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October 2015

MEDICAID AND INSURANCE EXCHANGES

Additional Federal Controls Needed to Minimize Potential for Gaps and Duplication in Coverage

Accessible Version

GAO-16-73

GAO Highlights

Highlights of GAO-16-73, a report to congressional requesters

October 2015

MEDICAID AND INSURANCE EXCHANGES

Additional Federal Controls Needed to Minimize Potential for Gaps and Duplication in Coverage

Why GAO Did This Study

Due to changes in income and other factors, it is likely that under PPACA many low-income individuals will transition between Medicaid and subsidized exchange coverage. Federal regulations require that state Medicaid agencies and exchanges coordinate to facilitate these transitions, including transferring individuals' accounts to the appropriate form of coverage when eligibility changes occur. However, given the complexity of coordinating policies and procedures for both coverage types, challenges could arise during the transition process resulting in individuals experiencing coverage gaps or duplicate coverage. GAO was asked to review information related to transitions between Medicaid and exchange coverage.

In this report, among other objectives, GAO examines the extent to which the federal government had policies and procedures that minimize the potential for coverage gaps and duplicate coverage. GAO reviewed relevant federal regulations, guidance, FFE documentation, and federal internal controls standards, and interviewed CMS officials. GAO also collected information from eight states selected, among other factors, to include four FFE states.

What GAO Recommends

GAO recommends that CMS take three actions, including routinely monitoring the timeliness of account transfers from states, establishing a schedule for regular checks for duplicate coverage, and developing a plan to monitor the effectiveness of the checks. HHS concurred with GAO's recommendations.

View GAO-16-73. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov or John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

What GAO Found

CMS's policies and procedures do not sufficiently minimize the potential for coverage gaps and duplicate coverage in federal exchange states. GAO found that individuals transitioning from Medicaid to exchange coverage—that is, private health insurance purchased through the exchanges created under the Patient Protection and Affordable Care Act (PPACA)—may experience coverage gaps, for example, if they lose Medicaid eligibility toward the end of a month. Individuals who experience coverage gaps may decide to forgo necessary care. In addition, GAO found that some individuals had duplicate coverage, that is, were enrolled in Medicaid while also receiving federal subsidies for exchange coverage. While some amount of duplicate coverage may be expected during the transition from exchange to Medicaid coverage and is permissible under federal law, GAO found that duplicate coverage was also occurring under other scenarios. Individuals may be held liable for repaying certain exchange subsidies received during the period of duplicate coverage. Further, the federal government could be paying twice, subsidizing exchange coverage and reimbursing states for Medicaid spending for those enrolled in both.

While the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that operates a federally facilitated exchange (FFE) in 34 states, has implemented policies and procedures that help minimize the potential for coverage gaps and duplicate coverage, GAO identified weaknesses in CMS's controls for FFE states based on federal internal control standards. Specifically:

- GAO found that CMS's controls do not provide reasonable assurance that accounts—that is, records—for individuals transitioning from Medicaid to exchange coverage in FFE states are transferred in near real time. CMS regulations require that such transfers occur promptly to facilitate eligibility determinations and enrollment. However, as of July 2015, CMS was not monitoring the timeliness of transfers. CMS officials told GAO that transfers are not happening in real time, but their understanding was that states typically send transfers at least daily. Officials from three of the four selected FFE states reported that account transfers were occurring at least daily; officials from the remaining state reported that transfers were sent to CMS three times per week. To the extent transfers are not happening in a timely fashion, individuals may be more likely to have gaps in coverage.
- GAO found weaknesses in CMS's controls for preventing, detecting, and resolving duplicate coverage in FFE states. For example, as of July 2015, CMS did not have procedures to detect cases of duplicate coverage. According to CMS officials, CMS planned to implement periodic checks for duplicate coverage beginning later that month. However, CMS had not yet determined the frequency of the checks, a key to their effectiveness. In addition, CMS had no specific plan for monitoring the effectiveness of the checks and other planned procedures, making it difficult for the agency to provide reasonable assurance that its procedures are sufficient or whether additional steps are needed to protect the federal government and individuals from duplicative and unnecessary expenditures.

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Abbreviations

APTC	advance premium tax credit
CHIP	State Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
FFE	federally facilitated exchange
FPL	federal poverty level
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
IT	information technology
PPACA	Patient Protection and Affordable Care Act
SBE	state-based exchange

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
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October 9, 2015

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

Starting in 2014, the Patient Protection and Affordable Care Act (PPACA) provided many low-income Americans new options for obtaining health insurance coverage.[1] Specifically, under PPACA, states may opt to expand eligibility for Medicaid—the joint federal-state program that finances health insurance coverage for certain categories of low-income individuals—to individuals who are not eligible for Medicare and whose incomes are at or below 133 percent of the federal poverty level (FPL).[2] Additionally, PPACA required the establishment in all states of health insurance exchanges—marketplaces where eligible individuals may compare and select among private health plans—by January 1, 2014.[3] States may elect to establish and operate an exchange, known as a state-based exchange (SBE), or allow the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) responsible for overseeing Medicaid and the

[1]Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010). For the purposes of this report, references to PPACA include the amendments made by HCERA.

[2]PPACA also provides for a 5 percent disregard when calculating income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the FPL. The federal poverty level for a family of four in the 48 contiguous states and the District of Columbia in 2015 was $24,250; 138 percent of this amount would be $33,465. For the purposes of this report, we consider the District of Columbia a state.

[3]CMS commonly refers to the exchanges as marketplaces. Where we discuss exchanges in this report, we are referring only to the individual exchanges, rather than the small business exchanges also required under PPACA. We refer to health plans purchased through the exchanges as exchange coverage.

exchanges—to do so within the state, known as a federally facilitated exchange (FFE).[4] In addition, PPACA provides for federal subsidies to assist qualifying low-income individuals in affording exchange coverage, referred to as subsidized exchange coverage. For example, individuals may be eligible for premium tax credits if their incomes fall between 100 and 400 percent of the FPL, and they do not have access to minimum essential coverage through government-sponsored programs, such as Medicaid, or private insurance plans, such as employer-sponsored health insurance.[5]

Changes in income and other factors can change an individual's eligibility for Medicaid and for subsidized exchange coverage and, as many low-income individuals experience income volatility, transitions between the two coverage types are likely under the law. Transitions may be more likely to occur in the 29 states that as of March 2015 had expanded Medicaid as allowed under PPACA, because in these states there is no gap in eligibility between the coverage types. In states that have not chosen to expand, there is generally a gap in eligibility between the two coverage types for adults with incomes under 100 percent of the FPL.[6] Previous research has estimated that 6.9 million, or 7 percent, of individuals who receive either Medicaid or exchange subsidies will experience a change in eligibility from one to the other each year.[7]

[4]In this report, we also refer to federally facilitated exchanges as federal exchanges, and states with federally facilitated exchanges as FFE states.

[5]In addition to the premium tax credit, exchange subsidies may also include cost-sharing reductions for eligible individuals between 100 and 250 percent of the FPL. Eligibility for premium tax credits and cost-sharing reductions is limited to U.S. citizens and legal immigrants. Individuals may also purchase exchange coverage at the full market price—that is, without subsidies—and we refer to such coverage as unsubsidized exchange coverage.

References to Medicaid coverage in this report do not include Medicaid plans that provide less than full benefits such as Medicaid plans that cover only family planning. This is because such plans do not constitute minimum essential coverage and do not preclude individuals from being eligible for subsidized exchange coverage.

[6]Nonelderly adults with household incomes less than 100 percent of the FPL are not eligible for subsidized exchange coverage under PPACA and, if their state chose not to expand Medicaid to such individuals, they may not be eligible for Medicaid.

[7]See M.Buettgens, A.Nichols, and S. Dorn. *Churning Under the ACA and State Policy Options for Mitigation*, (Washington, D.C.: Urban Institute and Robert Wood Johnson Foundation, June 2012). This study also notes that some of these individuals may choose not to enroll in the coverage for which they become eligible and instead become uninsured.

Questions have been raised about whether individuals transitioning between Medicaid and exchange coverage could experience disruptions in care if, for example, individuals are not able to continue seeing their providers. In states with Medicaid managed care programs, where issuers of health insurance coverage administer Medicaid benefits, individuals may be able to remain with the same issuer when moving between coverage types to the extent that issuers offer both types of coverage.[8] Some stakeholders have suggested that remaining with the same issuer could diminish the likelihood of disruptions in care.

PPACA required the establishment of a coordinated eligibility and enrollment process for Medicaid and exchange coverage that ensures that individuals are enrolled in the coverage for which they are eligible and transferred to the appropriate form of coverage if their eligibility changes. This may require significant coordination between various information technology (IT) systems within states, as well as between federal and state IT systems. Given the complexity of designing coordinated policies and systems, challenges could arise during the transition process, including that individuals may experience gaps in coverage or become simultaneously enrolled in both Medicaid and subsidized exchange coverage (referred to as duplicate coverage), which is generally not permitted under federal law.[9]

You asked that we examine information related to individuals' transitions between Medicaid and exchange coverage. In this report, we examine (1) the extent to which the federal government and states had policies and procedures that minimize the potential for coverage gaps and duplicate coverage when individuals transition between Medicaid and exchange coverage; (2) the extent to which individuals are transitioning between Medicaid and exchange coverage; and (3) the participation of issuers in both Medicaid and exchange coverage in a state.

[8]States may have different types of managed care arrangements in Medicaid. In this report where we use the term managed care, we are referring to comprehensive, risk-based managed care, the most common type of managed care arrangement.

An issuer is an insurance company, insurance service, or insurance organization that is required to be licensed to engage in the business of insurance in a state.

[9]Individuals enrolled in subsidized exchange coverage who are found to be eligible for Medicaid are permitted to be enrolled in both types of coverage through the end of the month of the eligibility determination. See 26 U.S.C. § 36B(c)(2)(A)-(B); 26 C.F.R. § 1.36B-2(c)(iv).

To examine the extent to which the federal government and states had policies and procedures that minimize the potential for coverage gaps and duplicate coverage when individuals transition between Medicaid and exchange coverage, we reviewed relevant PPACA provisions as well as federal regulations and guidance for Medicaid programs and for the exchanges. This included reviewing regulations related to coordination between Medicaid and the exchanges, eligibility redeterminations and termination of both Medicaid and exchange coverage, and technical guidance on Medicaid and exchange IT systems. We also reviewed relevant documentation of procedures for FFE states and interviewed CMS officials to determine whether the agency's policies and procedures for FFE states include internal controls that are consistent with standards for internal control in the federal government.[10] In addition, we collected information from and interviewed Medicaid and, in states with SBEs, exchange officials about state policies and procedures in eight selected states. We selected states to include four with SBEs—Colorado, Kentucky, New York, and Washington—and four with FFEs—Arizona, Iowa, Texas, and Utah—and to include states that expanded as well as states that did not expand their Medicaid programs. The eight states we selected accounted for at least 20 percent of Medicaid and exchange coverage enrollment nationwide (see appendix I for more information on our selected states). To supplement information from CMS and selected states, we interviewed representatives of five issuers, selected because they offered both Medicaid and exchange coverage in one or more of our selected states, as well as a trade association that represents issuers that offered both Medicaid and exchange coverage in multiple states throughout the country, and we reviewed related documentation.[11] In addition, as the Internal Revenue Service (IRS) is responsible for reconciliation of advance payments of the premium tax credit, we

[10]See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

[11]The five issuers from which we interviewed representatives were Centene Corporation, Humana, Molina Healthcare, UnitedHealthcare, and The University of Arizona Health Plans. The trade association from which we interviewed representatives was the Blue Cross Blue Shield Association. We refer to this association as an issuer for reporting purposes.

interviewed IRS officials on this process, including how the agency might identify cases of duplicate coverage.[12]

To examine the extent to which individuals are transitioning between Medicaid and exchange coverage, we interviewed officials from our eight selected states about the availability of data that would allow for analysis of the extent of transitions and requested and analyzed the data where available. Specifically, we analyzed data available from three of the states on the number of individuals who transitioned (1) from Medicaid to exchange coverage and (2) from exchange to Medicaid coverage in 2014 and whether the movement was to or from subsidized versus unsubsidized exchange coverage. We interviewed CMS officials about state and federal data sources that would allow for analysis of the extent of transitions in FFE states and whether CMS had conducted or planned to conduct any such analysis. To assess the reliability of the state data, we performed manual tests of the data to identify any outliers or anomalies, followed up with officials as necessary, and incorporated the corrections we received. We determined that the data were sufficiently reliable for the purposes of this report.

To examine the participation of issuers in both Medicaid and exchange coverage in a state, we collected and analyzed data from our eight selected states on the extent to which issuers offered both Medicaid and exchange coverage in those states in 2014 and 2015, as well as the extent to which Medicaid and exchange enrollees were enrolled in those issuers' plans in 2014.[13] We also reviewed an analysis CMS performed on the extent to which issuers offered both Medicaid and exchange coverage in all states with Medicaid managed care in 2014. To

[12]The premium tax credit may be paid to issuers during the coverage year—in advance of tax filing—to reduce eligible enrollees' premium costs for exchange plans. However, the final amount of the credit is determined when the enrollee files an income tax return for the taxable year. This reconciliation process may result in a tax liability or refund if the enrollee's actual, reported household income is greater or less than the anticipated income on which the advance payments of the tax credit were based. See 26 U.S.C. § 36B(f); 26 C.F.R. § 1.36B-4(a).

[13]In requesting data from states, we asked that states consider issuers managed by the same parent company to be equivalent when listing issuers that offered both types of coverage. One state, Texas, was not able to provide complete information on issuers offering both types of coverage. In this case, we supplemented state data with publicly available CMS data and used identical name matches to determine which issuers offered both types of coverage. We did not determine whether multiple issuers in Texas were affiliated with the same parent company.

supplement these analyses, we interviewed officials from our selected states about issuer participation in Medicaid and exchange coverage in those states as well as the implications of such participation for individuals transitioning between the coverage types. In addition, we interviewed representatives of our selected issuers about their Medicaid and exchange coverage in states in which they offered both, as well as their experiences offering such coverage. To assess the reliability of the data we received from states and CMS, we performed manual and electronic tests of the data to identify any outliers or anomalies, clarified with officials as necessary, and incorporated the corrections we received. We determined that the data were sufficiently reliable for the purposes of this report.

The information that we obtained from our selected states and issuers cannot be generalized to other states. We conducted this performance audit from October 2014 through September 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

Beginning January 1, 2014, PPACA required most citizens and legal residents of the United States to maintain health insurance that qualifies as minimum essential coverage for themselves and their dependents or pay a tax penalty.[14] Most Medicaid coverage and private health insurance coverage purchased through the exchanges qualifies as minimum

[14]Individuals are exempt from the requirement to have minimum essential coverage when such coverage is not "affordable," as defined by PPACA. In general, individuals qualify for the affordability exemption if they would have to pay more than 8.05 percent in 2015 of their household income for the lowest-cost self-only health plan that is available to the individual. Similarly, families are exempt when the lowest-cost health plan available to the family exceeds 8.05 percent of household income. Other exemptions may be available for certain eligible individuals, such as those determined to have suffered certain hardships, members of Native American tribes, and those who qualify for an exemption for religious reasons.

essential coverage.[15] To expand individuals' access to minimum essential coverage, PPACA provided states the option to expand eligibility for Medicaid coverage, with increased federal financing for the newly eligible population.[16] As of January 2014, 25 states had expanded their Medicaid programs, and an additional 4 states had expanded as of March 2015.[17]

Beginning in October 2013, individuals were able to shop for private health insurance qualifying as minimum essential coverage through the exchanges, with coverage effective beginning as early as January 1, 2014. As of March 2015, the federal government operated an FFE in 34 states, and 17 states were approved to operate SBEs (see fig. 1).[18] States with SBEs may use the FFE IT systems for eligibility and enrollment functions. In 2014, two states with SBEs used the FFE IT systems for eligibility and enrollment, while in 2015 three states with SBEs did so.[19]

[15]Coverage through the State Children's Health Insurance Program (CHIP) also qualifies as minimum essential coverage. CHIP is a joint federal-state program that finances health insurance for low-income children whose household incomes are above the threshold for Medicaid eligibility. Health insurance coverage that provides limited benefits, such as dental-only coverage, does not constitute minimum essential coverage.

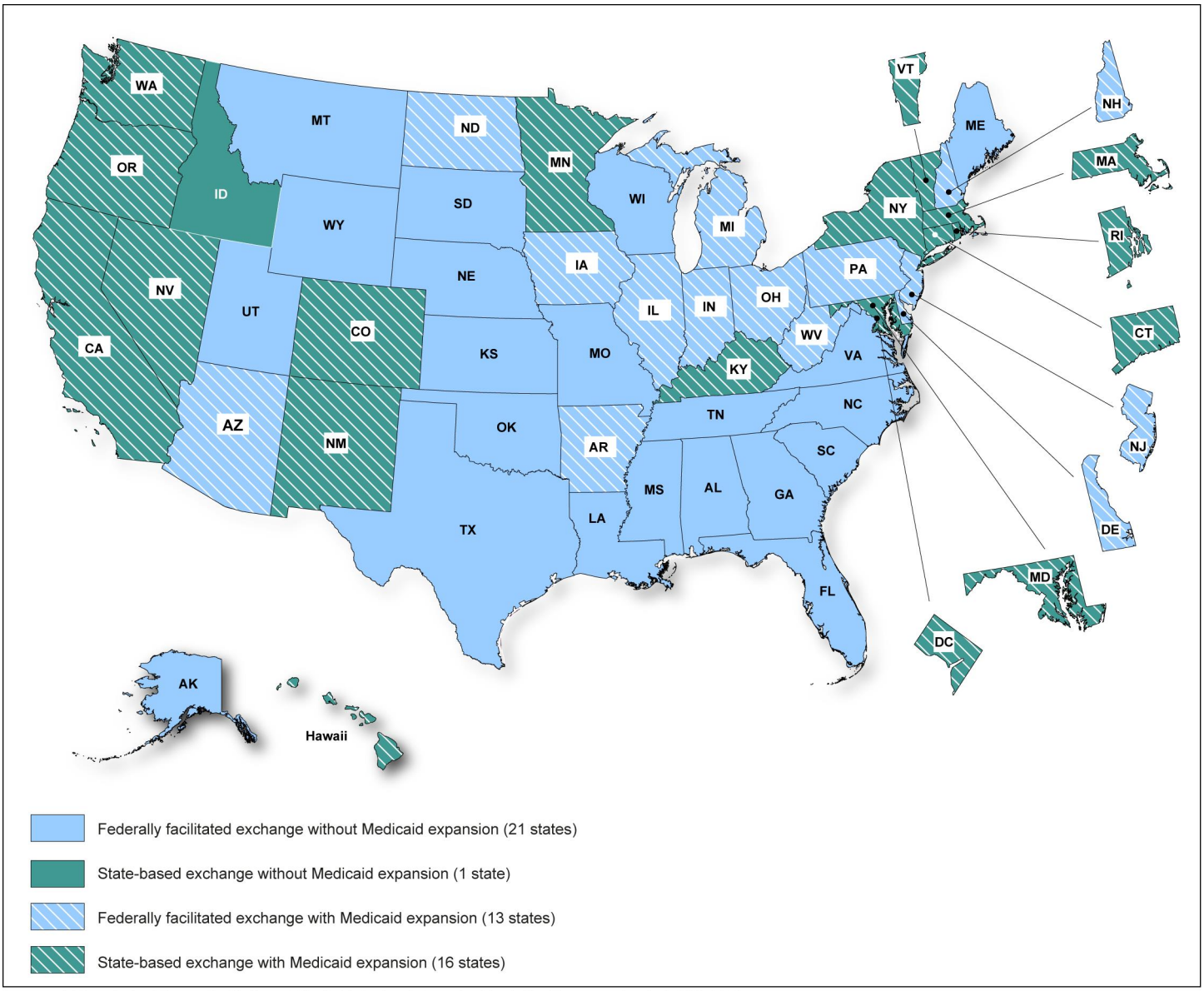
[16]States and the federal government share in the financing of the Medicaid program, with the federal government matching most state expenditures for Medicaid services on the basis of a statutory formula based in part on a state's per capita income. Federal law specifies that this federal match may range from 50 to 83 percent. For states that expand Medicaid, the federal government will pay an enhanced match—100 percent of the cost of covering newly eligible enrollees—in 2014, 2015, and 2016, with the federal match gradually reduced to 90 percent by 2020. PPACA also permitted an early expansion option, whereby states could expand Medicaid coverage for their eligible population (or a subset of this population) starting on April 1, 2010, with the regular level of federal financial participation until 2014, when the enhanced match rate took effect.

[17]As of June 2015, an additional state, Montana, had taken steps to expand its Medicaid program, with the expansion pending federal approval. For those states that opted not to expand Medicaid, eligibility for adults is largely limited to certain categories of low-income individuals, such as pregnant women and individuals who are aged or disabled.

[18]Some states that elected not to establish an SBE entered into a partnership with CMS in which CMS established and operates the exchange while states assist with certain functions of the exchange. Because a partnership exchange is a variation of an FFE, we include partnership states as FFE states in this report.

[19]In 2014, Idaho and New Mexico used the FFE IT systems. In 2015, Idaho used its own SBE system, while two additional SBE states—Oregon and Nevada—began using the FFE IT systems.

Figure 1: State Exchange Type and Medicaid Expansion Status as of March 2015



Sources: GAO analysis of Centers for Medicare & Medicaid Services information (data); Map Resources (map). | GAO-16-73

Note: Idaho and New Mexico used the federally facilitated exchanges' information technology systems in 2014, while Nevada, New Mexico, and Oregon did so in 2015.

PPACA also created federal subsidies for exchange coverage, most notably the premium tax credit available to eligible individuals with household incomes between 100 and 400 percent of the FPL. Individuals eligible for Medicaid or other minimum essential coverage, such as qualifying employer-sponsored coverage, are not eligible for the premium tax credit. The tax credit is refundable and is generally paid to issuers in advance to reduce enrollees' premium costs for exchange plans. Advance payments of this tax credit are known as advance premium tax credits (APTC) and are calculated based on an eligible individual's family size and anticipated household income relative to the cost of premiums for a benchmark plan.[20] According to HHS, approximately 87 percent of individuals selecting a plan for the 2015 coverage year in FFE states qualified for the APTC, with an average per person, monthly APTC amount ranging from $155 in Arizona to $534 in Alaska, and an average reduction in premiums of about 72 percent.[21] In addition to the premium tax credit, PPACA provides for cost-sharing reductions to reduce out-of-pocket costs, such as deductibles and copayments, for eligible individuals with household incomes between 100 and 250 percent of the FPL.[22]

[20]The benchmark plan is the second-lowest-cost silver tier plan available in the state's exchange, with silver tier referring to the plan's actuarial value (plans are also available within other metal tiers, such as gold and platinum, and the tiers have different actuarial values as established by PPACA). The individual is to receive an APTC amount based on this benchmark plan even if the individual chooses to enroll in a different plan.

Because APTC is calculated based on an eligible individual's anticipated household income, individuals receiving APTC must file federal income tax returns with the IRS to reconcile the amount of the premium tax credit allowed with the amount received in advance. If the amount of APTC paid to the issuer based on the individual's anticipated income exceeds the amount allowed based on the individual's reported income, the individual owes the excess amount as an additional income tax liability, subject to certain caps. As an alternative to APTC, individuals may claim the credit when filing their tax return for the year, which will either lower the amount of taxes owed on that return or increase their refund based on their reported income.

[21]In addition to the 34 FFE states, these estimates also included the 3 SBE states using the FFE IT systems in 2015. See Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report* (Washington, D. C.: Mar. 10, 2015).

[22]Individuals must enroll in a silver tier plan through an exchange to receive cost-sharing reductions.

Medicaid and Exchange Eligibility and Enrollment Policies and Procedures

PPACA required the establishment in all states of a coordinated eligibility and enrollment process for Medicaid and the exchanges. Since the enactment of the law in March 2010, CMS has issued regulations and technical guidance outlining aspects of this coordination. In particular, exchanges and state Medicaid agencies must enter into agreements with one another to ensure prompt eligibility determinations and enrollment of individuals in the appropriate programs regardless of where they apply, and must transmit individuals' account information—that is, their records—via secure electronic interface. However, the mechanisms through which this coordination occurs may vary depending on the state.

- In FFE states, CMS has established an account transfer process through which accounts for individuals enrolled in or applying for exchange or Medicaid coverage are electronically transmitted between CMS and state Medicaid agencies where appropriate. If individuals apply for coverage in an FFE state, CMS is responsible for determining or assessing individuals' eligibility for Medicaid and determining eligibility for exchange coverage, including exchange subsidies and, if applicable, facilitating enrollment in an exchange plan.[23] If CMS determines or assesses that an individual is or may be eligible for Medicaid, it must transfer the individual's account to the appropriate state Medicaid agency for enrollment, where appropriate. Individuals may also apply for coverage directly through the state Medicaid agency. In this case, the state is responsible for determining eligibility for Medicaid and, for individuals determined ineligible, transferring accounts to CMS for a determination of eligibility to enroll in subsidized exchange coverage.
- Conversely, states with SBEs are responsible for determining eligibility for both Medicaid and exchange coverage, including exchange subsidies, as well as enrolling individuals in the appropriate programs.

[23]Some states, known as determination states, have agreed to allow CMS to perform the final Medicaid eligibility determination for individuals applying for coverage through the FFE in those states, while other states, known as assessment states, perform the final Medicaid eligibility determination. This also includes determining or assessing, as appropriate, eligibility for CHIP.

CMS will only determine or assess individuals' eligibility for Medicaid or determine eligibility for exchange subsidies if individuals request a determination for insurance affordability programs—which include Medicaid, CHIP, and exchange subsidies—in their coverage application.

There are differences in eligibility and enrollment policies for Medicaid and exchange coverage.

- **Medicaid.** Individuals may enroll in Medicaid coverage at any point in time during the year, with their coverage effective as of the date of application, reported eligibility change, or earlier.[24] Individuals enrolled in Medicaid are generally required to report any changes—such as changes to income or household composition—that may affect their Medicaid eligibility.[25] Outside of self-reported changes, eligibility for Medicaid must generally be redetermined every 12 months.[26] When individuals are determined ineligible for Medicaid, states are required to send them notification that their coverage will be terminating at least 10 days prior to their Medicaid termination date.[27] In addition, states may opt to extend Medicaid coverage through the end of the month if it would otherwise be terminated earlier in the month.
- **Exchange coverage.** Individuals' options for enrollment in exchange coverage are generally restricted to an annual open enrollment period that starts near the end of the calendar year, unless they experience a change that qualifies them for a special enrollment period.[28] Exchange coverage is generally prospective, meaning that individuals must select an exchange plan by a certain date in order to have coverage effective the following month.[29] If individuals choose to end their

[24]States may choose to make coverage effective on the first day of the month in which the individual applied if the individual was eligible at any time during that month. 42 C.F.R. § 435.915(b). In addition, under certain circumstances, Medicaid coverage could be effective up to 3 months prior to the month of application or reported eligibility change; this is known as retroactive Medicaid coverage. Individuals may be eligible for retroactive coverage if they received covered services during the 3 months prior to the month of application or reported eligibility change and would have been eligible for Medicaid at the time. 42 C.F.R. § 435.915(a).

[25]42 C.F.R. § 435.916(c).

[26]This requirement applies to individuals whose Medicaid eligibility is determined based on modified adjusted gross income—PPACA's new uniform method of calculating income. For other Medicaid enrollees, eligibility must be redetermined at least every 12 months, but could be redetermined more frequently. 42 C.F.R. § 435.916(a)-(b).

[27]42 C.F.R. §§ 431.200(b), 431.211.

[28]45 C.F.R. §§ 155.410, 155.420.

[29]See 45 C.F.R. § 155.410(c). In some cases, such as in the birth of a child, the coverage may be retroactive—in this case to the date of birth.

exchange coverage, they must generally provide advance notice at least 14 days before the requested termination date.[30] As with Medicaid, individuals enrolled in subsidized exchange coverage are required to report any changes that may affect their eligibility. Eligibility for subsidized exchange coverage is redetermined during open enrollment and any time an individual reports a change, regardless of when coverage began during the year. If individuals are determined ineligible for continued subsidized exchange coverage, such subsidies must be terminated or they may be held liable for repayment of the APTC as part of the reconciliation process with IRS.

The coordination of federal payments for individuals transitioning between Medicaid and subsidized exchange coverage is addressed through Medicaid's third party liability rule and IRS's reconciliation process for the APTC. Specifically:

- **Third party liability in Medicaid.** Where individuals are enrolled in Medicaid along with another form of coverage, Medicaid operates as the payer of last resort. This means that the other source of coverage must pay to the extent of its liability before Medicaid pays, referred to as third party liability.[31] For example, for individuals enrolled in both Medicaid and exchange coverage for some period of time, the issuer of exchange coverage is required to pay to the extent of its liability before Medicaid does.
- **Reconciliation of the APTC with the IRS.** Individuals enrolled in exchange coverage and receiving the APTC must file federal income tax returns with the IRS to reconcile the amount of the premium tax credit allowed with the amount received in advance, and may be liable to pay back any excess credits received during the taxable year.[32] For individuals transitioning from exchange coverage to Medicaid during

[30]Individuals may submit a request to their issuer to terminate exchange coverage fewer than 14 days from the date of the request.

[31]See generally 42 C.F.R. § 433.135 et seq. 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. When private third parties, such as issuers, pay for health care services instead of Medicaid, savings accrue to states and the federal government.

[32]26 C.F.R. § 1.36B-4.

the year, this reconciliation could include repayment of APTC received after an individual was determined eligible for Medicaid.[33]

Issuer Requirements for Participation in Medicaid Managed Care and Exchange Coverage

Most state Medicaid programs have implemented managed care systems, under which the state pays contracted issuers a set amount per beneficiary per month to arrange for all covered services and the issuer assumes the risk for the cost of providing those services.[34] In states that offer managed care in their Medicaid programs, issuers have the potential to participate in both Medicaid and the exchange market. Issuers approved to offer Medicaid managed care, exchange coverage, or both, must comply with applicable state and federal requirements for the respective programs. For example, issuers offering Medicaid managed care must comply with any applicable state and federal restrictions on marketing their plans to Medicaid beneficiaries. In addition, some states may require issuers contracting with the Medicaid program to offer such coverage statewide, while in other states issuers may offer their Medicaid coverage statewide or to enrollees in selected geographic regions within the state. Issuers of exchange coverage have the option of offering their exchange plans statewide or within selected geographic regions.

[33]Per IRS regulations, individuals determined eligible for Medicaid are liable for repaying any APTC received the first day of the month following the Medicaid eligibility determination, subject to certain caps on repayment for individuals who have income less than 400 percent of the FPL. 26 C.F.R. § 1.36B-2(c)(2)(iv). For the 2014 tax year these caps ranged from $300 to $2,500. 26 C.F.R. § 1.36B-4(a)(3). However, if individuals are determined eligible for and receive the APTC during a tax year, but their incomes fall back into the Medicaid eligibility range later that year, they are not liable for repaying any excess premium tax credits as long as they were not determined eligible for Medicaid. See 26 C.F.R. § 1.36B-2(c)(2)(v).

[34]According to CMS officials, 40 states offered comprehensive, risk-based managed care in 2014. The alternative to a managed care model is fee-for-service, in which states pay health care providers for each service delivered.

CMS's Policies and Procedures Do Not Sufficiently Minimize the Potential for Coverage Gaps and Duplicate Coverage in Federal Exchange States

Information from CMS and selected states and issuers indicates that individuals transitioning from Medicaid to exchange coverage may experience coverage gaps, and that duplicate coverage is occurring under several scenarios. CMS and our selected states had a number of enrollment policies, IT mechanisms, and consumer education efforts that minimize the potential for coverage gaps and duplicate coverage; however, our assessment of CMS's policies and procedures for FFE states found that additional controls are needed.

Individuals Transitioning between Medicaid and the Exchanges May Experience Coverage Gaps or Duplicate Coverage under Certain Circumstances

Officials from CMS and four of our eight selected states told us that individuals may experience gaps in coverage when transitioning between Medicaid and exchange coverage, though they did not have information on the extent to which such gaps were occurring. Specifically, as Medicaid coverage is effective as of the date an eligibility change is reported or earlier, officials from two states explained that coverage gaps should generally not occur for individuals who lose eligibility for exchange coverage and are transitioning to Medicaid.[35] However, as exchange coverage is generally prospective, coverage gaps could occur in the other direction. In particular, officials from one state told us that individuals who lose eligibility for Medicaid toward the end of a month may be more likely to experience coverage gaps because they would have a short window of time to enroll in exchange coverage so that coverage is effective the first day of the following month.[36] Individuals who experience gaps in coverage may decide to forgo necessary care rather than pay out-of-pocket, which could negatively affect health outcomes and result in sicker individuals enrolling in exchange coverage.

[35]According to CMS officials, gaps could occur if individuals failed to take steps to finalize Medicaid enrollment.

[36]According to the officials, this state extends Medicaid coverage through the end of the month in which individuals become ineligible. States are not required to do so. While CMS officials could not tell us the number of states that have implemented this policy, the agency has publicly stated that many states have. In states that do not extend Medicaid coverage through the end of the month, coverage gaps may be likely to occur regardless of when in the month individuals lose eligibility for Medicaid.

Information from selected states and issuers indicated that duplicate coverage—that is, enrollment in both Medicaid and subsidized exchange coverage—was occurring under the three scenarios outlined below, the first of which is permitted under federal law. However, the full extent to which duplicate coverage was occurring was unknown.

- **Scenario 1: Individuals who are completing the transition from subsidized exchange to Medicaid coverage.** According to officials from three of our eight selected states, some amount of duplicate coverage may be expected for individuals transitioning from subsidized exchange coverage to Medicaid. For example, if an individual with subsidized exchange coverage reports a change and is determined eligible for Medicaid on September 16th, the individual could have duplicate coverage for the period of September 16th through September 30th. This is primarily due to differences in the effective dates of coverage. Medicaid coverage is effective as of the date an eligibility change is reported or earlier—while in general exchange coverage can only be terminated prospectively, generally with at least 14 days advance notice.[37] The period of duplicate coverage could be extended if the Medicaid eligibility determination takes longer—and per federal regulations it can take up to 45 days for applicants not applying on the basis of disability.[38] This transitional period of duplicate coverage is permitted under the law; that is, individuals are permitted to be enrolled in both types of coverage through the end of the month of the Medicaid eligibility determination.[39]
- **Scenario 2: Individuals who do not end their subsidized exchange coverage after being determined eligible for Medicaid.** One of our selected states identified that 3,500 individuals had duplicate coverage at some point from January to July 2014, in part because some of the individuals did not end their subsidized coverage after being determined eligible for Medicaid. Individuals may not end subsidized exchange coverage for a variety of reasons, including that, depending on their income level and plan selection, some individuals

[37]Individuals may submit a request to their issuer to terminate exchange coverage fewer than 14 days from the date of the request.

[38]See 42 C.F.R. § 435.912(c)(3)(ii). The determination can take up to 90 days for applicants applying on the basis of disability.

[39]See 26 U.S.C. § 36B(c)(2)(A)-(B); 26 C.F.R. § 1.36B-2(c)(iv).

receiving subsidies may not have to make a premium payment and thus may not realize they are still enrolled and need to take steps to end their coverage.[40] If individuals do not end coverage, but stop paying premiums once Medicaid coverage begins, the APTC must still be paid out for a 3-month grace period after premium payments have ceased, though issuers must return the APTC amount for the final 2 months of this period under certain circumstances.[41]

- **Scenario 3: Individuals who enroll in subsidized exchange coverage when already enrolled in Medicaid.** One of our selected issuers reported that a small number of individuals enrolled in one of the issuer's Medicaid plans and later also obtained subsidized coverage through one of its exchange plans—18 individuals as of February 2015.[42] Officials from the Medicaid agency in the state where this issuer operates also told us that they had identified cases of duplicate coverage by selecting a small sample of individuals from one of their Medicaid issuers, and that they had heard from some other issuers in the state that they had members enrolled in both coverage types. Additionally, another of our selected issuers reported that one of its plans had experienced a number of instances of duplicate coverage—which tended to last for many months—and that the volume had increased during 2015 open enrollment for exchange coverage, likely because Medicaid coverage was not identified.

To the extent duplicate coverage occurs, there could be financial implications for the federal government. In cases where the state Medicaid program has identified that an individual is enrolled in exchange coverage—and Medicaid is operating as the payer of last resort—there may not be a significant difference in federal costs for the individual during the period of duplicate coverage compared with what would have been spent if duplicate coverage had not occurred. However, evidence suggests that some states may face challenges identifying exchange

[40]According to CMS officials, these individuals would receive a bill indicating that their premiums for exchange coverage are covered by APTC.

[41]If individuals do not pay outstanding premiums during the entire 3 month period, coverage is terminated retroactive to the last day of the first month of the period and issuers are required to return the APTC received for the second and third months of the period. See 45 C.F.R. § 156.270.

[42]This issuer's experience with duplicate coverage is limited to enrollment within its own health plans, which could underestimate the degree to which it is occurring more generally.

coverage. We recently found that states face challenges identifying whether Medicaid enrollees have other sources of coverage, which could include exchange coverage.[43] In addition, officials from our four selected FFE states told us that they do not currently have access to exchange enrollment information, and that such information could help them better identify information on Medicaid enrollees' other sources of coverage. CMS officials told us that CMS has provided exchange enrollment data to one state that requested it for third-party liability purposes, and the agency would consider the appropriateness of providing such data to other states if requested.

If the state is not aware of an individual's exchange coverage, the federal government could be paying twice—that is, subsidizing exchange coverage and reimbursing states for Medicaid spending for the same individual.[44] The risk of duplicate payments may be higher in states with higher Medicaid managed care penetration as the state pays issuers a monthly fee for each enrolled individual, regardless of whether services are received. The tax reconciliation process for the APTC has the potential to reduce the financial implications of any duplicate payments. However, according to IRS officials, the IRS will generally not have the information necessary to identify duplicate coverage as part of reconciling the amount of the APTC an individual may owe until 2016—that is, the tax filing season for tax year 2015—when states are required to report Medicaid enrollment data to IRS.[45] Officials told us that once IRS begins receiving the data their ability to identify the need for repayment due to duplicate coverage will depend on the quality of the data and the IRS's available resources. Officials said that depending on resources, they may check for Medicaid coverage for each individual receiving the APTC or for a sample of individuals.

[43]We found that states face challenges to their third-party liability efforts—efforts to identify and collect payment from other insurance held by Medicaid enrollees—and recommended additional federal actions to improve such efforts. HHS concurred with our recommendations and noted plans to address them. See GAO, *Medicaid: Additional Federal Action Needed to Further Improve Third-Party Liability Efforts*, GAO-15-208. (Washington, D.C.: Jan. 28, 2015).

[44]Subsidizing exchange coverage could include payments of the APTC and, for those eligible, cost-sharing reductions for any services used.

[45]Officials explained that, prior to 2016, if a taxpayer is under audit for APTC for a reason other than duplicate coverage, it is possible that the IRS would find that the individual was also enrolled in Medicaid during the course of the audit.

Duplicate coverage could also have financial implications for individuals. As long as individuals end subsidized exchange coverage upon receiving their Medicaid eligibility determination, they would generally not be liable for repaying the APTC received during the transitional period of duplicate coverage discussed in the first scenario above; however, according to CMS officials, individuals would be responsible for their portion of the exchange premiums during this period. To the extent duplicate coverage occurs outside of the transitional period and the IRS identifies duplicate coverage during the tax reconciliation, individuals may be liable for repaying all or a portion of the APTC received.[46]

CMS and States Had Policies and Procedures That Minimize the Potential for Coverage Gaps and Duplicate Coverage, but Additional Controls Are Needed in Federal Exchanges

CMS and our selected states had policies and procedures that minimize the potential for coverage gaps or duplicate coverage when individuals transition between Medicaid and the exchanges.

- **Enrollment-related:** CMS and selected states had enrollment policies and procedures that minimize the potential for coverage gaps by facilitating alignment of Medicaid and exchange coverage periods. For example, for individuals transitioning from Medicaid to exchange coverage, CMS requires that, as long as individuals select an exchange plan on or before the day that Medicaid coverage ends, exchanges must ensure that coverage is effective on the first day of the following month.[47] In contrast, most individuals enrolling in exchange coverage must select a plan by the fifteenth of the month in order to have a coverage effective date for the first day of the following month. Additionally, in February 2015, CMS adopted a new regulation governing premium payments in FFE states, allowing individuals transitioning from Medicaid 30 calendar days from enrolling in exchange coverage to pay their first premium.[48] At the

[46]Per IRS regulations, individuals determined eligible for Medicaid are liable for repaying premium tax credits received the first day of the month following the Medicaid eligibility determination, subject to certain caps on repayment for individuals who have income less than 400 percent of the FPL. For the 2014 tax year these caps ranged from $300 to $2,500. See 26 C.F.R. §§ 1.36B-2(c)(2)(iv), 1.36B-4(a)(3).

[47]See 45 C.F.R. § 155.420(b)(iv), (d)(1)(i). According to CMS officials, for individuals transitioning from Medicaid to exchange coverage in FFE states, exchange coverage will begin the first day of the month following the date of plan selection.

[48]See HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10750, 10866 (Feb. 27, 2015) (to be codified at 45 C.F.R. § 155.400(e)(1)(ii)). This regulation took effect on April 28, 2015.

state level, officials from one state told us they increased the deadline for mailing notification of Medicaid coverage termination to 20 days prior to termination instead of the minimum required 10, so that individuals have more time to shop for a plan on the exchange. Additionally, officials from all of our selected states reported extending Medicaid coverage to at least the end of a month even when an individual becomes ineligible for Medicaid coverage earlier in the month.[49]

- **IT-related:** CMS and selected SBE states also had IT-related policies and procedures that minimize the potential for coverage gaps as well as duplicate coverage. For example, in FFE states, when individuals are determined potentially eligible for subsidized exchange coverage, CMS conducts automated checks of state IT systems to determine if individuals already have Medicaid coverage, thus helping to prevent duplicate coverage.[50] At the state level, officials from all four of our selected SBE states reported that their states had implemented integrated eligibility and enrollment systems for Medicaid and exchange coverage that, among other things, helped avoid gaps in coverage by making eligibility determinations in real time: in other words, at the time an individual reports a change.[51] Officials also said that these integrated systems included system rules that help prevent duplicate coverage by not allowing an individual to be determined

[49]Officials in these states generally reported that Medicaid coverage would be extended to the end of the second following month if coverage was terminated less than 10 days before the end of a month. In New York, individuals have 12 month continuous eligibility for Medicaid and if an individual becomes ineligible for Medicaid during an eligibility redetermination, the individual is given 60 days advance notice that Medicaid coverage will end.

[50]This also includes a check for CHIP coverage. For this check to work, states' Medicaid IT systems must respond to electronic inquiries from the FFE on applicants' current Medicaid coverage. We previously reported that while none of the 36 states using the FFE in 2014 were able to perform this check as of October 1, 2013—the first day of the initial open enrollment period for exchange coverage—most states were able to implement this functionality over time. See GAO, *Medicaid: Federal Funds Aid Eligibility IT System Changes, but Implementation Challenges Persist,* GAO-15-169 (Washington, D.C.: Dec. 12, 2014). According to CMS officials, six states—Alaska, Kansas, New Jersey, Tennessee, Oregon, and Wyoming—remained unable to perform this check as of July 2015. This check supplements the question in the application asking the applicant to attest to whether they have minimum essential coverage, including Medicaid or CHIP.

[51]While real time determinations are the goal, some may take longer, if, for example, individuals are missing information on their applications. One of our selected SBE states reported that as of May 2015, 78 percent of the eligibility determinations through its integrated system were being made in real time.

eligible for Medicaid and exchange subsidies simultaneously.[52] In addition, officials from three of these states noted that their systems automatically terminate subsidized exchange coverage once individuals are determined eligible for Medicaid, while officials in the fourth state said their systems would have this ability beginning in September 2015.[53]

- **Consumer education-related:** Both CMS and an SBE state reported including guidance on exchange websites that could help individuals avoid coverage gaps and duplicate coverage during the transition between Medicaid and exchange coverage. For example, CMS has added guidance on coverage transitions on the FFE website that outlines the steps individuals must take when they have subsidized exchange coverage and are later determined eligible for Medicaid, including that they are responsible for ending subsidized exchange coverage. CMS also notifies individuals in FFE states of this responsibility when they are enrolling in exchange coverage. Similarly, officials from one of our SBE states said that they have tried to improve the clarity of instructions on their exchange website, because most individuals are making eligibility changes online.

Despite the steps CMS has taken, its current policies and procedures do not sufficiently minimize the potential for coverage gaps and duplicate coverage in the 34 states that had an FFE in 2015.[54] According to federal internal control standards, in its responsibilities for administering and overseeing Medicaid and the exchanges, CMS should design and

[52]Officials from one of our SBE states did not have an integrated system at the start of 2014 and, after identifying duplicate coverage was occurring, set up a manual process to check for it on a bi-weekly basis and resolve any identified cases. While the state now has an integrated system, officials said they are continuing the manual process as an additional check.

[53]For our reporting purposes, automatically terminating subsidized exchange coverage refers to automatically terminating exchange subsidies, including the APTC. Some states may automatically terminate exchange subsidies as well as enrollment in an exchange plan. According to state officials, in two of the three states, subsidized exchange coverage is automatically terminated the month of the Medicaid eligibility determination. In the third state, such coverage is automatically terminated at the end of the month of the determination if the determination occurs prior to the twenty-third of the month. If the determination occurs after the twenty-third of the month, automatic termination occurs at the end of the following month.

[54]The control weaknesses we identified for the 34 FFE states also apply to SBE states using the FFE IT systems, which in 2015 were Nevada, New Mexico, and Oregon.

implement necessary policies and procedures to enforce agency objectives and assess program risk. These policies and procedures should include internal controls, such as conducting monitoring to assess performance over time, that provide reasonable assurance that an agency has effective and efficient operations and that program participants are in compliance with applicable laws and regulations.[55] We identified a number of weaknesses in CMS's controls for minimizing coverage gaps and duplicate coverage for individuals transitioning between Medicaid and exchange coverage in FFE states.

Control Weaknesses Related to Coverage Gaps

With regard to coverage gaps, we found that CMS's controls do not provide reasonable assurance that the accounts of individuals transitioning from Medicaid to exchange coverage in FFE states are transferred by states in near real time, which puts individuals in these states at greater risk of experiencing such gaps. Specifically, federal regulations require that state Medicaid agencies should transfer accounts to CMS promptly and without undue delay.[56] However, according to CMS officials, as of July 2015, the agency was not monitoring the timeliness of account transfers from states, and thus CMS would not be aware if account transfers from FFE states were happening promptly. CMS officials told us that account transfers are not happening in real time, but their understanding was that states typically send transfers at least daily.[57] Officials from three of our four selected FFE states reported that account transfers were occurring at least daily, while officials from the remaining state reported that transfers were sent to CMS three times per week.

Given the number of steps involved in the transition from Medicaid to exchange coverage, individuals may be more likely to have gaps in coverage to the extent account transfers from states to CMS are not happening in a timely fashion. For example, if a state sends a notification of termination on September 20, individuals could have just over a week

[55]See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

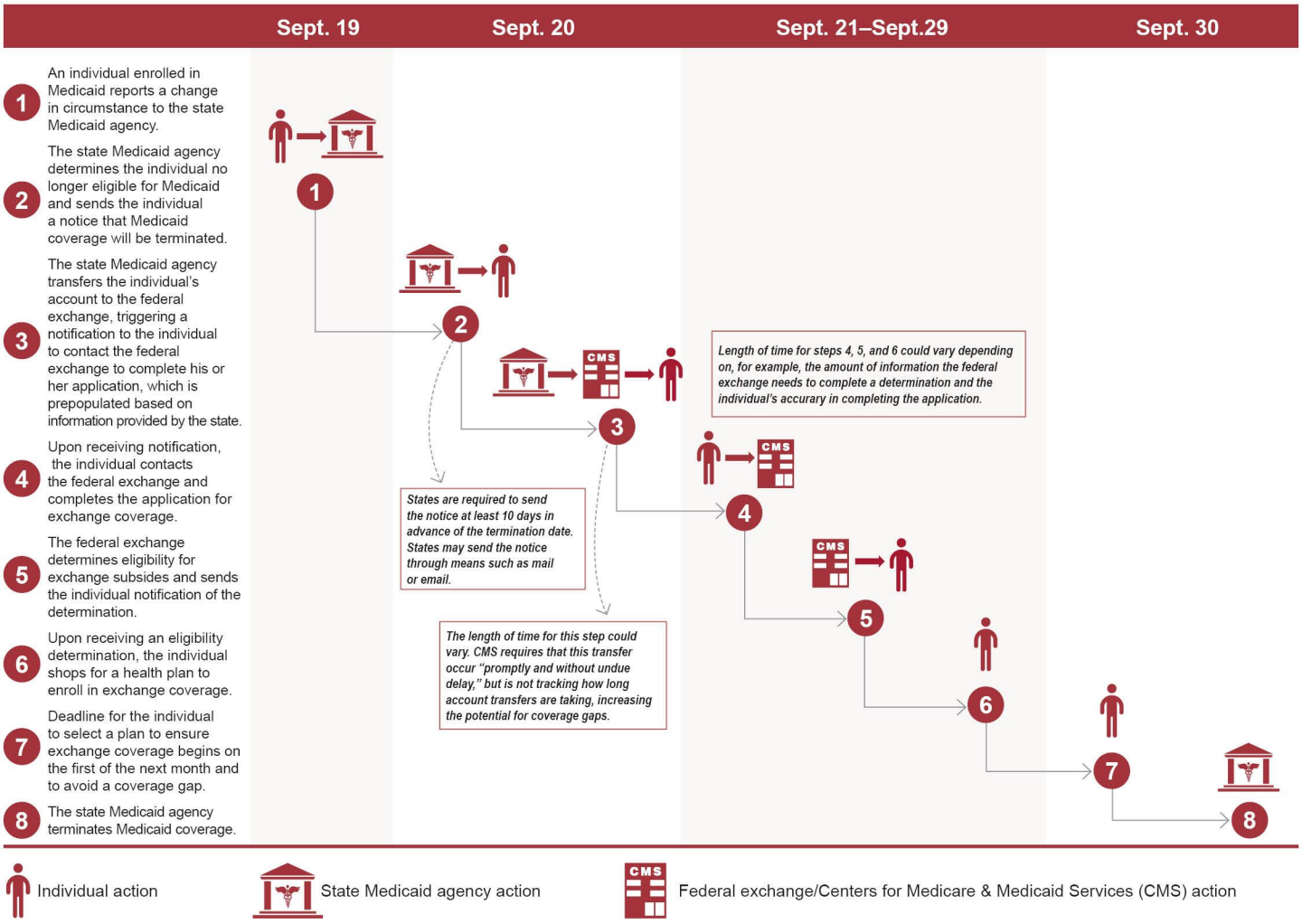
[56]42 C.F.R. § 435.1200(e).

[57]In December 2014, we reported on account transfers in FFE states and found that the capability to conduct real time transfers for immediate eligibility determinations remained elusive in all states and would likely not begin in most states for years. See GAO-15-169.

to have their accounts transferred, apply for exchange coverage, and select a plan to avoid a coverage gap (see fig. 2).[58]

[58]This scenario assumes the state follows the 10-day minimum for notification of Medicaid termination and extends Medicaid coverage to the end of the month an eligibility change is reported. CMS officials noted that, rather than waiting for the account transfer to occur, individuals could also submit a new application. However, individuals may not do so and, if they did, would need to fill out an entirely new application rather than complete one that is prepopulated through the account transfer process.

Figure 2: Illustration of the Transition from Medicaid to Exchange Coverage in a Federally Facilitated Exchange State Via the Account Transfer Process



Source: GAO analysis of state and CMS information. | GAO-16-73

Note: This illustration assumes that Medicaid eligibility is determined the day after the change was reported, the state notifies the individual on the date of the eligibility determination, and the state extends Medicaid coverage to the end of the month in which an eligibility change is reported. To the extent certain steps in this illustration take longer, the amount of time an individual has to avoid a coverage gap would be less or a coverage gap would be more likely to occur.

Control Weaknesses Related to Duplicate Coverage

With regard to duplicate coverage, we found weaknesses in CMS's controls for preventing, detecting, and resolving duplicate coverage in FFE states.

- **Vulnerabilities in methods to prevent individuals from maintaining subsidized exchange coverage after being determined eligible for Medicaid.** Individuals in FFE states might not end subsidized exchange coverage when they are determined eligible for Medicaid. According to CMS officials, in April 2015, the agency revised the notice individuals receive when they are determined eligible or potentially eligible for Medicaid to make clear individuals are responsible for doing so. However, individuals who apply for Medicaid directly through their state Medicaid agency may not receive such notification. In addition, CMS does not have procedures to automatically terminate subsidized exchange coverage when individuals are determined eligible for Medicaid, though CMS officials told us that they are considering options for doing so in the future.[59]
- **Vulnerabilities in methods to prevent individuals enrolled in Medicaid from enrolling in subsidized exchange coverage.** While CMS generally checks for Medicaid coverage before initially determining someone eligible for subsidized exchange coverage, officials recognized that there are limitations to this check. Specifically, officials said these checks identify at a point in time whether the person is enrolled in Medicaid. Thus, if, for example, the Medicaid determination was pending, CMS would not know that from the check. Also, according to CMS officials, CMS is not able to conduct checks for Medicaid for the small percentage of individuals who do not provide social security numbers on their applications.[60] Further, CMS did not perform a check for Medicaid coverage for the 1.96 million individuals who were auto-reenrolled in exchange

[59]For our reporting purposes, automatically terminating subsidized exchange coverage refers to automatically terminating exchange subsidies, including the APTC.

[60]CMS officials explained that applicants may not be able to provide a social security number because they are in the process of applying for one or have applied but not yet received one. Officials said that exchanges cannot deny an application on the basis of the applicant not being able to provide a social security number. Applicants who have a social security number are required to provide one at the time of application.

coverage during 2015 open enrollment for FFE states.[61] The absence of such a check increases the risk that duplicate coverage occurring during the year would continue when individuals are enrolled in subsidized exchange coverage for another year.

- **No methods to detect and resolve duplicate coverage.** As of July 2015, CMS did not have procedures to detect and resolve cases of duplicate coverage in FFE states. Further, CMS had generally not provided FFE states with exchange enrollment information that they would need to identify cases of duplicate coverage.

While CMS has not conducted a formal risk assessment to identify the potential causes of duplicate coverage in FFE states, CMS officials told us that the agency has a number of planned steps to address the risk. The planned approach focuses on taking steps to identify and resolve rather than prevent duplicate coverage. Specifically, CMS has plans to implement periodic checks for duplicate coverage starting in the summer of 2015, and CMS officials told us in July 2015 that the first check would occur later that month.[62] CMS officials estimated that the first check will take about 2 to 3 weeks to perform and will involve, among other steps, querying each FFE state's Medicaid system.[63] According to the officials, after the first check is complete CMS will notify individuals found to have duplicate coverage that they must contact the FFE to update their coverage information. Further, in 2016, if CMS can build the IT functionality to do so, the agency plans to begin automatically terminating exchange subsidies if individuals identified through the checks do not

[61]During 2015 open enrollment, of those already enrolled in exchange coverage, 2.21 million actively selected a new plan or renewed their existing plan, while 1.96 million auto-reenrolled into an exchange plan. This includes individuals in the 34 FFE states as well as the 3 SBE states using the FFE IT systems. See Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report* (Washington, D. C.: Mar. 10, 2015).

[62]CMS is required to periodically examine available data sources to identify, among other things, if an enrollee for whom ATPCs or cost-sharing reductions are being provided has been determined eligible for Medicaid. 45 C.F.R. § 155.330(d). According to CMS officials, the periodic check will also include a check for individuals enrolled in both subsidized exchange coverage and CHIP.

[63]Officials were unsure about the length of time that will be required for subsequent checks and noted that it will depend in part on how long it takes state systems to process the queries from CMS's systems.

respond within 30 days of being notified.[64] CMS officials told us that they are considering performing the periodic checks ahead of future open enrollment periods for exchange coverage, which could help prevent duplicate coverage among those automatically reenrolled in exchange coverage. CMS officials told us that the planned checks and notification process are a more efficient way of detecting and resolving duplicate coverage compared to providing exchange enrollment information to states and requiring them to identify duplicate coverage, which CMS would then need to resolve.

The effectiveness of CMS's plans to address duplicate coverage will depend in part on how frequently the checks are conducted and, as of July 2015, CMS had not yet decided the frequency. CMS officials told us that they are considering performing the checks on a regular basis—possibly quarterly—but said the frequency of the checks will depend in part on the agency's analysis of the first check, including the level of effort required by state Medicaid agencies. Determining the frequency of the checks after completing an analysis of the first check is reasonable and could provide CMS with important insights. However, until CMS establishes the frequency of its checks, the risk of duplicate coverage going undetected continues to exist. Further, the less frequently the checks are conducted, the longer duplicate coverage could last if individuals do not independently take steps to end their subsidized exchange coverage. For example, for individuals who have subsidized exchange coverage and are determined eligible for Medicaid, if the checks are conducted monthly, duplicate coverage could last up to 2 months longer than what might be expected during the transition period;

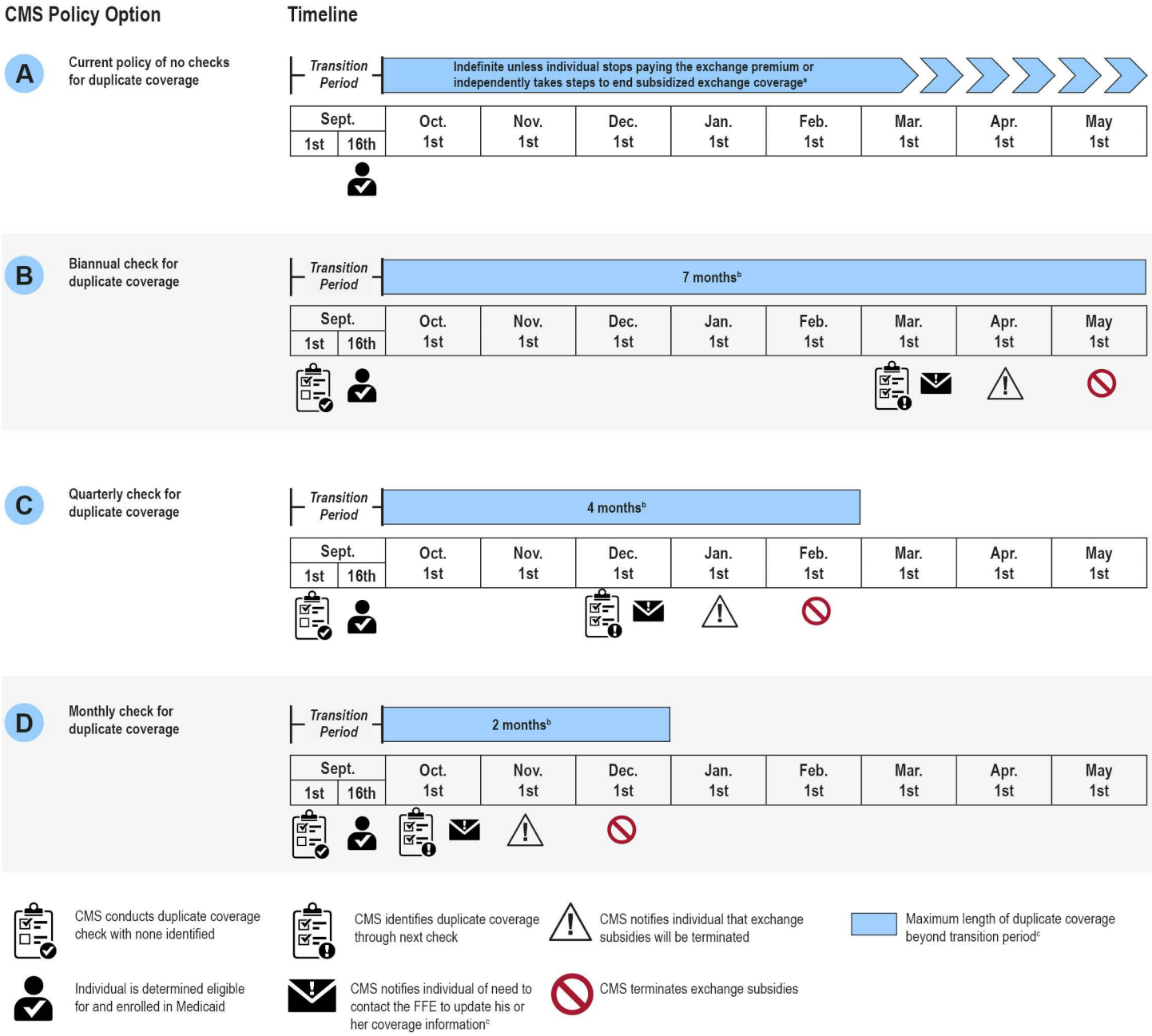
[64]CMS officials said that their tentative plan for notifying individuals after duplicate coverage is identified is as follows. Individuals will first receive notification that they have 30 days to contact the FFE to update their information, which will include attesting to whether they are enrolled in Medicaid or other minimum essential coverage. Individuals could choose to end their subsidized exchange coverage at this point. If individuals believe that the duplicate coverage was identified in error, they may contest the determination and will have up to 90 days to provide proof that they are not enrolled in other minimum essential coverage. If individuals do not respond to the initial notice, CMS will send a second notice 30 days after the mailing date of the initial notice to tell them that their exchange subsidies will be terminated at the end of the current or following month, depending on whether this final notice is sent on or before the fifteenth of the month. For individuals whose subsidies are terminated, the FFE will, as appropriate, recalculate subsidies for other individuals on the application.

if quarterly, up to 4 months; and if biannually, up to 7 months (see fig. 3).[65]

[65]This illustration is based on CMS automatically terminating exchange subsidies after consumer inaction. If individuals take steps to end their subsidized exchange coverage either before or after being notified, the period of duplicate coverage would be shorter.

Some amount of duplicate coverage is expected as part of the process of transitioning from subsidized exchange coverage to Medicaid, primarily because Medicaid coverage is effective back to at least the date an eligibility change is reported and because exchange coverage can only be terminated prospectively—generally with at least 14 days advance notice.

Figure 3: Potential Length of Duplicate Coverage for Individuals with Subsidized Exchange Coverage Who Become Enrolled in Medicaid in FFE States, under Different CMS Policy Options



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-16-73

Notes: FFE states are those with federally facilitated exchanges. CMS refers to the Centers for Medicare & Medicaid Services.

Some amount of duplicate coverage may be expected as part of the process of transitioning from subsidized exchange coverage to Medicaid, primarily because Medicaid coverage is effective the date an eligibility change is reported or earlier, and because exchange coverage can only be terminated prospectively—generally with at least 14 days advance notice unless the issuer approves an earlier termination date. This illustration is based on CMS's reported plan for notifying individuals after duplicate coverage is identified and is also based on the following: the Medicaid eligibility change being reported and determined on the same day, the state making Medicaid coverage effective the first of the month the change was reported, the individual not being eligible for retroactive Medicaid coverage, the check for duplicate coverage occurring over the period of one day, CMS sending the first notice to the individual on the day duplicate coverage is identified, and the individual not responding to the notice. To the extent these factors vary, the length of duplicate coverage resulting from the transitional period could be shorter or longer.

[a]For example, an individual might take steps to end subsidized exchange coverage if the Internal Revenue Service identities that the individual has duplicate coverage during tax reconciliation.

[b]If the individual stops paying the exchange premium or takes steps to end subsidized exchange coverage either before or after being notified of duplicate coverage, the period of duplicate coverage would be shorter.

[c]According to CMS officials, individuals will receive notification that they have 30 days to contact the FFE to update their information, which will include attesting to whether they are enrolled in Medicaid or other minimum essential coverage. Individuals could choose to end their subsidized exchange coverage at this point.

In addition, while CMS officials told us that they intend to monitor the results of the periodic checks, they do not have a specific plan to routinely monitor the effectiveness of their planned checks and other procedures. According to CMS officials, the agency is exploring metrics to help measure the success of the periodic checks, such as identifying the number of people who received notification of duplicate coverage and subsequently ended their subsidized exchange coverage. However, CMS has not set a level of duplicate coverage that it deems acceptable, both in terms of the time period for which individuals have duplicate coverage and the proportion of Medicaid or exchange enrollees that experience duplicate coverage within a given time frame. Without such thresholds, it will be difficult for the agency to provide reasonable assurance that its procedures are sufficient or whether additional steps are needed.

Limited Data Show Small Percentages of Enrollees Transitioned between Coverage Types, but Transitions May Increase in the Future

Data from three of our selected states—Kentucky, New York, and Washington—indicated that collectively over 70,000 individuals transitioned between Medicaid and exchange coverage in 2014.[66] Specifically, the three states—all of which were SBE states that had expanded Medicaid—reported that about 73,000 individuals transitioned in 2014 (see table 1). These individuals accounted for between 7.5 percent and 12.2 percent of exchange coverage enrollment and less than 1 percent of Medicaid enrollment in those states.[67] Data from the three states also indicated that most individuals transitioned to or from subsidized exchange coverage, rather than unsubsidized exchange coverage. While states were not able to provide data on the demographics of those transitioning, New York officials told us that it was likely mostly adults transitioning, because children have access to CHIP. In New York, CHIP covers children up to 400 percent of FPL—the same income limit as that set for the premium tax credit—compared with the Medicaid limit for adults of 133 percent of FPL.[68] While individuals transitioning accounted for a relatively small percentage of enrollment, the total number of individuals transitioning across states could be significant. Out of the 25 states that had expanded Medicaid as of January 2014, we

[66]Data provided for the Medicaid population varied by state. Washington provided data for its entire Medicaid population, and Kentucky and New York provided data for individuals who enrolled in Medicaid through the states' exchanges and were determined eligible for Medicaid by PPACA's new uniform method for calculating income—modified adjusted gross income.

[67]To analyze the proportions of Medicaid and exchange enrollment that these individuals accounted for, we used total Medicaid and exchange enrollment counts provided by the states. The enrollment counts provided by Kentucky reflect the number of individuals that had ever enrolled in the applicable program in 2014. The enrollment counts provided by New York and Washington reflect enrollment as of, respectively, November and December 2014.

The data from the three states likely do not reflect the total number of individuals who experienced eligibility changes during 2014 that could have resulted in a transition between Medicaid and exchange coverage. Some individuals might have experienced eligibility changes but not reported them, meaning that they maintained their current type of coverage even though they were eligible for the other. Other individuals experiencing eligibility changes may have been disenrolled from one type of coverage but failed to enroll in the other, becoming uninsured instead.

[68]The 24 other states that expanded Medicaid as of January 2014 generally had income eligibility standards that were higher for children (either in Medicaid or CHIP) than for adults as of October 2014. However, none were as high as New York's. Thus, there may be a greater likelihood of children transitioning between coverage types in states other than New York though the likelihood may still be less than that of adults.

estimate that Kentucky, New York, and Washington accounted for 22.9 percent of total Medicaid and CHIP enrollment and 18.3 percent of total exchange enrollment in 2014.[69]

Table 1: Number of Individuals Transitioning between Medicaid and Exchange Coverage, Selected States, 2014

State	Medicaid to exchange	Exchange to Medicaid	Total individuals transitioning
Kentucky[a]	5,988	7,429	**13,417**
New York[b]	NP[c]	26,758	**26,758**
Washington	7,097	25,709	**32,806**
Total	**13,085**	**59,896**	**72,981**

Legend: NP = not provided.

Source: GAO summary of data from selected states. I GAO-16-73

[a]Kentucky data were limited to those who enrolled in Medicaid through the state's exchange and were determined eligible for Medicaid by PPACA's new uniform method for calculating income—modified adjusted gross income.

[b]New York provided data through November 15, 2014. The data do not reflect any changes that may have occurred during the annual redetermination of eligibility for exchange coverage. Data were also limited to those who enrolled in Medicaid through the state's exchange and the portion of the population whose eligibility is determined using modified adjusted gross income.

[c]New York did not track movement from Medicaid to exchange coverage in 2014, but planned to do so in 2015.

The data from the three states may understate the extent to which transitions between Medicaid and exchange coverage could occur in those states in future years. In particular, the number of individuals moving from Medicaid to exchange coverage may be greater in future years than in 2014. Individuals newly eligible for and enrolled in Medicaid in early 2014 would not have gone through their first annual redetermination of Medicaid eligibility, and officials in one state told us that they did not expect to see a lot of movement from Medicaid to exchange coverage until those redeterminations began. In addition, the number of individuals moving from exchange coverage to Medicaid in the three states may be greater in future years. Annual redeterminations of eligibility for subsidized exchange coverage are to occur during the

[69]To estimate total 2014 enrollment in states that expanded Medicaid, we used Medicaid and CHIP enrollment data as of March 2014. The exchange enrollment data represent the number of individuals that selected a plan for 2014 coverage through the exchange from October 1, 2013 through March 31, 2014, as well as reported special enrollment period activity through April 19, 2014.

annual open enrollment period for exchange coverage, which may extend from the end of a calendar year through the beginning of the following calendar year.[70] As 2014 was the first year of exchange coverage, the data for this year reflected, at the maximum, only changes resulting from annual redeterminations of eligibility during the end of the calendar year—the beginning of the open enrollment period for 2015 exchange coverage.[71]

Where selected SBE states were not able to provide data on transitions between Medicaid and exchange coverage, officials told us they were developing or improving the functionality to track those data.

- In Colorado, which was not tracking transitions in 2014, officials told us that tracking transitions was considered a high priority. Officials told us that, as of July 2015, the state had made changes to its IT system that would provide the functionality to track transitions and they anticipated being able to do so later that year.
- In New York, officials reported being in the process of developing the functionality to track transitions from Medicaid to exchange coverage, and, in July 2015, the officials told us that they had recently started tracking these transitions.
- In Washington, a state already tracking transitions, officials told us that, as of July 2015, they had a project underway to begin looking at the demographics of those transitioning, including age and gender.

Selected states and CMS could not provide data on the extent to which individuals are transitioning between Medicaid and exchange coverage in FFE states. Officials from all four of our selected FFE states told us that the state did not have access to exchange enrollment information, and therefore the state was not able to provide data on transitions between Medicaid and exchange coverage. Similarly, as of July 2015, CMS could not provide data on transitions between Medicaid and exchange coverage in FFE states. CMS officials told us that the FFE and state Medicaid IT

[70]For example, for 2015 coverage, open enrollment extended from November 15, 2014, to February 15, 2015.

[71]The data from Kentucky and Washington included transitions that occurred through the end of December 2014—a portion of the open enrollment period for 2015 exchange coverage. The data from New York did not include any of the transitions that may have occurred due to annual redeterminations.

systems are not integrated in a way that would allow for real-time tracking of transitions.[72] Additionally, though CMS has access to both exchange and Medicaid enrollment data for FFE states, officials told us that, as of July 2015, they could not use those data to determine the number of individuals transitioning retrospectively. Officials explained that, for example, there was no single, unique identifier for an individual between the data sets, making it difficult to match people between the two data sets. CMS officials told us that, as of May 2015, representatives from CMS as well as from the Office of the Assistant Secretary for Planning and Evaluation had been working for about a year on a methodology for examining transitions. Officials said these efforts have primarily focused on analyzing transitions in SBE states, but that the findings may inform how to perform such an analysis for FFE states.

At Least One Issuer Offered Both Coverage Types in Most States, but Many Individuals Transitioning May Not Stay with Their Issuer

Information from our selected states and CMS indicated that most states with Medicaid managed care had one or more Medicaid issuers that also offered coverage through the state's exchange. Seven out of our 8 selected states—all but Iowa—reported having at least 1 issuer offering both Medicaid and exchange coverage in the state in 2014, ranging from 2 to 13 issuers.[73] These results are consistent with an analysis completed by CMS that indicated, in the 40 states with Medicaid managed care, the majority—33—had 1 or more issuers offering both Medicaid and exchange coverage in 2014.[74] CMS did not identify any issuers offering both types of coverage in the remaining 7 states.

[72]These CMS officials noted that, when developing the FFE IT systems, it was not feasible to integrate them with state Medicaid IT systems in this way, in part because it would require ongoing FFE system changes to adjust to any relevant changes in the 34 FFE states' Medicaid policies and IT systems.

[73]Iowa had only one issuer that offered comprehensive, risk-based Medicaid managed care, and this issuer did not offer exchange plans. According to state officials, Medicaid managed care is relatively small in the state, with approximately 89 percent of Medicaid beneficiaries enrolled in fee-for-service as of January 2015. In addition, the state uses Medicaid funds as premium assistance to purchase exchange coverage for certain newly eligible Medicaid beneficiaries under a demonstration under section 1115 of the Social Security Act.

[74]CMS considered issuers owned by the same parent company to be equivalent for the purpose of matching issuers across Medicaid and exchange coverage.

However, information from our selected states also indicated that in some states, the majority of Medicaid and exchange enrollees may not be enrolled with issuers offering both types of coverage. In the 7 selected states with issuers offering both types of coverage, the issuers accounted for between 8 and 76 percent of Medicaid enrollment and 19 and 74 percent of exchange enrollment where data were available from states (see table 2). The proportion of Medicaid enrollees in plans offered by issuers that also offer exchange coverage is affected by the proportion of Medicaid enrollees who participate in managed care in the state, as enrollees in fee-for-service Medicaid would not be enrolled with an issuer. For example, in Colorado, which had a relatively low percentage of Medicaid enrollees in plans offered by issuers also offering exchange coverage, the majority, or about two-thirds, of Medicaid enrollees were in fee-for-service as of February 2015 according to state officials.

Table 2: Issuer Participation and Share of Exchange and Medicaid Enrollment in Selected States in 2014

State	Number of issuers offering coverage in the individual exchange	Number of issuers offering Medicaid managed care	Number of issuers offering both coverage types	Percent of exchange enrollees in a plan offered by an issuer that also offered Medicaid coverage	Percent of Medicaid enrollees in a plan offered by an issuer that also offered exchange coverage
Colorado	10	5	2	19	8
Kentucky[a]	3	5	2	22	18
Arizona[b]	8	8	4	Not available	32
Texas[c]	11	19	10	Not available	42
Utah	6	4	2	Not available	55
Washington	8	5	3	19	59
New York[d]	16	15	13	74	76
Iowa	4	1	0	Not applicable	Not applicable

Source: GAO analysis of state and Centers for Medicare & Medicaid Services data. I GAO-16-73

Notes: Managed care refers to comprehensive, risk-based managed care. Information on individual exchange coverage excludes standalone dental plans offered through the exchanges. Except where otherwise noted, enrollment data are as of between August and December 2014.

[a]Enrollment data from Kentucky reflect the number of individuals ever enrolled in Medicaid or exchange coverage, where applicable, in 2014. In addition, the Medicaid enrollment data from Kentucky include only those who enrolled in Medicaid through the state's exchange and were determined eligible using modified adjusted gross income.

[b]The information on issuer participation in Medicaid for Arizona excludes participation in the Arizona Long Term Care System, a managed care program for elderly individuals who are blind or disabled and in need of long term care.

[c]The Medicaid enrollment data from Texas exclude Medicaid enrollees receiving partial benefits such as women's health program services.

[d]The Medicaid enrollment data from New York include only those who enrolled in Medicaid through the state's exchange and were determined eligible using modified adjusted gross income.

Additionally, not all individuals enrolled with issuers offering both types of coverage would be able to remain with their issuer when transitioning, due to differences in issuers' service areas for their Medicaid and exchange coverage. For example, one of the two issuers that offered both types of coverage in Kentucky in 2014 offered Medicaid coverage statewide, but offered exchange coverage in just 15 of the 120 counties in the state, representing about 41 percent of the state's population. The other issuer offered exchange coverage statewide and Medicaid coverage in 111 counties, representing about 76 percent of the population. In 7 counties, representing about 5 percent of the population, neither of the issuers offered both Medicaid and exchange coverage.

A larger proportion of individuals may have the opportunity to remain with their issuer when transitioning between the coverage types in future years. In 2015, the total number of issuers offering both Medicaid and exchange coverage increased in 3 of our selected states.[75] In addition, information from selected states indicated that in some cases, issuers that already offered both Medicaid and exchange coverage in some counties within a state began to do so in additional counties in 2015. Evidence from selected issuers also suggests that a growing number of individuals may have the opportunity to remain with their issuer moving forward—for example, representatives from one issuer reported that the number of states in which the issuer offered both types of coverage grew from 3 states in 2014 to 16 states in 2015. Representatives from another issuer told us that, given the complexities of offering two new types of coverage, it had so far chosen not to offer exchange coverage in some states in which it was newly participating in Medicaid but anticipated beginning to offer exchange coverage in those states in future years.

While a growing number of individuals may have the opportunity to remain with their issuer when transitioning between the coverage types, the extent to which individuals will choose to do so will likely depend on a number of factors, including the following:

- **Desire to change plans.** Studies suggest that some individuals are likely to change plans—which may be offered by different issuers—

[75]In Kentucky and Washington, there was 1 additional issuer offering both, while in Arizona there were 2 additional issuers offering both. The total number of issuers offering both types of coverage remained constant in the remaining 5 selected states.

when provided the option to do so.[76] This change may be positive, such as in cases where the new plan better addresses the individual's health care needs.

- **Cost of exchange plans.** Individuals may be less likely to remain with their issuer when transitioning from Medicaid to the exchange if issuers offering both types of coverage are unable to offer competitive premiums for their exchange plans. Representatives from two selected issuers that offered both types of coverage reported that they had relatively low exchange market share in 2014 most likely because they were unable to offer competitive premiums, but said they were able to offer lower premiums in 2015 and have seen or expected to see increased enrollment.
- **Awareness of issuer participation in both types of coverage.** Individuals transitioning between coverage types may not be aware that their issuer also offers plans in the new coverage type. For example, in some states Medicaid managed care marketing restrictions may prohibit issuers from marketing their exchange plans to existing Medicaid enrollees.[77] For instance, representatives from one selected issuer reported piloting an outreach program in some states to inform Medicaid members whose coverage was terminating about the issuer's exchange plans, but noted that the issuer was not permitted to operate this program in at least one state. In addition, issuers may operate under different names in Medicaid and for their exchange coverage, which could make it difficult for individuals to identify whether their issuer operates in the new coverage type.
- **Auto-assignment in Medicaid managed care.** Many states with managed care auto-assign individuals to issuers either at the initial eligibility determination or if an individual does not select his or her

[76]For example, according to HHS, 29 percent of individuals who were enrolled in exchange coverage in 2014 and reenrolled for 2015 exchange coverage between November 2014 and February 2015, switched plans between the coverage years. See Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report* (Washington, D. C.: Mar. 10, 2015). According to another study, 7.5 percent of nonelderly individuals with employer-sponsored coverage switched plans for reasons other than a job change in 2010—generally because of a change in offered benefits. See National Institute for Health Care Reform, *Few Americans Switch Employer Health Plans for Better Quality, Lower Costs* (Washington, D.C.: 2013).

[77]Federal regulations allow issuers to provide information to enrollees about exchange plans they may enroll in if permitted by the state.

own plan within a certain time period.[78] While such individuals may have the opportunity to change their Medicaid issuer after auto-assignment, they may choose not to do so or may not be aware of this ability, which may affect their likelihood of remaining with their issuer when transitioning from exchange coverage.

Finally, for individuals transitioning between Medicaid and exchange coverage, the benefits of remaining with the same issuer for continuity of care are uncertain. Representatives of some selected issuers reported that covered benefits, cost-sharing, and drug formularies for their Medicaid and exchange plans differed to some extent due in part to differences in state and federal requirements for Medicaid and exchange coverage, with Medicaid requiring coverage of additional services and lower cost-sharing as compared to exchange coverage.[79] These differences will likely persist regardless of whether individuals remain with the same issuer. However, officials from some selected states told us that remaining with the same issuer when transitioning may allow individuals to keep their health care providers, which could lead to improved continuity of care. There is some evidence to suggest that certain issuers offering both Medicaid and exchange coverage offer similar provider networks. Specifically, representatives of three selected issuers that traditionally offered Medicaid coverage reported leveraging their existing Medicaid provider networks when expanding to the exchange, and two of the issuers noted that most providers elected to participate. At the same time, some officials told us that provider networks for issuers offering both

[78]States may use different methodologies for auto-assignment and may take into account factors such as individuals' provider relationships, enrollment of family members, and the distribution of Medicaid enrollment among issuers. In May 2015, CMS issued a proposed rule that, if finalized, would modify requirements for auto-assignment in managed care enrollment processes. For example, under this proposed rule, states would be required to provide at least a 14-day period for enrollees to actively select their managed care issuer prior to auto-assignment going into effect.

[79]For example, while both Medicaid and exchange plans must cover certain basic benefits, such as hospital and laboratory services, Medicaid mandates coverage of certain additional services that exchange plans are not required to cover, such as Early and Periodic Screening, Diagnostic, and Treatment services for children, and transportation to medical appointments. In addition, federal Medicaid regulations limit cost-sharing to nominal amounts—in fiscal year 2013, the maximum nominal copayment for enrollees in Medicaid managed care was $4. However, according to one study, the average copayment for primary care office visits in calendar year 2015 ranged from $14 to $23 for individuals receiving cost-sharing reductions in the 34 FFE states as well as the 3 SBE states using the FFE IT systems. See G. Claxton and N. Panchal, *Cost-Sharing Subsidies in Federal Marketplace Plans* (Menlo Park, Calif.: Kaiser Family Foundation, 2015).

types of coverage could differ. Whether individuals transitioning between the coverage types are able to keep their providers may depend in part on the specific exchange plan they choose, as issuers often offer multiple plan options on the exchange, some of which may have more similar provider networks to Medicaid than others.

Conclusions

Through the creation of subsidized exchange coverage and the state option to expand Medicaid eligibility under PPACA, many low-income individuals have a new pathway to maintain health coverage despite changes in income or other factors. Federal and state Medicaid and exchange policies and procedures influence the extent to which individuals are able to seamlessly transition between coverage types, including whether they are able to transition without a gap in coverage and whether they end up enrolled in both Medicaid and subsidized exchange coverage for extended periods of time. To the extent coverage gaps and duplicate coverage occur, individuals may decide to forgo needed care or may unnecessarily be paying any remaining share of exchange premiums after APTC when they should only be enrolled in Medicaid. Additionally, duplicate coverage could mean that the federal government is paying for both Medicaid and subsidized exchange coverage for some individuals.

SBE states are better positioned to minimize the potential for coverage gaps and duplicate coverage to the extent they are able to share enrollment data across Medicaid and the exchange as well as build controls into their IT systems to prevent duplicate coverage. For FFE states as well as SBE states using the FFE IT systems, CMS implemented several policies and procedures and has additional controls planned that represent positive steps towards minimizing coverage gaps and duplicate coverage. However, as per federal internal control standards, those plans do not sufficiently address the risks. In particular, CMS does not currently track and has no plans to track the timeliness of account transfers from states, which could increase the potential that individuals transitioning from Medicaid to the exchange will experience coverage gaps. Additionally, CMS has not determined the frequency of its planned checks for duplicate coverage, a factor that will be critical to their effectiveness, and does not have a plan—including target levels of duplicate coverage the agency deems acceptable—for monitoring the checks and other procedures. Despite the addition of the checks, vulnerabilities related to preventing duplicate coverage are likely to persist, as, for example, the automated check for Medicaid during eligibility determinations for subsidized coverage will continue to have

limitations. Thus, given the potential financial implications of duplicate coverage and if the checks identify that it is occurring at a significant rate, additional steps could protect the federal government and individuals from unnecessary and duplicative expenditures.

Our findings indicate that a relatively small proportion of Medicaid and exchange enrollees may be transitioning between coverage types, and thus the incidence of coverage gaps and duplicate coverage could be limited. However, to the extent that transitions increase in the future—particularly if exchange enrollment continues to grow and if additional states expand Medicaid—improvements to CMS controls to minimize coverage gaps and duplicate coverage for these individuals will be increasingly important.

Recommendations for Executive Action

To better minimize the risk of coverage gaps and duplicate coverage for individuals transitioning between Medicaid and the exchange in FFE states, we recommend that the Administrator of CMS take the following three actions:

1. Routinely monitor the timeliness of account transfers from state Medicaid programs to CMS and identify alternative procedures if near real time transfers are not feasible in a state.
2. Establish a schedule for regular checks for duplicate coverage and ensure that the checks are carried out according to schedule.
3. Develop a plan, including thresholds for the level of duplicate coverage it deems acceptable, to routinely monitor the effectiveness of the checks and other planned procedures to prevent and detect duplicate coverage, and take additional actions as appropriate.

Agency Comments

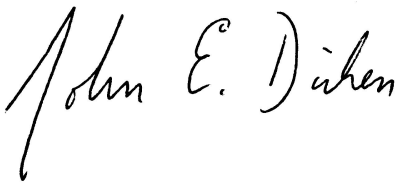
We provided a draft of this report to HHS and IRS for comment. In its written comments—reproduced in appendix II—HHS concurred with our recommendations. With regard to our first recommendation, HHS commented that HHS monitors and reviews account transfers through standard weekly reporting and that, if there are concerns with the frequency of transfers, HHS resolves any issues with the states. However, knowing the frequency of account transfers—that is, how often the state is sending them electronically to HHS—may not provide enough information without HHS also having information on the timeliness of states' transfers—that is, the amount of time it takes the state to transfer an individual's account after making a determination that the individual is

no longer eligible for Medicaid. Thus, HHS using its weekly reporting process has the potential to meet our recommendation if the process monitors not only the frequency of transfers but also the timeliness of transfers. With regard to our other recommendations, HHS stated that its first check for duplicate coverage was underway in August 2015, and that HHS will analyze the rate of duplicate coverage identified and gather input from states on the level of effort needed to conduct the check in order to establish the frequency of checks going forward. HHS also stated that it will monitor the rate of duplicate coverage identified in periodic checks. Finally, HHS stated that it is working to implement additional internal controls to reduce duplicate coverage, including automatically ending subsidized exchange coverage for individuals also found to have been determined eligible for Medicaid or CHIP who have not ended this coverage themselves. HHS also provided technical comments, which we incorporated as appropriate. IRS had no comments on the draft report.

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 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 Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov or John E. Dicken at (202) 512-7114 or dickenj@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 III.

Carolyn L. Yocom
Director, Health Care



John E. Dicken
Director, Health Care

Appendix I: Information on States Selected for Our Review

State	Exchange type[a]	Total Medicaid enrollment[b]	Percent of national Medicaid enrollment[c]	Total individual exchange enrollment[d]	Percent of national individual exchange enrollment[d]
States that expanded Medicaid[e]					
Arizona	Federally facilitated	**1,475, 310**	2.7%	**120,071**	1.5%
Colorado	State-based	**976,972**	1.8	**125,402**	1.6
Iowa	Federally facilitated	**523,281**	1.0	**29,163**	0.4
Kentucky	State-based	**1,060,566**	2.0	**82,747**	1.0
New York	State-based	**5,672,421**	10.5	**370,451**	4.6
Washington[f]	State-based	**1,545,269**	2.9	**163,207**	2.0
States that did not expand Medicaid[e]					
Texas	Federally facilitated	**3,965,101**	7.3	**733,757**	9.1
Utah	Federally facilitated	**296,528**	0.5	**84,601**	1.1
Total for states that expanded and did not expand Medicaid		**15,515,448**	**28.7**	**1,709,399**	**21.3**

Source: GAO analysis of Department of Health and Human Services data. I GAO-16-73

[a]Refers to the state's individual exchange type for coverage year 2014.

[b]Refers to Medicaid enrollment as of March 2014.

[c]To calculate these percentages, we used total Medicaid enrollment counts reported by states to the Department of Health and Human Services as of March 2014. These data were not available for three states—California, the District of Columbia, and North Dakota. With the exception of these states, total national Medicaid enrollment as of March 2014 was 54,055,856. With the addition of these states' enrollment data, the percentages in this column would be smaller.

[d]Except where otherwise noted, refers to the number of individuals who selected an individual exchange plan during the initial open enrollment period between October 1, 2013, and March 31, 2014, as well as reported special enrollment period activity through April 19, 2014. Data are as of May 1, 2014. Total national individual exchange enrollment—in other words, the total number of individuals who selected an individual exchange plan during this time period—was 8,019,763.

[e]Data are as of March 2014.

[f]The individual exchange enrollment data for Washington include only the number of individuals who selected a plan and paid for coverage.

Appendix II: 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

SEP 0 4 2015

Carolyn Yocom
Director, Health Care Team
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid and Insurance Exchanges: Additional Federal Controls Needed to Minimize Potential for Gaps and Duplication in Coverage*" (GAO-15-728).

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

Sincerely,

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 DRAFT REPORT ENTITLED: MEDICAID AND INSURANCE EXCHANGES: ADDITIONAL FEDERAL CONTROLS NEEDED TO MINIMIZE POTENTIAL FOR GAPS AND DUPLICATION IN COVERAGE (GAO-15-728)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS is committed to reducing coverage gaps and duplication of coverage between the Medicaid program and the Marketplaces. As GAO notes in their draft report, a small number of individuals are transitioning between Medicaid and subsidized Marketplace coverage and thus the incidence of coverage gaps and duplicate coverage could be limited.

Both the Medicaid program and the Marketplaces play a critical role in achieving one of the Affordable Care Act's (ACA) core goals: reducing the number of uninsured Americans by providing affordable, high-quality health coverage. Since Medicaid expansion has taken effect, Medicaid enrollment has grown from 57.8 million enrollees (July-September 2013) to 70.0 million enrollees in January 2015, which represents a 19.3 percent growth in enrollment. In addition to the growth of Medicaid, about 11.7 million Americans selected plans or were automatically re-enrolled in coverage through the Marketplaces during Open Enrollment for 2015. As of March 31, 2015, about 10.2 million consumers had "effectuated" coverage which means those individuals paid for Marketplace coverage and still had an active policy on that date.

HHS has implemented various internal controls to reduce coverage gaps as well as duplicate coverage. The Marketplaces have a multi-layer verification process for applications, including checking applicants' enrollment in non-employer sponsored Minimum Essential Coverage (non-ESC MEC) in real-time using the Data Services Hub's trusted data sources. This real-time verification process includes checking the applicant's enrollment in Medicaid or CHIP with state Medicaid or CHIP agencies. Additionally, applicants who attest to having Medicaid or CHIP that qualifies as minimum essential coverage on their application are denied advance payments of premium tax credits (APTC) and Cost Sharing Reductions (CSR). Those who do not provide such an attestation but are found to be enrolled in Medicaid or CHIP through the verification process are flagged as having a data matching issue, which the applicant must resolve by providing supporting documentation in order to maintain their APTC/CSR eligibility. The Marketplace will end any APTC or CSR after 90 days if the consumer does not provide sufficient documentation proving that they do not have Medicaid or CHIP coverage. As a result, this verification helps to prevent duplicate coverage in Medicaid or CHIP and subsidized coverage through the Marketplace.

In addition, consumers completing the application attest under penalty of perjury that the information provided is correct. Knowingly and willfully providing false information is a violation of federal law and can be subject to up to a $250,000 fine.

For the small number of consumers transitioning to Medicaid or CHIP after being enrolled in Marketplace coverage, HHS advises consumers that they should end their Marketplace coverage with APTC/CSR to help avoid any associated tax liability. HHS includes language on this topic in the consumer attestation language of the Marketplace application in the eligibility determination notice, and provides detailed instructions on HealthCare.gov on ending Marketplace coverage with APTC/CSR when consumers are covered through Medicaid or CHIP. A consumer enrolled in Marketplace coverage with APTC/CSR who becomes eligible for

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Medicaid may choose to remain enrolled in Marketplace coverage, but no longer will be eligible for APTC/CSR to help pay for that coverage or for covered services.

Enrollees who stopped paying their premiums because they transitioned to Medicaid or CHIP and, and subsequently were terminated from coverage by their QHP issuers, are still responsible for APTC paid to the issuers for the first month of a three-consecutive-month grace period given to QHP enrollees who are receiving APTC. Any APTC paid to enrollees' issuers for the second and third months of three-consecutive-month grace periods must be returned by the issuers if the enrollees are terminated for non-payment of premium. Once a month, issuers restate/update their prior month enrollment counts for a number of events including retroactive enrollments, terminations, special enrollment periods, and grace periods. HHS uses the re-statement process to recoup any APTC provided to issuers for individuals whose enrollment in coverage through the Marketplace was terminated using the re-statement process.

Lastly the IRS, through the tax filing process, will reconcile the difference between the APTC paid to the Marketplace issuer on the tax filer's behalf and the actual amount of the premium tax credit that the tax filer is entitled to claim for the enrollee. Subject to statutory limits, tax filers are required to repay excess APTC. If consumers do not end their Marketplace coverage with APTC once determined eligible for Medicaid or CHIP, the tax filers will likely have to pay back all or some of the APTC received for a Marketplace plan during the months the consumers were eligible for Medicaid or CHIP—with liability starting the first of the month following the Medicaid or CHIP eligibility determination.

HHS is addressing additional issues related to coverage gaps and duplicate coverage, and taking steps to address and help prevent such occurrences. HHS is currently collecting data from state Medicaid and CHIP agencies through periodic data matching, which allows HHS to identify consumers who are enrolled in Marketplace coverage with APTC or CSRs *and* Medicaid or CHIP, and conduct outreach/notification to them, regarding ending their Marketplace coverage with APTC/CSR. HHS is also working to implement additional internal controls to reduce duplicate coverage including automatically ending Marketplace coverage with APTC or CSRs for consumers who are found also to have been determined eligible for Medicaid or CHIP, who do not end their Marketplace coverage with financial assistance themselves. HHS is also considering the frequency at which periodic checks for Medicaid and CHIP enrollment will be conducted.

GAO Recommendation

GAO recommends that the Administrator of the Centers for Medicare & Medicaid Services (CMS) routinely monitor the timeliness of account transfers from state Medicaid programs to HHS and identify alternative procedures if near real-time transfers are not feasible in a state.

HHS Response

HHS concurs with GAO's recommendation. To minimize gaps in coverage, the ACA required the establishment of a coordinated eligibility and enrollment process for Medicaid and the Marketplaces. In states served by an FFM, HHS employs an account transfer process that electronically transfers an individual's account between the FFM and the state Medicaid agency, where applicable. A majority of account transfers are occurring on a daily basis and HHS monitors and reviews account transfers through standard weekly reporting. If there are concerns with the frequency of the account transfers, HHS works with states to resolve any issues.

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GAO Recommendation
GAO recommends that the Administrator of CMS establish a schedule for regular checks for duplicate coverage and ensure that the checks are carried out according to schedule.

HHS Response
HHS concurs with this recommendation. As mentioned above, HHS is currently collecting data from state Medicaid/CHIP agencies through periodic data matching, which will help identify consumers who are enrolled in both Marketplace coverage with APTC or CSRs and Medicaid or CHIP. After the first phase of periodic data matching is complete in August/September 2015, HHS will analyze the rate of duplicate coverage and gather input from states on the level of effort needed to conduct the check in order to establish the frequency of checks.

GAO Recommendation
GAO recommends that the Administrator of CMS develop a plan, including thresholds for the level of duplicate coverage it deems acceptable, to routinely monitor the effectiveness of the checks and other planned procedures to prevent and detect duplicate coverage, and take additional actions as appropriate.

HHS Response
HHS concurs with this recommendation. HHS plans to analyze and monitor the rate of duplicate coverage identified in the periodic checks as the data become available and gather input from states on the level of effort needed to conduct the check in order to establish the frequency of checks. HHS is also working to implement additional internal controls to reduce duplicate coverage including automatically ending Marketplace coverage with APTC or CSRs for consumers who are also found to have been determined eligible for Medicaid or CHIP, who do not end their Marketplace coverage with financial assistance themselves.

3

Appendix III: GAO Contacts and Staff Acknowledgments

GAO Contacts

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov
John E. Dicken, (202) 512-7114 or dickenj@gao.gov

Staff Acknowledgments

In addition to the contacts named above, Susan Barnidge, Assistant Director; Priyanka Sethi Bansal; Keith Haddock; Laurie Pachter; Vikki Porter; Rachel Svoboda; and Emily Wilson made key contributions to this report.

Appendix IV: Accessible Data

Agency Comment Letter

Text of Appendix II: Comments from the Department of Health and Human Services

Page 1

Carolyn Yocom

Director, Health Care Team

U.S. Government Accountability Office 441 G Street NW

Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicaid and Insurance Exchanges: Additional Federal Controls Needed to Minimize Potential for Gaps and Duplication in Coverage" (GA0-15-728).

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

Sincerely,

Jim R. Esquea

Assistant Secretary for Legislation

Attachment

Page 2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (H HS> ON THE GOVERNMENT ACCOU NTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID AND INSURANCE EXCHANGES: ADDITIONAL FEDERAL CONTROLS

NEEDED TO MINIMIZE POTENTIAL FOR GAPS AND DUPLICATION IN COVERAGE (GA0-15-728)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS is committed to reducing coverage gaps and duplication of coverage between the Medicaid program and the Marketplaces. As GAO notes in their draft report, a small number of individuals are transitioning between Medicaid and subsidized Marketplace coverage and thus the incidence of coverage gaps and duplicate coverage could be limited.

Both the Medicaid program and the Marketplaces play a critical role in achieving one of the Affordable Care Act's (ACA) core goals: reducing the number of uninsured Americans by providing affordable, high-quality health coverage. Since Medicaid expansion has taken effect, Medicaid enrollment has grown from 57.8 million enrollees (July-September 2013) to 70.0 million enrollees in January 201 5, which represents a 19.3 percent growth in enrollment. In addition to the growth of Medicaid, about 1 1 .7 million Americans selected plans or were automatically re-enrolled in coverage through the Marketplaces during Open Enrollment for 2015. As of March 31, 2015, about 10.2 million consumers had "effectuated" coverage which means those individuals paid for Marketplace coverage and still had an active policy on that date.

HHS has implemented various internal controls to reduce coverage gaps as well as duplicate coverage. The Marketplaces have a multi-layer verification process for applications, including checking applicants' enrollment in non-employer sponsored Minimum Essential Coverage (non- ESC MEC) in real-time using the Data Services Hub's trusted data sources. This real-time verification process includes checking the applicant's enrollment in Medicaid or CHIP with state Medicaid or CHIP agencies. Additionally, applicants who attest to having Medicaid or CHIP that qualifies as minimum essential coverage on their application are denied advance payments of premium tax credits (APTC) and Cost Sharing Reductions (CSR). Those who do not provide such an attestation but are found to be enrolled in Medicaid or CHIP through the verification process are flagged as having a data matching issue, which the applicant must resolve by providing supporting documentation in order to maintain their APTC/CSR eligibility. The Marketplace will end any APTC or CSR after 90 days if the consumer does not provide sufficient documentation proving that they do not have Medicaid or CHIP coverage.

As a result, this verification helps to prevent duplicate coverage in Medicaid or CHIP and subsidized coverage through the Marketplace.

In addition, consumers completing the application attest under penalty of perjury that the information provided is correct. Knowingly and willfully providing false information is a violation of federal law and can be subject to up to a $250,000 fine.

For the small number of consumers transitioning to Medicaid or CHIP after being enrolled in Marketplace coverage, HHS advises consumers that they should end their Marketplace coverage with APTC/CSR to help avoid any associated tax liability. HHS includes language on this topic in the consumer attestation language of the Marketplace application in the eligibility determination notice, and provides detailed instructions on HealthCare.gov on ending Marketplace coverage with APTC/CSR when consumers are covered through Medicaid or CHIP. A consumer enrolled in Marketplace coverage with APTC/CSR who becomes eligible for

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Medicaid may choose to remain enrolled in Marketplace coverage, but no longer will be eligible for APTC/CSR to help pay for that coverage or for covered services.

Enrollees who stopped paying their premiums because they transitioned to Medicaid or CHIP and, and subsequently were terminated from coverage by their QHP issuers, are still responsible for APTC paid to the issuers for the first month of a three-consecutive-month grace period given to QHP enrollees who are receiving APTC. Any APTC paid to enrollees' issuers for the second and third months of three-consecutive-month grace periods must be returned by the issuers if the enrollees are terminated for non-payment of premium. Once a month, issuers restate/update their prior month enrollment counts for a number of events including retroactive enrollments, terminations, special enrollment periods, and grace periods. HHS uses the re-statement process to recoup any APTC provided to issuers for individuals whose enrollment in coverage through the Marketplace was terminated using the re-statement process.

Lastly the IRS, through the tax filing process, will reconcile the difference between the APTC paid to the Marketplace issuer on the tax filer's behalf and the actual amount of the premium tax credit that the tax filer is entitled to claim for the enrollee. Subject to statutory limits, tax filers are required to repay excess APTC. If consumers do not end their Marketplace coverage with APTC once determined eligible for Medicaid

or CHIP, the tax filers will likely have to pay back all or some of the APTC received for a Marketplace plan during the months the consumers were eligible for Medicaid or CHIP-with liability starting the first of the month following the Medicaid or CHIP eligibility determination.

HHS is addressing additional issues related to coverage gaps and duplicate coverage, and taking steps to address and help prevent such occurrences. HHS is currently collecting data from state Medicaid and CHIP agencies through periodic data matching, which allows HHS to identify consumers who are enrolled in Marketplace coverage with APTC or CSRs and Medicaid or CHIP, and conduct outreach/notification to them, regarding ending their Marketplace coverage with APTC/CSR . HHS is also working to implement additional internal controls to reduce duplicate coverage including automatically ending Marketplace coverage with APTC or CSRs for consumers who are found also to have been determined eligible for Medicaid or CHIP, who do not end their Marketplace coverage with financial assistance themselves. HHS is also considering the frequency at which periodic checks for Medicaid and CHIP enrollment will be conducted.

GAO Recommendation

GAO recommends that the Administrator of the Centers for Medicare & Medicaid Services (CMS) routinely monitor the timeliness of account transfers from state Medicaid programs to HHS and identify alternative procedures if near real-time transfers are not feasible in a state.

HHS Response

HHS concurs with GAO's recommendation. To minimize gaps in coverage, the ACA required the establishment of a coordinated eligibility and enrollment process for Medicaid and the Marketplaces. In states served by an FFM, HHS employs an account transfer process that electronical y transfers an individual's account between the FFM and the state Medicaid agency, where applicable. A majority of account transfers are occurring on a daily basis and HHS monitors and reviews account transfers through standard weekly reporting. If there are concerns with the frequency of the account transfers, HHS works with states to resolve any issues.

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GAO Recommendation

GAO recommends that the Administrator of CMS establish a schedule for regular checks for duplicate coverage and ensure that the checks are carried out according to schedule.

HHS Response

HHS concurs with this recommendation. As mentioned above, HHS is currently collecting data from state Medicaid/CHIP agencies through periodic data matching, which will help identify consumers who are enrolled in both Marketplace coverage with APTC or CSRs and Medicaid or CHIP. After the first phase of periodic data matching is complete in August/September 2015, HHS will analyze the rate of duplicate coverage and gather input from states on the level of effort needed to conduct the check in order to establish the frequency of checks.

GAO Recommendation

GAO recommends that the Administrator of CMS develop a plan, including thresholds for the level of duplicate coverage it deems acceptable, to routinel y monitor the effectiveness of the checks and other planned procedures to prevent and detect duplicate coverage, and take additional actions as appropriate.

HHS Response

HHS concurs with this recommendation. HHS plans to analyze and monitor the rate of duplicate coverage identified in the periodic checks as the data become available and gather input from states on the level of effort needed to conduct the check in order to establish the frequency of checks.

HHS is also working to implement additional internal controls to reduce duplicate coverage including automatically ending Marketplace coverage with APTC or CSRs for consumers who are also found to have been determined eligible for Medicaid or CHIP, who do not end their Marketplace coverage with financial assistance themselves.

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