

Finding the Real Party in Interest: Using Medicaid Law to Combat the Unreasonable Life Care Plan

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In the catastrophic personal injury case, defense counsel routinely see the plaintiff's future alleged needs summarized in a so-called "life care plan," used by plaintiff's counsel at trial as the foundation for a demand of economic damages from the jury. The life care plan, a creature that exists solely in the realm of litigation, purports to predict various medical (and other) needs of the injured plaintiff, for the remainder of the plaintiff's predicted life. While there is often no dispute that a particular plaintiff has sustained serious injuries, and requires some future care, life care plans are often disappointingly used by plaintiff's counsel to "run up the score" with exaggerated costs, unrealistic life expectancies, and services that are neither needed nor helpful to the injured plaintiff.

To combat excessive life care plans, defense counsel typically retain their own consultants to evaluate the merits of those plans. However, in doing so, defense counsel often overlook the effect that plaintiff's receipt of Medicaid benefits has on those claims for future medical care. The issue is not simply one of costing out future care, but more fundamentally, to whom the cause of action for future medical expenses *actually belongs*. Under Medicaid law, the right of recovery for past medical expenses

paid by Medicaid belongs to the State, not the plaintiff. Furthermore, the State's entitlement to control over recovery of past medical expenses can also give the State control over the recovery of future medical expenses, a right for which the State may be willing to accept a much more realistic sum in settlement than the plaintiff's attorney.

A future article will discuss the propriety of using public assistance rates as the basis for future costs in a life care plan, particularly through the presentation to the jury of an annuity purchase option. This article, however, will consider the more fundamental issue — to whom does the right of recovery for medical expenses, past or future, truly belong, when the plaintiff has received Medicaid assistance? And if that right belongs to the State, as I argue it does, how does that interest affect defense counsel's ability to combat unrealistic demands for future medical expenses?

The Medicaid Program, and its Mandatory Assignment of Claimant's Right of Recovery

Created in the 1960s as part of Lyndon Johnson's Great Society, Medicaid serves the worthy cause of providing needed medical assistance to those who cannot otherwise afford it. Medicaid is jointly funded and managed by federal and State governments, although States have

much of the day-to-day responsibility for administering the program to actual recipients. State governments often re-brand their Medicaid services with some local moniker, such as "MediCal" in California, or "Badgercare" in Wisconsin, particularly when those services are combined with those authorized by the State Children's Health Insurance Program (SCHIP).

Authorized by Title XIX of the Social Security Act, Medicaid has spawned a byzantine array of statutes and regulations specifying the manner in which services can and cannot be provided. Of particular interest here are the laws and rules governing the State's right to repayment for medical expenses, and the rights that inure to the State to effectuate that repayment.

Like a private insurer, Medicaid programs have the right to recoup medical payments from third-party tortfeasors. Medicaid's mechanism for recovering those payments is unorthodox, but critically important. Typically, a private insurer obtains a subrogation interest, or lien, upon any right of recovery for medical expenses it has funded. Not so with Medicaid. In fact, Medicaid law specifically prohibits States from placing *any lien* upon the property of a Medicaid recipient while he or she is still living. 42 U.S.C. § 1396p(a)(1). Because a claimant's right of action is typically

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considered personal property, this provision will usually prohibit the State from placing a “lien” on any pre-death recovery for an injured claimant on whose behalf Medicaid bills were paid. On the other hand, Medicaid does require each Medicaid recipient to *assign* any right she may have “to receive payments for medical expenses from third parties liable for payment of those expenses.” 42 U.S.C. § 1396k(a).

The Minnesota Supreme Court has analogized this provision to the “bundle of sticks” familiar to some from law school: if the claimant’s right of action consists of a bundle of sticks, each reflecting one aspect of the claimant’s potential recovery, the claimant, by receiving Medicaid, thereby assigns the stick encompassing all recovery for medical care to the State. While the claimant retains a separate, and inalienable right to the remaining “sticks” of her bundle — wage loss, pain and suffering, and other general damages — the right for recovery of medical expenses has been wholly transferred (as opposed to merely subrogated) to the State. *See generally Martin v. City of Rochester*, 642 N.W.2d 1 (Minn. 2002).

The implications of this “stick” transfer are significant.

The “Assignment” in Action — Dealing with the State as Real Party in Interest

The effect of Medicaid’s assignment law is to make the State in any personal injury action implicating Medicaid benefits not simply a lienholder, but rather the *owner* (as assignee) of the claimant’s cause of action for medical expenses. This means the State is the true “real party in interest” with the power to resolve claims for medical expenses arising

out of the subject incident.

The implications of the assignment for *past* medical expenses is fairly straightforward. Experienced trial lawyers have long sought to purchase the rights of either the State or the plaintiff’s insurance company to outstanding medical bills. Through a buy-out of this interest, typically at an amount which reflects both the discounted amount originally paid, and the discount further obtained through the settlement negotiation process, the defendant can often wipe out the plaintiff’s ability to recover past medical expenses entirely, especially at the inflated “list” prices the collateral source rule sometimes allows plaintiffs to recover. It is also theoretically possible, although perhaps unlikely, that the defendant could characterize such a buy-out as a secondary “assignment” of its own, and attempt to assert the full amount of the outstanding obligation against any plaintiff’s verdict at trial, even if the defendant purchased that interest at a discount.

But, the real power of the Medicaid buy-out scenario rests with the threat it poses to the plaintiff’s ability to recover *future* medical expenses. If the State’s right was solely one of lienholder, its rights would obviously be limited to expenses which had actually been incurred to date. But, the State is an assignee, not a lienholder. So, under terms satisfactory to it, the State has the ability to release the right of recovery for *future* medical expenses as well.

The implications of this power were dramatically displayed in the Minnesota case of *Guzman v. US West, Inc.*, 667 N.W.2d 489 (Minn. Ct. App. 2003). In that case, the minor plaintiff sued *US West* for damages arising from injuries she sustained in a motor vehicle accident. The minor plaintiff had received

medical assistance for her post-accident care from the State of Minnesota through its Medicaid program. The State settled the claims relating to the plaintiff’s past and future medical care directly with *US West* for just under \$329,000.00, in exchange for a full release as to both past and future medical expenses, and the district court thereafter granted *US West*’s motion to dismiss the plaintiff’s claims for future medical care, in light of the settlement. *Id.* at 490. The plaintiffs had claimed several million dollars in future medical needs, which were now extinguished.

On appeal, the plaintiff contended that the district court had erred in dismissing a claim for future medical expenses which had not yet fully accrued, and argued the State could only release the defendant from liability for expenses it had actually incurred to date. The Minnesota Court of Appeals unanimously rejected these arguments, finding that these contentions mistook the State as a mere lienholder, rather than the outright assignee of plaintiff’s medical expense claims. After all, the assignment process had conferred upon the State the “stick” representing “all claims for medical care.” *Id.* at 492. Interpreting that assignment to refer only to assistance previously provided would be nonsensical, as the entire purpose of signing up for medical assistance is to receive future medical care, *id.* at 493, and the minor plaintiff plainly had received care after her assistance application undisputedly subject to recovery by Medicaid. As such, the distinction drawn between past and future medical expenses was untenable. The Court found the effect of that assignment to be clear:

The district court correctly interpreted the law to hold that appel-

lants, as a condition of eligibility for medical assistance, assigned to the state all rights to recovery for medical expenses, including future medical expenses. The state's settlement with US West extinguished appellants' rights to pursue a claim for future medical expenses. The district court properly dismissed that claim.

Id.

Implications: Defending Claims Involving Medicaid Payouts

The implications of Medicaid's "assignment" requirement are wide-ranging.

First, defense counsel in any consequential personal injury case should determine as soon as possible, through discovery, whether plaintiff has received any public assistance for medical expenses incurred as a result of the injury giving rise to the claim. If so, the State, rather than the plaintiff or plaintiff's counsel, is the true real party in interest with whom you ought to be negotiating. Even if plaintiff has received both Medicaid and private health insurance benefits, the State ultimately should have the first right of recovery for all such expenses, with a possible secondary lien due and owing to any private insurer who provided additional benefits.

Second, upon learning of any Medicaid-sponsored assistance, defense counsel should carefully consult her own State's enabling laws for its Medicaid program, which by federal decree must include an assignment provision granting the State the right of any recovery for medical expenses. In the author's experience, the actual application signed by the claimant or her parent / guardian will sometimes explicitly state that this assignment is occurring by virtue of the claimant's execution of the application.

Demand and obtain copies of these applications in discovery. Your trial judge may be more easily persuaded by a signed and acknowledged contract than a public assistance regulation by itself.

Third, defense counsel should make every effort to engage the responsible State Medicaid official once counsel has had adequate opportunity to evaluate the case. State officials may not always be cooperative, because they do not understand how Medicaid assignment law works, because they are lazy, or because they are used to dealing with plaintiff's lawyers instead. But, be persistent. In dealing with plaintiff's lawyers, State Medicaid personnel are often stuck discounting their recovery once for plaintiff counsel's attorney fee (often 20% or more), and then pressured to discount it further to serve the "best interests" of the claimant.

Defense counsel can beat that offer almost any day, particularly if a full release of liability for future medical expenses is realistically on the table. In the author's experience, a Medicaid claims manager (or his appointed attorney) will sit up straight when offered the opportunity to receive a significantly better return, even when a condition for that recovery is a full release of any right of recovery for both past and even future medical expenses. While future medical expenses can be expensive down the road, that fact may have little significance to a claims manager looking to close a budget gap in *this* fiscal year. Defense counsel's case becomes even more persuasive if she can persuade the Medicaid official that many of the future medical expenses claimed by the plaintiff's attorney are exaggerated, or that plaintiff has a low chance of recovery on the merits. In such a situation, the claims manager should become jus-

tifiably concerned that if plaintiff fails at trial, or succeeds but recovers almost exclusively non-economic damages, the Medicaid program may receive little or nothing at all in return.

Conclusion

Medicaid law can be complex, but the realities underlying the assignment obligation make at least that aspect of Medicaid law worth understanding. If nothing else, defense counsel who treats Medicaid as "just another lienholder," is potentially overlooking one of their client's best bulwarks against a runaway verdict at trial, or an extortionate settlement.