MEMORANDUM

TO: Interested People

FROM: Paula Roberts

DATE: August 12, 2005

RE: Recent State Efforts in Medical Child Support

In 1998, Congress authorized the creation of a Medical Child Support Working Group (MCSWG) to make recommendations for revamping medical child support. The MCSWG issued its report in 2000, providing more than 70 suggestions for improvement.[1] The recommendations highlighted the need for change in federal law and policy as well as the need for states to innovate and explore ways to ensure that all children in the state child support system had access to health care coverage. Progress on implementing the MCSWG recommendations at the federal level has been slow.[2] However, several states have adopted the innovative policies recommended by the MCSWG and created other new approaches. Some of these were highlighted in a previous CLASP publication.[3] This memo updates and expands that discussion. It describes state efforts in three areas: 1) establishing and enforcing orders for private health care coverage when such coverage is adequate, accessible, and affordable; 2) ensuring that children are enrolled in Medicaid or the State Children's Health Insurance Program (SCHIP) if they are eligible for these programs and do not have access to private coverage; and 3) expanding options for coverage when children are qualified for neither private coverage nor Medicaid/SCHIP.

Establishing and Enforcing Orders For Private Health Care Coverage

Background

The MCSWG recommends that children be enrolled in comprehensive private health care coverage if such coverage is available, accessible and affordable. To accomplish this task, the MCSWG recommends that states look beyond just non-custodial parents to custodial parents and step-parents to see if any of these adults has access to adequate and affordable coverage through

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[1] The report is called *21 Million Children's Health: Our Shared Responsibility* and can be downloaded from www.acf.hhs.gov/programs/cse/prgrpt.

[2] See, Paula Roberts. *Failure to Thrive: The Continuing Poor Health of Medical Child Support* (2003) and *Medical Support Update: The Federal Scene* (2005). Both publications are available at www.clasp.org in the Child Support and Low Income Fathers section.

[3] Roberts, *Failure to Thrive, supra.*

his/her employer or union. If such coverage is available, the child support order should require that parent to provide coverage.[4] The order should allocate any associated costs between the parties in accordance with the state's child support guidelines.[5] Thereafter, the order is to be enforced through the use of the new National Medical Support Notice (NMSN).[6] Promulgated in final form in late 2000, the NMSN is like an income withholding order: the state agency issues the NMSN to the covered parent's employer who is required to honor it. If health care coverage is available, the employer's health care plan administrator must enroll the child. Any applicable premiums are deducted from the employee's wages.

Tackling the Existing Caseload

An initial problem for state agencies is identifying current cases in which it would be appropriate to take action. These are cases in which a parent has been ordered to provide private coverage but the agency records do not show whether the coverage has – in fact – been obtained. As a result, the agency does not know whether it needs to send an NMSN to the employer.

Beginning in October 2000, *New York* tackled this problem through a state/local multi-year review of all IVD orders to ascertain whether health insurance has been provided as ordered. The data generated was used to update the state's Child Support Management System (CSMS). One interesting finding was the number of cases in which a child had been enrolled in private coverage but that this was not known to the custodial parent or the CSMS. Thus, the review alone provided children with access to private coverage.[7]

Implementing the NMSN

The NMSN is a lengthy document and requires state agency staff, employers, and health plan administrators to take action within specific time periods. As with any effort that requires participation by the private sector, a state's attention to education, outreach, and problem solving can be very helpful in securing an orderly process.

Many states conducted outreach campaigns with the employer community to help them understand the new NMSN and what was required to make it work. *New Jersey* worked with employers, benefits administrators, payroll associations,

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[4] MCSWG Recommendations 1 and 13. New York and New Jersey have developed comprehensive schemes that parallel the MCSWG recommendations.

[5] Federal regulations require that all child support guidelines describe how the children's health care needs are to be met. 45 CFR §302.56 (2005).

[6] The NMSN was authorized in 1998 to provide a clear, uniform method for informing employers that a medical support order had been issued. Employer's must honor NMSNs. 42 USC § 666(a)(19) and 29 USC §1169(a)(5)(C)).

[7] Presentation of Lee Sapienza, Chief, Bureau of Policy and Planning, New York State Division of Child Support Enforcement, at the Eastern Regional Interstate Child Support Enforcement Annual Conference, Portland, Maine, May 2005.

human services organizations, and the Chamber of Commerce to get the word out when it began issuing NMSNs. It prepared fact sheets, brochures, Frequently Asked Question (FAQ) sheets, and informational packets. It trained staff and established a toll-free hot line as well as an email site that employers and plan administrators can contact if they have questions. Hot line staff are also able to answer questions from non-custodial parents and, if no private coverage is available, the staff provides information about Medicaid and SCHIP. [8]

New York also conducted extensive employer outreach and established a toll free help line for employers. New York's IVD agency also developed a cover letter to accompany the NMSN to provide a quick reference to employers so they would understand what they were required to do and when they were required to do it. In addition, the state's Department of Labor included articles about the NMSN in its newsletter and the State of New York Insurance Department issued a letter to all licensed carriers in the state, reminding them that they are required to honor any NMSN they receive. The state IVD agency is also working with large employers (especially state and local governments) to reduce the amount of paperwork involved in the medical support process.

Follow-up is also important. Despite the law, employers do not always respond to the NMSN in a timely fashion. *New York* addresses this problem by sending a 60-day reminder notice to employers who have not responded to an NMSN. *Rhode Island* has taken a different tack. Its law authorizes a $100 fine as well as penalties under the Employee Retirement Income Security Act for an employer's failure to follow an NMSN.[9]

One lesson learned from NMSN implementation is that is advantageous to know early in the medical support process whether a particular employer offers dependant's health care coverage to its employees. That way NMSNs do not need to be sent to employers who do not offer such coverage.

Georgia's IVD agency discovered that its Medicaid program had a private vendor who pursued reimbursement owed to the state in Medicaid cases where the child also had private coverage. The vendor also identified children who were enrolled in the state's SCHIP program who could be removed because they had access to private coverage. To undertake this effort, the vendor has a data base of private insurance coverage. The data base also has information about private insurance available to children not in the Medicaid or SCHIP programs. This lead the state to realize that it could use this method for its child support cases. *New York* began a similar program to develop an employer data base in May 2005.

[8] Presentation by Alisha Griffin, IVD Director, State of New Jersey at the Eastern Regional Child Support Association Annual Conference, Atlanta, Georgia, May, 2004.
[9] R.I. Laws § 15-29-5 (2005).

Another time-saver for all concerned is automating the NMSN process. *New York* has developed such an automated process for issuing the NMSN. The state began using the NMSN for new and modified orders on December 22, 20003. Use of the NMSN in existing cases was phased in over the next 10 months. All cases with orders requiring the non-custodial parent to provide health care coverage in which there was a known employer have now been issued an NMSN. All NWSN documents are centrally processed and all data generated is being captured at that point. The data then updates the CSMS health insurance screen for the applicable case.

Other Innovative Practices

Through the withholding and NMSN processes, states have found that non-custodial parents in the IVD caseload frequently change jobs. Withholding orders and NMSNs are issued and followed for a few months, but no longer yield results when the employee terminates employment. In the case of medical support, this can lead to lengthy gaps in coverage. To avoid this result, *Rhode Island* requires employers to notify the IVD agency if an employee subject to a medical support order is terminated from employment.[10] The child support agency then knows to locate any new employer and quickly issue a new NMSN.

Defining Reasonable Cost

Whether looking to all parents and step-parents, or just non-custodial parents, one of the more difficult issues that state child support agencies have to address is whether the available private coverage can be obtained at reasonable cost.

Employers who offer dependant's health care coverage to their employees rarely do so for free. In recent years, the trend has been to charge employees increasingly large premiums.[11] However, federal regulation defines all employment-related dependants' coverage as reasonable in cost, 45 CFR §303.31(a). Since this is often not the case, states have to balance their obligation to seek health care coverage with the reality that the cost may either result in a reduction in needed cash support or push the amount witheld from the obligated parent's pay check to excessive levels.[12] In recognition of this conundrum, the federal Office of Child Support Enforcement issued PIQ-03-08 in July of 2003. [13] In essence, this document says that while state agencies must petition for health care coverage in every order (as required by federal law), their

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[10] Id. § 15-29-6.

[11] For a discussion of these issues, see, The Urban Institute. *Health Insurance Trends* (2004). Available at www.urban.org and The Commonwealth Fund, Task Force on the Future of Health Insurance. *Wages, Health Benefits, and Worker's Health* (2004) available at www.cmwf.org.

[12] Federal law imposes a maximum on the amount that can be withheld from a paycheck and many states have lower limits. 42 USC § 666(b)(1).

[13] This document is available at www.acf.hhs.gov/programs/cse/pol.doc.

courts can decline to order such coverage if the cost is deemed excessive under state law. In the discussion, the PIQ cites *Texas* law which deems health care coverage to be reasonable in cost if it does not exceed 10 percent of the responsible parent's monthly net income.[14] Thus, the Texas child support agency must seek private health care coverage if it is available, but the Texas courts can decline to order it without running afoul of federal law.

Several states have adopted similar statutes. For example, in *Colorado*, premiums are deemed reasonable if the are less than 20 percent of the obligated parent's gross income.[15] *New Jersey* child support guidelines define coverage as affordable if it does not cost more than 5 percent of the net income of the parent who is to provide the coverage. Moreover, no parent with a net income at or below 200 percent of poverty should be ordered to contribute to coverage premiums.

In other states, it is the judges who decide how to proceed. For example, under *Georgia's* guidelines, coverage is deemed reasonable in cost if it is employment-related. However, in several judicial districts, courts will not order coverage that cost in excess of 5% of the obligated parent's gross wages.[16] This approach is also consistent with PIQ 03-08.

Ensuring That Children Without Access to Private Coverage Obtain Medicaid or SCHIP Coverage When They Are Eligible

Background

If private health care coverage is not available, accessible or affordable, then additional steps need to be taken to make sure the child has coverage. Most of the children in the state child support system are eligible for either Medicaid or SCHIP.[17] Several states are now using some form of interface between child support and these publicly funded programs to insure that parents explore these avenues. For example, *Texas, Connecticut* and *New York* have statutes pursuant to which a court can order a parent to enroll his/her children in SCHIP if private coverage is determined not to be an option and the child is eligible.[18] However, developing systems that properly explore all the options is a challenge.

The Use of Medical Support Facilitators

[14] Texas Family Code §154.181(e).
[15] Col. Rev. Stat. § 14-10-115(g).
[16] Presentation by Robert Riddle, at the National Child Support Enforcement Association Mid-Year Conference, Washington, DC, January 25, 2005.
[17] Within federal parameters, states have flexibility in establishing income and resource limits for program participants. Thus, there is some state variation as to which program a child will be eligible for.
[18] Conn. Gen. Stat.§ 17B-745(A)(2)(a); N.Y. Dom. Rel. Law § 240.1g; Texas Code §154.182(b)(4). The processes used by Connecticut and Texas are described in detail in Lynn Fender and Jen Bernstein. *State practices in Medical Support Cross-Program Coordination* (2003) available at www.aspe.hhs.gov.

Sorting through the private and public options can be time consuming. Before the hearing that establishes or modifies the support order, someone needs to gather and evaluate all the possibilities. This task places an additional burden on child support workers.

Colorado received a Section 1115 demonstration grant from OCSE to see if using Medical Support Facilitators (MSFS) was a viable approach to this problem for IVD cases. Over a two year period, in two selected counties, an MSF determined:

- Whether health care coverage was being provided as ordered.
- If so, was the pertinent information recorded in the state's automated system.
- If not, what types of private coverage were available to the child.
- If more than one private plan was available, which plan was the most appropriate.

The MSF then made a recommendation for what should be included in the medical support portion of the order. Thereafter, the MSF monitored enrolment to see that coverage was actually provided. If the MSF determined that private coverage was not available at reasonable cost, he or she would assist the custodial parent in applying for Medicaid or SCHIP as appropriate. An evaluation documented that the result was a significant increase in health care coverage among children who already had a support order (the enforcement caseload). However, the results for new cases were not so promising: in large part, that was because these cases involved children already receiving Medicaid coverage. In those cases, private coverage was less likely to be available or affordable. Nonetheless, 9 percent of the Medicaid cases worked by an MSF became privately insured during the course of the project. [19]

New Jersey received a Special Improvement Project (SIP) grant to experiment with a similar concept called a Medical In-Court Facilitator (MICF). In this model, the MICF reviews health care coverage available to both parents (including Medicaid and SCHIP) before the case comes to court. Custodial parent coverage is the first choice followed by coverage available through a step-parent with whom the child resides, the non-custodial parent, and a step-parent with whom the child does not reside. The various options are looked at with an eye to comprehensiveness of coverage, accessibility, stability, and affordability. If private coverage is not available or appropriate, Medicaid and SCHIP eligibility are explored. The MICF then determines the best coverage and makes a recommendation to the court. If private coverage is the best option, costs are allocated between the parties under the state's child support guidelines. If public

[19] The overall goal—to ensure that every child had some coverage—was not achieved. In large part this was because the state capped SCHIP enrollment half-way through the project, eliminating this option at least temporarily. For more details see, Policy Studies Inc. *Increasing Healthcare Coverage for Children: A New Coordinated Approach Findings from Colorado (*2004).

coverage is the best option, the child support order will require the custodial parent to enroll the children in that coverage.

Other Innovative Practices

As noted above, in some cases, a parent has access to private health care coverage but the cost is too high. The children might then be enrolled in Medicaid or SCHIP with some cost-sharing by the parent (especially in SCHIP). However, it might be more cost effective for the state to subsidize the private coverage than to enroll the child in Medicaid or SCHIP.

Rhode Island has developed a system in which it is possible to pursue this option.[20] *Rhode Island* offers a standard Medicaid program for those without access to private coverage called RIte Care. However, if a parent or spouse has access to comparable private coverage through employment, the state may pay all or part of the employee's share of the health care premium through a program called RIte Share. RIte Share will also subsidize any co-payments associated with the coverage. Families with incomes up to 150% of the federal poverty line receive RIte Care and RIte Share at no cost. Families with income between 150% and 185% of poverty pay a monthly premium of $61; those with income between 185% and 200% of poverty pay a monthly premium of $77; and those families with an income between 200% and 250% of poverty pay $92 per month.[21]

Rhode Island's child support guidelines require private coverage to be ordered if it is available to one of the parents at no or "reasonable" cost. "Reasonable cost" is defined to be 5 percent of gross income. If private coverage is not available at reasonable cost, then the non-custodial parent is ordered to make a 5 percent medical cash support payment. If the child is enrolled in RIte Care or RIte Share, the amount is retained by the state to offset the premium costs.

Expanding the Options When Neither Private nor Public Coverage is Available

Even with these efforts, there will be some children who are not eligible for either private or public coverage. *California* has made strong efforts to enroll every eligible child in Medicaid or SCHIP. Through Express Lane Eligibility, schools, child care centers, WIC programs and similar child-serving programs have assisted parents in signing their children up through a shorter, simpler enrollment process. San Mateo County – building on prior experiences in Santa Clara and San Francisco counties—accompanied its efforts to enroll eligible children in Medicaid and SCHIP with the development of a new program (Healthy

[20] See R.I. Gen. Laws § 40-8.4-12.
[21] These numbers represent 5% of annual income, R.I. Laws § 40-8.4-12(b).

Kids) to provide coverage to children not eligible for either private or public coverage. The program provides coverage similar to SCHIP, and is financed through the contributions of the county, the First 5 San Mateo Commission (using tobacco tax revenue), two local hospital districts, and private foundations. In its first year, the program enrolled almost five thousand children. The vast majority were school-aged or adolescents from low-income, immigrant families. [22]

Georgia is exploring the feasibility of offering a statewide (or possibly regional) health care coverage program to children unable to secure either public or private coverage. The state has received an 1115 grant to study the feasibility of establishing such a program.

Conclusion

Many states are making substantial efforts to ensure that children in the child support system have access to comprehensive health care coverage. The lessons learned from these efforts could guide other sates in undertaking a more comprehensive approach to medical support.

[22] The program is being evaluated over a five-year period by the Urban Institute. The first year evaluation is available at www.urbaninstitute.org in the Health care Section.