United States Government Accountability Office

GAO

Report to the Chairman, Committee on Finance, U.S. Senate

September 2006

MEDICAID THIRD-PARTY LIABILITY

Federal Guidance Needed to Help States Address Continuing Problems

GAO-06-862

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GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-06-862, a report to the Chairman, Committee on Finance, U.S. Senate

Why GAO Did This Study

Medicaid, jointly funded by the federal government and the states, finances health care for about 56 million low-income people at an estimated total cost of about $298 billion in fiscal year 2004.

Congress intended Medicaid to be the payer of last resort: if Medicaid beneficiaries have another source of health care coverage—such as private health insurance or a health plan purchased individually or provided through an employer—that source, to the extent of its liability, should pay before Medicaid does. This concept is referred to as "third-party liability." When such coverage is used, savings accrue to the federal government and the states.

Using data from the U.S. Census Bureau and the states, GAO examined (1) the extent to which Medicaid beneficiaries have private health coverage and (2) problems states face in ensuring that Medicaid is the payer of last resort, including the extent to which the Deficit Reduction Act of 2005 may help address these problems.

What GAO Recommends

GAO recommends that the Administrator of CMS determine and provide guidance to states on (1) when states must have laws in place to implement the Deficit Reduction Act's requirements and (2) which entities are required to provide states with coverage and other data. CMS concurred with GAO's recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-06-862.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or allenk@gao.gov.

What GAO Found

On the basis of self-reported health coverage information from the Census Bureau's annual Current Population Surveys covering the 2002 through 2004 time period, an average of 13 percent of respondents who reported having Medicaid coverage for the entire year also reported having private health coverage at some time during the same year. This coverage most often was obtained through employment rather than purchased by individuals directly from an insurer: employment-based coverage averaged 11 percent nationwide, while individual coverage averaged 2 percent.

Problems states have faced in ensuring that Medicaid is the payer of last resort fall into two general categories: verifying Medicaid beneficiaries' private health coverage and collecting payments from third parties. Officials from 27 of 39 states responding to GAO's request for information about the top three problems they faced reported problems in verifying beneficiaries' private health coverage—a key step states must take to avoid paying claims for which a third party is liable. In cases where states have paid claims before identifying that other coverage was available, states must seek payment for the claims they have already paid. Officials from 35 responding states had problems collecting such payments.

Number of States Reporting Problems in Verifying Coverage and Collecting Payment from Third Parties and Their Contractors, with Available Estimates of Associated Annual Losses

Category of problems	Number of states reporting problems (n = 39)	Number of states able to estimate annual losses	Total estimated annual losses[a] (dollars in millions)
Verifying coverage	27	10	$54–60
Collecting payments	35	14	184–196

Source: GAO analysis of information provided by state officials.

[a]Expressed as a range because some states estimated their losses as a range.

Provisions in the Deficit Reduction Act of 2005 require states to have laws in effect that could help address some of the reported problems, but it is too soon to assess the extent to which the problems will be addressed. Further, GAO identified two issues that require resolution in order to aid states in complying with the Deficit Reduction Act's requirements, specifically, (1) the time frame by which states must have their laws in effect, and (2) which entities are subject to certain of the act's requirements. Regarding both issues, officials from the Centers for Medicare & Medicaid Services (CMS), which oversees Medicaid, said in June 2006 that they were considering how to interpret the law and how to best provide guidance to states to help them implement the requirements.

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Abbreviations

CMS Centers for Medicare & Medicaid Services
CPS Current Population Survey

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

September 15, 2006

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate

Dear Mr. Chairman:

Medicaid finances health care for about 56 million low-income individuals, including children and aged or disabled adults. Jointly funded by the federal government and the states at an estimated total cost of about $298 billion in fiscal year 2004, Medicaid has been on our list of high-risk programs since 2003 because of concerns about the program's size, growth, and fiscal oversight, including concerns over whether federal and state efforts ensure that payments are appropriate.[1] Congress intended that Medicaid be the payer of last resort; in other words, if a Medicaid beneficiary also has another source of payment for health services, that source is to pay instead of Medicaid. Federal law and regulation refer to these other sources of payment as "third parties," which may include private health insurers and employer health plans.[2] In addition, insurers and employer health plans often hire contractors—such as plan administrators[3] or benefit managers—to administer part or all of their health care plans. Some adults may have access to private health coverage because they may be working and covered by an employer's health plan even though they also qualify for Medicaid. In addition, children may

[1]See, for example, GAO, *High-Risk Series: An Update*, GAO-05-207 (Washington D.C.: January 2005).

[2]This report focuses on private health coverage, excluding federal health programs, such as Medicare or veterans health programs. It excludes automobile insurance, court judgments and settlements with a liability insurer, state workers' compensation, and estate recoveries. In addition to private health insurance purchased by individuals, employers, or unions, "private health coverage" may include health coverage provided by employers who self-insure, which we refer to in this report as employer "health plans." According to the Centers for Medicare & Medicaid Services' (CMS) regulations, a third party is an individual, entity, or program that is or may be liable to pay for all or some of the expenditures for services provided under a state Medicaid plan. See 42 C.F.R. § 433.136 (2005).

[3]A plan administrator—also referred to as a third-party administrator—is generally a person or group that, according to a service contract, processes claims and may also provide one or more administrative services.

qualify for Medicaid and also be included on a parent's health plan provided by the parent's employer or purchased directly by the parent from a private insurer. To the extent that private health coverage pays for health care services instead of Medicaid, savings can accrue to the federal government and to the states. Such savings can be substantial. States reported savings of nearly $5.5 billion in fiscal year 2004 from ensuring that private third parties paid before Medicaid.

In administering their Medicaid programs, states are required to take reasonable measures to identify other sources of health coverage that Medicaid beneficiaries may have and to ensure that such parties pay to the extent of their liability. States have considerable flexibility in designing and operating their Medicaid programs, although they must comply with federal requirements. States can typically avoid paying claims for Medicaid beneficiaries when they have verified that other coverage is available—for this purpose, knowing which services are covered and the eligibility period for the other coverage is critical[4]—or they can seek reimbursement from third parties for previously paid claims for which the third party is legally liable.[5] In the early 1990s, we reported certain problems that hindered states' ability to ensure that beneficiaries' other health care resources paid before Medicaid.[6] Some third parties, for example, avoided paying costs for Medicaid beneficiaries by taking actions that significantly limited states' ability to recover the costs.[7] In response to our earlier recommendations, Congress passed legislation in 1993 to help strengthen states' ability to collect from responsible third parties.[8] Recently, however, Members of Congress have become aware that states are experiencing difficulties with their third-party efforts. In February 2006, Congress passed the Deficit Reduction Act of 2005, which contained some

[4]Throughout this report, we refer to the process of determining both the eligibility period and the services that are covered as "verifying health coverage."

[5]In certain circumstances (described in footnote 17), states may not avoid paying claims.

[6]GAO, *Medicaid: Legislation Needed to Improve Collections from Private Insurers*, GAO/HRD-91-25 (Washington, D.C.: Nov. 30, 1990); *Medicaid: Ensuring That Noncustodial Parents Provide Health Insurance Can Save Costs*, GAO/HRD-92-80 (Washington, D.C.: June 17, 1992).

[7]For example, some third parties included provisions in their benefit plans that excluded payments to Medicaid programs under certain conditions. See GAO/HRD-91-25.

[8]Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13622, 107 Stat. 312, 632–633.

provisions related to Medicaid third-party liability.[9] Because of your interest that Medicaid not pay for costs that are the responsibility of third parties, you asked us to review states' efforts to ensure that Medicaid is the payer of last resort. Specifically, we examined (1) the extent to which Medicaid beneficiaries have private health coverage and (2) problems affecting states' ability to ensure that Medicaid is the payer of last resort, including the extent to which the Deficit Reduction Act of 2005 might address these problems.

To determine the extent to which Medicaid beneficiaries nationwide and in individual states have private health coverage, we analyzed data from the only national data source containing this information, the Current Population Survey (CPS) conducted by the U.S. Census Bureau. CPS is designed to represent a cross section of the nation's civilian noninstitutionalized population. The survey provides estimates for a variety of demographic characteristics for the nation as a whole and, for some estimates, furnishes data for individual states and other geographic areas.[10] Each March, CPS gathers information about health coverage that survey respondents had at any time in the previous calendar year, including government health coverage, such as Medicaid, and private health coverage, such as coverage provided through an employer or union (employment-based health coverage) and coverage directly purchased by the beneficiary (individual health coverage).[11] CPS also asks for the number of months that survey respondents had Medicaid coverage. To identify individuals who had Medicaid and private health coverage concurrently in the same year, we focused our analysis on individuals who reported that they had Medicaid coverage for the entire year along with private health coverage at some point during the same year. In 2005, about 84,700 households nationwide were included in the survey. Because the CPS sample size is relatively small in some states in any particular year, we calculated a 3-year average for each state to help mitigate single-year anomalies. We used data collected in CPS from 2003 through 2005, which

[9]Pub. L. No. 109-171, § 6035, 120 Stat. 4, 78–80 (2006).

[10]We report information collected in CPS for the District of Columbia but not for U.S. territories.

[11]CPS refers to private health coverage purchased by an individual (termed "individual health coverage" in this report) as "direct-purchase" coverage. CPS's information on employment-based health coverage captures both private health insurance coverage purchased by employers or unions and private health plan coverage provided by employers or unions that self-insure.

asked respondents health coverage questions about the 2002 through 2004 time period. To assess the reliability of our use of CPS data, we discussed our methodology with officials from the U.S. Census Bureau and reviewed the agency's data quality-control procedures and related documentation. We determined that the data were sufficiently reliable for the purposes of this report. We also interviewed officials from the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services that oversees the Medicaid program, about available data on Medicaid beneficiaries' private health coverage. For additional information on CPS and our methods for and outcomes from analyzing the data, see appendix I.

To determine what problems affect states' ability to ensure that Medicaid is the payer of last resort, in December 2005 we requested information from states' Medicaid third-party liability coordinators regarding the three most significant problems they encountered in ensuring that Medicaid was the payer of last resort; we received responses from 39 states.[12] These 39 states covered approximately 82 percent of Medicaid beneficiaries and 72 percent of Medicaid payments in fiscal year 2003. We also asked states to estimate, to the extent possible, any financial losses to the state resulting from each identified factor or problem. We did not assess the underlying basis for states' reported estimates; however, we did compare the total losses reported by states with Congressional Budget Office estimates of potential Medicaid savings from the third-party liability provisions of the Deficit Reduction Act of 2005 and determined that the states' estimates were sufficiently reliable for the purposes of this report. We met with officials from a consulting firm that assists 27 states with

[12]Specifically, we asked state third-party liability coordinators by e-mail to specify what, in their view, represented the three most significant factors or problems that hindered their ability to collect from private third parties and to include an estimate of losses to the state from each of these factors or problems. We followed up with states through phone calls and e-mails to clarify their responses and to improve our response rate. We did not independently assess, in the instances identified by state officials, whether the private health coverage was legally liable for payment for services provided to Medicaid beneficiaries. The 39 responses included the District of Columbia, which we include in our discussion of states.

third-party liability issues.[13] We reviewed the Deficit Reduction Act of 2005 (hereafter referred to as the "Deficit Reduction Act" or the "act"), which was enacted in February 2006 during our review; examined its potential effect; and discussed the act's requirements with CMS officials and state representatives. We conducted our work in accordance with generally accepted government auditing standards from October 2005 through September 2006.

Results in Brief

On the basis of self-reported health coverage information from the Census Bureau's annual CPS covering the 2002 through 2004 time period, an average of 13 percent of respondents who reported having Medicaid coverage for the entire year also reported having private health coverage at some time during the same year. Medicaid beneficiaries in Alabama, Arizona, and California reported the lowest rates of private health coverage among Medicaid beneficiaries (about 9 percent), while Medicaid beneficiaries in Iowa, South Dakota, and Wyoming reported the highest rates of such coverage (about 22 percent to 23 percent). Most often, the source of the coverage for Medicaid beneficiaries was an employer or union: employment-based coverage averaged 11 percent nationwide, while individual health coverage averaged 2 percent. In addition, states identify and collect information on beneficiaries' private health coverage as part of administering their own Medicaid programs. According to CMS officials, however, inconsistencies in how state Medicaid agencies collect and report their data preclude using these state data to measure the extent to which beneficiaries nationwide have private health coverage or to make comparisons across states or with CPS data.

In responding to our information request about the top three problems they faced in ensuring that Medicaid is the payer of last resort, state officials reported problems that fell into two general categories:

[13]Many state Medicaid agencies hire consulting firms to assist them with their activities in identifying and collecting from liable third parties. States contract with private consulting firms to carry out activities such as matching states' and health insurers' or health plans' electronic coverage files (data matching) to identify private health coverage, verifying covered services and eligibility periods, and billing and collecting from third parties on claims paid by state Medicaid agencies for which third parties were liable. In performing these activities, these firms face the same challenges that state Medicaid programs face in working with third parties. For this reason, we have used some information from a firm in discussing some of the problems faced by states. Where we used such information, we discuss it apart from the responses provided to us by states and identify the information as coming from that firm.

- **Problems verifying Medicaid beneficiaries' private health coverage.** Officials in 27 of 39 states reported one or more types of problems related to their ability to verify coverage information from third parties or their contractors, such as pharmacy benefit managers. Specific problems included third parties' or their contractors' not verifying coverage information when requested to do so, and citing patient privacy provisions as justification for withholding such information, and not granting states electronic access to their member coverage files.

- **Problems collecting payments from third parties.** Officials in 35 of the 39 responding states reported problems collecting payments from third parties or their contractors once the states had established that those parties were liable for a claim the state had paid. Some state officials reported that third parties denied claims because they were not filed within a certain time frame; others reported that these entities simply refused to acknowledge or respond to claims the states had submitted for payment. Several state officials also pointed to weak or problematic federal or state laws.

  The Deficit Reduction Act could help address some of the problems reported by state officials because it adds a Medicaid requirement that states have legislation in effect so that, as a condition of doing business in the state, health insurers and certain other entities, such as pharmacy benefit managers and others that are legally responsible for payment of a claim, (1) provide states with information on coverage and other specified information and (2) agree not to deny claims from the state solely because of the date the claim was submitted or the form that was used, as long as the state seeks payment within time periods specified by the Deficit Reduction Act. It is too soon, however, to assess the extent to which—or when—the act will address reported problems. Further, we identified two issues that require resolution in order to aid states in complying with the Deficit Reduction Act's requirements. First, the time by which states must have their laws in effect is uncertain because an applicable provision of the law contains an inconsistency. Specifically, a section of the law concerning the effective date of certain third-party provisions refers to another section of the law that does not exist. Second, according to CMS officials and a private consulting firm, some disagreement exists in the industry as to the entities that are covered by the law's provisions requiring that information be provided to states on coverage and other matters. Regarding both issues, CMS program officials said in June 2006 that they were considering how to interpret the law and how to best help states implement the new requirements.

To resolve issues critical to the implementation of the Deficit Reduction Act's third-party provisions and to assist states in their efforts to ensure that Medicaid is the payer of last resort, we are recommending that the Administrator of CMS (1) determine and provide guidance to states concerning when states must have laws in effect implementing the Deficit Reduction Act's requirements regarding third parties and, if necessary, seek appropriate legislation to establish an effective date and (2) determine which entities are required to provide states with coverage and other information and provide guidance to states regarding this determination.

In commenting on a draft of this report, CMS concurred with our recommendations, stating that the agency plans to shortly issue a decision on both the issue of the time frames by which states must have laws in effect implementing the Deficit Reduction Act's requirements and the issue of the entities covered by the Deficit Reduction Act's requirement to provide states with coverage and other information.

Background

Established under title XIX of the Social Security Act[14] as a joint federal-state health financing program, Medicaid is one of the largest programs in the federal and state budgets. States, in administering their Medicaid programs, must comply with federal requirements. States pay qualified health providers for a broad range of covered services provided to eligible beneficiaries. The federal government then reimburses states for a share of their expenditures. The federal share of each state's program expenditures is calculated according to a formula specified in the Medicaid statute, which allows the federal share to range from 50 to 83 percent.[15]

With Medicaid as payer of last resort, states are responsible for having plans in place to identify Medicaid beneficiaries' other sources of health coverage, determine the extent of the liability of such third parties, avoid payment of third-party claims, and recover reimbursement from third parties after Medicaid payment if the state can reasonably expect to recover more than it spends in seeking reimbursement.[16] Individuals

[14]Codified at 42 U.S.C. §§ 1396 et seq. (2000).

[15]States with lower per capita incomes receive higher federal matching percentages.

[16]See 42 C.F.R. part 433, subpart D (2005).

eligible for Medicaid assign their right to third-party payments to the state's Medicaid agency, which allows the state to claim payments for medical care directly from third parties. In general, state Medicaid agencies are required whenever possible to avoid paying for services for which the state agency has reason to believe another party is legally liable.[17] Whenever states are reimbursed by third parties, they must ensure that the federal government is given its share of the reimbursement.[18]

Third parties that may be liable for payment of services furnished to Medicaid beneficiaries can include private insurers and health plans of employers who self-insure.[19] Private health coverage can be delivered through managed care plans—plans in which enrollees, or their employers, pay a monthly payment in exchange for health care services through affiliated physicians, hospitals, and other providers. In addition, private insurers and health plans often contract with other entities, such as plan administrators or pharmacy benefit managers, to administer part or all of their health care plans. Plan administrators process claims and manage the day-to-day operations of the associated health plan. Pharmacy benefit managers negotiate drug prices with pharmacies and drug manufacturers on behalf of health plans and, in addition to other administrative, clinical, and cost-containment services, process prescription drug claims for the health plans. When a Medicaid beneficiary has pharmacy coverage administered through a pharmacy benefit manager, the state generally bills the pharmacy benefit manager directly for reimbursement instead of billing the insurer or the employer.

For states to avoid paying costs for which a third party may be liable, or to recover from a liable third party payments the state may already have made, states need to verify when Medicaid beneficiaries have other health coverage, as well as the services that are covered and the period of

[17]Exceptions to this requirement are for prenatal care services, preventive pediatric services, and services provided to a minor for whom the state is enforcing a child-support order against a noncustodial parent. See 42 C.F.R. § 433.139(b)(3) (2005).

[18]See Social Security Act §1903(d)(2)(B).

[19]Insurance companies sell health coverage to businesses and to individuals and pay a certain proportion of covered individuals' health care costs. Rather than purchase health coverage through insurance companies, however, large employers may elect to pay directly for health benefits for their employees and dependents (referred to as "self-insured" or "self-funded" health plans). The Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829, established the framework within which employer group health plans must operate.

eligibility. States obtain information on other health coverage in two common ways:

- When initially applying for enrollment in a state's Medicaid program, applicants are asked to report to the state any other sources of health coverage they may have.[20] States then verify the applicant's coverage with the source of the health coverage, including coverage dates, type, benefits, and limits. State Medicaid programs often have staff who, on receiving information suggesting that a Medicaid applicant has other health coverage, contact the sources of such coverage by phone, mail, or other means to obtain specific coverage information.

- States also often independently identify and verify health coverage of Medicaid beneficiaries by electronically matching the states' coverage files with those of the other coverage sources. This type of verification is important because information provided by Medicaid applicants may be incomplete. Applicants may not report other sources of health coverage, or they may not know if they have such coverage; for example, a custodial parent may not realize that his or her child has health coverage through the noncustodial parent's employment-based health plan. Additionally, Medicaid beneficiaries who do not have other coverage when they first enroll in Medicaid may obtain it later. States may have agreements, called data-matching agreements, through which insurers, health plans, and other potential third parties periodically provide states with an electronic copy of their coverage files or with access to company databases. Third parties that are willing to work with states to electronically share their coverage files facilitate appropriate billings and reduce the administrative burden, on states and on third parties, associated with verifying coverage on a case-by-case basis.

  Once verification of any available private health coverage occurs, the state can redirect health care providers' claims to a responsible third party (a process known as cost avoidance), and it can seek reimbursement from the third party for payments it has already made (a process known as "pay and chase").[21] Identifying and verifying coverage early is important,

[20]States are required to take all reasonable measures to determine the legal liability of third parties, including collecting health insurance information at the time of any determination or redetermination of eligibility for Medicaid. See Social Security Act §1902(a)(25)(A).

[21]States are required to ensure that their automated claims systems compare any verified private health coverage with claims paid by the state over at least the previous year to identify any funds recoverable from that third party. See *State Medicaid Manual*, part 03, 3902.3.

because it is administratively more costly and time-consuming for states to seek reimbursement for payments that have already been made. If third parties do not readily pay claims for which the state Medicaid agency is seeking payment, it is often not cost-effective for states to spend resources pursuing payment on a claim-by-claim basis, even though substantial total dollars could be involved. For example, the states might not have the resources to further pursue payment through legal action. Conversely, success in verifying coverage, avoiding Medicaid payments for those beneficiaries with private health coverage, and collecting on previously paid claims from third parties can result in substantial Medicaid savings. Of the $5.5 billion that states reported in third-party-related savings in fiscal year 2004, states reported more than $4.9 billion in Medicaid payments avoided and more than $524 million in third-party recoveries.[22]

An Estimated 13 Percent of Medicaid Beneficiaries Have Private Health Coverage

On the basis of self-reported health coverage information from the Census Bureau's annual CPS covering the 2002 through 2004 time period, an average of 13 percent of respondents who reported having Medicaid coverage for the entire year also reported having private health coverage at some time during the same year. Individual state estimates ranged from 9 percent in Alabama, Arizona, and California to 22 percent in Iowa and South Dakota and 23 percent in Wyoming (see table 1). Most often, the source of private health coverage was an employer or union. Nationwide, an estimated 11 percent of Medicaid beneficiaries reported having employment-based health coverage (ranging from about 7 percent in Arizona and Alabama to about 17 percent in Colorado, Michigan, New Hampshire, and Wyoming), whereas about 2 percent reported having individual health coverage (ranging from about 1 percent in 11 states to about 8 percent in Iowa).

[22]This information is based on data states report to CMS. According to CMS's report, 39 states provided information on third-party payments avoided, and 47 states provided information on third-party recoveries.

Table 1: Percentage, by State, of Individuals Who Reported Having Medicaid Coverage for the Entire Year Who Also Reported Having Private Health Coverage at Some Time during the Same Year (2002–2004)

	Estimated proportion of Medicaid beneficiaries with private health coverage		
State	**Total[a]**	**Employment-based**	**Individual**
Alabama	9	7	2
Alaska	18	16	3
Arizona	9	7	2
Arkansas	11	10	1
California	9	8	1
Colorado	20	17	4
Connecticut	15	11	4
Delaware	17	15	2
District of Columbia	10	9	1
Florida	11	9	2
Georgia	12	11	1
Hawaii	16	14	3
Idaho	14	11	2
Illinois	12	10	3
Indiana	12	11	2
Iowa	22	15	8
Kansas	17	13	5
Kentucky	12	9	3
Louisiana	11	8	1
Maine	16	14	2
Maryland	14	11	3
Massachusetts	14	12	1
Michigan	19	17	2
Minnesota	16	12	3
Mississippi	15	15	1
Missouri	17	13	2
Montana	10	8	1
Nebraska	13	10	3
Nevada	12	10	1
New Hampshire	21	17	4
New Jersey	16	14	2

State	Estimated proportion of Medicaid beneficiaries with private health coverage		
	Total[a]	Employment-based	Individual
New Mexico	14	13	2
New York	12	10	2
North Carolina	12	10	2
North Dakota	18	12	6
Ohio	17	15	1
Oklahoma	12	11	2
Oregon	15	11	4
Pennsylvania	16	13	3
Rhode Island	18	15	2
South Carolina	16	15	3
South Dakota	22	16	5
Tennessee	12	9	3
Texas	11	10	2
Utah	14	12	1
Vermont	18	16	3
Virginia	16	14	2
Washington	18	13	5
West Virginia	13	11	2
Wisconsin	13	10	3
Wyoming	23	17	7
Nationwide	**13**	**11**	**2**

Source: GAO analysis of CPS data.

Note: Numbers represent average percentages of Medicaid beneficiaries reporting coverage for calendar years 2002 through 2004, as collected by the Current Population Surveys of 2003 through 2005.

[a]The sum of employment-based and individual health coverage does not always equal the total because some respondents indicated that they had both employment-based and individual health coverage, and other respondents indicated that they had private health coverage but did not specify whether it was employment-based or individual health coverage.

States also identify and collect information on private health coverage as part of administering their own Medicaid programs, but this information cannot be used to assess Medicaid beneficiaries' private health coverage on a nationwide basis. State Medicaid agencies capture from their automated systems information on private health coverage they have identified for their Medicaid beneficiaries. According to CMS, however, this information is not reliable for measuring the extent of beneficiaries' private health coverage nationwide, for comparing among states, or for

comparing states' identified coverage with that identified by CPS.[23] Certain states may, for example, capture information only for those beneficiaries whose coverage has been verified, while other states may capture coverage even though the state has not yet verified the services that are covered or the period of eligibility.

States Face Problems in Verifying Coverage and in Collecting from Third Parties

Problems states face in ensuring that Medicaid is the payer of last resort fall into two broad categories: problems verifying whether beneficiaries have private health coverage and problems collecting payments (or "paying and chasing") when such coverage exists. Third-party liability provisions in the Deficit Reduction Act could help address some of these problems, although two issues require resolution in order to aid states as they implement the act. In particular, federal guidance is needed to clarify the time by which states must comply with the relevant provisions and also to clarify the entities covered by requirements to provide states with information regarding third-party coverage.

Problems Verifying Whether Medicaid Beneficiaries Have Private Health Coverage

Verification of available private health coverage for Medicaid beneficiaries is key to ensuring that states are able to appropriately avoid paying claims or to collect from those that are liable. Nevertheless, state officials often told us, one of the top three problems they faced in ensuring that Medicaid was the payer of last resort was related to verifying beneficiaries' other coverage. Some state officials reported their problem broadly, stating, for example, that third parties would not cooperate in providing eligibility or coverage information. Others cited specific problems related to the verification process, stating, for example, that third parties would not assist with the state's verification process by sharing coverage files electronically. Officials from 27 of the 39 responding states reported one or more different types of problems with verifying the services that were covered and the period of eligibility, which we summarized in two categories (see table 2): (1) verifying coverage information and (2) accessing electronic coverage files. Although most states' officials

[23]The automated system that states use to capture health coverage data is known as the Medicaid Management Information System. Health coverage information gathered by states is maintained in this system. By determining the number of beneficiaries for whom it has identified other health coverage in its Medicaid Management Information System, a state can estimate the proportion of all of its Medicaid beneficiaries for whom such coverage has been identified. See Centers for Medicare & Medicaid Services, "Overview: Medicaid Management Information System," http://www.cms.hhs.gov/mmis/ (downloaded May 25, 2006).

were not able to estimate the losses to the Medicaid program due to these verification problems, officials in 10 states did provide an estimate.[24] The estimated loss for these 10 states totaled $54 million–$60 million (the loss is stated as a range because some states estimated their losses as a range rather than as a single dollar estimate).

Table 2: Number of States Reporting Problems Verifying Whether Medicaid Beneficiaries Have Private Health Coverage, with Estimates of Associated Annual Losses

Category	Number of states reporting problems (n = 39)	Number of states able to estimate annual losses	Total estimated annual losses[a] (dollars in millions)
Problems with verification	27[b]	10	$54–60
Verifying coverage information (not specific to accessing electronic coverage files)	23	8	47–52
Accessing electronic coverage files	5	2	7–8

Source: GAO analysis of information provided by state officials.

[a]Amounts reported as a range because officials in some states could estimate their losses only as a range.

[b]Numbers do not add to 27 because officials in some states reported both types of problems.

Problems verifying coverage information. Officials in 23 states reported problems verifying coverage information; of these, officials in 8 states were able to estimate their annual losses due to third parties' failure to provide coverage information, for a total of $47 million–$52 million.[25] State officials reported a range of problems they experienced in verifying coverage information. For example, officials in 12 states indicated that certain third parties or their contractors, such as self-insured plans, pharmacy benefit managers, or plan administrators, ignored the state's requests for verification information about Medicaid beneficiaries or

[24]In addition to these 10 states, 1 state estimated the percentage of increased annual savings it could accrue if its problems were resolved but was not able to provide a dollar amount. Another state estimated losses from all three of its reported top problems in aggregate and could not estimate its losses due to each problem. We did not include these 2 states in our total of states estimating annual losses due to third-party problems.

[25]We report these values as a range because some states could estimate their losses only as a range.

declined to verify coverage. Four states reported that third parties cited privacy provisions in the Health Insurance Portability and Accountability Act of 1996 as one reason they could not share coverage information with state Medicaid offices.[26] Additionally, an official in 1 state reported that some third parties would not verify coverage for seasonal workers and that some insurance companies limited the number of verifications they were willing to provide during a single phone call.

Problems accessing electronic coverage files. Officials in five states reported verification problems specifically related to accessing the electronic coverage files of third parties and their contractors; officials in two of these states were able to estimate their annual losses due to lack of access to electronic coverage files, for a total of $7 million–$8 million. The systematic cross-checking of state and third-party health coverage data, which access to electronic files makes possible, improves states' ability to identify beneficiaries with third-party health coverage. Officials in two states commented, for example, that data-matching agreements would enhance their discovery of private health coverage or would greatly improve their billing capabilities. Officials in five states reported that third parties would not participate in data-matching agreements or that electronic coverage files were not made available to the states.

The potential losses to Medicaid because of lack of verification information, both electronic and other, may be sizable. Officials from the private consulting firm we contacted estimated that its recoveries from a major pharmacy benefit manager increased by more than 200 percent after the pharmacy benefit manager shared coverage information with the consulting firm. Given such an increase from this one-time sharing of information, the consulting firm estimated that recoveries from the four largest pharmacy benefit managers could potentially rise by more than $300 million a year if such information sharing occurred regularly.

[26]See Pub. L. No. 104-191, §§ 262–264, 110 Stat. 1936, 2033. Rules implementing the Health Insurance Portability and Accountability Act of 1996 place limits on the use and disclosure of individually identifiable health information. See 67 Fed. Reg. 53182 (2002). Exceptions to these rules permit the disclosure of appropriate information to ensure payment for health care services. See 45 C.F.R. § 164.506(a) (2005).

Problems Collecting Payments from Third Parties and Their Contractors

If a state has not established the existence of third-party coverage at the time a claim is submitted, it must pay the claim and collect its payment from the liable party later, after that coverage has been verified. Officials in 35 of the 39 reporting states listed problems with such "pay-and-chase" scenarios among their top three problems faced in ensuring that Medicaid is the last payer. We summarize these problems in five categories: (1) time limits for filing claims, (2) restrictions imposed by managed care and health plans, (3) inconsistent claiming requirements imposed by third parties, (4) lack of response or cooperation from third parties, and (5) weak or problematic state or federal legislation. Although officials in most states were unable to estimate their losses due to problems associated with collecting payments from third parties, officials in 14 states estimated a total annual loss of $184 million–$196 million (see table 3). (The loss is stated as a range because some states estimated their losses as a range rather than as a single dollar figure.)

Table 3: Number of States Reporting Problems Collecting from Third Parties and Their Contractors, with Estimates of Associated Annual Losses

Category	Number of states reporting problems (n = 39)	Number of states able to estimate annual losses	Total estimated annual losses[a] (dollars in millions)
Problems collecting payments	35[b]	14[b]	$184–196
Time limits for filing claims	15	10	76–77
Restrictions imposed by managed care and other health plans	17	10	74
Inconsistent claiming requirements among third parties and limited capacity of states to bill electronically	13	3	13
Lack of response or cooperation from third parties	12	3	4–6
Weak or problematic state or federal legislation	7	2	17–26

Source: GAO analysis of information provided by state officials.

[a]Amounts reported as a range because some states estimated their losses only as a range.

[b]Numbers do not add because some states experienced several problems.

Problems with time limits for filing claims. Officials in 15 states reported problems related to timely filing of claims; officials in 10 states were able to estimate their annual losses in this category, for a total of $76 million–$77 million. State officials reported that some third parties and

their contractors have established specific time limits for filing claims. That is, a third party or its contractor might process a claim only if it is filed within a certain time period after services are provided—such as within 60 or 90 days from the date of service. If a state does not submit its claim for services provided to a Medicaid beneficiary within the specified time, some third parties deny payment of the claim. According to state officials, time limits—such as 60 or 90 days from the date of service—pose a particular problem because of how long it can take to verify Medicaid beneficiaries' private health coverage. An official in 1 state, for example, estimated that in 1 year (November 2004 through October 2005), third-parties rejected more than $32 million in claims from the state because the state did not submit the claims within the third-parties' established time frames.

Problems with restrictions imposed by managed care and health plans. Officials in 17 states reported problems imposed by managed care and health plan restrictions; officials in 10 of these states were able to estimate their annual losses in this category, for a total of $74 million. State officials reported a range of issues relating to restrictions the plans imposed as to when services are covered or to whom reimbursements for claims can be made. For example, officials in 9 states reported that some third parties or their contractors would not reimburse the state for services provided to covered Medicaid beneficiaries if the Medicaid beneficiaries did not follow requirements established in the third parties' managed care plans, such as obtaining prior authorization for services.[27] One state official estimated an annual loss to the state's Medicaid program of more than $11 million per year because of managed care plans' requirements that the Medicaid beneficiaries also covered under the managed care plan obtain preauthorization for services; if such authorization was not obtained by the beneficiary, the managed care plans would not reimburse the state Medicaid program. Another type of restriction that states reported related to requirements for whom the health plan would reimburse. For example, officials in 2 states reported problems with health plans whose coverage provisions did not allow them to pay state Medicaid programs directly but instead required that payments be made to the Medicaid beneficiaries themselves. An official in

[27]Certain managed care features, such as prior authorization for services, may constitute substantive benefit limitations, and claims that do not conform with the managed care requirements may not be reimbursable. We did not independently assess, in the instances identified by state officials, whether the private health coverage was legally liable for payment for services provided to Medicaid beneficiaries.

1 state remarked that it was labor intensive and often impossible to recoup such payments from beneficiaries.

Problems with inconsistent claims requirements among third parties and limited state capacity to bill electronically. Officials in 13 states reported problems related to third parties' or their contractors' inconsistent requirements for claims or problems related to limits in the states' capacity to bill electronically; officials in 3 states were able to estimate their annual losses in this category, for a total of $13 million. Some third parties or their contractors, for example, required claims to be submitted electronically, while others could not accept electronic claims. Third parties or their contractors also rejected claims because they were not in a format acceptable to the third party or did not contain specific pieces of information. For example, an official in 1 state told us that third parties may require information on their claim forms that Medicaid does not require or collect, such as a unique provider number, and a state can have difficulty obtaining such information after the fact. The official in this state estimated a loss of $600,000 in a single year because of such problems. Administrative problems like these are compounded because states submit claims to many different third parties, each with their own formats and requirements.

Problems with lack of response or cooperation from third parties or their contractors. Officials in 12 states reported problems related to third parties' lack of response to or cooperation with claims filed for payment; of these, 3 states were able to estimate their annual losses in this category, for a total of $4 million–$6 million. Some problems arose, for example, when third parties' contractors, such as pharmacy benefit managers, were not specifically authorized by the third parties to process or pay the claims on the third parties' behalf when the claims originated from state Medicaid programs. According to CMS, one problem involves Medicaid beneficiaries who have pharmacy coverage administered through a pharmacy benefit manager that has not been specifically authorized by its contracting health plan or insurer to process Medicaid claims from the state. If the beneficiary provides a pharmacist with information on his or her Medicaid coverage, rather than information on the pharmacy benefit manager, the pharmacist may receive payment from the state Medicaid program, which must then seek reimbursement for its payment from the pharmacy benefit manager ("pay and chase"). Often, the pharmacy benefit manager returns these claims unpaid to the state and suggests that the state bill the third party directly. This situation creates an administrative problem for the state, since beneficiaries' health plan cards generally identify only the pharmacy benefit manager and not the

contracting insurer or health plan. An official in 1 state also commented that third parties created inappropriate denial reasons, such as the state's failure to submit a copy of a Medicaid beneficiary's health insurance card with the state's claim. Officials in 3 states reported that third parties would not respond to their claims. An official in another state observed that third parties can ignore claims submitted to them because no penalty or requirement exists for third parties to reimburse Medicaid.

Weak or problematic state or federal legislation. Officials in seven states—responding to our information request before the 2006 enactment of the Deficit Reduction Act—reported that weak or problematic state or federal legislation hindered their efforts to ensure that Medicaid was the payer of last resort; officials in two of these states were able to estimate their annual losses in this category, for a total of $17 million–$26 million. Officials suggested the need for stronger state or federal legislation, which would require third parties to pay Medicaid claims, participate in electronic data matching of coverage information, or extend the time frames for states to file claims. One state official, for example, indicated that stronger legislation, with more comprehensive requirements that third parties doing business in the state reimburse the state, would be helpful. Two other state officials indicated that an existing provision in Medicaid legislation, which requires the states to pay claims under certain circumstances even when the state is aware of other coverage, was problematic. Specifically, this requirement—intended to prevent delays in care for pregnant women and for children—requires states to pay and chase when claims are for prenatal care and preventive pediatric services and when services are provided to a minor for whom the state is enforcing a child-support order against a noncustodial parent. The President's fiscal year 2007 budget included a legislative proposal to change this requirement. Under the proposal, states would be allowed to avoid costs, rather than pay and chase, for claims for prenatal and preventive pediatric services when a third party is responsible through a noncustodial parent's obligation to provide coverage, if the states ensure protection for providers and beneficiaries.[28]

[28]Specifically, the administration proposed that legislation be passed to "allow states to avoid costs for prenatal and preventive pediatric care claims where a third party is responsible through a non-custodial parent's obligation to provide coverage for a limited time while assuring protection for providers and beneficiaries." In providing technical comments on a draft of this report, CMS officials told us they believed that the purpose of the legislative proposal is to allow states to avoid costs for all categories of claims for which states must currently pay and chase.

Although in most cases—21 of 35 states that reported problems collecting from third parties or their contractors—state officials we contacted were unable to estimate the losses to Medicaid due to problems collecting from third parties, the total losses could be sizable. The private consulting firm that works with states reported collecting $60 million for states in 2005 by rebilling third parties for previously unprocessed claims. According to state officials and CMS, many states do not have the resources to follow up repeatedly on claims that have been rejected or otherwise unpaid and so potentially suffer annual losses in the millions of dollars.

Legislation Enacted in 2006 Includes Provisions Related to Third-Party Liability Problems Raised by States, but Certain Issues Require Resolution

The Deficit Reduction Act addresses some of the problems reported by state officials. For example, the new law adds to the existing list of entities that may be considered third parties certain entities that were previously not specifically listed, including "self-insured plans"; "managed care organizations"; "pharmacy benefit managers"; and "other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service." In addition, the law requires states to have in effect laws requiring certain specified entities, as a condition of doing business in their state, to

- provide the state, upon request, with coverage and other data, including information on the nature of coverage and the periods of time during which individuals or their spouses or dependents were covered;[29]
- accept the states' right of recovery for services and assignment of a Medicaid enrollee's right to payment by those entities or organizations;
- respond to inquiries by the state regarding a claim for payment submitted within 3 years after the date a service was provided; and

[29]In particular, the law requires a state to provide assurances to the Secretary of Health and Human Services that the state has laws in effect requiring health insurers—including self-insured plans; group health plans; service benefit plans; managed care organizations; pharmacy benefit managers; or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service—as a condition of doing business in the state, to provide, with respect to persons who are eligible for or who are provided Medicaid services, information to determine during what period the individual or their spouses or dependents may be (or have been) covered and the nature of the coverage that is or was provided by the health insurer. See Pub. L. No. 109-171, § 6035(b), 120 Stat. 4, 79–80 (to be codified at 42 U.S.C. § 1396a(a)(25)(I)).

- agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form, or failure to provide proper documentation at the time of service, as long as the claim is submitted by the state within 3 years of the service date and the state enforces its rights with respect to the claim within 6 years of submitting it.

Officials from some states and the private consulting firm that works with states told us that the act's requirements may help alleviate states' reported problems with verifying coverage information, time limits for filing claims, and certain third parties' lack of response or cooperation with claims submitted for payment—three of the problems most often reported by states responding to our questions. Losses due to these problems can be substantial: in response to our information request, 30 states estimated such losses at collectively more than $120 million annually. The private consulting firm reported that, after discussing with pharmacy benefit managers the new Deficit Reduction Act provision related to time limits for filing claims, the firm agreed to loosen its own time frames for filing, resulting in an estimated $2 million dollars in savings for outstanding claims.

Because the Deficit Reduction Act requires states to have legislation in effect to implement the new provisions, it is too soon to assess the extent to which the act will address the problems that states reported to us. Further, we identified two issues that require resolution in order to aid states in complying with the act's requirements:

- First, the time frame by which states must have their laws in effect is uncertain because of an apparent inconsistency within the Deficit Reduction Act concerning the effective date of that provision. Specifically, the section of the law that determines the date by which states must have

these laws in effect references a section of the law that does not exist.[30] In June 2006, CMS officials said they had not determined how to interpret the apparently inconsistent language and whether legislation would be necessary to resolve it. Until this determination is made, states may be uncertain as to the date by which they must comply with this requirement of the Deficit Reduction Act. Some state legislatures, for example, may act upon new Medicaid requirements such as this one only upon notification of a specific implementation date.

- Second, there is also some disagreement in the industry as to whether the statutory provisions regarding the requirement to provide states with coverage and other information apply to certain entities. According to CMS and officials from the private consulting firm, some entities, such as certain pharmacy benefit managers and plan administrators, have indicated that the requirement that states have laws in effect to require reporting of coverage and related information does not apply to them. For example, private insurers and health plans may hire pharmacy benefit managers and plan administrators to process the claims—that is, to pay the claims on their behalf—and the pharmacy benefit managers and plan administrators may not view themselves as "legally responsible for payment of a claim for a health care item or service." Without cooperation from these contracted entities in sharing coverage information and in paying claims, states may continue to have many of the problems they reported. CMS officials said that they had met with trade associations representing pharmacy benefit managers and plan administrators to discuss and obtain input about these entities' responsibilities under the Deficit Reduction Act.

[30]Section 6035(c) of the Deficit Reduction Act of 2005 establishes the effective dates of the third-party provisions (found in section 6035(b)) but appears to contain an error. Section 6035(c) provides that "[e]xcept as provided in section 6035(e), the amendments made by this section take effect on January 1, 2006." The statute, however, does not contain a section 6035(e). The conference report on the legislation suggests that the reference to section 6035(e) in section 6035(c) should be, instead, section 6034(e). See H.R. Conf. Rep. No. 109-362 at 78–79, 308–310. Section 6034(e), in turn, provides in effect a delayed effective date in those instances in which the Department of Health and Human Services determines a state is required to enact legislation in order to comply with the requirements of section 6035(b). Courts have held that a statute should be construed literally, except in those instances in which literal application of a statute will produce a result demonstrably at odds with the intentions of its drafters. See, for example, Appalachian Power Co. v. EPA, 249 F.3d 1032 (D.C. Cir. 2001); Consolidated Rail Corp. v. U.S., 896 F.2d 574 (D.C. Cir. 1990). In such instances, the legislative history should be given significant consideration in construing the statute.

With regard to both provisions, in June 2006, CMS officials said that they were determining how best to help states implement the new requirements. The agency was reviewing how to interpret the law to address both the effective date for the requirement to have state legislation in effect and which entities are covered by requirements to provide states with information on coverage and other matters. The effectiveness of the Deficit Reduction Act's third-party liability provisions in addressing the problems that states identified may depend on the guidance CMS issues and in what manner states carry out the new law's provisions.

Conclusions

In an era of fiscal pressure on both federal and state budgets, it is important to ensure that Medicaid is administered as efficiently and effectively as possible. States have a key role in Medicaid's successful administration, including efforts to ensure, as Congress intended, that Medicaid does not pay for services when other sources of health care coverage are available. With an estimated 13 percent of Medicaid beneficiaries having private health coverage available to them, significant savings can accrue to both the federal government and the states when states are able to avoid costs and recover payments from liable third parties. We found, however, that states often encounter problems in identifying beneficiaries' private health coverage and in collecting payments from liable third parties. The Deficit Reduction Act includes provisions related to some of the states' concerns, and CMS could facilitate states' efforts to implement the act's requirements by providing guidance to states as to the time frame under which states must have their laws in effect and the types of entities to which the law applies.

Recommendations for Executive Action

To resolve issues that are critical to the implementation of the Deficit Reduction Act's third-party provisions and to assist states in their efforts to ensure that Medicaid is the payer of last resort, we recommend that the Administrator of CMS take the following two actions:

- Determine and provide guidance to states with regard to the time frames by which states must have in effect laws that implement relevant third-party requirements of the Deficit Reduction Act.
- Determine and provide guidance to states with regard to the entities covered by the Deficit Reduction Act's requirements to provide states with coverage and other information.

Agency Comments

We provided a draft of this report to CMS for comment and received a written response from the agency (reproduced in app. II). The agency acknowledged that our report identified many of the challenges state Medicaid agencies face in attempting to ensure that Medicaid is the payer of last resort. CMS concurred with both recommendations and said that the agency planned to issue a decision with respect to the effective implementation date of, and the entities covered under, the Deficit Reduction Act. CMS also provided technical comments, including a comment that the report should clarify discussions regarding the provision of both coverage and eligibility data. We clarified our text to indicate that in this report we refer collectively to the process of determining the eligibility period and the services that are covered as "verifying health coverage." We made a corresponding clarification to our recommendation. Other technical comments were incorporated as appropriate.

As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issue date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff members have any questions, please contact me at (202) 512-7118 or allenk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are acknowledged in appendix III.

Sincerely,

Kathryn G. Allen
Director, Health Care Issues

Appendix I: GAO's Analysis of the Current Population Survey Conducted by the U.S. Census Bureau

To assess the extent to which Medicaid beneficiaries have private health coverage, we analyzed the Annual Social and Economic Supplement of the Current Population Survey (CPS), conducted by the U.S. Census Bureau for the Bureau of Labor Statistics. This appendix describes CPS, our analysis of CPS, and our results.

Description of the Current Population Survey

CPS is designed to represent a cross section of the nation's civilian noninstitutionalized population. The sample provides estimates for the nation as a whole and serves as part of model-based estimates for individual states and other geographic areas. The supplement is designed to estimate family characteristics, including health coverage, during the previous year. In 2005, about 84,700 households were included in the sample for the Annual Social and Economic Supplement, with a total response rate of about 83 percent. In 2004 about 84,500 households were included with a total response rate of 84 percent. The totals for 2003 were approximately 81,000 and 85 percent, respectively.

Each March, CPS gathers information about health coverage that respondents had at any time during the previous calendar year, including government health coverage such as Medicaid and private health coverage such as coverage provided through an employer or union (employment-based health coverage) and coverage directly purchased by the beneficiary (individual health coverage).[1] CPS also asks for the number of months that beneficiaries had Medicaid coverage during that same year. Research has shown that health coverage is underreported in CPS for a variety of reasons; for example, many people may be unaware that a health insurance program covers them or their children if they have not recently used covered services. In addition, CPS underreports Medicaid coverage compared with enrollment and participation data from the Centers for Medicare & Medicaid Services.

[1]CPS refers to health coverage purchased by an individual (called "individual health coverage" in this report) as "direct-purchase" coverage. See http://www.census.gov/hhes/www/hlthins/hlthinsvar.html (downloaded June 8, 2006) for information on the definitions of private health coverage.

Description and Results of GAO's Analysis

We analyzed data from the Annual Social and Economic Supplement to CPS from 2003 through 2005, which asked about health coverage during the prior year (2002 through 2004). To prepare official statistics from CPS on type of health insurance coverage, CPS identifies Medicaid beneficiaries by analyzing responses from multiple questions about whether the respondent had Medicaid at any time during the prior year. One of these questions has a related field allowing respondents to report the number of months that Medicaid coverage was provided. To identify individuals who had Medicaid and private health coverage concurrently in the same year, we focused our analysis on individuals who responded positively to the one Medicaid question and also reported having Medicaid coverage in all 12 months of the year. Specifically, we selected individuals who reported that they were covered by Medicaid for the entire prior year and determined the percentage of these Medicaid beneficiaries who reported that they also had employment-based health coverage or individual health coverage at some point in the prior year.[2]

To assess the reliability of the CPS data, we discussed with officials from the Census Bureau's Poverty and Health Statistics Branch the use of this definition of Medicaid beneficiaries, and we reviewed the Census Bureau's data quality-control procedures and related documentation. We determined that the data were sufficiently reliable for the purposes of this report. For additional information on Census efforts to ensure the reliability of CPS data—including adjustment for nonresponse, controls on nonsampling error, computing composite weights, estimation of variance, and derivation of independent population controls—see U.S. Department of Labor, Bureau of Labor Statistics; and U.S. Department of Commerce, U.S. Census Bureau, *Current Population Survey: Design and Methodology*, Technical Paper 63RV (Washington, D.C.: March 2002), http://www.bls.census.gov/cps/tp/tp63.htm (downloaded April 13, 2006). Updated survey information is available on the Web at http://www.bls.census.gov/cps.

Because CPS is a probability-based sample, estimates derived from it are subject to sampling error: slightly different estimates can result from different samples. We expressed our confidence in the precision of the particular samples' results as 95 percent confidence intervals (i.e., plus or

[2]Our analysis—focusing on individuals who reported having Medicaid coverage the entire prior year—comprised 71 percent of individuals in the CPS who reported that they had Medicaid coverage at any time during the prior year.

minus 4 percentage points). This confidence interval is the interval that would contain the actual population value for 95 percent of the samples that could have been drawn. We used CPS's general variance methodology in the technical documentation to estimate this sampling error for our 3-year average, reported as confidence intervals. All CPS percentage estimates contained in this report have 95 percent confidence intervals within plus or minus 7 percentage points of the estimate itself.

Table 4: Percentage and Confidence Intervals, by State, of Individuals Who Reported Having Medicaid Coverage for the Entire Year Who Also Reported Having Private Health Coverage at Some Time during the Same Year (2002–2004)

	Estimated proportion of Medicaid beneficiaries with private health coverage	
State	Percentage	95 percent confidence interval
Alabama	9	6–12
Alaska	18	13–24
Arizona	9	6–13
Arkansas	11	8–14
California	9	8–11
Colorado	20	15–26
Connecticut	15	10–20
Delaware	17	12–22
District of Columbia	10	7–12
Florida	11	9–14
Georgia	12	8–16
Hawaii	16	12–21
Idaho	14	9–18
Illinois	12	9–15
Indiana	12	9–16
Iowa	22	17–28
Kansas	17	11–23
Kentucky	12	8–16
Louisiana	11	7–14
Maine	16	13–19
Maryland	14	9–19
Massachusetts	14	11–17
Michigan	19	16–22
Minnesota	16	11–21

State	Estimated proportion of Medicaid beneficiaries with private health coverage	
	Percentage	95 percent confidence interval
Mississippi	15	12–19
Missouri	17	13–20
Montana	10	6–14
Nebraska	13	9–17
Nevada	12	6–17
New Hampshire	21	15–28
New Jersey	16	12–19
New Mexico	14	11–18
New York	12	10–14
North Carolina	12	9–15
North Dakota	18	12–24
Ohio	17	13–20
Oklahoma	12	9–16
Oregon	15	10–19
Pennsylvania	16	13–20
Rhode Island	18	15–22
South Carolina	16	13–20
South Dakota	22	17–27
Tennessee	12	9–15
Texas	11	9–14
Utah	14	9–19
Vermont	18	15–22
Virginia	16	11–21
Washington	18	13–22
West Virginia	13	10–17
Wisconsin	13	9–17
Wyoming	23	17–29
Nationwide	**13**	**12–13**

Source: GAO analysis of CPS data.

Note: Numbers represent average percentages of Medicaid beneficiaries reporting coverage for calendar years 2002 through 2004, as collected by the Current Population Surveys of 2003 through 2005.

Appendix II: Comments from the Centers for Medicare & Medicaid Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

AUG 4 2006

Administrator
Washington, DC 20201

TO: Kathryn G. Allen
Director, Health Care
Government Accountability Office

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Government Accountability Office (GAO) Draft Report: "MEDICAID THIRD-PARTY LIABILITY: Federal Guidance Needed to Help States Address Continuing Problems" (GAO-06-862)

Thank you for the opportunity to review and comment on the above-referenced GAO report. We are pleased that the report identifies many of the challenges State Medicaid agencies face in attempting to assure that Medicaid is the payer of last resort. We particularly appreciate the efforts made by GAO to determine the number of Medicaid beneficiaries with private health insurance coverage. The Centers for Medicare & Medicaid Services (CMS) continues to be committed to an aggressive strategy in resolving the remaining issues and removing the barriers that stand in the way of coordinating benefits among various payers.

As pointed out by GAO, the Deficit Reduction Act of 2005 (DRA), P.L. 109-171, includes a number of provisions that are designed to help guide state efforts in this area and address some of the problems reported by State officials. We are confident that the DRA will provide important additional tools to assist States in identifying third parties and to facilitate the processing of Medicaid claims.

GAO Recommendation

Determine and provide guidance to States with regard to the time frames by which States must have in effect laws that implement relevant third party requirements of the DRA.

CMS Response

We concur. We agree that the technical error included in the DRA needs to be clarified. CMS will shortly issue a decision with respect to the effective date issue.

GAO Recommendation

Determine and provide guidance to States with regard to the entities covered by the DRA requirement to provide States with coverage eligibility and other information.

CMS Response

We concur. CMS is in agreement with the recommendation and will shortly issue a decision with respect to the entities that are covered by the DRA requirements.

We have provided a number of technical comments for your consideration. Thank you again for the opportunity to respond to this report.

Attachment

Appendix III: Contact and Staff Acknowledgments

GAO Contact

Kathryn G. Allen, (202) 512-7118 or allenk@gao.gov

Acknowledgments

In addition to the contact mentioned above, Katherine M. Iritani, Assistant Director; Ellen W. Chu; Kevin Dietz; Kevin Milne; Jill M. Peterson; and Terry Saiki made key contributions to this report.

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