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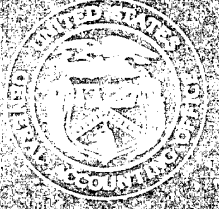
MEDICAID

Ensuring That Noncustodial Parents Provide Health Insurance Can Save Costs



GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-246421

June 17, 1992

The Honorable John Conyers, Jr.
Chairman, Committee on Government Operations
House of Representatives

Dear Mr. Chairman:

In fiscal year 1990, the states and the federal government paid about $18 billion in medical assistance payments for low-income families with children. These families generally qualify for medical assistance because they receive Aid to Families With Dependent Children (AFDC), an income-support program for primarily single-parent families. Since 1985, states have been required to take steps to ensure that the noncustodial parent in such families provide health insurance for the children, if such insurance is available through the noncustodial parent's employer. At the federal level, the Office of Child Support Enforcement (OCSE) within the Department of Health and Human Services (HHS) has oversight responsibility for this requirement. This report responds to your request that we evaluate state and federal efforts to ensure that noncustodial parents with available health insurance resources cover their Medicaid-eligible children.

Results in Brief

States are not ensuring that noncustodial parents provide health insurance for their children, even when such insurance is available through the noncustodial parents' employers. We estimate that the states and the federal government can save at least $122 million in medical expenditures annually if noncustodial parents provide health insurance that is available to them through their employment.

Two main problems limit the effectiveness of state enforcement efforts. First, federal requirements lack specificity, permitting wide variability in the laws and practices states have adopted to enforce medical support. For example, federal requirements specify only that states "take steps to enforce" a noncustodial parent's medical support obligation, but provide no guidance on the most effective approaches or the desired outcomes. Consequently, the extent to which states have adopted effective laws and procedures varies widely.

Even when states have effective procedures in place, a second problem has surfaced: employers with health plans covered by the Employee Retirement Income Security Act of 1974 (ERISA) that self-insure can

exclude a noncustodial parent's children from coverage. These plans do so either by (1) narrowly prescribing who is eligible for dependent coverage, such as requiring that dependents live with the policyholder in order to be covered, or (2) otherwise not complying with state medical support laws, such as those requiring that health insurers enroll the children of noncustodial parents in their health plan. Since state authority over these plans is limited, states cannot compel their compliance with state medical support requirements. A further discussion of our findings can be found in appendix I.

To help assure that state compliance with federal regulations results in effective state medical support programs for children, we are recommending that the Congress require, as a condition of federal participation in their child support programs, that states enact effective enforcement laws. Further, we are recommending that OCSE clarify state medical support responsibilities, either by specifying required enforcement steps and the time frames states have for taking them, or establishing outcome-oriented standards by which states' performance can be measured.

Additionally, states cannot implement programs that maximize savings without a means to ensure that ERISA plans comply with state medical support enforcement requirements. Accordingly, we are recommending that the Congress amend ERISA to broaden current state authority over ERISA plans. Our suggested legislative language, with an accompanying explanation, appears in appendix II.

Scope and Methodology

To determine whether states have implemented effective medical support programs, we relied in part on past reviews of state medical support efforts. In addition, using the child support and alimony supplement of the 1990 Bureau of Census Current Population Survey, we developed estimates of the savings lost to Medicaid when noncustodial parents did not provide health insurance coverage (see app. III). For a more detailed analysis at the state level, we selected 12 states across the country: Arkansas, California, Connecticut, Maryland, Michigan, North Dakota, Oregon, South Carolina, Tennessee, Texas, Utah, and Washington. We reviewed these states' child support enforcement laws and procedures and interviewed state Medicaid and Child Support Enforcement (CSE) officials. In Michigan and Washington, we also conducted on-site reviews of case files to assess the extent to which noncustodial parents were providing medical support. For additional information on the effect ERISA has on

state medical support efforts, we identified and contacted 6 additional states that we were told could have further information on ERISA.

We conducted our work between February 1991 and January 1992 in accordance with generally accepted government auditing standards.

As agreed with your office, we did not obtain written comments from HHS. However, we discussed the results of our work with OCSE officials, including the deputy, associate deputy, audit division, program division, and policy division directors. Their comments are summarized on page 19.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties, and make it available to others on request.

This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues. Should you have any questions concerning the report, please call her on (202) 512-7119. Other major contributors are listed in appendix IV.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Contents

Abbreviations

AFDC	Aid to Families With Dependent Children
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
CPS	Current Population Survey
CSE	child support enforcement
ERISA	Employee Retirement Income Security Act of 1974
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OCSE	Office of Child Support Enforcement
OIG	Office of Inspector General

Medicaid: Ensuring That Noncustodial Parents Provide Health Insurance Can Save Costs

Background

In fiscal year 1990, about 25 million low-income people received medical care under Medicaid, a program funded jointly by the federal government and the states. A large percentage of these people qualify for Medicaid because they receive Aid to Families With Dependent Children, an income-support program for low-income, generally single-parent families. As a condition of eligibility for AFDC, single-parent families must use the services of the state's child support enforcement agency. These services include establishing paternity, locating noncustodial parents, and establishing and enforcing child support orders.

State CSE agency efforts, which are also available to the general public, are intended to promote family responsibility and save money for the federal and state governments. For AFDC applicants and recipients,[1] state CSE agencies must petition the courts for child support orders that include two types of support—cash support payments and health insurance. Cash support payments are used to offset AFDC expenditures, while health insurance reduces the need for Medicaid expenditures. CSE agency efforts also may benefit the federal and state governments by getting financial and medical support for nonwelfare families, thus preventing the need for their support. For many of these nonwelfare children, CSE agency medical support services—which must be offered to all families seeking services—may mean the difference between having health insurance, and not.[2]

While cash support enforcement has been a responsibility of state CSE agencies since OCSE was established in 1975, mandatory medical support enforcement was not addressed until the passage of the Child Support Enforcement Amendments of 1984. Implementing regulations required that state CSE agencies petition the courts or administrative authorities for available medical insurance in all support orders, unless other insurance already covered the custodial parent and children. The decision to require cash and medical support rests with the courts or administrative authorities, who are required to follow state guidelines for determining support amounts. Regulations also require that state CSE agencies

[1]In addition, CSE agencies are required to provide medical support services for some non-AFDC Medicaid eligibles.

[2]According to a May 1986 Urban Institute report, The Inclusion of Medical Coverage in Child Support Cases: Current Status and Options for the Future, Contract HHS-100-84-0032, of the 4.5 million children with a noncustodial parent and without any health care coverage, about 30 percent, or 1.4 million, might benefit from increased medical support efforts.

- take steps to enforce the medical support order if health insurance is available at a reasonable cost[3] to the noncustodial parent and has not been obtained at the time the order is in place and
- communicate the health insurance information to the state Medicaid agency.[4]

At the federal level, OCSE's responsibilities include providing technical assistance to states, establishing standards for effective state CSE programs, and overseeing CSE programs to assure their compliance with federal requirements.

Federal Reviews and Census Data Show Ineffective Medical Support Programs

State CSE agencies often have not assured that noncustodial parents provided available health insurance coverage, or that Medicaid was informed of noncustodial parents' insurance, recent audits and studies have shown. In 1987, the HHS Office of Inspector General (OIG) reported that health insurance was not included in the support orders for the majority of cases reviewed in nine states' medical support programs. In 1989, the OIG found that child support orders included medical support in a greater percentage of cases (57 percent, up from 43 percent in 1987). However, when the orders included medical support, the state CSE agencies often did not assure that (1) the noncustodial parent enrolled the dependent in available coverage or (2) Medicaid was provided with known insurance coverage information. The OIG reported that compliance with medical support requirements had worsened between 1987 and 1989.[5]

Concerned that states were not meeting federal medical support requirements, OCSE and the Health Care Financing Administration (HCFA) jointly conducted 34 reviews of state CSE medical support programs between 1987 and 1991. Our review of 27 of these[6] found that of the 27 programs, at least 13 were not consistently petitioning to include health insurance in support orders, 20 were not enforcing orders to provide

[3]Federal regulations state that health insurance cost is considered reasonable if it is employment-related or other group health insurance, regardless of the service delivery mechanism.

[4]Once the state CSE agency has obtained the health insurance information and transmitted it to the state Medicaid agency, it is the Medicaid agency's responsibility to ensure that the absent parent's insurance pays for medical expenses.

[5]Based on its case review, the OIG estimated losses totaling $32 million nationally per year. The OIG's estimate was based only on the new and modified cases that occurred during the time of the review, and did not account for cases already in the system.

[6]All reviews were not available at the time of our work.

health insurance, and 18 were not providing known insurance information to Medicaid.[7]

Bureau of the Census Data Show Potential Medicaid Savings

Our analysis of 1990 Bureau of the Census data on child support and alimony indicates that noncustodial fathers[8] of Medicaid children often do not provide required medical support. The data show that nationwide, 51.5 percent of Medicaid children whose noncustodial fathers pay cash support are receiving the health insurance also required under the agreement. The Bureau of Labor Statistics' 1989 and 1990 surveys of employee benefits indicate that 81 percent of adult workers have insurance available through their employer.[9] Thus, if these noncustodial fathers are typical, an additional 29.5 percent of these children likely could be covered. Based on the average Medicaid expenditure for a Medicaid-eligible child, we estimate that Medicaid could save at least $122 million annually if noncustodial fathers paying cash support provided health insurance as required.

The lack of medical support enforcement also affects children who are not receiving Medicaid support and who may lack any other insurance coverage. Our analysis showed that, nationwide, about 285,000 such children had custodial parents who had (1) used a state CSE agency for child support services and (2) obtained cash support from the noncustodial father, but not the health insurance required under the agreement.

[7]Not all of the joint reviewers conclusively stated that the states were out of compliance with each of the requirements. For these states, we reviewed the case sample results and concluded that the state was not complying if fewer than 75 percent of the cases met the requirement. For a number of the states, we could not make a determination on some of the requirements.

[8]The Census data contain information on noncustodial fathers only. The survey asked custodial mothers about their award status in 1990 and the receipt of support the previous year. For a more detailed explanation of our methodology, see appendix III.

[9]Employee Benefits in Medium and Large Firms, 1989, June 1990, Bulletin 2363; and Employee Benefits in Small Private Establishments, 1990, September 1991, Bulletin 2388.

Adequate Federal Guidance Is Lacking for Medical Support Enforcement

The statutory scheme for enforcing the support obligations of noncustodial parents includes a requirement that OCSE establish standards for state CSE agencies that will assure effective performance. In fact, with regard to paternity establishment, specific performance standards are explicitly imposed on states as a condition of participation.[10] In addition, for cash support, federal law and regulations specify stringent enforcement requirements. States must have legislation allowing certain enforcement options, such as immediate wage withholding, and actions must be taken within specified time frames. For example, once the support order is established, if the noncustodial parent does not pay cash support as ordered, state CSE officials must take action to enforce the order within no more than 30 calendar days of identifying a delinquency. Nearly all of the states we contacted[11] had a monitoring system to identify delinquent cash support payments within 30 days of when the payment was late, according to state officials.[12]

By contrast, federal regulations and other guidance lack specificity for medical support enforcement requirements. Federal regulations merely indicate that states should "take steps to enforce" a noncustodial parent's medical support obligations, but do not specify minimum required steps or time frames for taking action. State CSE agencies are required to provide health insurance information to Medicaid in a timely manner, but timeliness is not defined in the regulation. The regulation leaves it to states to decide how and when they will (1) determine whether health insurance has been obtained as ordered and (2) enforce a medical support order once noncompliance with the order is identified.

The difference in handling the two types of support is also evident in the federal incentive payments provided to states for effective enforcement. States are rewarded for the outcome of their cash support enforcement efforts, in that they receive a cash incentive based on their collections. At the time of our review, the incentive formula did not reward states'

[10]The specific performance standards were added after publication of an earlier GAO report that focused on problems associated with paternity establishment and the obstacles they created for the enforcement of child support obligations. Child Support: Need to Improve Efforts to Identify Fathers and Obtain Support Orders (GAO/HRD-87-37, Apr. 30, 1987).

[11]Specifically, 10 of 12 states' officials indicated they had such systems. Two states' officials indicated that the county or local districts were responsible for establishing systems to monitor for cash compliance.

[12]Regulations require that states have a monitoring system to identify noncompliance with support obligations. The preamble to final regulations including 45 C.F.R 303.6 indicated that this system was to include monitoring for health insurance. However, the regulation does not, on its face, specify this requirement for medical support. Further, the OCSE audit director told us that states are not held to a requirement that they monitor for health insurance.

medical support efforts.[13] Consequently, state CSE officials have indicated that they have little incentive for medical support activities.[14] Given a choice, caseworkers would prefer spending time pursuing cash support, one state official told us.

An OCSE official told us that developing outcome-oriented standards for medical support, such as Medicaid savings from medical support efforts, would be difficult due to difficulties measuring the savings accruing from state medical support efforts.[15]

In the absence of such standards, clear and specific regulations and other guidance, such as that found in policy transmittals to states, are even more important to assuring effective state programs. Such guidance is the basis for OCSE audits, which are to be conducted at least every 3 years for state compliance with federal requirements. States found not complying can be subject to a penalty equal to a specified percentage of the federal AFDC contribution. However, these audits can only measure how well states meet the federal standards set forth in regulation and policy transmittals. OCSE auditors told us that in those states taking minimal actions to comply, determining states' noncompliance is difficult because requirements are not specific.

Given the minimal federal guidance and incentives on medical support enforcement, states have medical support laws and programs that vary greatly in comprehensiveness and effectiveness. State laws give state CSE agencies authority to enforce medical support orders, and the effectiveness of medical support efforts depends on these laws. While some states reviewed had specific legislation for the enforcement of health insurance orders, many did not. For example, legislation permitting state CSE officials to order employers to enroll children in their health insurance plan if the noncustodial parent had not complied—a procedure similar to the income-withholding procedures for cash support—was present in only 6 of the 12 states we contacted. Oregon estimated reduced Medicaid expenditures of $1.2 million over a 2-year period from this legislation (1989-91); Washington estimated savings in medical assistance

[13]At that time, OCSE had proposed to change incentive payments to encourage states to take into account performance areas deserving positive recognition. OCSE indicated that it was considering medical support in the restructuring of incentive payments.

[14]Even though state CSE agency medical support efforts would save state Medicaid dollars, several state CSE agency officials we talked to seemed focused on the direct incentives for the CSE agency.

[15]Medicaid agencies have historically experienced difficulties in accurately tracking Medicaid third-party savings. Even states that track claims paid by the other insurer may not always get accurate counts on savings. Savings may be "hidden" when the provider bills the other insurer without alerting the state.

expenditures of up to $5.5 million per year. In the absence of such laws, officials in the remaining six states had to take the noncustodial parent to court for not complying with the order, which can be a long, time-consuming, and costly process.

Another major difference between state programs is the degree of monitoring to ensure that the noncustodial parent obtains the insurance as ordered. Only 5 of the 12 states had systematic procedures for monitoring the noncustodial parent's compliance. For example, Arkansas law requires insurers and other groups to respond to requests for information necessary to determine the coverage status for minor children and requires employers to notify the state (specifically, the court or its representative) should the noncustodial parent drop insurance for the child. Further, the state's system generates letters to noncustodial parents and employers requesting insurance information when a court order is in place, and monthly management reports track whether such information has been obtained. In contrast, four states had no proactive procedures for assuring that the noncustodial parent had actually obtained the health insurance as required.[16] These states typically pursued noncompliance with a medical support order only when Medicaid or the custodial parent requested enforcement, or when the caseworker reviewed the case for another reason, such as the noncustodial parent's noncompliance with the cash support requirement.

Figure I.1 lists procedures that we believe improve program effectiveness. It also shows in more detail the extent of differences among state programs, including the differences in their effectiveness in terms of referrals of insurance information to Medicaid.

[16]Another three states had a formal policy requiring caseworkers to follow up on cases to see if the absent parent had complied, but only one of them had a control to assure the responsible persons did so.

Figure I.1: Variances in Enforcement Controls and Case Referrals to Medicaid for 12 States' Medical Support Programs

State Medical Support Program Features	AR	CA	CT	MD	MI	ND	OR	SC	TN	TX	UT	WA
Monitoring system to identify noncomplying noncustodial parents	✔	[a]	[a]	[a]			[b] ✔	[b] ✔		[c] ✔	✔	[b] ✔
Legislation to require employers to provide insurance information to the state	✔	✔	✔		✔		✔			✔	[d]	✔
Legislation to allow enforcement through the employer	✔	✔					✔			✔	✔	✔
Procedures have time frames for enforcing from day of order	✔			✔		✔						[e]
State has system or formal procedures with time frames for transferring health information to Medicaid	✔	✔						✔	✔		✔	✔
Management reports track medical support cases for follow-up	✔										✔	✔
Estimated referrals of insurance information to Medicaid for 1990	N/A[f]	3,326	412	1,394[g]	540	N/A	800	139	N/A	N/A	N/A	4,960
Referrals as a percentage of average quarterly open cases in 1990	N/A	0.6%	0.6%	1.2%	0.1%	N/A	1.4%	0.3%	N/A	N/A	N/A	5.5%

[a]California, Connecticut, and Maryland had formal policies requiring caseworkers or the district attorney to monitor cases in some manner to see if the noncustodial parent had complied. Only California, however, had explicitly directed responsible persons to follow up to assure the forms were returned.

[b]Oregon and South Carolina have automated aspects of their monitoring systems; however, these systems did not provide mechanisms for assuring complete follow-up on cases. Washington's system did not automatically generate follow-up letters. However, Washington's system did track cases by status of medical support efforts and provide a mechanism for follow-up on cases.

[c]The Texas CSE agency does not monitor for medical support compliance. The agency sends wage-withholding information to Medicaid, which uses this information to monitor for medical support compliance.

[d]Utah law requires insurers to provide proof of health insurance upon request.

[e]Washington had time frames associated with all required enforcement steps, except for taking initial action on the case.

[f]Arkansas referrals were not available for 1990. Estimated referrals for 1991 were 3,929, which would result in a referral rate as a percentage of average quarterly open cases of 8.9 percent.

[9]CSE agencies are supposed to refer cases only if the intake office has not already done so. All but 369 (26 percent) of those cases had already been referred to Medicaid before the CSE referral, according to a Medicaid official.

Michigan and Washington Show Effect of Differing Laws and Programs

To determine if differences in procedures for enforcing medical support orders cause differences in program effectiveness, we reviewed the programs in Michigan and Washington in more depth. The two states have very dissimilar approaches to enforcement, with Washington's being more extensive.

- Washington's procedures require the caseworkers to identify noncomplying noncustodial parents and enforce orders. The caseworkers are required to pursue all medical assistance cases with medical support orders to ensure that the noncustodial parent meets the obligation.[17] For example, the caseworkers are expected to query the noncustodial parent and the employer to determine if health insurance is available and to ensure that the noncustodial parent complies with the health insurance order. Noncustodial parents and employers are given certain time frames in which to respond. Washington law permits the CSE agency to order the employer, upon notification of the health insurance requirement, to enroll the children in the noncustodial parent's insurance policy and deduct the premiums from the parent's salary. On a monthly basis, all CSE insurance information is matched against the state Medicaid data base to assure that any new insurance information is known to Medicaid. Quarterly management reports track cases for follow-up.
- Michigan's efforts are not proactive. Specifically, the county agency we reviewed did not monitor noncustodial parent compliance with the court order, but instead relied on the custodial parent or Medicaid to inform the agency when a noncustodial parent failed to comply with the health insurance requirement. If the noncustodial parent refuses to comply with the health insurance order, the state's only option to force compliance is to file suit for contempt of court. Unlike Washington, Michigan has no automated means of transferring insurance information to the state Medicaid agency. Instead, caseworkers send forms with insurance information to the state Medicaid agency as they receive them from employers. The agency had no management reports that tracked cases for follow-up.

For the cases we reviewed, the two states showed marked differences in the extent to which medical insurance had been provided when available

[17]With the exception of cases in which the order requiring health insurance is silent on costs and the cost, when added to current support, would exceed 50 percent of the noncustodial parent's income.

to noncustodial parents. In Washington, our review of 48 cases identified 5 cases of 20 with insurance likely or confirmed as available[18] (25 percent) where the CSE agency had not appropriately assured that the noncustodial parents with available health insurance resources were complying with the support order. In all of the cases where the CSE agency should have provided insurance information to the Washington Medicaid agency, the Medicaid agency had received the information. In Michigan, by comparison, our review of 96 cases found that 39 of the 59 with insurance likely or confirmed as available (66 percent) had noncustodial parents with available insurance who (1) were not insuring their Medicaid-eligible children or (2) were insuring their children, but the CSE agency had not informed the state Medicaid agency about the existence of such insurance. In 33 of the 39 cases, Medicaid had made payments for which the other insurance may have been liable.

The two states also showed a marked difference in the extent to which Medicaid received information about noncustodial parents' medical insurance. The Washington Medicaid agency had received at least 4,960 referrals of health insurance information on cases where medical support had been obtained (as compared to 90,988 average quarterly open cases)[19] during 1990. The state Medicaid agency attributed $3.7 million in Medicaid savings for that year to the state CSE agency's efforts. By comparison, in 1990 Michigan received 540 referrals (as compared to 619,011 average quarterly open cases) from state CSE contacts. Michigan Medicaid officials told us that they did not track program savings resulting specifically from state CSE agency efforts.

[18]Our case review results cannot be projected to the states. Michigan case review results include 49 cases in which the order had been modified since it had been put in place. Due to time limitations, we did not review the same number of cases in Washington. We determined that insurance was likely if we noted in the CSE case file, or other available databases or sources such as insurance company records, that the noncustodial parent was employed, and the employer provided health insurance to its employees.

[19]States report, among other things, a count of the AFDC and foster care cases with orders remaining open that were continued from the prior quarter. The Washington Medicaid agency tracks case referrals by calendar year, whereas the federal figures on open cases are maintained by federal fiscal year.

ERISA Plans Can Avoid Providing Medical Support

In the past, the regulation of health insurance was typically left to the states. However, with the passage of the Employee Retirement Income Security Act of 1974, states were prevented from regulating employee welfare benefit plans, including employer-provided health plans.[20] While states can regulate the insurance purchased by employers, the employers who self-insure are not bound by state insurance and medical support laws. In 1990, 56 percent of the nation's employees had health coverage through such ERISA plans.

Some states are finding that ERISA plans are adopting practices that exclude the children of noncustodial parents from health coverage. While half of the states we reviewed had laws prohibiting these types of practices,[21] ERISA plans did not have to comply because ERISA supersedes state laws. A common practice ERISA plans use to avoid covering these children is to narrowly define an eligible dependent—for example, by requiring that the child reside with the policyholder, or that the noncustodial parent claim the child as a federal income tax exemption. Although these eligibility definitions apply to all dependents, they nearly categorically affect AFDC children receiving Medicaid and CSE services, since most would not typically reside with the policyholder.

A 1991 Washington CSE survey of the predominant health plan providers that interact with the state's Medicaid agency found that 14 percent of the respondents had narrowly defined eligibility requirements that would exclude many noncustodial children from coverage.[22] To gain a better understanding of how widespread these practices were, we contacted 6 states in addition to the 12 in our original sample.[23] Of the 18 states

[20]Based on the way coverage is provided, there are two types of employer-provided ERISA plans. Employers can purchase insurance from a state-regulated insurance carrier, or they can self-insure, that is, directly pay for the medical care of covered employees and their dependents. The problems we identified were with self-insured ERISA plans. For purposes of this report, we refer to self-insured plans as ERISA plans. For a further discussion concerning ERISA plans and Medicaid, see app. II.

[21]Of the states reviewed, Arkansas, California, Illinois, Minnesota, Missouri, Oregon, Texas, and Wyoming have laws prohibiting insurers from denying coverage to children because they do not live with the policyholder. Pennsylvania law generally prohibits discrimination in providing coverage based on place of residence.

[22]A 1989 OIG review in eight states found that 7 percent of the employers offering dependent health coverage would not cover a child living outside the insured's home or required the insured to provide a specific amount of financial support to a noncustodial child and/or claim the child as a federal income tax exemption in order for the child to be covered. (Coordination of Third-Party Liability Information between Child Support Enforcement and Medicaid, December 1989, OAI-07-00860)

[23]The six additional states—Illinois, Minnesota, Missouri, Pennsylvania, Virginia, and Wyoming—were selected because they were identified by a state official from one of the original states as either having a law prohibiting certain insurance practices or being knowledgeable about ERISA's impact on medical support enforcement.

contacted on this matter, 6 stated they had encountered enforcement problems with ERISA plans because the child did not meet eligibility requirements.[24] For example:

- Minnesota passed a law explicitly prohibiting ERISA plans from limiting or denying coverage to children because of the amount of support that the policyholder provides to the child or because the child does not live with the insured. However, some ERISA plans have opted not to comply with the law and continue to use these practices. A Minnesota official provided us with correspondence from several large ERISA plans which states that the Minnesota law did not apply to them and that their exclusionary practices were valid. The Minnesota official said all the state's medical support enforcement problems involved ERISA health plans.
- A Texas CSE official told us all the ERISA plans the state has encountered while enforcing medical support deny coverage to children if they do not live with the policyholder. According to a study of the Texas insurance industry, 63 percent of the privately insured Texas population was covered by ERISA plans as of December 1990.

A second problem commonly encountered by state CSE agencies occurs when health coverage is available through employment, but ERISA plans refuse to comply with state laws requiring employers to enroll the noncustodial parents' children in their plan. Of the 18 states we reviewed, we identified 9 with wage-withholding laws for health insurance premiums, similar to those providing for income withholding for cash support.[25] Of these, 4 have encountered problems with ERISA plans not enrolling employees' children because ERISA supersedes state laws requiring them to do so. Virginia CSE officials told us the state's largest private employer is self-insured and will not comply with the state's enrollment orders.

Employers who had notified states that enrollment laws did not apply to them because of ERISA included Chevron, Bridgestone/Firestone, US West Communications, Conoco, 3M, and Jennie-O Foods. When an employer does not have to comply with a state's employer-mandated enforcement process, the only alternative enforcement mechanism the state can use is to file a contempt action against the noncustodial parent, which is a long, time-consuming, and costly process.

[24]The states that aggressively pursue medical support, such as those using income withholding for medical support, are more likely to encounter problems with ERISA plans, we believe.

[25]Although 9 states adopted such laws, 1—Utah—had not implemented the law at the time of our review, according to a Utah CSE official.

The full effect of ERISA plans' use of narrow eligibility definitions and noncompliance with state medical support requirements is not known, because most of the states reviewed were not assessing the problems in detail. However, one state—Minnesota—has conducted a survey to determine the extent of the problems caused by ERISA plans. A state CSE program advisor projected that over a 1-year period, approximately 5,000 children receiving child support services did not receive medical coverage because of ERISA, with 50 to 75 percent of them covered by Medicaid. Based on the advisor's projected losses for all 5,000 children, we estimated that, at a minimum, Medicaid lost $2.1 million over this period.

In cases where states have prohibited narrow definitions of eligible dependents in insurance policies they regulate, the savings can be significant. For example, Oregon estimated saving at least $7.1 million every 2 years because of its law prohibiting insurers from denying coverage to children not living with the policyholder.

Resolving Problems Would Require Changes in ERISA

As the number of self-insured ERISA plans continues to grow, problems in enforcing medical support will likely increase. Between 1974 and 1990 the number of the nation's employees covered by self-insured ERISA plans increased from 5 to 56 percent. Studies indicate that the number of self-insurers will continue to grow, as employers attempt to control health care costs and avoid state regulation by self-insuring.

The ability of ERISA plans to avoid medical support efforts means that state enforcement efforts will be of limited effectiveness no matter how strong the state law is or how well the state is prepared to implement it. In an earlier report, we identified problems that state Medicaid agencies were having collecting from out-of-state insurers and ERISA plans.[26] We noted that the Congress had amended ERISA in 1985 to allow states to prohibit ERISA plans from using exclusionary contract provisions that made Medicaid primary payer. We recommended broadening states' authority to cover the collection problems identified at that time. With a slight modification to include medical support, the change we recommended at that time would address the ERISA problems discussed in this report. The suggested legislative language to correct the problems identified in this report, together with a more detailed explanation of what it would accomplish, is in appendix II.

[26]Medicaid: Legislation Needed to Improve Collections From Private Insurers (GAO/HRD-91-25, Nov. 30, 1990).

Conclusions

Effective medical support programs can help stem rising Medicaid costs, in addition to meeting the broader social goals of promoting family responsibility and helping children who might lose Medicaid eligibility or otherwise be uninsured. Because federal regulations leave states discretion as to how to enforce medical support, and fail to set outcome-oriented standards against which states' performance can be measured, some states have not adopted legislation or practices to meet the goals of the program. This contributes to Medicaid's paying at least an estimated $122 million a year in medical expenditures that might be paid by noncustodial parents' insurance.

To assure that state compliance with federal regulations translates into effective programs, the federal government needs to improve its guidance to states. As is done for cash support, this can be done either by (1) explicitly specifying in regulations or policy guidance minimum process-oriented enforcement steps and time frames, including states' responsibilities for monitoring for compliance with a health insurance order and the time frames for identifying noncompliance and for passing known health insurance information to Medicaid, or (2) establishing outcome-oriented performance standards for medical support activities and measuring states' performance against them. While we recognize the inherent difficulties in developing such outcome-oriented standards for medical support activities, unlike cash support efforts which are easily measured, we believe such standards or goals would be necessary to assure the program's effectiveness in the absence of more specific process-oriented requirements.

Further, as with cash support, the Congress should require that state CSE programs have enforcement laws that assure that their medical support efforts are efficient and effective. Until states can enforce medical support through all employers without going back to court, and employers are required to cooperate with the state, states' medical support efforts will be labor-intensive, time-consuming, costly, and largely ineffective.

States that have implemented strong laws and programs are frustrated because ERISA plans, which fall outside their authority, can thwart their efforts. We believe that the Congress did not intend that ERISA plans be allowed to avoid covering Medicaid recipients. States need sufficient authority over ERISA plans to ensure that these plans cover children for whom the state is enforcing support.

Recommendations to the Secretary of HHS

We recommend that the Secretary direct the Office of Child Support Enforcement to improve state efforts to establish noncustodial parents' medical support obligations by

- specifying in program guidance the minimum steps and time frames that states must meet to monitor and enforce medical support obligations or
- developing outcome-oriented performance standards for medical support activities and monitoring whether these standards are met.

Recommendations to the Congress

We recommend that the Congress require, as a condition of federal participation in their child support programs, that states enact laws enabling the programs to enforce health insurance requirements on employers, such as is done with income withholding for cash support. We also recommend that the Congress amend federal ERISA law to give states the authority needed to assure that their medical support efforts can be effective. Our suggested language, with an accompanying explanation, is contained in appendix II.

Agency Comments

As you requested, we did not obtain written comments on this report. However, we did discuss its contents with OCSE officials and have incorporated their comments where appropriate. OCSE officials commented that our recommendation that the agency clarify medical support standards had merit and could be done through policy transmittals. While OCSE officials also commented that state legislation allowing the enforcement of medical support on employers is beneficial, they indicated that states were adopting such laws on their own and therefore considered a federal mandate unnecessary. Our review of 12 states' laws, and OCSE documentation of states with such laws, however, indicates that many states have not passed such laws on their own. Finally, OCSE officials commented that our recommendation to amend federal ERISA law to give states needed authority would help address problems states were experiencing with ERISA plans.

Suggested Legislative Language and Explanation

LANGUAGE

SEC. ___. MEDICAL SUPPORT OBLIGATIONS OF PARENTS.

(a) AMENDMENT TO STATE PLAN FOR CHILD AND SPOUSAL SUPPORT REQUIREMENTS.--Section 454 of the Social Security Act is amended--

(1) by deleting the period at the end of paragraph (24) and inserting a semicolon, and

(2) by adding after paragraph (24) a new paragraph as follows:

"(25) provide that--

(A) with respect to a case for which there is an assignment, unless the custodial parent and child have satisfactory health insurance other than Medicaid, the State shall petition the court or administrative authority to include health insurance that is available (or may become available) to the noncustodial parent at reasonable cost in new or modified orders for support;

(B) a private insurer (including health benefit plan, fund, third-party administrator, or similar entity or program providing payments for medical assistance) may not--

(i) take into account that a dependent (I) does not receive a certain amount of support from the insured parent, (II) is not claimed for tax purposes by the insured parent, (III) does not reside with the insured parent, (IV) was born out-of-wedlock, or

(ii) prevent effective coverage for dependents enrolled under subparagraph (C) below; and

(C) once an employment-related group health plan that provides for coverage of dependents receives notice that a noncustodial parent who is eligible for coverage under the plan has been ordered to provide a dependent with health insurance that is available to the parent at reasonable cost, the plan must enroll such dependent and provide for such coverage, as specified by the State, with or without the noncustodial parent's consent.".

(b) AMENDMENT TO REQUIREMENT OF STATUTORILY PRESCRIBED PROCEDURES TO IMPROVE EFFECTIVENESS OF CHILD SUPPORT ENFORCEMENT.--Section 466 of the Act is amended--

(1) in subsection (a)(1), by inserting "or to provide medical support" after "payable as support",

(2) in subsection (b), by inserting "or to provide medical support" after "payable as support", and

(3) in subsection (b)(5), by inserting--

(A) "or to provide medical support in the form of health insurance coverage" after "with section 457 of this title",

(B) "and provision of medical support in the form of health insurance coverage" after ""will assure prompt distribution",

(4) in subsection (b)(6), by inserting "or to provide for medical support in the form of health insurance coverage" after "with section 457 of this title",

(5) in subsection (b)(8), by inserting "and medical support in the form of health insurance coverage provided" after "the State will be collected", and

(6) in subsection (b)(9), by inserting "and medical support in the form of health insurance coverage provided" after "other State will be collected".

(c) ERISA AMENDMENT.--Section 514(b) of the Employee Retirement Income Security Act of 1974 is amended--

(1) in subparagraph (2)(B) by striking "Neither" and substituting "Except to the extent necessary to comply with sections 454(25) and 466(b) of the Social Security Act, neither"; and

(2) by adding at the end a new paragraph as follows:

"(9) Subsection (a) of this section shall not apply to any State law to the extent necessary to comply with sections 454(25) and 466(b) of the Social Security Act.".

(d) EFFECTIVE DATE.--

(1) Except as specified in paragraph (2), amendments made by this section shall apply to calendar quarters beginning after completion of the first full calendar quarter after the date of enactment.

(2) In the case of a State plan for child and spousal support (under section 454 of the Social Security Act), that the Secretary determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of section 454 before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be treated as a separate regular session of the State legislature.

Explanation

Legislative Background

In 1975, the Congress created the federal child support enforcement program as title IV-D of the Social Security Act. The purpose of the program is to strengthen state and local child support enforcement efforts, which are directed at locating noncustodial parents, establishing paternity, obtaining child support orders, and collecting child support payments.

In 1984, title IV-D was amended to, among other things, direct the Secretary of Health and Human Services to issue regulations requiring the inclusion of medical support in child support orders. The amendment was intended to ensure that parents provide medical support for their children, typically in the form of health insurance coverage, whenever they have a reasonable opportunity to do so. Medicaid would not then end up paying for the medical care of such children—that is, private insurers would be the primary payers to providers so that Medicaid would be the payer of last resort.

In 1991, the resulting regulations were issued. Some states have recently made improvements, but the quality of state efforts—to comply with the regulations and to ensure that private insurers pay before Medicaid—have varied widely. Furthermore, even states that have made reasonable efforts to comply with the requirements have been frustrated in their efforts by impediments over which they have little or no control.

That is largely because regulation of insurance is generally left to the states, but the Employee Retirement Income Security Act of 1974 supersedes state law. This means that while states can impose legal requirements on insurance companies, the states are precluded from imposing such requirements on, or otherwise regulating, employee welfare benefit plans, including employer-provided health plans. Consequently, employers are essentially unaffected by state requirements if the employers provide employees with health coverage by paying employee health expenses directly rather than by purchasing traditional health insurance—that is, through self-insured ERISA plans.

These ERISA plans are free to ignore state laws that would otherwise, for example, (1) require the plans to cooperate in ensuring that parents provide medical support when ordered to do so and (2) prevent plans from narrowing the coverage of dependents, which may otherwise preclude

many eligible Medicaid children from coverage. In other words, under one federal law, title IV of the Social Security Act, states are supposed to ensure that private insurers pay before Medicaid. Under another federal law, ERISA, state efforts to do so are, however, to a great extent undermined.

The purpose of the proposed legislation is to (1) facilitate effective state efforts to ensure that parents provide medical support for their children and (2) eliminate the paradox of ERISA being a major obstacle to state efforts to ensure that private insurers pay before Medicaid, so that Medicaid will always be the payer of last resort.

State Plan for Spousal and Child Support Enforcement Requirements

Regulations already require that whenever a custodial parent has assigned his or her rights to support, states must petition courts or administrative authorities to include, in new or modified support orders, health insurance that is available to the noncustodial parent at reasonable cost unless the custodial parent and child(ren) already have satisfactory private insurance. Subsection (a) would strengthen, and slightly modify, this requirement by codifying it in statute as a state plan requirement. The Secretary would continue to define all terms and provide additional policy clarification as needed.

States would also be required to prohibit all private insurers—including any entity providing payments for medical assistance—from, in effect, narrowing the coverage of dependents in ways that may have a disproportionate impact on children likely to become eligible for Medicaid. In addition, states would be required to provide that an employment-related health plan enroll children—with or without the consent of the noncustodial parent—when the plan is informed that this parent has been ordered to provide medical support. This would cover, for example, an employer- or union-provided plan. If an employer offered employees several options for the type of coverage, the state could specify that the employer enroll the dependent under whichever was the most advantageous option.

If the plan permits dependents to be covered only under a family option, this may necessitate enrolling a noncustodial parent as well. In any event, coverage is extended to the dependent without the consent of the noncustodial parent. The health plan provider, however, would be expected to arrange for the noncustodial parent to pay the participant's

share of such coverage in the same way, such as through payroll deduction, as if the parent had consented to or initiated the coverage.

Statutorily Prescribed Procedures to Improve Effectiveness of Child Support Enforcement

Support is already defined in the law to include medical support. The distribution of amounts withheld, however, is prescribed in relative detail elsewhere in title IV-D, with no mention of procedures for the allocation of amounts toward the cost of health insurance. Therefore, some states do not have an effective tool for enforcing medical support obligations such as that available for enforcing cash support obligations.

Subsection (b) would amend the current requirements for statutorily prescribed procedures. It would clarify that state laws must provide that amounts may be withheld from a noncustodial parent's salary not only to provide cash support, but also to pay his or her share of health insurance.

ERISA Amendment

ERISA generally preempts state laws affecting covered employee welfare benefit plans, including health plans. Health plans seek to avoid cooperating with state efforts to ensure that parents provide medical support for their children so that Medicaid would be the payer of last resort. These plans, therefore, have raised ERISA as a barrier.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) created an exception to this preemption to eliminate obstacles to the collection of third-party liabilities, but that amendment has been insufficient to eliminate many such obstacles. Whatever is done to encourage states to aggressively circumscribe the means by which private insurers manage to avoid liability—or at least payment—for the medical expenses of children—for whom Medicaid is otherwise apt to be the sole provider of health coverage—will be of limited effectiveness unless this COBRA exception is broadened.

ERISA has previously been identified as an obstacle to state efforts to recover from liable third parties—typically private insurers or health plans—when Medicaid has provided medical assistance to individuals who actually had other health coverage that should have been the primary payers to Medicaid.

Subsection (c) would provide that ERISA not supersede state laws passed in compliance with federal requirements related to medical child support. Should previous recommendations included in the cited GAO report

become law, subsection (d) would need to be modified and perhaps integrated with similar amendments to ERISA that were part of the previous recommendations.

Effective Date

Many states already have laws and regulations aimed at facilitating effective enforcement of obligations for medical support for children. For some of those states, it may be unnecessary to pass additional laws in order to be in compliance with the new or modified statutory requirements. These states will simply be able, for the first time, to apply their laws to ERISA self-insured plans. Other states, however, will need to pass laws, or at least regulations, to comply with the new legislative specifications.

Subsection (e) would ensure that states would have to comply with these specifications within a reasonable time. States that need to pass legislation in order to comply would have until the end of the next session of the state legislature to pass the necessary laws.

Detailed Scope and Methodology

To determine whether states have implemented effective medical support programs, we reviewed relevant federal studies and audits that evaluated state CSE medical support activities. These reports included 1987 and 1989 HHS OIG reports of nine states' medical support systems;[1] relevant sections of 1989, 1990, and 1991 OCSE audit reports; and joint HCFA/OCSE reviews conducted between 1987 and 1991 of medical support programs of 26 states and the District of Columbia. We also reviewed an Urban Institute report examining the issue of medical coverage in child support cases.[2]

Further, we reviewed medical support procedures from state CSE agencies in Arkansas, California, Connecticut, Maryland, North Dakota, Oregon, South Carolina, Tennessee, Texas, Utah. We selected these states to have a mixture of large, medium, and small programs across the country and to include some states that had done well on federal audits as well as some that had not passed the medical support element. We conducted in-depth reviews in Michigan and Washington, including reviewing a total of 144 randomly selected cases, reviewing state procedures, and interviewing state Medicaid and CSE agency officials. Our case reviews in Michigan and Washington were randomly selected at the largest CSE office in each state, for purposes of testing the states' procedures and identifying potential problems. The case review results are not projectable to the states. In Michigan, the review was at the Wayne County office, where 37 percent of Medicaid eligibles reside. In Washington, the review was at the Seattle office, which handles about 23 percent of the state's AFDC caseload.

To determine whether federal regulations assure that states implement procedures that maximize medical support, we obtained information from OCSE program and policy officials in headquarters and two regions, OCSE auditors in headquarters and four regions, HCFA officials in headquarters and two regions, state CSE officials in the 12 states listed above, and state Medicaid third-party officials in those states.

[1]Child Support Enforcement/Absent Parent Medical Liability, September 1987, OAI-07-86-00045; Coordination of Third-Party Liability Information Between Child Support Enforcement and Medicaid, December 1989, OAI-07-88-00860; and State Child Support Enforcement Criteria for Targeting Medical Support, August 1991, OEI-07-90-00120. The OIG in 1987 and 1989 reviewed Arkansas, Michigan, Missouri, North Carolina, Ohio, Pennsylvania, Virginia, and Utah. California was reviewed in 1987 but dropped from the 1989 data analysis. The OIG's 1989 national estimate of losses based on projections from the eight states was about $32 million annually. We believe our estimate is higher because it accounts for the total number of cases with a health insurance requirement in which the noncustodial parent is making cash payments but not providing the required medical insurance. The OIG based its estimates on the number of new or modified cases entering the system during a 3-month period, as reported to the OIG by the states. The OIG did not account for paying cases already in the system, an OIG official told us.

[2]The Inclusion of Medical Coverage in Child Support Cases: Current Status and Options for the Future, The Urban Institute, May 1986.

To determine whether states faced barriers in conducting their medical support efforts, we discussed concerns with state Medicaid and CSE officials in the 12 states listed above. We also contacted officials in Illinois, Minnesota, Missouri, Pennsylvania, Virginia, and Wyoming. These additional states were selected because state officials from the original states identified the six states as either having laws prohibiting certain insurance practices or being knowledgeable about ERISA's impact on medical support enforcement.

Estimates of Medicaid Losses

We relied on Bureau of the Census and HCFA data to formulate estimates of lost savings to Medicaid when noncustodial parents did not provide health insurance coverage to their Medicaid children. The 1990 child support and alimony supplement of the Current Population Survey (CPS) was used to determine the potential for additional health insurance coverage for Medicaid children. The Bureau of Labor Statistics' surveys of employee benefits in medium and large firms, and small private firms, were used to determine the potential availability of insurance. HCFA's Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services was then used to apply a cost to Medicaid because of this lost coverage. The following discussion describes in more detail the Census Bureau's child support and alimony supplement and the methodology that we used.

The child support and alimony supplement to the CPS, conducted every 2 years in April, questions mothers age 15 and above who are custodial parents of their own children under age 21 whose father does not live with them. It asks mothers about their current child support award status and receipt of support payments during the previous calendar year for children from their most recent marriage, husband, or partner. The CPS collects primarily labor-force data about the civilian noninstitutional population and members of the Armed Forces living with their families in civilian housing units or on a military base.

From the child support and alimony data base, we determined the number of Medicaid children with a noncustodial father who was required to provide cash support and health insurance coverage. This number was 744,457.

Because it is unlikely that noncustodial fathers who are unable to provide cash support will provide health insurance, we determined the number of those noncustodial fathers who were actually paying cash support. The resulting number was 626,540.

About 51.5 percent, or 322,725, of those children's noncustodial fathers were providing the health insurance as required. This leaves 48.5 percent, or 303,815 Medicaid children, who were not covered.[3]

We also took into account that only 81 percent of employees working full time have health insurance available through their employment.[4] The resulting number of 184,772 represents our estimate of uncovered Medicaid children for whom the state CSE agencies could take enforcement action.

To estimate potential Medicaid savings from shifting costs to the insurers of noncustodial parents, we applied a savings rate of $658 per child[5] to the 184,772 Medicaid children, to get a potential federal and state savings of $121,579,976.[6] This savings rate represents the average Medicaid expenditure per AFDC-eligible child for fiscal year 1990, as derived from HCFA's Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services, Fiscal Year 1990.[7]

Because of the nature of the Census data, our estimate contains some inherent weaknesses. Some custodial mothers of Medicaid children may have not used the services of the CSE agencies to enforce their medical support, which would reduce the estimate of potential savings from

[3]We recognize that a noncustodial parent's ability to pay cash support does not necessarily indicate that the noncustodial parent is employed. This estimate would be reduced to the extent that those paying cash support are not employed. However, an offsetting factor is that some noncustodial parents may be willing to provide health insurance if ordered although they are unwilling or unable to provide cash support. Our analysis found that almost 26,000 Medicaid children had noncustodial fathers who were voluntarily providing health insurance and not providing the cash support required.

[4]The percentage of employees with employer-provided medical benefits was derived from the Bureau of Labor Statistics' 1989 survey of employee benefit plans in medium and large firms, and its 1990 survey of small private establishments in nonagricultural industries. The Census data did not allow us to calculate the incidence of insurance for the noncustodial parent population.

[5]Other studies confirm that using a $658 average is reasonable. Two large states, Michigan and New York, have sampled to derive estimates of annual Medicaid savings from another insurance resource and found a comparable per-case savings potential. Also a 1989 OIG report (Coordination of Third-Party Liability Information Between Child Support Enforcement and Medicaid, Dec. 1989) found an actual per-case savings rate in its eight-state review of about $631 per year.

[6]The above methodology is similar in concept to that used by the Urban Institute in 1986. At that time, based on an estimated average Medicaid cost of $343 per year, the Urban Institute projected Medicaid cost savings of between $102.9 million and $149.8 million.

[7]We did not account for the extent that Medicaid may still have to pay for deductibles and coinsurance because such reductions do not appear to be appropriate. According to an OIG report (Child Support Enforcement/Absent Parent Medical Liability, OIG Office of Analysis and Inspections, Sept. 1987), a review of existing court orders containing medical support revealed that state CSE agencies generally require noncustodial parents to be responsible for all extraordinary medical, dental, orthodontic, and optical expenses, as well as payment of deductibles, coinsurance, and noncovered expenses.

improved CSE practices. HCFA and OCSE officials told us that, while state CSE agencies are required to provide medical support services to Medicaid eligibles with a noncustodial parent, state Medicaid agencies have not explicitly been required to refer all Medicaid eligibles to OCSE for support enforcement services. The Census data showed that about one-third of the Medicaid children in our analysis[8] had custodial mothers who indicated that they did not seek the services of a government agency for enforcing child support. At the time of our review, a HCFA official told us that HCFA was drafting a new regulation to clarify the requirement for referral of Medicaid cases to state CSE agencies.

On the other hand, our estimate of savings could be significantly understated due to other, mitigating factors. We did not take into account in our estimate the cases in which a noncustodial parent was paying cash support as required, but not ever ordered to provide health insurance. The Census data show that as many as 800,000 Medicaid children had noncustodial parents who were paying cash but not providing health insurance and were never required to do so. To the extent these noncustodial fathers could provide health insurance if required to do so, savings to Medicaid could be higher. We did not factor these cases into our estimate because we could not identify through the Census data base the extent to which these orders were not in place for reasons beyond the control of the CSE agency. For example, several federal and state officials told us that in some cases CSE agencies may petition for medical support, but judges or courts may not order it.

Finally, savings to Medicaid could increase to the extent that states improve other aspects of their child support enforcement programs, such as enforcing interstate cases, establishing paternity, and locating noncustodial parents. We have reported on other aspects of the Child Support Enforcement program, including recently the differences in state child support enforcement efforts between in-state and interstate cases (Interstate Child Support: Mothers Report Receiving Less Support From Out-of-State Fathers, GAO/HRD-92-39FS, Jan. 9, 1992). A list of related GAO reports is at the end of this report.

[8]Specifically, Medicaid children whose custodial mothers were receiving the required cash support, but not the required health insurance.

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Related GAO Products

Interstate Child Support: Mothers Report Receiving Less Support From Out-of-State Fathers (GAO/HRD-92-39FS, Jan. 9, 1992).

Interstate Child Support Enforcement: Computer Network Contract Not Ready to Be Awarded (GAO/IMTEC-92-8, Oct. 23, 1991).

Medicaid: HCFA Needs Authority to Enforce Third-Party Requirements on States (GAO/HRD-91-60, Apr. 11, 1991).

Child Support Enforcement: A Framework for Evaluating Costs, Benefits, and Effects (GAO/PEMD-91-6, Mar. 5, 1991).

Medicaid: Millions of Dollars Not Recovered From Michigan Blue Cross/Blue Shield (GAO/HRD-91-12, Nov. 30, 1990).

Medicaid: Legislation Needed to Improve Collections From Private Insurers (GAO/HRD-91-25, Nov. 30, 1990).

Children's Issues: A Decade of GAO Reports and Recent Activities (GAO/HRD-90-162, Sept. 21, 1990).

Child Support Enforcement: More States Reporting Debt to Credit Bureaus to Spur Collections (GAO/HRD-90-113, July 31, 1990).

Interstate Child Support: Better Information Needed on Absent Parents for Case Pursuit (GAO/HRD-90-41, May 24, 1990).

Child Support: State Progress in Developing Automated Enforcement Systems (GAO/HRD-89-10FS, Feb. 10, 1989).

Interstate Child Support: Case Data Limitations, Enforcement Problems, Views on Improvements Needed (GAO/HRD-89-25, Jan. 27, 1989).

Child Support: Need to Improve Efforts to Identify Fathers and Obtain Support Orders (GAO/HRD-87-37, Apr. 30, 1987).

Child Support: States' Progress in Implementing the 1984 Amendments (GAO/HRD-87-11, Oct. 3, 1986).