

## Special points of interest:

- PLANS REQUIRED TO REIMBURSE MEDICAID
- EMPLOYERS CAN REDUCE RETIREE BENEFITS

**PLANS REQUIRED TO REIMBURSE MEDICAID****DOL: Plans Required To Reimburse Medicaid Even If Participant Failed To Obtain Required Preauthorization For Services**

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www.ebia.com

[DOL Advisory Opinion 2008-03A (Mar. 21, 2008)] For a copy: <http://www.dol.gov/ebsa/regs/aos/ao2008-03a.html>

In this advisory opinion, the DOL addressed whether ERISA preempts state laws allowing state Medicaid programs to recover benefits in dual coverage situations involving Medicaid beneficiaries who are also participants in private ERISA health plans. As background, under ERISA Section 609(b)(3), if state Medicaid pays for a covered item or service which an ERISA plan has a "legal liability" to pay--and thereby acquires a participant's right to payment for the item or service under state law--then the plan must comply with any state law requiring it to reimburse Medicaid for the payment. The opinion addressed this very specific scenario: the participant fails to notify the provider that he or she has private coverage, so the provider submits the claim to Medicaid. When Medicaid discovers that the participant has private coverage and seeks reimbursement from the plan, the plan claims that it is not legally obligated to pay because the participant failed to follow the plan's preauthorization procedures, and any state-law requirement to repay Medicaid is preempted by ERISA. At issue was whether the plan is required to comply with state laws requiring it to reimburse

Medicaid despite the participant's failure to obtain preauthorization as required by the plan.

The DOL concluded that the plan is required to reimburse Medicaid in this scenario if the procedure would have been covered had the participant sought preauthorization. The DOL considers the plan "legally required" to pay the benefits, and thus any state laws requiring payment fall within ERISA Section 609(b)(3) and are not preempted. The DOL reasoned that enforcing the preauthorization provision in this circumstance would always preclude Medicaid from obtaining reimbursement from the plan, since at the time of its payment Medicaid (and presumably the provider) would be unaware of plan coverage and any preauthorization requirement. The DOL distinguished this scenario from other circumstances where the plan does not have "legal liability" for the claim, citing as examples situations where the preauthorization request was denied or the service was not covered under the plan even with preauthorization.

This opinion builds on Advisory Opinion 2005-05A, in which the DOL concluded that ERISA does not preempt state laws that authorize states to recoup Medicaid payments from a plan if the plan would have been liable to any third party before the Medicaid payment was made. According to that advisory opinion, such state laws may be enforced "notwithstanding the plan's procedural requirements governing participant benefit claims" (for instance, Medicaid does not have to comply with the plan's filing time limits). But a state cannot compel a plan to reimburse it for items or services for which the plan is

not legally liable to pay because the participant was not entitled to payment from the plan for procedural reasons (for example, Medicaid cannot compel payment if the participant had already received a final denial from the plan before Medicaid paid for the claim). Thus, while we can see a plan's argument that items or services for which no preauthorization was obtained should not have to be covered by the plan because the participant was not entitled to payment, plan administrators faced with a state Medicaid claim for reimbursement should be aware of the DOL's position that the plan is required to reimburse Medicaid for these claims.

## **EMPLOYERS CAN REDUCE RETIREE BENEFITS**

### **Court Effectively Confirms that Employers Can Reduce Retiree Benefits Without Violating ADEA**

Source: MyHealthGuide 3/31/08  
[www.myhealthguide.com](http://www.myhealthguide.com) Source: Jerry Geisel, Business Insurance, 3/24/08, Article and EEOC Release 12/26/07

WASHINGTON—As expected, the U.S. Supreme Court declined to review a federal appeals court ruling that effectively upholds employers' ability to reduce health care benefits when retirees become eligible for Medicare, putting a final end to nearly eight years of litigation and uncertainty.

In a unanimous ruling in June 2007, a three-judge panel of the 3rd U.S. Circuit Court of Appeals said the Equal Employment Opportunity Commission had the authority to implement a rule to exempt retiree health plans from the Age Discrimination in Employment Act when those plans reduce benefits for retired workers after they become eligible for Medicare.

The EEOC proposed the rule in 2003 as a way of counteracting a decision by the 3rd Circuit three years earlier that found the plans were subject to ADEA. That decision, known as the "Erie County" case, exposed employers to age discrimination lawsuits if they cut retiree health care plan benefits when retirees reached age 65.

## **EEOC Rule Implications**

The practical effect of the EEOC rule, which the agency finalized last year, is that employers can provide a two-tier system of retiree health care coverage, with younger retirees receiving richer benefits than Medicare-eligible retirees.

The EEOC feared that, without such a rule, employers would equalize retiree health care benefits by reducing younger retirees' benefits to the level provided to older retirees, or eliminate retiree benefits altogether.

The AARP, though, had asked the Supreme Court to review the 3rd Circuit ruling upholding the EEOC's right to issue the ADEA retiree health care plan exemption rule.