CLASP

CENTER FOR LAW AND SOCIAL POLICY

TO: Interested People

FROM: Paula Roberts

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RE: Medical Support Update: The Federal Scene

BACKGROUND

Children living in single parent families can obtain two different kinds of support through the state child support enforcement (IVD) program. *Cash support* is money that comes from the non-custodial parent. The amount is usually set in accordance with state child support guidelines. While the guidelines vary from state to state, the amount is generally calculated as a percentage of income. It also varies by the number of children in the household. As a result, higher income parents—and those with multiple children—pay more cash support than those with lower income or fewer children. *Medical support* may be a cash contribution toward the costs of covering the children's health care needs. More typically, however, medical support comes in the form of an order to the non-custodial parent to enroll the children in employer-sponsored dependant's health insurance coverage. Employees frequently have to pay a premium to obtain such coverage, and the premium is usually not related to the employee's income or the number of children to be covered.

Federal law requires that all orders enforced through the state child support enforcement (or IVD) system contain provision for the children's health care coverage.[1] If private health care coverage is available to the non-custodial parent at reasonable cost, it must be pursued. (All employment related or group policies are deemed to be available at "reasonable cost.")[2] The IVD agency sends the non-custodial parent's employer a Qualified Medical Child Support Order (QMCSO) and the employer must honor that order in accordance with the Employee Retirement Income Security Act of 1998.[3] However, if the premium cost associated with the coverage, in combination with the non-

[1] 42 USC § 652 (f) and 45 CFR §§303.31(b) and 303.31(c).
[2] 45 CFR §303.31(a).
[3] See 29 USC §1169(a)(5)(C). See, also 42 USC § 666(a)(19)(A).

custodial parent's cash support obligation, exceeds certain limits, then some adjustment in the order will have to be made.[4]

Parents, child support officials, and a federal commission have all identified problems with this system.[5] Briefly:

- It is difficult to obtain accurate information about health care coverage available to non-custodial parents through their employment. A data base of employers and the types of coverage they offer does not exist at either the state or national level. The effort to determine whether coverage is available is very labor-intensive.

- Over time, the number of employers who offer dependant health care coverage to their employees has greatly diminished.[6] Thus, the chance of success—especially if the non-custodial parent is a low or moderate wage worker—appears slim.

- Even when dependant coverage is offered, it may not be affordable. High premium costs can raise the amount of the combined cash and medical support obligation over the state or federal withholding limit. Even if the limit is not breached, the amount may be so high that the non-custodial parent has too little income to meet his/her basic needs.

- Even when coverage is available and affordable, it may not be accessible to the child. If the non-custodial parent has HMO coverage in a limited geographic area, and the child does not live in that area, the coverage will not be useful to the child. It may be that the custodial parent (or a step-parent) has coverage through employment that is accessible, but the system is not now authorized to order such parents to provide coverage or enforce such coverage if it is ordered.

- There is no federal incentive payment associated with medical support so, in many states, it does not receive as much attention as activities that do generate incentive payments.

As detailed below, during the last 18 months efforts have been made at the federal level to deal with some of these issues. Below is a summary of recent federal activities.

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[4] Federal law limits the amount of wages that can be withheld for child support and states may set lower limits. 42 USC §666(b)(1).

[5] In 1998, Congress created a Medical Child Support Working Group (MCSWG) to explore the issues and make recommendations for improvement. The MCSWG issued a report, *21 Million Children's Health: Our Shared Responsibility*. 2000. www.acf.ocse.gov For more detail on the issues discussed in this memo, and other aspects of medical support, the report is an invaluable resource. See, also, Solomon-Fears, Carmen. *A Review of Medical Child Support: Background, Policy and Issues*. 2003.

[6] See, National Center for Children in Poverty, *Parental Employment Does Not Guarantee Health Insurance for Children.* 2004. See, also Child Trends. *New Data Show Decline in the Number of Children with Private Health Insurance.* 2004.

Federal Legislation

In 2000, the National Medical Support Working Group (NMSWG) issued a report to the Departments of Health and Human Services (HHS) and Labor (DOL) which contained seventy-six recommendations for change. Eighteen of these recommendations called for changes in federal law. The NWSWG believed these recommendations would improve IVD agencies' ability to obtain and enforce medical support. Progress on implementing the recommendations has been slow.[7] However, in both its 2005 and 2006 budget requests, the Administration has sought enactment of three key recommendations. They are:

- Authorization for IVD agencies to look at health care coverage available to both custodial and non-custodial parents when assessing the availability of private coverage. This would increase the number of potential sources from which private coverage might be obtained. The custodial parent might have coverage available or have a new spouse who could cover the children since he/she would be a step-parent to them.

- Authority for IVD agencies to enforce medical support orders against custodial parents when such parents have been ordered to provide coverage and have failed to do so. (Authority to enforce against non-custodial parents already exists.)

- A requirement that health care plan administrators notify the IVD agency when a child covered by a medical support order enforced by that agency loses coverage. This would alert the agency that some action needs to be taken to secure alternative coverage.[8]

In addition, the Senate version of the bill to reauthorize the Temporary Assistance to Needy Families (TANF) program contains these provisions.[9] Whether they will be enacted in 2005 remains to be seen as the full Senate has not yet taken up this proposed legislation. If legislation is enacted, it would address some of the major issues described above and provide states with a framework for addressing those issues.

Incentive Payments

Despite the federal requirement that IVD orders address children's health care needs, only 49 percent of the orders contain a provision for health insurance coverage. Even then, coverage is frequently not provided: parents complied with only 49 percent of these orders. [10] In 1998, pursuant to the Child Support Performance and Incentive Act

[7] For a detailed update on implementation of the recommendations see Roberts, Paula. *Failure to Thrive: The Continuing Poor Health of Medical Child Support*. 2003. www.clasp.org/publications/child support and fathers/2003.
[8] Parents already receive these notices under a provision of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA). The plan administrator would simply have to send a copy of the COBRA notice to the IVD agency.
[9] S. 667, 109th Cong, §320 and 321.
[10] Solomon-Fears, *supra at* CRS-3.

(CSPIA), Congress required the Secretary of HHS to develop a medical child support performance indicator. The indicator was then to be included in the existing performance incentive system so that states would receive a reward for good performance in this area.[11] Despite several attempts to develop such an indicator, this task has not yet been accomplished.

In 2004, some progress was made. HHS and a state work group reached agreement on two possible medical support performance indicators:

- The percentage of cases with a support order (excluding arrears-only cases) that include medical support.

- The percentage of cases (again excluding arrears-only cases) in which medical support is both ordered and provided.

States are now gathering data which will be audited for reliability over the next 2-3 years. Once data reliability is assured, a baseline performance measure will be established and a decision will be made on which indicator to use for incentive purposes. At that point, the process for integrating the indicator into the current incentive scheme in a revenue-neutral manner will be decided. HHS's goal is to implement the medical support indicator in 2008.

Implementation of the National Medical Support Notice (NMSN)

CSPIA also required the development and implementation of a National Medical Support Notice (MMSN). This notice is used by state IVD agencies in enforcing medical support orders. It consists of two parts: Part A goes to the obligated parent's employer and Part B goes to the health care plan administrator. If it is properly filled out, the employer must honor the NMSN as it is deemed to be a Qualified Medical Child Support Order (QMCSO) under the federal Employee's Retirement and Income Security Act (ERISA). While there was some delay in implementing this requirement, all states now report that they are using the NMSN and many have automated the form.[12]

The original notice was developed in 1999-2000, and, after public comment and input from the NWCSWG, was promulgated in final form in December 2000. In 2002, PIQ-02-03 provided additional guidance to states on the proper use of the NMSN. In February 2005, changes to Part A were promulgated through Action Transmittal 05-05.[13] These changes include language clarifying that if:

- The children are already enrolled in their obligated parent's coverage, the employer should contact the IVD agency to provide coverage information.

[11] 42 USC § 65X

[12] State-by-state information on the NMSN as well as the state's order of priority for withholding can be found at www.acf.hhs.gov/programs/cse/newhire/employer/contacts/ms_matrix.pdf

[13] Both this Action Transmittal and the PIQ referenced above are available at www.acf.hhs.gov/programs/cse/pol

- The employer is also the health care plan administrator; the employer should fill out Part B of the NMSN.

- There is a waiting period before the obligated parent is eligible for dependant's coverage, the employer should inform the IVD agency of that fact and what the waiting period is.

- The child cannot be enrolled because the cost associated with the coverage would require withholding premiums and cash support in an amount in excess of the state or federal limitations on withholding or due to case prioritization.

Since implementation of these changes will require some reprogramming, both the old and the new versions of Part A are likely to be in use for some time.

OCSE Strategic Plan

Within HHS, the Office of Child Support Enforcement (OCSE) of the Administration on Children and Families (ACF) is the entity responsible for program guidance and oversight. Every five years, OCSE (in conjunction with state IVD agencies) develops a Strategic Plan to emphasize the IVD programs goals and objectives in the next period. The 20005-2009 Strategic Plan places great emphasis on improving medical coverage for children. It acknowledges that private coverage has value regardless of its source. Therefore, coverage available through custodial parents and step-parents should be considered in determining whether such coverage is available to the child. In addition, OCSE notes the burgeoning cost of Medicaid and notes the potential role IVD agencies can play in helping reduce Medicaid costs by obtaining private coverage and /or obtaining cash medical support.[14]

The latter point is partcularly interesting as more states look to custodial parents to pay premiums, co-pays and/or deductibles in the Medicaid program. The Medicaid statute currently prohibits asking custodial parents with income below 133% of the poverty line to contribute toward the costs of coverage, but states can obtain a waiver of this provision. In 2005, a number of states considered asking even very poor custodial parents to contribute to the costs of coverage, and seeking federal waivers to allow them to do so. If this trend continues, then asking non-custodial parents to contribute as well seems a likely scenario.

OIG Studies

In this regard, it is also worth noting that the HHS Office of Inspector General (OIG) has been investigating the potential of non-custodial parents to contribute to the

[14] A copy of the Strategic Plan can be found on the OCSE web site www.hhs.acf.gov/programs/cse

cost of their children's Medicaid or SCHIP coverage for some time.[15] It issued two reports in 2004. In May 2005, yet another report was issued on the potential of non-custodial parents in eight states to contribute toward the cost of SCHIP coverage.[16] In the first two reports, the OIG was not estimating a medical child support obligation. Rather, it was estimating the income of non-custodial parents in excess of their cash support payments plus a self-support reserve that might be available to offset state SCHIP premium costs. In other words, it assumed that any income in excess of the amount needed to maintain the non-custodial parent at a minimal level and pay child support was available for the payment of health care coverage. It is not clear how the savings in the 2005 report were calculated.

Because the OIG believes that the federal government could save substantial money by requiring non-custodial parents to contribute toward SCHIP costs, it recommended the Center for Medicaid Services (CMS) issue program guidance to state agencies advising them that they have authority under federal law to collect SCHIP costs from non-custodial parents. CMS declined to issue formal guidance, but agreed to alert states through the CMS SCHIP Technical Advisory Group and regional offices that they have the option to pursue non-custodial parents for such costs.

The OIG also recommended an examination of whether additional federal administrative funds were necessary to assist states in interfacing their SCHIP and IVD systems. (Several states surveyed indicated that this was a barrier to pursuing the OIG strategy.) CMS responded that states can already use 10 percent of their SCHIP funds for administrative costs. Within this cap, states could use the funds to create this SCHIP/IVD interface. However, the OIG suggests that more administrative funds may be needed.

Multi-Agency Collaboration

Under the auspices of the Assistant Secretary for Children and Families and the Director of the Center for Medicaid and State Operations, a series of regional meetings are being held in the summer of 2005. These meetings involve officials responsible for the state's IVD, child welfare, Medicaid and SCHIP programs. Their goal is to develop better collaborations between these agencies to improve medical support for children.

CONCLUSION

The basic problems in medical support have been known for some time. After years of limited progress, the federal government is beginning to address some of the critical issues. While these efforts may eventually bear fruit, the results will be a long time coming. In the meantime, many states are developing innovative approaches to medical support and these efforts will be addressed in the next memo in this series.

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[15] See, Roberts, Paula, *OIG Studies on Possible Recoupment of SCHIP Costs Through the Child Support Program.* 2004 and *OIG Studies on Potential Medicaid Savings Through Cost Contributions from Non-Custodial Parents.* 2004, available at www.calsp.org/publications/childsupportandfathers/2004

[16] Department of Health and Human Services, Office of the Inspector General. *Eight State Review of the Ability of Non-Custodial Parents to Contribute Toward the costs of Title IVD Children under the State Children's Health Insurance Program.* 2005. www.oig.hhs.gov?oas/reports/region1/10302502.pdf