MAINE SUPREME JUDICIAL COURT Reporter of Decisions
Decision: 2026 ME 95
Docket: And-25-479
Argued: June 2, 2026
Decided: September 1, 2026

Panel: STANFILL, C.J., and MEAD, CONNORS, LAWRENCE, DOUGLAS, and LIPEZ, JJ.

ASHLEY LYNNE

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES et al.

CONNORS, J.

[¶1] When MaineCare pays the costs of medical treatment of an injury for which a third party is liable and the MaineCare recipient settles a tort claim with the third party, the Department of Health and Human Services may recover "the cost of benefits provided" by MaineCare, but only "to the extent of the recovery for medical expenses." 22 M.R.S. § 14(1) (2026). The question presented in this appeal is how to determine the extent to which a recipient has recovered for medical expenses, and, thus, the upper limit of the Department's reimbursement, when a settlement between the recipient and the third party does not allocate damages between medical expenses and other damages. In this action between a recipient and the Department to determine the amount that the Department may recover, the Superior Court (Androscoggin County,

Archer, J.) entered summary judgment in favor of the recipient. We conclude that in order to allocate this settlement, the court must resolve disputed factual issues, and so we vacate and remand for further proceedings.

I. BACKGROUND

[¶2] The following facts are drawn from the summary judgment record and are presented in the light most favorable to the Department as the nonprevailing party. *See Lytle v. Lind*, 2026 ME 36, ¶ 2, 355 A.3d 702.

[¶3] At all relevant times, L.W., the minor plaintiff, was covered by MaineCare, Maine's Medicaid program. On April 10, 2021, L.W. suffered an injury to her arm and elbow. This injury required medical treatment, for which providers billed MaineCare $207,591.04. MaineCare ultimately paid the providers $34,078.70.

[¶4] On May 18, 2023, Lynne, L.W.'s mother, filed suit on behalf of L.W. against two third-party tortfeasors. This tort claim was valued at $375,000 in total damages, including $204,183.78 in medical bills. In October 2024, Lynne settled the claim against the third-party tortfeasors for $160,000—42.67% of $375,000.

[¶5] The Department asserted a lien against the settlement in the amount of $34,078.70, the total amount it had paid for L.W.'s treatment. That

same month, Lynne, on behalf of L.W., filed a complaint against the Department pursuant to 22 M.R.S. § 14(2-F).[1] In the complaint, Lynne alleged that the settlement "accounts for a fraction of" the "non-medical damages claim" and asserted that under *Arkansas Department of Health and Human Services v. Ahlborn*, 547 U.S. 268 (2006), the Department must reduce its lien "to the extent that" Lynne's "recovery for non-medical damages is incomplete." Lynne sought an order from the court "in accordance with the so-called '*Ahlborn* formula.'"[2]

[¶6] The Department moved for summary judgment. It accepted that the pro-rata "*Ahlborn* formula" should be applied but disagreed as to the values that the court should use for the calculation. Specifically, the Department argued

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[1] Section 14 is entitled "Action against parties liable for medical care rendered to assistance recipients; assignment of claims." Section 14(2-F) provides:

Disbursement. Except as otherwise provided in this subsection, a disbursement of any award, judgment or settlement may not be made to a recipient without the recipient or the recipient's attorney first paying to the department that amount of the award, judgment or settlement that constitutes reimbursement for medical payments made or obtaining from the department a release of any obligation owed to it for medical benefits provided to the recipient. If a dispute arises between the recipient and the commissioner as to the settlement of any claim that the commissioner may have under this section, the 3rd party or the recipient's attorney shall withhold from disbursement to the recipient an amount equal to the commissioner's claim. Either party may apply to the Superior Court or the District Court in which an action based upon the recipient's claim could have been commenced for an order to determine a reasonable amount in satisfaction of the statutory lien, consistent with federal law.

[2] The formula is

$$\frac{Total\ Value\ of\ Settlement}{Total\ Value\ of\ Claim} \times Total\ Medical\ Expenses = X$$

where X is the limit of the Department's recovery. *Cf. Ahlborn*, 547 U.S. at 274, 281 n.10.

that it was the portion of the total claim attributable to medical bills, $204,183.78, rather than the amount paid by the Department, $34,078.70, that should be reduced pro-rata, i.e., that the "Total Medical Expenses" term in the formula consisted of the billed amount. The result would be that $86,400[3] of the settlement would be attributable to medical expenses, out of which the Department could recover the full amount of its lien, $34,087.70. Under Lynne's calculation, the "total medical expenses" would include only the amount paid by the Department, so that the Department would recover $14,540.25, constituting 42.67% of $34,078.70.

[¶7] Subsequently, in the course of opposing summary judgment, Lynne took the position that because it had not been established in Maine whether the medical-expenses term in the "*Ahlborn* formula" should mean the bills charged or the sums paid, "no formula works in this case," and the court had to look at the "negotiated reasonable value of medical services," which was a factual question not resolvable on summary judgment.

[¶8] The court entered summary judgment against the Department in October 2025. *See* M.R. Civ. P. 56(c) ("Summary judgment, when appropriate,

[3] The Department rounded down the amounts in its calculations. Using the actual values from the summary judgment record, the result would be that $87,118.41 of the settlement would be attributable to medical expenses.

may be rendered against the moving party."). Consistent with the request in the complaint, the court multiplied the Department's lien by the percentage of L.W.'s total damages that she recovered in the settlement, 42.67%, using the amount actually paid by the Department as the "total medical expenses," which reduced the Department's recovery to $14,540.25, less than it paid and less than the amount of its lien.

[¶9] The Department timely appealed. *See* M.R. App. P. 2B(c)(1).

II. DISCUSSION

[¶10] We review the grant of a motion for summary judgment de novo "and consider both the evidence and any reasonable inferences that the evidence produces in the light most favorable to the party against whom the summary judgment has been granted in order to determine if there is a genuine issue of material fact. Summary judgment is properly granted when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law." *Lytle*, 2026 ME 36, ¶ 13, 355 A.3d 702 (quotation marks omitted). Although both Lynne and the Department contend that summary judgment is appropriate on this record, we "independently determine whether the record supports the conclusion that there is no genuine issue of material fact and that the prevailing party is entitled to judgment as a matter of law."

Littlebrook Airpark Condo. Ass'n v. Sweet Peas, LLC, 2019 ME 3, ¶ 12, 199 A.3d 677 (quotation marks omitted).

A. Under Maine law, when the Department pays medical costs for which a third party is responsible, it is entitled to recover from a settlement between the recipient and the third party the costs of the benefits it has paid.

[¶11] "MaineCare is a joint federal-state program that pays for medical assistance provided to individuals of limited income." *H.D. Goodall Hosp. v. Dep't of Health & Hum. Servs.*, 2008 ME 105, ¶ 2, 951 A.2d 828. Although funded primarily by the federal government, MaineCare is administered by the State of Maine. *Doane v. Dep't of Health & Hum. Servs.*, 2017 ME 193, ¶¶ 19-20, 170 A.3d 269; *see* 22 M.R.S. § 3173 (2026).

[¶12] Maine law provides for MaineCare to be reimbursed for medical costs paid to third parties on behalf of recipients of the program. 22 M.R.S. § 14(1). Specifically, "[w]hen benefits are provided or will be provided to a member under the MaineCare program . . . for the medical costs of injury . . . for which a 3rd party is, or may be, liable, the [Commissioner of Health and Human Services] may recover from that party the cost of the benefits provided." *Id.* The Department "must" be subrogated, "to the extent of any benefits provided under the MaineCare program, to any cause of action or claim that a member has against a 3rd party who is or may be liable for medical costs incurred by or

on behalf of the member." *Id*. "The receipt of benefits under the MaineCare program constitutes an assignment by the recipient" to the Department "of the right to recover from 3rd parties for the medical cost . . . for which the recipient receives medical benefits," measured by "the amount of medical benefits received by the recipient." *Id*. § 14(2-A).

[¶13] The Department need not proceed against the third-party tortfeasor in its own name. *See id.* § 14(1). Rather, the Department may recover its costs from any settlement between the recipient and the third party, and this right of recovery constitutes a statutory lien on the settlement. *See id.* ("The commissioner's right to recover the cost of benefits provided constitutes a statutory lien on the proceeds of an award or settlement from a 3rd party if recovery for MaineCare costs was or could have been included in the recipient's claim for damages from the 3rd party to the extent of the recovery for medical expenses. The commissioner is entitled to recover the cost of the benefits actually paid out . . . ."). A disbursement of a settlement to the recipient may not be made without first paying to the Department the amount of the settlement that constitutes reimbursement for the Department's payments. *Id.* § 14(2-F).

B. Federal law permits the Department to recover its costs only from the portion of a recipient's settlement allocated for medical expenses.

[¶14] The Department's right to recover from a recipient's settlement is subject to limitations imposed by federal Medicaid law. *See Gallardo v. Marstiller*, 596 U.S. 420, 424 (2022) ("States participating in Medicaid must comply with the Medicaid Act's requirements or risk losing Medicaid funding." (alteration and quotation marks omitted)). *See also* § 14(2-F) (quoted *supra* n.1) (providing that the amount in satisfaction of the statutory lien must be "consistent with federal law").

[¶15] Several conflicting provisions of the Medicaid statutes govern a state's ability to impose a statutory lien on a Medicaid recipient's tort settlement. On the one hand, federal law requires states to acquire from all Medicaid recipients assignments of "any rights . . . to payment for medical care from any third party." 42 U.S.C.A. § 1396k(a)(1)(A) (West, Westlaw through Pub. L. No. 119-102); *see also* 22 M.R.S. § 14(2-A) (requiring such an assignment). States must also (when cost-effective) seek reimbursement from third parties liable for medical costs. 42 U.S.C.A. § 1396a(a)(25)(B) (West, Westlaw through Pub. L. No. 119-102). States must also enact laws providing that when the State pays the expenses of a recipient for "medical assistance for

health care items or services" and "a third party has a legal liability to make payment for such assistance," "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." *Id.* § 1396a(a)(25)(H).

[¶16] On the other hand, 42 U.S.C.A. § 1396p(a)(1) (West, Westlaw through Pub. L. No. 119-102), the so-called "anti-lien" provision, provides, with exceptions not relevant here, "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."

[¶17] The Supreme Court has harmonized these provisions and held that "the Medicaid statute sets both a floor and a ceiling on a State's potential share of a beneficiary's tort recovery." *Wos v. E.M.A.*, 568 U.S. 627, 633 (2013). "Federal law requires an assignment to the State of the right to recover that portion of a settlement that represents payments for medical care, but it also precludes attachment or encumbrance of the remainder of the settlement." *Id.* (quotation marks omitted). Thus, the Department is entitled to recover its costs only from the portion of a settlement allocated for "payments for medical care." *See id.* (quotation marks omitted).

C. States are given discretion to establish procedures for allocating between medical expenses and other damages when a settlement does not do so, but the allocation cannot be arbitrary.

[¶18] If a settlement does not allocate funds between medical expenses and other damages, questions arise as to how the parties are to determine the portion of a settlement that is allocated for medical expenses and therefore available to reimburse the Department. The Supreme Court has held that "States have considerable latitude to design administrative and judicial procedures to ensure a prompt and fair allocation of damages." *Id.* at 641. This latitude is not completely unfettered. Most importantly, states must employ processes to determine, in each case, "what portion of a beneficiary's tort recovery is attributable to medical expenses," rather than establishing an irrebuttable presumption that a certain percentage of each settlement is attributable to medical care. *Id.* at 636; *see id.* at 639. The resulting allocations, "while to some extent perhaps not precise, need not be arbitrary," because "[t]rial judges and trial lawyers . . . can find objective benchmarks to make projections of the damages the plaintiff likely could have proved had the case

gone to trial."[4] *Id.* at 640.[5]

[¶19] *Ahlborn*, a decision that preceded *Wos*, involved an Arkansas statute that provided that when a Medicaid recipient obtained a tort settlement following payment of medical costs on her behalf, a lien was automatically imposed on the settlement in an amount equal to Medicaid's costs. *Ahlborn*, 547 U.S. at 272. When that amount exceeded the portion of the settlement representing medical expenses, satisfaction of the state's lien required payment out of proceeds meant to compensate the recipient for damages distinct from those expenses, such as pain and suffering, lost wages, and loss of future earnings. *Id.* In that case, the Arkansas Department of Health and Human

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[4] The Supreme Court also left open the possibility that "if States are concerned that case-by-case judicial allocations will prove unwieldy, they may even be able to adopt *ex ante* administrative criteria for allocating medical and nonmedical expenses, provided that these criteria are backed by evidence suggesting that they are likely to yield reasonable results in the mine run of cases." *Wos*, 568 U.S. at 643. No such administrative criteria are before us here.

[5] In rejecting the states' ability to impose via statute an irrebuttable presumption, the Court focused on how the facts in an individual case could affect what portion of a settlement reflected medical expenses:

> The facts of the present case demonstrate why *Ahlborn* anticipated that a judicial or administrative proceeding would be necessary [when the parties do not agree on an allocation]. Of the damages stemming from the injuries [the recipient] suffered at birth, it is apparent that a quite substantial share must be allocated to the skilled home care she will require for the rest of her life. It also may be necessary to consider how much [the recipient] and her parents could have expected to receive as compensation for their other tort claims had the suit proceeded to trial. An irrebuttable, one-size-fits-all statutory presumption is incompatible with the Medicaid Act's clear mandate that a State may not demand any portion of a beneficiary's tort recovery except the share that is attributable to medical expenses.

Wos, 568 U.S. at 638-39 (citation omitted).

Services had paid medical providers $215,645.30 on the recipient's behalf. *Id.* at 273. The recipient received a settlement from the tortfeasors causing her damages for a total of $550,000. *Id.* at 273-74. The parties to the settlement did not allocate the settlement between medical expenses and other damages. *Id.* at 274. The parties stipulated that the settlement amounted to approximately one-sixth of the reasonable value of Ahlborn's claim. *Id.* at 274. The parties then took approximately one-sixth of the amount paid by Arkansas for medical expenses, which was $35,581.47, and stipulated that that was the amount "that constituted reimbursement for medical payments made." *Id*. Given this stipulation, the Supreme Court held that the Arkansas Department could not assert a lien exceeding that amount. *Id*. at 292.[6]

[¶20] In sum:

- By Maine statute, the Department is entitled to recover the amount of benefits it paid on behalf of a recipient (here $34,078.70);
- Under Maine statute and federal law, the Department cannot recover

[6] In *Wos*, in discussing the *Ahlborn* decision, the Court stated:

> The instant case, to be sure, is not quite so clear cut [as *Ahlborn*]; for there was no allocation of the settlement by either judicial decree or binding stipulation of the parties. But the reasoning of *Ahlborn* and the design of the federal statute contemplate that possibility. When the State and the beneficiary are unable to agree on an allocation, *Ahlborn* noted, the parties could "submi[t] the matter to a court for decision."

Wos, 568 U.S. at 638 (quoting *Ahlborn*, 547 U.S. at 288). The Court then noted the individual facts in *Wos* that could impact what portion of the settlement reflected medical expenses. *Wos*, 568 U.S. at 638-39; *see supra* n.5.

those costs from the portion of a settlement between the recipient and the third party not allocated to medical expenses;

- States may by statute set a rebuttable *ex ante* formula for determining the portion of the settlement that comprises medical expenses;[7]

- The Maine Legislature has not enacted any such formula;

- In an individual case, parties may stipulate as to the amount of a settlement that comprises medical expenses;[8] and

- There was no such stipulation here.[9]

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[7] In *Wos,* the Supreme Court noted that several states had adopted rebuttable presumption formulas, *e.g.*, Haw. Rev. Stat. Ann. § 346–37(h) (West, Westlaw through 2026 Reg. Sess.) (rebuttable presumption of a one-third allocation); Mass. Gen. Laws Ann. ch. 118E, § 22(c) (West, Westlaw through Ch. 101 of the 2026 2nd Ann. Sess.) (rebuttable presumption of full reimbursement); Okla. Stat. Ann. tit. 63, § 5051.1(D)(1)(d) (West, Westlaw through Second Reg. Sess. of the 60th Leg. (2026)) (rebuttable presumption of full reimbursement, "unless a more limited allocation of damages to medical expenses is shown by clear and convincing evidence"), and stated, "Without holding that these rules are necessarily compliant with the federal statute, it can be concluded that they are more accurate [than an irrebuttable presumption]." *Wos*, 568 U.S. at 641. Based on that language, the Eleventh Circuit concluded that federal law permitted a Florida statutory formula that provided for the state to receive half of the recovery after a twenty-five percent reduction for attorney fees and costs, up to the total amount provided by the Medicaid agency, which the recipient could contest by showing by clear and convincing evidence that this portion is too high. *Gallardo v. Dudek*, 963 F.3d 1167, 1172-73, 1181-82 (11th Cir. 2020), *aff'd sub nom.*, *Gallardo v. Marstiller*, 596 U.S. 420.

[8] Courts have indicated that any allocation agreed upon by the parties to the settlement is not binding on the agency, so that the agency may contest the allocation as collusive. *See Ahlborn*, 547 U.S. at 288 (noting that "the risk that parties to a tort suit will allocate away the State's interest can be avoided" by "submitting the matter to a court for decision"); *K.H. v. Agency for Health Care Admin.*, 358 So. 3d 1284, 1286 (Fla. Dist. Ct. App. 2023) (concluding that a court was not bound to follow a letter of understanding between parties to a settlement agreeing that five percent of the settlement amount, or $13,000, was for medical care where the settlement totaled $350,000 and the agency had paid over $120,000 for the recipient's medical care).

[9] The Department argues that the parties here have "agree[d]" to the use of a prorated calculation. The parties have not agreed, however, to all the terms of the formula; they disagree as to the value for total medical expenses. Lynne has also at times argued that no pro-rata formula should be used at all. Indeed, at oral argument Lynne expressly stated that the parties had not stipulated to the allocation formula.

D. When the recipient and the Department disagree, the court engages in an individual, fact-specific analysis, examining, inter alia, what the likely recovery at trial would have been.

[¶21] As noted above, Maine statutes do not include a rebuttable *ex ante* formula for determining the portion of a settlement allocated between a recipient and a third-party tortfeasor reflecting medical expenses when those parties did not stipulate as to what that portion was. If the recipient and the Department disagree, either the recipient or the Department may then apply to the court "for an order to determine a reasonable amount in satisfaction of the statutory lien, consistent with federal law." 22 M.R.S. § 14(2-F).

[¶22] In the absence of a stipulation between the recipient and a Medicaid agency as to the portion of an unallocated settlement attributable to medical expenses from which the agency may be reimbursed the amounts it has paid to the recipient, as noted above, there must be an individualized evidentiary hearing to determine that allocation, looking at, for example, the likely result had the case gone to trial.

[¶23] Both Lynne and amicus curiae Maine Trial Lawyers Association argue that the language of section 14(2-F) allows a court to reduce the Department's recovery below the amount that the Department has paid by applying a formula that, although not drawn from a Maine statute, the court in

that matter deems reasonable. In other words, they argue that the court's task when the recipient and the Department disagree as to the portion of the settlement attributable to medical expenses is not to look at all the factors relevant to an individualized determination to identify the amount of the settlement that the parties reasonably attributed to medical expenses, then order the Department to be reimbursed up to the amount it paid, capped by the calculation of the amount of the settlement that the court determined to be attributable to medical expenses. Rather, an individual court may choose not only to forgo assessing these factors and simply use a formula, but it may also use that formula not only to determine the amount of the settlement attributed to medical expenses that caps what the Department may recover, but also to order that the Department be reimbursed an amount lower than its payments, even if that amount is lower than the amount of the settlement allocated to medical expenses.

[¶24] We disagree. A state legislature is free to enact a statute that includes a rebuttable statutory formula for identifying the portion of a settlement allocated to medical expenses, and may perhaps even provide that the court may order that the Medicaid agency recover some amount less than the amount it paid even if the amount it paid is lower than the amount of the

settlement allocated to medical expenses.[10] We must, however, apply the statute that our Legislature enacted, and we must read section 14(2-F) in concert with the other subsections of 22 M.R.S. § 14. *See Monteith v. Monteith*, 2021 ME 40, ¶ 23, 255 A.3d 1030 ("Statutes must be read together and in light of the entire statutory scheme to produce cohesive results." (alteration and quotation marks omitted)).

[¶25] Section 14(1) provides that the Department may recover "the cost of benefits provided." Consistent with Supreme Court jurisprudence, the Department's "right to recover" the cost of the benefits provided constitutes a "statutory lien" "to the extent of the recovery [in the settlement] for medical expenses." 22 M.R.S. § 14(1). Section 14(1) further provides that the commissioner "must" be subrogated "to the extent of any benefits provided." *Id*. The commissioner may compromise this lien only "if the commissioner determines the collection will not be cost-effective or that the best possible outcome requires compromise, release or settlement." *Id.* Section 14(2-A)

[10] For example, N.H. Rev. Stat. Ann. § 167:14-a(IV) (West, Westlaw through Ch. 337 of the 2026 Reg. Sess.) provides the court with the authority to determine an "equitable apportionment," giving the court "broad discretion to apportion the amount withheld as justice may require." *See also* Va. Code Ann. § 8.01-66.9 (West, Westlaw through 2026 Reg. Sess.) ("The court . . . may . . . reduce the amount of the liens and apportion the recovery . . . as the equities of the case may appear . . . ."). *But see Farah v. Dep't of Med. Assistance Servs.*, 868 S.E.2d 422, 426 (Va. 2022) ("Although United States Supreme Court precedent does not compel the use of a particular formula, precedent from that Court does cabin a court's discretion under Code § 8:01-66.9. Courts are not free to simply choose a number that seems fair.").

provides that the receipt of MaineCare benefits constitutes an assignment by the recipient "of the right to recover from 3rd parties for the medical cost[s]" for which the recipient received medical benefits, limited "to the amount of medical benefits received by the recipient." *Id*. § 14(2-A). Section 14(2-F) provides that a settlement may not be disbursed to a recipient without first paying the Department the portion of the settlement "that constitutes reimbursement for medical payments" made by the Department or obtaining a release from the Department. *Id*. § 14(2-F). Reading Section 14 as a whole, nothing in its language suggests that the Department is not entitled to the entire amount of its payments for medical care, so long as that amount does not exceed the amount in a settlement allocated to medical expenses.[11]

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[11] The entire thrust of section 14 is to provide for the Department to recover the entire amount it paid in benefits so long as that amount falls within the amount of a settlement allocated to medical expenses, which the Supreme Court has indicated is determined, in the absence of a stipulation, by a fact-intensive review. *See Wos*, 568 U.S. at 640-41.

If we were to conclude that the language of section 14 is ambiguous, warranting an examination of legislative history, *see State v. McKusick*, 2025 ME 80, ¶ 14, 345 A.3d 1, we would find no support in the legislative history of section 14(2-F) for the expansive discretion to reduce the Department's lien that Lynne argues the trial court possesses. At one point in time, section 14(2-F) allowed the court to make an "equitable apportionment between the commissioner and the recipient" of the lien amount. P.L. 1989, ch. 778, § 2 (effective July 14, 1990). This language was then repealed, the result of which was that there was no statutory mechanism by which the lien could be reduced. P.L. 1997, ch. 795, § 2 (effective July 9, 1998). The bill proposing repeal of the "equitable apportionment" language included in its summary the following: "[The bill] will ensure that the courts do not apply principles of subrogation or otherwise deny the [D]epartment the right to be reimbursed fully from any kind of damage award or settlement." L.D. 2152, Summary (118th Legis. 1998).

Subsequently, the Legislature reinstituted a procedure by which the Department's recovery could be reduced. In P.L. 1999, ch. 483, § 2 (effective Sep. 18, 1999), the Legislature provided that either

[¶26] Section 14(2-F) provides that the court's determination must be "consistent with federal law." It is consistent with federal law to engage in an individualized review of relevant evidence to determine the amount of an unallocated settlement attributable to medical expenses and to allow the Department to recover the sum of what it paid up to that amount. We cannot stretch the use of the word "reasonable" in section 14(2-F) to mean that an individual court may engage in whatever equitable analysis it selects to reduce the amount to which the Department would otherwise be entitled. Among other things, the results of proceedings under section 14(2-F), where the total amount that the Department would receive would be entirely within the

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party could bring an action for "an order to determine a reasonable amount in satisfaction of the statutory lien, consistent with federal law, considering whether an independent action by the commissioner would have been cost-effective." As to the cost-effectiveness of an independent action, the Legislature at the same time amended section 14(1) to require the commissioner to consider "all factors that diminish potential recovery by the [D]epartment," including "questions of liability and comparative negligence or other legal defenses, exigencies of trial that reduce a settlement or award in order to resolve the recipient's claim and limits on the amount of applicable insurance coverage that reduce the claim to the amount recoverable by the recipient." P.L. 1999, ch. 483, § 1. Thus, when enacted, the "reasonable amount" language, like the previous version of the statute, did not refer to a reduction of the lien based on equitable principles.

The Legislature then amended the statute again to provide that the Department would receive in every case no less than the lesser of seventy-five percent of the settlement, minus attorney fees and costs, or the full value of its lien. P.L. 2003, ch. 20, § K-2 (emergency, effective July 1, 2003). Following the Supreme Court's decision in *Ahlborn* forbidding states from recovering their costs from a recipient's recovery for damages other than medical expenses, however, the seventy-five-percent minimum and the reference to the cost-effectiveness of an independent action were removed. P.L. 2007, ch. 381, § 4 (effective Sep. 20, 2007). Thus, nothing in the legislative history resulting in the current version of section 14(2-F) suggests an intent to allow individual judges to reduce the recovery of the Department's lien below what federal law allows based on a formula or what a judge deems to be equitable.

unfettered discretion of a court, would be arbitrary, a result that the Supreme Court has expressly indicated is unacceptable. *See Wos*, 568 U.S. at 636-37, 639-40, 643.

[¶27] For example, one court might conclude that an award to the Department is "reasonable" under section 14(2-F) using a version of the *Ahlborn* formula in which the total medical expenses would be the amount paid by the Department, while another court might conclude instead that the award should be based on a version of the *Ahlborn* formula using the amount billed; in both cases, the court would skip the necessary exercise of identifying a reasonable calculation, based on relevant factors, of the amount allocated in the settlement for medical expenses in favor of a flat, one-size-fits-all formula. The Supreme Court has ruled that a state (and, therefore, at a minimum, a court) cannot impose a rigid formula. Section 14(2-F)'s use of "reasonable" reflects the understanding that when a settlement does not allocate an amount for medical expenses, the court's identification of that amount cannot be determined with pinpoint certainty; only a reasonable calculation based on the facts in that case is required. *See Wos*, 568 U.S. at 640-41 (the allocation "may be difficult to determine" and the court can look at how much the recipient "reasonably" could have expected to receive had the tort action gone to trial);

id. at 643 ("[I]f States are concerned that case-by-case judicial allocations will prove unwieldy, they may even be able to adopt *ex ante* administrative criteria for allocating medical and nonmedical expenses, provided that these criteria are backed by evidence suggesting that they are likely to yield reasonable results in the mine run of cases. What they cannot do is what North Carolina did here: adopt an arbitrary, one-size-fits-all allocation for all cases.").

[¶28] Nor is there any basis to read section 14(2-F) as giving courts unfettered power to preclude the Department from obtaining a full recovery out of the medical expenses portion of a settlement when the amounts it paid do not exceed that portion. General lien law in Maine does not give the courts such power. Mechanics' liens must be paid in full. *See* 10 M.R.S. § 3260 (2026). Mortgage foreclosure law does not allow for equitable reductions in amounts due. *See* 14 M.R.S. § 6322 (2026). The exception is hospital liens, where the Legislature has expressly provided that a hospital lien must be satisfied on a "just and equitable basis" and lists specific factors that may be taken into account. 10 M.R.S. § 3412-A (2026). No such language is included in section 14.

E. The record in this case reflects disputed issues of material fact precluding summary judgment.

[¶29] In *Ahlborn*, the parties stipulated that the formula they used reflected the amount of the settlement in that particular case allocated for medical expenses. 547 U.S. at 274. The Supreme Court did not endorse that as a formula that should or could be used in a "one-size-fits-all" approach. *See Wos*, 568 U.S. at 634 ("A question the Court had no occasion to resolve in *Ahlborn* is how to determine what portion of a settlement represents payment for medical care."). It has, indeed, ruled to the contrary. *See id.* at 643 ("What [states] cannot do is . . . adopt an arbitrary, one-size-fits-all allocation for all cases."). In the absence of a statutory starting point or a stipulation, the relevant question is not what an equitable result might be in the eyes of a particular judge but rather the amount the Department paid, capped by what constitutes the reasonable computation of the portion of the settlement reflecting medical expenses. To identify that cap, the court must hold a hearing in which it examines all the evidence that Lynne and the Department offer that may be relevant, such as "projections of the damages the plaintiff likely could have proved had the case gone to trial."[12] *See id.* at 640-41 (stating that the

[12] To see why such evidence may prove relevant, one can imagine a case in which recovery for medical expenses is near certain, but proof of other types of damages is highly speculative. It could also be the case that the causal relationship of some or all of the medical expenses to the injury is

portion of a settlement that constitutes compensation for each individual claim depends "both on how likely [the plaintiffs] would have been to prevail on the claims at trial and how much they reasonably could have expected to receive on each claim if successful, in view of damages awarded in comparable tort cases"). Any fact that may be relevant to the factual determination as to the portion of this settlement attributable to medical expenses may be considered.[13]

III. CONCLUSION

[¶30] Out of a settlement between a recipient and a third party, the Department is entitled to the full amount it paid to the recipient, capped by that portion of the settlement allocated to medical expenses. In the absence of a stipulation or a (rebuttable) statutory formula as to how to determine that

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speculative, with recovery of other damages more certain. In either case, a pro-rata allocation would obscure the amount of the settlement that is attributable to medical expenses and thus available to the Department for reimbursement.

[13] In section 14(1), when legislating the Department's ability to compromise a claim, the Legislature provided, "[T]he commissioner shall consider all factors that diminish potential recovery by the [D]epartment, including but not limited to questions of liability and comparative negligence or other legal defenses, exigencies of trial that reduce a settlement or award in order to resolve the recipient's claim and limits on the amount of applicable insurance coverage that reduce the claim to the amount recoverable by the recipient. The [D]epartment's statutory lien may not be reduced to reflect an assessment of a pro rata share of the recipient's attorney's fees or litigation costs." Such language is similar to language the Legislature used with hospital liens under 10 M.R.S. § 3412-A(1). These factors are, in turn, similar to the factors cited by the Supreme Court in identifying how to calculate the portion of an unallocated settlement that is attributable to medical expenses. *See Wos*, 568 U.S. at 640-41 (identifying the "likel[ihood]" that the plaintiffs would have "prevail[ed] on the claims at trial and how much they reasonably could have expected to receive on each claim if successful, in view of damages awarded in comparable tort cases").

portion of a settlement attributable to medical expenses when the settlement does not contain an allocation, the court's task is to arrive at a reasonable calculation of that portion, and, if the amount paid by the Department exceeds that amount, cap the Department's recovery by that calculated amount. In determining what portion of an unallocated settlement is attributable to medical expenses in the absence of a judgment or stipulation, the court examines all evidence relevant to identifying that portion. Because this determination requires an evidentiary hearing, we must remand the matter to the Superior Court for that hearing.

The entry is:

> Judgment vacated. Remanded for further proceedings consistent with this opinion.

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