



January 2015

MEDICAID

Additional Federal Action Needed to Further Improve Third-Party Liability Efforts

Why GAO Did This Study

In fiscal year 2013, Medicaid—jointly financed by states and the federal government—provided health care coverage to over 70 million individuals at a total cost of about \$460 billion. Congress generally established Medicaid as the health care payer of last resort, meaning that if enrollees have another source of health care coverage—such as private insurance—that source should pay, to the extent of its liability, before Medicaid does. This is referred to as third-party liability (TPL). There are known challenges to ensuring that Medicaid is the payer of last resort. GAO was asked to provide information on the prevalence of private insurance among Medicaid enrollees and on state and CMS efforts to ensure that Medicaid is the payer of last resort.

This report examines (1) the extent to which Medicaid enrollees have private insurance, and (2) state and CMS initiatives to improve TPL efforts. GAO analyzed the 2012 ACS; interviewed Medicaid officials from eight states with high program spending or enrollment that used managed care; interviewed CMS officials and stakeholders; and reviewed relevant laws, regulations, and CMS guidance.

What GAO Recommends

GAO recommends that the Secretary of the Department of Health and Human Services (HHS) direct CMS to (1) routinely monitor and share across all states information regarding key TPL efforts and challenges, and (2) provide guidance on state oversight of TPL efforts conducted by Medicaid managed care plans. HHS concurred with GAO's recommendations and noted plans to address them.

View [GAO-15-208](#). For more information, contact Katherine M. Iritani at (202) 512-7114 or iritanik@gao.gov.

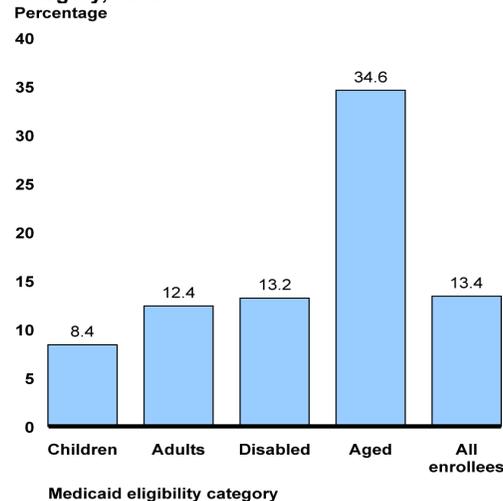
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What GAO Found

Based on responses to the 2012 U.S. Census Bureau's American Community Survey (ACS)—the most recent available at the time the work was conducted—GAO estimates that 7.6 million Medicaid enrollees (13.4 percent) had private health insurance in 2012. The estimated prevalence of private health insurance varied among Medicaid eligibility categories, which may differ with respect to Medicaid benefits and costs. The number of Medicaid enrollees with private health insurance is expected to increase with the expansion of Medicaid.

Estimated Prevalence of Private Health Insurance among Medicaid Enrollees by Eligibility Category, 2012



Source: GAO analysis of 2012 U.S. Census Bureau data. | GAO-15-208

Note: GAO defined children as non-disabled individuals aged 0 through 18; adults as non-disabled individuals aged 19 through 64; disabled as individuals aged 0 through 64 who reported a disability; and aged as individuals aged 65 and older.

Selected states reported taking various steps to address challenges to ensuring that Medicaid is the payer of last resort and acknowledged recent Centers for Medicare & Medicaid Services (CMS) support, while also suggesting additional federal action. Four of the eight reviewed states reported various initiatives to improve coverage identification, such as arranging to participate in a data registry that allows participants to identify individuals with overlapping coverage. CMS has taken steps to issue TPL guidance and share some information on effective state practices, and such federal efforts should be ongoing to ensure that evolving approaches are captured and shared across states. In addition, officials in five states reported that enrollees with third-party coverage may be eligible to enroll in Medicaid managed care—in which states contract with health plans to provide services to enrollees and may delegate TPL activities such as payment recoveries to these plans. One of the five states had initiated a program to oversee plans' TPL recoveries, while other states did not report similar oversight. The National Association of Medicaid Directors reported that, in the absence of explicit CMS guidance in this area, it can be difficult for states to work with plans to improve TPL oversight and has recommended CMS provide such guidance.

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Abbreviations

ACS	American Community Survey
CHIP	State Children’s Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
COB	coordination of benefits
DRA	Deficit Reduction Act of 2005
ERISA	Employee Retirement Income Security Act of 1974
FAQ	Frequently Asked Questions
HHS	Department of Health and Human Services
MHPA	Medicaid Health Plans of America
OIG	Office of Inspector General
PIE	payer initiated eligibility/benefit
PPACA	Patient Protection and Affordable Care Act
PUMS	Public Use Microdata Sample
TAG	technical advisory group
TPL	third-party liability
VA	Department of Veterans Affairs

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January 28, 2015

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Michael C. Burgess, M.D.
House of Representatives

In fiscal year 2013, Medicaid provided health care coverage to over 70 million individuals at a total cost of about \$460 billion.¹ Congress generally established Medicaid as the health care payer of last resort, meaning that if Medicaid enrollees have another source of health care coverage, that source should pay, to the extent of its liability, before Medicaid does. Federal regulation refers to this requirement as third-party liability (TPL).² In administering their Medicaid programs, states are required to take certain steps to identify sources of third-party coverage that Medicaid enrollees may have, and to ensure that these sources pay to the extent of their liability.³ When private third parties—such as health insurers—pay for health care services instead of Medicaid, savings accrue not only to states, but also to the federal government, which

¹See Medicaid and State Children’s Health Insurance Program (CHIP) Payment and Access Commission, *Report to the Congress on Medicaid and CHIP, March 2014* (Washington, D.C.: March 14, 2014). Medicaid is jointly financed by the federal government and states.

²See 42 C.F.R. §§ 433.135 et seq. (2013).

³States administer their individual Medicaid programs subject to approval and oversight by the Centers for Medicare & Medicaid Services (CMS), a federal agency within the Department of Health and Human Services (HHS).

historically has financed over half of the overall Medicaid program costs.⁴ In addition, federal financing of Medicaid is increasing with the implementation of the Patient Protection and Affordable Care Act (PPACA), under which states may expand Medicaid eligibility to certain low-income individuals and which specified that the federal government would pay 100 percent of costs for these individuals from 2014 through 2016, and a minimum of 90 percent of such costs thereafter.⁵ Therefore, state efforts to ensure that health insurers pay to the extent of their liability, particularly for Medicaid enrollees who are newly eligible for the program, could lead to increased federal cost savings.

States have substantially improved their TPL identification and recovery efforts (which we refer to hereafter as TPL efforts) in recent years, generating significant savings for the federal government as well as for themselves. A 2013 Department of Health and Human Services (HHS) Office of Inspector General (OIG) report indicated that states identified about \$13.6 billion in combined federal-state cost savings from private health insurers in 2011, compared to about \$3.7 billion in 2001—with states largely crediting increased cost savings to enhanced use of

⁴This report focuses on private health insurance. Under federal regulations, private insurance includes commercial insurance companies offering insurance to individuals or groups, prepaid plans offering medical services or payment for services covered by Medicaid, and organizations administering insurance plans for professional organizations, unions, fraternal groups, employer-employee benefit plans, and other similar organizations, including self-insured and self-funded plans. See 42 C.F.R. § 433.136 (2013). Besides private health insurance, other sources of third-party payment include Medicare, which provides health coverage for individuals aged 65 and over or with certain disabilities and individuals with end-stage renal disease; TRICARE, the health care program generally for active duty military personnel and their dependents, and retirees and their dependents and survivors; and the Department of Veterans Affairs (VA), which provides health care generally for qualifying veterans.

⁵Pub. L. No. 111- 148, §§ 2001 and 10201(c), 124 Stat. 119, 271, 918 (2010), as amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, § 1201, 124 Stat. 1029, 1051 (2010). Under PPACA, states may expand Medicaid eligibility under their state plans to nonpregnant, nonelderly adults who are not eligible for Medicare and whose income does not exceed 133 percent of the federal poverty level. PPACA also imposes a 5 percent income disregard when calculating modified adjusted gross income, which in effect, raises this income limit to 138 percent of the federal poverty level. We refer to state expansion under this authority as the Medicaid expansion. As of July 2014, 26 states and the District of Columbia had opted to expand their Medicaid programs.

available technology to identify Medicaid enrollees with other insurance.⁶ However, the report also found that states commonly face challenges to their TPL efforts, such as health insurers refusing to provide coverage information to states or denying liability for procedural reasons, that pose potential barriers to realizing cost savings. Furthermore, state Medicaid agencies face administrative capacity constraints that may limit their ability to go beyond basic program requirements to further improve cost savings.⁷

Given the PPACA Medicaid expansion and the importance of ensuring that Medicaid appropriately pays only after other liable third parties have done so, you asked us to examine the prevalence of private sources of health insurance among Medicaid enrollees, and state and Centers for Medicare & Medicaid Services (CMS) efforts to ensure that Medicaid is the payer of last resort. In this report, we examine (1) the extent to which Medicaid enrollees have private health insurance and (2) state and CMS initiatives to improve TPL efforts.

To examine the extent to which Medicaid enrollees have private health insurance, we analyzed 2012 data—the most recent data available at the time we conducted the work—from the American Community Survey (ACS), a nationally representative annual survey conducted by the U.S. Census Bureau. The ACS collects self-reported information, such as each individual's type of health coverage (if any) as of the date of the survey, disability status, age, and state of residence. For the ACS question regarding each individual's type of health coverage, Medicaid is grouped with other types of means-tested public coverage as a single response

⁶HHS Office of Inspector General, *Medicaid Third-Party Liability Savings Increased, but Challenges Remain*, OEI-05-11-00130 (January 2013). State-reported, inflation-adjusted cost savings increased from about \$34 billion in 2001 to about \$72 billion in 2011, with the majority of the overall cost savings attributable to cost avoidance and payment recoveries from Medicare. However, there are methodological limitations of the cost savings figures reported by states. For example, states may use various methods to calculate cost savings, and some forms of cost avoidance, such as when a provider directly bills a third party rather than Medicaid, are not possible for states to capture or report.

⁷Limitations in states' administrative capacities are discussed in more detail in a recent Medicaid and CHIP Payment and Access Commission report. For example, see Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP, June 2014* (Washington, D.C.: June 13, 2014).

option.⁸ Therefore, for purposes of the report, we refer to these groups collectively as Medicaid enrollees. We further divided Medicaid enrollees into four broad Medicaid eligibility categories—children, adults, disabled, and aged.⁹ For all Medicaid enrollees, and for each Medicaid eligibility category, we estimated the number and percentage with private health insurance and other sources of health coverage. We defined individuals as having private health insurance if they reported health insurance provided through an employer or union, or health insurance purchased individually. Unless noted otherwise, estimates presented in this report have a relative standard error of less than 15 percent. To determine the reliability of the ACS data, we reviewed related documentation and compared our results to other published estimates and determined that the ACS data were sufficiently reliable for our purposes. (A more detailed description of our methodology is provided in app. I.)

To examine CMS and state initiatives to improve TPL efforts, we reviewed relevant federal laws, regulations, and related documents, and interviewed officials from CMS and a sample of 8 states. To select the sample of states, we began by identifying states that: (1) were among the top 15 states with respect to either Medicaid enrollment or spending; and (2) used capitated managed care—in which states pay health plans a monthly fee per Medicaid enrollee in exchange for services provided—to deliver services to some or all Medicaid enrollees.¹⁰ We then reviewed challenges states reported in the 2013 HHS OIG report and obtained input from federal officials and stakeholders about related state legislation or practices and selected 8 of these states to include in our review:

⁸The ACS question combines Medicaid coverage with other types of means-tested public coverage, such as health coverage through any kind of government assistance plan for individuals with low incomes or a disability. Therefore, some individuals we identified as Medicaid enrollees may have other types of means-tested coverage, such as CHIP coverage. While it is not possible to differentiate these groups in ACS data, Medicaid is the largest means-tested program, with over 70 million individuals enrolled during fiscal year 2012.

⁹We defined the child eligibility category as individuals aged 0 through 18 who did not report a disability, we defined the adult eligibility category as individuals aged 19 through 64 who did not report a disability, we defined the disabled eligibility category as individuals aged 0 through 64 who reported a disability, and we defined the aged eligibility category as individuals aged 65 and older.

¹⁰We included state use of managed care as part of our selection criteria to ensure our review included specific considerations related to conducting TPL efforts in a managed care environment.

Georgia, Massachusetts, Michigan, Minnesota, Missouri, New York, Ohio, and Washington. In several cases, officials in these states asked the contractor responsible for aspects of TPL work in their state to respond to our questions or included contractor representatives in the interviews. To supplement information from the selected states, we also interviewed or reviewed information provided by representatives of HMS—a firm that conducts various TPL services on behalf of over 30 states and about 160 Medicaid managed care plans—national associations representing Medicaid directors and Medicaid managed care plans, and other stakeholders.

We conducted this performance audit from December 2013 through January 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicaid enrollees across various eligibility categories may have access to private health insurance for a number of reasons. For example, some adults may be covered by employer-sponsored private health insurance even though they also qualify for Medicaid. Children similarly may be eligible for Medicaid while also being covered as a dependent on a parent's private health plan. Individuals age 65 and older may receive private coverage from a former employer or purchase such coverage to supplement their Medicare coverage. Medicaid benefits and costs may vary depending on an enrollee's eligibility category.¹¹ CMS requires states to provide for the identification of Medicaid enrollees' other sources of health coverage, verification of the extent of the other sources' liability for services, avoidance of payment for services in most circumstances where the state believes a third party is liable, and recovery of reimbursement from liable third parties after Medicaid payment, if the state can reasonably expect to recover more than it spends in seeking

¹¹For example, we previously estimated that, in 2008, average state per enrollee Medicaid spending varied across eligibility categories, ranging from \$2,973 for the child category to \$17,609 for the aged category and \$19,135 for the disabled category. See GAO, *Medicaid: Assessment of Variation among States in Per-Enrollee Spending*, [GAO-14-456](#) (Washington, D.C.: June 16, 2014).

reimbursement.¹² Specifically, states must provide that the following steps are taken:

1. **Coverage identification.** To identify enrollees with third-party health coverage, states are required to request coverage information from potential Medicaid enrollees at the time of any determination or redetermination of eligibility for Medicaid. States are also required to obtain and use information pertaining to third-party liability, for example by conducting data matches with state wage information agencies, Social Security Administration wage and earning files, state motor vehicle accident report files, or state workers compensation files.
2. **Coverage verification.** When other health coverage is identified, states need to verify the information, including the services covered through the other insurance and the dates of eligibility.
3. **Cost avoidance.** Cost avoidance occurs when states do not pay providers for services until any other coverage has paid to the extent of its liability, rather than paying up front and recovering costs later. After a state has verified other coverage, it must generally seek to ensure that health care providers' claims are directed to the responsible party.¹³ The cost-avoidance process accounts for the bulk of the cost savings associated with third-party liability.
4. **Payment recovery.** When states have already paid providers for submitted claims for which a third party is liable, they must seek reimbursement from the third party, if it is cost effective to do so.

States have flexibility in determining specific approaches to achieve these ends. For example, states are increasingly contracting with managed care plans to deliver services to Medicaid enrollees (such plans are hereafter referred to as Medicaid managed care plans), and may delegate TPL responsibilities to such plans.¹⁴ Both states and Medicaid managed care plans may obtain the services of a contractor to identify third-party

¹²See 42 C.F.R. §§ 433.137—433.139 (2013).

¹³Exceptions include claims for prenatal or pediatric services or when coverage is through a parent whose obligation to pay for medical support is enforced by the state's child enforcement agency. See 42 C.F.R. § 433.139(b)(2),(3) (2013).

¹⁴Alternatively, states may retain TPL responsibilities for individuals in managed care, or they may elect not to enroll individuals with identified TPL in managed care, among other options.

coverage by conducting electronic data matches and to conduct other TPL responsibilities, such as payment recovery.

Ensuring compliance with Medicaid TPL requirements has long been challenging for states. The McCarran-Ferguson Act affirms the authority of states to regulate the business of insurance in the state, without interference from federal regulation, unless federal law specifically provides otherwise.¹⁵ Thus, states generally regulate private health insurers operating in the state. However, states may not have authority over private insurers that are not licensed to do business in the state but still provide coverage to state residents. For example, some individuals work and receive health insurance through employment in one state but live in a neighboring state. In addition, states are preempted by the Employee Retirement Income Security Act of 1974 (ERISA) from regulating employer-sponsored health benefit plans that self-insure coverage rather than purchase coverage from an insurer.¹⁶

Due to the bifurcated nature of private health insurance regulation, both federal and state legislation has been required to allow states to enforce TPL requirements. For example, the Omnibus Budget Reconciliation Act of 1993 required all states to enact laws prohibiting insurers from taking Medicaid status into account in enrollment or payment for benefits and to enact laws giving the state rights to payments by liable third parties.¹⁷ In addition, the Deficit Reduction Act of 2005 (DRA) contained provisions affecting state authority to verify coverage and recoup payments from liable health insurers. Under the DRA, states must attest that they have laws in place to require health insurers to, among other requirements, provide information necessary to identify Medicaid enrollees with third-party coverage and, within specified time limits, respond to inquiries from the state regarding claims, as well as to agree not to deny claims solely

¹⁵Pub. L. No. 79-15, ch. 20, § 2, 59 Stat. 33, 34 (1945) (codified as amended at 15 U.S.C. § 1012).

¹⁶29 U.S.C. § 1144(a). This ERISA preemption therefore results in a different regulatory framework depending on whether the employer purchases its health care coverage from an insurer, which the state regulates, or self-funds its health plan, avoiding many state regulations.

¹⁷Pub. L. No. 103-66, § 13622, 107 Stat. 312, 632.

because of the date the claim was submitted, the form that was used, or the failure to properly document coverage at the point of service.¹⁸

The 2013 HHS OIG report on TPL cost savings and challenges concluded that the DRA provisions likely had a positive effect on states' ability to avoid costs and recover payments from private health insurers, in part through improvements in states' identification of enrollees with insurance. States also credited process improvements, such as online verification of coverage and electronic data matching agreements with private insurers, as well as contractor assistance. However, the study reported that states continue to face key challenges working with private insurers, including the following:

- 96 percent of states reported challenges with insurers denying claims for procedural reasons.
- 90 percent of states reported challenges with insurer willingness to release coverage information to states.
- 86 percent of states reported challenges with insurers providing incomplete or confusing information in response to attempts to verify coverage.
- 84 percent of states reported problems with pharmacy benefit managers—entities which administer pharmacy benefits on behalf of insurers or employers—such as pharmacy benefit managers not providing coverage information or claiming a lack of authority to pay claims to Medicaid agencies.¹⁹

¹⁸Pub. L. No. 109-171, § 6035, 120 Stat. 4, 78 (2006).

¹⁹See OEI-05-11-00130. Prior GAO and HHS-OIG reports also identified similar challenges. See GAO, *Medicaid Third-Party Liability: Federal Guidance Needed to Help States Address Continuing Problems*. [GAO-06-862](#) (Washington, D.C.: Sept. 15, 2006) and HHS OIG, *Medicaid Recovery of Pharmacy Payments From Liable Third Parties*, OEI-03-00-00030 (August 2001).

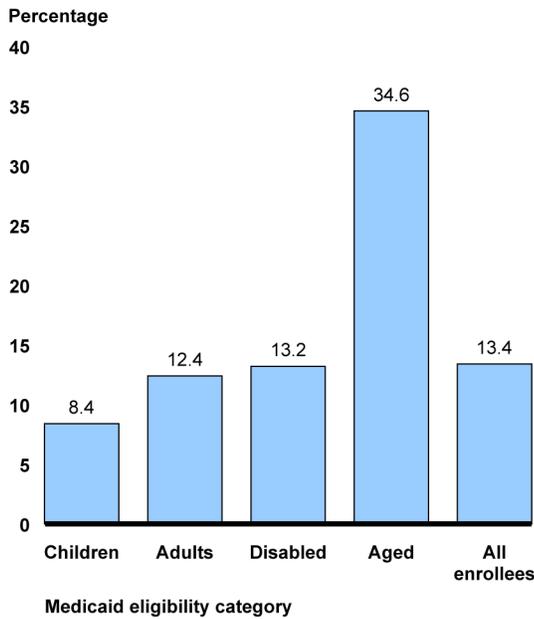
An Estimated 7.6 Million Medicaid Enrollees Had Private Insurance in 2012 and This Number Is Expected to Increase with the Medicaid Expansion

Based on responses to the U.S. Census Bureau's ACS, we estimate that 7.6 million Medicaid enrollees—13.4 percent—also had a private source of health insurance in 2012.²⁰ However, the prevalence of private health insurance varied among four Medicaid eligibility categories that we analyzed—children, adults, disabled, and aged. For example, according to our estimates, 34.6 percent of aged Medicaid enrollees also had private health insurance, compared to 12.4 percent of adult Medicaid enrollees and 8.4 percent of children.²¹ (See fig. 1 and see app. II, table 1, for more detailed estimates).

²⁰Our estimates of the extent to which individuals with Medicaid have private insurance are relatively consistent with older available estimates. For example, we estimated, based on responses to the 2010 ACS, that about 14 percent of individuals with Medicaid had private insurance in 2010. Similarly, we reported in 2006 that 13 percent of individuals enrolled in Medicaid for an entire year had private insurance at some point during the year, based on an analysis of a separate data source that covered 2002 to 2004. See [GAO-06-862](#).

²¹In addition to private insurance, Medicaid enrollees may also have public health coverage through federal programs such as Medicare or veterans health programs. For example, we estimate that about 18.6 percent of Medicaid enrollees in 2012 also had coverage through Medicare. This report focuses on private sources of third-party coverage, but we provide more detailed estimates of various additional sources of coverage in appendix II.

Figure 1: Estimated Prevalence of Private Health Insurance among Medicaid Enrollees by Eligibility Category, 2012



Source: GAO analysis of 2012 U.S. Census Bureau data. | GAO-15-208

Notes: Estimates are based on responses to the 2012 American Community Survey (ACS), and have relative standard errors of less than 15 percent. For purposes of this report, the child eligibility category included individuals aged 0 through 18 who did not report a disability; the adult eligibility category included individuals aged 19 through 64 who did not report a disability; the disabled eligibility category included individuals aged 0 through 64 who reported a disability; the aged eligibility category included individuals aged 65 and older.

The number of Medicaid enrollees who also have private health insurance is expected to increase beyond the estimated 7.6 million with the expansion of Medicaid; however, the extent of the increase is uncertain. The Congressional Budget Office projected that approximately 7 million nonelderly individuals would enroll in Medicaid in 2014 as a result of the Medicaid expansion and other PPACA provisions.²² While some newly Medicaid eligible individuals can be expected to have access to private sources of health insurance, the extent to which they will participate in Medicaid, or maintain private insurance once enrolled in Medicaid, is

²²See Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014*. This number includes CHIP enrollees, and was projected to increase to approximately 13 million by 2018. These estimates reflect that states are permitted but not required to expand Medicaid.

unknown. If these individuals' rates of private insurance are similar to the 12.4 percent of adult Medicaid enrollees whom we estimated had private insurance in 2012, about 868,000 of the projected 7 million new enrollees in 2014 would be expected to have private insurance.

Selected States Reported Some Success Addressing Challenges to Their TPL Efforts and Additional CMS Action Could Improve Such Efforts Nationwide

States face multiple challenges in ensuring that Medicaid is the payer of last resort for enrollees that have private health insurance. Selected states and CMS have taken various steps to address some of these challenges; however, selected states and stakeholders suggested that further CMS guidance and efforts to facilitate information sharing among states could improve TPL efforts nationwide.

Selected States Have Taken Various Actions to Address Challenges with Coverage Identification, Managed Care Plan TPL Activities, and Coverage Denials

State Actions to Address Challenges with and Improve Coverage Identification

As the identification of Medicaid enrollees with private health insurance is a critical first step for achieving TPL cost savings, many states nationwide conduct electronic data matches of Medicaid enrollment files with insurer files themselves or through a contract with a vendor that conducts matches on the state's behalf. While not required, such state efforts to independently identify enrollees with private insurance can lead to

significant cost savings.²³ For example, Minnesota officials reported that by contracting with a vendor for electronic data matching, the state nearly doubled identified cases of TPL in a 5-year period, saving the state an estimated \$50 million over this period.²⁴ Despite such efforts, states we included in our review reported experiencing the following challenges to their coverage identification efforts:

- **Challenges obtaining out-of-state coverage data.** Medicaid enrollees in one state may have coverage from a health insurer that is licensed in a different state—for example, some enrollees work and participate in employer-sponsored insurance in one state while living and enrolling in Medicaid in a neighboring state. State laws requiring insurers to provide coverage data may not apply if insurers are not licensed in the state, and officials from two of the states we reviewed noted that insurers sometimes refuse to provide coverage data to Medicaid agencies outside the state in which they are licensed. HMS representatives reported that, while HMS advocates that insurers provide coverage data to Medicaid agencies outside the state in which the insurers are licensed, many insurers refuse to do so. According to CMS, there is a significant amount of third-party coverage derived from insurers licensed in a different state from where the Medicaid enrollee resides.²⁵

²³Such efforts can be important because Medicaid applicants may not be aware of or report other insurance. Additionally, Medicaid enrollees who do not have other insurance when they first enroll may obtain it later. Some state officials also noted potential concerns about the completeness of self-reported insurance information obtained during new online application procedures—underscoring that the importance of independently obtaining coverage information may be increasing.

²⁴While contracting with a vendor to conduct data matches can be beneficial, some states noted limitations with this approach. For example, Minnesota officials noted that the national coverage database maintained by its vendor does not necessarily contain information on all insurers in the state.

²⁵CMS guidance highlights the need for states to request that insurers provide coverage data on individuals covered in other states. See CMS, *Medicaid and CHIP FAQs: Identification of Medicaid Beneficiaries' Third-Party Resources and Coordination of Benefits with Medicaid* (Baltimore, Md.: Sept. 11, 2014). HMS representatives reported that when insurers do not share this data with out-of-state Medicaid agencies or Medicaid managed care plans, it is difficult for HMS to reliably identify or bill for otherwise recoverable out-of-state TPL recoveries on behalf of those state Medicaid agencies or plans.

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- **Challenges with insurers conducting data matches.** State and HMS representatives reported that, rather than providing coverage data to the state (or its contractor, as applicable), some insurers request the Medicaid data and perform the data match themselves. HMS representatives reported that, in such cases, states only have access to matches identified by the insurer, which may understate the number of individuals with overlapping coverage. One state reported estimating that insurers missed the identification of about 7 percent of the individuals with private insurance when insurers conducted the match instead of the state's contractor.
 - **Challenges with obtaining key data elements.** Insurers may not maintain or provide states or their contractors access to key data elements, such as Social Security numbers, and not having access to these data can reduce the efficiency or usefulness of data matches, according to officials in several states we reviewed. For example, officials from two selected states noted that data matches are more difficult and error-prone when Social Security numbers are not available. Similarly, officials from two other states we reviewed reported that their ability to verify identified coverage would be assisted if employer identification numbers were included in insurer coverage data.
 - **Challenges with timeliness of data matches.** Most selected states reported that there is a time lag, typically up to 15 to 30 days, between an individual's enrollment in Medicaid and when the individual is included in a data match with private insurers. As a result, states may not be able to identify other coverage until after enrollees have already begun using services. States would generally then seek reimbursement for paid claims.

States in our review reported taking various steps to address these and other coverage identification challenges. Four of the eight selected states reported initiatives underway or completed to improve data-matching strategies to identify private coverage, some of which focused on nationally coordinated approaches. For example, Minnesota officials reported that Minnesota law allows the state Medicaid agency and Medicaid managed care plans to participate in a national coverage data registry, launched in late 2013 by CAQH, an association of health plans and trade associations.²⁶ The data registry allows participating insurers

²⁶See Minn. Stat. § 256.01, subdivision 18a (2014).

and states to submit coverage data files for comparison with files of other participants in order to identify individuals with overlapping coverage. Minnesota officials commented that the registry was at an early stage but expected that participation of private insurers would increase over time because of benefits to private insurers of coordinating with one another. Table 1 describes a variety of initiatives underway or completed to improve coverage data in selected states.

Table 1: Examples of Initiatives in Selected States to Improve Coverage Identification

State	Description of initiative
Massachusetts	The state is in the process of arranging for its vendor to conduct real time data matches—that is, to check for additional insurance at the point that an individual enrolls in Medicaid—which will allow for earlier identification of overlapping coverage. Officials reported aiming for implementation at the end of calendar 2015.
Michigan	The state obtained national coverage data from insurers and developed an in-house, third-party liability (TPL) tracking and billing system, which was implemented in 2006. Officials reported that as a result, cost savings related to TPL had increased exponentially in recent years, and the state was able to reduce its reliance on a vendor to conduct data matches.
Minnesota	The state and Medicaid managed care plans with which it contracts plan to participate in a registry launched by CAQH in late 2013 that allows participating insurers and states to identify individuals with overlapping coverage. Participating insurers submit full national coverage data to be matched against data submitted by all other participants in the registry on a weekly basis. State officials anticipated that the registry could possibly be leveraged to permit identification of TPL at the point of enrollment. State officials anticipated that participation in this registry would begin in early 2015.
Washington	The state implemented a nationally standardized format for receiving coverage data developed by the Centers for Medicare & Medicaid Services (CMS), called the Payer Initiated Eligibility/Benefit (PIE) Transaction. The PIE Transaction allows states that elect to adopt it to obtain eligibility information from insurers automatically and allows insurers to set up one standard file to share with any state that had implemented it.

Source: GAO analysis of interviews with selected state officials. | GAO-15-208

In addition, at least two of the eight states had laws that addressed challenges with obtaining private insurer compliance with TPL requirements, including requirements to provide coverage data. For example, Michigan law authorizes the state to collect coverage data from insurers to determine TPL and to assess penalties on insurers for noncompliance.²⁷ Michigan officials reported that the state was successful in obtaining national coverage data from insurers. In addition, Minnesota

²⁷Mich. Comp. Laws §§ 550.283, 550.287 (2014).

State Actions to Support and Oversee Medicaid Managed Care Plan TPL Activities

law requires that all insurers that cover state Medicaid enrollees must comply with TPL requirements irrespective of where they are licensed.²⁸

Selected states have taken various actions that support or increase oversight of Medicaid managed care plan TPL activities, as applicable. For example, in five of the eight states in our review, individuals with third-party coverage may be eligible to enroll in Medicaid managed care plans and certain TPL responsibilities are delegated to these plans.²⁹ The laws of two selected states—Ohio and Minnesota—specifically authorize Medicaid managed care plans to recover TPL payments on the state’s behalf.³⁰ Ohio officials in particular credited the legislation as effective in improving insurer cooperation with the state’s Medicaid managed care plans. While the DRA required states to have laws in effect compelling insurers to provide states with access to data and recognize the states right to recoup payments, it did not provide that those laws specifically require insurers to similarly cooperate with Medicaid managed care plans conducting such work on behalf of states. CMS provided guidance that, when states delegate TPL responsibilities to a Medicaid managed care plan, third-parties should treat the plan as if it were the state.³¹ HMS representatives reported that this guidance has been effective in garnering cooperation from insurers that previously refused to provide coverage data or pay claims to Medicaid managed care plans in various states without legislation specifically requiring them to do so. However, a few insurers continue to refuse to cooperate with such plans despite this guidance, according to information provided by representatives of HMS

²⁸Specifically, the statute imposes these requirements “as a condition of doing business in Minnesota or providing coverage to residents of Minnesota” who are enrollees in state medical programs. See Minn. Stat. § 62A.045 (2014). Although Minnesota officials were not aware of their contractor experiencing significant problems accessing coverage data from insurers licensed in other states, they reported difficulty in collecting payments from a large out-of-state insurer under this statute. Officials said they had asked their contractor to begin providing reports of insurers that refuse to cooperate with either providing data or paying claims.

²⁹Officials in the other three selected states said that the state generally does not enroll Medicaid enrollees with known private insurance in Medicaid managed care plans.

³⁰See Ohio Rev. Code § 5160.40(B) (2014) and Minn. Stat. § 62A.045(c) (2014).

³¹CMS had provided this clarification on its website and also included the information in a set of frequently asked questions (FAQ) published in September 2014. See CMS, *Medicaid and CHIP FAQs: Identification of Medicaid Beneficiaries’ Third-Party Resources*.

and Medicaid Health Plans of America (MHPA)—an association of Medicaid managed care plans.

In addition, Minnesota sought to improve its oversight of Medicaid managed care TPL activities by initiating a program to allow the state to review Medicaid managed care plan TPL payment recoveries and to arrange for conducting supplemental recoveries when the plans had not recouped payment within a set time.³² However, according to a representative of the National Association of Medicaid Directors, it can be difficult for states to work with Medicaid managed care plans and insurers as needed to strengthen state oversight. The other states included in our review that delegate TPL work to Medicaid managed care plans did not report conducting this type of oversight, which is consistent with information provided by MHPA in which plans indicated that some states that contract with Medicaid managed care plans to perform TPL activities do not specifically review these activities. We have previously found that some Medicaid managed care plans may have a conflict of interest in conducting payment recoveries. Specifically, Medicaid managed care plans may not have appropriate incentives to identify and recover improper payments—which include payments made for treatments or services that were not covered by program rules, that were not medically necessary, or that were billed for but never provided—because doing so could reduce future capitation rates.³³

State Actions to Reduce Denials by Insurers for Procedural Reasons

Most selected states reported challenges with denials from private insurers for procedural reasons, such as for not obtaining prior authorization before receiving services or not using in-network providers.³⁴ HMS representatives estimated that in 2013, insurers had

³²Minn. Stat. § 256B.69, subdivision 34 (2014).

³³We recommended that CMS increase its oversight of program integrity efforts, in part through updating its guidance on Medicaid managed care plan program integrity. See GAO, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, [GAO-14-341](#). (Washington, D.C.: May 19, 2014). These concerns about incentives could similarly apply to identifying and recovering payments for services from liable third-parties.

³⁴Private health plans may place certain conditions on their coverage of services. For example, an insurer may require enrollees to obtain services from providers that are within its provider network, and it may require enrollees to obtain prior authorization before obtaining covered services. When enrollees do not follow these procedures, insurers may deny payment for services that would have been covered had the conditions been met.

denied about \$120 million in claims for failure to obtain prior authorization, and about \$30 million for failure to use an in-network provider, for states and for Medicaid managed care plans with which HMS contracted. Selected states reported various methods to reduce such denials:

- Ohio and Missouri laws explicitly prohibit denials due solely to a lack of prior authorization for services.³⁵
- Massachusetts, Georgia, and New York officials reported that they contest denials due solely to a lack of prior authorization for services based on general state legislation passed in accordance with the DRA, which requires states to prohibit insurers from denying claims based solely on the date the claim was submitted, the form that was used, or the failure to properly document coverage at the point of service.³⁶
- Michigan and Minnesota, through their Medicaid provider manuals, require providers to check for third-party coverage and specify that providers are not to be paid by Medicaid for services provided to enrollees if rules of the third-party coverage were not followed.³⁷ For example, Michigan's Medicaid provider manual states that Medicaid will not cover charges incurred when enrollees elect to go out of their third-party insurer's preferred provider network. Michigan and Minnesota officials reported that these types of denials were generally not problems for the state.

³⁵See Ohio Rev. Code § 5160.40(A) (2014) and Mo. Rev. Stat. § 208.215.1(1) (2013).

³⁶We did not independently assess whether denials due to lack of prior authorization for services are prohibited under the DRA. HMS representatives, however, commented that it is difficult and inefficient to address such denials in states without more specific statutory prohibitions against them.

³⁷See Michigan Medicaid Provider Manual, Coordination of Benefits, §§ 1.3, 2.1 (October 2014) and Minnesota Medicaid Provider Manual, Billing Policy (Overview), Section on Coordination of Services (September 2014) and Medicare and Other Insurance, Section on Third-Party Liability (TPL) (December 2013).

While CMS Has Taken Action to Support State TPL Efforts, Additional Federal Action Could Benefit TPL Efforts Nationwide

CMS has taken steps, including issuing additional guidance, to address certain challenges that states face in ensuring that Medicaid is the payer of last resort. For example, CMS published a set of frequently asked questions (FAQ) in September 2014 that clarified the parameters under which health insurers are permitted to release coverage information to states in light of Health Insurance Portability and Accountability Act of 1996 privacy restrictions, and emphasized the role of state legislation in specifying the scope of information required to be submitted by health insurers.³⁸ The guidance also reiterated previously published information, such as clarifying that when states delegate TPL responsibilities to a Medicaid managed care plan, third parties are required to treat the plan as if it were the state.³⁹ CMS officials also noted that the agency is available to provide technical assistance relating to TPL at the request of states or other entities.

In addition, CMS has also taken steps to foster collaboration among states. For example, CMS solicited effective TPL practices that had been implemented as of 2013 from states and published the responses.⁴⁰ On a related note, CMS officials highlighted the role of the Coordination of Benefits (COB)-TPL Technical Advisory Group (TAG) in providing states with opportunities to coordinate and share information on TPL challenges and effective practices.⁴¹ Specifically, CMS officials said that COB-TPL TAG representatives are responsible for canvassing states about

³⁸See CMS, *Medicaid and CHIP FAQs: Identification of Medicaid Beneficiaries' Third-Party Resources*.

³⁹These CMS FAQs also provided guidance on additional issues noted in the 2013 HHS OIG report on TPL. For example, CMS clarified that states must require insurers to either authorize pharmacy benefit managers or other entities with which they contract to provide coverage information to states, or to provide coverage information directly to states without such entities' assistance.

⁴⁰See CMS, *Coordination of Benefits and Third-Party Liability (COB/TPL) in the Medicaid Program: A Guide to Effective State Agency Practices*, (Baltimore, Md.: July 2014). Ten states submitted responses, including some of our selected states. For example, Washington officials submitted information about implementation of the PIE Transaction, and Ohio officials submitted information about a state law prohibiting denials based on lack of prior authorization for services.

⁴¹The COB-TPL TAG includes CMS officials, a state chair, and 10 state representatives, which represent the other states in their respective CMS regions (CMS divides the United States into 10 geographic regions). CMS and state officials also reported that a listserv run by states without CMS involvement is a channel for state communication and collaboration.

problems that may be occurring and reporting these back to CMS. However, officials from one state suggested that COB-TPL TAG representatives need to do more to proactively survey states and share information about problems that states not directly represented on the COB-TPL TAG are experiencing.

While acknowledging CMS's efforts, stakeholders and officials from selected states suggested a need for additional federal action, commenting on how, for example, additional or clarified guidance could facilitate state efforts to conduct certain TPL activities.

- The National Association of Medicaid Directors recommended, given the growth in states' use of managed care, that CMS require states to share available insurance coverage information with Medicaid managed care plans and provide an approved approach for conducting oversight of such plans' TPL activities. According to a representative of this association, several states indicated that explicit CMS guidance in this area would provide states leverage to strengthen their Medicaid managed care plan contracts and oversight related to TPL.
- HMS representatives recommended that CMS strengthen its statements encouraging insurers to share coverage information with out-of-state Medicaid agencies, and further clarify through regulations existing CMS guidance regarding insurer cooperation with Medicaid managed care plans that conduct TPL activities on behalf of states.
- State officials suggested that CMS could provide information to ensure all states are aware of promising available data-matching strategies.

CMS, however, may have incomplete information to inform such guidance as, according to CMS, the agency does not actively track all states' coverage-identification strategies on an ongoing basis, and in some cases, may not be aware of promising state initiatives. While the effective state practices CMS solicited and shared with states included information on initiatives implemented as of 2013, other state initiatives underway were not included. For example, Minnesota officials said they had submitted information about the CAQH data registry; however, the state's submission did not meet the criteria for inclusion in the effective practices document because the state had not yet implemented the registry. In addition, while CMS suggests that states should oversee Medicaid managed care plan TPL activities, as applicable, the agency does not track which states delegate TPL responsibilities to Medicaid managed

care plans, nor the problems with or oversight of related Medicaid managed care plan TPL activities in states that do.

Officials from selected states also emphasized efficiencies and other benefits that could be gained from state collaboration and information sharing, which CMS could support. For example, Michigan officials noted that the state wanted to explore sharing the national coverage data it obtained from insurers, as well as the TPL tracking and billing system it developed, with other states, noting the cost-effectiveness of states using its system and data rather than each developing their own. In addition, officials in multiple states noted the value of CMS-facilitated national TPL conferences that provide states with opportunities to discuss emerging problems and share expertise regarding solutions.⁴² CMS officials indicated that the last conference occurred when there were significant changes under the DRA and that CMS has no specific plans to facilitate future TPL conferences, but officials noted that discussions were underway regarding additional conferences or other training opportunities.

Conclusions

National survey data suggest that a substantial number of Medicaid enrollees—7.6 million—had private health insurance in 2012 and that many of these enrollees were in eligibility groups that incur, traditionally, higher medical costs. Furthermore, this number is expected to increase because of the Medicaid expansion. States have front-line responsibility for ensuring that Medicaid is the payer of last resort and are required to take steps to identify individuals with other health insurance and ensure that other insurance pays to the extent of its liability. Substantial increases in TPL cost savings in recent years highlight that improvements to TPL efforts, such as heightened attention to coverage identification, can substantially improve TPL cost avoidance and recoveries. The scale of the cost savings to Medicaid at both federal and state levels through the identification of coverage through, and payment of services by, private health insurance—reportedly nearly \$14 billion in 2011—underscores the potentially significant return on investment that may be gained from

⁴²States may share TPL information through other avenues that are not necessarily specifically focused on TPL. For example, New York officials reported sharing TPL-related information with other states at a Medicaid program integrity conference, and at the Medicaid Integrity Institute—a national Medicaid program integrity training program. While federal program integrity efforts center on combating provider fraud, waste, and abuse, some states include TPL under the umbrella of program integrity activities.

continued TPL improvement efforts and attention to resolving remaining gaps in state access to available coverage data.

Selected states have taken a variety of steps to further improve TPL efforts, and other states may also be implementing initiatives to address persistent challenges states report in ensuring Medicaid pays after other liable third parties. The various initiatives that selected states have undertaken—such as initiatives to improve identification of enrollees with private health insurance through data matches or to ensure that TPL efforts are maintained in an increasingly managed care environment—highlight options that other states could consider to improve their respective TPL savings. Other states may also have initiatives that could be adopted more broadly. CMS has taken steps to support states and publicize effective state practices. However, as new strategies emerge over time, a robust ongoing effort to collect and share information about state initiatives would ensure that states—particularly any states that may not conduct data matches with private insurers—are aware of available data matching strategies and solutions to challenges states or Medicaid managed care plans may face in conducting TPL activities. Given the significant federal Medicaid outlays, which are increasing as Medicaid expands under PPACA, the federal government has a vested financial interest in further increasing states’ TPL cost savings, and CMS should play a more active leadership role in monitoring, understanding, supporting and promoting state TPL efforts.

Recommendations

In light of the federal interest in ensuring that Medicaid should pay only after other liable third parties; state initiatives to improve TPL efforts, such as coverage identification strategies; and states’ increasing use of managed care, we recommend that the Secretary of Health and Human Services direct CMS to take the following two additional actions to oversee and support state TPL efforts:

- Routinely monitor and share across all states information regarding key TPL efforts and challenges.
- Provide guidance to states on their oversight of TPL efforts conducted by Medicaid managed care plans.

Agency Comments

We provided a draft of this report to HHS for comment. In its written comments—reproduced in appendix III—HHS concurred with our recommendations. HHS stated that it will continue to look at ways to provide guidance to states to allow for sharing of effective practices and to increase awareness of initiatives under development in states. HHS also stated that it will explore the need for additional guidance regarding state oversight of TPL efforts conducted by Medicaid managed care plans.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.



Katherine M. Iritani
Director, Health Care

Appendix I: Scope and Methodology of the American Community Survey (ACS) Analysis

To assess the extent to which Medicaid enrollees have private health insurance, we utilized the ACS, an annual survey conducted by the U.S. Census Bureau. The ACS includes representative samples of households from each state and also includes individuals residing in institutions such as nursing homes. The ACS collects self-reported information, such as the type of health insurance coverage as of the date of the survey (if any), disability status, age, and state of residence. We analyzed data from the most recent ACS Public Use Microdata Sample (PUMS) that was available at the time we conducted our work, which covered calendar year 2012.¹

Our analysis of ACS PUMS data is subject to limitations. The analysis uses 2012 data and therefore does not include individuals who were newly eligible for Medicaid in 2014 as a result of the optional program expansion under the Patient Protection and Affordable Care Act. In addition, our estimates are based on responses from the ACS PUMS sample and may differ from actual figures that would be obtained if the full population had been surveyed using the same methods. Similarly, as the ACS collects self-reported information, errors may exist due to factors such as differing interpretations of survey questions, the inability or unwillingness of survey participants to provide correct information, or data processing errors. The Census Bureau reported that quality control and edit procedures were used to reduce such errors. For example, an eligibility edit was applied to assign Medicaid, Medicare, and TRICARE coverage to individuals based on program eligibility rules.² To determine the reliability of the ACS PUMS data, we reviewed related documentation and compared the results to estimates based on data from another Census Bureau survey, the Current Population Survey. We determined

¹The ACS PUMS dataset contains a sample of actual responses to the ACS, as well as variables that were constructed based on responses. The ACS PUMS file for 2012 contains data on approximately one percent of the U.S. population.

²Medicare is a federal health insurance program for individuals aged 65 and older or with certain disabilities and individuals with end-stage renal disease. TRICARE is a federal health program generally for active-duty military personnel and their dependents, and retirees and their dependents and survivors.

Medicaid coverage was assigned to foster children, certain individuals receiving Supplementary Security Income or Public Assistance, and the spouses and children of certain Medicaid beneficiaries. Medicare coverage was assigned to individuals aged 65 and older who received Social Security or Medicaid benefits. TRICARE was assigned to active-duty military personnel and their spouses and children.

that the ACS PUMS data were sufficiently reliable for the purposes of our engagement.

Key Analysis Variables

From the available ACS PUMS data, we constructed the following variables for our analysis:

- **Medicaid coverage and eligibility category.** We defined individuals as having Medicaid if they reported health coverage through Medicaid, medical assistance, or any kind of government assistance plan for individuals with low incomes or a disability. These sources of coverage are combined in one question in the ACS PUMS.³ For purposes of the report, we refer to these individuals collectively as Medicaid enrollees.

We further categorized Medicaid enrollees into four broad Medicaid eligibility categories—children, adults, disabled, and aged:

- We defined the child eligibility category as individuals aged 0 through 18 who did not report a disability.
- We defined adult eligibility category as individuals aged 19 through 64 who did not report a disability.
- We defined the disabled eligibility category as individuals aged 0 through 64 who reported one or more of the 6 disability indicators included in the ACS data.⁴
- We defined the aged eligibility category as individuals aged 65 and older.
- **Third-party private and public health coverage.** We defined individuals as having private insurance coverage if they reported having health insurance through a current or former employer or union, insurance purchased directly from an insurance company, or both. We defined individuals as having public coverage other than Medicaid if they reported coverage through Medicare or TRICARE, or

³Because the ACS PUMS variable combines Medicaid coverage with other types of public coverage, some individuals we identified as Medicaid enrollees may have other types of means-tested coverage, such as Children's Health Insurance Program coverage.

⁴These indicators were (1) self-care difficulty, (2) hearing difficulty, (3) vision difficulty, (4) independent living difficulty, (5) ambulatory difficulty, and (6) cognitive difficulty.

having ever used or enrolled in health care provided through the Department of Veterans Affairs (VA).⁵

Methodology

Based on the variables defined above, we used calendar year 2012 ACS PUMS data to estimate the number and percentage of Medicaid enrollees with private and other sources of health coverage. We produced separate estimates by Medicaid eligibility group and state of residence. To generate our estimates, we applied the appropriate weights contained in the ACS PUMS data files in order to expand the sample to represent the total population and to account for the complex sample design. Specifically, we used the person weights to generate estimated numbers and percentages.⁶ We used the person replicate weights to generate standard errors.

To assess the precision of our estimates, we calculated a relative standard error for each estimate. A relative standard error is calculated by dividing the standard error of the estimate by the estimate itself. For example, if an estimate has a mean of 100 and a standard error of 20, the relative standard error would be 20/100, which would be 20 percent. Estimates with small relative standard errors are considered more reliable than estimates with large relative standard errors. A small relative standard error is a more precise measurement since there is less variance around the mean. Unless otherwise noted, estimates included in this report have relative standard errors of less than 15 percent.

⁵VA provides health care generally for veterans who served in active military duty and who were discharged or released under conditions other than dishonorable. We did not include Indian Health Service coverage as a third-party source of coverage because when individuals have both Medicaid and Indian Health Service coverage, Indian Health Service is the payer of last resort. See 42 C.F.R. § 136.61.

⁶The ACS PUMS data includes survey weights in order to allow users to generate accurate estimates and standard errors from the sample data. The ACS PUMS contains person weights and household weights; person weights are used to generate estimates that pertain to individuals, and household weights are used to generate estimates pertaining to housing units and households. Person and household replicate weights are used to generate accurate standard errors for estimates pertaining to individuals or households respectively.

Appendix II: Detailed Estimates of Medicaid Enrollees with Other Sources of Health Coverage

The following tables provide more detailed information about the estimates derived from our analysis of the 2012 American Community Survey (ACS) Public Use Microdata Sample (PUMS). Specifically, tables 1 and 2 provide estimates of the number and percentage of Medicaid enrollees with other sources of health coverage by Medicaid eligibility category and by state.

Table 2: Estimated Number and Percentage of Medicaid Enrollees with Other Private or Public Sources of Health Coverage in 2012, by Eligibility Category

Source of coverage	Medicaid eligibility category ^a				
	Children	Adults	Disabled	Aged	All categories
Private ^b	2,254,373 (8.44%)	1,664,062 (12.39%)	1,276,605 (13.23%)	2,363,891 (34.60%)	7,558,931 (13.35%)
Medicare ^c	178,071 (0.67%)	855,302 (6.37%)	2,646,272 (27.42%)	6,831,506 (100%)	10,511,151 (18.56%)
TRICARE ^d	156,862 (0.59%)	135,644 (1.01%)	123,540 (1.28%)	319,184 (4.67%)	735,230 (1.30%)
Department of Veterans Affairs (VA) ^e	23,948 (0.09%)	155,347 (1.16%)	190,109 (1.97%)	471,094 (6.90%)	840,498 (1.48%)
No other coverage	24,203,047 (90.58%)	10,952,795 (81.56%)	6,040,083 (62.59%)	0 (0.00%)	41,195,925 (72.75%)

Source: GAO analysis of 2012 U.S. Census Bureau data. | GAO-15-208

Notes: Estimates are based on self-reported information from the American Community Survey (ACS) Public Use Microdata Sample (PUMS) dataset. Individuals may report multiple sources of health coverage. For example, an enrollee may report Medicaid, Medicare, and private coverage. Therefore, estimated numbers for each eligibility category may sum to greater than the total number of enrollees, and estimated percentages may sum to greater than 100 percent. All estimates shown have relative standard errors of less than 15 percent.

^aWe categorized Medicaid enrollees into four broad Medicaid eligibility categories—children (individuals aged 0 through 18 who did not report a disability), adults (individuals aged 19 through 64 who did not report a disability), disabled (individuals aged 0 through 64 who reported a disability), and aged (individuals aged 65 and older).

^bWe defined private sources of health insurance to include employer- or union-sponsored and individually purchased health insurance.

^cMedicare is a federal health insurance program for individuals aged 65 and older or with certain disabilities and individuals with end-stage renal disease.

^dTRICARE is a health program operated by the Department of Defense generally for active duty personnel and their dependents, and retirees and their dependents and survivors.

^eVA provides health care generally for persons who served in active military duty and who were discharged or released under conditions other than dishonorable. In the ACS PUMS, individuals who have ever used or enrolled in VA health care are included in this category.

Appendix II: Detailed Estimates of Medicaid Enrollees with Other Sources of Health Coverage

Table 3: Estimated Number and Percentage of Medicaid Enrollees with Other Private or Public Health Coverage in 2012, by State

State	Type of additional coverage			
	Private ^a		Public ^b	
Alabama	148,707	15.93 %	221,293	23.71 %
Alaska	15,418 ^c	13.87	21,307	19.17
Arizona	145,995	11.37	196,618	15.31
Arkansas	73,411	11.69	138,000	21.97
California	808,909	10.56	1,384,444	18.07
Colorado	101,233	12.93	138,385	17.68
Connecticut	91,340	14.30	127,763	20.00
Delaware	34,832	18.36	33,802	17.81
District of Columbia	26,258	15.62	29,433	17.50
Florida	381,354	11.23	801,696	23.60
Georgia	214,039	12.52	339,391	19.85
Hawaii	33,903	14.30	43,251	18.25
Idaho	43,127	17.11	46,407	18.41
Illinois	275,647	11.87	357,409	15.39
Indiana	154,077	14.98	191,184	18.59
Iowa	116,280	22.54	121,483	23.55
Kansas	68,438	17.41	82,946	21.10
Kentucky	111,051	13.51	188,333	22.91
Louisiana	120,964	11.70	197,423	19.10
Maine	48,732	15.53	77,923	24.83
Maryland	133,520	14.81	162,353	18.01
Massachusetts	241,265	16.38	298,749	20.29
Michigan	332,911	17.11	368,583	18.95
Minnesota	118,720	15.05	141,811	17.98
Mississippi	76,244	10.47	157,527	21.63
Missouri	115,410	12.17	196,883	20.76
Montana	23,543	15.24	33,277	21.55
Nebraska	38,139	15.86	55,229	22.97
Nevada	54,776	16.31	68,847	20.50
New Hampshire	28,746	17.85	38,175	23.71
New Jersey	184,708	14.48	282,584	22.16
New Mexico	52,755	11.11	79,717	16.79
New York	599,711	13.46	817,949	18.36

Appendix II: Detailed Estimates of Medicaid Enrollees with Other Sources of Health Coverage

State	Type of additional coverage			
	Private ^a		Public ^b	
North Carolina	211,977	12.13	357,624	20.47
North Dakota	13,232	20.59	20,226	31.47
Ohio	298,374	14.76	371,395	18.37
Oklahoma	84,954	12.78	118,692	17.86
Oregon	115,430	16.84	128,846	18.79
Pennsylvania	390,012	17.83	461,480	21.09
Rhode Island	33,356	17.78	50,650	27.01
South Carolina	112,300	12.85	184,120	21.08
South Dakota	20,869	16.80	29,197	23.51
Tennessee	164,825	13.46	251,776	20.55
Texas	466,512	9.99	779,806	16.69
Utah	64,392	19.55	55,008	16.70
Vermont	24,169	15.88	31,576	20.74
Virginia	130,910	14.38	200,777	22.06
Washington	174,679	16.09	217,385	20.03
West Virginia	46,548	13.94	79,360	23.77
Wisconsin	176,384	17.99	195,305	19.92
Wyoming	15,845	20.60	20,019	26.02

Source: GAO analysis of 2012 U.S. Census Bureau data. | GAO-15-208

Notes: Estimates are based on self-reported information from the American Community Survey (ACS) Public Use Microdata Sample (PUMS) dataset. Individuals may report multiple sources of health coverage. For example, an enrollee may report Medicaid, Medicare, and private coverage. Therefore, estimated numbers for each state may sum to greater than the total number of enrollees in the state, and estimated percentages may sum to greater than 100 percent. Estimates shown have relative standard errors of less than 15 percent unless otherwise noted.

^aWe defined private sources of health insurance to include employer- or union-sponsored and individually purchased health insurance.

^bWe defined public sources of coverage to include coverage through Medicare, TRICARE, or the Department of Veterans Affairs (VA). Medicare is a federal health insurance program for individuals aged 65 and older or with certain disabilities and individuals with end-stage renal disease. TRICARE is a health program operated by the Department of Defense generally for active duty military personnel and their dependents and retirees and their dependents and survivors. VA provides health care generally for persons who served in active military duty and who were discharged or released under conditions other than dishonorable. In the ACS PUMS, individuals who have ever used or enrolled in VA health care are included in this category.

^cThe relative standard error of the estimate is 15.6 percent.

Appendix III: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

2/24/15 9:05 AM

Katherine Iritani
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "MEDICAID: Additional Federal Action Needed to Further Improve Third-Party Liability Efforts" (GAO-15-208).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL FEDERAL ACTION NEEDED TO FURTHER IMPROVE THIRD-PARTY LIABILITY EFFORTS (GAO-15-208)

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report.

GAO Recommendation

The Government Accountability Office (GAO) recommends that the Secretary of HHS direct the Centers for Medicare & Medicaid Services (CMS) to take additional actions to oversee and support state Third Party Liability (TPL) efforts, including:

- Routinely monitoring and sharing across all states information regarding key TPL efforts and challenges.
- Provide guidance on state oversight of TPL efforts conducted by Medicaid managed care plans.

HHS Response

HHS concurs with GAO's recommendations. HHS will continue to look at ways to provide guidance to states, to allow for continued sharing of proven effective practices and to increase awareness of initiatives under development among the states. HHS will consider the collection and publication of effective state practices that are working and proposed practices that are scheduled for implementation within the submitting states. HHS will remind the states that they may request technical assistance in resolving general or specific Medicaid Coordination of Benefits and Third Party Liability (COB/TPL) issues by contacting the CMS Regional Office staff or CMS Central Office COB/TPL staff, and that any state may raise an issue for discussion by the COB/TPL Technical Advisory Group (TAG) by contacting the TAG State Representative for its region.

HHS is pleased that the GAO acknowledged several effective measures that HHS has taken to assist states to meet TPL challenges, such as issuing guidance through the Frequently Asked Questions posted on the Medicaid.gov web site in September 2014 ("FAQs: Identification of Medicaid Beneficiaries' Third Party Resources and Coordination of Benefits with Medicaid") and fostering collaboration among states by publishing effective state practices on Medicaid.gov in July 2014 ("Coordination of Benefits and Third Party Liability in the Medicaid Program: A Guide to Effective State Agency Practices"¹).

Additionally, HHS is pleased that GAO acknowledged the guidance HHS recently published to clarify that, when states delegate TPL responsibilities to the Medicaid managed care organizations (MCOs), third parties are required to treat the MCOs as if they were the state. HHS will remind state Medicaid agencies of the availability of this guidance, and explore the need for additional guidance regarding state oversight of TPL efforts conducted by Medicaid MCOs.

¹ This guide was developed in response to a recommendation by the Office of the Inspector General, U.S. Department of Health and Human Services, in its study "Medicaid Third-Party Liability Savings Increased, but Challenges Remain", OEI-05-11-00130, issued January 2013.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Katherine M. Iritani, Director, Health Care, (202) 512-7114,
iritanik@gao.gov

Staff Acknowledgments

In addition to the contact named above, Susan Anthony, Assistant Director; Emily Beller; George Bogart; Britt Carlson; Laurie Pachter; and Ying Long made key contributions to this report.

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