Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medical Insurance For Dependents Receiving Child Support

JUNE GIBBS BROWN
Inspector General

JUNE 2000
OEI-07-97-00500

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG) mandated by Public Law 95-452, as amended by Public Law 100-504, is to protect the integrity of the Department of Health and Human Services programs as well as the health and welfare of beneficiaries served by them. This statutory mission is carried out through a nationwide program of audits, investigations, inspections, sanctions, and fraud alerts. The Inspector General informs the Secretary of program and management problems and recommends legislative, regulatory, and operational approaches to correct them.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) is one of several components of the Office of Inspector General. It conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The inspection reports provide findings and recommendations on the efficiency, vulnerability, and effectiveness of departmental programs.

OEI's Kansas City Office prepared this report under the direction of James H. Wolf, Regional Inspector General and Brian Pattison, Deputy Regional Inspector General. Principal OEI staff included:

REGION

Ray Balandron, *Project Leader*
Hugh Owens, *Program Analyst*
Perry Seaton, *Program Analyst*
Dennis Tharp, *Program Analyst*
Michael Barrett, *Program Analyst*
Mike Craig, *Program Analyst*

HEADQUARTERS

Linda Hall, *Program Specialist*
Susan Burbach, *Program Specialist*
Barbara Tedesco, *Mathematical Statistician*
Scott Horning, *Program Analyst*

To obtain copies of this report, please call the Kansas City Regional Office at (816) 426-3697.
Reports are also available on the World Wide Web at our home page address:

http://www.dhhs.gov/progorg/oei

EXECUTIVE SUMMARY

PURPOSE

To determine if State Child Support Enforcement (CSE) agencies have made progress in the detection of available dependent health insurance.

BACKGROUND

Between 1980 and 1998, numerous legislative and regulatory changes have been made governing identification and enforcement of medical support as it relates to court or administrative child support orders. Some of the changes that have taken place include: requiring child support agencies to collect medical support information; requiring that a health care provision is in all child support orders; and ensuring that the noncustodial parent obtain medical insurance if available at a reasonable cost. This means, in some cases, that the child support agency must send notice to an employer to enroll the child in its health care plan, and notify the State Medicaid agency of the existence and specifics of medical coverage. Also, there is currently a National Medical Support Notice being developed that will be used by States as a withholding mechanism to enforce the health care coverage provisions in the child support order.

This inspection is an update on two previous Office of Evaluation and Inspections' studies entitled, "Child Support Enforcement/Absent Parent Medical Liability" and "Coordination of Third Party Liability Information Between Child Support Enforcement and Medicaid." In this study we sampled 360 court ordered cases from nine States covering the period of July-September 1997 and projected our results nationally. We reviewed court orders and case files, and interviewed various State CSE, Medicaid, employer, and insurance company staff to determine availability of dependent health insurance and any improper payments made by the Medicaid program.

FINDINGS

Considerable Progress Has Been Made in the Identification and Enforcement of Medical Support

We estimated that 93 percent of the child support orders in our study included a provision requiring medical coverage for the dependent children. This compares to 24 percent in our previous study. Since our last study, we also determined that potential savings dropped dramatically. Previously we found 48 percent of the cases reviewed had undetected health insurance available to the dependents with projected potential savings to Medicaid of over $32 million. Currently, we found 30 percent of the child support cases with undetected health insurance available. We estimated potential fee-for-service savings of just under $3 million and Medicaid managed care premiums of $2.3 million made on behalf of children whose noncustodial parents had employer based insurance, but had not enrolled their children. This projected annual loss for all States of

$5.2 million is a significant reduction when compared to the loss of $32 million Medicaid paid out in fee-for-service payments 10 years ago.

However, Weaknesses Still Exist in the Detection of Health Insurance Availability and Enrolling Dependents

We found child support agencies deficient in pursuing health insurance availability in 126 cases out of 247 that had noncustodial employer information in the file. We contacted the employers for 115 of these cases and determined that dependent health care coverage was available to the noncustodial parents in 36 percent of the cases. In this regard, child support staff indicated that they do make limited efforts to gather employment and health insurance information. However, they strongly believe that their primary efforts should be spent in retrieving cash support payments.

Managed Care Premiums Present a New Challenge in the Enforcement of Medical Support for Child Support Children

With managed care becoming a major means of coverage for Medicaid-eligible children's medical care, new issues have arisen regarding the ability of States to coordinate their managed care benefits with the employer based insurance of the noncustodial parents. One possibility would be to collect either all or part of the State Medicaid monthly premiums from the noncustodial parent. However, it was beyond the scope of this study to determine the processes needed to do so. We understand that there are various types of contracts established between the State Medicaid agencies and the different managed care organizations. These contracts include such requirements as disenrolling the children from the managed care plan when private insurance is available, keeping the children enrolled in Medicaid managed care regardless of the existence of private insurance, or reducing the premium by a specific amount when there is private insurance available. We believe to fully address this issue, additional study is required.

RECOMMENDATIONS

The Administration for Children and Families Should Ensure That State Child Support Agencies Comply with Current Regulations Requiring Them to Fully Enforce Medical Support

The Administration for Children and Families (ACF) should ensure that State child support agencies are persistent in following through to determine if health insurance is available to the noncustodial parent and his/her dependents. This should include cases where the child is enrolled in Medicaid managed care programs or could be enrolled in an employer based managed care program. However, these situations may require new approaches discussed in the next recommendation.

The Administration for Children and Families, in Conjunction With The Health Care Financing Administration, Should Examine Alternatives to Recover The Costs of Managed Care Premiums From The Noncustodial Parents

The ACF, in conjunction with the Health Care Financing Administration (HCFA), should examine alternatives to address the loss of State/Federal funds for children enrolled in Medicaid managed care. We realize there are various State practices regarding coordination of benefits whenever children are enrolled in a Medicaid managed care plan. Depending on the unique State practices, they could consider the option of requiring the noncustodial parent to enroll the child in private coverage or pay toward the Medicaid managed care coverage. The following could be considered.

- If insurance is available at a reasonable cost to a noncustodial parent but he/she prefers not to enroll in it or to enroll himself/herself only and not the children, he/she could have the option of paying the State Medicaid managed care premium.

- If insurance is not available at a reasonable cost to a noncustodial parent and there is no employer based health plan, he/she could have the option of paying the State Medicaid managed care premium.

- If insurance is available at a reasonable cost to a noncustodial parent and the parent and child are enrolled in it, the Medicaid managed care coverage, unless discontinued, could be assessed as a secondary payer to the noncustodial parent's insurance.

We realize that the actual implementation and administration of such a policy would entail addressing many factors such as cost-efficiency, identification and enforcement, billing and collection of the managed care premium, and need for legislative changes.

AGENCY COMMENTS

In their comments, the Administration for Children and Families expressed their commitment to working with the Health Care Financing Administration and the States to improve access to medical coverage for children. In addition, they described various efforts and initiatives being undertaken that will further strengthen medical child support.

The ACF also noted that the Medical Child Support Working Group will be issuing recommendations to improve medical support and coordination between child support agencies and Medicaid. We are aware of the working group's upcoming report to Congress and have provided information to them on our prior and present efforts on these topics.

While recommendations in the draft report were not directed to HCFA, they did provide comments. The HCFA indicated that they will continue to work with ACF to assure every effort is made to identify parents who can provide or contribute to the coverage of

health insurance for their children and to see that Medicaid dollars are spent appropriately.

Where appropriate, we made revisions to the report to address various technical comments offered by ACF and HCFA. The full text of their comments are included in Appendix E.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

To determine if State Child Support Enforcement (CSE) agencies have made progress in the detection of available dependent health insurance.

BACKGROUND

CSE Legislation and Regulations

For some time, policy makers have expressed concern about the responsibility of noncustodial parents to provide medical support for their dependent children. Various laws have been passed requiring court ordered decrees to include medical support by the noncustodial parent, and establishing mechanisms for their enforcement.

The Social Security Act requires that the Medicaid program pay for beneficiary medical services secondary to other health insurance that may exist for beneficiaries, e.g., private health insurance or an employer group health plan. This provision also pertains to dependents of noncustodial parents for whom a court or administrative order exists that requires them to provide medical insurance.

Federal regulations published in February 1980 implemented Section 1912 of Title XIX of the Social Security Act. These regulations promoted cooperative agreements between State child support and Medicaid agencies to obtain information about medical insurance where it is available in an effort to reduce or eliminate Medicaid payments. However, under the Child Support Enforcement provisions of Title IV D, States received a higher percentage of Federal funding for collections of child support payments than for enforcement of medical support under the Medicaid program. This could provide an incentive for States to use available resources to collect child support payments since this effort produces a higher rate of return than the identification of noncustodial parents' private health insurance.

Congress passed the 1984 Child Support Enforcement amendments (P.L. 98-378), adding Section 452(f), to the Social Security Act. This section required the Secretary of Health and Human Services (HHS) to issue regulations requiring State child support agencies to gather specified medical support information in all child support cases involving Medicaid-eligible children in the Aid to Families with Dependent Children program, and to take steps to enforce medical support ordered by the court.

In response to these amendments, the Secretary issued Federal regulations in October 1985 requiring State Child Support Enforcement agencies to collect 1) the policy name(s) and number(s) of any health insurance available to the noncustodial parent, and 2) the names of persons covered if the noncustodial parent has available health insurance. Child support agencies are also required to submit medical support information obtained to the

State Medicaid agency for use in coordinating benefits. The 1985 regulations allowed for manual or automated exchange of third-party liability information from State child support agencies to Medicaid, but required them to provide it as specified in the State Plan, in a timely manner, and by the most efficient and cost-effective means available. They are also required to inform the Medicaid agency of any new or modified orders that include medical support.

In addition, these regulations require State Child Support Enforcement agencies to seek the inclusion of medical support in all court and administrative orders, whether or not health insurance is available to the noncustodial parent at a "reasonable cost" at the time the order is entered or modified. State child support agencies must also make every effort possible to ensure that the noncustodial parent obtains the required medical insurance, if it is available at a reasonable cost, and enrolls the children. The regulations define "health insurance to be reasonable in cost if it is employment-related or other group health insurance, regardless of service delivery mechanism."

Revised Federal regulations published in 1988 expanded these requirements to include modification of existing court or administrative orders for the sole purpose of obtaining medical support. This expansion required State child support agencies to:

- develop written criteria to identify cases with a high potential for obtaining medical support;

- petition the court or administrative authority to modify support orders to include medical support for targeted cases, even if they anticipate no other modification; and

- petition the court or administrative authority to include medical support in all child support orders, even if health insurance coverage is unavailable at the time of the order, thus enabling the child support agency to enforce it if coverage should become available in the future without returning to court to obtain a new order.

The Omnibus Budget Reconciliation Act of 1993 (OBRA), P.L. 103-66, contained provisions intended to remove some of the impediments to State child support agencies' attempts to secure and enforce medical coverage. OBRA contained many improvements that facilitated obtaining and enforcing medial coverage, including: prohibiting discriminatory health care coverage practices; creating "qualified medical child support orders" to obtain coverage from group health plans subject to the Employer Retirement Income Security Act of 1974 (ERISA); and allowing employers to deduct the costs of health insurance premiums from the noncustodial parents' income.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), P.L. 104-193, requires that all child support orders enforced under the Act specifically include a provision for health care coverage. Child support agency staff carry out the orders by determining employment of the noncustodial parent and insurance availability for dependent coverage. If the noncustodial parent changes jobs and the new

employer provides health care coverage, the State sends notice of required coverage to the new employer. This will require them to enroll the child(ren) in its group health plan.

More recently, Congress followed PRWORA with the Child Support Performance and Incentive Act of 1998, which stipulated that the Secretary, in consultation with State Child Support Directors, develop a measure based on the effectiveness of States in establishing and enforcing medical support obligations and to make recommendations for incorporating the measure, in a revenue neutral manner, into the current incentive payment system established by section 458A of the Social Security Act, which is based on cash support collections.

The Child Support Performance and Incentive Act of 1998 also required the Secretaries of HHS and Department of Labor to jointly establish a Medical Child Support Working Group, and to develop and promulgate by regulation a National Medical Support Notice. Such Notice will make it possible to readily enforce enrollment of children in ERISA medical insurance plans without obtaining a new qualified medical child support order. This will permit more effective enforcement of OBRA health care coverage provisions in compliance with the child support order.

Previous OIG Reports

A 1987 Office of Inspector General report entitled "Child Support Enforcement/Absent Parent Medical Liability"[1] revealed that 60 percent of the noncustodial parents in the sampled cases had dependent health insurance available through their employers and that Medicaid would have saved almost $34 million nationally if this insurance had been used to pay for their dependents medical care. Also, a second report, released in 1989,[2] showed that third-party liability health insurance coverage was available to dependent children through noncustodial parents' employers in 48 percent of the sampled child support cases. The projected potential savings to Medicaid in this study were more than $32 million. The study also detected that State child support agencies were not routinely collecting health insurance information.

METHODOLOGY

This report is a follow-up to the two prior studies. For comparison purposes, we chose to conduct this national inspection in a manner similar to the previous inspections except for the selection of the sample States. We examined nine States in all three studies, reviewing samples of child support court orders for a 3-month period and analyzing them for

[1] Child Support Enforcement/Absent Parent Liability, Office of Inspector General, HHS, September 1987.

[2] Coordination of Third-Party Liability Information Between Child Support Enforcement and Medicaid, Office of Inspector General, HHS, December 1989.

covered medical insurance. We also determined the accuracy of Medicaid payments for our sample. In the two prior studies, we selected the nine States based on a probability proportional to size using a two-stage sampling design. In this study, we selected the nine States using a stratified-cluster design, which allows us to project our results nationally. All the States were divided into three strata to produce a broader mix of States than those in the previous studies. The three strata are:

- Strata 1 - includes nine States which various child support and Medicaid representatives recommended for review during our preliminary research. They suggested these States because of their effective detection efforts or innovative processes.

- Strata 2 - includes six States considered "large States" (based on Fiscal Year 1995 Aid to Families with Dependent Children and Foster Care average caseload greater than 240,000) but not included in Strata one.

- Strata 3 - includes the remaining 33 continental States and the District of Columbia.

We randomly selected nine States for this study, five from Strata 1, two from Strata 2, and two from Strata 3. The nine States are: Strata 1 - Massachusetts, Minnesota, Texas, Washington, Wisconsin; Strata 2 - Michigan, North Carolina; and Strata 3 - Oklahoma and Vermont.

We contacted the child support agency in each of the sampled States and requested a listing of all new or modified court or administrative child support orders established during the period July through September 1997 for dependent children entitled under the Temporary Assistance to Needy Families (TANF) program. In addition, we asked them to 1) check the listing against the support payments they have received and to only include cases where at least one support payment had been made during our review period, and 2) that the child(ren) was Medicaid eligible. Once we received the lists of cases from each State child support agency, we randomly selected 40 cases for review from each State. These 360 cases constituted the total number of cases included in our study; however, many of these represented multiple children. We considered all children in carrying out the study. We determined later in the study that 21 cases were not Medicaid-eligible and one could not be located, leaving us with 338 cases in our sample.

We requested the States to send us a copy of the court order or administrative order for each of the selected cases. We reviewed these orders to determine whether or not they included a medical support requirement. In addition, we checked with each State's Medicaid agency to see if their claims history records showed any third-party medical insurance information on any of the sampled cases. Following receipt and review of the child support orders, we visited each of the nine States to review the actual child support case files and to interview State Child Support Directors, local child support caseworkers and supervisors, Medicaid Directors and Recovery Unit personnel, local TANF income maintenance staff, and, as necessary, State insurance commissioners, child support attorneys and judges or court administrators. Through our onsite review of the CSE case

files and contacts with noncustodial parents' employers and insurance companies, we determined if employer group health insurance was available to the noncustodial parents for coverage of their dependent children. We identified three cases where health insurance was available to the noncustodial parents, although the child support order did not include a provision for medical support.

We examined Medicaid payment histories for the dependent children named in the court orders to determine whether the State Medicaid agency was adequately receiving and processing information when medical support was ordered. We also looked to see if group health insurance existed and if the dependent(s) were enrolled. In such cases, if Medicaid had made payments for medical care, we determined the third-party's liability against Medicaid expenditures to determine the amount of potential savings. Based upon the results of our sample review, estimates have been weighted according to the sample design and we projected national savings to the Medicaid program. See Appendix D for a summary of confidence intervals pertinent to report data.

This inspection was conducted in accordance with the ***Quality Standards for Inspections*** issued by the President's Council on Integrity and Efficiency.

FINDINGS

Over the past several years, numerous changes have been made to the regulations governing the identification and enforcement of medical support as it relates to the child support court order. These changes include such things as requiring child support agencies to collect medical support information, including medical insurance coverage in all child support orders, and ensuring that the noncustodial parent obtains health insurance if available at a reasonable cost. Enforcement mechanisms include the child support agency notifying the employer to enroll the child in the health care plan, and the subsequent transfer of medical coverage information from child support agencies to State Medicaid agencies. Our study indicates that while the State child support agencies have made strides toward progress in these areas, the need for improvement still exists.

Considerable progress has been made in the identification and enforcement of medical support

We estimated in our study that 93 percent of the child support cases included a provision requiring that medical coverage be provided for the dependent child(ren). This compares to 24 percent in our previous study. Much of this improvement is because these States generally use a uniform support order form that includes the required medical support provision. This is considered an important tool by the child support staff and court personnel. Appendix A shows unweighted sample data by State.

Since our last study, we also determined that potential savings dropped dramatically. Ten years ago, we identified that 48 percent of the child support cases had health insurance coverage available to dependent children through noncustodial parents' employers which was not identified by Child Support Enforcement or Medicaid. The projected potential savings to the Medicaid program for these cases were more than $32 million. Our current study identified 30 percent of the child support cases had health insurance coverage available to the noncustodial parent. Nationally, States spent an annual projected $5.2 million in fee-for-service and managed care payments on behalf of children where other insurance is available but they were not enrolled. This improvement demonstrates that Child Support Enforcement has progressed in the identification and enforcement of medical support for child support children.

Of the $5.2 million, just under $3 million was for children for whom Medicaid made payments under a fee-for-service arrangement.[3] The additional $2.3 million was for

[3] See Appendix C for a summary of our calculation of potential savings where we identified insurance available to dependent children and Appendix D for the projected potential savings.

capitation payments made for children enrolled in Medicaid under a managed care arrangement. While we are aware that States are responsible for payment of Medicaid covered services that are not included in the contracted benefit package with the managed care plan, we determined that 7 of the 9 sampled States enroll Medicaid-eligible children in managed care and, and for the most part, pay the monthly premiums. To determine the extent that managed care premiums were being paid when medical insurance was available for the children, we looked at three factors of their insurance coverage: the noncustodial parent had health insurance available to him/her; the children were not enrolled for coverage in this insurance; and the children were covered by the State in a managed care plan for which premiums were being paid. Considering these factors for the 7 States, we estimated that 43 percent of the child support cases had beneficiaries enrolled in a managed care plan with Medicaid paying premiums projected to exceed $2.3 million.

However, weaknesses still exist in the detection of employer health insurance availability and enrolling dependents

We identified 247 cases where child support agencies had noncustodial parent employer information in the file. In 126 of these cases, the child support agency did not pursue health insurance availability with these employers. We contacted the employers in 115 of these cases and determined that health insurance was available to the noncustodial parent through their employer in 36 percent of these cases. In developing our contacts we inquired as to the availability of health insurance and whether or not the dependent children were included on the policy. See Appendix B for unweighted sample data by State.

Although State child support staff indicated that they make an initial attempt to gather employment and health insurance information when an individual applies for child support services, child support staff make only limited efforts to pursue medical support after this because they believe their primary efforts should be spent in retrieving cash support payments. A major justification for this approach is that the Federal match is greater for collection of these cash payments than pursuit of medical support. However, as noted in the background section of this report, the Child Support Performance and Incentive Act of 1998 has addressed the issue by calling for a performance measure based on the effectiveness of States enforcing medical support. It also deals with how this measure could be made part of the existing incentive payment system established by section 458A of the Social Security Act which is based on cash support collections.

Hopefully, with the development and the States' implementation of the National Medical Support Notice (NMSN), child support agencies and employers should find the process of enforcing medical support greatly facilitated.[4] The NMSN must comply with the requirements of section 609(a)(3) and (4) of ERISA, which means it will be deemed

[4] Required as part of the provisions of the "Child Support Performance and Incentive Act of 1998."

to be a "qualified medical child support order." In addition, the NMSN must include a severable employer withholding notice informing the employer of: (1) the requirement to withhold the employee's contributions due under any employer-related health plan; (2) the duration of the withholding requirement; (3) the applicability of limitations on any such withholding under title III of the Consumer Credit Protection Act; (4) the applicability of any prioritization required under State law between cash support and medical support amounts to be withheld if the funds available are insufficient for full withholding of both; and (5) the name and telephone number of the appropriate unit or division to contact at the State child support agency regarding the NMSN.

Managed care premiums present a new challenge in the enforcement of medical support for child support children

The noncustodial parent's responsibility for the children's medical care is established through the court requirement to provide medical insurance coverage unless it is financially unreasonable. This is supported further by the requirement that State child support agencies enforce such coverage by seeking out employment information and insurance entitlement. Since our previous studies when Medicaid reimbursed for medical care with fee-for-service payments, managed care has become a major means of medical care coverage for children who are Medicaid-eligible. With the exception of those services not covered by the managed care program, there would be limited fee-for-service claims payment liability by the Medicaid program.

To further quantify the full impact of this evolution, we identified all children in our study enrolled in managed care plans for whom Medicaid paid premiums. We found that Medicaid agencies were paying managed care premiums in 140 cases and these payments projected to more than $10 million. In fact, as noted in the prior finding, Medicaid agencies provided $2.3 of this $10 million in premiums for managed care coverage even when insurance was available from the noncustodial parent's employer.

It might be appropriate for States to make even these premium payments when we consider the difficulty that States could have in coordinating benefits under their managed care programs with other insurance available to the noncustodial parent.

It was beyond the scope of this study to determine the processes needed to collect the managed care premiums from the noncustodial parents who do not enroll their children in the employer's insurance plan or for whom insurance is not available on the market at a reasonable cost. We understand that there are various types of contracts established between State Medicaid agencies and the different managed care organizations. State practices may include disenrolling the children from the managed care plan when private insurance is available, or keeping the children enrolled in Medicaid managed care regardless of the existence of private insurance, while reducing the premium to account for possible third party coverage. We believe to fully address these issues, additional study is required and joint consideration of the various contingencies that exist from establishing the support amount to collection of the premiums.

RECOMMENDATIONS

Our review indicates a high level of medical support provision in court orders and an increase in medical support compared to prior studies, but there still are weaknesses in the detection of available health insurance and its enforcement. While we are aware of the difficulties in following the population of noncustodial parents, some of whom may frequently move from job to job, we believe that increased efforts toward compliance of the court order and detection of health insurance can result in substantial savings nationally to the Medicaid program. We offer the following recommendations:

The Administration for Children and Families should ensure that State child support agencies comply with current regulations requiring them to fully enforce medical support

Whenever child support identifies cases where a high potential exists for obtaining medical support, such as noncustodial parents' employment information, they should be persistent in following through to determine if health insurance is available to the noncustodial parent and to his/her dependents. This should include cases where the child is enrolled in Medicaid managed care programs or could be enrolled in an employer based managed care program. However, these situations may require new approaches discussed in the next recommendation.

The Administration for Children and Families, in conjunction with the Health Care Financing Administration, should examine alternatives to recover the cost of managed care premiums from the noncustodial parents

The Administration for Children and Families (ACF), in conjunction with the Health Care Financing Administration (HCFA), should examine alternatives to address the loss of State/Federal funds for children enrolled in Medicaid managed care. We realize there are various State practices regarding coordination of benefits whenever children are enrolled in a Medicaid managed care plan. Depending on the unique State practices, they could consider the option of requiring the noncustodial parent to enroll the child in private coverage or pay toward the Medicaid managed care coverage. The following could be considered.

- If insurance is available at a reasonable cost to a noncustodial parent but he/she prefers not to enroll in it or to enroll himself/herself only and not the children, he/she could have the option of paying the State Medicaid managed care premium.

- If insurance is not available at a reasonable cost to a noncustodial parent and there is no employer based health plan, he/she could have the option of paying the State Medicaid managed care premium.

- If insurance is available at a reasonable cost to a noncustodial parent and the parent and child are enrolled in it, the Medicaid managed care coverage, unless discontinued, could be assessed as a secondary payer to the noncustodial parent's insurance.

We realize that the actual implementation and administration of such a policy would entail addressing many factors such as cost-efficiency, identification and enforcement, billing and collection of the managed care premium, and need for legislative changes.

AGENCY COMMENTS

In their comments, the Administration for Children and Families expressed their commitment to working with the Health Care Financing Administration and the States to improve access to medical coverage for children. In addition, they described various efforts and initiatives being undertaken that will further strengthen medical child support.

The ACF also noted that the Medical Child Support Working Group will be issuing recommendations to improve medical support and coordination between child support agencies and Medicaid. We are aware of the working group's upcoming report to Congress and have provided information to them on our prior and present efforts on these topics.

The ACF had technical comments regarding the sampling and weighting schemes used in the study. We have revised the report to address these comments. The full text of ACF's comments are included in Appendix E.

While the recommendations in the draft report were not directed to HCFA, they did provide comments. The HCFA indicated that they will continue to work with ACF to assure every effort is made to identify parents who can provide or contribute to the coverage of health insurance for their children and to see that Medicaid dollars are spent appropriately.

Where appropriate, we also made revisions to the report to address HCFA's technical comments. The full text of HCFA's comments are included in Appendix E.

APPENDIX A

CHILD SUPPORT ORDERS WITH A PROVISION FOR MEDICAL SUPPORT [1]

State	Yes	%	No	%	Don't Know	%	Cases Dropped [2]	
Massachusetts	28	70.0	10	25.0	2	5.0	0	0
Michigan	34	85.0	0	0	0	0	6	15.0
Minnesota	20	50.0	18	45.0	2	5.0	0	0
North Carolina	38	95.0	2	5.0	0	0	0	0
Oklahoma	37	92.5	2	5.0	0	0	1	2.5
Texas	25	62.5	0	0	0	0	15	37.5
Vermont	35	87.5	5	12.5	0	0	0	0
Washington	40	100	0	0	0	0	0	0
Wisconsin	37	92.5	2	5.0	1	2.5	0	0

APPENDIX B

HEALTH INSURANCE AVAILABILITY

Cases where OIG Determined Health Insurance is Available Through Contacting Employers [1]

State	Employer in File	CSE Pursued Insurance	CSE Didn't Pursue Insurance	Employer in File, CSE Didn't Pursue, OIG Did Pursue Insurance	
Massachusetts	30	11	19	18	8
Michigan	16	10	6	6	3
Minnesota	35	12	23	22	6
North Carolina	29	18	11	9	3
Oklahoma	29	15	14	12	6
Texas	15	8	7	6	2
Vermont	31	19	12	8	1
Washington	24	21	3	3	2
Wisconsin	38	7	31	31	13
Totals	247	121	126	115	44

APPENDIX C

MEDICAID PAYMENTS MADE WHEN HEALTH INSURANCE EXISTED BUT DEPENDENTS NOT ENROLLED [1]

State	Total Number of Cases	Number of Sample Cases	Total Dollars Paid	Number with Insurance	Number With Dependents Not Enrolled	
Massachusetts	1,714	40	$33,576	12	6	$891.76
Michigan	2,666	34	$6,669	10	6	$481.37
Minnesota	1,185	40	$20,622	11	7	$251.16
North Carolina	1,539	40	$23,672	17	10	$2,029.26
Oklahoma	295	39	$9,944	11	6	$33.69
Texas	15,128	25	$5,675	6	1	$0
Vermont	363	40	$12,824	15	7	$31.92
Washington	994	40	$10,311	17	7	$0
Wisconsin	599	40	$12,388	16	8	$65.77
Total	24,483	338	$135,681	115	58	$3,784.93

APPENDIX D

WEIGHTED ESTIMATES

Data	Weighted Estimate	90% Confidence Interval
Sample cases reviewed (338)		
Medical Support included in order (294)	93%	+/- 4.7%
Insurance available to noncustodial parent (115)	30%	+/-5.6%
Medicaid enrolled dependents in managed care plan (140)	23%	+/-12.2%
Insurance available to noncustodial parent (115)		
Dependents enrolled in insurance plan (57)	57%	+/- 11.2%
Dependents not enrolled in insurance plan (58)	43%	+/- 11.2%
Dependents in managed care plan (30)	43%	+/- 15.3%
Employer information in file, but state did not pursue. OIG did pursue (115)		
OIG determined insurance available (44)	36%	+/-11.0%
Total dollars paid for premiums to managed care plans	**$10,082,312**	**+/- $2,643,508**
Managed Care Premium payments where insurance exists and children not enrolled	$2,320,669	+/-$1,199,244
Fee-for-Service Dollars paid by States for children not enrolled, but insurance is available	$2,923,944	+/- $2,172,028
Total dollars paid by the State on behalf of children where other insurance is available, but not enrolled	**$5,244,613**	**+/- $3,271,272**

Weighting of the sample was performed using standard statistical formulas for a stratified-cluster sample; therefore, the weight was based on both the probability of picking the State and the probability of choosing the case within the selected State. There were a total of nine weights used depending on the strata and the number of cases for that State.

APPENDIX E

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIE
Office of the Assistant Secretary, Suite 600
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447

DATE: June 1, 2000

TO: June Gibbs Brown
Inspector General

FROM: Olivia A. Golden
Assistant Secretary
for Children and Families

SUBJECT: Comments on the OIG Draft Report entitled: "Medical Insurance for Dependents Receiving Child Support" (OEI-07-97-00500).

Attached are the Administration for Children and Families' comments on the above captioned report. If you have any questions, please contact David Gray Ross, Commissioner, Office of Child Support Enforcement, at (202) 401-9370.

Attachment

COMMENTS OF THE ADMINISTRATION FOR CHILDREN AND FAMILIES ON THE OFFICE OF INSPECTOR GENERAL'S DRAFT REPORT: MEDICAL INSURANCE FOR DEPENDENTS RECEIVING CHILD SUPPORT (OEI-07-97-00500)

The Administration for Children and Families (ACF) is committed to working with the Health Care Financing Administration (HCFA) and our State partners to improve access to medical coverage for children. Medical support is a top priority for ACF. Today, there are many children in the United States without health care coverage -- close to 11.5 million children. Of the 21 million children who are considered to be eligible for child support, approximately three million are without health care coverage. Children without coverage have substantially less access to health care services, including preventative care that ensures childhood immunizations, vision and hearing screening, and dental care. Uninsured children are also far more likely to delay care due to cost. Unmet health care needs reduce children's ability to grow into healthy and productive adults.

The Child Support Program (IV-D) was given the responsibility to include medical support establishment and enforcement as part of its child support efforts. States are required to include provisions for health care coverage in State child support guidelines, and the IV-D program was required to pursue private health care coverage when such coverage was available through a noncustodial parent at a reasonable cost.

Legislative changes have strengthened medical support enforcement and removed some of the impediments to providing children with health care coverage.

- The Omnibus Reconciliation Act of 1993 (OBRA '93) created the Qualified Medical Child Support Order (QMCSO), a tool to help provide health insurance for children. It requires States to enact laws which prohibit employers and insurers from discriminating in the provision of health insurance when children are born out of wedlock or are outside the insurer's service area.

- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) also made a number of important changes in medical support enforcement in IV-D child support orders. All child support orders must now include a provision for health care coverage. The Child Support Enforcement agency must notify the employer of the noncustodial parent's obligation.

Despite these legislative reforms and other improvements, there is a fundamental problem with the state of medical support enforcement. This may be a result of larger societal changes, such as the rising cost of health insurance, the move towards new health insurance models (such as Health Maintenance Organizations) that limit service area and choice of provider, changes in the labor market, the transformation of the American welfare system, and changes in family structure.

The Child Support Performance and Incentive Act (CSPIA) of 1998 directed the Secretary of Health and Human Services and the Secretary of Labor to jointly establish a Medical Child Support Working Group. The Medical Support Working Group is in the process of developing solutions to help improve medical support enforcement and coordination between child support enforcement agencies and Medicaid. Central to its mission is the identification of barriers, and the development of recommendations to address whether reasonable cost should remain a consideration [under section 452(f) of the Social Security Act]. This Working Group will also potentially identify appropriate measures to improve the availability of alternate types of medical support, aside from health care coverage offered through the noncustodial parent's health plan and unrelated to the noncustodial parent's employer. When the Working Group finalizes recommendations, these recommendations will provide a framework for efforts to improve medical support.

OIG Recommendation:

The Administration for Children and Families should ensure that State Child Support Agencies comply with current regulations requiring them to fully enforce medical support.

ACF Response:

The Administration for Children and Families will provide this Inspector General's report to all State Child Support agencies. When transmitting the report, OCSE will summarize present regulations as they apply to medical support. Additionally, OCSE will be promoting information about good practices. Other initiatives undertaken by ACF that will further strengthen medical child support provisions are discussed below.

- The National Medical Support Notice, as issued by the Office of Child Support Enforcement (OCSE) as a proposed regulation on November 15, 1999, will help facilitate State child support agencies' efforts to secure health care coverage for children. The National Notice is intended to alleviate many of the problems experienced by State agencies, employers and plan administrators. CSPIA specifically directed the Working Group to make recommendations on the form and content of the Notice. In addition, the Working Group intends to make recommendations to HHS and DOL on ways to identify and educate organizations and individuals with a need for or interest in using the Notice.

- The CSPIA authorized creation of a sixth incentive measure, on medical support enforcement. The statute requires that the incentive measure be based on the States' effectiveness in establishing and enforcing medical support obligations. Once a medical support performance measure is adopted, medical support will be added to the list of activities for which States can receive incentive payments.

  The CSPIA also authorized the Secretary of HHS to consult with States and advocates for children in need of medical support to develop a medical support incentive. Secretary

Shalala convened the Medical Support Incentive Work Group to help develop the medical support incentive measure. The Incentive Group's June 23, 1999, preliminary report to Congress states that the primary obstacle to development of such a measure is the lack of reliable data. The Group also raised concerns about implementing a performance measure before states actually have adequate tools to improve their performance. The Incentive Group and the Medical Child Support Working Group both considered a numeric formula that would reward the full range of medical support activities, but determined that application of such a formula would be premature due to the aforementioned lack of sufficient and valid data. Enhancing the extent and reliability of data in this area should be a top priority, since establishing a performance incentive will help make medical support a core child support activity.

- The Medical Child Support Working Group was also charged with looking more broadly at impediments to effective enforcement of medical support orders. The Working Group is, as part of this work, identifying areas in the medical support arena where improvements are needed, but there is insufficient information to determine the exact nature of these improvements. Further exploration, evaluation and study through research and demonstration activities may be the best approach with regard to these areas. These demonstrations may help link public and private health coverage to build a more effective and efficient system of seamless coverage.

OIG Recommendation:

The Administration for Children and Families, in conjunction with the Health Care Financing Administration, should examine alternatives to recover the costs of managed care premiums from the noncustodial parents.

ACF Response:

It is anticipated that the Medical Child Support Working Group will issue recommendations to improve medical support and coordination between child support enforcement agencies and Medicaid. The Medical Support Working Group, like the IG, also identified Medicaid Managed Care and cost recovery as an issue. Those recommendations will serve to guide ACF's efforts to coordination.

Technical Comments:

It would be useful to know the basis of the sampling and weighting schemes. They are not explained fully.

1. Was the sample based on children or noncustodial parents? It would be unlikely that there was only one child for each noncustodial parent, but it is not apparent.

2. Was the finding of undetected health care coverage limited to those with medical support in the order or to all cases? If all cases, was there undetected health insurance in any of the cases that did not have a medical support order? If so, what proportion of cases?

3. Do the findings represent the nine States in the sample or do they represent the Nation as a whole? If they represent the Nation, on what basis were the weights determined?

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: JUN - 9 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Medical Insurance for Dependents Receiving Child Support" (OEI-07-97-00500)

We appreciate the opportunity to comment on this draft report. As OIG acknowledged, considerable progress has been made by the child support agencies in the identification and enforcement of medical support compared to outcomes from OIG's previous study. The OIG inspection found that weaknesses still exist in the detection of health insurance availability and enrolling the dependents in health insurance plans. In addition, OIG reported that the growing prominence in Medicaid of prepaid, capitated managed care presents a new challenge in the enforcement of medical support for child support children and in coordinating benefits and payments in Medicaid with those available through medical support.

The Health Care Financing Administration (HCFA) will continue to work with the Administration for Children and Families (ACF) to assure every effort is made to identify parents who can cover or contribute to the coverage of health insurance for their children. Enforcement of medical support awards is important both to the children enrolled in Medicaid and to HCFA, because it protects state and federal dollars from being spent needlessly when a parent may be able to supply private insurance. We will continue to work with ACF and state agencies to see that Medicaid dollars are spent appropriately.

General Comments

The report should state more clearly at the outset that the $5.2 million in total projected savings is an annual figure for all States, which is a projection based on data collected over three months in seven States. The difference between this number and OIG's earlier projected savings of $32 million represents a significant improvement in States' performance in child support enforcement, an observation we think the report could make more clearly.

Of the $5.2 million total savings, OIG attributes $2.3 million to Medicaid payments for managed care premiums on behalf of children who have access to other health insurance available through a noncustodial parent. There are circumstances where States continue to pay managed care premiums even when the Medicaid beneficiary has other private coverage. In some instances, it may be more beneficial to have the noncustodial parent pay a portion of the Medicaid premium (or the entire premium when considered reasonable). Therefore, it is unlikely States would realize savings of the entire premium amount. Our detailed comments to the report recommendations follow.

OIG Recommendation
ACF should ensure that state child support agencies comply with current regulation requiring them to fully enforce medical support.

HCFA Response
We defer comments to ACF.

OIG Recommendation
ACF, in conjunction with HCFA, should examine alternatives to recover the costs of managed care premiums from the noncustodial parents.

HCFA Response
We suggest the second recommendation incorporate language describing various practices of States in regard to coordinating benefits whenever children are enrolled in a Medicaid managed care plan. Furthermore, we suggest the recommendation indicate that these practices be taken into consideration when determining the best approach to achieving Medicaid savings while at the same time protecting the child. In light of the various State practices, we offer the following language as a replacement for the examples (i.e., the 3 bullets) to be considered under the second recommendation: *Depending on unique State practices, providing States the option of requiring the non-custodial parent to enroll the child in private coverage or pay toward the Medicaid managed care coverage.*

Technical Comments

- Page 6, first line - We suggest revising the language to read, "... State Medicaid agency for use in coordinating benefits."

- Page 11, first paragraph - The draft report indicates that, "... States enroll Medicaid-eligible children in managed care and, for the most part, pay only the monthly premiums." We would like to point out that States are responsible for payment of Medicaid covered services that are not included in the contracted benefit package with the managed care plan.

- Page 12, third full paragraph is confusing. We suggest deleting it.

- Page 12, last paragraph - We suggest the first sentence should read, "It is beyond the scope of this study to determine the processes needed to collect the managed care premiums from the noncustodial parents." The next to the last sentence should read, "State practices may include disenrolling the children from the managed care plan when private insurance is available, or keeping the children enrolled in Medicaid managed care regardless of the existence of private insurance, while reducing the premium to account for possible third party coverage."