CLASP

CENTER FOR LAW AND SOCIAL POLICY

MEMORANDUM

TO: Interested People

FROM: Paula Roberts

DATE: March 15, 2004

RE: OIG Studies on Potential Medicaid Savings Through Cost Contributions from Noncustodial Parents

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According to a recent report from the Center on Budget and Policy Priorities (CBPP), budget pressures have caused 34 states to make cuts in public health insurance programs like Medicaid and the State Children's Health Insurance Program (SCHIP) in the last two years. As a result, more than half-million children and large numbers of their parents have lost health care coverage. Some states have done this by restricting Medicaid and SCHIP eligibility; others have made it more difficult to enroll in the programs or retain coverage. Still others have instituted or raised premiums. Moreover, states continue to look for ways to restrain costs.

In this context, it is important for advocates to be aware of a recent series of eight reports from the Office of the Inspector General (OIG) of the United States Department of Health and Human Services (HHS) studying the potential for recouping some of the state's Medicaid costs for children in single-parent families through improved medical support enforcement. In particular, the OIG was interested in the capacity of noncustodial parents who did not provide private health care coverage to their children to contribute toward the cost of their children's Medicaid coverage. The reports from Connecticut, Indiana, New Jersey, New York, North Carolina, Texas, and Virginia are now posted on the OIG's website, http://www.oig.hhs.gov/oas/reading/acf.html. The Michigan report is not yet available. The available reports are summarized below.

Because the OIG has concluded that there is a potential for cost savings by requiring at least some noncustodial parents to contribute toward the cost of Medicaid coverage for their children, it is likely that many states will be examining this issue. In fact, as noted below, some of the studied states have already moved in this direction. The OIG recommended that the other studied states do so. Also, the OIG recommendations could easily be adapted by non-study states as they become aware of the potential cost

recovery. Moreover, it is anticipated that this issue will come up at the federal level, and CLASP will be monitoring those developments. In the meantime, it would be wise for state and local advocates concerned about both child support and health care coverage to follow the issue as it unfolds.

The tension here is obvious. We have struggled for years to move the mission of the child support program from cost recovery for the state and federal governments to the delivery of regular, reliable support payments to custodial parents and their children. A move in the opposite direction would severely undermine this work. At the same time, Medicaid and SCHIP cuts affect the very children we care about, and there will need to be strong efforts to protect children and their parents from further weakening of these systems. The OIG reports suggest a partial "quick fix" that may be very tempting to states facing budget constraints. Thus, child support and Medicaid/SCHIP advocates need to work together to find alternate approaches to the funding dilemma.

Background

For the past several years, a federal requirement mandated that orders enforced by the state's child support enforcement program (IV-D) contain some provision for the children's health care coverage. 42 USC § 666(a) (19). If private insurance is available through employment or a group such as a union, this coverage is to be provided. 45 CFR § 303.31(a) (1). If such coverage is not available (or in some states it is deemed to be too costly), the order will specify that private coverage is to be provided when it becomes available. Thus, orders in the IV-D system should contain some provision for addressing children's health care needs either now or in the future.

While there are a significant number of orders that do not yet contain the required provision, many do. It is these orders that were the focus of the OIG work.

The OIG Methodology

The OIG looked at children who were in the state's child support (IV-D) system and also receiving Medicaid. In each state, the OIG selected a one-year period and conducted a statistically valid sample of cases in which:

- The child received IV-D services;
- The child support order required the noncustodial parent to provide health care coverage for the child; and
- The non-custodial parent had made at least three child support payments during the study period. (This measure was a proxy for stability. If a parent made fewer than three payments, it was assumed that he/she would not be a good source of contributions toward Medicaid costs.)

For each sample case, the OIG reviewed IV-D files to determine the amount of support paid, and whether health care coverage was available to the non-custodial parent and if the cost was reasonable. It then verified the accuracy of the coverage information and identified whether the child had incurred Medicaid costs.

To assess potential payments from the non-custodial parent, the OIG calculated cash support using the state's child support guidelines. It also assumed that no parent would pay more support than the federal Consumer Credit Protection Act (CCPA) limit of 50 percent of disposable earnings. If the state did not already have a minimum amount for a self-support reserve for the non-custodial parent, the OIG set such a reserve at roughly the poverty level for one person ($700 per month). The OIG then subtracted the amount of child support and the self-support reserve from net income. If there was any remaining money, it was divided by the number of children the noncustodial parent was responsible for. This amount was deemed available for each child's Medicaid coverage.

To determine the potential cost savings, the OIG calculated the cost of providing Medicaid coverage for the children and determined what percentage of this cost could be recovered through parental contribution. In this regard, it is worth noting that North Carolina is a fee-for-service state, Connecticut and Indiana are HMO model states, and New York, New Jersey, and Virginia have hybrid systems. It was not clear from the report which system Texas uses.

Summary of Findings

Below is a summary of the OIG findings by state. Where the state responded and raised issues about the OIG's estimated cost recovery, that is noted. Also noted are other issues raised by states including the potential downward effect on cash support awards, the competition between medical support and recovery of child support arrears, and the relationship of this issue to the recovery of Medicaid birthing costs.

Connecticut—The OIG found that 33,791 children received Medicaid benefits in Connecticut during the study period (April 2001 – March 2002) since their noncustodial parents did not provide court-ordered health care coverage because it was either not offered through employment or was too costly. Of that group, 12,503 children had a non-custodial parent who could have contributed toward the cost of Medicaid coverage. The aggregate amount deemed collectible was a little more than $9.3 million per year. Had it obtained these funds, the state could have recovered 67 percent of the total cost of $13.8 million for covering these children.

Connecticut is one of the states that has recently enacted laws giving courts discretionary authority to order non-custodial parents to contribute toward Medicaid premium costs. The OIG identified three problems in implementing this law: 1) insufficient resources to do outreach to parents and court personnel about this new requirement; 2) the need to modify old orders; and 3) the need to develop a standard methodology for determining the non-custodial parent's contribution. The OIG recommended that the state address these concerns. The state concurred with this analysis.

Indiana—The OIG estimated that 16,366 children received Medicaid benefits in Indiana during the study period (June 2001 – May 2002) since their non-custodial parents did not provide court-ordered health care coverage because it was either not offered through employment or was too costly. Of that group, 4,808 had a non-custodial parent who could have contributed to the cost of Medicaid. The aggregate amount deemed collectible was a

little more than $3 million. Had it obtained these funds, the state could have recovered 22 percent of the total cost of $13.4 million for covering these children.

As noted above, the non-custodial parent's ability to contribute was calculated by subtracting the cash support order and a self-support reserve of $700 from net income. If sufficient income remained, it was divided by the number of supported children and considered to be available to cover part or all of each child's Medicaid expenses. The state disagreed with this methodology. It pointed out that the result of the OIG's approach was to reduce the money available to pay cash arrears owed to the state and/or the family. The state also noted that it pursues Medicaid birthing costs. So far, the state has asked non-custodial parents to repay Medicaid $4,870,201 in such costs and has collected $499,795. If the OIG approach is adopted, there would be less flexibility to do this.

As a result of the state comments, the OIG adjusted its estimate of potential savings slightly downward to $3 million.

New Jersey—The OIG estimated that 14,692 children who received public assistance also received Medicaid during the study period (September 2001 – August 2002) since their noncustodial parents did not provide court-ordered medical support because it was either not available through employment at reasonable cost or the noncustodial parent was unemployed. Of that group, 5,930 had a non-custodial parent who could have contributed toward the cost of the Medicaid coverage. The aggregate deemed collectible was $2.5 million. Had it obtained these funds, the state could have covered 21 percent of the total cost of $11.8 million for covering these children. Of this, 89 percent would have gone to reimburse Medicaid premiums and 11 percent would have gone to fee-for-service plans.

The OIG recommended that the state modify its child support guidelines to require noncustodial parents to contribute to the Medicaid costs for their dependent children. The state did not officially respond to this recommendation.

New York—The OIG estimated that 71,158 children received Medicaid benefits in New York during the study period (January 2001 – December 2001) since their non-custodial parent did not provide court- or administratively-ordered health care coverage because it was either not offered through employment or was too costly. Of that group, 41,138 children had a non-custodial parent who could have contributed toward the cost of coverage. The aggregate deemed collectible was $32.9 million. Had it obtained these funds, the state could have recovered 59 percent of the total cost of $56.1 million for covering these children. Of this, $13.1 million would have gone to premium costs and $19.8 million would have off-set fee-for-service costs.

In its response, New York noted that it was in the process of implementing new legislation pursuant to which non-custodial parents could be required to contribute toward the Medicaid or SCHIP premium costs when they had the financial means to do so, but they could not provide private coverage since it was unavailable or unaffordable. However, the contribution would not be of the magnitude envisioned by the OIG. Moreover, this legislation did not address cost recovery in Medicaid fee-for-service cases. Thus, the state felt that the OIG estimate of potential cost recovery was too high.

The OIG suggested that the state amend the legislation to consider cost recovery in fee-for-service cases. The state said it would consider this recommendation. However, since it felt that OIG's cost recovery scheme required a higher contribution from noncustodial parents than New York policy envisioned, the state continued to believe that the potential cost savings was less than envisioned by the OIG.

North Carolina—The OIG estimated that 88,533 children received Medicaid benefits in North Carolina during the study period (June 2001 – May 2002) since their non-custodial parent did not provide court-ordered health care coverage because it was either not offered through employment or was too costly. Of that group, 30,987 children had a non-custodial parent who could have contributed to the cost of Medicaid. The aggregate deemed collectible was a little more than $17.4 million.

The OIG recommended that the state adopt laws that would require noncustodial parents to contribute toward their child's Medicaid costs.

The state responded positively to the report, but noted that implementation of recommended changes would be costly. It asked for clarification about potential federal funding from IV-D or Medicaid and pointed out that the bulk of the savings would be federal, so the federal government should help pay the costs of the proposal. The state will appoint a committee to further research this issue and may introduce legislation in the 2005 legislative session.

Texas—The OIG estimated that 86,011 children received Medicaid benefits in Texas during the study period (June 2001 – May 2002) since their non-custodial parent did not provide court-ordered health care coverage because it was either not offered through employment or was too costly. Of that group, 60,271 children had a non-custodial parent who could have contributed toward the cost of Medicaid coverage. The aggregate amount deemed collectible was a little more than $16.6 million. Had it obtained these funds, the state could have recovered 45 percent of the total cost of $36.9 million for covering these children.

During the study period, Texas enacted legislation requiring non-custodial parents to contribute to the cost of Medicaid or SCHIP if the parent had the ability to pay and could not provide private coverage because it was unavailable or not affordable. The OIG reviewed a random sample of new cases on which at least one such payment had been made during the study period. It estimated that using the new law, the state collected $2.4 million. Cash medical support collections increased an average of 78 percent for state fiscal years 1999 to 2002.

The OIG recommended that Texas review and adjust old orders to require premium contributions under similar circumstances. Texas is in the process of doing this. However, it noted that the OIG projected cost savings may be too optimistic given the current economy. It also noted a potential inconsistency with the proposed medical child support enforcement performance indicator.

Virginia—The OIG estimated that 30,085 children received Medicaid benefits in Virginia during the study period (June 2001 – May 2002) since their non-custodial parent did not

provide court- or administratively-ordered health care coverage because it was either not offered through employment or was too costly. Of that group, 15,449 children had a non-custodial parent who could have contributed toward the cost of Medicaid coverage. The aggregate deemed collectible was a little more than $6.8 million. Had it obtained these funds, the state could have recovered 60 percent of the total cost of the $11.3 million spent covering these children. The OIG also noted that, given the Virginia child support guideline, the cash support available to children would decrease by an aggregate of $347,996 if its scheme were implemented.

The OIG recommended that Virginia consider legislation and other steps that would allow it to obtain contributions from noncustodial parents toward their children's Medicaid costs. The state agreed that it could play a greater role, but noted the need to update its automated systems to do so. The state also noted the need for federal guidance on handling interstate cases and the need for massive case review and adjustment to reach the OIG's projected cost savings.