U.S. Department of Labor **Employee Benefits Security Administration**
Washington, D.C. 20210

March 21, 2008

2008-03A
ERISA SEC.
514 & 609(b)(3)

Ginni Hain, Director
Division of Eligibility, Enrollment & Outreach
Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, MD 21244-1850

Dear Ms. Hain:

This responds to your request for guidance regarding Title I of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you request guidance on whether ERISA would preempt an action by a State Medicaid Agency to recover Medicaid benefit payments made on behalf of individuals who are also participants in ERISA-covered private health insurance plans that require prior authorization for covered health care items or services.

Your inquiry focuses on ERISA-covered plans that provide, in order for a participant or beneficiary to receive certain items or services, that the participant, beneficiary or health care provider must obtain specific authorization in advance from the plan. You state that when a plan participant or beneficiary, who is also a State Medicaid beneficiary, fails to inform the provider at the point of service that he or she has private health coverage, the provider may bill and Medicaid may pay for health care items or services received by the participant or beneficiary. When the State Medicaid Agency discovers that the participant or beneficiary had coverage under a private employee benefit plan, and seeks reimbursement, the plan may reject the State's claim on the ground that the participant or beneficiary failed to obtain the required prior authorization. The plan may assert that, without prior authorization, the plan does not cover the items or services, and that any State law entitling the State to obtain reimbursement in this situation is preempted by ERISA.

ERISA section 514(a), 29 U.S.C. 1144(a), provides that, with certain exceptions, Title I of ERISA preempts any and all State laws insofar as they may now or hereafter relate to any employee benefit plan subject to Title I. Section 514(b)(8) (as follows) specifically saves from preemption State causes of action to obtain reimbursement for State Medicaid programs from ERISA plans:

> Subsection (a) of this section shall not be construed to preclude any State cause of action—

> (A) with respect to which the State exercises its acquired rights under section 609(b)(3) with respect to a group health plan (as defined in section 607(1)), or
> (B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

Moreover, ERISA section 609(b)(3), 29 U.S.C. 1169(b)(3), provides:

> [a] group health plan shall provide that, to the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act in any case in which a group health plan has a legal liability to make payment for items or services constituting such assistance; payment for benefits under the plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a participant to such payment for such items or services.

The Department previously expressed its views on the scope of these provisions in Advisory Opinion 2005-05A (March 23, 2005). In that Advisory Opinion, the Department stated that one of Congress' primary purposes in enacting these provisions (as part of OBRA '93 (Pub. L. 103-66)) was to reflect changes to the Medicaid provisions of the Social Security Act (Title XIX) requiring enactment of State laws to recoup Medicaid payments from liable third parties, including self-funded ERISA plans. 42 U.S.C. 1396a(a)(25)(G) and (H).

In the Department's view, a plan that requires participants and beneficiaries to obtain prior authorization for health care items or services, but that makes no provision for reimbursing a State Medicaid Agency for payment of those items or services in cases where prior authorization was not requested, would not be in compliance with ERISA section 609(b)(3). If prior authorization from the private plan were required for a State Medicaid Agency to obtain reimbursement from the plan under section 609(b)(3), the State Medicaid Agency would never be able to obtain such reimbursement because the very act of the State's paying for the item or service in the first instance (the prerequisite for the Agency obtaining reimbursement rights under ERISA section 609(b)(3)) precludes any possibility of obtaining prior authorization from the employee benefit plan. It is the Department's view that ERISA would not preempt a State cause of action to recoup Medicaid payments made for covered expenses to the extent that the private plan would have been liable for those expenses if the participant had followed the appropriate prior authorization procedures under the plan before the State made the payment for the items or services.

We note, however, that ERISA section 609(b)(3) limits the private employee benefit plan's obligation to cases "in which a group health plan has a legal liability to make payment for items or services . . . ." In Advisory Opinion 2005-05A, the Department, relying on that provision in ERISA section 609(b)(3), explained that the State cannot compel the plan to reimburse it for items or services to which the participant was not entitled for procedural reasons, citing as an example the participant having already received a final denial of benefits for failure to follow the plan's claims procedures. Accordingly, if, before seeking to have the State Medicaid Agency pay for the item or service, the participant or provider had filed a benefit claim with the plan, and the plan (or State external review decisionmaker, if applicable) had issued a final denial based on the participant's failure to obtain prior authorization, the Department would not view the plan as legally liable to pay for the item or service. Nor, in the Department's view, could a plan be required to reimburse the full amount of the State's payment for a particular item or service if, under the terms of the plan, the plan would have paid a lesser amount or would have required the participant to seek an alternative treatment.

This letter constitutes an advisory opinion under ERISA Procedure 76-1, and is issued subject to the provisions of that procedure, including section 10 thereof relating to the effect of advisory opinions.

Sincerely,

Lisa M. Alexander
Chief, Division of Coverage, Reporting and Disclosure
Office of Regulations and Interpretations