

GAO

Report to the Chairman, Subcommittee
on Health and the Environment,
Committee on Energy and Commerce,
House of Representatives

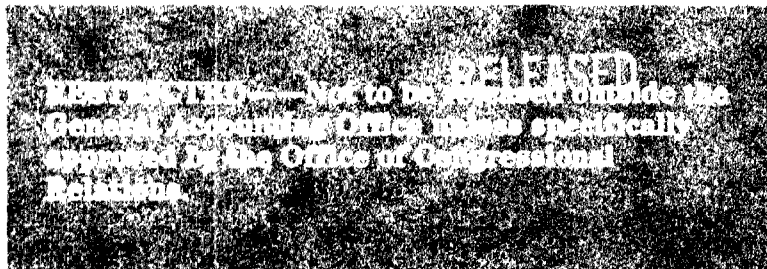
November 1990

MEDICAID

Legislation Needed to Improve Collections From Private Insurers



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Human Resources Division

B-238267

November 30, 1990

The Honorable Henry A. Waxman
Chairman, Subcommittee on Health and
the Environment
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

This report responds to your request that we review problems experienced by state Medicaid agencies in collecting from certain third parties. As a public assistance program, it was intended that Medicaid would pay for health care only after Medicaid recipients had used all their other health care resources. As agreed with your office, we focused our review on out-of-state insurers and employee health benefit plans covered under the Employee Retirement Income Security Act of 1974 (ERISA). State Medicaid agencies have reported problems collecting from these types of insurers. We agreed to provide information on the type and extent of the problems and discuss any potential legislative remedies needed to resolve them.

Results in Brief

Two major problems hinder states in collecting from private insurers for Medicaid recipients' covered health care costs.¹

1. States cannot prohibit some out-of-state insurers from taking actions that allow them to avoid paying state Medicaid agencies for such costs. States lack jurisdiction over insurers that operate only incidentally in the state.
2. States' limited authority over ERISA plans² does not allow them to prohibit these plans from certain actions to avoid payments for recipients' covered costs. Further, many states have not exercised the authority

¹The Secretary of Health and Human Services was expressly granted authority to define the term "private insurer." He has defined it broadly to include, for example, any commercial insurance company, prepaid medical plan, employer-employee benefit plan, or self-insured plan. Therefore, in this report we use "private insurer" and "insurer" (depending on the specific context), as the Secretary has defined the former term in regulation.

²ERISA provides that employers, labor organizations, and other employee organizations that wish to establish welfare benefit plans, which may include health benefits, must meet certain minimal requirements. The Department of Labor is responsible for administering ERISA. In this report, we refer to welfare benefit plans, which include health benefits, that are covered under ERISA, as "ERISA plans."

they do have to mandate that no ERISA plan include any contract provision having the effect of limiting or excluding payments for Medicaid recipients' health care costs.

State officials could not easily identify Medicaid losses through their payment systems, and we did not independently estimate the extent of the losses resulting from these problems. However, some state Medicaid officials gave examples of their Medicaid losses. These examples and information from federal agencies suggest that the losses may be substantial—perhaps millions of dollars annually—and are likely to grow in the near future. To minimize future losses, federal legislation is needed to clarify Medicaid's role as payer of last resort and enhance the states' abilities to collect from out-of-state insurers and ERISA plans.

Background

Medicaid is a federally aided, state-administered medical assistance program that in fiscal year 1988 served about 23 million low-income people. Generally, people receiving public assistance under the Aid to Families With Dependent Children (AFDC) and Supplemental Security Income programs are eligible for Medicaid assistance. Within broad federal limits, states determine the coverage and payment rates for medical services offered and normally make payments directly to providers who render the services.

The federal portion of state Medicaid payments is based on each state's per capita income. States with lower per capita incomes receive higher rates of federal matching. In fiscal year 1988, Medicaid medical assistance expenditures totaled about \$51.6 billion, of which the federal government paid \$29.0 billion (56 percent) and the states \$22.6 billion (44 percent).

At the federal level, the Department of Health and Human Services (HHS) has responsibility for overseeing state Medicaid administration. Within HHS, the Health Care Financing Administration (HCFA) is responsible for developing program policies, setting standards, and ensuring state compliance with federal Medicaid legislation and regulations.

Medicaid Intended to Be Payer of Last Resort

The Congress intended that Medicaid would pay for health care only after Medicaid recipients had used all other health care resources. Third parties providing health care coverage include health and liability insurers, ERISA plans, employee welfare benefit plans, workers' compensation plans, and Medicare. Up to 14 percent of Medicaid recipients may

have other health insurance, HCFA estimated in 1989. As a condition of Medicaid eligibility, individuals assign their rights to payments for medical care to the state Medicaid agency. A state shares any third-party savings with the federal government in the same proportion as Medicaid payments.

On its face, Medicaid law does not explicitly require that insurers treat Medicaid as the last payer. However, the law is structured to achieve this by requiring that states ascertain the legal liability of third parties and seek reimbursement to the extent of their liability. The law also prohibits federal cost-sharing when private insurers are allowed to use contract provisions to limit their costs to the amount not paid by Medicaid. The legislative history reveals that the intent was to prompt states to adopt laws that have the effect of requiring insurers to pay ahead of Medicaid.

States have passed laws that require insurers to reimburse the state Medicaid agency for Medicaid recipients' health care costs. However, some Medicaid recipients are covered by insurers not normally regulated by the Medicaid recipients' state, that is, insurers located outside of the recipients' state or ERISA plans.

Some Medicaid Recipients Covered by Out-of-State Insurers or ERISA Plans

Some Medicaid recipients who have health care coverage are likely to be covered by out-of-state insurers or ERISA plans that fall outside of state regulatory authority, although exact figures are unavailable. For example, Medicaid recipients may

- if they are children, have health coverage through a parent who lives in another state. These parents may be required by support agreements to provide their children with health benefits. AFDC families make up about 70 percent of the Medicaid population; one parent is usually absent.³ About 25 percent of absent parents live in a different state than their children.
- have coverage from out-of-state insurers because they obtained it in one state before moving to another.
- have coverage from out-of-state insurers because they work and obtain coverage in one state but live in another.
- have coverage from out-of-state or in-state ERISA plans through their employers or the employers of an absent parent, guardian, spouse, former spouse, or other relative. A 1988 Health Insurance Association of

³Fiscal year 1985 data, the latest available.

America survey indicated that 46 percent of American workers are covered by ERISA plans.

Scope and Methodology

We obtained information on the type and extent of problems states experienced in recovering from out-of-state insurers and ERISA plans. To do so, we contacted officials from HHS, HCFA, and the state Medicaid agencies in Alabama, California, Idaho, Illinois, Maryland, Michigan, Minnesota, New York, Texas, Washington, and Wisconsin. These states were selected because they had indicated to either HCFA or us that they were having problems collecting from certain liable third parties. We visited HCFA headquarters in Baltimore, Maryland, and Medicaid agencies in California, Michigan, and Washington; we contacted Medicaid agencies in the other eight states by phone. We limited our review to obtaining examples of losses. As agreed with your office, in order to provide this report to you as soon as possible, we did not audit or verify state-provided examples of losses.

To explore options for correcting problems with third-party liability, we reviewed Medicaid law and the legislative history behind the third-party provisions. Additionally, we met with HHS attorneys to discuss potential legislative remedies.

We conducted our work in accordance with generally accepted government auditing standards. The majority of the information was collected in January 1990.

Out-of-State Insurers Avoid Paying Costs for Medicaid Recipients

Out-of-state insurers are avoiding paying costs for Medicaid recipients they insure. They do this through actions that either preclude or significantly limit state Medicaid agencies' ability to recover, according to officials in 9 of 11 states we contacted. For example, some out-of-state insurers write clauses in contracts that exclude, or have the effect of excluding, payment for out-of-state Medicaid recipients. In other instances, the insurers will not recognize the Medicaid recipients' assignment of rights to medical payments to the state Medicaid agency.

States Lack Jurisdiction Over Some Insurers

From the legislative history, it is clear that the Congress intended that states pass laws preventing private insurers from limiting their liability to amounts not paid by Medicaid. However, an individual state cannot necessarily regulate all insurers that may be liable for a Medicaid recipient's medical expenses in the state. Insurers with fewer than "minimal

contacts” in a state generally are not within that state’s legal jurisdiction.⁴ Furthermore, federal law does not specifically address an out-of-state insurer’s obligation to reimburse state Medicaid agencies for paid claims.

A state may not be able to require that out-of-state insurers pay its Medicaid agency. However, the state can prohibit state-regulated insurers—those conducting business in its state—from treating another state’s Medicaid agency as primary payer. At the time of our review, no state had done so, a HCFA official told us. A state has little incentive to protect other states’ Medicaid agencies, as it will benefit financially only from recoveries made by its own state Medicaid agency.

Exclusionary Clauses Used to Deny Payment

Some insurers include clauses in their plans that exclude or have the effect of excluding payment for medical services payable by another state’s Medicaid plan. States have reported to HCFA problems in collecting from as many as 32 insurers. The principal cause was these insurers’ use of exclusionary clauses in their contracts, a HCFA official told us.

The exclusionary clause relieves the insurers of any “legal liability” to pay out-of-state Medicaid agencies, according to one of these “problem” insurers. The assertion was made in a letter from the insurer’s legal counsel to a state attempting recovery from the out-of-state insurer. Until a legal liability is created by federal statute, its own state’s statute, or private contract, the letter said, the insurer will continue to refuse reimbursement to out-of-state Medicaid agencies. Officials in 6 of the 11 states we contacted said that they had been denied payment by this one insurer for billing totaling about \$1 million between 1987 and 1989.

Medicaid Assignment of Rights Thwarted

Medicaid requires that recipients assign to the state Medicaid agency any rights to medical payments. But third parties may thwart the purpose of this requirement by refusing to pay for any of several reasons, such as:

- The insurer does not recognize the Medicaid assignment.
- The contract permits payment to be made only to the policyholder.

⁴Determining whether minimal contacts are present in a specific situation can be difficult to ascertain. Case law provides some guidance. See, for example, *International Shoe Company v. Washington*, 326 U.S. 310, or *Worldwide Volkswagen v. Woodson*, 444 U.S. 286.

Unless the state recovers its payment from the Medicaid recipient or the policyholder, which can be difficult or impractical, the state Medicaid agency may have to pay the claim. Also, a policyholder who is an absent parent may collect and retain the medical payment at the expense of the Medicaid program.

An insurer's refusal to recognize recipients' assignment of rights to the state Medicaid agency creates administrative problems. When this happens, the agency may try to convince the recipient to submit a claim to the insurer and return any payment received to Medicaid. In many cases, it is not cost beneficial for the states to pursue recoveries on a claim-by-claim basis because individual claims may be relatively small. In total, however, "substantial dollars" can be involved, as in the case of money Minnesota cannot recover from an out-of-state Blue Cross/Blue Shield organization. The organization did not recognize the recipients' assignment of medical payments to the Minnesota Medicaid program, a state Medicaid official told us. As the state could not justify the cost of pursuing payment from each recipient involved, it experienced substantial losses.

Likewise, substantial losses occur when insurers refuse to honor a Medicaid assignment because of contract provisions providing for payment to policyholders only. This creates problems, particularly if the policyholders are absent parents whose coverage includes their children. Chances of collecting from out-of-state absent parents are low, officials from some states say, because the policyholders have little incentive to pay either the provider or the Medicaid agency. To pursue recovery from these absent parents on a claim-by-claim basis is difficult, costly, and time-consuming, one state official said, and recovery is unlikely.

Failure to recognize the states' claims for recovery of payment can result in the financial gain of out-of-state absent parents at the expense of Medicaid. California Medicaid officials tell of an absent parent in Massachusetts who was receiving medical payments from his Massachusetts insurer. The payments were for the ongoing treatment of his child, a Medicaid recipient in California. Having billed the absent parent repeatedly, without success, the provider now has approached Medicaid about reimbursement for the care. Health care costs for the recipient were about \$48,000 at the time of our review. The California Attorney General was aware of the state's problems collecting from out-of-state insurers, a California Medicaid official indicated, but felt the state did not have the resources to pursue recovery. In addition, because federal

law is silent on the obligations of out-of-state insurers, a state attorney said, litigation does not hold much promise.

Lost Out-of-State Collections May Be Substantial

As many as 18 states have reported problems recovering from out-of-state insurers, a HCFA official told us. Although 9 of the 11 states we contacted reported such losses, officials said that they could not easily identify through their payment systems the losses from out-of-state insurers. Medicaid officials in four states did provide some examples:

- California billed 23 out-of-state insurers over a 1-year billing period for more than an estimated \$6.5 million that was not recovered.
- Illinois billed four out-of-state insurers over a 3-year period for an estimated \$369,000 that was not recovered.
- Wisconsin billed two out-of-state insurers over a 2-year period for an estimated \$220,000 that was not recovered.
- Michigan submitted 879 bills to 57 out-of-state insurers over an 8-month period for about \$397,000. For 635 of these bills and \$378,893 of the billed amount, the state received either rejection notices or no response.

States Unable to Collect From Some ERISA Plans

Most states have not taken advantage of the Congress's 1985 change to ERISA—allowing states to prohibit ERISA plans from using contract provisions that have the effect of limiting or excluding payments for Medicaid recipients. Even if states pass these prohibitions, they cannot forbid certain practices that have the same effect. In early 1990, state Medicaid agencies still were having difficulty collecting from some ERISA plans, even plans in the same state as the agency. Consequently, the savings to Medicaid anticipated from the Congress's action may not be realized.

As we reported in 1984, ERISA plans could legally avoid paying Medicaid because they could write provisions in their contracts that exclude payment for Medicaid recipients.⁵ ERISA provides that state laws generally do not apply to employee health benefit plans. Accordingly, the Congress amended ERISA in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). In effect, COBRA permitted states to pass laws that prohibit ERISA plans from limiting or excluding payments for individuals who would otherwise receive Medicaid benefits.

⁵Need for Legislative Change Affecting the Medicaid Program (GAO/HRD-85-9, Nov. 30, 1984).

State Authority Not Used, Some ERISA Plans Note

Only nine states have passed appropriate legislation covering ERISA plans as now permitted by COBRA.⁶ At least two plans have denied payments to states that lacked legislation specifically addressing ERISA plans. These plans will continue denying Medicaid recipient claims, plan representatives said, until the states pass the necessary legislation.

COBRA did not require that ERISA plans be subject immediately to pertinent third-party laws enacted by the states, but established time frames that depended on such conditions as when plan contracts were renegotiated. Not until April 1989 did all ERISA plans become subject to such state laws.

To preclude ERISA plans from using contract provisions to exclude payment for Medicaid recipients' health care costs, states must enact specific laws. Officials from two of the states we contacted said that a state law was unnecessary because ERISA plans had been paying voluntarily. Others interpreted COBRA as prohibiting ERISA plans from treating Medicaid as primary payer, thus making state action unnecessary. At least one state's Medicaid officials based their interpretation on an April 1988 memorandum from a HCFA headquarters official to HCFA regions. The memorandum indicated that COBRA prohibited ERISA plans from limiting or excluding coverage for Medicaid recipients.

State Regulatory Authority Over ERISA Plans Limited

Even if states pass the laws anticipated under COBRA, they can prohibit ERISA plans only from using exclusionary contract clauses that have the effect of limiting payment for a Medicaid-eligible individual. COBRA language may not be broad enough to enable states to prohibit ERISA plans from using other practices--such as those employed by out-of-state insurers—that have the same effect. Specifically, states apparently cannot preclude ERISA plans from not recognizing the Medicaid recipients' assignment of rights or following a procedure of paying only the policyholder. Thus, states have little recourse in dealing with ERISA plans that use such practices.

Some ERISA plans include in their contracts language providing that benefits are not assignable to the medical provider, state officials said. This results in the same problems that occur when out-of-state insurers do not honor the assignment. Without a means to preclude these practices, as can happen with out-of-state insurers, states may be unable to recover payments cost effectively.

⁶Research Institute of America, Benefits Coordinator, Vol. 1, par. 11,724.

Anticipated Savings From COBRA in Jeopardy

As with losses from out-of-state insurers, losses from ERISA plans are not easily identified through state payment systems, state officials told us. Such losses could be substantial, other estimates suggest. To determine the potential impact of the ERISA amendment on COBRA, the Congressional Budget Office (CBO) and HCFA estimated recoveries expected from ERISA plans that were excluding payment for Medicaid-eligible individuals. For fiscal years 1990 and 1991, CBO estimated recoveries of approximately \$35 million and \$40 million, respectively. HCFA officials estimated fiscal year 1990 recoveries of \$250 to \$475 million.⁷ The problems described above jeopardize the realization of such savings.

Losses From Out-of-State Insurers and ERISA Plans Likely to Grow

Future Medicaid losses may not be limited to those reported from out-of-state insurers and ERISA plans not paying state Medicaid agencies. Losses to Medicaid are likely to increase because recently

- a major insurance association has taken the position that Medicaid is not always last payer and
- HCFA regulations have required, on the basis of COBRA, that states assume more of the responsibility from providers for recoveries and hence the losses from nonrecoveries.

Medicaid Not Always Last Payer, Blue Cross/Blue Shield Asserts

Some insurers appear to be changing their position with regard to when they are liable for paying Medicaid recipients' health care costs. In 1988, the Blue Cross/Blue Shield Association adopted the position that insurers need not treat Medicaid as the payer of last resort. The association believes that its member plans may not be required to treat Medicaid as last payer so long as their contracts comply with state laws. This conflicts with broad language included in the association's third-party liability manual, published in 1980. The manual acknowledged that federal law requires Medicaid to be the last payer. It was distributed to all association member plans and state Medicaid agencies.

In May 1988, a HCFA official met with national Blue Cross/Blue Shield Association officials to discuss problems states had in collecting from out-of-state Blue Cross/Blue Shield insurers. According to his written

⁷CBO could not tell us the assumptions upon which its estimates were based or the reasons for the discrepancies between CBO and HCFA estimates. HCFA based its estimates on assumptions that (1) 40 percent of employer-sponsored health insurance is self-insured, (2) 60 percent of current third-party recoveries arise from employer-sponsored health insurance, (3) 1.8 to 3.6 percent of federal Medicaid expenditures will be recovered from third-party resources, (4) the above percentages apply to the Medicaid program uniformly, and (5) the impact of the provision will "grade in" over 3 years.

summary of the meeting, the association questioned the legal basis for Medicaid's being designated as last payer. In addition, even though federal law required state Medicaid agencies to pursue recovery or risk losing federal matching funds, the association asserted that the liability of third-party payers is governed by the terms of local association contracts. If the provisions of the insurers' contracts conform to applicable state law, the association spokesman said, the insurer may not be required to honor claims by Medicaid agencies.

States Given More Responsibility for Recovering Medicaid Costs

To assure that Medicaid is treated as last payer, states use two processes—"postpay recovery" and "cost avoidance:"

- After state officials determine that a Medicaid recipient has another health care resource available, they attempt to recover costs the states paid from the liable third party (postpay recovery).
- The state then places an indicator in the claim processing system so that Medicaid does not pay future claims for that person but requires the provider to bill the third party (cost avoidance).

Cost avoidance provides the majority of states' third-party savings. For example, the federal share of state third-party liability savings in fiscal year 1988 was about \$1.3 billion in cost avoidance and about \$109 million in postpay recoveries, states reported. Accordingly, states most likely have avoided recovery problems to a great extent by not paying the provider for costs when the state knew the recipient had insurance. Instead, states rejected the claims from the providers, who then had to pursue the payment from insurers. Providers in turn are having extensive problems in collecting from ERISA plans and, to some extent, out-of-state insurers who do not recognize the recipient's assignment of rights or are only paying the policyholder, a provider representative in Washington told us. In these cases, providers may be experiencing losses due to their inability to collect from the plans.

New federal Medicaid regulations require the states to pay the provider in certain situations and assume more of the responsibility for recovering from the liable third parties. In January 1990, HCFA finalized regulations based on COBRA that require states to pay prenatal care, preventive pediatric care, and absent parent-related claims and then

seek recovery from the known third party.⁸ These requirements were intended to protect a mother and her dependent children from having to pursue an absent parent, his employer, or the insurer for third-party liability. Further, the Congress was concerned that the administrative burdens associated with third-party liability collection efforts not discourage participation in the Medicaid program by physicians and other providers of preventive pediatric and prenatal care.

This change is likely to increase losses to Medicaid because the state will have to pursue claims previously pursued by the providers. One state official estimated that these requirements would affect over half of all claims processed for third-party liability. As states assume more of the responsibility from providers for billing third parties, they will have more problems collecting from out-of-state insurers and ERISA plans, Medicaid officials from 10 of the 11 states we contacted said.

Legislation Needed to Clarify Federal Policy, Improve Collections

To close loopholes in the law that allow some insurers that should pay state Medicaid agencies to avoid doing so, legislative action is needed. Legislation should clarify federal Medicaid policy and establish an effective means for states to directly recover from all appropriate third parties. Analogous Medicare legislation, known as the Medicare secondary payer (MSP) provision, can serve as a model for similar Medicaid legislation. Medicare law provides a much more effective statutory basis for the federal government to recover from private insurers than that currently available to states in Medicaid statute. However, this model must be adapted to account for the federal/state nature of the Medicaid program. Any legislative remedy necessarily would be somewhat complex.

Under the MSP provision, the federal government has a right to recover from liable third parties regardless of their contract provisions. The United States can bring an action against an insurer that is not paying appropriately for a Medicare recipient's costs. Further, insurers are given an incentive to comply because the MSP provision provides for payment of a penalty double the amount originally owed as a result of such suits. This double damage provision was necessary because insurers that did not appropriately pay beneficiaries' medical bills faced

⁸Specifically, COBRA requires the state to make payment for services and seek reimbursement from third parties in cases where there is prenatal or preventive pediatric care, or where the third-party liability is derived from the parent whose obligation to pay support is being enforced by child support enforcement agencies.

no penalty and saved themselves money by not doing so, as we previously reported.⁹ Finally, as an additional enforcement mechanism, the MSP provision allows anyone to sue for double damages when they become aware that a liable third party is not fulfilling its payment obligations under the provisions.

The administrative aspects of the Medicaid program typically are handled at the state level, and primary responsibility for enforcement should remain with the states. But legislation based on the MSP provisions could improve collections significantly. Adapting the Medicare model for the Medicaid program would require federal legislation to do the following:

1. Make it explicit that Medicaid is payer of last resort.
2. Clarify that appropriate third parties have a duty to pay or reimburse Medicaid regardless of any contract provision.
3. Provide an efficient and comprehensive enforcement scheme. The existing pertinent provision in ERISA also would have to be adjusted to give states the necessary means to fulfill all their third-party obligations under Medicaid law.

Conclusions

While states have been required by law to pursue recoveries from liable third parties, the current statutory framework does not provide an adequate means for states to recover from some out-of-state insurers and ERISA plans. As a result, Medicaid may be spending millions of dollars for Medicaid recipients' health care costs that others should be paying. The problem is likely to grow as the states assume more of the responsibility for recovering from liable third parties and more insurers exploit loopholes in current Medicaid law to avoid paying recipients' costs.

Recommendations to the Congress

We recommend that the Congress amend federal law to explicitly state that Medicaid is payer of last resort, give states the authority needed to recover from all liable third parties, and provide effective mechanisms for enforcement. Our suggested language, with an accompanying explanation, appears in appendix I.

⁹Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 1988).

Agency Comments

GAO requested written comments on a draft of this report from HHS and the Department of Labor. Their written comments, summarized below, are presented in full in appendices II and III.

HHS concurred with our findings. It agreed that federal legislation is needed, in some cases, to address insurance industry practices not effectively dealt with by current law and, in other cases, to require states to use authority they already have to control abuses. Because it was still reviewing the full extent of the problem and the legislative changes needed to resolve it, HHS took no position on our specific proposed legislative changes. HHS proposed a technical change, which we made to clarify congressional intent concerning legislation requiring states to pay claims in cases involving prenatal care and absent parents. After sending the draft to HHS for written comment, we learned that HCFA's preliminary estimate of losses occurring because out-of-state insurers were not reimbursing state Medicaid agencies was about \$200 million (federal and state).

Labor commented about the primary focus of our ERISA-related concerns and the distinction between problems states have with out-of-state insurers and those with ERISA plans. We have considered their comments and made clarifications, where appropriate. Labor also indicated that part of our proposed amendment to ERISA may be unnecessary. We believe that it is necessary; our rationale is included in our response to Labor's comments in appendix III.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties.

This report was prepared under the direction of Janet Shikles, Director, Health Financing and Policy Issues. Should you have any questions concerning this report, please call her on (202) 275-5451. Other major contributors are listed in appendix IV.

Sincerely yours,

Edward A. Blensmore

for

Lawrence H. Thompson
Assistant Comptroller General

Contents

Letter	1
Appendix I Suggested Legislative Language and Explanation	16
Appendix II Comments From the Department of Health and Human Services	22
Appendix III Comments From the Department of Labor	25
Appendix IV Major Contributors to This Report	32

Abbreviations

AFDC	Aid to Families With Dependent Children
CBO	Congressional Budget Office
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
ERISA	Employee Retirement and Income Security Act of 1974
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
MSP	Medicare secondary payer

Suggested Legislative Language and Explanation

SEC. []. MEDICAID AS PAYER OF LAST RESORT.

(a) AMENDMENTS TO STATE PLAN REQUIREMENTS.—(1) Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended—

(A) by striking “and” at the end of subparagraph (F),

(B) by inserting “and” at the end of subparagraph (G), and

(C) by adding the following new subparagraph:

“(H) that states meet the requirements of 1902(z) related to Medicaid being the payer of last resort;”.

(2) Section 1902 (42 U.S.C 1396a) is amended by adding the following new subsection:

“(z)(1) In order for a state to meet the requirements of subsection (a)(25)(H), a State must provide that—

“(A) a private insurer (including health benefit plan, fund, third-party administrator, or similar entity or program providing payments for medical assistance) may not take into account that an individual is eligible for or receiving medical assistance under any State plan under this title;

“(B) no payment for medical assistance is made under this title, except as provided in subparagraph (C), to the extent that payment has been made, or can reasonably be expected to be made, by a third party; and

“(C) all payments for medical assistance under the State plan are conditioned on prompt reimbursement to the plan when a third party learns, or receives information indicating, that it is liable for payment of such medical assistance.

“(2) In order to recover payment for medical assistance paid under its State plan, a State may join or intervene in any action related to events that gave rise to the need for such medical assistance.

“(3) To the extent payment for any medical assistance has been made under its State plan, a State shall be subrogated to the right of any party to payment for such medical assistance.

“(4) There is established a private cause of action for double the amount originally owed against any party that fails to provide for payment or appropriate reimbursement in accordance with paragraph (1). If a party other than the State affected brings an action under this paragraph, that State shall be entitled to a portion of any judgment or settlement equal to the amount originally owed.”.

(b) AMENDMENT TO PAYMENT RESTRICTIONS.—(1) Section 1903(o) of such act (42 U.S.C. 1396b(o)) is amended to read 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 (including health benefit plan, fund, third-party administrator or similar entity, or program providing payments for medical assistance) would have been obligated to provide such assistance but for a contract provision, policy, practice, or pattern having the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under any State plan under this title.”

(c) CONFORMING AMENDMENTS.—(1) Section 1912 of such Act (42 U.S.C. 1396k) is amended—

(A) in subsection (a) before paragraph (1), by inserting “or on behalf of” after “care owed to”; and

(B) by adding at the end the following new subsection:

“(c) The State shall prohibit any contract provision, policy, practice, or pattern on the part of a private insurer (including health benefit plan, fund, third-party administrator or similar entity or program providing payments for medical assistance) that has the effect of preventing effective assignment of benefits as required by this section.”

(2) Section 1917(b) of such Act (42 U.S.C. 1396p(b)) is amended by adding at the end the following new paragraph:

“(3) Paragraph (1) shall not be construed to prohibit reimbursement of payments as necessary to meet the requirements of section 1902(z).”

(d) ERISA AMENDMENT.—Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(8)) is amended (1) in subparagraph (2)(B) by striking “Neither” and substituting “Except to the extent necessary to comply with sections 1902(a)(25) and (45) of the Social Security Act, neither”; and

(2) by striking paragraph (8) and substituting the following new paragraph (8):

“(8) Subsection (a) of this section shall not apply to any State law to the extent necessary to comply with section 1902(a)(25) and (45) of the Social Security Act.”

(e) REGULATIONS.—Within 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall promulgate final regulations necessary to carry out the amendments made by this section

(f) EFFECTIVE DATES.—(1) Except as specified in paragraph (2), amendments made by this section shall apply to calendar quarters beginning on or after the date of enactment.

(2) In the case of a State plan for medical assistance (under title XIX of the Social Security Act that the Secretary determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to

meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

Explanation

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) set forth certain state plan requirements and other provisions related to third-party liability. The intent of these provisions was to make certain that Medicaid be the payer of last resort; that is, that other available third-party resources (for example, employee health benefit plans, commercial insurance, tort damage awards, compensation programs, and so forth) be used before the program pays for the care of an individual eligible for Medicaid.¹

State Medicaid agencies have experienced several types of problems, however, in collecting from certain liable third parties. It has been particularly difficult for states to collect from out-of-state insurers and employee benefit plans that may be covered by the Employee Retirement Income Security Act of 1974. The purpose of this section is to eliminate any obstacles that hinder the states' ability to collect fully from these and other liable third parties. It is similar in many ways to section 1862(b) of the Social Security Act (Act) (42 U.S.C. 1396y(b)), which is known as the Medicare secondary payer (MSP) provision.

State Plan Requirements.—In recognition of the difficulties associated with collecting from liable third parties (despite the fact that the Act already provides for Medicaid to be the payer of last resort), subsection (a) amends state plan requirements to impose specifications intended to ensure that Medicaid be the payer of last resort in each and every case. In addition, this subsection enhances the power of the states to collect from liable third parties.

Specifically, this subsection requires states to provide that a private insurer may not take into account that an individual is eligible for, or receiving, Medicaid benefits whether under that state's Medicaid plan or any other state Medicaid plan. The amendment would make it clear that

¹The McCarran-Ferguson Act (15 U.S.C. 1011 et seq.) provides that the business of insurance be subject to the laws of the States except when federal statute specifically relates to the business of insurance, as in the case of Medicaid third-party liability. This section is generally not intended to alter that arrangement.

the term “private insurer” is used in the broadest possible sense to include all entities or programs that are in a position to be primary to Medicaid. Reference to any state plan should lessen the difficulties currently associated with collecting from out-of-state insurers. The phrase “take into account” is used as it is in the MSP provision.

This subsection, in general, also requires states to provide that payments may not be made to providers for cases in which liable third parties have been identified.² Under certain circumstances, however, payments may be made, but are conditioned on prompt reimbursement. Such circumstances may include, for example, those in which prompt payment was required for (1) prenatal or preventive pediatric care or (2) services on behalf of an individual for whom child support enforcement was being sought.

Furthermore, the states are provided an explicit right to join or intervene in any action giving rise to the need for any medical assistance that has been paid under its state plan (such as a tort suit or the like). As an additional enforcement mechanism, states are subrogated—to the extent that the state plan has paid for medical assistance—to the related rights of any beneficiary, provider, or other party.

This subsection also permits suits to be brought in federal court against liable third parties to recover payments made under a state plan. It is hoped that this mechanism will provide a strong incentive for third parties to pay or reimburse states promptly. A party that prevails in such a suit would be awarded double the amount of the original liability. It is anticipated that access to federal courts will mitigate constitutional and procedural obstacles involved in collecting from out-of-state parties.

In the event that a party other than a state that paid for medical assistance institutes a suit, the state that paid for the medical assistance is entitled to a portion of any judgment or settlement equal to the amount that was paid under the state plan. This gives the state the option of pursuing reimbursement directly against a liable third party and getting double the amount originally owed or benefitting from suits brought by others and collecting the amount of the original liability.

²Although the type of third parties affected is necessarily comprehensive, this is not intended to affect the application of the Indian Self-Determination Act (beginning at 25 U.S.C. 450), which provides for certain institutions to be reimbursed by Medicaid in the same manner as other similar institutions.

Payment Restrictions.—Subsection (b) amends section 1903(o) for three purposes. First, to clarify that private insurers should be precluded from excluding or limiting by any means payment on behalf of any individual eligible or receiving Medicaid. Second, that private insurers should be precluded from excluding or limiting such payment in any state whether or not it is the state where the private insurer is located. And, third, that the prohibition on excluding or limiting such payment should extend to all appropriate third-party entities. This will require each state to take action to ensure that its sister states are not denied payments, but it is anticipated that the Secretary will, by regulation, provide the necessary guidance to enable states to comply.

Conforming Amendments.—Subsection (c) amends section 1912 of the Act, requiring states to eliminate obstacles to Medicaid recipients' assignment of benefits. Such assignment makes it easier for states to recover from liable third parties. In addition, to eliminate any confusion, the subsection also clarifies that section 1917 of the Act does not bar recovery for the purpose of ensuring that Medicaid is the payer of last resort.

ERISA Amendment.—The Employee Retirement Income Security Act of 1974 (ERISA) preempts state laws affecting covered employee retirement and welfare plans. This preemption has been raised as a barrier by parties seeking to avoid fulfilling their third-party obligations with respect to Medicaid. COBRA amended ERISA to provide a limited exception to this preemption. However, this COBRA amendment has not been sufficient to eliminate at least procedural obstacles to collection of third-party liabilities associated with Medicaid.

Subsection (d) broadens the exception to the ERISA preemption so that states have the necessary power to ensure that Medicaid is the payer of last resort even with respect to plans that may be covered by ERISA. This subsection also provides that state insurance laws may be construed as applicable to employee benefit plans, but only to the extent necessary to facilitate third-party identification and recovery.

When COBRA was passed, there was concern that because the ERISA amendment could expose some plans to new liabilities, it could produce hardships for insurers who had not anticipated these liabilities when they designed their plans. To address this concern, the ERISA amendment provided for a delayed effective date. Since all insurers should by now

have adjusted their plans to provide primary coverage for their beneficiaries, the ERISA amendment takes effect when the rest of the section becomes effective.

Regulations.—In recognition of the severe problems experienced by the states in collecting against liable third parties and the urgency of achieving related program savings, subsection (e) requires the Secretary to promulgate implementing regulations promptly (that is, within 6 months of enactment).

Effective Dates.—Subsection (f) provides for the section to take effect on the first calendar quarter beginning on or after the date of the enactment of the section. A delayed effective date is provided in cases where the Secretary ascertains that state legislation will be necessary in order for the state to comply with the section.

Comments From the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

SEP 4 1990

Ms. Janet L. Shikles
Director
Health Financing and Public Health Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Shikles:

Enclosed are the Department's comments on your draft report, "Medicaid: Legislation Needed to Improve Collections From Private Insurers." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "R. Kusserow".

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Medicaid: Legislation Needed to Improve
Collections From Private Insurers"

We have reviewed the GAO draft report and are very interested in the findings. We agree that a small but significant number of private health insurers, including plans covered under the Employee Retirement Income Security Act of 1974, are showing great ingenuity in using loopholes and gaps in current Federal and State law regulating health insurance to avoid Congress' intent that Medicaid be the payer of last resort. We concur in the report's conclusions that increasing numbers of insurance policies include language indicating that coverage is not available if the insured is eligible for Medicaid, Medicare, or county or municipality-provided health benefits; that certain private insurers are refusing to honor recipients' assignment to Medicaid of rights to third-party payments; and that it is becoming an increasingly common practice to incorporate exclusionary clauses in health benefit plans or policies (excluding, for example, coverage of dependent children who are not members of the same household as the named insured, or who are born out of wedlock).

We also concur with the report's conclusion that Federal legislation is needed. It is needed in some cases to address insurance industry practices that cannot effectively be addressed under current law. In others it is needed to require States to use authority they already have to control these abuses. However, the Department is still reviewing the full extent of the problem and the legislative changes needed to resolve it. Consequently, we take no position at this time on the specific legislative changes proposed in the GAO report.

We would like to correct a statement in the paragraph beginning at the bottom of page 21 of the draft report. The statement indicates that the regulations requiring States to pay prenatal, preventive pediatric care, and absent parent-related claims and then seek recovery from the known third party are designed ". . . to prevent harassment by providers of pregnant women and single-parent Medicaid recipients whose children receive support from an absent parent." This is not what Congress stated.

The conference report accompanying this legislation states that, in the case of beneficiaries on whose behalf a child support enforcement is being carried out by a State agency under title IV-D of the Social Security Act, the intent is to protect the mother and her dependent children from having to pursue the absent spouse, his employer, or his insurer for third party coverage. In

**Appendix II
Comments From the Department of Health
and Human Services**

Page 2

addition, it was indicated that the changes were made so as not to discourage participation in the Medicaid program by physicians and other providers of preventive pediatric and prenatal care, since the beneficiaries in need of such services already have difficulty finding quality providers in many communities.

Comments From the Department of Labor

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

U.S. Department of Labor

Pension and Welfare Benefits Administration
Washington, D.C. 20210



JUL 31 1990

Janet J. Shikles
Director,
Health Financing and Policy Issues
United States General Accounting Office
Washington, DC 20548

Dear Ms. Shikles:

Thank you for providing the Department of Labor with an opportunity to comment on your draft proposed report regarding the problems faced by state Medicaid agencies in collecting from insurers and employee benefit plans.

Attached are the Department's comments with respect to this draft proposed report.

Sincerely,

A handwritten signature in cursive script, appearing to read "Ann L. Combs".

Ann L. Combs
Deputy Assistant Secretary for
Policy

Department of Labor Comments on GAO Draft Proposed Report
Regarding the Problems Faced by State Medicaid Agencies in
Collecting from Insurers and Employee Benefit Plans:

1. With respect to the RESULTS IN BRIEF section of the draft proposed report:

See comment 1.

Item 2. of the "RESULTS IN BRIEF" section (page 2 of the draft proposed report) begins with the statement that "State's limited authority over ERISA plans does not allow them to prohibit these plans from certain actions to avoid payments for Medicaid recipients' covered health care costs." This statement is an overgeneralization that is not supported by the subsequent discussion in the report.

See comment 2.

First, the report recognizes that many state Medicaid agencies have experienced difficulty collecting from third-party payers because only nine states have enacted legislation prohibiting employee benefit plans from adopting provisions that deny coverage of medical claims based on a participant's eligibility for Medicaid. This is the primary cause of states' failure to collect; therefore, it should be the primary conclusion of item 2. ERISA section 514(b)(8) expressly provides that such state laws are not preempted by ERISA section 514(a). While some states may have misconstrued their ability to enact such legislation or the necessity to enact such legislation, the fact that they have failed to enact such legislation can not be attributed to ERISA "not allowing" them to do so.

See comment 3.

Second, the fact that states can not "cross state lines" in order to reach out-of-state employee benefit plans is not the result of any legal obstacle created by ERISA. There is nothing in ERISA section 514(b)(8) that limits its express exception from the preemptive effect of ERISA section 514(a) to state laws applicable to in-state plans as opposed to out-of-state plans. It is general limitations on state insurance law jurisdiction, not ERISA, that prevents states from asserting their authority "across state lines". If the Social Security Act (or other federal law) is amended to give states the authority to "cross state lines" to enforce Medicaid secondary payer requirements, ERISA section 514(b)(8), read in conjunction with ERISA section 514(d) which provides that ERISA does not preempt other federal laws, would generally pose no obstacle to states exercising their authority over out-of-state plans and insurers.

2. With respect to the main body of the draft proposed report:

Toward the end of the subsequent detailed discussion of ERISA-related issues, the report draws the following conclusion (on page 17): "Even if states pass the laws anticipated under COBRA, they may only prohibit ERISA plans from using exclusionary contract clauses that limit payment

when an individual is eligible for Medicaid. COBRA language was not broad enough to enable states to prohibit ERISA plans from using other practices -- such as those employed by out-of-state insurers -- that have the same effect. Specifically, states can not preclude ERISA plans from not recognizing the Medicaid recipients' assignment of rights or paying only the policy holder."

See comment 4.

ERISA section 514(b)(8) reads in part that "Subsection (a) of this section shall not apply to any State law mandating that an employee benefit plan not include any provision which has the effect of limiting or excluding coverage or payment for any health care...." GAO apparently concludes that this provision authorizes states to prohibit plan provisions that expressly deny liability because the participant is Medicaid-eligible, but that states can neither compel plans to incorporate provisions recognizing such liability nor proceed against plan administrators who deny liability even though the plan is silent on the issue of a participant's eligibility for Medicaid. This restrictive interpretation of the relief from ERISA preemption granted by ERISA section 514(b)(8) is unsupported in the report by any legal analysis of the statutory language, analysis of congressional intent as reflected in the section's legislative history, or any citation of court interpretation of the statutory language.

3. With respect to the draft legislation in Appendix I of the proposed draft report:

Appendix I contains proposed legislation to address the concerns expressed in the report. Section (d) of the proposed legislation would amend ERISA sections 514(b)(2)(B) and 514(b)(8).

See comment 5.

Without commenting on the merits of the proposed amendment to the Social Security Act itself, the proposed amendment to ERISA Section 514(b)(8) which would expressly cross-reference the Social Security Act sections authorizing states to enforce Medicaid secondary payer provisions does not appear to raise any significant technical concerns. We note, however, that since the amendment is not drafted in usual statutory drafting parlance, there is some ambiguity whether the amendment to ERISA section 514(b)(8) would strike the entire current text of the section and substitute new text, or simply append the new sentence to the end of the current text. Further, since ERISA section 514(d) expressly states that ERISA does not preempt other federal laws, the proposed amendment to ERISA section 514(b)(8) may not be necessary at all in order to grant states the desired authority under the Social Security Act.

See comment 6.

See comment 7.

The proposed amendment to ERISA section 514(b)(2)(B) is unnecessary and inappropriate. ERISA's general preemption rule is established by ERISA section 514(a). ERISA section 514(b)(2)(B) (the so-called "deemer clause") is intended to be read in conjunction with ERISA section 514(b)(2)(A) (the so-called "saving clause") to draw a distinction between employee benefit plans which states are prohibited from regulating under the general rule of ERISA section 514(a) and residual state authority to regulate insurers, banks, trust companies and investment companies. In the context of health benefit plans, these tandem provisions create certain distinctions between self-insured plans and insured plans. These distinctions between self-insured plans and insurance policies or contracts is not relevant to the Medicaid secondary payer issue, however. The ERISA-specific issue is state regulation of employee benefit plans per se (whether or not they self-insure). Thus, both the current text of ERISA section 514(b)(8) and the proposed revised version of ERISA section 514(b)(8) make reference to the general preemption rule of ERISA section 514(a), not the "deemer clause" of ERISA section 514(b)(2)(B). There is no compelling legal or policy reason why an employee benefit plan needs to be deemed an insurer under ERISA section 514(b)(2)(B) in order to effectuate an exception to the broad preemptive scope of ERISA section 514(a) under the proposed revision to ERISA section 514(b)(8).

The following are GAO's comments on the Department of Labor's letter dated July 31, 1990.

GAO Comments

1. We disagree that the statement discussed is an overgeneralization. The information presented on p. 8—specifically, that states are unable to preclude ERISA plans from disregarding the Medicaid recipient's assignment of rights or paying only the policyholder—supports the statement.
2. We disagree that state laws prohibiting ERISA plans from adopting certain provisions—those having the effect of denying coverage based on a person's eligibility for Medicaid—would be sufficient. Moreover, states have little incentive to pass the laws anticipated by COBRA when ERISA plans are likely to get around them. The bottom line is that the states do not have adequate authority to stop ERISA plans from excluding Medicaid.
3. We agree that ERISA does not create a legal obstacle to states' crossing state lines to reach out-of-state ERISA plans and did not mean to imply that. We have modified the report to clarify that problems with out-of-state insurers and ERISA plans—both in-state and out-of-state—are independent of one another.
4. We disagree with Labor's suggestion that an amendment to the law is unnecessary. We believe the current statutory language is inadequate because ERISA plans use a variety of actions and practices—as opposed to contract provisions—to avoid paying states; understandably, plans have demonstrated an unwillingness to concede any legal issue that would result in their having to pay. When an ERISA plan disputes its liability for payment, a state's only recourse is to incur the expense and uncertainty of litigating the issue.

As discussed in our report, some ERISA plans apparently construe section 514(b)(8) as only permitting states to prohibit including in contracts “any provision” that has the proscribed effect; so long as contract provisions with the proscribed effect are not used, plan payments can be avoided. When an ERISA plan takes such a position, the state's recourse—to litigate the issue—may be impractical: the cost of litigation may exceed the disputed amount.

If a state contests an ERISA plan's refusal to pay, the outcome is, we believe, more uncertain than Labor's comments suggest. We are not convinced that a court would construe section 514(b)(8) as broadly as Labor, essentially, speculates. The section does not expressly permit states, first, to require specific contract provisions in plans or, second, to prohibit practices or actions by plans that may have the proscribed effect.

In conclusion, section 514(b)(8) is open to the interpretation that the plans have adopted. Labor does not refer to any court decision, legal analysis, or legislative history to support a contrary conclusion, nor have we found any. Therefore, amending the law would facilitate state recovery; such an amendment would be of more practical value to the states than an assertion by us or Labor that the plans' interpretation of the section is wrong.

5. We revised the language proposed for paragraph (8), subsection (b), section 514. We believe the current version is unambiguous.

6. As Labor indicates, section 514(d) says that ERISA does not preempt federal law. It does not, however, make any reference to state law. It is conceivable that a court could construe section 514(d) broadly enough to enable states to pass laws providing for effective recovery from ERISA plans. But our interviews with state officials suggest that states typically would not have the resources and tenacity to advance an argument based on such a construction. Even if a state did advance such an argument, we think it doubtful that a court would accept this argument because it would essentially require a court to rule that the state's law preempted ERISA. Furthermore, presumably, the Congress would not have created the current section 514(b)(8) if section 514(d) was broad enough to enable states to pass fully effective laws.

Our proposed amendment would eliminate any doubt. It would have the effect of preventing litigation and other delays that discourage states and prevent aggressive recovery efforts from being cost-effective. Moreover, Labor raises no substantive objections to the amendment.

7. We disagree that the amendment to section 514(b)(2)(B) of ERISA is unnecessary and inappropriate.

We acknowledge that the so-called deemer clause is generally read in conjunction with the savings clause. We also recognize that the two clauses pertain to the distinction between self-insured plans and insured

plans and that this distinction is not directly relevant to the Medicaid third-party liability issue. The primary purpose of the amendment, however, is to make it as simple as possible for states to make certain that for Medicaid third-party purposes, all ERISA plans are subject to the same rules as other insurers.

As our report discusses, states have not utilized the latitude they currently have under section 514(b)(8). Nothing in this section successfully communicates to states their need to pass third-party laws expressly and specifically applicable to ERISA plans (that is, ERISA-specific laws). Indeed, in the relatively few states that have passed relevant laws, the majority of such laws are explicitly applicable only to insurers (that is, the laws are non-ERISA-specific laws). On the basis of our consultations with state officials, we understand that many states may have expected that their laws would apply to ERISA plans.

Section 514 (b)(2)(B) (as a counterpart to section 514(b)(2) (A)) precludes an ERISA plan, independent of section 514(b)(8), from being deemed an insurer. Therefore, in response to a state proceeding, based on a non-ERISA-specific law against an ERISA plan, the plan could argue that it could not be deemed an insurer and, consequently, was not covered by the state law at issue. As a result, we are concerned that even if section 514(b)(8) was amended—giving states greater latitude in proscribing actions on the part of ERISA plans so as to avoid third-party liability—section 514(b)(2)(B) could be raised as an obstacle to applying some current and future state laws to ERISA plans. To eliminate this possibility, we believe that section 514(b)(2)(B) should be amended as suggested.

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