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MEDICAID THIRD-PARTY LIABILITY

Federal Guidance Needed to Help States Address Continuing Problems

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.