U.S. Department of Labor Pension and Welfare Benefits Administration
Washington, D.C. 20210

SEP 3, 1993

93-23A
ERISA SEC. 514(d), 404(a)(1)

Frederick D. Hunt, Jr., President
Society of Professional Benefit Administrators
Two Wisconsin Circle, Suite 670
Chevy Chase, MD 20815-7003

Dear Mr. Hunt:

This is in response to your request on behalf of your members for the Department of Labor's (the Department's) views on the application of the fiduciary responsibility provisions of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA), 29 U.S.C. §1001 et. seq.. Specifically, you have raised a number of issues with respect to claims submitted to ERISA-covered employee benefit plans, pursuant to the Medicare Secondary Payer provisions of Title XVIII of the Social Security Act, 42 U.S.C. §1395y(b) (MSP statute), for recovery of mistaken primary payments made by Medicare.

As you are aware, the MSP statute, administered by the Health Care Financing Administration (HCFA), generally provides that Medicare will not make payments, as primary payer, for services if the patient receiving such services is covered under an employee benefit plan, sponsored or contributed to by an employer, that is required by the MSP statute to make primary payment for the services. See 42 U.S.C. §1395y(b)(1)(A)(i).

However, because some claims are mistakenly sent to Medicare for primary payment without adequate information to identify a primary payer to Medicare and because Congress requires Medicare to make prompt payment on all claims submitted, Medicare makes conditional primary payments on those claims and subsequently seeks recovery of mistaken primary payments if a primary payer is later identified.

Under the MSP statute, the United States has a direct right of action to recover such conditional payments from any entity responsible for making primary payment, including an employer, insurance carrier, plan, program, or third party administrator if certain conditions are satisfied. HCFA contracts with certain entities, known as Medicare contractors, to administer some aspects of the Medicare program, including the recovery of Medicare payments on those claims for which it is later determined that Medicare should have been the secondary payer. See 42 U.S.C. §1395y(b)(2); 42 C.F.R. §411.24(e).

In requesting the Department's views as to the appropriate actions to be taken by plan administrators under Title I of ERISA, when presented with recovery requests from Medicare contractors, you have raised three primary issues of concern to your members: 1) how claims that are not timely or otherwise have not been submitted in accordance with the terms of the plan should be treated; 2) whether a plan must reimburse Medicare for claims that may have been previously paid by the plan when the plan administrator had no knowledge of conditional payments by Medicare for those claims; and 3) how plan fiduciaries should handle claims if the information submitted by a Medicare contractor is insufficient to determine whether the service is or was covered under the plan. You also ask whether medical providers or plan participants who have been paid for the same services by both Medicare and employee benefit plans, or who have otherwise misled plan fiduciaries, could be held liable as knowing participants in any fiduciary breach resulting from such actions.

As you are aware, under section 3(21)(A) of ERISA, 29 U.S.C. §1002(21)(A), a person is a fiduciary if he or she performs one or more of the functions described in that section, including exercising "any discretionary authority or discretionary control respecting management" of a plan. The Department has stated, in an Interpretive Bulletin at 29 C.F.R. §2509.75-8 (Question Number D-3), that "[s]ome offices or positions of an employee benefit plan by their very nature require persons who hold them to perform one or more of the functions described in section 3(21)(A)." The Interpretive Bulletin refers to the plan administrator and trustee as examples of positions that, by their very nature, require persons holding them to have discretionary authority or responsibility in the administration of a plan.

Under the fiduciary provisions of Title I of ERISA, fiduciaries are required to discharge their duties with respect to plans solely in the interests of plan participants and beneficiaries; for the exclusive purpose of providing benefits and defraying reasonable administrative expenses of the plan; and with the care, skill, prudence and diligence that a prudent person familiar with such matters acting in a like capacity would use under the prevailing circumstances in the conduct of an enterprise of a like character and with like aims. Fiduciaries are also required to act in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with ERISA.

In general, plan fiduciaries must evaluate claims for reimbursement under the MSP statute in accordance with the fiduciary provisions of ERISA and the substantive provisions of the plan. In the Department's view, however, plan fiduciaries are responsible for administering their plans to assure compliance with both ERISA and other applicable federal laws, in recognition of the fact that such other laws are not preempted by ERISA. See 29 U.S.C. §1144(d). Similarly, where the terms of a plan are consistent with ERISA, but are not consistent with the requirements of other applicable Federal laws or regulations, plan fiduciaries should take appropriate steps to assure that the plan is amended to comply with all applicable legal requirements. Although, under section 514 of ERISA, 29 U.S.C. §1144, state laws are generally preempted insofar as they may relate to employee benefit plans, section 514(d) of ERISA provides that nothing in Title I of ERISA shall be construed to alter, amend, modify, invalidate, impair or supersede any law of the United States. Thus, if an employee benefit plan that provides health benefits is covered by the MSP statute as well as by Title I of ERISA, non-compliance with the MSP statute and any regulations issued thereunder would not be excused on the basis that the plan is in compliance with ERISA.

For example, if a fiduciary fails to acknowledge a plan's responsibility as primary payer under the MSP statute, where such fiduciary has no reasonable basis to believe that the plan should not be the primary payer, a violation of the prudence requirement of ERISA may arise. On the other hand, if a fiduciary unnecessarily causes a plan to act as primary payer, where the plan clearly should not be primary payer, such fiduciary would not be acting in a prudent manner and solely in the interests of the plan's participants and beneficiaries. If there is a reasonable doubt as to the plan's responsibility to act as primary payer, it is incumbent upon the appropriate plan fiduciary to make a prudent decision, based upon all of the facts and circumstances available, whether to honor a recovery request for the Medicare payment or to dispute the recovery request.

Your request details a number of specific situations relating to the general issue you have raised. For example, you ask how plan fiduciaries should treat claims for services that are not submitted in accordance with the terms of the plan or within the time limits imposed under the plan. Regulations issued under the MSP statute explicitly authorize HCFA to seek recovery without regard to any claim filing requirements that a plan imposes on a claimant. See 42 C.F.R. §411.24(f)(1). Because HCFA has a clear right of action against plans and other entities within statutorily prescribed time periods, it would appear that fiduciaries must, in complying with the MSP statute, disregard the

plan's terms as to form and timeliness for claims submissions.[1] Therefore, the fact that the claim is not submitted in accordance with such procedural requirements otherwise applicable to the filing of claims generally will not relieve a plan administrator of his or her responsibility for assuring compliance with the MSP statute.

With reference to the second issue you have raised, you state that plans are being billed by Medicare contractors for claims that such plans have previously paid. We are informed by HCFA that, under its regulations at 42 C.F.R. §411.24(i)(2), in those cases in which a plan properly makes a primary payment to an entity other than Medicare when the plan fiduciary did not know, and had no reason to know, that Medicare had also made primary payment, the plan is not required to reimburse Medicare for such payment. (In these cases, Medicare seeks recovery from the entity it paid.) However, if a plan fiduciary permitted the payment of a claim to an entity other than Medicare when he or she was aware, or should have been aware, that Medicare had already made a conditional payment of that claim, HCFA may seek recovery under its regulations, and the fiduciary could be liable under ERISA to the plan for any losses incurred from having improperly permitted a double payment. We have been advised by HCFA that, in most cases, it will not pursue a claim against a plan that has made a primary payment for a particular service covered under the plan if a plan fiduciary submits evidence that the plan in fact made such full primary payment and provides information on who received the payment.[2] In such cases, Medicare will typically seek recovery directly from that entity.

You have represented, with regard to the third issue you have raised, that you are aware of situations in which information provided by a Medicare contractor has been insufficient to enable plan fiduciaries to determine whether the claim relates to a service covered under the plan. You ask how a fiduciary is to fulfill his or her responsibilities under ERISA in handling such claims. It is our understanding that a Medicare contractor presenting a recovery claim will provide the plan fiduciary with the following information to the extent that it is available: the name of the patient, the date the medical service was provided, the name of the medical provider, the actual charges reflected on the claim, the diagnosis code (ICD-9-CM) or other explanation of the patient's illness or injury, the procedure code (generally CPT-4) that explains the item or service provided, and to whom Medicare made payment and in what amount.[3] If the information provided is not sufficient to enable plan fiduciaries to determine the specific service that is referenced in the claim, it is incumbent upon such fiduciaries to take all reasonable action to ascertain the necessary information, including requesting additional information from the provider, the policyholder, the patient and the Medicare contractor.

You raise questions regarding the liability of medical providers who receive payments from both Medicare and an ERISA-covered plan on the same claims, or of plan participants or beneficiaries who mislead plan fiduciaries or fail to follow plan procedures, as knowing participants in a fiduciary breach. Whether such medical providers, plan participants or beneficiaries, or other persons are liable under either a "knowing participant" or any other theory of

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[1] It should be emphasized, however, that the fiduciary must determine that the health care services are covered by the plan and that, aside from questions of timeliness and form of the claim, the plan bears the legal responsibility of being primary payer for those services.

[2] We note that, pursuant to section 107 of ERISA, 29 U.S.C. §1027, certain records of a plan, including claims records, must be maintained for at least six years after the filing date of documents required to be filed under ERISA based on any information contained in the records. This requirement applies irrespective of any exemptions or simplified filing requirements.

[3] The Department notes, however, that whether or not the information provided is sufficient for the purpose of ascertaining if the benefit is covered under the Plan is generally a matter for individual fiduciaries to determine.

fiduciary liability may only be ascertained from facts and circumstances that are unique to each such alleged fiduciary violation.[4] The same facts and circumstances analysis applies with respect to the remedies available to plan fiduciaries who seek to recover from such persons. As you may be aware, the Department generally declines to opine on such inherently factual determinations. See ERISA Procedure 76-1, §5.01, 41 Fed. Reg. 36281 (August 27, 1976).

To further assist you and your members, we have requested information from HCFA on its procedures for resolving problems arising out of MSP recovery claims. We are informed that if the information necessary to resolve a claim is not provided by the Medicare contractor, or if there are other problems with regard to a MSP recovery claim, fiduciaries are advised to contact the Medicare Secondary Payment Coordinator at the offices of the Medicare contractor (the Contractor Coordinator). The Contractor Coordinator should be provided with the following information: 1) the patient's name and Medicare claim number; 2) the date of the service in question; 3) the name of the service provider; and 4) a description of the problem with respect to the claim for reimbursement.

If the problem cannot be resolved by the Contractor Coordinator, the fiduciary should contact the HCFA Regional Medicare Secondary Payment Coordinator (the Regional Coordinator), whose name and address may be obtained from the Medicare contractor. Finally, problems that cannot be resolved through the Regional Coordinator may be addressed to Director, Division of Entitlement and Benefits Coordination, Health Care Financing Administration, 6325 Security Boulevard, ME-367, Baltimore, Maryland 21207.

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

Sincerely,

ROBERT J. DOYLE
Director of Regulations and Interpretations

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[4] We note that the Supreme Court's recent decision in Mertens v. Hewitt, 113 S. Ct. 2063 (1993), precludes only liability for money damages against nonfiduciaries who knowingly participate in a fiduciary's breach of fiduciary duty.