

**HB**

**426**

**SFIN**

**FILE**

**SENATE FINANCE COMMITTEE REPORT**

REPORTED OUT  
MAY 05 2006  
SENATE FINANCE COMMITTEE

DATE: 5/2/06

FURTHER:

DATE TURNED IN TO OFFICE: 5 May 2006

Finance Committee considered CS FOR HOUSE BILL NO. 426(FIN)(title am)

**HB 426 MEDICAL ASSISTANCE/INS COOPERATION**

"An Act relating to cooperation of insurers with the Department of Health and Social Services; relating to subrogation, assignment, and lien rights and notices for medical assistance claims; relating to recovery of medical assistance overpayments; relating to asset transfers and income diversion by medical assistance applicants; relating to assets and Medicare enrollment as they affect medical assistance coverage; relating to home and community-based services; relating to medical assistance applications for persons under 21 years of age; requiring a report by the Department of Health and Social Services; and providing for an effective date."

and recommends:

- be replaced with 5 CS CS HB 426 (FIN)
- adopt previous \_\_\_\_\_ CS CS forthcoming : (\_\_\_\_\_)
- attached amendment(s)
- adopt Letter of Intent by \_\_\_\_\_ Committee
- further referral to \_\_\_\_\_ Committee

<b>CS Senate Bill:</b>	
<input type="checkbox"/>	Same Title
<input type="checkbox"/>	New Title
<b>SCS House Bill:</b>	
<input checked="" type="checkbox"/>	Same Title
<input type="checkbox"/>	Technical Title Change
<input type="checkbox"/>	New Title w/ SCR # _____

**NEW FISCAL NOTE(S):**

Department	Date	Fiscal	Ind.	Zero	FN#

**PREVIOUS FISCAL NOTE(S):**

Department	Date	Fiscal	Ind.	Zero	FN#
DHSS Behavioral	4/12/06			<input checked="" type="checkbox"/>	#1
DHSS Pub. Asst	4/12/06	51.7			#2
DHSS Sen Disabl	4/12/06	(89.1)			#3
DHSS HealthCare	4/12/06	(2,734.9)			#4
DHSS Med. Asst	4/12/06	190.3			#5

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS;	DO PASS	DO NOT PASS	NO REC	AMEND
<i>[Signature]</i>	<input checked="" type="checkbox"/>			
<i>[Signature]</i>			<input checked="" type="checkbox"/>	
<i>[Signature]</i>			<input checked="" type="checkbox"/>	
<i>[Signature]</i>	<input checked="" type="checkbox"/>			
<i>[Signature]</i>	<input checked="" type="checkbox"/>			
COCHAIR: <i>[Signature]</i>	<input checked="" type="checkbox"/>			
COCHAIR: <i>[Signature]</i>	<input checked="" type="checkbox"/>			

# FISCAL NOTE

REPORTED OUT  
MAY 05 2006  
SENATE FINANCE COMMITTEE

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1  
 Bill Version: CSHB 426(HES)  
 ( H ) Publish Date: 4/12/06  
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: RELATING TO MEDICAL ASSISTANCE  
ELIGIBILITY AND COVERAGE FOR PERSONS RDU Behavioral Health  
UNDER 21  
 Component: Behavioral Health Administration

Sponsor: COGHILL  
 Requester: HOUSE (FIN) Component No. 2665

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES (0)</b>						
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
<b>TOTAL</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2006) cost: \_\_\_\_\_  
 Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

Section 11 of this bill requires the Department to prepare a report of recommendations for changes for residential psychiatric and substance abuse treatment programs that address reduction of medical assistance expenditures, enhancement of parental responsibility, and maximization of third-party resources.

This provision will have a zero fiscal cost under the assumption that the new Bring the Kids Home Project Manager position in the FY07 proposed budget is funded. The report would be written by the new position.

This is the only section of the bill that affects the Division of Behavioral Health. The eligibility groups affected (recipients of long-term care services and minors applying for themselves) by this bill generally do not use mental health services.

Prepared by: Christy Willer, Director Phone 269-3410  
 Division: Behavioral Health Services Date/Time 04/12/2006  
 Approved by: Karleen Jackson, Commissioner Date 04/12/2006  
 Agency: Department of Health and Social Services

# FISCAL NOTE

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

Fiscal Note Number: 2  
Bill Version: CSHB 426(HES)  
( H ) Publish Date: 4/12/06  
Depl. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: RELATING TO MEDICAL ASSISTANCE ELIGIBILITY AND COVERAGE FOR PERSONS UNDER 21 RDU Public Assistance  
Component: Public Assistance Field Svcs  
Sponsor: COGHILL  
Requester: HOUSE (FIN) Component No. 236

**Expenditures/Revenues (Thousands of Dollars)**

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services	40.6	162.4	162.4	162.4	162.4	162.4
Travel						
Contractual	4.3	17.0	17.0	17.0	17.0	17.0
Supplies	6.8	5.0	5.0	5.0	5.0	5.0
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>51.7</b>	<b>184.4</b>	<b>184.4</b>	<b>184.4</b>	<b>184.4</b>	<b>184.4</b>
<b>CAPITAL EXPENDITURES</b>						
<b>CHANGE IN REVENUES (0)</b>						

**FUND SOURCE (Thousands of Dollars)**

FUND SOURCE	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
1002 Federal Receipts	25.9	92.2	92.2	92.2	92.2	92.2
1003 GF Match	25.8	92.2	92.2	92.2	92.2	92.2
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
<b>TOTAL</b>	<b>51.7</b>	<b>184.4</b>	<b>184.4</b>	<b>184.4</b>	<b>184.4</b>	<b>184.4</b>

Estimate of any current year (FY2006) cost: \_\_\_\_\_  
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

POSITIONS	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Full-time	2	2	2	2	2	2
Part-time	1	1	1	1	1	1
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)  
This bill contains provisions that change medical assistance eligibility in AS 47.07.020, which will increase the workload of Eligibility Technicians.  
  
Section 7, subsection (j-k) limits who may apply for medical assistance for a person under 18 years of age.  
Section 7, subsection (l) requires that persons applying for medical assistance must enroll for Medicare if eligible.  
  
These provisions increase workload by requiring Eligibility Technicians to spend more time with applicants searching for legal guardians or parents of minors, and assisting eligible persons to enroll in Medicare.

Prepared by: Kitty Farnham, Director Phone: 465-5835  
Division: Public Assistance Date/Time: 04/12/2006  
Approved by: Karleen Jackson, Commissioner Date: 04/12/2006  
Agency: Department of Health and Social Services

**COMMITTEE COPY**

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

**MINORS APPLYING FOR MEDICAID**

Currently, any adult may apply on behalf of a minor and minors may apply for themselves. Section 7, subsections (j) and (k) provide that only an adult who has a legal or vested interest may apply for Medicaid on behalf of a child under age 18. The department must make reasonable efforts to contact the parent or legal guardian before granting a waiver of consent. If a waiver of consent is granted, the department must document the reason for the waiver in the child's medical assistance record. Under this provision, Division staff will have to spend more time with applicants to contact and obtain consent of the parent or legal guardian or document a waiver.

Total Annual Costs = \$110.6 thousand for an additional 1.5 positions plus an extra \$4.4 thousand in FY07

Assumptions:

- ~Approximately 3800 minor children apply for Medicaid each year.
- ~An additional 45 minutes per application, on average, will be needed for eligibility staff to contact a minor applicant's parent(s) or legal guardian to obtain consent (or make a reasonable attempt to obtain consent) for the application, or to gather enough information needed to waive consent.
- ~3800 applications/per year x 45 minutes = 171,000 minutes per year or 2,850 hours
- ~Eligibility staff work 162 hours/month x 12 = 1944 hours/year
- ~2850 hours per year / 1944 hours per technician = 1.5 workers
- ~Average personnel costs for an Eligibility Technician II is \$64,944/year
- ~One-time cost for computers and software in FY2007 = \$2,200/position
- ~Annual costs for office space, phones & supplies = \$8,800/position
- ~1 Eligibility Technician II full time = \$64,944 + 1 Eligibility Technician II part-time = \$32,472 = \$97,416/year
- ~Supplies & contractual costs for 1.5 positions = \$15,400 in FY07; \$13,200/year FY08 and beyond

**ENROLLMENT IN MEDICARE**

Currently, enrollment in Medicare is optional for medical assistance applicants. Section 7, subsection (l) requires that a person who is eligible must first enroll in the Medicare program before they are eligible to receive benefits through Medicaid. Under this provision Division staff will have to spend more time with applicants to evaluate Medicare eligibility and monitor their continued enrollment in Medicare.

Total Annual Costs = \$73.7 thousand for an additional 1 position plus an extra \$2.2 thousand in FY07

Assumptions:

- ~On average, 1800 individuals per month appear eligible for, and not enrolled in Medicare
- ~Eligibility for Medicare will be assessed at initial application and during the 6-month eligibility review
- ~Eligibility staff will need an additional 60 minutes per month to evaluate an individual's eligibility for Medicare, and to require and monitor enrollment as a condition of eligibility for Medicaid
- ~1800 individuals per month x 60 mins/case = 1800 hours / 12 months = 150 hours/month

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

- ~Average personnel costs for an Eligibility Tech II is \$64,944/year
- ~One-time cost for computers and software in FY2007 = \$2,200/position
- ~Annual costs for office space, phones & supplies = \$8,800/position
- ~1 Eligibility Technician II full time = \$64,944/year
- ~Supplies & contractual costs for 1 position = \$15,400 in FY07; \$13,200/year FY08 and beyond

**Other Assumptions:**

- ~The bill takes effect July 1, 2006; however, implementation would be delayed until the 4th Quarter while waiting for approval of a Medicaid State Plan Amendment. For this reason, FY07 is 25% of a full year.
- ~The federal matching rate is 50%.
- ~The other sections of this bill will not substantially increase the workload and do not need a fiscal note in this component.

# FISCAL NOTE

REPORTED OUT  
MAY 05 2006  
SENATE FINANCE COMMITTEE

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

Fiscal Note Number: 3  
 Bill Version: CSHB 426(HES)  
 ( H ) Publish Date: 4/12/06  
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: RELATING TO MEDICAL ASSISTANCE ELIGIBILITY AND COVERAGE FOR PERSONS UNDER 21 RDU Senior and Disabilities Svcs  
 Component: Senior/Disabilities Medicaid Svc

Sponsor: COGHILL  
 Requester: HOUSE (FIN) Component No. 2662

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	( 83.1)	( 415.0)	( 500.0)	( 500.0)	( 500.0)	( 500.0)
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>( 83.1)</b>	<b>( 415.0)</b>	<b>( 500.0)</b>	<b>( 500.0)</b>	<b>( 500.0)</b>	<b>( 500.0)</b>
<b>CAPITAL EXPENDITURES</b>						
<b>CHANGE IN REVENUES (0)</b>						

**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts	( 47.8)	( 220.9)	( 252.2)	( 250.0)	( 250.0)	( 250.0)
1003 GF Match	( 35.3)	( 194.1)	( 247.8)	( 250.0)	( 250.0)	( 250.0)
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
<b>TOTAL</b>	<b>( 83.1)</b>	<b>( 415.0)</b>	<b>( 500.0)</b>	<b>( 500.0)</b>	<b>( 500.0)</b>	<b>( 500.0)</b>

Estimate of any current year (FY2006) cost: \_\_\_\_\_  
 Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** (Attach a separate page if necessary)

This bill contains provisions that bring Alaska Statute into line with the deficit Reduction Act of 2005 including many mandatory rule changes related to determining financial eligibility for long-term-care related Medicaid.

Sec. 6 makes it more difficult to use an annuity to shelter assets when trying to qualify for Medicaid.

Sec. 7, subsection (m) allows the State to impose stricter penalties for transferring assets at below-market value.

Sec. 7, subsection (n) allows that a home valued over \$500,000 can be a resource in determining eligibility. Sec. 8 clarifies when a person on a home and community based waiver may be terminated from the waiver.

The 2 provisions will reduce Medicaid costs by reducing the number of persons eligible for Medicaid, most of whom are eligible for the Older Alaskans waiver program.

Prepared by: Rod Moline, Director Phone 465-3819  
 Division: Senior and Disabilities Services Date/Time 04/12/2006  
 Approved by: Karleen Jackson, Commissioner Date 04/12/2006  
 Agency: Department of Health and Social Services

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

**MEDICAID-QUALIFYING ANNUITIES**

Currently, various kinds of trusts and annuities can be used to shelter assets when trying to qualify for Medicaid. The federal law cited in the bill places more restrictions on annuities used for Medicaid purposes than exist now. Section 6 limits the annuities that do not affect eligibility to only those that meet the requirements of the federal law. This bill also gives the State the right to recover the balance of an annuity should a recipient die before the annuity has fully paid out.

Annual savings: \$0. This provision will not have a fiscal impact as it is not included in the budget now.

**TRANSFER OF ASSETS AT BELOW-MARKET VALUE**

Generally speaking, if a person applying for or receiving Medicaid benefits has transferred an asset at below-market value, that person may be subject to a period of ineligibility. Currently, the State can impose a penalty period beginning with the date of transfer. Section 7, subsection (m) allows the penalty period to begin with the date of application for Medicaid. This will eliminate almost all instances when an individual escapes serving a penalty period because the penalty period has already run its course before the Medicaid application is submitted. This would mostly affect applicant's seeking long-term care coverage including long-term care services under the Older Alaskans waiver program.

Annual savings to Medicaid = \$250.0 thousand

Assumptions:

- ~The number of applicants penalized in past 6 months = 6, which is 12 annually
- ~Average number of months penalized = 5
- ~Estimated total number of months eligibility is delayed annually due to penalties = 60
- ~Applicants would have been eligible for the OA waiver program
- ~Average annual cost per OA waiver recipient = \$50,000, which is \$4,167 per month
- ~The savings will ramp up over a 3-year period

**HOMES AS A RESOURCE**

Normally, a person's home is an exempt resource for Medicaid eligibility purposes. Section 7, subsection (n) puts a limit on the value of a home that would still qualify for this exemption. In effect, an individual will be ineligible for Medicaid if their home has an equity value for more than \$500,000, unless they sell it, borrowed against it, or take out a reverse mortgage to reduce the equity below \$500,000. This would mostly affect applicants seeking long-term care coverage including long-term care services under the OA Waiver program.

Annual savings to Medicaid = \$250.0 thousand

Assumptions:

- ~Currently number of long-term care recipients known to have a home valued over \$500,000=0
- ~Don't have any data on number of applicants with homes valued over \$500,000
- ~Estimated number of applicants per year with homes valued over \$500,000 who would now be ineligible = 5
- ~Applicants would have been eligible for the OA waiver program
- ~Average annual cost per OA waiver recipient = \$50,000

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

**TERMINATING WAIVER  
SERVICES**

This section is in response to a class action lawsuit filed against the Division regarding how individuals from the Older Alaskans and Adults with Physical Disabilities waivers are assessed and terminated from the program. Prior to the litigation the Division only assessed individuals based on the current circumstances and level of client function. Section 8 says that a person who is eligible for a home and community based waiver may be terminated from the waiver only if the recipient scores below the eligibility standard on the assessment and an independent qualified health care professional certifies that the recipient's condition has materially improved from the previous assessment.

Annual savings: \$0. This provision will not have a fiscal impact as it is not included in the budget now. It will be a cost avoidance.

**Other Assumptions:**

~The bill takes effect July 1, 2006; however, implementation would be delayed until the 4th Quarter while waiting for approval of a Medicaid State Plan Amendment. For this reason, FY2007 is 25% of a full year.

~The federal matching rate is the estimated SFY quarterly average FMAP for the applicable year: FY07=57.58%, FY08=53.22%, FY09=50.44%; FY10 to FY12=50.00%.

~The other sections of this bill do not need a fiscal note in this component.

# FISCAL NOTE

REPORTED OUT  
**MAY 05 2006**  
 SENATE FINANCE COMMITTEE

STATE OF ALASKA  
 2006 LEGISLATIVE SESSION

Fiscal Note Number: 4  
 Bill Version: C IB 426(HES)  
 (H) Publish Date: 4/12/06  
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: RELATING TO MEDICAL ASSISTANCE ELIGIBILITY AND COVERAGE FOR PERSONS UNDER 21 RDU Health Care Services

Sponsor: COGHILL  
 Requester: HOUSE (FIN) Component: Medicaid Services  
 Component No. 2077

**Expenditures/Revenues (Thousands of Dollars)**

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	( 2,734.9)	( 10,884.6)	( 10,884.6)	( 10,884.6)	( 10,884.6)	( 10,884.6)
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>( 2,734.9)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES (0)</b>						
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**FUND SOURCE (Thousands of Dollars)**

1002 Federal Receipts	( 1,574.8)	( 5,792.8)	( 5,490.2)	( 5,442.3)	( 5,442.3)	( 5,442.3)
1003 GF Match	( 1,160.1)	( 5,091.8)	( 5,394.4)	( 5,442.3)	( 5,442.3)	( 5,442.3)
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
<b>TOTAL</b>	<b>( 2,734.9)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>	<b>( 10,884.6)</b>

Estimate of any current year (FY2006) cost: \_\_\_\_\_  
 Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** *(Attach a separate page if necessary)*

This bill contains provisions that would help to ensure repayment to the Medicaid program for cases involving Medicaid recipients receiving settlements or judgments from third party payers and would change medical assistance eligibility for minors and persons eligible for Medicare. These provisions will reduce Medicaid expenditures by increasing recoveries and reducing the number of persons eligible for Medicaid.

Sections 1-5 and 9-10 contain provisions that will result in more subrogation cases and increased recoveries for the Medicaid program.

Section 7, subsection (j-k) limits who may apply for medical assistance for a person under 18 years of age;

Section 7, subsection (l) requires that persons applying for medical assistance must enroll for Medicare if eligible.

Prepared by: Dwayne Peoples, Director Phone 465-5830  
 Division: Health Care Services Date/Time 04/12/2006  
 Approved by: Karleen Jackson, Commissioner Date 04/12/2006  
 Agency: Department of Health and Social Services

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

**SUBROGATION AND RECOVERIES**

Sections 1-5 and 9-10 of this bill requires insurers to coordinate benefits with other insurers (including Medicaid); clarifies that the department may take the role of the recipient when the department has paid medical claims on behalf of the recipient and the recipient may be in a position to recover funds that are partially attributable to the injury and medical care received; clarifies that the Department may take the place of the recipient and pursue recovery if the recipient chooses not to pursue a liable 3rd party; and requires that the state be notified of cases and settlements from third party payers. Section 5 provides the state the ability to attach Permanent Fund dividends of recipients in cases where the state is not notified of a Medicaid recipient's recovery and has no other recourse to recover amounts paid. Currently the Department is authorized to garnish a recipient's PFD to recover General Relief, Adult Public Assistance, food stamps and Alaska Temporary Assistance Program overpayments, but not Medicaid. The department needs the same authority to recoup overpayments from Medicaid recipients who have received Medicaid coverage but shouldn't have, including those who choose to receive continued Medicaid benefits pending a fair hearing, but who ultimately lose the fair hearing. One of the most efficient and least intrusive recovery methods has been to garnish the recipient's PFD.

Annual savings to Medicaid: \$1,010.2

Assumptions:

- ~Additional staff resources from Department of Law applied to subrogation cases
- ~Annual subrogation recoveries of \$1M are doubled
- ~Increased amount of subrogation recoveries = \$1,000,0
- ~Number of cases with a successful garnishment of PFD annually = 12
- ~Average amount collected by garnishing PFD = \$850
- ~Annual amount collected by garnishing PFD = \$10.2

**MINORS APPLYING FOR MEDICAID**

Currently, any adult may apply on behalf of a minor and minors may apply for themselves. Section 7, subsections (j) and (k) provide that only an adult who has a legal or vested interest may apply for Medicaid on behalf of a child under age 18. The department must make reasonable efforts to contact the parent or legal guardian before granting a waiver of consent. If a waiver of consent is granted, the department must document the reason for the waiver in the child's medical assistance record. Under this provision, some applicants will not be eligible because either the adult refuses to enroll the minor or the additional income makes the minor ineligible.

Annual savings to Medicaid: \$334.4

Assumptions:

- ~Number of minor children who apply themselves for Medicaid each year = 3800
- ~1% would be ineligible because the parent/guardian refuses to enroll = 38 minors
- ~1% would be ineligible because the parent/guardian's income exceeds the income limits = 38 minors
- ~Average annual cost per minor = \$4,400

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

**ENROLLMENT IN MEDICARE**

Currently, enrollment in Medicare is optional for medical assistance applicants. Section 7, subsection (1) requires that a person who is eligible must first enroll in the Medicare program before they are eligible to receive benefits through Medicaid. In June, 2005, the Centers for Medicare and Medicaid Services (CMS) informally revised its policy and now allows states to require Medicare enrollment as a condition of eligibility for those who qualify for it. Most, but not all, seniors have enrolled in Medicare and adding this requirement would help the department maximize the 100% federal dollars available from Medicare for all Medicare eligible recipients. Medicare Part A would pay for some of the most expensive individual cases, including those with end-stage renal disease. Medicaid would continue to pay the premiums and co-payments for the lowest income Medicare recipients.

Annual savings to Medicaid: \$9,540.0

**Assumptions:**

- ~On average, 1800 individuals per year appear eligible for, and not enrolled in Medicare
- ~Total Average annual Medicaid benefits costs avoided per Medicare enrollee = \$6,500.00
- ~Annual amount of Medicaid benefit costs saved by requiring Medicare enrollment = \$11,700.0  
( $\$6,500 \times 1,800$ )
- ~Savings are offset somewhat by the additional cost of premiums for Medicare recipients
- ~Weighted average monthly premium amount for Medicare = \$100 or \$1,200.00 p/year
- ~Increased annual costs for premium buy-in of persons required to enroll in Medicare = \$2,160.0  
( $\$1,200.00 \times 1800$ )

**Other Assumptions:**

~The bill takes effect July 1, 2006; however, implementation would be delayed until the 4th Quarter while waiting for approval of a Medicaid State Plan Amendment. For this reason FY2007 is 25% of a full year's costs.

~The federal matching rate is the estimated SFY quarterly average FMAP for the applicable year: FY07=57.58%, FY08=53.22%, FY09=50.44%; FY10 to FY12=50.00%.

~The other sections of this bill do not need a fiscal note in this component.

# FISCAL NOTE

REPORTED OUT  
MAY 05 2006  
SENATE FINANCE COMMITTEE

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

Fiscal Note Number: 5  
 Bill Version: CSHB 426(HES)  
 ( H ) Publish Date: 4/12/06  
 Dept. Affected: Health & Social Services

Revision Date/Time (Note if correction):

Title: RELATING TO MEDICAL ASSISTANCE  
ELIGIBILITY AND COVERAGE FOR PERSONS RDU Health Care Services  
UNDER 21  
 Component: Medical Assistance Admin.

Sponsor: COGHILL  
 Requester: HOUSE (FIN) Component No. 242

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual	190.3	190.3	190.3	190.3	190.3	190.3
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
<b>TOTAL OPERATING</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>
<b>CAPITAL EXPENDITURES</b>						
<b>CHANGE IN REVENUES (0)</b>						

**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts	95.2	95.2	95.2	95.2	95.2	95.2
1003 GF Match	95.1	95.1	95.1	95.1	95.1	95.1
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
<b>TOTAL</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>	<b>190.3</b>

Estimate of any current year (FY2006) cost: \_\_\_\_\_  
 Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

**POSITIONS**

Full-time						
Part-time						
Temporary						

**ANALYSIS:** *(Attach a separate page if necessary)*

This bill contains provisions that would help to ensure repayment to the Medicaid program for cases involving Medicaid recipients receiving settlements or judgments from third party payers.

The requirements contained in this bill will result in more subrogation cases and increased recoveries for the Medicaid program. This bill will increase the caseload for Department of Law employees working in the subrogation area.

Prepared by: Dwayne Peoples, Director Phone: 465-5830  
 Division: Health Care Services Date/Time: 04/12/2006  
 Approved by: Karleen Jackson, Commissioner Date: 04/12/2006  
 Agency: Department of Health and Social Services

COMMITTEE COPY

STATE OF ALASKA  
2006 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

**SUBROGATION AND RECOVERIES**

Sections 1-5 and 9-10 of this bill requires insurers to coordinate benefits with other insurers (including Medicaid); clarifies that the department may take the role of the recipient when the department has paid medical claims on behalf of the recipient and the recipient may be in a position to recover funds that are partially attributable to the injury and medical care received; clarifies that the Department may take the place of the recipient and pursue recovery if the recipient chooses not to pursue a liable 3rd party ; requires that the state be notified of cases and settlements from third party payers; and provides the state the ability to attach Permanent Fund dividends of recipients in cases where the state is not notified of a Medicaid recipient's recovery and has no other recourse to recover amounts paid.

These provisions will increase the caseload for Department of Law employees working in the subrogation area. Health Care Services currently has an RSA with the Department of Law for subrogation work. Health Care Services would expand the RSA by \$190.3 for additional Department of Law staff of 1 FTE attorney and 1 FTE law office assistant. With the additional staff, the Department of Law estimates subrogation recoveries could easily double.

Assumptions:

- Subrogation caseload doubles from \$1M per year to \$2M
  
- The bill takes effect July 1, 2006. The Department of Law intends to staff the new positions in July.
  
- The federal matching rate is 50%.
  
- The other sections of this bill will not substantially increase the workload and do not need a fiscal note in this component.

1 OF ANY ACTION OR CLAIM AGAINST A THIRD-PARTY PAYOR IF  
 2 MEDICAL ASSISTANCE WAS PROVIDED BY THE DEPARTMENT TO TREAT  
 3 AN INJURY OR ILLNESS FOR WHICH THE THIRD PARTY MAY BE LIABLE.]

4 Notwithstanding the assertion of any action or claim by the recipient of medical  
 5 assistance, the department may bring an action in the superior court against an alleged  
 6 third-party payor to recover an amount subrogated to the department for medical  
 7 assistance provided on behalf of a recipient.

8 \* **Sec. 3.** AS 47.05 is amended by adding new sections to read:

9 **Sec. 47.05.071. Duty of a medical assistance recipient.** (a) A medical  
 10 assistance recipient shall cooperate with and assist the department in identifying and  
 11 providing information concerning third parties who may be liable to pay for care and  
 12 services received by the recipient under the medical assistance program.

13 (b) A medical assistance recipient may not compromise or resolve an action or  
 14 claim seeking payment for or related to an injury or illness for which care or services  
 15 were provided or received under the medical assistance program against an insurer,  
 16 entity, or other person without first providing notice to the attorney general's office of  
 17 the facts and circumstances giving rise to the action or claim and the asserted basis for  
 18 supporting the action or claim.

19 (c) A medical assistance recipient may not receive payment from any source  
 20 on account of or related to care or services for which medical assistance was received  
 21 unless the recipient has received written consent of the attorney general's office and  
 22 has paid the department reimbursement of the amount of medical assistance provided  
 23 or paid.

24 (d) As a condition of medical assistance eligibility, a person who applies for  
 25 medical assistance shall, at the time of application,

26 (1) assign to the department the applicant's rights of payment for care  
 27 and services from any third party;

28 (2) cooperate with and assist the department in identifying and  
 29 providing information concerning third parties who may be liable to pay for care and  
 30 services received by the recipient under the medical assistance program;

31 (3) assign to the department the applicant's right to the applicant's

1 permanent fund dividend and agree to sign a new assignment each year; the  
2 department shall use the assignment obtained under this paragraph to obtain  
3 reimbursement or enforce repayment when a recipient does not pay to the state  
4 reimbursement received from a third party for care or services provided or paid by the  
5 medical assistance program or fails to satisfy a lien perfected under AS 47.05.075; and

6 (4) agree to make application for all other available third-party  
7 resources that may be used to provide or pay for the cost of care or services received  
8 by the medical assistance recipient or that may be used to finance reimbursement to  
9 the state for the cost of care or services received by the medical assistance recipient.

10 **Sec. 47.05.072. Duty of attorney for medical assistance recipient.** (a) An  
11 attorney representing a medical assistance recipient shall notify the attorney general's  
12 office.

13 (b) The notice to the attorney general's office required under (a) of this section  
14 includes submission of the following:

15 (1) identification of the medical assistance recipient's name, last  
16 known address, and telephone number, and the date of the injury or illness giving rise  
17 to the action or claim;

18 (2) copies of the pleadings and other papers related to the action or  
19 claim;

20 (3) the identification of each potentially liable third party, including  
21 that party's name, last known address, and telephone number;

22 (4) the identification of any insurance policy potentially responsive to  
23 the action or claim; and

24 (5) a description of the facts and circumstances supporting the action  
25 or claim.

26 (c) An attorney who represents a medical assistance recipient shall give the  
27 attorney general's office 30 days' notice before any judgment, award, or settlement  
28 may be satisfied in an action or claim by the medical assistance recipient to recover  
29 damages for an injury or illness that has resulted in the department's providing or  
30 paying for medical assistance.

31 (d) Except for payments under AS 23.30, an attorney representing a medical

1 assistance waivers; and

2 (3) the annual assessment must find that the recipient's condition has  
3 materially improved since the previous assessment; for purposes of this paragraph,  
4 "materially improved" means that a recipient who has previously qualified for a  
5 waiver for

6 (A) a child with complex medical conditions, no longer needs  
7 technical assistance for a life-threatening condition, and is expected to be  
8 placed in a skilled nursing facility for less than 30 days each year;

9 (B) mental retardation or developmental disability, no longer  
10 needs the level of care provided by an intermediate care facility for the  
11 mentally retarded either because the qualifying diagnosis has changed or the  
12 recipient is able to demonstrate the ability to function in a home setting without  
13 the need for waiver services; or

14 (C) an older Alaskan or adult with a physical disability, no  
15 longer has a functional limitation or cognitive impairment that would result in  
16 the need for nursing home placement, and is able to demonstrate the ability to  
17 function in a home setting without the need for waiver services.

18 ~~\* Sec. 9. AS 47.05.070(e) is repealed.~~

19 \* Sec. 10. The uncodified law of the State of Alaska is amended by adding a new section to  
20 read:

21 APPLICABILITY. Sections 2 - 4 of this Act apply to a cause of action related to a  
22 subrogation, assignment, or lien by the Department of Health and Social Services that accrues  
23 on or after the effective date of this Act.

24 \* Sec. 11. The uncodified law of the State of Alaska is amended by adding a new section to  
25 read:

26 REPORT. The Department of Health and Social Services shall prepare a report and  
27 deliver the report to the legislature not later than the first day of the First Regular Session of  
28 the Twenty-Fifth Alaska State Legislature. The report must include recommendations for  
29 statutory, regulatory, and systematic changes that will

30 (1) assist the department in reducing medical assistance expenditures for  
31 services received in mental health treatment facilities located in the state and outside the state,

1 including community mental health facilities, residential psychiatric treatment centers, and  
 2 substance abuse treatment facilities;

3 (2) enhance and clarify parental financial responsibility for children receiving  
 4 services provided by mental health treatment facilities located in the state and outside the  
 5 state, including community mental health facilities, residential psychiatric treatment centers,  
 6 and substance abuse treatment facilities; and

7 (3) maximize all third-party resources available to pay for the cost of services  
 8 provided by mental health treatment facilities located in the state and outside the state,  
 9 including community mental health facilities, residential psychiatric treatment centers, and  
 10 substance abuse treatment facilities, before a provider seeks reimbursement under AS 47.07.

11 \* Sec. 12. The uncodified law of the State of Alaska is amended by adding a new section to  
 12 read:

13 TRANSITION: REGULATIONS FOR HOME AND COMMUNITY-BASED  
 14 SERVICES. To the extent that regulations on home and community-based services that are in  
 15 effect on the effective date of sec. 8 of this Act are not inconsistent with the language and  
 16 purposes of sec. 8 of this Act, those regulations remain in effect as valid regulations  
 17 implementing sec. 8 of this Act.

18 \* Sec. 13. The uncodified law of the State of Alaska is amended by adding a new section to  
 19 read:

20 STATE PLAN. (a) The Department of Health and Social Services shall immediately  
 21 apply for federal approval of a revised state plan to implement the changes to the medical  
 22 assistance program made under secs. 1 - 7 and 9 of this Act.

23 (b) The commissioner of health and social services shall notify the revisor of statutes  
 24 of the date of the federal approval of the revised state plan submitted under (a) of this section.

25 \* Sec. 14. Sections 8 and 12 of this Act take effect immediately under AS 01.10.070(e).

26 \* Sec. 15. Section 1 of this Act takes effect July 1, 2007.

27 \* Sec. 16. Except as provided in secs. 14 and 15 of this Act, this Act takes effect July 1,  
 28 2006, or on the date of notification under sec. 13 of this Act of federal approval of a revised  
 29 state plan for medical assistance coverage incorporating the changes made by secs. 1 - 7 and 9  
 30 of this Act, whichever is later.

SENATE FINANCE  
COMMITTEE  
Amendment # #1  
To Bill Number: HB 426  
Sponsor: Green  
Date: 5/3/06 Logged by: Mindy

not offered

24-LS1602C.1  
Mischel  
5/3/06

AMENDMENT

OFFERED IN THE SENATE  
TO: SCS CS HB 426(HES)

by Sen. Green

- 1 Page 5, lines 19 - 21:
- 2 Delete all material.
- 3
- 4 Reletter the following subsections accordingly.
- 5
- 6 Page 5, line 22, following "payment":
- 7 Insert "for medical costs"
- 8
- 9 Page 5, line 24:
- 10 Delete "full"
- 11
- 12 Page 6, lines 4 - 6:
- 13 Delete all material.
- 14
- 15 Reletter the following subsections accordingly.
- 16
- 17 Page 6, line 14:
- 18 Delete "(a) - (g)"
- 19 Insert "(a) - (e)"

Adopted

SENATE FINANCE  
COMMITTEE  
Amendment # # 2  
To Bill Number: HB 426  
Sponsor: Green  
Date: 5/5/06 Logged by: Robin

24-LS1602C.2  
Mischel  
5/5/06

AMENDMENT

OFFERED IN THE SENATE

TO: SCS CSHB 426(HES)

1 Page 2, line 26:

2 Delete "If"

3 Insert "When [IF]"

4

5 Page 2, lines 27 - 30:

6 Delete "the rights of the recipient of that medical assistance for any claim arising from  
7 the injury or illness and to the proceeds of an insurance policy covering the injury or illness to  
8 the extent of the value of the medical assistance provided. ["

9 Insert "not more than the part of an insurance payment or other recovery by the  
10 recipient that is for medical expenses provided by the department [THE RIGHTS OF  
11 THE RECIPIENT OF THAT MEDICAL ASSISTANCE FOR ANY CLAIM ARISING  
12 FROM THE INJURY OR ILLNESS AND TO THE PROCEEDS OF AN INSURANCE  
13 POLICY COVERING THE INJURY OR ILLNESS TO THE EXTENT OF THE VALUE OF  
14 THE MEDICAL ASSISTANCE PROVIDED."

15

16 Page 3, line 3:

17 Delete ".]"

18 Insert "]."

19

20 Page 3, lines 13 - 23:

21 Delete all material.

22

23 Reletter the following subsection accordingly.

1

2 Page 3, line 27, following "party":

3 Insert "to the extent the department has paid medical assistance for care and services"

4

5 Page 3, line 30, following "program;":

6 Insert "and"

7

8 Page 3 line 31, through page 4, line 5:

9 Delete all material.

10

11 Renumber the following paragraph accordingly.

12

13 Page 4, line 28:

14 Delete "may be"

15 Insert "is"

16

17 Page 4, line 31, through page 5, line 10:

18 Delete all material.

19

20 Reletter the following subsection accordingly.

21

22 Page 5, lines 15 - 21:

23 Delete all material.

24 Insert "lien."

25

26 Reletter the following subsections accordingly.

27

28 Page 5, line 22, following "payment":

29 Insert "for medical costs"

30

31 Page 5, line 24:

- 1 Delete "full"
- 2
- 3 Page 5, line 31:
- 4 Delete "ful"
- 5
- 6 Page 6, lines 4 - 10:
- 7 Delete all material.
- 8
- 9 Reletter the following subsections accordingly.
- 10
- 11 Page 6, line 11, following "discharge":
- 12 Delete "or give written consent related to"
- 13
- 14 Page 6, line 12:
- 15 Delete "or consent"
- 16
- 17 Page 6, line 14:
- 18 Delete "(a) - (g)"
- 19 Insert "(a) - (c)"
- 20
- 21 Page 10, line 25:
- 22 Delete "and 12"
- 23 Insert ". 12, and 13"

# LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES  
LEGISLATIVE AFFAIRS AGENCY  
STATE OF ALASKA

(907) 465-3867 or 465-2450  
FAX (907) 465-2029  
Mail Stop 3101

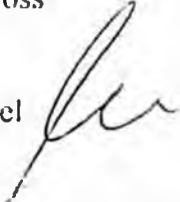
State Capitol  
Juneau, Alaska 99801-1182  
Deliveries to: 129 6th St., Rm. 329

## MEMORANDUM

May 5, 2006

**SUBJECT:** SCS CSHB 426 (HES) (Work Order No. 24-LS1602C.2)

**TO:** Representative John Coghill Jr.  
Attn: Rynniewa Moss

**FROM:** Jean M. Mischel  
Legislative Counsel 

Attached is the amendment you requested for SCS CSHB 426(HES). As we discussed by telephone, these changes are being made after discussions with Stacie Kraly of the Department of Law and reviewing the recent United States Supreme Court Decision, *Arkansas v. Ahlborn*, 547 U.S. \_\_\_ (5/1/06). You have directed me to preserve as much of the Department of Law's subrogation rights as possible while complying with federal law.

I have made one significant change to the draft faxed by Ms. Kraly in order to preserve the notice provision before a settlement or judgment is entered. At page 4, lines 26 through 30 of version C of the bill, I have retained subsection (c) in this amendment with one change: I have deleted "may be" and replaced it with "is" to avoid the circumstance of mandating a delay by the court in entering a judgment or approving a settlement on a third party claim. The goal, I think, in section 3 of the bill is to provide an opportunity for the department to enforce its lien on a judgment or settlement without unilaterally controlling the outcome of a case involving a medical assistance recipient. This change should better accomplish that.

If I may be of further assistance, please advise.

JMM:lmb  
06-163.lmb

Enclosure

Adopted  
SENATE FINANCE  
COMMITTEE  
Amendment # # 3  
To Bill Number: HB 426  
Sponsor: Green  
Date: 5/6/00 Logged by Mindy

SENATE FINANCE COMMITTEE

AMENDMENT No. 3

By Sen. Green

To: SCS CS HB ~~SENATE BILL~~ No. 426 (HEs)

To: \_\_\_\_\_ SENATE BILL No. \_\_\_\_\_

pg. 5, line 31:  
delete: (1)

pg. 6, line 3:

delete: (2) obtaining the  
express written consent of the  
attorney general.

SENATE FINANCE  
COMMITTEE  
Amendment # #4  
To Bill Number: HB 426  
Sponsor: Green  
Date: 5/1/00 logged by: Mindy

AMENDMENT # 4

24-LS1602\C  
Adopted

OFFERED IN THE SENATE FINANCE BY SENATOR Green

TO: SCS CSHB 426(HES)

- 1 Page 4, line 9, after the words "medical assistance recipient.":
- 2 Insert:
- 3 A medical assistance recipient is under no duty to file a civil or other<sup>s</sup> action in
- 4 Order to reimburse the state for the cost of care or services.

SENATE FINANCE  
COMMITTEE #5  
Amendment # #5  
To Bill Number: HB 426  
Sponsor: Green  
Date: 5/5/06 Logged by: Mindy

24-LS1602C

AMENDMENT # 5

OFFERED IN THE SENATE FINANCE

BY SENATOR Green

TO: SCS CS HB 426(HES)

- 1 Page 4, line 27:
- 2 Delete:
- 3 "30 days notice before"
- 4 Insert:
- 5 Notice within 30 days of
- 6
- 7 Page 4, line 28:
- 8 Delete:
- 9 "may be satisfied"

1 assistance recipient who has received care or services for the injury or illness provided  
2 or paid for by the medical assistance program shall maintain any lump sum settlement  
3 or judgment paid in connection with the action or claim in a trust account or deposit  
4 the proceeds into the registry of the court until any lien perfected by the department  
5 under AS 47.05.075 is satisfied or, if a lien has not been filed under AS 47.05.075, 60  
6 days from the attorney's receipt of the proceeds.

7 (e) An attorney who fails to comply with this section is not entitled to the pro  
8 rata reduction under AS 47.05.070(c). If the attorney has already received payment for  
9 the attorney's services through the pro rata reduction as provided in AS 47.05.070(c),  
10 the attorney is civilly liable to the department for the amount of that payment.

11 (f) If a medical assistance recipient is handling the action or claim on a pro se  
12 basis, the provisions of this section apply as if the medical assistance recipient were an  
13 attorney representing the medical assistance recipient.

14 **Sec. 47.05.073. Judgment, award, or settlement of a medical assistance**  
15 **lien.** (a) An action or claim brought by a medical assistance recipient or an attorney  
16 who represents the medical assistance recipient against a third party or insurer may not  
17 be compromised or discharged without the express written consent of the attorney  
18 general.

19 (b) A judgment, award, or settlement that requires or results in the  
20 compromise of a lien under AS 47.05.075 may not be entered into or granted by a  
21 court without the express written consent of the attorney general.

22 (c) A medical assistance recipient may not maintain any rights to payment as a  
23 result of a judgment, award, or settlement of an action or claim for which another  
24 person may be legally obligated to pay without first making full repayment to the  
25 department for costs of past medical assistance services provided to or paid for by the  
26 medical assistance recipient that relate to that action or claim.

27 (d) A medical assistance recipient may not place any payment as a result of a  
28 judgment, award, or settlement of an action or claim for which another person was  
29 legally obligated to pay because of injury or illness into any trust for the purpose of  
30 maintaining public assistance or medical assistance eligibility without first

31 (1) making ~~full~~ repayment to the department for costs of past medical

1 assistance services provided to the medical assistance recipient related to that action or  
2 claim; and

3 (2) obtaining the express written consent of the attorney general.

4 (e) The department's recovery under a subrogation right, assignment, or  
5 enforcement of a lien shall be applied to the entire payment made in satisfaction of  
6 judgment, award, or settlement.

7 (f) The doctrine of equitable subrogation, the equitable made whole doctrine,  
8 or the common fund doctrine may not be applied to defeat, reduce, limit, or prorate  
9 any recovery by the department based upon its subrogation rights, assignment, or lien,  
10 or the medical assistance recipient's obligation of repayment.

11 (g) The attorney general may only discharge or give written consent related to  
12 a medical assistance lien under AS 47.05.075 if the discharge or consent complies  
13 with federal law.

14 (h) Notwithstanding (a) - (g) of this section, a third-party payor shall have no  
15 further liability if it settles or compromises a dispute in good faith and without  
16 knowledge that the individual is a recipient of medical assistance.

17 **Sec. 47.05.074. Conflict with federal requirements.** If any provision of this  
18 chapter related to subrogation, assignment, or lien conflicts with federal law  
19 concerning the Medicaid program or receipt of federal money to finance the medical  
20 assistance program, the provision does not apply to the extent of the conflict.

21 \* **Sec. 4.** AS 47.05.075(d) is amended to read:

22 (d) A perfected lien under this section has priority over all other liens except  
23 tax liens and a lien perfected for attorney fees and costs [IMMEDIATELY AFTER  
24 A LIEN PERFECTED BY A HOSPITAL, NURSE, OR PHYSICIAN UNDER  
25 AS 34.35.450 - 34.35.480].

26 \* **Sec. 5.** AS 47.05.080(a) is amended to read:

27 (a) Benefit overpayments collected by the department in administering  
28 programs under AS 47.07 (medical assistance), AS 47.25.120 - 47.25.300 (general  
29 relief), AS 47.25.430 - 47.25.615 (adult public assistance), AS 47.25.975 - 47.25.990  
30 (food stamps), and 47.27 (Alaska temporary assistance program) shall be remitted to  
31 the Department of Revenue under AS 37.10.050(a), except for overpayments



Official Business

# Alaska State Senate

## Senate Finance Committee

Mail Stop 3100  
State Capitol  
Juneau, Alaska 99801-1182

### FAX COVER SHEET

DATE: 5 May 2006 TIME: 6:35 pm

TO: Legal Services

NUMBER OF PAGES, INCLUDING COVER SHEET: 2

FROM: MINDY ROWLAND  
SENATE FINANCE COMMITTEE SECRETARY  
PHONE: 465-4935  
FAX: 465-2187

NOTES: Final Please

SCS CS HB 426 (FIN) 24-LS1602\C

plus 5 amendments:

\C.2

and Amendments #3, #4, #5 & #6

attached

Thanks  
Mindy

SENATE CS FOR CS FOR HOUSE BILL NO. 426(FIN)  
IN THE LEGISLATURE OF THE STATE OF ALASKA  
TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

Offered:  
Referred:

Sponsor(s): REPRESENTATIVES COGHILL, Gardner

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to cooperation of insurers with the Department of Health and Social  
2 Services; relating to subrogation, assignment, and lien rights and notices for medical  
3 assistance claims; relating to recovery of medical assistance overpayments; relating to  
4 asset transfers and income diversion by medical assistance applicants; relating to assets  
5 and Medicare enrollment as they affect medical assistance coverage; relating to home  
6 and community-based services; relating to medical assistance applications for persons  
7 under 21 years of age; requiring a report by the Department of Health and Social  
8 Services; and providing for an effective date."

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

10 \* Section 1. AS 21.09 is amended by adding a new section to read:

11           Sec. 21.09.240. Cooperation with the Department of Health and Social  
12           Services. An insurer, including a pharmacy benefits manager, with respect to medical

1 assistance programs under AS 47.07, shall cooperate with the Department of Health  
2 and Social Services to

3 (1) provide, with respect to an individual who is eligible for or is  
4 provided medical assistance under AS 47.07, on the request of the department,  
5 information to determine during what period the individual or the individual's spouse  
6 or dependents may be or may have been covered by the insurer and the nature of the  
7 coverage that is or was provided by the insurer, including the name and address of the  
8 insurer and the identifying number of the health care insurance plan;

9 (2) accept the department's right of recovery and the assignment to the  
10 department of any right of an individual or other entity to payment from the party for  
11 an item or service for which payment has been made under AS 47.07;

12 (3) respond to any inquiry by the department regarding a claim for  
13 payment for any health care item or service that is submitted not later than three years  
14 after the date of the provision of the health care item or service; and

15 (4) agree not to deny a claim submitted by the department solely on the  
16 basis of the date of submission of the claim, the type or format of the claim form, or a  
17 failure to present proper documentation at the point-of-sale that is the basis of the  
18 claim if

19 (A) the claim is submitted by the department within the three-  
20 year period beginning on the date on which the item or service was furnished;  
21 and

22 (B) any action by the department to enforce its rights with  
23 respect to the claim is commenced within six years after the department's  
24 submission of the claim.

25 \* Sec. 2. AS 47.05.070(b) is amended to read:

26 (b) When [IF] the department provides or pays for medical assistance for  
27 injury or illness under this title, the department is subrogated to not more than the  
28 part of an insurance payment or other recovery by the recipient that is for  
29 medical expenses provided by the department. [THE RIGHTS OF THE  
30 RECIPIENT OF THAT MEDICAL ASSISTANCE FOR ANY CLAIM ARISING  
31 FROM THE INJURY OR ILLNESS AND TO THE PROCEEDS OF AN

Amendment  
#2

1 INSURANCE POLICY COVERING THE INJURY OR ILLNESS TO THE #2  
2 EXTENT OF THE VALUE OF THE MEDICAL ASSISTANCE PROVIDED. A  
3 RECIPIENT OF MEDICAL ASSISTANCE OR THE RECIPIENT'S ATTORNEY  
4 MUST NOTIFY THE DEPARTMENT IN WRITING OF ANY ACTION OR  
5 CLAIM AGAINST A THIRD-PARTY PAYOR IF MEDICAL ASSISTANCE WAS  
6 PROVIDED BY THE DEPARTMENT TO TREAT AN INJURY OR ILLNESS FOR  
7 WHICH THE THIRD PARTY MAY BE LIABLE.] Notwithstanding the assertion of  
8 any action or claim by the recipient of medical assistance, the department may bring  
9 an action in the superior court against an alleged third-party payor to recover an  
10 amount subrogated to the department for medical assistance provided on behalf of a  
11 recipient.

12 \* Sec. 3. AS 47.05 is amended by adding new sections to read:

13 Sec. 47.05.071. Duty of a medical assistance recipient. (a) A medical  
14 assistance recipient shall cooperate with and assist the department in identifying and  
15 providing information concerning third parties who may be liable to pay for care and  
16 services received by the recipient under the medical assistance program.

17 [(b) A medical assistance recipient...]

18 (b) As a condition of medical assistance eligibility, a person who applies for  
19 medical assistance shall, at the time of application,

20 (1) assign to the department the applicant's rights to payment for care  
21 and services from any third party to the extent the department has paid medical  
22 assistance for care and services;

23 (2) cooperate with and assist the department in identifying and  
24 providing information concerning third parties who may be liable to pay for care and  
25 services received by the recipient under the medical assistance program; and

26 [(3) assign to the department...]

27 (3) agree to make application for all other available third-party  
28 resources that may be used to provide or pay for the cost of care or services received  
29 by the medical assistance recipient or that may be used to finance reimbursement to  
30 the state for the cost of care or services received by the medical assistance recipient; a  
31 medical assistance recipient is under no duty to file a civil or other action for the  
purpose of reimbursing the state for the cost of care or services.

Sec. 47.05.072. Duty of attorney for medical assistance recipient. (a) An

1 attorney representing a medical assistance recipient shall notify the attorney general's  
2 office.

3 (b) The notice to the attorney general's office required under (a) of this section  
4 includes submission of the following:

5 (1) identification of the medical assistance recipient's name, last  
6 known address, and telephone number, and the date of the injury or illness giving rise  
7 to the action or claim;

8 (2) copies of the pleadings and other papers related to the action or  
9 claim;

10 (3) the identification of each potentially liable third party, including  
11 that party's name, last known address, and telephone number;

12 (4) the identification of any insurance policy potentially responsive to  
13 the action or claim; and

14 (5) a description of the facts and circumstances supporting the action  
15 or claim.

16 (c) An attorney who represents a medical assistance recipient shall give the  
17 attorney general's office notice within 30 days of any judgment, award, or settlement,  
18 in an action or claim by the medical assistance recipient to recover damages for an  
19 injury or illness that has resulted in the department's providing or paying for medical  
20 assistance.

21 ~~(d) If a medical assistance recipient is handling the action or claim on a pro se~~  
22 basis, the provisions of this section apply as if the medical assistance recipient were an  
23 attorney representing the medical assistance recipient.

24 ~~Sec. 47.05.073. Judgment, award, or settlement of a medical assistance~~  
25 ~~lien. (a) A medical assistance recipient may not maintain any rights to payment for~~  
26 ~~medical costs as a result of a judgment, award, or settlement of an action or claim for~~  
27 ~~which another person may be legally obligated to pay without first making~~ [Full]  
28 ~~repayment to the department for costs of past medical assistance services provided to or paid for~~  
29 ~~by the medical assistance recipient that relate to that action or claim.~~

30 (b) A medical assistance recipient may not place any payment as a result of a  
31 judgment, award, or settlement of an action or claim for which another person was

#5  
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#2

legally obligated to pay because of injury or illness into any trust for the purpose of maintaining public assistance or medical assistance eligibility without first <sup>[(1)]</sup> making <sup>#3</sup> repayment to the department for costs of past medical assistance services provided to <sup>#2, #6</sup> the medical assistance recipient related to that action or claim. <sup>#3</sup> <sup>[(2) obtaining the...]</sup> <sup>#2</sup> <sup>[(e) The department's recovery... (f) The doctrine of...]</sup> (c) The attorney general may only discharge a medical assistance lien under <sup>#2</sup> AS 47.05.075 if the discharge <sup>[or consent]</sup> complies with federal law. <sup>[or give written consent]</sup> <sup>#2</sup>

(d) Notwithstanding (a) - (c) of this section, a third-party payor shall have no further liability if it settles or compromises a dispute in good faith and without knowledge that the individual is a recipient of medical assistance.

Sec. 47.05.074. Conflict with federal requirements. If any provision of this chapter related to subrogation, assignment, or lien conflicts with federal law concerning the Medicaid program or receipt of federal money to finance the medical assistance program, the provision does not apply to the extent of the conflict.

\* Sec. 4. AS 47.05.075(d) is amended to read:

(d) A perfected lien under this section has priority over all other liens except tax liens and a lien perfected for attorney fees and costs [IMMEDIATELY AFTER A LIEN PERFECTED BY A HOSPITAL, NURSE, OR PHYSICIAN UNDER AS 34.35.450 - 34.35.480].

\* Sec. 5. AS 47.05.080(a) is amended to read:

(a) Benefit overpayments collected by the department in administering programs under AS 47.07 (medical assistance), AS 47.25.120 - 47.25.300 (general relief), AS 47.25.430 - 47.25.615 (adult public assistance), AS 47.25.975 - 47.25.990 (food stamps), and 47.27 (Alaska temporary assistance program) shall be remitted to the Department of Revenue under AS 37.10.050(a), except for overpayments recovered under AS 47.07 that cover the value of services paid from federal sources.

\* Sec. 6. AS 47.07.020(f) is amended to read:

(f) A person may not be denied eligibility for medical assistance under this chapter on the basis of a diversion of income or transfer of assets, whether by assignment or after receipt of the income, into a Medicaid-qualifying trust or annuity that, according to a determination made by the department.

1 (1) has provisions that require that the state will receive all of the trust  
 2 or annuity assets remaining at the death of the individual, subject to a maximum  
 3 amount that equals the total medical assistance paid on behalf of the individual; and

4 (2) otherwise meets the requirements of 42 U.S.C. 1396p(d)(4) for a  
 5 trust and 42 U.S.C. 1396p(c)(1)(F) and 42 U.S.C.1396p(e)(1) for an annuity.

6 \* Sec. 7. AS 47.07.020 is amended by adding new subsections to read:

7 (j) A person may not apply for medical assistance coverage on behalf of a  
 8 child under 18 years of age who is not emancipated unless the person is the parent or  
 9 legal guardian of the child or, if the parent or legal guardian can be contacted and  
 10 consents to the application and the person is

11 (1) an adult caretaker relative who lives with the child and who is  
 12 exercising care and control of the child; or

13 (2) an employee of the department who is applying on behalf of a child  
 14 who is in the custody of the department.

15 (k) A child who is unemancipated may apply for medical assistance coverage  
 16 on the child's own behalf if the parent or legal guardian of the child consents to the  
 17 application. The department may waive consent under this section if the child  
 18 expresses a reasonable fear of the child's parent or legal guardian or the department  
 19 has been unable to contact the parent or legal guardian after the department has made  
 20 reasonable efforts to do so. If a waiver of consent is granted, the department shall  
 21 document the reason for the waiver in the child's medical assistance record.

22 (l) Notwithstanding the eligibility provisions under (a) and (b) of this section,  
 23 a person may not receive medical assistance under this section unless the person first  
 24 enrolls in the Medicare program under 42 U.S.C. 1395 to the extent that the person is  
 25 eligible to receive benefits and services under the program.

26 (m) Except as provided in (g) of this section, the department shall impose a  
 27 penalty period of ineligibility for the transfer of an asset for less than fair market value  
 28 by an applicant or an applicant's spouse consistent with 42 U.S.C. 1396p(c)(1).

29 (n) Except as provided under 42 U.S.C. 1396p(f) and 42 U.S.C. 1396u-1, the  
 30 department shall include as an asset for eligibility purposes the value of an applicant's  
 31 home if the equity value in the home exceeds \$500,000 at the time the application is

1 completed. Nothing in this subsection prohibits an applicant from reducing the equity  
2 value in the applicant's home by selling the home or by taking out a loan that affects  
3 the equity.

4 \* Sec. 8. AS 47.07 is amended by adding a new section to read:

5 **Sec. 47.07.045. Home and community-based services.** (a) The department  
6 may provide home and community-based services under a waiver in accordance with  
7 42 U.S.C. 1396 - 1396p (Title XIX, Social Security Act), this chapter, and regulations  
8 adopted under this chapter, if the department has received approval from the federal  
9 government and the department has appropriations allocated for the purpose. To  
10 supplement the standards in (b) of this section, the department shall establish in  
11 regulation additional standards for eligibility and payment for the services.

12 (b) Before the department may terminate payment for services provided under  
13 (a) of this section,

14 (1) the recipient must have had an annual assessment to determine  
15 whether the recipient continues to meet the standards under (a) of this section;

16 (2) the annual assessment must have been reviewed by an independent  
17 qualified health care professional under contract with the department; for purposes of  
18 this paragraph, "independent qualified health care professional" means,

19 (A) for a waiver based on mental retardation or developmental  
20 disability, a person who is qualified under 42 CFR 483.430 as a mental  
21 retardation professional;

22 (B) for other allowable waivers, a registered nurse licensed  
23 under AS 08.68 who is qualified to assess children with complex medical  
24 conditions, older Alaskans, and adults with physical disabilities for medical  
25 assistance waivers; and

26 (3) the annual assessment must find that the recipient's condition has  
27 materially improved since the previous assessment; for purposes of this paragraph,  
28 "materially improved" means that a recipient who has previously qualified for a  
29 waiver for

30 (A) a child with complex medical conditions, no longer needs  
31 technical assistance for a life-threatening condition, and is expected to be

1 placed in a skilled nursing facility for less than 30 days each year:

2 (B) mental retardation or developmental disability, no longer  
3 needs the level of care provided by an intermediate care facility for the  
4 mentally retarded either because the qualifying diagnosis has changed or the  
5 recipient is able to demonstrate the ability to function in a home setting without  
6 the need for waiver services; or

7 (C) an older Alaskan or adult with a physical disability, no  
8 longer has a functional limitation or cognitive impairment that would result in  
9 the need for nursing home placement, and is able to demonstrate the ability to  
10 function in a home setting without the need for waiver services.

11 \* Sec. 9. AS 47.05.070(e) is repealed.

12 \* Sec. 10. The uncodified law of the State of Alaska is amended by adding a new section to  
13 read:

14 APPLICABILITY. Sections 2 - 4 of this Act apply to a cause of action related to a  
15 subrogation, assignment, or lien by the Department of Health and Social Services that accrues  
16 on or after the effective date of this Act.

17 \* Sec. 11. The uncodified law of the State of Alaska is amended by adding a new section to  
18 read:

19 REPORT. The Department of Health and Social Services shall prepare a report and  
20 deliver the report to the legislature not later than the first day of the First Regular Session of  
21 the Twenty-Fifth Alaska State Legislature. The report must include recommendations for  
22 statutory, regulatory, and systematic changes that will

23 (1) assist the Department in reducing medical assistance expenditures for  
24 services received in mental health treatment facilities located in the state and outside the state,  
25 including community mental health facilities, residential psychiatric treatment centers, and  
26 substance abuse treatment facilities;

27 (2) enhance and clarify parental financial responsibility for children receiving  
28 services provided by mental health treatment facilities located in the state and outside the  
29 state, including community mental health facilities, residential psychiatric treatment centers,  
30 and substance abuse treatment facilities; and

31 (3) maximize all third-party resources available to pay for the cost of services

1 provided by mental health treatment facilities located in the state and outside the state,  
2 including community mental health facilities, residential psychiatric treatment centers, and  
3 substance abuse treatment facilities, before a provider seeks reimbursement under AS 47.07.

4 \* Sec. 12. The uncodified law of the State of Alaska is amended by adding a new section to  
5 read:

6 TRANSITION: REGULATIONS FOR HOME AND COMMUNITY-BASED  
7 SERVICES. To the extent that regulations on home and community-based services that are in  
8 effect on the effective date of sec. 8 of this Act are not inconsistent with the language and  
9 purposes of sec. 8 of this Act, those regulations remain in effect as valid regulations  
10 implementing sec. 8 of this Act.

11 \* Sec. 13. The uncodified law of the State of Alaska is amended by adding a new section to  
12 read:

13 STATE PLAN. (a) The Department of Health and Social Services shall immediately  
14 apply for federal approval of a revised state plan to implement the changes to the medical  
15 assistance program made under secs. 1 - 7 and 9 of this Act.

16 (b) The commissioner of health and social services shall notify the revisor of statutes  
17 of the date of the federal approval of the revised state plan submitted under (a) of this section.

18 \* Sec. 14. Sections 8, 12, and 13 of this Act take effect immediately under AS 01.10.070(c). #2

19 \* Sec. 15. Section 1 of this Act takes effect July 1, 2007.

20 \* Sec. 16. Except as provided in secs. 14 and 15 of this Act, this Act takes effect July 1,  
21 2006, or on the date of notification under sec. 13 of this Act of federal approval of a revised  
22 state plan for medical assistance coverage incorporating the changes made by secs. 1 - 7 and 9  
23 of this Act, whichever is later.

SCS CS HB 426 MEDICAL ASSISTANCE/INS COOPERATION

5/02/2006 version SCS CSHB 426(HES) HB04026E

Fiscal Note Summary by Section

		FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	Assumptions
<i>Dollars in thousands</i>	% Federal	57.58%	53.22%	50.44%	50.00%	50.00%	50.00%	Federal % is Title XIX SFY average FMAP.
<b>Total All</b>	Total	(\$2,575.9)	(\$10,924.9)	(\$11,009.9)	(\$11,009.9)	(\$11,009.9)	(\$11,009.9)	Effective date of bill is July 1, 2006. Savings begin FY07 Q4 waiting for new regulations and approved SPA, plus normal lag in billing delays except for Law RSA.
	Federal	(\$1,501.6)	(\$5,826.2)	(\$5,555.1)	(\$5,504.9)	(\$5,504.9)	(\$5,504.9)	
	GF Match	(\$1,074.2)	(\$5,098.7)	(\$5,454.8)	(\$5,505.0)	(\$5,505.0)	(\$5,505.0)	
<b>Sections 1-4, 9-10.</b>	Total	(\$59.7)	(\$809.7)	(\$809.7)	(\$809.7)	(\$809.7)	(\$809.7)	amt projected in 2005=\$1,000.0; recoveries increase=\$1,000.0. HCS admin costs for Dept Law RSA=\$190.3 @ 50% FMAP.
Subrogation of medical assistance overpayments	Federal	(\$48.8)	(\$437.1)	(\$409.3)	(\$404.8)	(\$404.8)	(\$404.8)	
	GF Match	(\$10.9)	(\$372.7)	(\$400.5)	(\$404.9)	(\$404.9)	(\$404.9)	
<b>Section 5.</b>	Total	(\$2.6)	(\$10.2)	(\$10.2)	(\$10.2)	(\$10.2)	(\$10.2)	# cases garnish PFD=12; avg amt collected=\$850.
Garnish Permanent Fund Dividend	Federal	(\$1.5)	(\$5.4)	(\$5.1)	(\$5.1)	(\$5.1)	(\$5.1)	
	GF Match	(\$1.1)	(\$4.8)	(\$5.1)	(\$5.1)	(\$5.1)	(\$5.1)	
<b>Section 6.</b>	Total	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	cost avoidance: not budgeted so no fiscal impact
Medicaid-qualifying annuities and transfer of assets	Federal	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	
	GF Match	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	
<b>Section 7, subsection (j-k).</b>	Total	(\$52.5)	(\$223.7)	(\$223.7)	(\$223.7)	(\$223.7)	(\$223.7)	# self-enrolled < age 19=3800; 1% ineligible w/ parent's income=38; 1% parents refuse=38; avg annual cost per enrollee=\$4,400; DPA admin 1.5 FTE = \$110.6 @ 50% FMAP.
Parent or legal guardian must submit the application for a person under age 18	Federal	(\$32.6)	(\$122.7)	(\$113.4)	(\$111.9)	(\$111.9)	(\$111.9)	
	GF Match	(\$19.9)	(\$101.0)	(\$110.3)	(\$111.8)	(\$111.8)	(\$111.8)	
<b>Section 7, subsection (l).</b>	Total	(\$2,378.0)	(\$9,466.3)	(\$9,466.3)	(\$9,466.3)	(\$9,466.3)	(\$9,466.3)	est. 15.7% age 65+ eligible but not enrolled in Medicare=1800; avg annual cost avoided per enrollee=\$6,500; est wt avg mo premium for buy-in=\$100. DPA admin 1 FTE= \$73.7 @ 50% FMAP.
Must enroll in Medicare if eligible	Federal	(\$1,370.9)	(\$5,040.2)	(\$4,775.1)	(\$4,733.1)	(\$4,733.1)	(\$4,733.1)	
	GF Match	(\$1,007.1)	(\$4,426.1)	(\$4,691.2)	(\$4,733.2)	(\$4,733.2)	(\$4,733.2)	
<b>Section 7, subsection (m).</b>	Total	(\$20.6)	(\$165.0)	(\$250.0)	(\$250.0)	(\$250.0)	(\$250.0)	# penalties in past 6 mos=6; avg months penalized: 5; avg annual cost per OA waiver enrollee=\$50,000; ramp up savings over 3 years
Penalty period for transfer of assets at less than fair market value (DRA 2006)	Federal	(\$11.9)	(\$87.8)	(\$126.1)	(\$125.0)	(\$125.0)	(\$125.0)	
	GF Match	(\$8.7)	(\$77.2)	(\$123.9)	(\$125.0)	(\$125.0)	(\$125.0)	
<b>Section 7, subsection (n).</b>	Total	(\$62.5)	(\$250.0)	(\$250.0)	(\$250.0)	(\$250.0)	(\$250.0)	# LTC recipients with \$500K home=0; est # enrollees=5; avg annual cost per OA waiver enrollee=\$50,000
Homes exceeding \$500K are resource for Medicaid eligibility	Federal	(\$36.0)	(\$133.1)	(\$126.1)	(\$125.0)	(\$125.0)	(\$125.0)	
	GF Match	(\$26.5)	(\$117.0)	(\$123.9)	(\$125.0)	(\$125.0)	(\$125.0)	
<b>Section 8</b>	Total	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	cost avoidance: not budgeted so no fiscal impact
Terminating waiver services if "materially improved"	Federal	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	
	GF Match	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	
<b>Section 11</b>	Total	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	DBH admin costs for report=\$0 if BTKH Project Mgr is funded in SFY07 budget
Report on RPTC changes recommended by DHSS	Federal	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	
	GF Match	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	



Representative John Coghill  
State Capitol, Room 204  
Juneau, AK 99801-1182

### HB 426 Medical Assistance Eligibility Sponsor Statement

In times when federal dollars are diminishing, the legislature will have to review policies for providing for the public health. To better provide medical assistance to the truly needy, some eligibility requirements need to be changed.

As the department has put it, we are trying to address the "low hanging apples" that drain millions of dollars a year from a program that is growing in astounding increments.

HB 426 puts best practices to use by increasing third-party reimbursement, reducing Medicaid abuse and fraud, setting home equity limits, and implementing new federal requirements on the State for asset transfers and treating annuities like a Miller's Trust.

This bill also requires a person applying for medical assistance for a minor to be that person's parent or legal guardian, unless the parent or legal guardian is a minor. If a child is in state custody, an employee of the department can apply for coverage. The HSS committee substitute provides a waiver for unemancipated children who express fear of a parent or guardian, or whose parent or legal guardian cannot be located after a reasonable effort to do so by the department.

Currently, the unmarried father's income and resources are not considered in determining the eligibility of a pregnant woman for Medicaid. While the new CS eliminates income guidelines for unmarried fathers, we are exploring other ways to make the unmarried father financially responsible for the medical costs of a child.

HB 426 legislation repeals a statute that allowed the department to waive subrogation rights to third party reimbursements in cases of undue hardship. The department will now be required to pursue all third party reimbursements.

Section 8 of the bill addresses a lawsuit filed against the state, which would require the State to determine the medical condition of a client on a Medicaid Waiver had "materially improved" before removing the client from the waiver. HB 426 adds that requirement to Alaska Statute.

Lastly, this bill directs the department to report back to the legislature no later than the first day of the Twenty-Fifth Legislature on ways to reduce medical assistance expenditures for services received in mental health treatment facilities including community mental health facilities, residential psychiatric treatment centers, and substance abuse treatment, enhancing parental financial responsibilities and maximizing third-party resources available. Under current law a child could be placed in residential treatment and qualify for medical assistance after being out of the family home for thirty days, even though one or both parents have medical insurance.

# ALASKA STATE HOUSE OF REPRESENTATIVES

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Session

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## REPRESENTATIVE JOHN COGHILL

### SCS CSHB 426(HES) Medical Assistance Eligibility

Sectional for Version C

**Section 1:** This section requires insurers, upon request of the department, to coordinate benefits, provide information on their covered population, provide for a three-year timely filing limit for the Medicaid program, and enforcement of rights to claim must be exercised within six years of the claim.

Medicaid often bills other insurance for claims paid by the program when other insurance is found to exist for the recipient. A common problem has been short timely filing requirements by other insurance, which has resulted in a failure to recover the claim.

**Section 2:** This section clarifies that if the department has paid medical claims on behalf of the recipient and the recipient may be in position to recover funds, which are partially attributable to the injury and medical care received, the Department can act on behalf of the recipient to recover funds even when the recipients does not pursue a liable third-party.

**Section 3:** A common problem has been that settlements will occur without the department's knowledge and recovery against recipients or their attorney after the fact is near impossible. This section requires not only the recipient, but also the recipient's attorney, to notify the department of any case or action, which may involve the recovery of payments made, by the department on behalf of the recipient.

In subsection (d) we have amended an attorney's requirement to maintain a court registry of all proceeds in a trust and now require lump sum settlements or judgments to be noticed in the court registry.

It also provides for remedies when the law is not followed. A lawyer will be held civilly liable for not notifying the department of recovery actions.

Another provision of this section requires the Attorney General to sign off on any settlement that involves a recipient of medical assistance requiring past medical expenses paid by the department in a case that results in a settlement to be reimbursed.

Finally, AS 47.05.07 disqualifies any new provision of the law related to subrogation, assignment, or lien conflicts contrary to federal law.

**Section 4.** This section creates a priority for liens that places the State's claims from Medicaid reimbursements over all other liens except tax liens, child support, and attorneys fees and costs. This gives a preference to the Medicaid claims over health care providers who would otherwise collect from Medicaid and leave it to the State to get reimbursement.

**Section 5.** Benefit overpayments occur under several circumstances. One situation would be someone is found guilty of program abuse or fraud. The department would seek repayment. Another would be a person's coverage is discontinued and that person requests a fair hearing. Benefits continue until the fair hearing occurs. If the fair hearing finds in favor of the State, the department can seek repayment of those benefits provided during the period of time between notice of discontinuance and the fair hearing.

This section adds medical assistance to the list of programs for which the department may garnish a recipient's PFD in order to secure reimbursement for an overpayment. The state paid portion of the overpayment goes to the Dept. of Revenue, the federal portion to the federal government.

**Section 6.** The section brings Alaska Statute in line with the Deficit Reduction Act of 2005 in regards to transfer of assets and annuities. It allows person to transfer assets into a Miller Trust and treats annuities like a Miller Trust. This allows them to qualify for medical assistance without having to sell resources or gives them the option of selling large resources and invest the proceeds in an annuity. The income from the annuity is counted as income in determining eligibility, but the annuity is not counted as a resource. When assets are transferred or an annuity is established, the applicant agrees to grant the State a claim to the assets remaining at the death of the individual to reimburse the total medical assistance paid on behalf of the individual.

**Section 7.** Subsection (j) limits who may apply for Medicaid coverage for a person under 18 years of age. Only a parent or legal guardian, an adult caretaker relative who lives with the child, or an employee of the department who is applying for a child in state custody can apply for Medicaid coverage for the child.

(k) Allows the department to waive the parental consent requirement for applying for medical assistance when the parents cannot be located.

(l) Requires Medicare enrollment for senior citizens and certain individuals with disabilities before they can qualify for benefits and services under the Medicaid program. The department believes this change will maximize the 100% federal dollars available from Medicare.

(m) When a person transfers an asset for less than fair market value, the State can impose a penalty period beginning only with the date of the less than fair market value transfer. This provision will allow the penalty period to start with the date of application for Medicaid.

(n) This covers another provision of the Deficit Reduction Act of 2005. Generally, a home is an exempt resource. The provision puts a limit on the value of a home at \$500,000 to still qualify for this exemption.

**Section 8.** This section addresses two lawsuits that have been filed against the state in which the judge said the state must show proof a client has "materially improved" and, in the case of older Alaskans or adults with a physical disability, be able to demonstrate the ability of the client to function in a home setting without the need for waiver services, before waiver services can be denied in the assessment process. Contrary to testimony that this undermines the court's decision, this section places in statute the judges' decision.

**Section 9.** Section 9 repeals a subsection of AS 47.05.070 that allows the department to waive subrogation rights to all or part of the amount of medical assistance paid on behalf of a recipient of medical assistance in cases of undue hardship. The State would be mandated to pursue third party reimbursement.

**Section 10.** Sections 2 - 4 of HB 426 would apply to a cause of action related to subrogation, assignment, or lien by DISS on or after the effective date.

**Section 11.** This section addresses concerns Representative Coghill has about the State paying for residential psychiatric treatment and substance abuse treatment for minors whose parents have medical insurance coverage. In discussing the issue with the department it became apparent the problem is not easily solved.

This section directs the department to review the authorization process with private insurance carriers and how they differ from the assessment process of the department. They are instructed to report back to the legislature no later than the first day of the next regular legislative session on how to maximize third-party coverage, enhance and clarify parental financial responsibility, and reduce medical assistance expenditures for mental health treatment facilities including community mental health facilities, residential psychiatric treatment centers, and substance abuse treatment.

**Section 12.** Transition language that makes the regulation in effect on the effective date of section 8 that are not inconsistent with section 8 remain in effect.

**Section 13.** Directs the department to, on enactment of HB 426, to apply for federal approval of a revised state plan reflecting the changes made in the bill.

**Section 14.** Section 8, the "materially improved" provision, and Section 12, transitional regulations, have an immediate effective date.

**Section 15.** Section 1 effective date of July 1, 2007. This amendment was made in Senate HESS on the advice given that the federal Budget Deficit Reduction Act had a delayed effective date of July 1, 2007. However, the delayed effective date was for legislatures that had not passed legislation to enact the federal provisions or are not holding a legislative session this year.

**Section 16.** The effective date of all sections but 1, 8, and 12 will be July 1, 2006 or when the federal government approves the revised state plan, whichever is later.

# LEGAL SERVICES

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## MEMORANDUM

May 2, 2006

**SUBJECT:** Separation of powers and court rule changes issues  
(SCS CSHB 426(HES), Work Order No. 24-LS1602C)

**TO:** Senator Fred Dyson, Chair  
Senate Health, Education and Social Services Committee

**FROM:** Jean M. Mischel  
Legislative Counsel 

Attached is the CS for the Senate HESS committee as requested. In reviewing the bill as a whole, I note that a provision added by the bill but not amended in the Senate HESS committee suffers from constitutional and title problems as follows.

Section 47.05.073(b) states:

A judgment, award, or settlement that requires or results in the compromise of a lien under AS 47.05.075 may not be entered into or granted by a court without the express written consent of the attorney general.

AS 47.05.075 authorizes a recipient of medical assistance services to compromise a lien owed by a third-party payor by settlement or judgment.

The Alaska Supreme Court has recognized a "separation of powers doctrine" (*Bradner v. Hammond*, 553 P.2d 1, 5-6 (Alaska 1976)) and has applied the doctrine in a variety of circumstances, including circumscribing interference with the discretion of the judicial branch. When an act is committed to judicial discretion, the exercise of that discretion within constitutional bounds is not subject to the control or review of the executive branch and interference with that discretion would be a violation by the executive branch of the doctrine of separation of powers.

In addition, it seems to me that adding the attorney general's consent as a precondition to a court judgment and award on a medical assistance lien at least indirectly affects Civil Rules 55 through 58, necessitating a title change and 2/3 vote of the legislature.

If I may be of further assistance, please advise.

JMM:lmb  
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"(v) \$60,000,000 for fiscal year 2010 and each fiscal year thereafter."

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(e) **DELAYED EFFECTIVE DATE FOR CHAPTER.**—Except as otherwise provided in this chapter, in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this chapter, the State plan shall not be regarded as failing to comply with the requirements of such Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

**SEC. 603G. ENHANCING THIRD PARTY IDENTIFICATION AND PAYMENT.**

(a) **CLARIFICATION OF THIRD PARTIES LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR SERVICE.**—Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1395a(a)(25)) is amended—

(1) in subparagraph (A), in the matter preceding clause

(i)—

(A) by inserting ", self-insured plans" after "health insurers"; and

(B) by striking "and health maintenance organizations" and inserting "managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service"; and

(2) in subparagraph (G)—

(A) by inserting "a self-insured plan," after "1974," and

(B) by striking "and a health maintenance organization" and inserting "a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service".

(b) **REQUIREMENT FOR THIRD PARTIES TO PROVIDE THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS DATA.**—Section 1902(a)(25) of such Act (42 U.S.C. 1395a(a)(25)) is amended—

(1) in subparagraph (G), by striking "and" at the end;

(2) in subparagraph (H), by adding "and" after the semicolon at the end; and

(3) by inserting after subparagraph (H), the following:

"(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

Opinion of the Court

NOTICE: This opinion is subject to formal revision before publication in the preliminary print of the United States Reports. Readers are requested to notify the Reporter of Decisions, Supreme Court of the United States, Washington, D. C. 20543, of any typographical or other formal errors, in order that corrections may be made before the preliminary print goes to press.

**SUPREME COURT OF THE UNITED STATES**

No. 04-1506

**ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS v. HEIDI AHLBORN**

**ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT**

[May 1, 2006]

JUSTICE STEVENS delivered the opinion of the Court.

When a Medicaid recipient in Arkansas obtains a tort settlement following payment of medical costs on her behalf by Medicaid, Arkansas law automatically imposes a lien on the settlement in an amount equal to Medicaid's costs. When that amount exceeds the portion of the settlement that represents medical costs, satisfaction of the State's lien requires payment out of proceeds meant to compensate the recipient for damages distinct from medical costs—like pain and suffering, lost wages, and loss of future earnings. The Court of Appeals for the Eighth Circuit held that this statutory lien contravened federal law and was therefore unenforceable. *Ahlborn v. Arkansas Dept. of Human Servs.*, 397 F. 3d 620 (2005). Other courts have upheld similar lien provisions. See, e.g., *Houghton v. Dept. of Health*, 2002 UT 101, 57 P. 3d 1067; *Wilson v. Washington*, 142 Wash. 2d 40, 10 P. 3d 1061 (2000) (en banc). We granted certiorari to resolve the conflict, 545 U. S. \_\_\_\_ (2005), and now affirm.

I

On January 2, 1996, respondent Heidi Ahlborn, then a

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19-year-old college student and aspiring teacher, suffered severe and permanent injuries as a result of a car accident. She was left brain damaged, unable to complete her college education, and incapable of pursuing her chosen career. Although she possessed a claim of uncertain value against the alleged tortfeasors who caused her injuries, Ahlborn's liquid assets were insufficient to pay for her medical care. Petitioner Arkansas Department of Health Services (ADHS) accordingly determined that she was eligible for medical assistance and paid providers \$215,645.30 on her behalf under the State's Medicaid plan.

ADHS required Ahlborn to complete a questionnaire about her accident, and sent her attorney periodic letters advising him about Medicaid outlays. These letters noted that, under Arkansas law, ADHS had a claim to reimbursement from "any settlement, judgment, or award" obtained by Ahlborn from "a third party who may be liable for" her injuries, and that no settlement "shall be satisfied without first giving [ADHS] notice and a reasonable opportunity to establish its interest."<sup>1</sup> ADHS has never asserted, however, that Ahlborn has a duty to reimburse it out of any other subsequently acquired assets or earnings.

On April 11, 1997, Ahlborn filed suit against two alleged tortfeasors in Arkansas state court seeking compensation for the injuries she sustained in the January 1996 car accident. She claimed damages not only for past medical costs, but also for permanent physical injury; future medical expenses; past and future pain, suffering, and mental anguish; past loss of earnings and working time; and permanent impairment of the ability to earn in the future.

ADHS was neither named as a party nor formally notified of the suit. Ahlborn's counsel did, however, keep ADHS informed of details concerning insurance coverage

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<sup>1</sup>Affidavit of Wayne E. Olive, Exhs. 5 and 6 (Mar. 6, 2003).

## Opinion of the Court

as they became known during the litigation.

In February 1998, ADHS intervened in Ahlborn's lawsuit to assert a lien on the proceeds of any third-party recovery Ahlborn might obtain. In October 1998, ADHS asked Ahlborn's counsel to notify the agency if there was a hearing in the case. No hearing apparently occurred, and the case was settled out of court sometime in 2002 for a total of \$550,000. The parties did not allocate the settlement between categories of damages. ADHS did not participate or ask to participate in settlement negotiations. Nor did it seek to reopen the judgment after the case had been dismissed. ADHS did, however, assert a lien against the settlement proceeds in the amount of \$215,645.30—the total cost of payments made by ADHS for Ahlborn's care.

On September 30, 2002, Ahlborn filed this action in the United States District Court for the Eastern District of Arkansas seeking a declaration that the lien violated the federal Medicaid laws insofar as its satisfaction would require depletion of compensation for injuries other than past medical expenses. To facilitate the District Court's resolution of the legal questions presented, the parties stipulated that Ahlborn's entire claim was reasonably valued at \$3,040,708.18; that the settlement amounted to approximately one-sixth of that sum; and that, if Ahlborn's construction of federal law was correct, ADHS would be entitled to only the portion of the settlement (\$35,581.47) that constituted reimbursement for medical payments made. See App. 17–20.

Ruling on cross-motions for summary judgment, the District Court held that under Arkansas law, which it concluded did not conflict with federal law, Ahlborn had assigned to ADHS her right to any recovery from the third-party tortfeasors to the full extent of Medicaid's payments for her benefit. Accordingly, ADHS was entitled to a lien in the amount of \$215,645.30.

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The Eighth Circuit reversed. It held that ADHS was entitled only to that portion of the judgment that represented payments for medical care. For the reasons that follow, we affirm.

II

The crux of the parties' dispute lies in their competing constructions of the federal Medicaid laws. The Medicaid program, which provides joint federal and state funding of medical care for individuals who cannot afford to pay their own medical costs, was launched in 1965 with the enactment of Title XIX of the Social Security Act (SSA), as added 79 Stat. 343, 42 U. S. C. §1396 *et seq.* (2000 ed. and Supp. III). Its administration is entrusted to the Secretary of Health and Human Services (HHS), who in turn exercises his authority through the Centers for Medicare and Medicaid Services (CMS).<sup>2</sup>

States are not required to participate in Medicaid, but all of them do. The program is a cooperative one; the Federal Government pays between 50% and 83% of the costs the State incurs for patient care,<sup>3</sup> and, in return, the State pays its portion of the costs and complies with certain statutory requirements for making eligibility determinations, collecting and maintaining information, and administering the program. See §1396a.

One such requirement is that the state agency in charge of Medicaid (here, ADHS) "take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan." §1396a(a)(25)(A) (2000 ed.).<sup>4</sup> The agency's obligation

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<sup>2</sup>Until 2001, CMS was known as the Health Care Financing Administration or HCFA. See 66 Fed. Reg. 35437.

<sup>3</sup>The exact percentage of the federal contribution is calculated pursuant to a formula keyed to each State's per capita income. See 42 U. S. C. §1396d(b).

<sup>4</sup>A "third party" is defined by regulation as "any individual, entity or

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extends beyond mere identification, however;

“in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability.” §1396a(a)(25)(B).

To facilitate its reimbursement from liable third parties, the State must,

“to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, [have] in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services.” §1396a(a)(25)(H).

The obligation to enact assignment laws is reiterated in another provision of the SSA, which reads as follows:

“(a) For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the State plan approved under this subchapter, a State plan for medical assistance shall—

“(1) provide that, as a condition of eligibility for medical assistance under the State plan to an indi-

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program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.” 42 CFR §433.136 (2005).

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vidual who has the legal capacity to execute an assignment for himself, the individual is required—

“(A) to assign the State any rights . . . to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party;

“(B) to cooperate with the State . . . in obtaining support and payments (described in paragraph (A)) for himself . . . ; and

“(C) 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 available under the plan . . . .” §1396k(a).

Finally, “any amount collected by the State under an assignment made” as described above “shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of” the Medicaid recipient. §1396k(b). “[T]he remainder of such amount collected shall be paid” to the recipient. *Ibid.*

Acting pursuant to its understanding of these third-party liability provisions, the State of Arkansas passed laws that purport to allow both ADHS and the Medicaid recipient, either independently or together, to recover “the cost of benefits” from third parties. Ark. Code Ann. §§20-77-301 through 20-77-309 (2001). Initially, “[a]s a condition of eligibility” for Medicaid, an applicant “shall automatically assign his or her right to any settlement, judgment, or award which may be obtained against any third party to [ADHS] to the full extent of any amount which may be paid by Medicaid for the benefit of the applicant.” §20-77-307(a). Accordingly, “[w]hen medical assistance benefits are provided” to the recipient “because of injury, disease, or disability for which another person is liable,” ADHS “shall have a right to recover from the person the

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cost of benefits so provided.” §20-77-301(a).<sup>5</sup> ADHS’ suit “shall” not, however, “be a bar to any action upon the claim or cause of action of the recipient.” §20-77-301(b). Indeed, the statute envisions that the recipient will sometimes sue together with ADHS, see §20-77-303, or even alone. If the latter, the assignment described in §20-77-307(a) “shall be considered a statutory lien on any settlement, judgment, or award received . . . from a third party.” §20-77-307(c); see also §20-77-302(a) (“When an action or claim is brought by a medical assistance recipient . . . , any settlement, judgment, or award obtained is subject to the division’s claim for reimbursement of the benefits provided to the recipient under the medical assistance program”).<sup>6</sup>

The State, through this statute, claims an entitlement to more than just that portion of a judgment or settlement that represents payment for medical expenses. It claims a right to recover the entirety of the costs it paid on the Medicaid recipient’s behalf. Accordingly, if, for example, a recipient sues alone and settles her entire action against a third-party tortfeasor for \$20,000, and ADHS has paid that amount or more to medical providers on her behalf, ADHS gets the whole settlement and the recipient is left with nothing. This is so even when the parties to the settlement allocate damages between medical costs, on the one hand, and other injuries like lost wages, on the other.

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<sup>5</sup>Under the Arkansas statute, ADHS’ right to recover medical costs appears to be broader than that of the recipient. When ADHS sues “no contributory or comparative fault of a recipient shall be attributed to the state, nor shall any restitution awarded to the state be denied or reduced by any amount or percentage of fault attributed to a recipient.” §20-77-301(d)(1) (2001).

<sup>6</sup>The Arkansas Supreme Court has held that ADHS has an independent, nonderivative right to recover the cost of benefits from a third-party tortfeasor under §20-77-301 even when the Medicaid recipient also sues for recovery of medical expenses. See *National Bank of Commerce v. Quirk*, 323 Ark. 769, 792-794, 918 S. W. 2d 138, 151-152 (1996).

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The same rule also would apply, it seems, if the recovery were the result not of a settlement but of a jury verdict. In that case, under the Arkansas statute, ADHS could recover the full \$20,000 in the face of a jury allocation of, say, only \$10,000 for medical expenses.<sup>7</sup>

That this is what the Arkansas statute requires has been confirmed by the State's Supreme Court. In *Arkansas Dept. of Human Servs. v. Ferrel*, 336 Ark. 297, 984 S. W. 2d 807 (1999), the court refused to endorse an equitable, nontextual interpretation of the statute. Rejecting a Medicaid recipient's argument that he ought to retain some of a settlement that was insufficient to cover both his and Medicaid's expenses, the court explained:

"Given the clear, unambiguous language of the statute, it is apparent that the legislature intended that ADHS's ability to recoup Medicaid payments from third parties or recipients not be restricted by equitable subrogation principles such as the 'made whole' rule stated in [*Franklin v. Healthsource of Arkansas*, 328 Ark. 163, 942 S. W. 2d 837 (1997)]. By creating an automatic legal assignment which expressly becomes a statutory lien, [Ark. Code Ann. §20-77-307 (1991)] makes an unequivocal statement that the ADHS's ability to recover Medicaid payments from insurance settlements, if it so chooses, is superior to that of the recipient even when the settlement does not pay all the recipient's medical costs." *Id.*, at 308, 984 S. W. 2d, at 811.

Accordingly, the Arkansas statute, if enforceable against Ahlborn, authorizes imposition of a lien on her settlement proceeds in the amount of \$215,645.30. Ahlborn's argu-

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<sup>7</sup>ADHS denies that it would actually demand the full \$20,000 in such a case, see Brief for Petitioners 49, n. 13, but points to no provision of the Arkansas statute that would prevent it from doing so.

## Opinion of the Court

ment before the District Court, the Eighth Circuit, and this Court has been that Arkansas law goes too far. We agree. Arkansas' statute finds no support in the federal third-party liability provisions, and in fact squarely conflicts with the anti-lien provision of the federal Medicaid laws.

## III

We must decide whether ADHS can lay claim to more than the portion of Ahlborn's settlement that represents medical expenses.<sup>8</sup> The text of the federal third-party liability provisions suggests not; it focuses on recovery of payments for medical care. Medicaid recipients must, as a condition of eligibility, "assign the State any rights . . . to payment for medical care from any third party," 42 U. S. C. §1396k(a) (1)(A) (emphasis added), not rights to payment for, for example, lost wages. The other statutory language that ADHS relies upon is not to the contrary; indeed, it reinforces the limitation implicit in the assignment provision.

First, ADHS points to §1396a(a)(25)(B)'s requirement that States "seek reimbursement for [medical] assistance to the extent of such legal liability" (emphasis added) and suggests that this means that the entirety of a recipient's settlement is fair game. In fact, as is evident from the context of the emphasized language, "such legal liability" refers to "the legal liability of third parties . . . to pay for care and services available under the plan." §1396a(a)(25)(A) (emphasis added). Here, the tortfeasor

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<sup>8</sup>The parties here assume, as do we, that a State can fulfill its obligations under the federal third-party liability provisions by requiring an "assignment" of part of, or placing a lien on, the settlement that a Medicaid recipient procures on her own. Cf. §§1396k(a)(B)-(C) (the recipient has a duty to identify liable third parties and to "provid[e] information to assist the State in pursuing" those parties (emphasis added)).

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has accepted liability for only one-sixth of the recipient's overall damages, and ADHS has stipulated that only \$35,581.47 of that sum represents compensation for medical expenses. Under the circumstances, the relevant "liability" extends no further than that amount.<sup>9</sup>

Second, ADHS argues that the language of §1396a(a)(25)(H) favors its view that it can demand full reimbursement of its costs from Ahlborn's settlement. That provision, which echoes the requirement of a mandatory assignment of rights in §1396k(a), says that the State must have in effect laws that, "to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual," give the State the right to recover from liable third parties. This must mean, says ADHS, that the agency's recovery is limited only by the amount it paid out on the recipient's behalf—and not by the third-party tortfeasor's particular liability for medical expenses. But that reading ignores the rest of the provision, which makes clear that the State must be assigned "the rights of [the recipient] to payment by any other party *for such health care items or services.*" §1396a(a)(25)(H) (emphasis added). Again, the statute does not sanction an assignment of rights to payment for anything other than medical expenses—not lost wages, not pain and suffering, not an inheritance.

Finally, ADHS points to the provision requiring that, where the State actively pursues recovery from the third party, Medicaid be reimbursed fully from "any amount collected by the State under an assignment" before "the remainder of such amount collected" is remitted to the recipient. §1396k(b). In ADHS' view, this shows that the

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<sup>9</sup>The effect of the stipulation is the same as if a trial judge had found that Ahlborn's damages amounted to \$3,040,708.12 (of which \$215,645.30 were for medical expenses), but because of her contributory negligence, she could only recover one-sixth of those damages.



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State must be paid in full from any settlement. See Brief for Petitioners 13. But, even assuming the provision applies in cases where the State does not actively participate in the litigation, ADHS' conclusion rests on a false premise: The "amount recovered . . . under an assignment" is not, as ADHS assumes, the entire settlement; as explained above, under the federal statute the State's assigned rights extend only to recovery of payments for medical care. Accordingly, what §1396k(b) requires is that the State be paid first out of any damages representing payments for medical care before the recipient can recover any of her own costs for medical care.<sup>10</sup>

At the very least, then, 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.<sup>11</sup> They did not mandate

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<sup>10</sup> Implicit in ADHS' interpretation of this provision is the assumption that there can be no "remainder" to remit to the Medicaid recipient if all the State has been assigned is the right to damages for medical expenses. That view in turn seems to rest on an assumption either that Medicaid will have paid all the recipient's medical expenses or that Medicaid's expenses will always exceed the portion of any third-party recovery earmarked for medical expenses. Neither assumption holds up. First, as both the Solicitor General and CMS acknowledge, the recipient often will have paid medical expenses out of her own pocket. See Brief for United States as *Amicus Curiae* 12 (under §1396k(b), "the beneficiary retains the right to payment for any additional medical expenses personally incurred either before or subsequent to Medicaid eligibility and for other damages"); CMS, State Medicaid Manual §3907 (last modified Sept. 16, 2005) (envisioning that "medical insurance payments," for example, will be remitted to the recipient if possible). Second, even if Medicaid's outlays often exceed the portion of the recovery earmarked for medical expenses in tort cases, the third-party liability provisions were not drafted exclusively with tort settlements in mind. In the case of health insurance, for example, the funds available under the policy may be enough to cover both Medicaid's costs and the recipient's own medical expenses.

<sup>11</sup> ADHS concedes that, had a jury or judge allocated a sum for medical payments out of a larger award in this case, the agency would be

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the enactment of the Arkansas scheme that we have described.

IV

If there were no other relevant provisions in the federal statute, the State might plausibly argue that federal law supplied a recovery "floor" upon which States were free to build. In fact, though, the federal statute places express limits on the State's powers to pursue recovery of funds it paid on the recipient's behalf. These limitations are contained in 42 U. S. C. §§1396a(a)(18) and 1396p. Section 1396a(a)(18) requires that a State Medicaid plan comply with §1396p, which in turn prohibits States (except in circumstances not relevant here) from placing liens against, or seeking recovery of benefits paid from, a Medicaid recipient:

"(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

"(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

"(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

"(B) [in certain circumstances not relevant here]

.....

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entitled to reimburse itself only from the portion so allocated. See Brief for Petitioners 49, n. 13; see also Brief for United States as *Amicus Curiae* 22, n. 14 (noting that the Secretary of HHS "ordinarily accepts" a jury allocation of medical damages in satisfaction of the Medicaid debt, even where smaller than the amount of Medicaid's expenses). Given the stipulation between ADH&S and Ahlborn, there is no textual basis for treating the settlement *in rem* differently from a judge-allocated settlement or even a jury award; all such awards typically establish a third party's "liability" for both "payment for medical care" and other heads of damages.

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“(b) Adjustment or recovery of medical assistance correctly paid under a State plan

“(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except [in circumstances not relevant here].” §1396p.

Read literally and in isolation, the anti-lien prohibition contained in §1396p(a) would appear to ban even a lien on that portion of the settlement proceeds that represents payments for medical care.<sup>12</sup> Ahlborn does not ask us to go so far, though; she assumes that the State’s lien is consistent with federal law insofar as it encumbers proceeds designated as payments for medical care. Her argument, rather, is that the anti-lien provision precludes attachment or encumbrance of the remainder of the settlement.

We agree. There is no question that the State can require an assignment of the right, or chose in action, to receive payments for medical care. So much is expressly provided for by §§1396a(a)(25) and 1396k(a). And we assume, as do the parties, that the State can also demand as a condition of Medicaid eligibility that the recipient “assign” in advance any payments that may constitute reimbursement for medical costs. To the extent that the forced assignment is expressly authorized by the terms of §§1396a(a)(25) and 1396k(a), it is an exception to the anti-

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<sup>12</sup>Likewise, subsection (b) would appear to forestall any attempt by the State to recover benefits paid, at least from the “individual.” See, e.g., *Martin ex rel. Hoff v. Rochester*, 642 N.W. 2d 1, 8, n. 6 (Minn. 2002); *Wallace v. Estate of Jackson*, 972 P.2d 446, 450 (Utah 1998) (Durham, J. dissenting) (reading §1396p to “prohibit[] not only liens against Medicaid recipients but also any recovery for medical assistance correctly paid”). The parties here, however, neither cite nor discuss the anti-recovery provision of §1396p(b). Accordingly, we leave for another day the question of its impact on the analysis.

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lien provision. See *Washington State Dept. of Social and Health Servs. v. Guardianship Estate of Keffeler*, 537 U. S. 371, 383-385, and n. 7 (2003). But that does not mean that the State can force an assignment of, or place a lien on, any other portion of Ahlborn's property. As explained above, the exception carved out by §§1396a(a)(25) and 1396k(a) is limited to payments for medical care. Beyond that, the anti-lien provision applies.

ADHS tries to avoid the anti-lien provision by characterizing the settlement proceeds as not Ahlborn's "property."<sup>13</sup> Its argument appears to be that the automatic assignment effected by the Arkansas statute rendered the proceeds the property of the State.<sup>14</sup> See Brief for Petitioners 31 ("[U]nder Arkansas law, the lien does not attach to the recipient's 'property' because it attaches only to those proceeds already assigned to the Department as a condition of Medicaid eligibility"). That argument fails for two reasons. First, ADHS insists that Ahlborn at all times until judgment retained her entire chose in action—a right that included her claim for medical damages. The statutory lien, then, cannot have attached until the proceeds materialized. That much is clear from the text of the Arkansas statute, which says that the "assignment shall be considered a statutory lien on any settlement . . . received by the recipient from a third party." Ark. Code Ann. §20-77-307(c) (2001) (emphasis added). The settle-

<sup>13</sup>"Property" is defined by regulation as "the homestead and all other personal and real property in which the recipient has a legal interest." 42 CFR §433.36(b) (2005).

<sup>14</sup>The United States as *amicus curiae* makes the different argument that the proceeds never became Ahlborn's "property" because "to the extent the third party's payment passes through the recipient's hands en route to the State, it comes with the State's lien already attached." Brief as *Amicus Curiae* 18. Even if that reading were consistent with the Arkansas statute (and it is not, see *infra*, at 16), the United States' characterization of the "assignment" simply reinforces Ahlborn's point: This is a lien that attaches to the property of the recipient.

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ment is not "received" until the chose in action has been reduced to proceeds in Ahlborn's possession. Accordingly, the assertion that any of the proceeds belonged to the State all along lacks merit.

Second, the State's argument that Ahlborn lost her property rights in the proceeds the instant she applied for medical assistance is inconsistent with the creation of a statutory lien on those proceeds. Why, after all, would ADHS need a lien on its own property? A lien typically is imposed on the property of *another* for payment of a debt owed by that other. See Black's Law Dictionary 922 (6th ed. 1990). Nothing in the Arkansas statute defines the term otherwise.

That the lien is also called an "assignment" does not alter the analysis. The terms that Arkansas employs to describe the mechanism by which it lays claim to the settlement proceeds do not, by themselves, tell us whether the statute violates the anti-lien provision. See *United States v. Craft*, 535 U. S. 274, 279 (2002); *Drye v. United States*, 528 U. S. 49, 58–61 (1999). Although denominated an "assignment," the effect of the statute here was not to divest Ahlborn of all her property interest; instead, Ahlborn retained the right to sue for medical care payments, and the State asserted a right to the fruits of that suit once they materialized. In effect, and as at least some of the statutory language recognizes, Arkansas has imposed a lien on Ahlborn's property.<sup>15</sup> Since none of the federal

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<sup>15</sup> Because ADHS insists that "Arkansas law did *not* require Ahlborn to assign her claim or her right to sue," Brief for Petitioners 33 (emphasis in original), we need not reach the question whether a State may force a recipient to assign a chose in action to receive as much of the settlement as is necessary to pay Medicaid's costs. The Eighth Circuit thought this would be impermissible because the State cannot "circumvent the restrictions of the federal anti-lien statute simply by requiring an applicant for Medicaid benefits to assign property rights to the State before the applicant liquidates the property to a sum certain." App. to Pet. for Cert. 6. Indeed, ADHS acknowledges that Arkansas cannot, for

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third-party liability provisions excepts that lien from operation of the anti-lien provision, its imposition violates federal law.

V

ADHS and its *amici* urge, however, that even if a lien on more than medical damages would violate federal law in some cases, a rule permitting such a lien ought to apply here either because Ahlborn breached her duty to "cooperate" with ADHS or because there is an inherent danger of manipulation in cases where the parties to a tort case settle without judicial oversight or input from the State. Neither argument is persuasive.

The United States proposes a default rule of full reimbursement whenever the recipient breaches her duty to "cooperate," and asserts that Ahlborn in fact breached that duty.<sup>16</sup> But, even if the Government's allegations of obstruction were supported by the record, its conception of the duty to cooperate strays far beyond the text of the statute and the relevant regulations. The duty to cooperate arises principally, if not exclusively, in proceedings initiated by the State to recover from third parties. See 42 U. S. C. §1396k(a)(1)(C) (recipients must "cooperate with

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example, require a Medicaid applicant to assign in advance any right she may have to recover an inheritance or an award in a civil case not related to her injuries or medical care. This arguably is no different; as with assignment of those other choses in action, assignment of the right to compensation for lost wages and other nonmedical damages is nowhere authorized by the federal third-party liability provisions.

<sup>16</sup> See, e.g., Brief for United States as *Amicus Curiae* 14 (alleging that Ahlborn "omitt[ed] or understat[ed] the medical damages claim from her lawsuit and attempt[ed] to hoard for herself the third-party liability payments"); *id.*, at 15 ("[H]aving forsaken her federal and state statutory duties of candid and forthcoming cooperation . . . [Ahlborn] respondent, rather than the taxpayers, must bear the financial consequences of her actions"); *id.*, at 21, 24 (referring to Ahlborn's "backdoor settlement" and "obstruction and attrition," as well as her "calculated evasion of her legal obligations").

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the State in identifying . . . and providing information to assist the State in pursuing" third parties). Most of the accompanying federal regulations simply echo this basic duty; all they add is that the recipient must "[p]ay to the agency any support or medical care funds received that are covered by the assignment of rights." 42 CFR §433.147(b)(4) (2005).

In any event, the aspersions the United States casts upon Ahlborn are entirely unsupported; all the record reveals is that ADHS, despite having intervened in the lawsuit and asked to be apprised of any hearings, neither asked to be nor was involved in the settlement negotiations. Whatever the bounds of the duty to cooperate, there is no evidence that it was breached here.

ADHS' and the United States' alternative argument that a rule of full reimbursement is needed generally to avoid the risk of settlement manipulation is more colorable, but ultimately also unpersuasive. The issue is not, of course, squarely presented here; ADHS has stipulated that only \$35,581.47 of Ahlborn's settlement proceeds properly are designated as payments for medical costs. Even in the absence of such a post-settlement agreement, though, 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.<sup>17</sup> For just as there are risks in underestimating the value of readily calculable damages in settlement negotiations, so also is there a countervailing concern that a rule

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<sup>17</sup>As one *amicus* observes, some States have adopted special rules and procedures for allocating tort settlements in circumstances where, for example, private insurers' rights to recovery are at issue. See Brief for Association of Trial Lawyers of America 20-21. Although we express no view on the matter, we leave open the possibility that such rules and procedures might be employed to meet concerns about settlement manipulation.

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of absolute priority might preclude settlement in a large number of cases, and be unfair to the recipient in others.<sup>18</sup>

VI

Finally, ADHS contends that the Court of Appeals' decision below accords insufficient weight to two decisions by the Departmental Appeals Board of HHS (Board) rejecting appeals by the States of California and Washington from denial of reimbursement for costs those States paid on behalf of Medicaid recipients who had settled tort claims. See App. to Pet. for Cert. 45-67 (reproducing *In re Washington State Dept. of Social & Health Servs.*, Dec. No. 1561, 1996 WL 157123 (HHS Dept. App. Bd., Feb. 7, 1996)); App. to Pet. for Cert. 68-86 (reproducing *In re California Dept. of Health Servs.*, Dec. No. 1504, 1995 WL 66334 (HHS Dept. App. Bd., Jan. 5, 1995)). Because the opinions in those cases address a different question from the one posed here, make no mention of the anti-lien provision, and, in any event, rest on a questionable construction of the federal third-party liability provisions, we conclude that they do not control our analysis.

Normally, if a State recovers from a third party the cost of Medicaid benefits paid on behalf of a recipient, the Federal Government owes the State no reimbursement, and any funds already paid by the Federal Government must be returned. See 42 CFR §433.140(a)(2) (2005) (federal financial participation "is not available in Medi-

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<sup>18</sup>The point is illustrated by state cases involving the recovery of workers' compensation benefits paid to an employee (or the family of an employee) whose injuries were caused by a third-party tortfeasor. In *Flanigan v. Department of Labor and Industry*, 123 Wash. 2d 418, 869 P. 2d 14 (1994), for example, the court concluded that the state agency could not satisfy its lien out of damages the injured worker's spouse recovered as compensation for loss of consortium. The court explained that the department could not "share in damages for which it has provided no compensation" because such a result would be "absurd and fundamentally unjust." *Id.*, at 426, 869 P. 2d, at 17.

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caid payments if . . . [t]he agency received reimbursement from a liable third party"); §433.140(c). Washington and California both had adopted schemes according to which the State refrained from claiming full reimbursement from tort settlements and instead took only a portion of each settlement. (In California, the recipient typically could keep at least 50% of her settlement, see App. to Pet. for Cert. 72; in Washington, the proportion varied from case to case, see *id.*, at 48–51.) Each scheme resulted in the State's having to pay a portion of the recipient's medical costs—a portion for which the State sought partial reimbursement from the Federal Government. CMS (then called HCFA) denied this partial reimbursement on the ground that the States had an absolute duty to seek full payment of medical expenses from third-party tortfeasors.

The Board upheld CMS' determinations. In California's appeal, which came first, the Board concluded that the State's duty to seek recovery of benefits "from available third party sources to the fullest extent possible" included demanding full reimbursement from the entire proceeds of a Medicaid recipient's tort settlement. *Id.*, at 76. The Board acknowledged that §1396k(a) "refers to assignment only of 'payment for medical care,'" but thought that "the statutory scheme as a whole contemplates that the actual recovery might be greater and, if it is, that Medicaid should be paid first." *Ibid.* The Board gave two other reasons for siding with CMS: First, the legislative history of the third-party liability evinced a congressional intent that "the Medicaid program . . . be reimbursed from available third party sources to the fullest extent possible," *ibid.*; and, second, California had long been on notice that it would not be reimbursed for any shortfall resulting from failure to fully recoup Medicaid's costs from tort settlements, see *id.*, at 77. The Board also opined that the State could not escape its duty to seek full reimbursement by relying on the Medicaid recipient's efforts in litigating her

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claims. See *id.*, at 79–80.

Finally, responding to the State's argument that its scheme gave Medicaid recipients incentives to sue third-party tortfeasors and thus resulted in both greater recovery and lower costs for the State, the Board observed that "a state is free to allow recipients to retain the state's share" of any recovery, so long as it does not compromise the Federal Government's share. *Id.*, at 85.

The Board reached the same conclusion, by the same means, in the Washington case. See *id.*, at 53–64.

Neither of these adjudications compels us to conclude that Arkansas' statutory lien comports with federal law. First, the Board's rulings address a different question from the one presented here. The Board was concerned with the Federal Government's obligation to reimburse States that had, in its view, failed to seek full recovery of Medicaid's costs and had instead relied on recipients to act as private attorneys general. The Board neither discussed nor even so much as cited the federal anti-lien provision.

Second, the Board's acknowledgment that the assignment of rights required by §1396k(a) is limited to payments for medical care only reinforces the clarity of the statutory language. Moreover, its resort to "the statutory scheme as a whole" as justification for muddying that clarity is nowhere explained. Given that the only statutory provisions CMS relied on are §§1396a(a)(25), 1396k(a), and 1396k(b), see *id.*, at 75–76; *id.*, at 54–55, and given the Board's concession that the first two of these limit the State's assignment to payments for medical care, the "statutory scheme" must mean §1396k(b). But that provision does not authorize the State to demand reimbursement from portions of the settlement allocated or allocable to nonmedical damages; instead, it gives the State a priority disbursement from the medical expenses portion alone. See *supra*, at 12. In fact, in its adjudication in the Washington case, the Board conceded as much:

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"[CMS] may require a state to assert a collection priority over funds obtained by Medicaid recipients in [third-party liability] suits *even though the distribution methodology set forth in section [1396k(b)] refers only to payments collected pursuant to assignments for medical care.*" App. to Pet. for Cert. 54 (emphasis added). The Board's reasoning therefore is internally inconsistent.

Third, the Board's reliance on legislative history is misplaced. The Board properly observed that Congress, in crafting the Medicaid legislation, intended that Medicaid be a "payer of last resort." S. Rep. No. 99-146, p. 313 (1985). That does not mean, however, that Congress meant to authorize States to seek reimbursement from Medicaid recipients themselves; in fact, with the possible exception of a lien on payments for medical care, the statute expressly prohibits liens against the property of Medicaid beneficiaries. See 42 U. S. C. §1396p(a). We recognize that Congress has delegated "broad regulatory authority to the Secretary [of HHS] in the Medicaid area," *Wisconsin Dept. of Health and Family Servs. v. Blumer*, 534 U. S. 473, 496, n. 13 (2002), and that agency adjudications typically warrant deference. Here, however, the Board's reasoning couples internal inconsistency with a conscious disregard for the statutory text. Under these circumstances, we decline to treat the agency's reasoning as controlling.

## VII

Federal Medicaid law does not authorize ADHS to assert a lien on Ahlborn's settlement in an amount exceeding \$35,581.47, and the federal anti-lien provision affirmatively prohibits it from doing so. Arkansas' third-party liability provisions are unenforceable insofar as they compel a different conclusion. The judgment of the Court of Appeals is affirmed.

*It is so ordered.*

# SENATE COMMITTEE REPORT

DATE: 4/25/06

FURTHER: Finance

DATE TURNED  
IN TO OFFICE: 5.02.06

Health, Education & Social Services Committee considered CS FOR HOUSE BILL NO. 426(FIN)(title am)

## HB 426 MEDICAL ASSISTANCE FOR PERSONS UNDER 21

"An Act relating to cooperation of insurers with the Department of Health and Social Services; relating to subrogation, assignment, and lien rights and notices for medical assistance claims; relating to recovery of medical assistance overpayments; relating to asset transfers and income diversion by medical assistance applicants; relating to assets and Medicare enrollment as they affect medical assistance coverage; relating to home and community-based services; relating to medical assistance applications for persons under 21 years of age; requiring a report by the Department of Health and Social Services; and providing for an effective date."

and recommends:

- be replaced with 5 CS for CS for HB 426 (HES)
- adopt previous \_\_\_\_\_ CS \_\_\_\_\_
- attached amendment(s)
- adopt Letter of Intent by \_\_\_\_\_ Committee
- further referral to \_\_\_\_\_ Committee

<b>CS Senate Bill:</b>	
<input type="checkbox"/> Same Title	
<input type="checkbox"/> New Title	
<b>SCS House Bill:</b>	
<input checked="" type="checkbox"/> Same Title	
<input type="checkbox"/> Technical Title Change	
<input type="checkbox"/> New Title w/ SCR # _____	

**NEW FISCAL NOTE(S):**

Department	Date	Fiscal	Indet.	Zero	FN#

**PREVIOUS FISCAL NOTE(S):**

Department	Date	Fiscal	Indet.	Zero	FN#
HSS	4/12			X	1
HSS	4/12	X			2
HSS	4/12	X			3
HSS	4/12	X			4
HSS	4/12	X			5

APPROPRIATION - no fiscal note

**SIGNATURES AND RECOMMENDATIONS:**

	DO PASS	DO NOT PASS	NO REC	AMEND
Elton			✓	
Willen			✓	
Green	✓			
Olson			✓	
Dyson CHAIR:	✓			