]

North Carolina Statutes

Three North Carolina statutes address third party liability in connection with the State's Medicaid program.

G.S. 108A-57

G.S. 108A-57 was enacted in 1974.[21]

This statute provides that the State is "subrogated," to the extent of all Medicaid payments made on behalf of a Medicaid beneficiary, to "all rights of recovery, contractual or otherwise, of the beneficiary … against any person."[22]

"Subrogation" may be defined broadly as the substitution of one party (the subrogee) in place of another (the subrogor) with respect to the second party's (subrogor's) legal right or claim against a third party (the obligor).[23]

North Carolina law recognizes three separate and distinct legal bases for a right of subrogation: contract, common law, and statute.

"Conventional" subrogation generally is based on an express or implied agreement or contract between the subrogor and the subrogee under which the subrogee, by paying a claim owed to the subrogor by a third party, will stand in the shoes of the subrogor with respect to the subrogor's claim against the third party.[24]

"Equitable" subrogation is based on the common law. It is "a device adopted by equity to compel the ultimate discharge of an obligation by [the person] who in good conscience ought to pay it" and "arises when one person [that is, the subrogee] has been compelled to pay a debt which ought to have been paid by [a third party] or for which the [third party] was primarily liable."[25] North Carolina's courts have

---

the Medicaid program. By contrast, a *lien* generally is imposed by one person (usually a creditor) on the property of another person (usually, the debtor who owes a debt to the creditor). It would make no sense for the state Medicaid program to impose a *lien* against a property right that has already been *assigned* to the Medicaid program. *See* Arkansas Department of Health and Human Services v. Ahlborn, 126 S.Ct. 1752, 1764 (May 1, 2006).

[20] 42 U.S.C. §1396p(a).

[21] N.C. Sess. Laws 1973, ch. 1031 (originally codified as G.S. 108-61.2).

[22] Although several North Carolina cases describe the State's right of subrogation under G.S. 108A-57 as a "lien," neither G.S. 108A-57, G.S. 108A-59, nor G.S. 108A-70(b) provide that the state Medicaid agency has a "lien" on any or all of a personal injury judgment or settlement payable to a Medicaid beneficiary and it is not legally correct to refer to Medicaid's right of subrogation or assignment as a "lien." *See* note 19. *Cf.* Ezell v. Grace Hospital, Inc., ___ N.C. App. ___, 623 S.E.2d 79 (2005); Campbell v. N.C. Dept. of Human Resources, 153 N.C. App. 305, 308, 569 S.E.2d 670, 672 (2002); Payne v. N.C. Dept. of Human Resources, 126 N.C. App. 672, 677, 486 S.E.2d 469, 471 (1997); N.C. Dept. of Human Resources v. Weaver, 121 N.C. App. 517, 520, 466 S.E.2d 717, 719 (1996).

[23] The subrogee, therefore, "stands in the shoes" of the subrogor with respect to the subrogor's claim against the third party. Because subrogation puts the subrogee in the position of the legal owner of the subrogor's right or claim against the third party it is similar, but not identical, to an assignment of the subrogor's right or claim by operation of law.

[24] *See* In re Declaratory Ruling by the North Carolina Insurance Commissioner Regarding 11 N.C.A.C. 12.0319, 134 N.C. App. 22, 31, 517 S.E.2d 134, 141 (1999), citing Journal Publishing Co. v. Barber, 165 N.C. 478, 488, 81 S.E. 694, 698-99 (1914) and Grantham v. Nunn, 187 N.C. 394, 121 S.E. 662 (1924). North Carolina law prohibits *conventional* subrogation provisions in health insurance policies. 11 N.C.A.C. 12.0319. This prohibition, however, does not apply with respect to health benefit plans that are governed by the federal Employee Retirement Income Security Act (ERISA), to other self-funded employer health benefit plans, or to the state employees' health plan. *See* Hampton Industries, Inc. v. Sparrow, 981 F.2d 726 (1992) (holding that ERISA preempted state law with respect to enforceability of subrogation clause included in employer's self-funded health benefits plan governed by ERISA); G.S. 135-40.13A (establishing a statutory right of subrogation with respect to payments made under the state employees' health plan). State law does not prohibit contractual subrogation provisions in automobile insurance policies that cover medical payments. *See* Carver v. Mills, 22 N.C. App. 745, 748, 207 S.E.2d 394, 396 (1974); Moore v. Beacon Ins. Co., 54 N.C. App. 669, 670, 284 S.E.2d 136, 138 (1981).

[25] Beam v. Wright, 224 N.C. 677, 683, 32 S.E.2d 213, 218 (1944).

recognized that an insurer who pays an insured's loss for property damage caused by the tortious conduct of a third party is equitably subrogated to the insured's rights against the third party.[26] It is less clear, however, whether or to what extent North Carolina law recognizes a right of equitable subrogation with respect to personal injury claims.[27]

The state Medicaid agency's right of subrogation under G.S. 108A-57, however, is a statutory, as opposed to a conventional (contractual) or equitable (common law), right of subrogation. As such, the nature and scope of Medicaid's right of subrogation and the procedures by which this right may be enforced depend primarily on the terms of the statute that creates this right, not on general legal principles governing conventional or equitable subrogation.

With respect to the nature and scope of Medicaid's right of subrogation, G.S. 108A-57 states, first, that the amount of Medicaid's claim is based on the amount that Medicaid has paid for the beneficiary's medical care, and, second, that Medicaid's claim may be asserted against "all rights of recovery, contractual or otherwise," that the Medicaid beneficiary may have "against any person."[28]

Read literally and in isolation, therefore, G.S. 108A-57 appears to create a broad right of subrogation that may be asserted

1. with respect to *all Medicaid payments* made on behalf of a Medicaid beneficiary (regardless of whether a third party would have been liable to the beneficiary for payment of the medical care that was covered by Medicaid), and
2. against *any right of recovery* the Medicaid beneficiary might have against a third party (regardless of whether the third party's liability involves payment of the medical care that was covered by Medicaid).

G.S. 108A-57, however, limits Medicaid's claim in cases in which a Medicaid beneficiary's attorney receives funds from a liable third party in connection with the beneficiary's injury or death. In this instance, G.S. 108A-57(a) provides that payment of Medicaid's subrogation claim may not exceed *one-third* of the gross amount obtained or recovered on behalf of a Medicaid beneficiary through a judgment against, settlement with, or payment by a third party by reason of personal injury to or death of the beneficiary.[29]

Although G.S. 108A-57 clearly establishes a statutory right of subrogation that allows the state Medicaid agency to assert claims against liable third parties, it provides only minimal guidance with respect to the procedures through which Medicaid third party liability claims may be enforced.

G.S. 108A-57(a), for example, states that the county attorney or an attorney retained by the county or State are responsible for "enforcing" Medicaid's right of subrogation. The statute, however, does not indicate the legal procedures that attorneys employed by the county or State may use to enforce Medicaid's claim against a third party.

Medicaid's right of subrogation under G.S. 108A-57 apparently is not such as to deprive a Medicaid beneficiary of her right to file a lawsuit against a

---

[26] *See* Smith v. Pate, 246 N.C. 63, 67, 97 S.E.2d 456, 460 (1957).

[27] The North Carolina Court of Appeals, for example, has held that an employer who paid an injured employee's medical expenses through a self-funded health benefit plan did not have a right of equitable subrogation against the third party whose negligence caused the employee's injuries. *See* Harris-Teeter v. Watts, 97 N.C. App. 101, 387 S.E.2d 203 (1990). North Carolina's court of appeals subsequently declined to address the issue of whether a health insurer that has paid the medical expenses of an insured person may assert a right of equitable subrogation against a third party whose tortious conduct injured the insured. *See* In re Declaratory Ruling by the North Carolina Insurance Commissioner Regarding 11 N.C.A.C. 12.0319, 134 N.C. App. at 32, 517 S.E.2d at 142.

[28] G.S. 108A-57(a) requires the State to pay to the federal government a portion of the amount recovered that is the equivalent to the federal government's proportionate share of the cost of the Medicaid payments made on behalf of the beneficiary.

[29] G.S. 108A-57 also provides, that in this instance, Medicaid's subrogation claim must be "prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered." The state Medicaid agency interprets this provision as limiting Medicaid's claim to (a) a proportionate share of one-third of the gross amount of the settlement or judgment or (b) the amount of its claim, whichever is less. It is less clear whether G.S. 108A-57 affects or limits the claims of health care providers under G.S. 44-49 and 44-50. G.S. 44-50 caps the claims of health care providers at 50 percent of the amount (exclusive of attorneys fees) recovered in connection with a personal injury claim. And neither of these statutes requires a pro rata distribution of funds among health care providers if the portion of a personal injury settlement or judgment to which medical liens attach is insufficient to pay all the liens of health care providers in full. N.C. Baptist Hospitals, Inc. v. Crowson, 155 N.C. App. 746, 573 S.E.2d 922 (2003), *aff'd*. 357 N.C. 499, 586 S.E.2d 90 (2003).

potentially-liable third party. In fact, the statute expressly recognizes that a Medicaid beneficiary may retain an attorney to represent the beneficiary in connection with her claim against a potentially-liable third party.

Surprisingly, though, G.S. 108A-57 does not expressly require a Medicaid beneficiary to notify the state Medicaid program when she files a lawsuit against a potentially-liable third party to recover damages for medical care that has been provided under the Medicaid program. The statute, though, does prohibit a Medicaid beneficiary from willfully failing to disclose to the county department of social services the identity of a potentially-liable third party.[30]

Several cases seem to suggest that the state Medicaid agency may enforce its right to subrogation by intervening in a pending personal injury lawsuit brought by a Medicaid beneficiary against a liable third party.[31] It is less clear, though, whether G.S. 108A-57 authorizes the state Medicaid agency or a county that administers the Medicaid program to file a lawsuit against a potentially-liable third party based on the State's or county's right of subrogation. North Carolina recognizes the common law rule against "claim-splitting," which requires that "all damages incurred as the result of a [single wrong] must be recovered in one lawsuit."[32] In the context of a cause of action for personal injuries, this means that a plaintiff's claim against a tortfeasor for payment of medical expenses resulting from the tort may not be "split off" from the plaintiff's claim for other damages resulting from the tort (for example, lost wages, pain and suffering, or physical impairment).[33] So to the extent that the State's right of subrogation under G.S. 108A-57 involves less than the full amount of a Medicaid beneficiary's claim against a third party, allowing the state Medicaid agency to sue the third party without joining the beneficiary as a party plaintiff appears to be in derogation of the common law.[34]

In at least two reported appellate cases, though, the state Medicaid agency or a county filed a lawsuit against a Medicaid beneficiary or a liable third party seeking to enforce Medicaid's right of subrogation *after* the beneficiary settled her claim against the third party.[35] And there is a least one reported case in which a Medicaid beneficiary filed a declaratory judgment action against the state Medicaid agency seeking a determination with respect to the validity or scope of Medicaid's claim against proceeds that were payable to or received by the beneficiary.[36] Read together, these three cases suggest that Medicaid's claim under G.S. 108A-57 need not be enforced in the context of a pending lawsuit between the Medicaid beneficiary and a third party, but rather may be enforced through a civil action by the state Medicaid agency against (a) a Medicaid beneficiary who has received a personal injury settlement from a liable third party, (b) a third party who has made a payment to a Medicaid beneficiary with notice of Medicaid's claim, or (c) an attorney who holds funds payable to a Medicaid beneficiary or who makes a payment to a Medicaid beneficiary if the attorney has notice of Medicaid's claim.[37]

---

[30] G.S. 108A-57(b).

[31] *See* Payne v. N.C. Dept. of Human Resources, 126 N.C. App. 672, 486 S.E.2d 469 (1997); Ezell v. Grace Hospital, Inc., ___ N.C. App. ___, 623 S.E.2d 79 (2005). In both of these cases, the trial court allowed the state's Division of Medical Assistance to intervene in a pending personal injury action brought by a Medicaid beneficiary against a third party tortfeasor, and the Medicaid agency's right to intervene was not contested on appeal. *Cf.* Malloy v. Daniel, 58 N.C. App. 61, 293 S.E.2d 285 (1982) (holding that the county, but not the county department of social services, would have standing to intervene).

[32] *See* Bockweg v. Anderson, 333 N.C. 486, 492, 428 S.E.2d 157 161 (1993); Smith v. Pate, 246 N.C. at 67, 97 S.E.2d at 460.

[33] *See* Harris-Teeter v. Watts, 97 N.C. App. 101, 387 S.E.2d 203 (1990) (reasoning that an employer's lawsuit against a third party tortfeasor to recover damages for medical expenses arising from the third party's injury of an employee under the employer's asserted right of subrogation would result in an impermissible splitting of the employee's claim against the third party for damages resulting from the injury).

[34] *See* Smith v. Pate, 246 N.C. at 68, 97 S.E.2d at 460 (when an "insurance company has paid only part of the loss resulting from defendant's tort, the … injured party has the right to maintain an action for all of the damage resulting from the tortious act of the defendant … [and] the insurer is a proper but not a necessary party" in the action).

[35] *See* Malloy v. Daniel, 58 N.C. App. 61, 293 S.E.2d 285 (1982); N.C. Department of Human Resources v. Weaver, 121 N.C. App. 517, 466 S.E.2d 717 (1996).

[36] Payne v. N.C. Department of Human Resources, 126 N.C. App. 672, 486 S.E.2d 469 (1997).

[37] A liable third party or attorney who pays funds to a Medicaid beneficiary without notice of Medicaid's claim against the funds, however, is not personally liable to the county or State under G.S. 108A-57. *See* Johnston County v. McCormick, 65 N.C. App. 63, 308 S.E.2d 872 (1983).

G.S. 108A-59

G.S. 108A-59 provides that the acceptance of medical assistance by a Medicaid beneficiary constitutes an automatic "*assignment* to the State of the [beneficiary's] right to third party benefits, contractual or otherwise, to which [the beneficiary] may be entitled."

G.S. 108A-59 was enacted in 1977, apparently in response to the 1977 amendments to the federal Medicaid statute requiring states to require Medicaid beneficiaries, as a condition of Medicaid eligibility, to assign to the state Medicaid program any rights they have to payment of medical care by a third party.[38]

Under North Carolina law, an "assignment" is the transfer by one party (the "assignor") of that party's legal title to or interest in property to another party (the "assignee").[39] When a cause of action is assigned, the assignee generally acquires all of the assignor's rights and interest in the claim. The assignee, therefore, may bring a lawsuit on the claim against a third party in the assignee's own name as the "real party in interest" rather than suing "on behalf of" the assignor or joining the assignor as a party.[40] The assignor, correspondingly, is divested of her interest in the claim and may not bring a legal action on the claim against the debtor or third party. If, however, the assignee has made only a partial assignment of her rights or property, the assignor *and* assignee generally are necessary parties in an action against a liable third party based on the assigned claim.[41]

North Carolina law generally prohibits the assignment of causes of action involving personal injury.[42] North Carolina law, however, will enforce an injured party's assignment of her right to all or part of the *proceeds* from her claim for personal injury.[43]

An assignee "stands in the shoes" of the assignor in the sense that the assignee acquires only such rights, title, and interest in the assigned property or claim as the assignor possessed with respect to the property or claim and has no greater rights against third parties with respect to the property or claim than the assignor had.[44] And while a valid assignment is binding between the assignee and the assignor, it generally is not binding against a third party unless the third party has notice, actual or constructive, of the assignment.[45]

Read literally and in isolation, the scope of rights acquired by the State under G.S. 108A-59 appears to be quite broad, though perhaps not quite as broad as the rights acquired by the State through subrogation under G.S. 108A-57.

As noted above, G.S. 108A-59 speaks of the assignment of a Medicaid beneficiary's "right to third party *benefits*, contractual or otherwise."[46] It therefore might be argued that, on its face, G.S. 108A-59 applies to *all* "benefits" to which a Medicaid beneficiary is, or may be, entitled, including a Medicaid beneficiary's right to receive lottery winnings, pension payments, inheritances, insurance proceeds, or other "benefits," as well as "benefits" payable as the result of a personal injury judgment or settlement.

To the extent that G.S. 108A-59 involves the assignment of a Medicaid beneficiary's right to compensation in connection with a personal injury claim against a third party, the assignment under G.S.

---

[38] G.S. 108A-59 was originally codified as G.S. 108-61.4. N.C. Sess. Laws, ch. 664. The 1977 federal Medicaid requirements are codified as 42 U.S.C. §1396k. *See* note 18 and accompanying text.

[39] *See* Morton v. Thornton, 259 N.C. 697, 699, 131 S.E.2d 378, 380 (1963); Aliamo Family Chiropractic v. Allstate Ins. Co., 155 N.C. App. 194, 197, 574 S.E.2d 496, 498 (2002). Although assignments usually arise voluntarily in the context of contracts between an assignor and assignee, they also may arise through operation of law.

[40] *See* NCNB National Bank of N.C. v. Western Surety Co., 88 N.C. App. 705, 708, 364 S.E.2d 675, 677 (1988).

[41] *See* Booker v. Everhart, 294 N.C. 146, 156, 240 S.E.2d 360, 366 (1978).

[42] *See* North Carolina Baptist Hospitals v. Mitchell, 88 N.C. App. 263, 266, 362 S.E.2d 841, 843 (1987), *rev'd on other grounds,* 323 N.C. 528, 374 S.E.2d 844 (1988); Horton v. New South Ins. Co., 122 N.C. App. 265, 268, 468 S.E.2d 856, 858 (1996).

[43] *See* Charlotte-Mecklenburg Hospital Authority v. First of Georgia Ins. Co., 340 N.C. 88, 90, 455 S.E.2d 655, 657 (1993); Aliamo Family Chiropractic v. Allstate Ins. Co., 155 N.C. App. at 197-98, 574 S.E.2d at 499.

[44] *See* Citizens Bank of Marshall v. Gahagan, 213 N.C. 511, 196 S.E. 827 (1938); William Iselin & Co. v. Saunders, 231 N.C. 642, 646, 58 S.E.2d 614, 616 (1950); Sprouse v. North River Ins. Co., 81 N.C. App. 311, 318, 344 S.E.2d 555, 561 (1986). *See also* G.S. 108A-59(c).

[45] *See* Lipe v. Guilford National Bank, 236 N.C. 328, 331, 72 S.E.2d 759, 761 (1952). *See also* Johnston County v. McCormick, 65 N.C. App. at 67, 308 S.E.2d at 874.

[46] As originally enacted, G.S. 108A-59 applied only to the assignment of "insurance benefits" for medical expenses payable to a Medicaid beneficiary under the terms of an insurance policy between the beneficiary and an insurance company. *See* Johnston County v. McCormick, 65 N.C. App. 63, 308 S.E.2d 872 (1983). The statute, however, was amended in 1980 to make it applicable to *all* "third party benefits" to which a Medicaid beneficiary is entitled. N.C. Sess. Laws 1979 (2nd Sess.), c. 1312, §§3–5.

108A-59 appears to be similar in nature and scope to an injured party's assignment of her right to all or part of the *proceeds* of a personal injury claim against a third party to an insurance company or health care provider who has provided or paid for her medical care. The provisions of G.S. 108A-59(c), however, could be read as implying that the assignment under G.S. 108A-59 is the assignment of all or part of a Medicaid beneficiary's personal injury *claim* against a third party, and not merely the beneficiary's rights with respect to the *proceeds* of the claim.[47]

So, like G.S. 108A-57, G.S. 108A-59 establishes a legal right on the part of the state Medicaid agency against third parties who are, or may be, liable to Medicaid beneficiaries. But, like G.S. 108A-57, G.S. 108A-59 is not entirely clear with respect to the procedures through which that right may be enforced against third parties.

G.S. 108A-59 states that the county attorney of the county from which Medicaid benefits were received, or an attorney retained by that county or the state Medicaid agency, is responsible for enforcing this statute. And G.S. 108A-59(b) requires the state Medicaid agency to establish a third party collection unit. But the statute does not expressly state *how* the State's rights, as assignee of a Medicaid beneficiary's right to third party benefits, are enforced.

As noted, G.S. 108A-59(c) provides that in any action brought pursuant to G.S. 108A-59(a), a third party's liability will be determined pursuant to the same laws and standards, including bases of legal liability and applicable defenses, that would apply if the action were brought by the Medicaid beneficiary. This suggests that the state Medicaid agency, as assignee, may bring a lawsuit in its own name against a liable third party without joining the Medicaid beneficiary as a party. If so, however, G.S. 108A-59(c) is less explicit than an almost identical provision in G.S. 130A-13(d) that specifically refers to actions "brought by the State" to recover the cost of medical care from third parties.

Nor is it clear how G.S. 108A-59 should be read or applied in conjunction with G.S. 108A-57. It is clear that both statutes involve the recovery of Medicaid payments from third parties who are liable to Medicaid beneficiaries. G.S. 108A-57, however, uses the term "subrogation" to define the state Medicaid agency's rights against third parties while G.S. 108A-59 defines the State's right as one arising by virtue of "assignment." Subrogation and assignment, though, are distinct legal concepts.[48] So, it is not entirely clear whether Medicaid's claim against a third party is a claim based on subrogation or a claim based on assignment, whether the State may assert a claim based on subrogation *and* assignment, whether the State must elect to pursue its claim based on subrogation *or* assignment, and whether the scope of the State's rights under G.S. 108A-59 is coextensive with, broader than, or narrower than the scope of its right of subrogation under G.S. 108A-57.[49] Nor is it clear whether the "pro rata" and "one-third cap" provisions of G.S. 108A-57 apply if the State's claim is based on an assignment under G.S. 108A-59 rather than subrogation under G.S. 108A-57.[50]

G.S. 108A-70(b)

G.S. 108A-70(b) provides that, to the extent that a third party is legally liable to pay the cost of medical services that have been provided under the state Medicaid program, the State is "considered to have acquired the [beneficiary's] rights … to payment" from the third party for those services.[51]

It seems clear that the scope of the State's rights under G.S. 108A-70(b) is narrower than the apparent scope of the State's rights under G.S. 108A-57 and

[47] G.S. 108A-59(c) provides that in any action brought pursuant to G.S. 108A-59(a), a third party's liability will be determined pursuant to the same laws and standards, including bases of legal liability and applicable defenses, that would apply if the action were brought by the Medicaid beneficiary. This subsection was added to the statute in 1995. N.C. Sess. Laws 1995, c. 508, §2.

[48] *See* Payne v. Buffalo Reinsurance Co., 69 N.C. App. 551, 553, 317 S.E.2d 408, 410-411 (1984).

[49] At least one reported appellate decision seems to indicate that the State's claim under G.S. 108A-59 is separate and distinct from the State's claim under G.S. 108A-57. *See* Johnston County v. McCormick, 65 N.C. App. 63, 308 S.E.2d 872 (1983). Other cases, however, fail to clearly indicate whether the state Medicaid agency's claim against a third party was based on G.S. 108A-57, on G.S. 108A-59, or on both. *See*, for example, Campbell v. N.C. Dept. of Human Resources, 153 N.C. App. 305, 569 S.E.2d 670 (2002).

[50] Unlike G.S. 108A-57, G.S. 108A-59 does not require that (a) the State's claim be "pro rated" with the claims of others who have medical liens or medical subrogation claims, or (b) the amount paid to the state Medicaid agency may not exceed one-third of the gross amount recovered on behalf of a Medicaid beneficiary.

[51] G.S. 108A-70(b) was enacted in 1994. N.C. Sess. Laws 1993 (Reg. Sess. 1994), c. 644, §3. The language of G.S. 108A-70(b) tracks the language of 42 U.S.C. §1396a(a)(25)(H) and was enacted in response to this federal requirement.

G.S. 108A-59. While G.S. 108A-57 and G.S. 108A-59 extend to "*all* rights of recovery" and any third party benefit to which a Medicaid beneficiary may be entitled, G.S. 108A-70(b) extends only to a Medicaid beneficiary's right to receive payment for *medical expenses* from a third party.

It is unclear, however, how G.S. 108A-70(b) should be applied in relation to G.S. 108A-57 and G.S. 108A-59, whether G.S. 108A-70(b) gives the State any additional legal rights beyond those provided under G.S. 108A-57 and G.S. 108A-59, and whether G.S. 108A-70(b) *limits* the scope of the State's rights under G.S. 108A-57 or G.S. 108A-59.

G.S. 44-49 and G.S. 44-50

North Carolina law gives hospitals, doctors, and other health care providers a statutory lien against the proceeds of a judgment, settlement, or other funds payable to an injured party in compensation for a personal injury claim to the extent that the injured party owes the health care provider money for medical care provided in connection with the injury.

G.S. 44-49 and G.S. 44-50, however, apply only with respect to unpaid debts owed to health care providers and do not create a lien in favor of the state Medicaid program with respect to reimbursement for Medicaid payments made on behalf of an injured Medicaid beneficiary.

The North Carolina Supreme Court's Decision in *Ezell v. Grace Hospital*

On June 30, 2006, the North Carolina Supreme Court issued a *per curiam* opinion reversing the North Carolina Court of Appeals' decision in *Ezell v. Grace Hospital*.[52]

Ezell involved a medical malpractice claim brought on behalf of a minor child.[53] The complaint alleged that the minor child was injured by the defendants' negligence in treating her respiratory distress immediately after her birth, that as a result of the defendants' medical malpractice the child suffered cerebral palsy, and that the minor child had suffered or would suffer damages, including damages for past and future medical expenses, pain and suffering, and diminished earning capacity, as a result of the defendants' negligence.[54]

After credible evidence by numerous experts revealed that no causal link existed between the defendants' alleged negligence and the minor child's cerebral palsy, the superior court approved a settlement agreement and consent judgment between the defendants and the minor plaintiff (acting through her guardian ad litem and attorneys) on January 2, 2004.

Prior to entry of this order, the North Carolina Division of Medical Assistance submitted to the superior court a claim against the settlement proceeds in the amount of $86,840.92 for Medicaid payments for the child's medical care.[55]

Under the terms of the approved settlement agreement, the child's guardian ad litem dismissed the lawsuit against the defendants and the defendants agreed to pay $100,000 in settlement of the plaintiff's claims.[56] The superior court, however, found that only $8,054.01 of Medicaid's claim was for medical care resulting from the defendants' alleged negligence. The court, therefore, ordered that only $8,054.01, rather than $33,333.33, of the settlement proceeds be paid to the state Medicaid agency.[57] The court did not specify

---

[52] *Ezell v. Grace Hospital*, ___ N.C. ___, ___ S.E.2d ___ (June 30, 2006), *reversing* ___ N.C. App. ___, 623 S.E.2d 79 (2005).

[53] The lawsuit was brought by the child's grandmother as the child's guardian ad litem. The child's mother was not named as a party plaintiff in the action. The parental rights of the child's father were terminated before the lawsuit was filed.

[54] It should be noted, however, that, under North Carolina law, a minor child generally does not have a claim for compensation for incurred medical expenses arising from personal injury, negligence, or medical malpractice by a third party. Vaughan v. Moore, 89 N.C. App. 566, 568, 316 S.E.2d 518, 520 (1988). Instead, any claim against a third party for medical expenses arising from personal injury to a minor child belongs to the child's parent(s) and must be brought by the child's parent(s) in the name(s) of the child's parent(s) unless the parent(s) has waived her right of recovery and assigned it to the child. Ellington v. Bradford, 242 N.C. 159, 160, 86 S.E.2d 925, 926 (1955).

[55] It is not entirely clear from the record whether this amount represented the amount that Medicaid paid for *all* of the child's medical care or only the amount that Medicaid paid for medical care resulting from the alleged negligence of the defendants (including treatment related to the child's cerebral palsy).

[56] The superior court previously had approved a similar settlement for $100,000 between the plaintiff and another defendant.

[57] The court approved distribution of the remaining portion of the settlement as follows: $35,000 to the plaintiff's attorneys for attorneys' fees; $21,319.40 to the plaintiff's

what portion of the settlement proceeds, if any, was for the child's past or future medical expenses, as opposed to compensation for pain and suffering, diminished earnings capacity, or other damages. The Division of Medical Assistance (DMA) appealed.[58]

The North Carolina Court of Appeals vacated the trial court's order and remanded the case for further findings because the superior court's finding that only $8,054.01 of the child's medical expenses was causally related to the defendants' alleged negligence was not supported by competent evidence.[59] In doing so, though, the majority opinion explicitly rejected DMA's argument that G.S. 108A-57 allows the state Medicaid program to assert a Medicaid TPL claim against the full amount of a Medicaid beneficiary's personal injury settlement regardless of whether the medical care provided by Medicaid is causally related to a third party's alleged negligence.[60] Writing for the majority, Judge Hudson stated:

> The legislature surely did not intend that DMA could recoup for medical treatment unrelated to the injury for which the beneficiary received third-party recovery. Without a requirement of a causal nexus between the DMA lien and a Medicaid beneficiary's third-party recovery, DMA could theoretically do so. For example, under the interpretation encouraged by [DMA], if a Medicaid beneficiary received treatment for cancer, and later received treatment for injuries sustained in a car accident for which she recovered damages from a third-party, DMA could impose a lien for the cancer treatment as well as for the injuries related to the accident. This would allow DMA unlimited subrogation rights to a beneficiary's proceeds obtained from a third-party, rather than to those proceeds obtained "by reason of injury or death," as specified in N.C. Gen. Stat. §108A-57(a).
>
> * * *
>
> We read the [controlling federal Medicaid] statute here as requiring reimbursement only to the extent of the third party's legal liability for injuries resulting in "care and service" paid by Medicaid.[61]

Judge Steelman dissented from this portion of the majority opinion. Citing *Cates v. Wilson* and *Campbell v. N.C. Dept. of Human Resources*, he reasoned that because G.S. 108A-57 "entitles the State to *full* reimbursement for *any* Medicaid payments made on a plaintiff's behalf in the event that the plaintiff recovers an award for damages" and "does not restrict [DMA's] right of subrogation to a beneficiary's right of recovery only for medical expenses," it is "irrelevant whether a settlement [on behalf of a Medicaid beneficiary compensates] the plaintiff for medical expenses."[62] And citing *Campbell* and *Payne v. N.C. Dept. of Human Resources*, Judge Steelman noted that North Carolina case law has "consistently rejected attempts by plaintiffs to characterize portions of settlements as being for medical bills or for pain and suffering in order to circumvent DMA's statutory lien."[63]

---

attorneys for expenses; and $35,626.59 to establish a "special needs trust" for the plaintiff.

[58] Following the court's January 2, 2004 order, DMA filed a motion to intervene and a motion for a new trial pursuant to G.S. 1A-1, Rule 59. On January 22, 2004, the superior court entered an order granting DMA's motion to intervene but denying its motion for a new trial. DMA appealed the trial court's denial of its motion for a new trial but did not appeal the trial court's January 2, 2004 order approving the settlement agreement and limiting Medicaid's claim to $8,054.01.

[59] Ezell v. Grace Hospital, ___ N.C. App. at ___, 623 S.E.2d at 83. It is not entirely clear whether the trial court's alleged error with respect to this finding was properly before the court of appeals. Although DMA assigned error with respect to this finding, it should be noted that this finding was included in the superior court's January 2, 2004 order and that DMA filed an appeal only with respect to the court's January 22, 2004 order and *not* with respect to the January 2, 2004 order. The only error that DMA assigned in connection with the January 22, 2004 order involved the superior court's "finding" (actually, a conclusion of law) that Medicaid's claim "should not be imposed upon [any portion of settlement funds that] represent recovery for claims independent and separate from [compensation for] medical expenses."

[60] Ezell v. Grace Hospital, ___ N.C. App. at ___, 623 S.E.2d at 82.

[61] Ezell v. Grace Hospital, ___ N.C. App. at ___, 623 S.E.2d at 82, 83.

[62] Ezell v. Grace Hospital, ___ N.C. App. at ___, 623 S.E.2d at 84 (dissent), citing Cates v. Wilson, 321 N.C. at 6, 361 S.E.2d at 738 and Campbell v. N.C. Dept. of Human Resources, 153 N.C. App. at 307, 569 S.E.2d at 672.

[63] Ezell v. Grace Hospital, ___ N.C. App. at ___, 623 S.E.2d at 85 (dissent), citing Campbell v. N.C. Dept. of Human Resources, 153 N.C. App. 305, 569 S.E.2d 670 (2002) and Payne v. N.C. Dept. of Human Resources, 126 N.C. App. 672, 486 S.E.2d 469 (1997). It should be noted, though, that, in *Ezell*, the decision regarding the amount of the settlement that was subject to Medicaid's claim was not accomplished unilaterally by the plaintiff but rather by the superior court after a hearing in which DMA participated.

Judge Steelman, however, did agree with the majority that "no DMA lien would attach to proceeds of a settlement from an automobile accident for Medicaid payments for unrelated cancer treatments."[64] He reasoned, though, that the basis of plaintiff's lawsuit was a single claim for medical negligence that allegedly caused plaintiff's cerebral palsy, that the settlement was a direct result of the lawsuit, and that the settlement compensated plaintiff for all of her claims, including those for medical expenses related to her cerebral palsy—even though the evidence in the case might not have supported a finding that the defendants' alleged negligence resulted in plaintiff's cerebral palsy.[65] Thus, in Judge Steelman's view, Medicaid's claim properly included medical expenses related to the plaintiff's cerebral palsy and could be asserted against the entire amount of plaintiff's settlement.

DMA appealed the court of appeals' decision in *Ezell* to the North Carolina Supreme Court and, as noted above, the supreme court issued a *per curiam* opinion on June 30, 2006, reversing the court of appeals' decision "for the reasons stated in [Judge Steelman's] dissenting opinion."[66] Judge Steelman's dissenting opinion, therefore, constitutes the holding of the North Carolina Supreme Court with respect to the scope of Medicaid's right of subrogation under G.S. 108A-57.

A close reading of Judge Steelman's dissent (and, thus, the supreme court's holding), though, suggests that *Ezell* involved two separate, but related, issues:

1. what medical expenses may be included in Medicaid's claim against the personal injury settlement of a Medicaid beneficiary; and
2. what portion of a Medicaid beneficiary's lump-sum settlement for personal injury is subject to Medicaid's claim.

And with respect to this second issue, the North Carolina Supreme Court's decision in *Ezell*, to the extent it holds that a Medicaid TPL claim may be asserted against portions of a Medicaid beneficiary's personal injury settlement that compensate the beneficiary for pain and suffering, lost earnings, or damages other than medical expenses, is clearly inconsistent with the United States Supreme Court's decision in *Arkansas Department of Health and Human Services v. Ahlborn*.[67]

The U.S. Supreme Court's Decision in *Arkansas DHHS v. Ahlborn*

On January 2, 1996, Heidi Ahlborn was injured in a car accident that was caused by the alleged negligence of a third party. Because she was unable to pay for the cost of her medical care, she applied for Medicaid. After she was found eligible for Medicaid, the Arkansas Medicaid program paid more than $215,000 to hospitals, doctors, and other health care providers for her medical care related to the accident.

On April 11, 1997, Ahlborn filed a lawsuit against the alleged tortfeasor (third party) to recover damages, including past and future medical expenses, pain and suffering, lost earnings, and permanent impairment of future earnings capacity, resulting from the 1996 car accident. In February, 1998, the Arkansas Department of Health and Human Services (ADHHS) intervened in the pending lawsuit to assert a lien in the amount of $215,645.30 against any proceeds that might be payable to Ahlborn. In 2002, Ahlborn settled the lawsuit for $550,000. Neither the court nor the parties allocated the settlement among Ahlborn's claims for past or future medical expenses, lost earnings, pain and suffering, etc. Ahlborn and ADHHS, however, subsequently stipulated that the settlement represented about one-sixth of the "full value" of Ahlborn's claims and that $35,581.47 of the settlement should be allocated for Ahlborn's past medical expenses.

ADHHS argued that its Medicaid lien was valid and should be paid in full ($215,645.30) from Ahlborn's $550,000 settlement. Ahlborn argued that the Medicaid lien attached only to that portion of the settlement allocated for past medical expenses related to the car accident ($35,581.47).

To resolve the dispute, Ahlborn filed a civil action against ADHHS in federal court claiming that ADHHS's Medicaid "lien" violated the federal Medicaid statute to the extent that it applied to the portion of a personal injury settlement that compensated a Medicaid beneficiary for damages other than past medical expenses. The federal court ruled

---

[64] Ezell v. Grace Hospital, ___ N.C. App. ___, 623 S.E.2d at 84.

[65] Ezell v. Grace Hospital, ___ N.C. App. at ___, 623 S.E.2d at 85.

[66] The supreme court remanded the case to the court of appeals with instructions to remand it to the superior court for further proceedings "not inconsistent with this opinion."

[67] The U.S. Supreme Court's decision in *Ahlborn* was published on May 1, 2006. *Ezell* was argued in the North Carolina Supreme Court on April 18, 2006. The appellant and appellee in *Ezell*, however, submitted a memorandum advising the North Carolina Supreme Court of the U.S. Supreme Court's decision in *Ahlborn* before the North Carolina Supreme Court issued its decision in *Ezell*.

that the Medicaid lien was valid and enforceable in full against Ahlborn's settlement because Ahlborn had assigned to ADHHS her right to *any* recovery from the third-party tortfeasor up to the full amount of Medicaid payments made on her behalf.

On appeal, the U.S. Court of Appeals for the Eighth Circuit reversed, holding that, under the federal Medicaid statute, Arkansas' Medicaid "lien" applied only to the portion of the settlement that represented payment for past medical expenses.[68] The United States Supreme Court granted certiorari and affirmed.[69]

The U.S. Supreme Court held that Arkansas' Medicaid third party liability statutes (Ark. Code Ann. §§20-77-301 through 20-77-309) violated the federal Medicaid statute, specifically the assignment provisions of 42 U.S.C. §1396k and the anti-lien provisions of 42 U.S.C. §1396a(a), to the extent that they applied to a Medicaid beneficiary's right to payment for damages for personal injury other than compensation for medical expenses.

Writing for a unanimous court, Justice Stevens first noted that 42 U.S.C. §1396k requires Medicaid beneficiaries to "assign the State any rights … *to payment for medical care* from any third party"—*not* rights to payment for lost wages or pain and suffering.[70] Second, Stevens observed that the language of 42 U.S.C. §1396a(a)(25)(B) requiring state Medicaid programs to seek reimbursement from third parties expressly refers to "the legal liability of third parties … to pay for [medical] care and services available under the [State's Medicaid] plan."[71] Third, Stevens determined that the rights acquired by state Medicaid programs pursuant to 42 U.S.C. §1396a(a)(25)(H) were only "the rights of [a Medicaid beneficiary] to payment by [a third party] *for … health care items or services*"—*not* rights to payment for lost wages, pain and suffering, an inheritance, or anything other medical expenses.[72]

Reading these statutory provisions together in context, Justice Stevens concluded that "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."[73]

Justice Stevens and the court then went on to conclude that federal law prohibits state Medicaid programs from asserting a Medicaid third party liability claim against a Medicaid beneficiary's settlement or judgment for personal injury damages other than medical expenses.

In support of this conclusion, Stevens cited 42 U.S.C. §1396p, which, with certain exceptions that are not relevant in the context of third party liability claims, prohibits state Medicaid programs from imposing liens against the property of Medicaid beneficiaries or seeking recovery of Medicaid payments from Medicaid beneficiaries. Reading the anti-lien prohibition literally and in isolation, Stevens noted, might lead one to the conclusion that a Medicaid lien on a Medicaid beneficiary's personal injury settlement is invalid even if the lien applies only to the portion of the settlement proceeds that represents payments for medical care. But given the express provisions of the federal Medicaid statute requiring the assignment of a Medicaid beneficiary's right to receive payments for medical care, Justice Stevens concluded that the Medicaid assignment provisions in 42 U.S.C. §§1396a and 1396k are a limited exception to the anti-lien prohibition in 42 U.S.C. §1396p.[74]

> [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 [and a state Medicaid program cannot force an assignment of, or place a lien on, any other portion of a Medicaid beneficiary's property].[75]

The Supreme Court, therefore, held that Arkansas' Medicaid third party liability lien attached only to that portion of Ahlborn's personal injury settlement that represented payment for medical expenses that had been paid by the Medicaid program ($35,581.47) and that the remainder of Arkansas' Medicaid claim could

---

[68] Ahlborn v. Arkansas Department of Health and Human Services, 397 F.3d 620 (8th Cir. 2005).

[69] Arkansas Department of Health and Human Services v. Ahlborn, 126 S.Ct. 1752 (May 1, 2006). Prior to *Ahlborn*, all but one of the state appellate courts that had considered the issue had ruled that a Medicaid third party liability claim could be asserted against the entire amount of a Medicaid beneficiary's personal injury settlement or judgment. *See*, for example, Houghton v. Dept. of Health, 57 P.3d 1067 (Utah 2002); Wilson v. Washington Dept. of Health and Human Services, 10 P.3d 1061 (Wash. 2000).

[70] Arkansas DHHS v. Ahlborn, 126 S.Ct. at 1761.

[71] Arkansas DHHS v. Ahlborn, 126 S.Ct. at 1761 citing 42 U.S.C. §1396a(a)(25)(A).

[72] Arkansas DHHS v. Ahlborn, 126 S.Ct. at 1761.

[73] Arkansas DHHS v. Ahlborn, 126 S.Ct. at 1762.

[74] Arkansas DHHS v. Ahlborn, 126 S.Ct. at 1763.

[75] Arkansas DHHS v. Ahlborn, 126 S.Ct. at 1763. The court rejected ADHHS's argument that, because Ahlborn had assigned her rights to the state Medicaid program, the settlement proceeds were not Ahlborn's property and thus were exempt from the anti-lien prohibition.

not be asserted against Ahlborn's settlement for lost earnings, pain and suffering, impaired earnings capacity, etc.[76]

What Does *Ahlborn* Mean for North Carolina?

G.S. 108A-57, G.S. 108A-59, *Ezell*, and *Campbell*

Like Arkansas' Medicaid third party liability statutes, G.S. 108A-57 and G.S. 108A-59, read literally, apply broadly to *all* of a Medicaid beneficiary's rights of recovery against tortfeasors, insurance companies, and other third parties.[77] G.S. 108A-57, for example, provides that the state Medicaid program is "subrogated to *all* rights of recovery, contractual or otherwise, of the [Medicaid] beneficiary … against *any* person." Similarly, G.S. 108A-59 requires the assignment of a Medicaid beneficiary's "right to third party benefits, contractual or otherwise," without any express limitation as to the type or scope of these rights or benefits. And the North Carolina Supreme Court's decision in *Ezell* only reinforces this reading.[78]

But to the extent that G.S. 108A-57 and G.S. 108A-59 apply to a Medicaid beneficiary's right to recover payments from a third party for claims other than those for medical expenses that have been, or will be, covered by the State's Medicaid program, they suffer from the same defect as Arkansas' Medicaid third party liability statutes and are therefore invalid under the federal Medicaid statute and the *Ahlborn* decision.

Similarly, to the extent that the North Carolina Supreme Court's decision in *Ezell* and the North Carolina Court of Appeals' decision in *Campbell* hold that a Medicaid TPL claim may be asserted against the portion of a personal injury settlement that compensates a Medicaid beneficiary for damages other than medical expenses, they are inconsistent with the U.S. Supreme Court's decision in *Ahlborn* and therefore are not good law.

Unlike the Arkansas statutes, neither G.S. 108A-57 nor G.S. 108A-59 characterizes the State's Medicaid claim as a "lien." This difference, however, is irrelevant with respect to the statutes' partial invalidity under *Ahlborn* and the federal Medicaid statute. In *Ahlborn*, Justice Stevens noted that the "terms that [a state Medicaid program] employs to describe the mechanism by which it lays claim to the settlement proceeds [of a Medicaid beneficiary] do not, by themselves, tell us whether the [state's third party liability] statute violates the anti-lien provision" in 42 U.S.C. §1396p.[79] And the Eighth Circuit's decision in *Ahlborn* expressly held that a state Medicaid program may not circumvent Medicaid's anti-lien provision by requiring a broad, future assignment of rights or property as opposed to placing a lien on funds or property after they are received by, or on behalf of, a Medicaid beneficiary.[80]

The federal Medicaid statute, as interpreted by *Ahlborn*,

1. allows state Medicaid programs to recover the cost of Medicaid payments through a third party liability claim only to the extent that a third party is legally liable to a Medicaid beneficiary for payment of the medical expenses that were, or will be, paid by Medicaid; and
2. except in the case of payments from third parties for medical expenses that were, or will be, paid by Medicaid, prohibits state Medicaid

---

[76] *See also* Martin v. Rochester, 642 N.W.2d 1 (Minn. 2002) (holding that a state Medicaid third party liability claim against portions of a Medicaid beneficiary's personal injury settlement that represent recovery for claims other than medical expenses covered under the Medicaid program is preempted by the federal Medicaid statute).

[77] *See* Campbell v. N.C. Dept. of Human Resources, 153 N.C. App. at 305, 569 S.E.2d at 672. Read literally, these statutes might even apply to a Medicaid beneficiary's right to receive payments as an heir or devisee, as the beneficiary under a life insurance policy, as the winner in the state lottery, etc., as well as payments for lost earnings, pain and suffering, etc. in personal injury settlements and judgments. Although the Supreme Court's decision in *Ahlborn* did not expressly address the legality of a state law that might require a Medicaid beneficiary to assign her right to receive payments for future earnings, lottery winnings, or inheritances, it seems clear that the scope of such an assignment would violate the limitations contained in 42 U.S.C. §1396p. *See* Ahlborn v. Arkansas DHHS, 397 F.3d at 624; Arkansas DHHS v. Ahlborn, 126 S.Ct. at 1764, n. 15.

[78] *See* Ezell v. Grace Hospital, ___ N.C. App. at ___, 623 S.E.2d at 85, *rev'd.* ___ N.C. ___, ___ S.E.2d ___ (2006) (holding, per the North Carolina Supreme Court's adoption of Judge Steelman's dissent, that "DMA's right of subrogation under N.C. Gen. State. §108A-57(a) is broad rather than narrow" and that Medicaid's TPL claim applies to the "*entire* amount" of a plaintiff's personal injury settlement, regardless of whether all or part of the settlement represents compensation for medical expenses).

[79] Arkansas DHHS v. Ahlborn, 126 S.Ct. at 1764.

[80] Ahlborn v. Arkansas DHHS, 397 F.3d at 624.

> programs from recovering the cost of correctly-made Medicaid payments from a Medicaid beneficiary's personal property (including money payable to or on behalf of a Medicaid beneficiary from personal injury settlements or judgments for lost earnings, impaired earnings capacity, and pain and suffering).

To the extent that G.S. 108A-57 and G.S. 108A-59 are inconsistent with these federal requirements and restrictions, they are invalid and unenforceable.

G.S. 108A-57 and G.S. 108A-59, however, are not completely invalid. Like the Arkansas statutes at issue in *Ahlborn*, G.S. 108A-57 and G.S. 108A-59 are valid and may be enforced with respect to payments owed by third parties for medical expenses that have been, or will be, paid by Medicaid. North Carolina courts, however, will need to interpret and apply G.S. 108A-57 and G.S. 108A-59 in accordance with the Supreme Court's decision in *Ahlborn*.

More importantly, though, *Ahlborn* will require North Carolina's courts or the General Assembly to establish and implement some sort of procedure that can be used to determine what portion, if any, of a Medicaid beneficiary's lump sum personal injury judgment or settlement represents payment for medical expenses that have been paid by Medicaid.[81]

In *Ahlborn*, the Arkansas Medicaid program expressed concern that if the parties to a personal injury settlement are allowed, unilaterally and without the participation of a state Medicaid program that has a valid third party liability claim, to allocate a Medicaid beneficiary's damages among past medical expenses, lost earnings, impaired earning capacity, pain and suffering, etc., the Medicaid beneficiary may unfairly manipulate the terms of the settlement in such a way as to minimize, if not eliminate, Medicaid's claim (for example, by providing that the entire amount of the settlement represents payment for lost earnings and pain and suffering rather than medical expenses).[82] The U.S. Supreme Court, however, concluded that "the risk that parties to a tort suit will allocate away the State's interest can be avoided either by obtaining the State's advance agreement to an allocation or, if necessary, by submitting the matter to a court for decision."[83]

The *Ahlborn* decision, therefore, invites North Carolina and other states to establish procedures for allocating personal injury judgments and settlements in cases involving Medicaid TPL claims, and suggests that these procedures might include provisions that would

1. prohibit unilateral actions that would circumvent valid Medicaid TPL claims,
2. require that state Medicaid programs be notified of pending lawsuits or settlements involving payment for medical services that have been covered by Medicaid,
3. grant state Medicaid programs a statutory right to intervene in such lawsuits, and
4. establish special rules or procedures allowing state courts to allocate tort settlements when a Medicaid claim is asserted.[84]

G.S. 108A-70(b)

Unlike G.S. 108A-57 and G.S. 108A-59, G.S. 108A-70(b) provides that the state Medicaid program's derivative right of recovery against a third party is limited to cases in which the "third party has a legal liability to make payments … for … health care items or services" that have been furnished to a Medicaid beneficiary under the State's Medicaid program. G.S. 108A-70(b), therefore, is more narrow in scope than G.S. 108A-57 and G.S. 108A-59 and appears to be consistent with the federal Medicaid statute and *Ahlborn*.

Some Unanswered Questions

Although *Ahlborn* does provide some clarification with respect to Medicaid third party liability claims, it (along with North Carolina's current Medicaid third party liability law) also leaves some unanswered questions.

---

[81] In North Carolina, neither jury verdicts, judgments, nor settlements generally designate the portions of a personal injury judgment or settlement that are intended to compensate an injured party for past or future medical expenses versus damages for pain and suffering, lost earnings, diminished earnings capacity, or other damages. *See* King v. Britt, 267 N.C. 594, 597, 148 S.E.2d 594, 597 (1966).

[82] Arkansas DHHS v. Ahlborn, 126 S.Ct. at 1765. *See also* Ezell v. Grace Hospital, ___ N.C. App. at ___, 623 S.E.2d at 85 (expressing concern regarding possible circumvention of Medicaid claims through characterization of portions of personal injury settlements as compensation for pain and suffering rather than medical expenses).

[83] Arkansas DHHS v. Ahlborn, 126 S.Ct. at 1765

[84] *See* Arkansas DHHS v. Ahlborn, 126 S.Ct. at 1765, n. 17, and the *amicus* brief of the Association of Trial Lawyers of America in *Ahlborn* (suggesting procedures for post-settlement allocation hearings similar to the "Henning" and "Rimes" hearing procedures established by Minnesota and Wisconsin). *See* Henning v. Wineman, 306 N.W.2d 550 (Minn. 1981); Rimes v. State Farm Mut. Ins. Co., 316 N.W.2d 348, 356 (Wis. 1982).

Can a Medicaid Third Party Claim Be Asserted Against a Personal Injury Settlement Payable to a Minor Child?

Heidi Ahlborn was a nineteen-year-old college student at the time she suffered the injuries that gave rise to Medicaid's claim against her settlement with the third party who was allegedly responsible for her injuries. And it was clear that her claim against the third party included a claim for compensation for medical expenses related to her injuries and that *some* portion of her settlement with the third party compensated her for the medical expenses she incurred as a result of her injuries (even though these expenses were paid by Arkansas' Medicaid program).

Thus, neither Ahlborn nor Arkansas' Medicaid program disputed that Medicaid's claim attached to the portion of Ahlborn's settlement that compensated her for medical expenses. The only questions were (1) what portion of Ahlborn's settlement represented compensation for past medical expenses related to her injuries, and (2) whether Medicaid's claim could be asserted against any portion of Ahlborn's settlement that represented compensation for damages other than past medical expenses. The first question was resolved by stipulation of the parties. The second question was answered negatively by the U.S. Supreme Court.

Suppose, though, that Ms. Ahlborn had been a fifteen-year-old child who was injured in North Carolina.

Under North Carolina law, "an injury to a minor creates two causes of action: (1) the parents may recover for the child's lost earnings and medical expenses during minority, and (2) the minor may recover for pain and suffering and impairment of future earning capacity."[85] Thus, a minor child, even after reaching the age of majority, generally may not recover from a third-party tortfeasor medical expenses that were incurred as a result of a personal injury that the child suffered during her minority.[86] It therefore follows that, in many if not most cases, *no portion* of a personal injury judgment or settlement payable to a minor child represents compensation for past medical expenses incurred in connection with the child's injuries.

Before *Ahlborn*, the fact that a personal injury settlement payable to a minor child did not include compensation for medical expenses for care that was paid by the State's Medicaid program was legally irrelevant, since the North Carolina Court of Appeals read G.S. 108A-57 as applying to *all* rights of recovery to which a Medicaid beneficiary, minor or adult, is entitled.[87]

Ahlborn, however, limits Medicaid's claim to the portion of a Medicaid beneficiary's personal injury settlement that compensates the beneficiary for medical care related to the beneficiary's injuries and prohibits the assertion of a Medicaid third party liability claim against those portions of a beneficiary's settlement that compensate the beneficiary for damages other than medical expenses.[88]

So it follows that, despite the holding in *Campbell*, a Medicaid third party liability claim may *not* be asserted against a personal injury settlement payable to a Medicaid beneficiary who was a minor at the time the injury occurred *unless* the beneficiary's parent has validly waived or assigned the parent's right of recovery with respect to medical expenses to the minor child or the claim involves medical care that was provided *after* the child was emancipated.

Whether this is, in fact, the case, however, cannot be determined definitively until the issue is resolved by future litigation or legislation.

Can the Legislature Establish a Presumption Regarding the Portion of a Lump-Sum Judgment or Settlement That Is Compensation for Medical Expenses?

Although Ahlborn requires that lump-sum personal injury judgments and settlements be allocated between compensation for medical expenses and other damages when a Medicaid third party liability claim is asserted, it does not establish any rules or procedures for determining how much, if any, of a personal injury judgment or settlement should be allocated for medical expenses versus other damages in cases involving Medicaid TPL claims.

Could a state legislature (or a state trial or appellate court) adopt a rule that presumes that some portion (say, one-third) of any personal injury judgment or settlement represents compensation for

---

[85] Vaughan v. Moore, 89 N.C. App. at 568, 366 S.E.2d at 520, citing Ellington v. Bradford, 242 N.C. at 160, 86 S.E.2d at 926. A parent, however, may expressly waive her right to recovery with respect to medical expenses incurred as a result of a minor child's injuries and assign that claim to the minor child. Vaughan v. Moore, 89 N.C. App. at 568, 366 S.E.2d at 520. The parent's waiver and assignment, however, must be executed within three years of the child's injury. Vaughan v. Moore, 89 N.C. App. at 568, 366 S.E.2d at 520.

[86] Vaughan v. Moore, 89 N.C. App. at 568, 366 S.E.2d at 520.

[87] Campbell v. N.C. Dept. of Human Resources, 153 N.C. App. at 307, 569 S.E.2d at 672.

[88] *See* notes 70 through 76 and accompanying text.

medical expenses and, absent evidence sufficient to rebut this presumption, that a Medicaid TPL claim may be asserted against that portion (for example, one-third) of the judgment or settlement?

Neither *Ahlborn* nor federal Medicaid law or policy provide an answer.

Can a Medicaid "Lien" Be Asserted With Respect to Settlements Involving Compensation for *Future* Medical Expenses?

Another unanswered question after *Ahlborn* involves personal injury settlements and judgments that include damages for an injured party's future, as well as past, medical expenses.

Suppose, for example, that Bob Black is injured in an automobile accident due to the fault of another driver (Wayne White). As a result of the accident, Mr. Black incurs $20,000 in medical expenses.[89] His injuries, however, are such that he will incur additional medical expenses in the future. Assume that Mr. Black settles his claim against White for $200,000, that $20,000 of the settlement is allocated for past medical expenses, $30,000 is allocated for future medical expenses, and the remainder is allocated for pain and suffering, lost earnings, and diminished earnings capacity.

Under *Ahlborn*, the state Medicaid program has the right to assert a claim against the part of the settlement that represents past medical expenses ($20,000) if the Medicaid program has paid for all or part of the medical care that Mr. Black received in connection with the accident.

But what if Medicaid pays for medical care that Mr. Black receives *after* the settlement and the medical care involves injuries that Mr. Black received in the accident and that were included in the settlement for Mr. Black's future medical expenses?[90]

Would the answer turn on whether Mr. Black also received Medicaid *before* the settlement, and thus assigned to the Medicaid program his right to payment for future medical expenses under the settlement to the extent that these expenses would be covered by Medicaid in the future? If so, how would the Medicaid program enforce its claim since that portion of the settlement probably would have been paid to (and perhaps spent by) Mr. Black *before* Medicaid paid for his post-settlement medical care? And would the answer be different in cases involving future payments (including payments for future medical expenses) under a structured settlement agreement?[91]

What Medicaid Payments May Be Recovered Through TPL Claims?

Judge Steelman's dissenting opinion in *Ezell*, which provides the basis for the North Carolina Supreme Court's holding, appears to question whether the state Medicaid agency must show a "causal connection" between a third party's injury of a Medicaid beneficiary and the medical expenses that are the basis for Medicaid's claim.[92] However, Judge Steelman expressly recognized that the state Medicaid agency could *not* assert a TPL claim with respect to medical expenses that are completely "unrelated" to the injury that is the basis for the beneficiary's claim against a third party.[93] It appears, therefore, that Judge Steelman and the supreme court's decision in *Ezell* do not reject the requirement of a "causal nexus" between a third party's liability to compensate a Medicaid beneficiary for medical expenses and the medical expenses that are the basis of a Medicaid TPL claim, but rather reject the "narrow" causation test adopted by Judges Hudson and Wynn.[94]

---

[89] These medical expenses may be incurred and paid out-of-pocket by Mr. Black, incurred by Mr. Black but not paid to the health care providers who provided the care, incurred by Mr. Black and paid by a private health insurance policy that covers Mr. Black, or incurred by Mr. Black and paid by Medicaid if he applies and is found eligible. Absent assignment, however, the legal claim against Mr. White for payment of Mr. Black's past medical expenses belongs to and is payable to Mr. Black even if it is subject to a medical care lien under G.S. 44-49 or 44-50 or an insurance company's right of subrogation.

[90] The receipt of a large personal injury settlement may temporarily disqualify an individual from receiving Medicaid if the amount of the settlement plus other "countable" assets owned by the individual exceeds Medicaid's financial resource limit. It does not, however, permanently prevent an individual from qualifying for Medicaid (if, for example, the individual spends the settlement funds or the settlement funds are placed in a "special needs trust").

[91] An individual who receives a large structured settlement might qualify for Medicaid despite the settlement if the structured settlement payments are made to a "special needs trust" established on behalf of the individual.

[92] Ezell v. Grace Hospital, ___ N.C. App. at ___, 623 S.E.2d at 84.

[93] Ezell v. Grace Hospital, ___ N.C. App. at ___, 623 S.E.2d at 84.

[94] Ezell v. Grace Hospital, ___ N.C. App. at ___, 623 S.E.2d at 85.

The U.S. Supreme Court's decision in *Ahlborn* did not expressly address this issue.[95] At least one provision in the federal Medicaid TPL statutes, however, appears to require *some* "causal nexus" between a third party's liability and the medical expenses that are the basis of a Medicaid TPL claim.[96]

What Priority, If Any, Do Medicaid Third Party Liability Claims Have?

Suppose, again, that Bob Black is injured in an automobile accident due to the fault of another driver (Wayne White). But now assume that Mr. Black incurs $50,000 in medical expenses, that Medicaid pays $40,000 of these expenses, that $10,000 of these expenses are owed to health care providers who have valid liens under G.S. 44-49 or G.S. 44-50, that Mr. Black's claim is settled for only $30,000 (due to evidence that he may have been contributorily negligent), that the entire amount of the settlement is allocated to Mr. Black's past medical expenses, and that Mr. Black's attorney claims a fee of $10,000.

Under *Ahlborn* and the federal Medicaid statute, the state Medicaid program could assert a valid claim against the settlement proceeds in the amount of $30,000. The other health care providers, though, have a lien against the settlement proceeds in the amount of $10,000 pursuant to G.S. 44-50. So, the amount of the settlement is insufficient to pay the Medicaid claim, the medical liens, and the attorney's fee.

As currently written, G.S. 108A-57(a) would require that Medicaid's claim be "pro rated" with the health care providers who have valid liens under G.S. 44-49 or G.S. 44-50 and would limit Medicaid's claim to no more than one-third of the total amount of Mr. Black's settlement (or $10,000).[97]

But could (and should) state law be revised to give the State's Medicaid claim priority over the claims of other health care providers (or other health insurers who have paid an injured party's medical expenses and assert a right of subrogation)?[98] And may state law limit the State's Medicaid claim when a settlement is subject to other claims involving the payment of a Medicaid beneficiary's medical expenses?[99]

The answers to these questions are not entirely clear.

Are Medicaid TPL Claims Subject to Claims for Attorneys' Fees?

Neither the federal Medicaid statute nor North Carolina's current Medicaid third party liability statutes address the question of whether or how a Medicaid TPL claim against a personal injury settlement or judgment is subject to a claim for attorneys' fees by the attorney who represented the Medicaid beneficiary in obtaining the settlement or judgment from which the Medicaid claim is paid.[100]

---

[95] As noted above, the Medicaid agency and plaintiff in *Ahlborn* entered into a stipulation regarding the parameters of Medicaid's claim.

[96] *See* 42 U.S.C. §1396a(a)(25)(B) (requiring state Medicaid programs to seek reimbursement for Medicaid payments *to the extent of a third party's legal liability to pay for medical care and services that have been covered by Medicaid*.

[97] Under the state Medicaid agency's interpretation of G.S. 108A-57(a), Mr. Black's attorney would be required to pay the agency only $8,000 of its $40,000 claim because Medicaid's claim is limited to $10,000 (one-third of Mr. Black's $30,000 settlement) and Medicaid's claim represents only 80% of the total claims against the settlement for medical expenses.

[98] The United States' right of subrogation under the federal Medicare program (42 U.S.C. §1395y(b)(2)(B)(iii)) against a personal injury settlement payable to an individual who receives Medicare and Medicaid benefits is superior to that of a state Medicaid program. *See* Filippi v. U.S. Dept. of Health and Human Services, 138 F.Supp.2d 545 (S.D.N.Y. 2001). State law (G.S. 135-40.13A) gives the state employees' health plan a "first right of recovery" with respect to a beneficiary's right of recovery against a liable third party but does not indicate whether this right is superior to the State's right of recovery under G.S. 108A-57 or G.S. 108A-59.

[99] 42 U.S.C. §1396a(a)(25)(B) requires state Medicaid programs to seek reimbursement from third parties "to the extent" of their legal liability for payment of medical expenses covered by Medicaid. This provision could be read as requiring *full* reimbursement of Medicaid third party liability claims within the limits established by *Ahlborn*. *See also* Fla. Stat. Ann. §409.910(1) (requiring that Medicaid "be repaid in full from, and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid").

[100] As originally enacted, G.S. 108A-57 provided that an attorney who represented a Medicaid beneficiary in obtaining a settlement or judgment subject to a Medicaid third party liability claim was entitled to an attorney's fee in an amount up to "one-third of the amount obtained or recovered to which the right of subrogation applies." *See* N.C. Dept. of Human Resources v. Weaver, 121 N.C. App. 517, 466 S.E.2d 717 (1996). This provision, however, was

Federal Medicaid policy, however, does provide that "legitimate costs of obtaining the settlement or award, such as attorney fees, may be deducted prior to reimbursement to the Medicaid program" for third party liability claims.[101]

So suppose, again, that Bob Black is injured in an automobile accident due to the fault of another driver (Wayne White), that Mr. Black incurs $20,000 in medical expenses, that all of these expenses are paid by Medicaid, that Mr. Black's claim is settled for $100,000 (of which $20,000 is allocated for past medical expenses), and that the retainer agreement between Mr. Black and his attorney allows the attorney to retain 35 percent of the settlement as his fee.

Under *Ahlborn* and federal and state Medicaid law, the state Medicaid program has a claim against the settlement in the amount of $20,000. And Mr. Black's attorney has a claim for $35,000.

May Mr. Black's attorney withhold 35 percent of the Medicaid claim ($7,000) in partial payment of his attorney's fee, pay the State $13,000 in satisfaction of the Medicaid claim, and take the remainder of his fee ($28,000) from the settlement proceeds that are payable to Mr. Black? Or must the full amount of the attorney's fee ($35,000) be paid from the portion of the settlement payable to Mr. Black ($80,000) and the full amount of the Medicaid claim ($20,000) be paid to the state Medicaid program?[102]

The answer is not clear under North Carolina's current Medicaid TPL statutes.

Conclusion

At a minimum, the U.S. Supreme Court's decision in *Ahlborn* will require North Carolina's Medicaid agency and courts to limit the scope of G.S. 108A-57 and G.S. 108A-59 to the portion of personal injury settlements and judgments that represents payment for medical care that has been provided to a Medicaid beneficiary under the State's Medicaid program and to allocate personal injury settlements between an injured party's medical expenses and the party's claims for lost wages, pain and suffering, and impaired earnings capacity when the settlement is subject to a Medicaid claim.

The *Ahlborn* decision, however, also presents an opportunity for North Carolina's General Assembly to reexamine and revise North Carolina's Medicaid third party liability statutes to ensure that they are consistent with federal law and the *Ahlborn* decision, to adopt rules and procedures for allocating personal injury judgments and settlements between compensation for medical expenses and other damages in cases involving Medicaid TPL claims, and to address some of the unanswered questions that remain after *Ahlborn*.

repealed in 1996. N.C. Sess. Laws 1996, 2nd Ex. Sess., c. 18, §24.2(a).

[101] U.S. Centers for Medicare and Medicaid Services, *State Medicaid Manual* §3907 (available on-line through the CMS web site: www.cms.gov).

[102] *See* Florida Agency for Health Care Administration v. Wilson, 782 So.2d 977 (Fla. Dist. Ct. App. 2001) (holding that, under Florida's Medicaid third party liability statute, costs and attorneys fees could not be deducted from the amount of the Medicaid claim against a personal injury settlement).

This bulletin is published by the School of Government to address issues of interest to government officials. Public officials may print out or photocopy the bulletin under the following conditions: (1) it is copied in its entirety; (2) it is copied solely for distribution to other public officials, employees, or staff members; and (3) copies are not sold or used for commercial purposes.

Additional printed copies of this bulletin may be purchased from the School of Government. To place an order or browse a catalog of School of Government publications, please visit the School's Web site at http://www.sog.unc.edu, or contact the Publications Sales Office, School of Government, CB# 3330 Knapp Building, UNC Chapel Hill, Chapel Hill, NC 27599-3330; e-mail sales@iogmail.iog.unc.edu; telephone (919) 966-4119; or fax (919) 962-2707. For general inquiries, call the School of Government's main number, (919) 966-5381.

The School of Government of The University of North Carolina at Chapel Hill has printed a total of 635 copies of this public document at a cost of $738.53 or $1.16 each. These figures include only the direct costs of reproduction. They do not include preparation, handling, or distribution costs.