COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

NOVEMBER 30, 1984

B-204545

To the President of the Senate and the
Speaker of the House of Representatives

Subject: Need for Legislative Change Affecting the Medicaid Program (GAO/HRD-85-9)

In our ongoing review of the Medicaid program, we noted a possible inequity that could result in states having to pay the full medical costs for certain Medicaid recipients. The Congress intended that Medicaid be used as a secondary payer--that is, any other insurance available to a recipient must be used before Medicaid pays claims. Moreover, Medicaid law provides that no federal funds can be used to make payments where Medicaid is not treated as a secondary payer. The possible inequity occurs when Medicaid recipients are also covered under other self-insured health plans which are regulated under the Employee Retirement Income Security Act (ERISA). These insurance plans are allowed to, and sometimes do, designate themselves as secondary payers to Medicaid.

States administer Medicaid and also regulate most private health insurance plans and are, therefore, capable of assuring that plans under their regulatory control do not operate as secondary payers to Medicaid. ERISA, however, is federally administered, and insurance plans operating under it are exempt from state regulation. As a result, to the extent ERISA plans designate themselves as secondary payers to Medicaid, states are placed in the position where they may have to pay the medical costs of Medicaid recipients without the federal government sharing in such costs.

Because states cannot regulate self-insured ERISA health plans, we do not believe the Congress intended to deny Medicaid funds to states because of the actions of such plans. However, the law and regulations as written require that federal funds be denied in some cases. The Department of Health and Human Services (HHS) recognizes this as inequitable and as yet has not disallowed federal participation in such situations. Allowing such participation, however, is contrary to Medicaid law and regulations.

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To eliminate the possible inequity to states, we believe the Congress has two options, which involve amending either ERISA or the Medicaid law.

BACKGROUND

The Medicaid program is a federally aided, state-administered medical assistance program that currently covers about 22 million low-income people. Medicaid became effective on January 1, 1966, under authority of title XIX of the Social Security Act (42 U.S.C. 1396). Within broad federal limits, states set the reimbursement rates for the health services covered and normally make payments directly to the providers who render the services. At the federal level, HHS' Health Care Financing Administration (HCFA) has overall responsibility for administering Medicaid.

Generally, persons receiving public assistance under the Aid to Families with Dependent Children and Supplemental Security Income programs are eligible for Medicaid. Also, at the option of each state, persons who do not qualify for public assistance but cannot afford to pay for necessary health care can be made eligible for Medicaid benefits.

Depending on a state's per capita income, the federal government pays from 50 to 78 percent of the state's costs for health services and also reimburses the state for 50 to 90 percent of its administrative costs, depending on the administrative function performed. In fiscal year 1984, Medicaid costs totaled an estimated $38 billion; the federal share was $21 billion and the state share was $17 billion.

The Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001) provides that employers, labor organizations, and other employee organizations that wish to establish welfare benefit plans, which may include medical insurance coverage, must meet certain minimum requirements. For instance, ERISA establishes funding, disclosure, and reporting requirements and outlines fiduciary responsibilities directed at protecting employee benefit rights. The Department of Labor is responsible for administering ERISA. Labor estimates that there are about 2,600 self-insured health plans, covering approximately 7.5 million employees and former employees, exempted from state regulation by ERISA.

MEDICAID IS BY LAW
A SECONDARY PAYER

The Congress intended that, as a public assistance program, Medicaid would pay for health care only after recipients had used any other available health care resources, thus making it a secondary payer (or payer of last resort). Accordingly, Medicaid law and regulations require that states make reasonable efforts to identify and collect from liable third parties, including health plans providing coverage to Medicaid recipients. The states share any savings with the federal government in the same proportion as medical expenditures.

According to Bureau of the Census statistics and HHS data,[1] between 18 and 20 percent of the Medicaid population have some form of private health insurance. Normally, Medicaid eligibles covered under health plans obtain coverage through their own or their parents' full- or part-time employment, wherein the employers pay for all or part of the premiums. For example, children in AFDC families qualify for Medicaid coverage, but they may also be covered under their parents' health plans.

Public Law 95-142 (approved Oct. 25, 1977) added to the Medicaid law section 1903(o), which prohibits the federal government from participating, and states from claiming federal sharing, in payments when health plans by a private insurer, as defined by the Secretary of HHS, treat Medicaid as a primary payer. This amendment was designed to remedy the situation where private health plans, which are regulated by the states, contained provisions that limit the insurers' liability to the amounts not paid by Medicaid, thus effectively making Medicaid the primary payer. Section 1903(o) provided an incentive to the states to prohibit the health insurers they regulate from making Medicaid the primary payer. The language of the law, however, is broader covering all private insurance plans, including those not regulated by the states.

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[1]National Medical Care Utilization and Expenditure Survey, conducted by HHS, on characteristics of the noninstitutionalized Medicaid population, 1980 sample data.

STATES CANNOT ENFORCE
MEDICAID AS SECONDARY PAYER
TO ERISA HEALTH PLANS

The states generally have no regulatory control over self-insured ERISA health plans because section 514 of ERISA (29 U.S.C. 1144) specifically exempts those plans from state regulation.[2] Therefore, states cannot prevent ERISA health plans from excluding payments for services covered by Medicaid. Likewise, ERISA does not preclude these plans from designating their coverage as secondary to Medicaid. ERISA legislation places no constraints on the plans' benefit packages, nor does it give Labor authority to define or regulate the benefits that the plans provide or exclude.

A dilemma exists in implementing section 1903(o) because ERISA health plans are private insurers. The Secretary of HHS has defined private insurers in regulations (42 C.F.R. 433.136) to include any organization that administers a health plan, including those under ERISA. Including ERISA health plans in the definition of private insurers is necessary to be consistent with congressional intent to make Medicaid the payer of last resort. Many ERISA health plans take the position, however, that they should not be included in the Secretary's definition of private insurers because section 1903(o) does not specifically mention health plans subject to ERISA.

We identified some ERISA health plans covering Medicaid recipients that paid for services only if they were not covered by Medicaid. State officials acknowledged that they were using federal Medicaid funds to pay for services that would have been covered under the ERISA plans if it were not for the plans' provisions that excluded coverage for Medicaid services. While the states had not maintained data on the amount of funds spent because of this practice and there are no overall data on the amount or the number of recipients involved, we were able to obtain the following information.

--In California, from July 1978 to April 1983, 139 of 239 ERISA plans that the state identified as covering Medicaid recipients had not reimbursed the Medicaid program for over $9 million of medical services provided to ERISA plan beneficiaries eligible for Medicaid. According to state

[2]Certain multiple employer welfare arrangements are not included in this exemption (see section 514(b)(6)).

Medicaid officials and correspondence from several of the nonpaying ERISA plans, this resulted because these plans excluded payment for Medicaid covered services.

--In New York, two large ERISA plans had informed state Medicaid program officials that because of exclusions, the plans would not pay medical bills for their beneficiaries also covered under Medicaid. The state Medicaid agency estimated that $2.5 million could be saved annually if all ERISA plans were considered a primary payer to Medicaid.

HCFA also provided correspondence from state Medicaid agencies in Wyoming, Wisconsin, Maryland, and Texas that showed instances where ERISA plans assumed the role of secondary payer to Medicaid by excluding payment for Medicaid covered services.

As discussed above, HCFA officials were aware that states were using federal Medicaid funds to pay for services that ERISA plans would have covered if they had not excluded payments for Medicaid services. But, HCFA had not denied federal financial participation in these situations. The HCFA official responsible for issues pertaining to Medicaid as secondary payer told us that denying federal participation would create an unintended hardship on the states, because they would have to absorb the full costs of the ERISA excluded services. He told us HCFA considered proposing legislation to make ERISA plans primary payer to Medicaid, thereby eliminating the need to deny federal financial participation. However, he believed that Labor should initiate the proposal, because Labor is responsible for enforcing ERISA legislation. According to this official, HCFA has held some discussions with Labor officials.

CONCLUSIONS

The Congress designed section 1903(o) of the Social Security Act to establish Medicaid as a secondary payer to private health insurance plans by encouraging states to use their regulatory authority or be denied federal matching funds. It was intended that states would prevent private insurers from unilaterally declaring themselves as secondary payer if the beneficiary was also eligible for Medicaid benefits.

Because the Congress intended Medicaid to be the payer of last resort, HHS also included employers' health plans covered by ERISA in its regulatory definition of private insurers. Many ERISA health plans believe, however, that they should not be included in the HHS definition because they are governed specifically by ERISA.

Although Medicaid law and regulations clearly prohibit federal sharing in Medicaid costs when ERISA health plans designate themselves as secondary to Medicaid, we do not believe that the Congress intended to penalize states in such situations because the states cannot prevent ERISA plans from doing so. HCFA recognizes the resulting inequity to states and as yet has not disallowed federal participation in situations involving Medicaid recipients whose ERISA health plans have designated themselves as secondary to Medicaid. Allowing such federal participation, however, is contrary to Medicaid law and regulations.

Two options are available to eliminate the possible inequity to the states and the legal dilemma facing HCFA. First, ERISA could be amended to require ERISA health plans to be primary payers to Medicaid. This action would make the relationship between ERISA health plans and Medicaid the same as the relationship between state-regulated health plans and Medicaid that the Congress required states to establish as a condition for receiving federal Medicaid funds.

Second, if the Congress does not desire ERISA plans to be primary payers to Medicaid, section 1903(o) could be changed so that states will not be penalized by the withholding of federal Medicaid funds caused by the actions of ERISA plans.

MATTERS FOR CONSIDERATION BY THE CONGRESS

To overcome the potential inequity created by the two acts, the Congress should consider enacting one of the following options:

--Amend the Employee Retirement Income Security Act of 1974 to establish ERISA health and welfare plans as primary payers to Medicaid.

--Amend section 1903(o) of the Social Security Act to restrict the denial of federal financial participation to only state-regulated insurance plans that exclude payment for services covered by Medicaid.

Enclosure I contains suggested legislative language that could be used in either case.

HHS COMMENTS

In commenting on this report (see enc. II), HHS agreed with the need to amend ERISA legislation to establish ERISA health and welfare plans as primary payers to Medicaid. HHS also agreed that such action would make the relationship between ERISA health plans and Medicaid the same as the relationship between state-regulated health plans and Medicaid which the Congress required states to establish as a condition for receiving federal Medicaid funds.

LABOR COMMENTS

Labor commented (see enc. III) that although it could not estimate the number of ERISA health plans that include provisions making Medicaid the primary payer, the number of such plans could be large enough to make this a significant budget issue. Labor also said that, given the current trend toward establishing self-insured plans under ERISA, the problem may increase over time.

Labor said that it would not oppose amending ERISA if the Congress determines this is the best solution and the amendment is worded narrowly to deal only with the exclusion of payment by ERISA health plans for services covered by Medicaid.

OBJECTIVE, SCOPE, AND METHODOLOGY

As part of a review of issues related to health insurance coverage of Medicaid recipients, we evaluated how Medicaid and ERISA interact.

The objective of that segment of our review was to determine whether barriers exist to accomplishing the intent of section 1903(o) when ERISA plans are involved. Our review was conducted in the three states with the largest Medicaid expenditures--New York, California, and Pennsylvania--which account for about one-third of the total Medicaid population. We interviewed state Medicaid officials in these states, and in New York and Pennsylvania we talked with representatives from the state insurance commissions about their experiences with enforcing section 1903(o). We also interviewed HCFA headquarters officials on problems with enforcing section 1903(o) as it relates to ERISA plans. The states provided correspondence documenting problems with insurance plans that treat Medicaid as primary payer. We attempted to determine the amount of funds paid by Medicaid because ERISA plans were excluding payments for services covered by Medicaid, but that information was not available except in

limited form from two states. The states do not record all instances when ERISA plans exclude payment for Medicaid services, nor do states know precisely how much the ERISA plans would have paid if Medicaid services were not excluded.

We conducted the review in accordance with generally accepted government auditing standards.

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Copies of this report are being sent to the Secretary of Labor; the Secretary of Health and Human Services; the Director, Office of Management and Budget; and the House and Senate committees and subcommittees having legislative and appropriation responsibilities for matters discussed in the report.

Charles A. Bowsher

Comptroller General
of the United States

Enclosures - 3

ENCLOSURE I

SUGGESTED LEGISLATIVE LANGUAGE

If the Congress chooses to amend the Employee Retirement Income Security Act, the following language, if added to section 402 (29 U.S.C. 1102), would effectively establish Medicaid as secondary payer to ERISA plans.

> "No employee welfare benefit plan shall contain any provision which has the effect of limiting or excluding benefits normally payable because a participant is also eligible for or is provided medical assistance under a state plan under title XIX of the Social Security Act. "

If the Congress chooses to amend section 1903(o) of the Social Security Act (42 U.S.C. 1396b(o)) so that states are not denied federal financial participation for ERISA plans that exclude payment for Medicaid services, this could be done by adding the underlined portion to section 1903(o) as follows:

> "Notwithstanding the preceding provisions of this section, no payment shall be made to a State under the preceding provisions of this section for expenditures for medical assistance provided for an individual under its State plan approved under this title to the extent that a private insurer (as defined by the Secretary by regulation), <u>except those exempted from State regulation by the Employee Retirement Income Security Act of 1974</u>, would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan."

ENCLOSURE II

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

OCT - 9 1984

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for the Department's comments on your draft report "Need for Legislative Change Affecting the Medicaid Program." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan Mitchell, Deputy IG
For Richard P. Kusserow
Inspector General

Enclosure

ENCLOSURE II

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Need for Legislative Change Affecting the Medicaid Program"

In its ongoing review of the Medicaid program, GAO noted a possible inequity that could result in States having to pay the full medical costs for certain Medicaid recipients. More specifically, the possible inequity occurs when Medicaid recipients have other insurance which is regulated under the Employee Retirement Income Security Act (ERISA) because these insurance plans are permitted to, and sometimes do, designate themselves as secondary payers to Medicaid. However, GAO notes, and we certainly agree, that the Congress intended that Medicaid be used as a secondary payer. Further, Medicaid law provides that no Federal funds may be used to make payments where Medicaid is not treated as a secondary payer.

To eliminate the possible inequity, GAO believes the Congress has two options: (1) amend the ERISA of 1974 to establish ERISA health and welfare plans as primary payer to Medicaid; (2) amend section 1903 of the Social Security Act to restrict the denial of Federal financial participation (FFP) to only State-regulated insurance plans that exclude payment for services covered by Medicaid. Clearly, we are in agreement with the need to amend the ERISA of 1974 to establish ERISA health and welfare plans as primary payer to Medicaid. This action would make the relationship between ERISA health plans and Medicaid the same as the relationship between State-regulated health plans and Medicaid which Congress required States to establish as a condition for receiving Federal Medicaid funds.

ENCLOSURE III

U.S. Department of Labor

Office of Pension and Welfare Benefit Programs
Washington, D.C. 20210

SEP 11 1984

Mr. Richard L. Fogel
Director
Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

In reply to your letter to Secretary Donovan dated August 9, 1984 requesting comments on the draft GAO report entitled "Need for Legislative Change Affecting the Medicaid Program," the Department's response is enclosed.

The Department appreciates the opportunity to comment on this report.

Sincerely,

Robert A.G. Monks
Administrator

Enclosure

ENCLOSURE III

U.S. Department of Labor's Response to the Draft General Accounting Report Entitled--

Need for Legislative Change Affecting the Medicaid Program

This GAO report deals with a problem resulting from conflicting Federal law. Under the Social Security Act, Medicaid is intended to be the payer of last resort, paying for health care after Medicaid recipients have used any other available health care resources. In certain situations however, Medicaid has become the payer of first resort.

Specifically, ERISA section 514 preempts all State law regulating health and welfare plans (except for insurance, banking, and several other exceptions). Thus certain self-insured welfare plans[1] cannot be prevented by State law from containing provisions which exclude payments for benefits covered under a state Medicaid plan. This results in states paying Medicaid expenses for costs normally born by health plans. According to GAO, the Federal Government is currently reimbursing states for paying such Medicaid expenses, although it is technically not permitted under the Social Security Act to do so. The GAO report recommends that Congress either amend ERISA so that self-insured health care plans cannot include provisions which designate Medicaid as a payer of first resort or amend the Social Security Act to permit reimbursement to states for expenses incurred by self-insured health care plans.

According to annual reports on file with the Department, there are approximately 2,600 self-insured health care plans covering roughly 7,500,000 participants. Although the Department has no way of estimating the number of these plans that include provisions making Medicaid the payer of first resort, it is at least conceivable that the number of plans could be sufficiently large to make this a significant budget issue. Furthermore, given the apparent current trend toward establishing self-insured plans the problems may well increase over time.

If Congress determines that amending ERISA is the best solution to this problem, then the Department would not oppose such an amendment so long as the amendment were very narrowly drafted to deal only with the matter described above, and without otherwise weakening the broad preemption of state law intended by Congress. The Department would work with Congress to develop the language of any such amendment.

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[1]Self-insured welfare plans are those plans which pay benefits directly rather than purchasing benefits from an insurance company.

ENCLOSURE III

The Department has two technical suggestions. Enclosure I contains draft legislative language developed by GAO. The GAO proposal for amending ERISA refers to section 102. Section 102 deals with the Summary Plan Description. Any such amendment should be made to ERISA section 514, " effect on other laws," or to section 402, "establishment of a plan". As stated before, the Department would work with Congress to develop the best language for such an amendment should such an amendment be deemed necessary.

In addition, page 4 of the GAO report contains a sentence which the Department feels should be changed to be technically accurate.

GAO note: Page number and enclosure reference have been changed to correspond to the final report.