U.S. Department of Labor

Employee Benefits Security Administration
Washington, D.C. 20210

MAR 23 2005

2005-05A

Mr. Patrick J. O'Connell
Chief, Civil Medicaid Fraud Section
Office of the Attorney General of Texas
P.O. Box 12548
Austin, Texas 78711-2548

Dear: Mr. O'Connell:

This responds to your request for guidance regarding Title I of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. 1101-1191c, in connection with an investigation of a pharmacy benefit manager (PBM) for potential violations of the False Claims Act. The investigation concerns allegations that the PBM improperly refused to reimburse government health insurance programs for prescription drug payments. In some cases, the States had made the payments without knowledge that the individuals involved were eligible for benefits under a private health insurance plan that was a customer of the PBM as well as for benefits under the State Medicaid program.[1]

It is our understanding that the great majority of the PBM's clients are self-funded group health plans covered by ERISA. You state that the PBM contends it properly rejected the States' reimbursement attempts with respect to such plans for either of two principal reasons: (1) the State submitted its reimbursement requests after the time allowed under the plan for submission of benefit claims, and (2) the plan only offers items or services at the point-of-sale (POS) and has no procedure for reimbursing either a participant or third party payer. The PBM views any State law entitling the State to obtain reimbursement in either of these situations as preempted by ERISA.

You have advised us generally about the States' difficulties in assuring that their Medicaid programs are the payers of last resort if a Medicaid recipient has another payment source for prescription drugs. In particular, you described the inability of States to meet plans' deadlines for submitting reimbursement claims due to unreasonably short filing deadlines imposed by plans or difficulties in determining whether a given Medicaid recipient is also eligible for other coverage. A State must generally obtain assistance from the PBM in matching Medicaid recipients against the PBM's lists of individuals eligible for other coverage, such as group health plan coverage. You indicate that PBMs are not always willing to provide such assistance. Moreover, in some cases, the State may not even receive a request for payment from a pharmacist until after the deadline set by the other coverage, particularly the time limits for a group health plan for filing participant claims.

In addition, some plans may only accept pharmacists' payment requests electronically and only when the request is presented at the time the participant receives the drug at the pharmacy. In such plans, participants may have their prescriptions paid for by the plan only if they have their

[1] The investigation also concerns allegedly improper rejection of reimbursement claims by Medicare and other government insurance programs, but only the Medicaid claims are relevant for purposes of this letter.

prescriptions filled by presenting a pharmacy benefit card at a covered pharmacy. Such plans may have no procedure to process claims for reimbursement from participants and they may refuse to accept reimbursement requests from State Medicaid agencies.

ERISA § 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. ERISA, however, contains provisions specifically addressing its interaction with State laws authorizing or directing Medicaid programs to obtain reimbursement from ERISA-covered group health plans. In particular, ERISA § 609(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.

In addition, ERISA § 514(b)(8) (as follows) saves from preemption State causes of action to obtain reimbursement for their Medicaid programs from ERISA plans:

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

Congress enacted these provisions as part of OBRA '93 (Pub. L. 103-66), which also amended ERISA to require that group health plans honor assignments of benefit rights to a State Medicaid plan (ERISA § 609(b)(1)), and enroll participants or beneficiaries and determine and pay benefits without regard to any individual's eligibility for Medicaid benefits (ERISA § 609(b)(2)).[2] These ERISA amendments reflect changes to the Medicaid provisions of the Social Security Act (Title XIX) requiring enactment of State laws (1) to prohibit insurers and group health plans from taking Medicaid eligibility into account in enrollment or in making benefit payments, and (2) to

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[2] The conference report accompanying OBRA '93 states that:

> [G]roup health plans are required to pay benefits in accordance with any assignments of rights on behalf of participants and beneficiaries that is required by Title XIX of the Social Security Act. . . . In addition, . . .to the extent that payment has been made under Title XIX, states would acquire the right of any other party to payment. State laws enforcing these rights must be honored by group health plans since those laws would be exempt from ERISA's preemption.

H. Conf. Rep. 103-213, 103rd Cong. 1st Sess. 1993, at 469; 1993 U.S. Code Cong. & Ad. News 1088, 1158.

recoup Medicaid payments from liable third parties, including self-funded ERISA plans. 42 U.S.C. §§ 1396a(a)(25)(G) & (H).

ERISA § 609(b)(3), quoted above, plainly requires an ERISA plan to pay for covered benefits as required by a State law under which the State, having made Medicaid payments, acquires the rights of a plan participant to receive plan benefits relating to such payments. Moreover, a State cause of action to enforce the rights created by such a State law against a plan is expressly saved from ERISA preemption by section 514(b)(8)(A). Actions described in section 514(b)(8)(A) are essentially actions by which the State agency asserts the rights of the participant to payment of benefits under the plan.

Section 514(b)(8), however, goes beyond saving State laws that assign a participant's benefit rights to State agencies. Subparagraph (B) of section 514(b)(8) separately saves from ERISA preemption a State cause of action for recoupment of its expenses where the State has paid for items or services covered by the plan, but would not have done so if the rights with respect to the participant under an ERISA plan had been executed before the State made payment (e.g., in the case of some pharmacy benefits, if the participant's or a third party's (such as the pharmacist's) right to payment by the plan had been executed at the POS). The existence of subparagraph (B) indicates that Congress intended to save from preemption not only those State causes of action that authorize State agencies to exercise subrogated participants' rights to benefits under a group health plan, but also causes of action that authorize State agencies to seek recoupment for payments that the State would not have made if, instead, the rights with respect to the participant had been executed before the State made payment.[3]

Thus, in our view, ERISA does not preempt a State cause of action to recoup the State's Medicaid payments to the extent that the plan would have been liable to any third party, including the participant or the pharmacist, for those expenses when the drug was dispensed (that is before the State made the payments). State law (including case law) that holds a plan liable for the reimbursement of the State under such circumstances would not be preempted by ERISA, notwithstanding the plan's procedural requirements governing participant benefit claims, including filing time limits.[4]

The State cannot, however, compel the plan to reimburse it for items or services for which the participant was not entitled to payment from the plan for procedural reasons. For example, if,

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[3] *See Health Ins. Assoc. v. Shalala*, 23 F.3d 412, 419, (D.C. Cir. 1994); *cert. denied*, 513 U.S. 1147 (1995); *U.S. v. Travelers Ins. Co.*, 815 F. Supp. 521, 523 (D. Conn. 1992); *Provident Life & Accident Ins. Co. v. U.S.*, 740 F. Supp. 492, 501-503 (E.D. Tenn. 1990); and *U.S. v. Blue Cross & Blue Shield,* 726 F. Supp. 1517, 1522 (E.D. Mich. 1989) making a similar distinction between actions based on subrogation and independent reimbursement actions by the Federal government under the Medicare Secondary Payer Act, 42 U.S.C. § 1395y. The court in *Shalala* invalidated a Medicare regulation authorizing the government to recover payments from an employer group health plan without regard to any claims filing requirements the plan imposed on other claimants, but the court based that part of its decision on language in the Act that differs substantially from the provisions of ERISA discussed here.

[4] To the extent that the holding in *Belshé v. Laborers Health and Welfare Trust Fund for Northern California*, 876 F. Supp. 216 (N.D. Cal. 1994), is not consistent with this position, we disagree with that case. Two other cases have cited Belshé for the proposition that § 514(b)(8) as a whole gives the States no greater rights than the participant in an action against the plan. *Commonwealth v. Lubrizol Corp. Employee Benefits Plan*, 737 A.2d 862, 868-869 (Pa. Commw. Ct. 1999); *Morrone v. Thuring*, 334 N.J. Super.456, 472, 759 A.2d 1238, 1247 (N.J. Super. 2000).

before seeking to have Medicaid pay for a drug, the participant had already filed a benefit claim for the drug with the plan, and the plan (or State external review decisionmaker, if applicable) had issued a final denial of the claim based on a failure to follow the plan's claims procedures, the Department of Labor would not view the plan as legally liable to pay for the item or service. On the other hand, if, at the time the participant presented a Medicaid card to the pharmacist and received the drug, the participant had not yet applied for benefits under the plan for that prescription, but still could have done so in accordance with the terms of the plan, a State action seeking reimbursement for what the plan would have paid with respect to the prescription would not be preempted. The plan could not, in such a case, reject a State Medicaid agency's request for reimbursement on the grounds that the plan had no procedure to process written claims for reimbursement from participants.

We also conclude that ERISA does not preempt a State action for reimbursement against a plan that provides benefits only at the POS and does not recognize subsequent claims for reimbursement from plan participants. A plan that makes no provision for reimbursing a State Medicaid agency for items or services covered by the plan would not be in compliance with ERISA § 609(b)(3). Under this section, the State's payment for the item or service is the precondition for the plan's obligation to pay for the benefit in accordance with State law. To deny a State's claim to reimbursement from a plan on the grounds that the plan provides only POS benefits and does not reimburse participants would make the statutory precondition that the State have paid for the item or service the very reason for denying the State's claim.

Section 514(b)(8)(B), however, does not save from preemption a State law requiring a group health plan to pay the State for items or services that the plan does not cover. Moreover, a plan could not be required to pay the full amount of the State's payment for a drug if the amount that the plan would have paid under its terms was less. For example, some plans pay one amount with respect to an item or service obtained from certain designated providers or pharmacies and pay a lesser amount for the same item or service obtained from non-designated providers or pharmacies. If the State had paid for an item or service obtained from a non-designated provider or pharmacy, such a plan could be required to reimburse the State only the lesser amount. In some other cases, it may be difficult to determine whether a plan provision affecting payment for an item or service is solely procedural in nature or whether it actually defines the covered benefits. These distinctions could be made only by analyzing the particular plan provision.

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,

John J. Canary
Chief, Division of Coverage, Reporting and Disclosure
Office of Regulations and Interpretations