DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of inspector General

Memorandum

Date JUN 18 1998

From June Gibbs Brown
Inspector General

Subject Review of Availability of Health Insurance for Title IV-D Children (A-01-97-02506)

To Olivia A. Golden
Assistant Secretary
for Children and Families

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This is to alert you to the issuance of our final report on Monday, June 22, 1998. A copy is attached. The objective of our review was to determine whether children under the Child Support Enforcement (IV-D) program are receiving Medicaid benefits because private health insurance is unavailable or unaffordable to noncustodial parents (NCPs). We also determined if alternative insurance arrangements could be established by the State that would (i) allow NCPs to meet their responsibility of providing health insurance, and (ii) result in a reduction in Medicaid expenditures. Our review was conducted in Connecticut.

We found that Connecticut has an opportunity to increase the number of NCPs providing medical support for their children and reduce Medicaid costs. These goals could be achieved by either:

(1) requiring NCPs to pay for all or part of the Medicaid managed care premiums, or

(2) establishing a new comprehensive health insurance plan for children with premiums paid by NCPs.

Our review disclosed that taxpayers, rather than NCPs, provided medical support to about 13,282 Title IV-D children through the Medicaid program between April 1996 and March 1997. We found that NCPs, while required by court order to provide health coverage to their children, were unable to meet their obligation because either their employers did not offer health insurance or available health insurance was not reasonable in cost. Using premium information from the State's current Medicaid managed care program, we believe Connecticut could save an estimated $11.4 million (Federal and State combined) in annual Medicaid costs if it required NCPs to offset Medicaid premiums paid by the State on behalf of their children.

We recommended that Connecticut either (i) implement policies and procedures to require NCPs to pay all or part of the Medicaid premiums for their dependent children, or (ii) establish a statewide health insurance plan that provides reasonably priced comprehensive health coverage for children and requires NCPs to contribute toward a premium payment.

In response to our early alert memorandum, dated December 29, 1997, both the Administration for Children and Families (ACF) and Health Care Financing Administration were in agreement with these recommendations. In Connecticut's written response to the draft report, the State agency concurred with the results of the review and stated that the audit findings have merit. State agency officials agreed to require NCPs to pay all or part of the insurance premiums for their dependent children enrolled in Medicaid. They stated that this was a reasonable alternative for NCPs to obtain health coverage for those children on Medicaid. Further, State officials will move to consider a legislative change and budget option that addresses our recommendation for the 1999 legislative session.

In a related matter, the State's response indicated that the health care plan it implemented in response to the Children's Health Initiative Program provides reasonably priced comprehensive health coverage for non-Medicaid children, including NCPs' children when employer health coverage is not available. This affords an additional opportunity to NCPs to ensure that their children receive health coverage when the traditional avenues are not available.

We suggest that ACF make this report available to other State agencies so that they can be apprised of the reasonable alternatives for increasing the number of NCPs providing medical support for their children and reducing Medicaid costs.

If you have any questions or comments on any aspect of this report, please call me or have your staff contact John A. Ferris, Assistant Inspector General for Administrations of Children, Family, and Aging Audits, at (202) 619-1175. To facilitate identification, please refer to Common Identification Number A-01-97-02506 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF AVAILABILITY OF HEALTH INSURANCE FOR TITLE IV-D CHILDREN

JUNE GIBBS BROWN
Inspector General

JUNE 1998
A-O l-97-02506

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

Ms. Joyce A. Thomas
Commissioner
Department of Social Services
25 Sigoumey Street
Hartford, Connecticut 06106-5033

Dear Ms. Thomas:

The enclosed final report presents the results of our review, "Review of the Availability of Health Insurance for Title IV-D Children." The objective of our review was to determine whether children under the Child Support Enforcement program are receiving Medicaid benefits because private health insurance is unavailable or unaffordable to noncustodial parents (NCPs). We also determined if alternative insurance arrangements could be established by the state that would (i) allow the NCPs to meet their responsibility of providing health insurance, and (ii) result in a reduction in Medicaid expenditures.

We found that Connecticut has an opportunity to increase the number of NCPs providing medical support for their children and reduce Medicaid costs. These goals could be-achieved by either (i) requiring NCPs to pay for all or part of the Medicaid premiums, or (ii) establishing a new comprehensive health insurance plan for children with premiums paid by NCPs. Our review disclosed that taxpayers, rather than NCPs, provided medical support to about 13,282 Title IV-D children through the Medicaid program between April 1996 and March 1997. We found that NCPs, while required by court order to provide health coverage to their children, were unable to meet their obligation because either their employers did not offer health insurance or available health insurance was not reasonable in cost. Using premium information from the state's current Medicaid managed care program, we believe Connecticut could save an estimated $11.4 million (Federal and state combined) in annual Medicaid costs if it required NCPs to offset Medicaid premiums paid by the state on behalf of their children.

We recommend that Connecticut either (i) implement policies and procedures to require NCPs to pay all or part of the Medicaid premiums for their dependent children, or (ii) establish a statewide health insurance plan that provides reasonably priced comprehensive health coverage for children and requires NCPs to contribute toward a premium payment.

In Connecticut's written response to the draft report, the state agency concurred with the results of the review and stated that the audit findings have merit. State agency officials agreed with our first recommendation to require NCPs to pay all or part of the insurance premiums for their dependent children enrolled in Medicaid. They stated that this was a reasonable alternative for

NCPs to obtain health coverage for those children on Medicaid. Further, state officials will move to consider a legislative change and budget option that addresses our recommendation for the 1999 legislative session.

In a related matter, the state's response indicated that the health care plan it implemented in response to the Children's Health Initiative Program provides reasonably priced comprehensive health coverage for non-Medicaid children, including NCPs' children when employer health coverage is not available. This affords an additional opportunity to NCPs to ensure that their children receive health coverage when the traditional avenues are not available.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination. To facilitate identification, please refer to Common Identification Number A-01 -97-02506 in all correspondence relating to this report.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

Sincerely yours,

William J. Hornby

William J. Hornby
Regional Inspector General
for Audit Services

Enclosure - as stated

Direct Reply to HHS Action Official:

Hugh Galligan
Regional Administrator
Administration for Children and Families
Room 2000, JFK Federal Building
Boston, MA 02203

EXECUTIVE SUMMARY

BACKGROUND

Congressional concern for obtaining medical coverage for children under the IV-D child support enforcement program has been evident in two recent laws. Specifically, the Omnibus Reconciliation Act (OBRA) of 1993 contained provisions requiring state IV-D agencies to establish medical support orders for children when the noncustodial parent (NCP) has access to medical coverage. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 provides the states with the authority to directly enrol! children in NCP's health plans. A recent study by the Employee Benefits Research Institute showed that from 1985 to 1995, the number of children covered by employer based insurance had decreased from 65 percent to 53 percent while the number of children on Medicaid grew from 15 percent to 25 percent and the number of uninsured children increased from 12 to 14 percent. In 1995, the total number of uninsured children was about 10 million. Medicaid expenditures for the period from 1987 to 1995 increased from $47.7 to $151.8 billion in 1995 (218 percent).

Due to the large numbers of uninsured children, Congress and the President initiated the state Children Health Initiative Program (CHIP) under The Balanced Budget Act of 1997. The CHIP program, under Title XXI, enhanced funding to address the health needs of about five million uninsured children in low income families that do not currently receive Medicaid benefits. Despite these initiatives, significant numbers of children under the state's child support enforcement program still do not receive medical support from their NCPs. Medical support orders are not always enforceable, especially when health insurance is not provided by employers or the cost is unreasonable for NCPs. Under these circumstances, NCPs' who qualify would receive medical assistance under the Medicaid or CHIP program.

The objective of our review was to determine whether children under the Child Support

unavailable or unaffordable NCPs.
could be established by the state that would (i) allow the NCPs
providing health insurance, and (ii) result in a reduction in Medicaid expenditures.

We believe Connecticut has an opportunity to increase the number of NCPs
support for their children and reduce Medicaid costs.
(i) requiring NCPs
comprehensive health insurance plan for children with premiums paid by NCPs.
disclosed that taxpayers, rather than NCPs,

children through the Medicaid program between April 1996 and March 1997. We found that 110 of 200 sample cases consisted of NCPs who were unable to meet their medical support obligations because either their employers did not offer health insurance, or available health insurance was not reasonable in cost. However, Connecticut's Medicaid program operates under a managed care system, and all of the 110 NCPs we reviewed could afford all or part of the Medicaid premiums.

Using premium information from the state's current Medicaid managed care program, we believe Connecticut could save an estimated $11.4 million (Federal and state combined) in annual Medicaid costs if it required NCPs to offset Medicaid premiums paid by the state on behalf of their children. The advantage of the offset arrangement is that Medicaid is already operating under a managed care program with established monthly premiums per enrollee. Another alternative would be to establish a statewide health insurance plan that provides reasonably priced comprehensive health coverage for children and requires NCPs to contribute toward a premium payment. These alternative arrangements not only benefit the Child Support Enforcement program by ensuring that IV-D children are receiving medical support from their NCPs, but also provides the Medicaid program with significant savings. As such, we believe that the successful implementation of either alternative arrangement will require appropriate coordination between the state's IV-D and Medicaid agencies. The establishment of either insurance arrangement will also facilitate the enforcement of medical support orders by providing magistrates with alternative choices when an employer does not offer health insurance, the cost of available insurance is unreasonable, or the NCP is self-employed and is unable to obtain insurance at reasonable cost.

RECOMMENDATIONS

We recommend that Connecticut either (i) implement policies and procedures to require NCPs to pay all or part of the Medicaid premiums for their dependent children, or (ii) establish a statewide health insurance plan that provides reasonably priced comprehensive health coverage for children and requires NCPs to contribute toward a premium payment.

State Agency Comments

In Connecticut's written response (See Appendix C) to the draft report, the state agency concurred with the results of the review and stated that the audit findings have merit. State agency officials agreed with our first recommendation to require NCPs to pay all or part of the insurance premiums for their dependent children enrolled in Medicaid. They stated that this was a reasonable alternative for NCPs to obtain health coverage for those children on Medicaid. Further, state officials will move to consider a legislative change and budget option that addresses our recommendation for the 1999 legislative session. In a related matter, the state's response indicated that the health care plan it implemented in response to the Children's Health Initiative Program provides reasonably priced comprehensive health coverage for non-Medicaid children, including NCPs' children when employer health coverage is not available. This affords an additional opportunity to NCPs to ensure that their children receive health coverage when the traditional avenues are not available.

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INTRODUCTION

BACKGROUND

The Child Support Enforcement program was enacted in 1975 under Title IV-D of the Social Security Act (SSA). The purpose of this program was to establish and enforce support and medical obligations owed by noncustodial parents (NCPs) to their children. In Connecticut the child support enforcement program is administered by the Bureau of Child Support Enforcement (BCSE), the IV-D agency within the Department of Social Services (DSS). The BCSE's responsibilities include intake, establishment of paternity, and child and medical support orders. The BCSE contracts with other state agencies to assist in administering the child support program. One of these agencies is the Support Enforcement Division (SED) of the Judicial Branch whose responsibilities include the enforcement of child and medical support orders.

Congressional concern for obtaining medical coverage for IV-D children has been evident in two recent laws. The Omnibus Reconciliation Act (OBRA) of 1993 contained provisions requiring state IV-D agencies to establish medical support orders for children when the NCP has access to medical coverage. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 provides the states with the authority to directly enroll children in NCPs' health plans.

A recent study showed that from 1985 to 1995, the number of children covered by employer based insurance had decreased from 65 percent to 53 percent while the number of children on Medicaid grew from 15 percent to 25 percent and the number of uninsured children increased from 12 to 14 percent (Figure 1). The number of uninsured children in 1995 was about 10 million. Furthermore, Medicaid expenditures increased from $47.7 in 1987 to $151.8 billion in 1995 (218 percent). As of June 1996, 48 states have either fully replaced or are in the process of replacing Medicaid fee for service plans with managed care programs'.

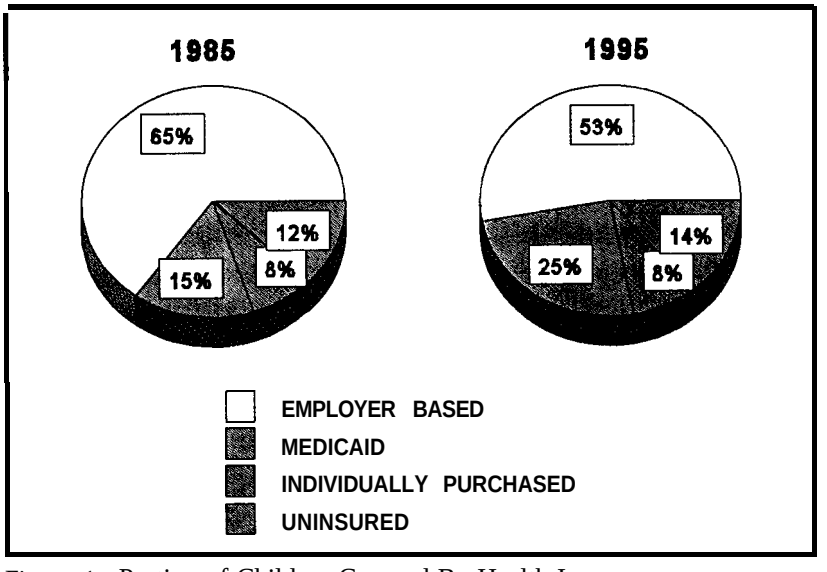

Figure 1 - Portion of Children Covered By Health Insurance
(Source: Employee Benefits Research Institute).

'Under managed care, provider organizations agree to provide a specific set of services to Medicaid enrollees in return for a fixed periodic payment per enrollee.

Medical support orders are not always enforceable, especially when health insurance is not provided by employers or the cost is unreasonable for NCPs. Under these circumstances, some of the health costs are paid by Medicaid. Jn addition, the states and Federal government may incur additional health care costs for children from low income families when the Children Health Initiative Program (CHIP) is fully implemented.

The Medicaid program covers medical expenses for certain vulnerable and needy individuals and families with low income and resources. Medicaid is an entitlement program funded by both Federal and state governments and is the payor of last resort. Connecticut and the Federal government equally cover the state's Medicaid costs. Many IV-D children are eligible for medical assistance under the Medicaid program. In Connecticut, the Division of Health Care Finance, Department of Social Services, oversees the Medicaid program. The state has arranged contracts with various managed care organizations to provide services to Medicaid recipients at negotiated capitation rates (premiums). The premiums are based on recipient age and county location, and are paid monthly to the managed care organization.

To address the large number of uninsured children, Congress and the President initiated the CHIP program under The Balanced Budget Act of 1997. The CHIP program, Title XXI under SSA, enhanced state funding intended to address the health needs of about five million uninsured children in low income families that do not currently qualify for Medicaid. In response to CHIP, Connecticut began implementation of an affordable health coverage under the Health Care for Uninsured Kids and Youth (HUSKY) Plan on June 1, 1998. This plan is intended to cover families with incomes between 185 to 300 percent of the federal poverty level, excluding families qualifying for Medicaid benefits.

Even before the CHIP program was enacted in October 1997, concerns over the number of uninsured children caused 36 states to establish reasonably priced health insurance plans for children. Within these 36 states, Arizona and Sacramento County, California, have also established private insurance plans that specifically limited health coverage to IV-D children and are subsidized solely through premiums paid by NCPs. Monthly premiums for the Arizona plan range from $40 to $61 per child depending on NCP income level, and the Sacramento County plan charges about $80 per child. Average annual Medicaid savings for Sacramento County were about $1.8 million for the first three years.

OBJECTIVES, SCOPE AND METHODOLOGY

Objective

The objective of our review was to determine whether children under the Child Support Enforcement program are receiving Medicaid benefits because private health insurance is unavailable or unaffordable to NCPs. We also determined if alternative insurance arrangements could be established by the state that would (i) allow NCPs to meet their responsibility of providing health insurance, and (ii) result in a reduction in Medicaid expenditures.

Scope

Our review was conducted in accordance with generally accepted government auditing standards. Our review of Connecticut's internal controls was limited to a review of the related procedures regarding Connecticut's medical enforcement process. To achieve our objective, we reviewed a computer file extract of IV-D children eligible for Medicaid whose NCPs had court orders to provide medical support. Our audit period was from April 1, 1996 through March 31, 1997.

We performed our fieldwork at the Connecticut Department of Social Services' BCSE, Medical Administration and Policy Division, and the Judicial Branch, SED, between February 1997 and October 1997. We discussed the results of our review with both SED and BCSE officials on October 1, and October 15, 1997, respectively.

Methodology

To accomplish our audit objective, we:

- selected a statistically random sample of 200 cases from our population of 24,150 IV-D children of NCPs with medical support orders who were Medicaid eligible during the period April 1, 1996 through March 3 1, 1997;
- reviewed Federal regulations and state policies and procedures pertaining to the state's enforcement of medical support;
- reviewed state IV-D guidelines for calculating child support payments;
- reviewed state IV-D computer files for child support payments and medical enforcement status;
- reviewed state Medicaid computer files for eligibility, payment histories, and managed care capitation rates used during the audit period for sampled cases;
- identified NCPs who could afford to pay for medical support using state IV-D agency information on child support payments and state Medicaid managed care capitation rates for FY 1997; and
- applied attribute and variable sample appraisal methodologies to project the number of uninsured children and potential Medicaid savings to the population (See Appendices A and B).

We tested the reliability of the computer file extract of IV-D children by comparing information for each sampled case to source documents. Specifically, we verified the child's name, date of birth, case identification number, Medicaid eligibility, and NCP name. We also verified the existence of a medical support order and the status of medical support using BCSE and SED

computerized records, respectively. We relied on the state IV-D medical enforcement process to determine if health insurance was available to the NCP, and whether the available insurance was reasonable in cost. We also used IV-D and Medicaid computerized records to determine the amount of the child support payment and NCP income, and Medicaid expenditures and eligibility for each sample case.

The draft report was issued to the Connecticut State agency on April 17, 1998. Connecticut responded to our report on May 19, 1998. (See Appendix C).

FINDINGS AND RECOMMENDATIONS

AVAILABILITY OF HEALTH INSURANCE FOR TITLE IV-D CHILDREN

We believe Connecticut has an opportunity to increase the number of NCPs providing medical support for their children and thus reduce Medicaid costs. These goals could be achieved by either (i) requiring NCPs to pay for all or part of the Medicaid premiums, or (ii) establishing a NCPs. We found taxpayers, rather than NCPs, provided medical support to about 13,282 IV-D children through the Medicaid program between April 1996 and March 1997. The NCPs in our sample, while required by a court order to provide medical insurance to their children, were unable to meet their obligations because either their employers did not offer health insurance, or available health insurance was not reasonable in cost. However, Connecticut's Medicaid program operates under a managed care system, and a significant number of the NCPs in the cases we reviewed could afford all or part of the premiums. Using current Medicaid managed care premiums, we believe Connecticut could save an estimated $11.4 million (Federal and state combined) in annual Medicaid costs if it required NCPs to offset Medicaid premiums paid by the state on behalf of their children. Accordingly, we recommend that Connecticut either (i) implement policies and procedures to require NCPs to pay all or part of the Medicaid premiums for their dependent children, or (ii) establish a statewide health insurance plan that provides reasonably priced comprehensive health coverage for children and requires NCPs to contribute toward a premium payment.

Process To Establish And Enforce Medical Support Orders For IV-D Children

Title 45, CFR, Section 303.3 1 (b)(l), regarding the securing and enforcing of medical support obligations, states that for AFDC and Medicaid cases, ".... the IV-D agency shall unless the custodial parent and child(ren) have satisfactory health insurance other than Medicaid, petition the court or administrative authority to include health insurance that is available to the absent parent at reasonable cost in new or modified court or administrative orders for support."

Connecticut's IV-D program is operated on a judicial basis meaning support must be ordered and modified through court. The process of establishing medical support enforcement begins when the state IV-D agency obtains a medical support order from the court. The medical support order is usually obtained at the same time that the state obtains the child support order. Although a medical support order may exist for each child, not all medical orders can be enforced even though the NCP is actively employed and is current on his or her child support payments. These situations occur when health insurance cannot be obtained by the NCP because it is not always available from the employer or the cost is unreasonable. State enforcement officials do not pursue NCPs for contempt of medical support if they believe the cost of health insurance offered by employers is unreasonable.

Medical Support Funded By Taxpayers

Federal regulations do not require NCPs to provide medical support if health insurance is not available to the NCP at a reasonable cost. In these situations, it is the taxpayers rather than the NCPs that are paying for the medical support of IV-D children through the Medicaid program. In Connecticut, we found that NCPs, while required by a court order to provide medical insurance for their children, were unable to meet this obligation because either their employers did not offer health insurance or available health insurance was not reasonable in cost. Accordingly, their children's health care coverage was funded by taxpayers under Connecticut's Medicaid program.

We reviewed a random sample of 200 cases from a population of 24,150 IV-D children eligible for Medicaid to: (1) determine the number of instances where health coverage was not provided by NCPs because of cost or availability; and (2) identify alternative arrangements that would allow NCPs to pay for all or part of the health coverage for their children.

Medicaid covered 110 of the 200 children (55 percent) although their NCPs could afford to pay all or part of Connecticut's Medicaid premiums.

Our results identified 125 (63 percent) out of 200 cases where health coverage was not provided by NCPs because of cost or availability. Instead, Medicaid covered the cost of health care for their children during our audit period.

As shown in Figure 2, we found 55 cases (27.5 percent) of children with NCPs that could afford to pay Connecticut's Medicaid premiums, another 55 cases (27.5 percent) with NCPs that could pay a portion of the cost, and 15 cases (8 percent) with NCPs who had no means to cover health insurance premiums. In essence, Medicaid covered 110 of 200 children (55 percent) when their NCPs could afford to pay all or part of Connecticut's Medicaid premiums. The remaining 75 cases either had health coverage provided by NCPs (46 cases), the state agency was in the process of enforcing medical support orders (2 1 cases), or the children were no longer Medicaid eligible in Connecticut (8 cases).

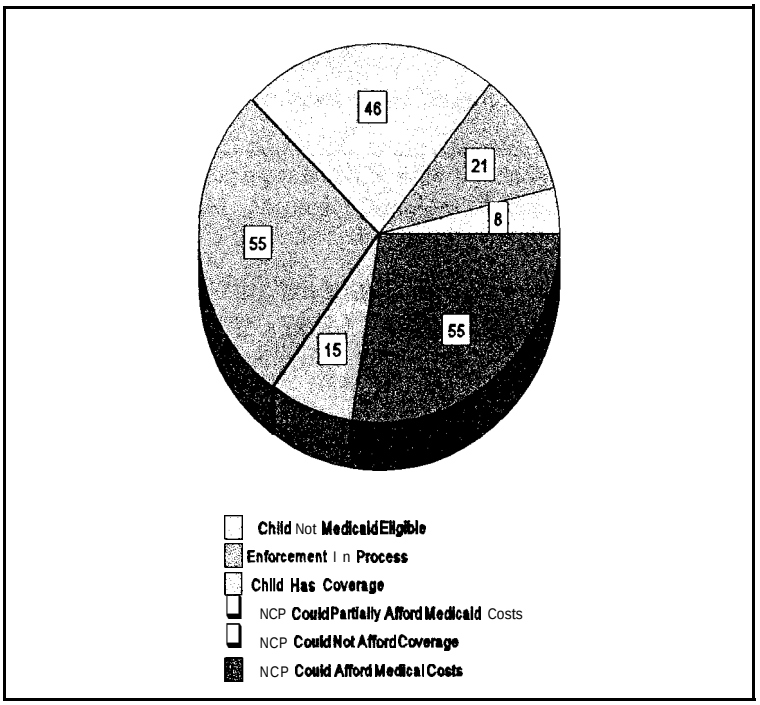

Figure 2 - Breakout of NCPs Who Could and Could Not Afford Connecticut's Medicaid Premiums.

Offering NCPs alternative arrangements for providing health coverage for their children could reduce annual Medicaid costs in Connecticut. Alternative solutions could consists of establishing (i) policies and procedures for NCPs to pay for all or part of Medicaid premiums, or (ii) a comprehensive low cost private insurance plan for children that closely approximates the coverages provided under Medicaid. We used Connecticut's managed care program to show savings because it was already established and in full operation. Specifically, the state could require NCPs to contribute towards the Medicaid premiums paid by Connecticut on behalf of their children. This action could save Connecticut an estimated **$11.4** million (Federal and state combined) in annual Medicaid costs.

To compute the possible savings for offering such an alternative, we used Connecticut's child support guidelines to identify those cases where NCPs could afford to pay for all or part of the state's Medicaid premiums for 1997. We primarily focused on NCP net pay, child support, minimum NCP income for self-support, and Medicaid premiums based on the age and residence of the NCP's child. Figure 3 illustrates this process. The NCP's net pay for the case we selected was $997 per month. Using Connecticut's child support guidelines, we determined that the monthly child support payment was $256, and the NCP was entitled to minimum monthly income of $628 for self-support. Deducting child and minimum self-support from the NCP's net pay left $113 for medical support. We compared this amount to the $93 in monthly Medicaid premiums the state pays on behalf of the NCP's child. Accordingly, the NCP could afford the monthly Medicaid premium.

NCP Net Pay	*$997*
Less:	
*Child Support Payment**	*(256)*
*Minimum Self-Support Reserve**	*(628)*
Amount Available for Medical Support	*113*
1997 Medicaid Premium	*(93)*
Residual Balance to NCP	*20*

Source - Connecticut Child Support Guidelines

Figure 3 **- Example of NCP Who Could Afford to Pay for All of the Monthly Medicaid Premium for Dependent Child.**

For the 55 NCPs who could afford the entire Connecticut Medicaid premium, 32 (58 percent) consisted of cases where medical insurance was not available from employers or available insurance was not reasonable in cost, 20 NCPs (36 percent) were self-employed, and three NCPs (6 percent) had lost coverage.

The monthly net income for the 32 cases where health coverage was not affordable or available ranged from $997 to $3,120, indicating that the NCPs we highlighted could afford reasonably priced health insurance. State enforcement officials indicated that self-employed NCPs generally do not have access to affordable insurance. However, we found that monthly net income for these 20 self-employed NCPs ranged from $997 to $2,708, demonstrating this group of NCPs could afford to pay for reasonably priced health coverage. The remaining three cases

represented NCPs who changed employers and lost coverage. The NCPs' net pay ranged between $1,235 and $1,582 per month, indicating that they too could afford reasonably priced health insurance for their children.

Projecting the 55 cases to our population, we found that about 6,641 IV-D children (See Appendix A) received Medicaid benefits between April 1996 and March 1997 when their NCPs earned sufficient income to fully offset Medicaid premiums paid by the state. We also used Connecticut's Child Support Guidelines to identify another 55 cases where the NCP could afford to pay a portion of Connecticut's Medicaid premiums. Projecting these cases to our population, we found that an additional 6,641 IV-D children (See Appendix A) received Medicaid benefits between April 1996 and March 1997 when their NCPs earned sufficient income to offset part of the Medicaid premiums paid by the state.

Implementing Alternative Solutions Could Save The State Millions In Medicaid Costs

Implementing alternative solutions, such as requiring NCPs to pay part or all of the Medicaid premiums for their child, provides NCPs with a way to meet their responsibility of providing health insurance to their children and could save Connecticut millions in Medicaid costs. Specifically, Connecticut could save an estimated $11.4 million (Federal and state share) in annual Medicaid premiums (See Appendix B) if it required the NCPs to offset the Medicaid premiums paid by the state on behalf of the 13,282 IV-D children. Using current capitation rates for the 6,641 cases that could fully afford Connecticut's Medicaid premiums, we projected the results to the population and found that the state could save about $7.9 million annually in Medicaid premiums. Likewise, the state could save about $3.5 million annually in Medicaid premiums from the 6,641 NCPs who could afford to pay a portion of the state's Medicaid premiums. We believe that these savings could be realized if the state used wage withholding to collect Medicaid premiums from NCPs, amended child support payments to include related Medicaid premiums for the self-employed, and treat unpaid medical premiums as an arrearage.

In calculating these estimated savings, we assumed that: (i) NCPs would consistently pay their monthly premiums, (ii) custodial parents have no income and cannot contribute towards the premiums, and (iii) NCPs have one dependent child. Other factors not included in our savings estimate include increases or decreases in caseload, increases in NCP income, and any additional savings in CHIP funds allotted to Connecticut if NCPs were required to pay all or part of the premiums for the HUSKY plan. The savings in allotted funds could be used by the state to cover more uninsured children.

CONCLUSION

Implementing alternative arrangements will provide NCPs with an opportunity to honor their responsibility of providing medical support to their children, while saving the state and Federal government substantial amounts in Medicaid costs. Alternative arrangements for Connecticut may include (i) establishing policies and procedures for the recovery of full or partial Medicaid or HUSKY premiums from NCPs, or (ii) implementing a reasonably priced health insurance

plan for children that requires NCPs to cover some or all of the premiums. We found that Connecticut could save an estimated $11.4 million (Federal and state share) in Medicaid premiums if it implemented the first option.

In regards to the feasibility of the second option, concerns over the number of uninsured children caused 36 states to establish reasonably priced health insurance plans for children even before CHIP was initiated. Within these 36 states, Arizona and Sacramento County, California, have also established private insurance plans that specifically limited health coverage to IV-D children and are subsidized solely through premiums paid by.NCPs. Monthly premiums for the Arizona plan range from $40 to $61 per child depending on NCP income level, and the Sacramento County plan charges about $80 per child. Average annual Medicaid savings for Sacramento County were about $1.8 million for the first three years.

These alternative arrangements not only benefit the Child Support Enforcement program by ensuring that IV-D children are receiving medical support from their NCPs, but also provides the Medicaid program with significant savings. As part of its responsibilities, the state Medicaid agency is responsible for ensuring that the Medicaid program is the payor of last resort. Accordingly, we believe that the successful implementation of either alternative arrangement will require appropriate coordination between the state IV-D and Medicaid agencies. The establishment of either insurance arrangement will also facilitate the enforcement of medical support orders by providing magistrates with alternative choices when an employer does not offer health insurance, the cost of available insurance is unreasonable, or the NCP is self-employed and is unable to obtain insurance at reasonable cost.

RECOMMENDATIONS

We recommend that Connecticut either (i) implement policies and procedures to require NCPs to pay all or part of the Medicaid premiums for their dependent children, or (ii) establish a statewide health insurance plan that provides reasonably priced comprehensive health coverage for children and requires NCPs to contribute toward a premium payment.

STATE AGENCY COMMENTS

In Connecticut's written response (See Appendix C) to the draft report, the state agency concurred with the results of the review and stated that the audit findings have merit. State agency officials agreed with our first recommendation to require NCPs to pay all or part of the insurance premiums for their dependent children enrolled in Medicaid. They stated that this was a reasonable alternative for NCPs to obtain health coverage for those children on Medicaid. Further, state officials will move to consider a legislative change and budget option that addresses our recommendation for the 1999 legislative session.

In a related matter, the state's response indicated that the health care plan it implemented in response to the Children's Health Initiative Program provides reasonably priced comprehensive health coverage for non-Medicaid children, including NCPs' children when employer health coverage is not available. This affords an additional opportunity to NCPs to ensure that their children receive health coverage when the traditional avenues are not available.

APPENDICES

ESTIMATE OF THE NUMBER OF TITLE IV-D CASES THAT COULD FULLY OR PARTIALLY AFFORD MEDICAID PREMIUMS

To obtain our population for attribute sampling, we extracted from Connecticut's IV-D agency computer files 24,150 IV-D cases of children eligible for Medicaid whose noncustodial parents (NCPs) had medical support orders. Our population was also limited to IV-D children enrolled in Connecticut's Medicaid program and cases where NCPs made at least three regular child support payments between April 1, 1996 and March 31, 1997.

From the population of 24,150 cases, we selected a simple random sample of 209 cases for review. We performed tests that identified:

- 55 children received Medicaid benefits between April 1996 and March 1997 when their NCPs could fully afford Connecticut's Medicaid premiums;
- 55 cases with NCPs who could afford a portion of the cost;
- 15 cases where NCPs had no means to provide health insurance; and
- 75 cases where NCPs provided health coverage, the state was in the process of enforcing medical support orders, or NCPs' children were no longer Medicaid eligible in Connecticut.

	Number of Cases in Sample	Projected Totals	90 Percent Confidence Interval	
			Lower Limit	Upper Limit
NCPs Who Could Fully Afford Medicaid Premiums	55	6641	5,398	8,006
NCPs Who Could Partially Afford Medicaid Premiums	55	6641	5,398	8,006
NCPs Who Could Fully or Partially Cover Medicaid Premiums	110	13,282	11,824	14,715

The table above shows the results of projecting the 110 cases of NCPs who could either fully or partially afford Connecticut's Medicaid premiums. It also provides the projections for each subgroup. Specifically, we estimated 13,282 cases with NCPs that could pay all or part of the cost between April 1, 1996 and March 3 1, 1997. We are 90 percent confident that the number of IV-D children who received Medicaid coverage because private health insurance was unavailable or unaffordable to NCPs who could afford all or part of Connecticut's Medicaid premiums fell between 11,824 and 14,715.

ESTIMATE OF MEDICAID SAVINGS FOR TITLE IV-D CASES THAT COULD FULLY OR PARTIALLY AFFORD MEDICAID PREMIUMS

We obtained the monthly Medicaid premiums for each of the 110 cases that could afford all or part of Connecticut's Medicaid premiums. These premiums were based on 1997 capitation rates established by the child's age and county of residence. In calculating the estimated savings, we assumed that: (i) noncustodial parents (NCPs) would consistently pay their monthly premiums, (ii) custodial parents have no income and cannot contribute towards the premiums, and (iii) NCPs have one dependent child. Other factors not included in our savings estimate include increases in caseload, increases in NCP income, and any additional savings if NCPs were required to pay all or part of the premiums for the HUSKY plan.

	Number of Cases in Sample	Projected Savings	90 Percent Confidence Interval	
			Lower Limit	Upper Limit
NCPs Who Could Fully Afford Medicaid Premiums	55	$7,936,883	$6,353,396	$9,520,370
NCPs Who Could Partially Afford Medicaid Premiums	55	$3,472,287	$2,662,018	$4,282,556
NCPs Who Could Fully or Partially Cover Medicaid Premiums	110	$11,409,170	$9,855,517	$12,962,823

The table above summarizes our statistical projections for the total amount Connecticut could save in Medicaid costs. It also provides the projections for each subgroup. Specifically, we estimated that Connecticut could save as much as $11.4 million in Medicaid costs for the 13,282 IV-D children with NCPs who could pay for all or part of Medicaid premiums. We are 90 percent confident that the Medicaid savings for children of NCPs where private insurance was unavailable or unaffordable fell between $9.9 and $13 .O million.

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

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May 19, 1998

William J. Homby
Regional inspector General for Audit Services
Office of Inspector General
John F. Kennedy Federal Building
Boston, MA 02203

SUBJECT **Office of Inspector General:** ***Review of Availability of Health Insurance for Tit& IV-D Children (*Identification Number: A-01-97-02506)**

Dear Mr. Homby:

Thánk you for *the* opportunity to comment *on the* draft *report Review of Availability of Health Insurance for Title IV-D Children I have* reviewed the report and am pleased to say that the office of inspector general did an accurate job analyzing the results of the data that was gathered from the child support automated system. I appreciated the emphasis on the cases for which the obtaining of medical insurance appeared to be feasible, rather than faulting Connecticut for lack of enforcement for those cases for which pursuit of insurance was not feasible.

I believe that the findings have merit. We are reviewing the possibility of proposing recommendation (1) implement policies and procedures to require NCPs to pay all or part of the Medicaid (e.g. Title XIX and Title XXX) premiums for their dependent children, as a legislative change and budget option for the legislative session for 1999. This would be a reasonable alternative way for noncustodial parents to obtain coverage for their children who are receiving Medicaid The Family Support Magistrates and Judges would be willing to support this idea, especially in those circumstances in which the cost of coverage through the employer is unreasonably priced or coverage is not available.

We will also determine if there are additional ways to reduce the cost, if possible, of Medicaid for those children whose noncustodial parents do have Third Party Liability (TPL) coverage. All Medicaid children are now covered by managed care. A capitation rate is set for all children, and any reimbursement obtained from TPL coverage is retained by the managed care organization. While these reimbursements are factored into future rate setting, there is no immediate savings for the state. We will conduct some analysis to determine if there is a way in the future to obtain direct savings for the state. Many noncustodial parents are paying for the medical insurance coverage, but neither their children nor the state is receiving any immediate benefit from those payments.

The second recommendation (2) ***establish a statewide health insurance plan that provides reasonably priced comprehensive health coverage for children and requires NCPs to contribute toward a premium payment*** is partially addressed by the new HUSKY plan. Public Act 97- 1 (Special Session October 29, 1997) defines an applicant to include ". . .a noncustodial Patent under order of a court or Family Support Magistrate to provide health insurance, who applies for coverage under the HUSKY Plan, Part B on behalf of a child . . ." This allows the noncustodial parent to apply for HUSKY Part B coverage for children who are not presently covered under Medicaid. This affords an additional opportunity to the noncustodial parent to ensure that his children receive health coverage, even when the traditional avenues ate not available to him The federal law does not, however, allow a noncustodial parent to cover a child who **is receiving Medicaid with** HUSKY Part B.

We have made considerable strides in the health care coverage arena during the past year, and will continue to explore additional alternatives to provide all children with coverage. I look forward to receiving the final version of this report.

Sincerely.

Joyce A. Thomas
Commissioner

C: Hugh Galligan, RA, ACF
Valerie R. Marino, Deputy Commissioner
Kevin Loveland, Director Family Services
David Parella, Director, Medical Care Administration
Diane M. Fray, IV-D Administrator

JAT/dmf

OIG-comm