



Memorandum

Date **MAR - 8 2002**

From Janet Rehnquist *Janet Rehnquist*
Inspector General

Subject Using State Child Support Enforcement (IV-D) Agencies to Increase SCHIP Enrollment (CIN: A-01-01-02500)

To Wade F. Horn, Ph.D.
Assistant Secretary for Children and Families

Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

I wanted to alert you that our final report entitled, "Using State Child Support Enforcement (IV-D) Agencies to Increase SCHIP Enrollment" will be issued to the Connecticut Department of Social Services within the next 5 business days. This review was undertaken as part of self-initiated audits by the Office of Inspector General. A copy of the report is attached.

Our objectives were to estimate: (1) how many uninsured children receiving IV-D services could be enrolled in the State Children's Health Insurance Program (SCHIP) if Connecticut's IV-D and SCHIP agencies coordinated the use of related information to enhance both enrollment processes; and (2) the amount non-custodial parents (NCPs) could contribute towards SCHIP premiums.

The Balanced Budget Act of 1997 established the SCHIP under Title XXI of the Social Security Act (Act) to provide funding to States to offer health coverage for uninsured children of low-income families that do not qualify for Medicaid and to expand Medicaid coverage. Our report points out that the information obtained by Connecticut's IV-D agency can be an effective tool for identifying and enrolling uninsured children. In this regard, we tested a sample of children from Connecticut's IV-D database and estimated that 13,100 uninsured children could have been enrolled in SCHIP from March 2000 through February 2001 as follows:

- 11,600 uninsured children of NCPs residing in Connecticut; and
- 1,500 uninsured children of NCPs residing in other States.

This potential enrollment tool could have increased SCHIP enrollment for Connecticut from 8,000 children (36 percent of its 1998 target of 22,300 children) to approximately 21,100 children (95 percent of the 1998 target) as of February 2001.

Our analysis also found that NCPs could contribute an estimated \$10.9 million (\$7.1 Federal Share) of the \$17.6 million (\$11.4 Federal share) that it would cost to enroll these 11,600 children into SCHIP. Further, we estimated that NCPs residing in other States could contribute 83 percent of the premiums for an estimated 1,500 additional IV-D children. Federal legislation would be required to collect premiums.

Under the provisions of the Child Support Performance and Incentives Act of 1998 (CSPIA), the Medical Child Support Working Group was formed to develop recommendations for effective enforcement of medical support orders by State IV-D agencies. However, States are not obligated to implement these recommendations. We compared barriers we identified for enrolling IV-D children into SCHIP in Connecticut with recommendations reported by the CSPIA working group. Based on our analysis, we recommended that the State:

- Improve the coordination of information between the IV-D agency and the enrollment broker throughout its SCHIP enrollment process, including informing applicants of services provided by both programs.
- Enact legislative change that would allow the IV-D agency to provide the CP's financial information to the enrollment broker when a NCP enrolls his/her child into SCHIP.
- Modify existing medical support orders written under prior laws to require NCPs to enroll their children in SCHIP if health insurance is not otherwise available at reasonable cost.
- Modify existing child support guidelines to provide standards for magistrates to determine and assess NCPs contributions towards SCHIP premiums.

The State concurred with our findings and recommendations. We are expanding our review to additional States to determine whether similar opportunities for increasing enrollment in SCHIP are available. We will also determine whether there are other factors which could impact the exchange of IV-D data with SCHIP and the NCPs participation in the SCHIP premiums.

If you have any questions or comments on any aspect of this report, please contact me or have your staff contact Donald L. Dille, 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-01-01-02500 in all correspondence relating to this report.

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**USING STATE CHILD SUPPORT
ENFORCEMENT (IV-D) AGENCIES
TO INCREASE SCHIP
ENROLLMENT**



**JANET REHNQUIST
INSPECTOR GENERAL**

**MARCH 2002
A-01-01-02500**



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CIN: A-01-01-02500

MAR 13 2002

Ms. Patricia A. Wilson-Coker
Commissioner
Connecticut Department of Social Services
25 Sigourney Street
Hartford, Connecticut 06106

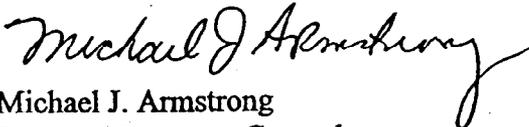
Dear Ms. Wilson-Coker:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Using State Child Support Enforcement (IV-D) Agencies to Increase SCHIP Enrollment" for the period March 2000 through February 2001. Should you have any questions or comments concerning the matters commented on in this report, please direct them to the HHS official named below.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available 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.)

To facilitate identification, please refer to Common Identification Number A-01-01-02500 in all correspondence relating to this report.

Sincerely,


Michael J. Armstrong
Regional Inspector General
For Audit Services

Enclosures - as stated

Direct reply to HHS Action Official:

Mr. Hugh F. Galligan
Regional Administrator
US Department of Health and Human Services
John F. Kennedy Federal Building, Room 2000
Boston, Massachusetts 02203

EXECUTIVE SUMMARY

BACKGROUND

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act (Act) to provide funding to States to provide health coverage for uninsured children of low-income families that do not qualify for Medicaid and to expand Medicaid coverage. This program is administered by the Centers for Medicare and Medicaid Services.

In response to SCHIP legislation, Connecticut implemented its Health Care for Uninsured Kids and Youth (HUSKY) Plan on June 1, 1998. The State originally estimated in Federal Fiscal Year (FFY) 1998 that it could enroll 22,300 uninsured children into SCHIP through the HUSKY Plan by the end of FFY 2000. Recognizing that a number of children in the IV-D program could benefit from the SCHIP, Connecticut enacted legislation requiring non-custodial parents (NCPs) to enroll their child(ren) into HUSKY when access to reasonable health insurance is unavailable. Title IV-D of the Act is administered by the Administration for Children and Families (ACF) and State IV-D agencies seek medical support, among other things, from NCPs. As of February 2001, Connecticut had enrolled over 8,000 uninsured children in SCHIP and about 400 of them were receiving IV-D services.

OBJECTIVE

Our objectives were to estimate (1) how many uninsured children receiving IV-D services could be enrolled in State Children's Health Insurance Program (SCHIP) if Connecticut's IV-D and SCHIP agencies coordinated the use of related information to enhance both enrollment processes; and (2) the amount non-custodial parents (NCPs) could contribute towards SCHIP premiums.

SUMMARY OF FINDINGS

We estimated that Connecticut could have enrolled an additional 11,600 uninsured children into SCHIP from March 1, 2000 through February 28, 2001, if the State IV-D agency was used as an enrollment tool. When combined with actual enrollment of 8,000 children as of February 2001, the State would have enrolled about 19,600 (88 percent) of its 1998 target of 22,300 children. If an estimated 1,500 children for interstate cases were included, Connecticut would have enrolled 21,100 children, reaching 95 percent of its 1998 enrollment target. Overall, the State could have provided approximately 13,100 additional uninsured children (11,600 + 1,500) with adequate health care, including immunizations and check-ups.

Further, we found that the non-custodial parents (NCPs) for the 11,600 children resided in Connecticut. Based on our review of IV-D records and formulas for calculating support, we estimated that these NCPs could have contributed about \$10.9 million (\$7.1 million Federal Share) of the \$17.6 million (\$11.4 million Federal Share) in HUSKY

premiums that were incurred by the State and the Federal government. Our cost estimate is based on the assumption that the custodial parents (CPs) could not contribute towards the HUSKY premiums and the NCPs would opt to pay the least amount possible. Further, we estimated that NCPs residing in other States could contribute 83 percent of the premiums for an estimated 1,500 additional IV-D children if State IV-D agencies had the authority to cross State boundaries and collect SCHIP premiums.

While Connecticut has been instrumental in developing legislation that involves the IV-D agency in the HUSKY enrollment process, certain barriers have minimized the full potential of this enrollment tool.

Although Congress passed the Child Support Performance and Incentives Act of 1998 (CSPIA), Public Law 105-200 (effective October 1, 2001) to encourage the States to enforce medical support orders and provide health coverage to uninsured children, we found that it will not eliminate the barriers identified in the report and addressed in our recommendations.

RECOMMENDATIONS

We recommend that Connecticut:

1. Improve the coordination of related information between the IV-D agency and the enrollment broker throughout the HUSKY enrollment process, including informing applicants of services provided by both programs.
2. Enact a legislative change that would allow the IV-D agency to provide the CP's financial information to the enrollment broker when a NCP enrolls his/her child into HUSKY.
3. Modify existing medical support orders written under prior laws to require NCPs to enroll their children in HUSKY if health insurance is not otherwise available at reasonable cost.
4. Modify existing child support guidelines to provide standards for magistrates to determine and assess NCPs contributions towards HUSKY premiums.

STATE AGENCY COMMENTS

The State concurred with the above recommendations (See Exhibit C).

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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) and is administered by the Administration for Children and Families (ACF). State child support enforcement agencies are responsible for administering the program, including locating absent parents, establishing paternity, establishing orders for financial and medical support, enforcing the orders, and collecting and disbursing the support due. In Connecticut, the Bureau of Child Support Enforcement (the State IV-D agency) administers the child support enforcement program. However, the function of enforcing financial and medical support orders is provided by the State's judicial branch under a cooperative agreement.

Enforcing medical support orders and providing children with adequate health care has been a key Congressional concern over the past decade.

- The Omnibus Reconciliation Act (OBRA) of 1993 requires IV-D agencies to establish medical support orders for children when the non-custodial parent (NCP) has access to medical coverage.
- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 directed the child support agency to notify an employer of the NCP's medical child support obligation.
- The Balanced Budget Act of 1997 established the State Children's Health Insurance Program (SCHIP) program under Title XXI of the Social Security Act to provide funding to States to provide health coverage for uninsured children of low-income families that do not qualify for Medicaid and to expand Medicaid coverage. This program is administered by the Centers for Medicare and Medicaid Services.

A 1994 study by the Census Bureau showed that the percentage of persons not covered by health insurance increased as income levels decreased. Further, a study by the Employee Benefits Research Institute found that:

- the number of uninsured children in 1995 was about 10 million; and
- the number of children covered by employer-based insurance had decreased from 67 percent in 1987 to 59 percent in 1995.

While the intention of SCHIP was to provide health coverage for about 5 million of the 10 million uninsured children in 1995, only 2.3 million have been enrolled as of FFY 2000.

In response to SCHIP legislation, Connecticut implemented its Health Care for Uninsured Kids and Youth (HUSKY) Plan on June 1, 1998. The Medicaid Policy Administration (MPA) administers the HUSKY program. To enroll in HUSKY, a parent contacts the HUSKY enrollment broker and fills out an application detailing the financial aspects of the household where the child lives. To encourage enrollment, Connecticut runs various outreach programs including television commercials, newspaper advertisements, and videos. The State originally estimated in FFY 1998

that it could enroll 22,300 uninsured children into SCHIP through the HUSKY Plan by the end of FFY 2000. This estimate was based on the 1990 Federal Census, adjusted for projected population growth and the rate of uninsured children. As of February 2001, Connecticut had enrolled over 8,000 uninsured children in SCHIP and about 400 of them were receiving IV-D services.

Children enrolled in HUSKY receive benefits through managed care organizations under contracts with MPA. Based on household income, parent(s) can pay between \$0 and \$200 in monthly premiums to the managed care facility. The difference between the amount paid by the parent(s) and the amount charged by the managed care facilities may be subsidized with State and Federal funds as follows:

- Both the State and Federal governments subsidize 50 percent of the Medicaid premiums when household income is less than 185 percent of the Federal poverty level.
- The Federal share of SCHIP subsidies is 65 percent and the State covers the remaining 35 percent of the premiums when household income falls between 185 and 300 percent of the Federal poverty level. The maximum amount Connecticut subsidizes for SCHIP coverage is \$133 per child.
- While Connecticut offers comprehensive health coverage to children who reside in households with income greater than 300 percent of the Federal poverty level, the State or Federal government does not subsidize the group rates charged by the managed care facility.

In Federal Fiscal Year (FFY) 1998, the Federal government allotted \$35.0 million to Connecticut to cover the Federal share for SCHIP and the Medicaid expansion through September 30, 2000. Despite efforts to enroll uninsured children into either health care program, Connecticut was identified as one of forty States that did not spend its 1998 allotment as of September 30, 2000. As a result, \$9.5 million of the \$35.0 million allotted to the Connecticut was reallocated to the ten States that fully spent their allotted funds.

OBJECTIVES, SCOPE AND METHODOLOGY

Objectives

Our objectives were to estimate (1) how many uninsured children receiving IV-D services could be enrolled in State Children's Health Insurance Program (SCHIP) if Connecticut's IV-D and SCHIP agencies coordinated the use of related information to enhance both enrollment processes; and (2) the amount non-custodial parents (NCPs) could contribute towards SCHIP premiums.

Scope and Methodology

Our review was conducted in accordance with generally accepted government auditing standards. To accomplish our audit objective, we:

- Reviewed Federal regulations and State policies and procedures for the enforcement of medical support orders.

- Selected a random sample of 200 children from a population of 21,631 children:
 - who received IV-D services,
 - whose NCPs had been court ordered to provide health coverage, if available by an employer, and
 - whose case files indicated that health coverage has not been provided, including Medicaid, from March 1, 2000 through February 28, 2001.

- Selected a random sample of 100 children from a population of 392 children:
 - who received IV-D services,
 - whose NCPs had been court ordered to provide health coverage, if available by an employer, and
 - who received SCHIP benefits from March 1, 2000 through February 28, 2001.

- Reviewed State IV-D computer files to determine the medical enforcement status for each child in both samples and the amount paid in child support. Also, we verified the accuracy of medical support information to computer files independently maintained by other State agencies. However, we relied on State IV-D records to determine if health insurance was available to the NCP and if the cost of insurance was reasonable.

- Tested the reliability of computer files used to determine the populations for both samples by tracing to source documents the child's name, date of birth, case identification number and NCP name.

- Verified whether custodial parent (CP) income did not exceed the SCHIP ceiling of 300 percent of the Federal poverty level by obtaining income information from the:
 - Department of Labor for the CPs for the sample of 200 children, and
 - managed care facilities for the sample of 100 children.

- Identified NCPs who could pay part or all of the HUSKY premiums for both samples by using State IV-D agency information and formulas for calculating child and medical support.

- Applied attribute sample appraisal methodologies to project the number of uninsured children (See Appendices A and B).

- Applied variable sample appraisal methodology to project the amount NCPs can contribute towards SCHIP (See Appendices A and B).

We performed our fieldwork at the State IV-D agency and Judicial Branch between June 2001 and October 2001. We issued our draft report on December 4, 2001, and received comments from Connecticut on January 3, 2002 (See Exhibit C).

FINDINGS AND RECOMMENDATIONS

We estimated that Connecticut could have enrolled an additional 11,600 uninsured children into the SCHIP option of the HUSKY Plan from the period March 1, 2000 through February 28, 2001, if the State IV-D agency was used as an enrollment tool. When combined with actual enrollment of 8,000

children as of February 2001, the State would have enrolled about 19,600 (88 percent) of its 1998 target of 22,300 children. If an estimated 1,500 children for inter state cases were included, Connecticut would have enrolled approximately 21,100 children, reaching 95 percent of its 1998 enrollment target. Overall, the State could have provided about 13,100 additional uninsured children (11,600 + 1,500) with adequate health care, including immunizations and check-ups.

Further, we found that the NCPs for the 11,600 children resided in Connecticut. Based on our review of IV-D records and formulas for calculating support, we estimated that these NCPs could contribute about \$10.9 million (\$7.1 million Federal Share) of the \$17.6 million (\$11.4 million Federal Share) in HUSKY premiums that was incurred by the State and the Federal government. Our cost estimate is based on the assumption that the CPs could not contribute towards the HUSKY premiums and the NCPs would opt to pay the least amount possible. Further, we estimated that NCPs residing in other States could contribute 83 percent of the premiums for an estimated 1,500 additional IV-D children if State IV-D agencies had the authority to cross State boundaries and collect SCHIP premiums.

While Connecticut has been instrumental in developing legislation that involves the IV-D agency in the HUSKY enrollment process, the barriers below have minimized the full potential of this enrollment tool.

1. Limited coordination of information between Connecticut's HUSKY (SCHIP) and IV-D programs.
2. Inaccessible financial information for the CP when the NCP enrolls his/her child in HUSKY.
3. Court orders written under prior legal requirements do not include the language needed to order HUSKY enrollment or enforce premium payments by NCPs.
4. State child support guidelines do not specify the amount NCPs can contribute towards HUSKY premiums.
5. Lack of Federal regulation to allow the States to collect SCHIP premiums across State lines.

Below demonstrates how the State IV-D agency can be used as an effective tool to increase SCHIP enrollment and to overcome inherent barriers.

STATE IV-D AGENCY CAN BE USED AS AN EFFECTIVE TOOL TO INCREASE SCHIP ENROLLMENT

Our analysis included the potential enrollment of IV-D Children into SCHIP, the estimated amount NCPs could contribute towards SCHIP premiums and the feasibility of NCP contributions.

Potential Enrollment of IV-D Children into SCHIP

Congress enacted SCHIP to assist the States in initiating and expanding child health assistance to uninsured, low-income children who do not qualify for Medicaid. Federal law requires that coverage and benefits be similar to health plans State and Federal governments offer their employees. Unlike Medicaid, families are required to contribute towards the premiums, limited to 5 percent of household income. Connecticut Law, Public Act 97-1, Section 17b –293 (a) requires, at minimum, that children receiving SCHIP benefits should include free preventative visits, health care, prescription drugs, eye care, and orthodontia. Also, the law does not preclude coverage for pre-existing conditions.

Recognizing that a number of children in the IV-D program could benefit from the SCHIP, Connecticut enacted legislation requiring NCPs to enroll their child(ren) into HUSKY when access to health insurance at reasonable cost is unavailable. The State's IV-D program is operated on a judicial basis meaning support must be ordered and modified through the courts. 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.

We reviewed a random sample of 200 State IV-D children to determine how many could be enrolled into SCHIP through the HUSKY Plan. Our sample was selected from 21,631 children:

- whose NCPs have been court ordered to provide health coverage, if available by an employer; and
- whose case files indicated that health coverage had not been provided, including Medicaid.

As shown in Figure 1, our results identified 107 out of 200 children that went without health coverage for at least the period March 2000 through February 2001. The NCPs for these children had not provided health care coverage because it was either too costly or it was not available. We also determined that household income where the children resided did not exceed Connecticut's SCHIP eligibility requirement of 300 percent of the Federal poverty level.

Further, we identified an additional 14 children whose files did not indicate that health coverage was provided by NCPs residing in other States. The

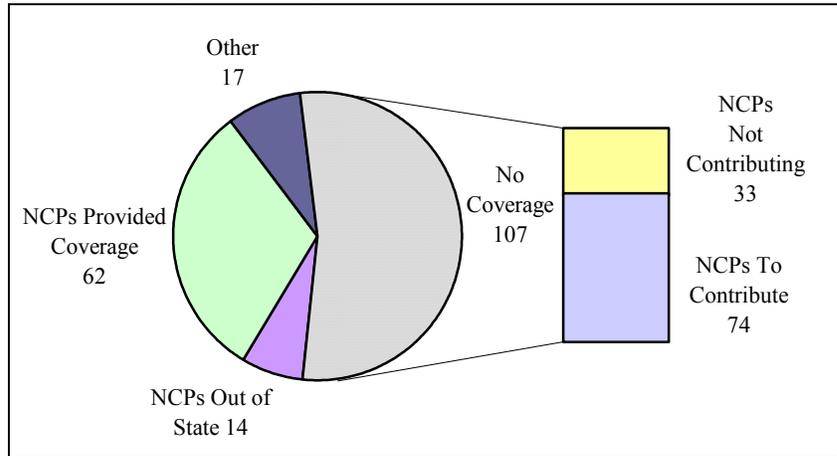


Figure 1—Health Coverage for Sample of 200 IV-D Children

The State IV-D agency has no authority and limited access to information for its interstate cases. For the remaining children in our sample, 62 received health coverage through their NCPs and 17 either received health coverage through their CPs, household income exceeded SCHIP eligibility¹ requirements or the CP moved out of the State.

Projecting our results of the 107 children without health coverage disclosed that Connecticut could have enrolled an estimated 11,600 children into SCHIP through the State IV-D agency from March 2000 through February 2001. When combined with actual enrollment of 8,000 as of February 2001, the State could have enrolled about 19,600 (88 percent) of its 1998 target of 22,300 children. In addition, we projected the 14 children representing interstate cases and found that if an estimated 1,500 children had been enrolled, Connecticut would have provided a total of 21,100 uninsured children (19,600 + 1,500) with access to adequate health care, including check-ups and immunizations.

Estimated Amount NCPs Could Contribute Towards SCHIP Premiums

Connecticut Law, Public Act 99-279 Section 28 (2) (A), adds that magistrates can order NCPs to pay a specified amount to offset part or all of the HUSKY premiums paid on behalf of their children. Also, State law protects current child support orders by stipulating that amounts paid by NCPs for child support cannot be reduced by the amount ordered as payment towards HUSKY premiums. However, State Support Enforcement officials do not pursue NCPs for contempt of medical support if they believe the cost of health insurance offered by employers is unreasonable or not available. In these situations, it is the CPs and/or taxpayers rather than the NCPs that pay the cost of health care services provided to uninsured children.

¹ Our review did not focus on children who reside in households with income greater than 300 percent of the Federal poverty level. However, comprehensive health coverage through HUSKY is available to these children at a group rate. In this regard, additional children could be enrolled into HUSKY, but not SCHIP.

To determine how much the NCPs could contribute towards the cost of enrolling their IV-D children in the HUSKY Plan, we used Connecticut’s IV-D guidelines and formulas for determining child and medical support, including the following information:

- NCP net pay.
- Monthly child support payments.
- Minimum NCP income for self-support.
- CP income not exceeding SCHIP eligibility requirements.
- Zero contributions to HUSKY premiums by CPs.
- SCHIP premiums for least expensive HUSKY Plan option.

Our analysis found that it would cost \$17.6 million to enroll the estimated 11,600 IV-D children in SCHIP. Using our sample results presented in Figure 1, we noted that NCPs for 33 of the 107 IV-D children without health coverage could not contribute towards the HUSKY premiums because they were incarcerated, indigent or low-income earners. Accordingly, Connecticut and the Federal government would bear an estimated cost of \$5.4 million for about 3,600 of the 11,600 IV-D children that could be enrolled into HUSKY.

However, NCPs for 74 of the 107 IV-D children could afford part or all of the HUSKY premiums. We estimated that the cost to enroll the remaining 8,000 IV-D children into HUSKY (11,600 less 3,569 children) would be \$12.2 million (\$7.8 million Federal share) and the NCPs could contribute \$10.9 million (\$7.1 million Federal share).

In addition, we estimated that the NCPs residing in other States could contribute 83 percent of the HUSKY premiums for an estimated 1,500 additional IV-D children if the State IV-D agencies had the authority to cross State boundaries and collect SCHIP premiums.

Feasibility of NCP Contributions

As previously described above, 392 IV-D children had enrolled in SCHIP from March 2000 through February 2001. To test the feasibility of our assertions, we tested a sample of 100 IV-D children from the population of 392 IV-D children. We confirmed that household income did not exceed the SCHIP ceiling of 300 percent of the Federal poverty level and analyzed NCP financial information to determine whether they could pay for all or part of the subsidized SCHIP premiums. As illustrated in the table below, we found that 68 percent of the NCPs could cover 83 percent of subsidized premiums paid in behalf of their children.

Base	NCPs to Contribute Towards Premiums	Percentage of NCPs to Contribute	Total HUSKY Premiums	Amount Payable by NCPs	Percentage of Premiums Payable by NCPs
100 IV-D Children in SCHIP	68	68%	\$417,621	\$346,532	83%
107 Uninsured IV-D Children	74	69%	\$12.2M	\$10.9M	89%

We compared the results for our sample of 100 IV-D children enrolled in SCHIP to the 107 uninsured IV-D children identified in our sample of 200 children. We found that the percentage of NCPs that can pay part or all of the SCHIP premiums for both samples is nearly exact (68 percent

verses 69 percent). Furthermore, our estimate that the NCPs could pay 89 percent of the SCHIP premiums is reasonable when compared to 83 percent of the NCPs that can contribute towards the cost of health care coverage for the IV-D children that were enrolled in SCHIP.

CURRENT BARRIERS

A more recent study estimated that 7 million out of 11 million uninsured children in the United States were eligible for health care coverage through SCHIPS or Medicaid in 2000. This statistic suggests that the States encountered unforeseen barriers for enrolling uninsured yet eligible children into government funded health care plans. Our review indicated that a substantial number of Connecticut's uninsured children received IV-D services. While the State has been instrumental in developing legislation that involves the State IV-D agency in the SCHIP enrollment process, certain barriers not unique to Connecticut need to be overcome to improve this enrollment tool.

On the Federal level, Congress passed the Child Support Performance and Incentives Act of 1998 (CSPIA), Public Law 105-200 (effective October 1, 2001) to encourage the States to enforce medical support orders and provide health coverage to uninsured children.

Under the provisions of CSPIA, the Medical Child Support Working Group was formed to develop recommendations for effective enforcement of medical support by State IV-D agencies and to report these recommendations to the HHS Secretary. Because these recommendations are not currently regulations, the States are not obligated to implement them. Below, we compared the barriers we identified for enrolling IV-D children into SCHIP in Connecticut with recommendations reported by the CSPIA working group.

1. *Limited coordination of information between Connecticut's HUSKY (SCHIP) and IV-D programs*—The State is in the process of developing a way for the HUSKY and IV-D agencies to share database information and inform applicants of services provided by both programs. The CSPIA working group recommended that the Secretary of HHS should establish a group to, among other things, assess the feasibility of each State creating a IV-D/Medicaid/SCHIP database to facilitate information exchange.
2. *Inaccessible financial information for the CP when the NCP enrolls his/her child in HUSKY*—In Connecticut, magistrates can order NCPs to enroll their children into HUSKY when health coverage is not available. In order for NCPs to enroll their children, they need the CP's financial information. The State found that CPs were reluctant to (1) provide this information to the NCPs for various personal reasons, and (2) apply for benefits when State laws would make them liable for any premiums imposed. This dilemma may result in neither the NCP or CP enrolling their child(ren) in SCHIP. The CSPIA working group recommended as a best practice that CPs should be directed to enroll their child in SCHIP and NCPs be required to pay for the premium (up to certain limitations) if coverage is not available.
3. *Court orders written under prior legal requirements do not include the language needed to order HUSKY enrollment or enforce HUSKY premium payments by NCPs*—Court orders for medical support written under prior laws only required NCPs to provide health coverage when it is available through their employer. Under the law passed to implement HUSKY, the State IV-D agency can require NCPs to enroll their children in HUSKY when medical

insurance is not available. To bring every medical support order in compliance with the current HUSKY laws, the State IV-D agency would have to modify through the courts the orders established before HUSKY legislation was passed. The CSPIA working group has not formulated specific recommendations to address this issue.

4. *State child support guidelines do not specify the amount NCPs can contribute towards HUSKY premiums*—Under Connecticut’s law, magistrates can use their discretion in assessing NCPs contributions towards HUSKY premiums. However, Connecticut officials have indicated that child support staff were reluctant to recommend an amount and magistrates have not imposed a charge in most cases to the NCPs because of a lack of definitive guidelines for determining NCP contributions. Accordingly, magistrates generally erred on the side of caution and did not impose a charge for HUSKY premiums. The CSPIA working group suggested a limit of 5 percent of gross income when determining NCP contributions for health care coverage. This appears reasonable considering the vast knowledge of working group members, including individuals from HHS, DOL, State child support and Medicaid directors, employers, group health plans, and related advocacy groups.

5. *Lack of Federal legislation to allow the States to collect SCHIP premiums across State lines* – Currently, Connecticut, like all States, does not have the authority to cross State borders and require NCPs to provide health care coverage or collect premiums when their child(ren) had been enrolled in HUSKY. The full implementation of CSPIA may vary from State to State based on whether they received a waiver. While CSPIA does not prohibit nor clearly provide guidance for States to cross State lines and enforce medical support, the intent of the law is to allow the States to contact employers and require them to directly enroll NCP children into their health plans. Further, the law does not provide States with the authority to cross borders and collect from NCPs premiums for children enrolled in SCHIP.

RECOMMENDATIONS

We recommend that Connecticut:

1. Improve the coordination of related information between the IV-D agency and the enrollment broker throughout the HUSKY enrollment process, including informing applicants of services provided by both programs.
2. Enact legislative change that would allow the IV-D agency to provide the CP’s financial information to the enrollment broker when a NCP enrolls his/her child into HUSKY.
3. Modify existing medical support orders written under prior laws to require NCPs to enroll their children in HUSKY if Health insurance is not otherwise available at reasonable cost.
4. Modify existing child support guidelines to provide standards for magistrates to determine and assess NCPs contributions towards HUSKY premiums.

STATE AGENCY COMMENTS

The State concurred with our recommendations for the first four barriers in which they have direct control (See Exhibit C). The fifth barrier directly involves the Federal Government and is addressed in a Memorandum to Management to ACF and CMS. As stated above, Connecticut's IV-D agency has been proactive in increasing SCHIP enrollment by adopting legislation that authorizes family magistrates to order NCPs to: (1) apply for HUSKY benefits; and (2) pay for part or all of the HUSKY premiums. Further, Connecticut is taking the below steps to eliminate the barriers we identified in our report.

- Providing HUSKY enrollment brokers with access to child support records to improve the coordination between the two programs (Barrier 1);
- Running cross-matches between the child support and HUSKY computer databases for the purpose of outreach to families to make them aware of the services both programs offer (Barrier 1);
- Proposing legislation that would allow the State agency to share relevant information concerning CPs and children with the HUSKY enrollment broker. This would allow the NCP to provide health coverage for his child through HUSKY without having access to the CPs personal information (Barrier 2);
- Training child support staff and providing outreach to magistrates regarding the use of the HUSKY program as an alternative when NCPs do not have access to affordable health care (Barrier 3); and
- Requesting a waiver from the Federal Offices of Child Support Enforcement to adopt five percent of a NCPs' gross income as a guideline for determining their ability to pay private health insurance. If approved, this will be used as a determining factor in identifying the amounts NCPs can contribute toward HUSKY premiums (Barrier 4).

**ESTIMATE OF IV-D CHILDREN THAT COULD BE
ENROLLED IN SCHIP FOR NCPs**

We reviewed a random sample of 200 cases from a population of 21,631 IV-D children eligible for SCHIP to determine how many children could be enrolled in HUSKY (SCHIP). Our sample was selected from 21,631 children:

- o who received IV-D services,
- o whose NCPs had been court ordered to provide health coverage, if available by an employer, and
- o whose case files indicated that health coverage has not been provided, including Medicaid, from March 1, 2000 through February 28, 2001.

In projecting our sample, we took a conservative approach by assuming that the CP had no income to contribute towards the HUSKY premiums and the NCP would opt for the lowest cost health plan. The table below summarizes our statistical results for NCPs residing in Connecticut (107 IV-D children) and NCPs residing in other states (14 IV-D children).

NCPs RESIDING IN CONNECTICUT	Number of Cases	Projected Totals (Mean)	90 Percent Confidence Interval	
			Lower Limit	Upper Limit
Number of children who could be enrolled	107	11,573 ^(a)	10,267	12,861
Cost to enroll these children into HUSKY	107	\$17.6M	\$15.7M	\$19.5M
NCPs that could pay all or part of the HUSKY Premiums				
Number of children who could be enrolled	74	8,003	6,777	9,293
Cost to enroll these children into HUSKY	74	\$12.2M	\$10.3M	\$14.0M
Amount NCPs can contribute to premiums	74	\$10.9M	\$9.2M	\$12.6M
NCPs that could not pay HUSKY Premiums				
Number of children who could be enrolled	33	3,569	2,670	4,632
Cost to enroll these children into HUSKY	33	\$5.4M	\$4.0M	\$6.8M

<i>NCPs RESIDING IN OTHER STATES</i>	Number of Cases	Projected Totals (Mean)	90 Percent Confidence Interval	
			Lower Limit	Upper Limit
Number of children who could be enrolled	14	1,514 ^(b)	928	2,317
Cost to enroll these children into HUSKY	14	\$2.3M	\$1.3M	\$3.3M
Amount NCPs can contribute to premiums	13	\$1.9M	\$1.0M	\$2.8M

*Note: \$1.9 million divided by \$2.3 million = 83%

*Note: (a) and (b) we rounded these number in the body of the report to 11,600 and 1,500 respectively.

EXHIBITS

Exhibit B

FEASIBILITY OF NCP CONTRIBUTIONS

We reviewed a random sample of 100 cases from a population of 392 children:

- who received IV-D services,
- whose NCPs had been court ordered to provide health coverage, if available by an employer, and
- who received HUSKY benefits from March 1, 2000 through February 28, 2001.

In projecting our sample results for the 68 NCPS who could contribute towards all or part of the cost of enrolling their children into HUSKY, we used actual premiums established by the managed care facility. The table below summarizes our statistical results.

	Number of Cases	Projected Totals (Mean)	90 Percent Confidence Interval	
			Lower Limit	Upper Limit
Cost of HUSKY premium for their children	68	\$417,621	\$376,286	\$458,956
Amount NCPs can contribute to premiums	68	\$346,532	\$307,105	\$385,959



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

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January 3, 2002

Michael J. Armstrong
Regional Inspector General for Audit Services
Region I
John F. Kennedy Building
Boston, MA 02203

Re: Review of Medical Availability by Expanding SCHIP Coverage
CIN: A-01-01-02500

Dear Mr. Armstrong:

In response to the Balanced Budget Act of 1997 which established the State Children Health Insurance Program (SCHIP) Connecticut implemented in 1998 the Health Care for Uninsured Kids and Youth (HUSKY) Plan. The HUSKY Plan combines Medicaid with newer services under SCHIP in a comprehensive health coverage package for children, teenagers and some eligible parents and relative caregivers.

Both HUSKY and the Child Support program are vital to the plans of families to become and remain self-sufficient. We recognized the importance of the two programs and how they can complement each other by adopting legislation in 1999 which authorizes Family Support Magistrates in child support cases to order either the custodial party or the noncustodial parent to apply for HUSKY, and allows the Magistrate to order the noncustodial parent to reimburse part or all of the HUSKY premium.

We have reviewed the draft report and concur with your findings and recommendations concerning methods to increase the number of children enrolled in HUSKY and increase the amount of money noncustodial parents pay to offset the cost of the HUSKY premiums.

In support of the recommendations contained in the report we are planning the following actions.

1. *Limited coordination of information between Connecticut's HUSKY (SCHIP) and IV-D programs*
To address the limited coordination between the Child Support Program and HUSKY we are taking two steps. First, Child Support and Husky staff will be arranging for the staff at the State's HUSKY enrollment broker to have display access to the Child Support's Program's automated system. This should be accomplished by the end of January, 2002.

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Secondly, HUSKY and Child Support staff will be discussing methods to cross-match the families in the two caseloads for the purpose of outreaching to families to make them aware of the services and benefits both programs offer. We will first target families in the child support caseload who are not Medicaid recipients (HUSKY B/SCHIP families) and who do not have private medical insurance. Our second effort will target single parent families who are receiving HUSKY benefits, and who are not receiving child support. We would like to start the outreach at the beginning of March, 2002, but the implementation will be determined by how quickly the system changes can be made to perform the match.

A third effort will be to convene a meeting of staff from DSS's Child Support, Family Services, and Medical and HUSKY Divisions, Support Enforcement Services from the Judicial Branch, and the HUSKY enrollment broker to review processes, identify barriers and propose recommendations to facilitate the enrollment of children in HUSKY. This effort will also include how to better inform clients about their rights and responsibilities and the state procedures when the child's health care coverage, specifically Medicaid (HUSKY A), interacts with the Child Support Program. We expect the first meeting to be held by February 1, 2002.

2. *Inaccessible financial information for the CP when the NCP enrolls his/her child in HUSKY*

It is our intent to propose legislation in the upcoming 2002 legislative session to allow the agency to share relevant information concerning the custodial party and the children with the HUSKY enrollment broker and medical insurance providers. This will assist in cases in which the noncustodial parent (NCP) is ordered to apply for health insurance or HUSKY, the NCP does not possess or have access to information necessary to process the application, and the required information is maintained by this agency. If accepted and passed by the legislature, this process can be implemented shortly after the effective date of such legislation.

3. *Court orders written under prior legal requirements do not include the language needed to order HUSKY enrollment or enforce HUSKY premium payments by NCPs*

The training on the Child Support and HUSKY provisions of P.A. 99-279 given to Department of Social Services' and Judicial Branch's child support staff, Assistant Attorneys General, and the Family Support Magistrates was not as effective as had been expected. To insure that the staff of the Child Support partner agencies, and the Family Support Magistrates maximize the use of the P.A. 99-279 as a way to first, insure that children have access to quality health care, and secondly, have the NCP meet the requirements of his medical support order, we intend to make a renewed effort starting in March 2002 to train staff, and outreach to the Magistrates, about the use of the HUSKY Program as an alternative when the NCP does not have access to affordable health care coverage.

As a result of this effort we expect cases that do not now contain HUSKY language in the order and who are docketed for a Family Support Magistrate session due to a modification or contempt action, will have a HUSKY provision in the final order.

4. *State child support guidelines do not specify the amount NCPs can contribute towards HUSKY premiums*

We acknowledge that the present federal regulation for determining the reasonable cost for health insurance, i.e., available through an employer or some other group plan, is problematic when determining how much a noncustodial parent can afford to pay for private health insurance. To remove the vagueness in this standard we will be seeking from the federal Office of Child Support Enforcement (OCSE) a waiver to adopt 5% of a noncustodial parent's gross income as a guideline for determining his ability to pay for private health insurance. The 5% of gross income standard is a recommendation of the national Medical Child Support Working Group, which was formed to develop and make recommendations to the HHS Secretary concerning the effective enforcement of medical support by IV-D agencies. Staff from this agency's Bureau of Child Support Enforcement have already contacted their OCSE regional representative to discuss how best to request such a waiver.

To address the issue of the State's Child Support And Arrearage Guidelines not specifying an amount which the NCP can pay towards the cost of the HUSKY premium, we will be proposing the same 5% of gross income as a recommended payment on the HUSKY premium, provided the NCP's net disposable income, after current support is deducted, is not below the minimum amounts in the Guidelines. The implementation of this proposal will depend on the adoption of the waiver noted above.

We would like to compliment George Nedder and his staff for their cooperative spirit and their efforts to make this report thorough and meaningful. This report is an example of how federal and state agencies can work together to produce a product which benefits the individuals and families who need and rely on our services.

Sincerely,



Patricia A. Wilson-Coker
Commissioner

- C: Rita M. Pacheco, Deputy Commissioner
Michael P. Starkowski, Deputy Commissioner
Diane M. Fray, IV-D Director
Kevin Loveland, Director of Family Services
David Parella, Director of Medical Care Administration
Rose Ciarcia, Director of HUSKY
David Dearborn, Manager of Communications