21 Million Children's Health: Our Shared Responsibility

The Medical Child Support Working Group's

Report to

The Honorable
Donna E. Shalala
Secretary
Department of Health and Human Services

The Honorable
Alexis M. Herman
Secretary
Department of Labor

"Executive Summary"
June 2000

Medical Child Support Working Group Membership List

U.S. Department of Labor:

- **Robert J. Doyle**, Director of Regulations and Interpretations, Pension and Welfare Benefits Association, **Co-Chair**
- David Lurie, Office of Regulations and Interpretations, Pension and Welfare Benefits Association
- Susan E. Rees, Staff Attorney, Plan Benefits Security Division, Office of the Solicitor

U.S. Department of Health and Human Services:

- **David Gray Ross**, Commissioner, Office of Child Support Enforcement, **Co-Chair**
- Paul Legler, Assistant Commissioner, Office of Child Support Enforcement
- Rachel Block, Deputy Director, Center for Medicaid and State Operations, Health Care Financing Administration
- Linda Mellgren, Senior Social Science Analyst, Office of the Assistant Secretary for Planning and Evaluation

State IV-D Directors and Medical Child Support Programs:

- Sallie H. Hunt, Commissioner, Bureau of Child Support Enforcement, Health and Human Resources, West Virginia
- Richard Harris, Director, Division of Child Support Enforcement, Department of Human Services, Mississippi
- Lee Sapienza, Chief of Policy and Planning, Division of Child Support Enforcement, New York
- Gaye L. McQueen, Child Support Enforcement Officer, Department of Social and Health Services, Washington

State Medicaid/SCHIP Directors:

- Mary C. Fontaine, Director, Benefit Coordination & Recoveries, Medicaid, Massachusetts
- Kay M. Keeshan, Director, Third Party Division, Medicaid, Alabama
- Robert D. Stampfly, Director, Managed Care Support Division, Medical Services Administration, Michigan

Employers and Human Resource and Payroll Professionals:

- Anthony J. Knettel, The ERISA Industry Committee
- Cornelia Gamlem, Society for Human Resource Management
- Rita Zeidner, American Payroll Association
- Theodore R. Earl, Jr., John Hancock, Inc.

Plan Administrators and Plan Sponsors of Group Health Plans:

- Elizabeth Ysla Leight, Society of Professional Benefit Administrators
- Howard Bard, National Coordinating Committee for Multi-Employer Plans
- Terry Humo, Association of Private Pension & Welfare Plans
- Lela Foremen, Communication Workers of America, AFL-CIO
- Ellen (Nell) Hennessy, Actuarial Sciences Associates, Inc/American Bar Association

Child Advocacy Organizations:

- Nancy E. Ebb, Children's Defense Fund
- Paula Roberts, Center for Law and Social Policy
- R. Ann Fallon, Attorney at Law, Whiting, Fallon & Ross
- S. Kay Farley, National Center for State Courts
- Jeffrey M. Johnson, Ph.D., National Center for Strategic Non-Profit Planning & Community Leadership
- Cristina B. Firvida, National Women's Law Center

Organizations Representing State Child Support Programs:

- Kelly D. Thompson, National Child Support Enforcement Association – resigned
- Ruth Bell Clark, National Child Support Enforcement Association

Working Group Staff

Samara Weinstein, Executive Director

U.S. Department of Health and Human Services

Office of Child Support Enforcement

- Beverly Bunn
- Andrew J. Hagan
- Stephanie Epps
- Susan Notar
- Nehemiah Rucker

Health Care Financing Administration

- Marlene Jones
- Sue Knefley

Office of the Assistant Secretary for Management and Budget

- Libbie Buchele
- Audrey Smolkin
- Caroline Washburn

Office of the Assistant Secretary for Planning and Evaluation

- Jennifer C. Pruszynski
- Jennifer Tolbert

U.S. Department of Labor

Pension and Welfare Benefits Administration

- Fred Wong
- Ellen Goodwin

Guide to Format of this Report

Chapters at a Glance

The first page of each chapter contains a "chapter at a glance" box (see box for Chapter 1, page 1-1, as sample). This box lists the contents of the chapter, including page numbers, and presents the theme of the chapter. Although a detailed table of contents appears at the beginning of this Report, the list of contents at the beginning of each chapter will help readers locate sections in individual chapters quickly and easily.

""Quote Boxes

Throughout the chapters, various quotes appear in quote boxes, as shown in the sample here. These quotes comment on and add to the discussion at hand.

> *"Your task is, quite simply, to keep the kids in mind and to think broadly beyond the scope of the work you all individually do to what's a good and workable solution to the issues that face you.... It's not just about the coverage; it's about better health outcomes for the people—for these kids."*
>
> **~Kevin Thurm, Deputy Secretary, HHS**

Cross-References

Cross-references to specific chapters, recommendations, and pages within this Report are highlighted in the margins as shown to the right.

x for more information on….

Acronym Reminders

While all acronyms are spelled out and defined in the list of acronyms at the beginning of this Report (see page v below), they are also spelled out and defined upon first usage. In addition, upon first use of an acronym in each chapter, an acronym reminder is provided in the margin as shown here.

PRWORA Personal Responsibility and Work Opportunity Reconciliation Act

Recommendations

Recommendations are numbered in sequential order throughout the Report and are presented in boxes at the bottom of the sections in which they are discussed. The category/type of each recommendation appears in parentheses following the recommendation number. The body of the recommendation follows. A sample recommendation is shown at the bottom of this page.

Recommendation 1 (Federal Regulation)

The HHS should require each State to maximize the enrollment of children in appropriate health care coverage; the first recourse should be appropriate private coverage of either parent. *("Appropriate coverage" is defined in Recommendation 8.)*

Background Boxes

Background information pertinent to the discussion at hand is presented in boxes, as shown in the sample to the right.

Definitions

As necessary, selected terms or phrases are defined in the text in definition boxes, as shown in the sample below ("child support-eligible children"). These and additional definitions may also be found in the Glossary at the end of this Report.

"Child Support-Eligible Children"
As used in this report, child support-eligible children are children under the age of 19 whose parents are divorced, separated, or never-married (and not living together). Not all child support-eligible children live in single parent households, about 17 percent live in married step-parent families. In this report 21 million children living in single or stepparent households are considered to be eligible for child support. Additional child support-eligible children live with a related adult, a guardian or foster parent. Our data is not able to count these children. (See APPENDIX D: Health Care Coverage for Child Support-Eligible Children, page A-32).

History of Federal Funding of the IV-D Program

In 1950, without providing funding, Congress required welfare agencies to inform appropriate law enforcement officials when AFDC was furnished to a child who had been abandoned by a parent. The rationale was to encourage law enforcement officials to take action, including the filing of non-support proceedings against those who had abandoned their children.

Acronyms Used in this Report

The box below lists all of the acronyms used in this report.

Acronyms

AFDC	Aid to Families with Dependent Children
CCPA	Consumer Credit Protection Act
CSHN	Children with Special Health Needs
CSPIA	Child Support Performance and Incentive Act of 1998
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
DOL	Department of Labor
HIPAA	Health Insurance Portability and Accountability Act of 1996
HHS	Department of Health and Human Services
ERISA	Employee Retirement Income Security Act of 1974
FFP	Federal Financial Participation
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HMO	Health Maintenance Organization
IV-D Program	Federal/State Child Support Enforcement Program
NAIC	National Association of Insurance Commissioners
NMSN	National Medical Support Notice
NPRM	Notice of Proposed Rule Making
OBRA '93	Omnibus Budget Reconciliation Act of 1993
OCSE	Federal Office of Child Support Enforcement
OIG	Office of the Inspector General
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act of 1996
PLPW	Poverty Level Pregnant Women Program
PPO	Preferred Provider Organization
QDRO	Qualified Domestic Relations Order
QMCSO	Qualified Medical Child Support Order
SCHIP	State Children's Health Insurance Programs
SDU	State Disbursement Unit
TANF	Temporary Assistance for Needy Families
TPA	Third-party Contract Administrator
UIFSA	Uniform Interstate Family Support Act
URESA	Uniform Reciprocal Enforcement of Support Act
WIC	The Supplemental Feeding Program for Women, Infants and Children

Preface/Cover Letter from Co-Chairs

At a time when children's health care coverage is the focus of much national attention, children who grow up in divorced, never-married, or separated families are at a greater risk than other children of not having health care coverage. Children without coverage have substantially less access to critical health care services, which are essential for their well-being and productivity.

Although the child support enforcement program has been increasingly successful in obtaining health care coverage for children, changes in the labor market, family structure, health care delivery systems, and social welfare policy require new approaches to ensure that children obtain appropriate coverage—public and/or private.

Recognizing the complexity of the issues involved and the willingness of interested parties to work together, Congress directed the joint establishment of the Medical Child Support Working Group by the Secretaries of Health and Human Services and Labor. The charge of the Working Group, which is comprised of thirty members who represent the broad range of interested and affected parties, was to submit a report to Secretary Shalala and Secretary Herman identifying the impediments to the effective enforcement of medical child support, and recommending solutions to these impediments. The Working Group's Report is an important step in our efforts to increase health care coverage for these children.

The recommendations contained in this Report establish a new model for the medical support enforcement system that puts the needs of children first. The goal in implementing this new model is to increase the number of children with private health care coverage and, for children who cannot obtain appropriate private coverage, to increase their enrollment in publicly-funded health care coverage.

We appreciate the commitment of the members of the Working Group in their efforts to ensure that children in this nation are not without health care coverage merely because their parents do not reside together, and we look forward to working with our partners to make this new vision of medical support a reality.

David Gray Ross
Commissioner,
Office of Child Support Enforcement,
Administration for Children and Families, HHS

Robert J. Doyle
Director of Regulations & Interpretations,
Pension & Welfare Benefits Administration, DOL

Executive Summary

Opening

For a child, health care is critical. Yet, in the United States today, there are close to over 10 million children without health care coverage. For children who grow up in divorced, separated, or never-married families, the risk of not having health care coverage is great. Of the 21 million children who are eligible for child support enforcement services, approximately 3 million are without health care coverage. These children have substantially less access to health care services, including preventive care that ensures childhood immunizations, vision and hearing screening, and dental care. Health care services are also far more likely to be delayed due to cost. Unmet health care needs reduce a child's ability to grow into a healthy and productive adult.

There is no single reason why children do not have the health care coverage they require. Children, particularly those impacted by the consequences of a family breakup, have not been held harmless from large societal changes: the rising cost of health insurance, the move towards new health insurance models (such as Health Maintenance Organizations) that limit service area and choice of provider, changes in the labor market, the transformation of the American welfare system, and changes in family structure.

Over time, the Federal and State governments have responded to the need for health care coverage for children in two ways. First, they have created publicly-subsidized programs such as Medicaid and, most recently, the State Children's Health Insurance Program (SCHIP). Both programs are need based, primarily serving families with incomes under 200 percent of poverty. Second, the establishment and enforcement of medical child support was added to the responsibilities of the national Child Support Enforcement Program established under Part D, Title IV of the Social Security Act. States are required to include provisions for health care coverage in State child support guidelines and the IV-D program is required to pursue private health care coverage when such coverage is available through a noncustodial parent at a reasonable cost.

Over the past five years a number of legislative changes have strengthened medical child support enforcement and removed some of the impediments to providing children with health care coverage. The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) created the Qualified Medical Child Support Order (QMCSO) and required State laws that prohibit insurers from discriminating in

the provision of health insurance when children are born out of wedlock or are outside the insurer's service area. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) required a provision for health care coverage in all child support orders and directed the child support enforcement agency to notify an employer of the noncustodial parent's medical child support obligation.

Despite such reforms, getting and keeping health care coverage for child support-eligible children remains complicated and resource intensive. New strategies and policies are required to make the system easier and more cost effective for parents, employers, health care plan administrators and the government. The goal is both to gain access to better coverage for more of these children and ensure health care coverage for all.

Medical Child Support Working Group -CSPIA & Charge

Congress recognized the scope of the problem and the eagerness of various sectors to address these issues by creating the Medical Child Support Working Group as part of the Child Support Performance and Incentive Act of 1998 (CSPIA). Jointly established by the Secretary of Health and Human Services and the Secretary of Labor, the Working Group was charged with identifying barriers to effective medical support enforcement and developing recommendations that address the following six areas:

- Assess the National Medical Support Notice
- Identify the Priority of Withholding from an Employee's Income, Including Medical Support Obligations
- Coordinate Medical Child Support with Medicaid/SCHIP
- Examine Alternates to a Medical Support Model Focused Exclusively on the Noncustodial Parent's Employer-Provided Health Plan
- Evaluate the Standard for "Reasonable Cost" in Federal Law
- Recommend Other Measures to Eliminate Impediments to Medical Support Enforcement

Working Group Membership - Represents Wide Range Of Sectors

The Working Group is a powerful example of very different worlds coming together, learning each other's languages, developing a greater understanding of legitimate competing concerns, and reaching consensus on real solutions to complex issues.

The Working Group includes thirty members with representatives from the U.S. Department of Labor (DOL), the U.S. Department of Health and Human Services (HHS), State IV-D Child Support Directors

and State Medical Child Support Programs, State Medicaid Directors and SCHIP programs, employers, including small business, trade or industry representatives and human resource and payroll professionals, plan administrators and sponsors of group health plans, child advocacy organizations, and organizations representing State child support programs.

The Working Group's greatest challenge was balancing the concerns and interests of the various stakeholders—Federal representatives, State IV-D/Child Support Enforcement, State Medicaid and SCHIP, employers, insurers, plan administrators, child advocates, private attorneys, and representatives of the courts.

Working Group's Principles

The Working Group met eight times since its first meeting in March 1999 and came to consensus on 76 recommendations. Based on testimony and research, the Working Group formulated a package of recommendations with children in the center, based on the idea that the system and structure should work toward what is best for the child. The Working Group was guided by a set of principles, including:

Increase the Number of Children in Single-Parent Households with Health Care Coverage

It is in the best interest of both children and the nation that the maximum number of children have access to health care coverage. Lack of such coverage affects children's current and future health and their ability to become productive citizens.

Appropriate Private Health Care Coverage Comes First

Parents share primary responsibility for meeting their children's needs. When one or both parents can provide comprehensive, accessible, and affordable health care coverage that coverage should be provided to the child. To the maximum extent possible, public dollars through enrollment in Medicaid/SCHIP should not replace private insurance but rather should serve as the payer of last resort where private health care coverage is unaffordable, unavailable, or not comprehensive enough. Public coverage is not intended to relieve able parents of their responsibility to provide health care for their children.

Both Parents are Responsible for Medical Support – Preference to the Custodial Parent (if all is equal) as the Source

Coverage available to both parents should be considered in setting a medical support obligation. Twenty-seven States recognize that both parents may have access to private

insurance and direct the decision maker to consider both parents as a potential source. However, nearly half of the States' child support guidelines do not direct the decision maker to consider coverage available to the custodial parent and, as a result, children may be missing out on potential coverage. These recommendations change the child support enforcement's medical support focus, which is now almost exclusively on the noncustodial parent.

Affordable Coverage

In deciding whether to pursue coverage, the cost of coverage is an important consideration. However, the current Federal definition of "reasonable" health insurance—that it is available through an employer—is not necessarily reasonable. The Working Group explored alternative State and Federal definitions, including the SCHIP guidance that the cost of SCHIP premiums should not exceed five percent of a family's gross income, and the applicable Consumer Credit Protection Act (CCPA) limits. The recommendations address concerns that the cost of private health care coverage could significantly lower the amount of cash support available to meet the child's basic needs and the child is eligible for some other form of health care coverage.

Accessible Coverage

When private health care coverage is available to a child, the child support enforcement agency should consider the geographic accessibility of covered services before it decides to pursue the coverage. Given, in particular, the large number of interstate child support cases, the Working Group concluded that children should not be enrolled in any limited provider plan whose services/providers are not accessible to them, unless the plan can provide financial reimbursement for alternate service providers. In its recommendations, the Working Group considers coverage by Health Maintenance Organizations (HMOs), and other plans which limit providers, accessible if the provider may be reached within 30 minutes or 30 miles, but allows States to adopt an alternative standard.

Comprehensive and Seamless Coverage

The child support enforcement program should work in close conjunction with Medicaid and the SCHIP to ensure that children who have access to private coverage obtain such coverage and those who need publicly subsidized coverage are covered by Medicaid or SCHIP.

Overview of Recommendations

The Working Group spent considerable time deliberating, listening to testimony, studying research, and meeting in subcommittees.

The Working Group's deliberations led to 76 recommendations. While many are

practical and technical, others are visionary—a dramatic shift to a new paradigm—necessitating fundamental changes to State and Federal government's management and operations of medical child support enforcement. Some of the recommendations are Federal mandates, others are "best practices" to be shared with States, employers, and others. The implementing strategy for each recommendation falls within one or more of the following categories:

- Federal Statute/Legislation
- Federal Regulation/Guidance
- Best Practice
- Technical Assistance and Education
- Research, Evaluation, and Demonstration

Considering the complex interplay of trends in health care delivery, labor market, and family structure, the Working Group has formulated a comprehensive strategy that overhauls the current medical support system for the country's 21 million child support-eligible children. Enactment or adoption of these recommendations will increase the number of children with private health care coverage and increase access to publicly-funded health care coverage for children who cannot obtain private coverage. Throughout, the Working Group recommends a broader, more proactive role and responsibility for IV-D agencies in ensuring that children have health care coverage. As a necessary companion to these mandates, the Working Group recommends immediate enhanced funding to IV-D programs for medical support enforcement. Although the enhanced funding is time-limited, the recommendations also address research and future funding.

The solutions developed by the Working Group are most easily considered in two broad categories: recommendations that ensure seamless health care coverage for all children and recommendations that streamline medical support enforcement. Below is a sampling of the Working Group's 76 recommendations:

Seamless Coverage for All Children

- State child support guidelines are based upon outdated assumptions and therefore fail to maximize private family health coverage enrollment for child support-eligible children. Even when State child support guidelines direct the decision maker to look at coverage available to both parents, this is not always the case. Therefore, the Working Group makes recommendations that require States to adopt medical child support guidelines that require the decision maker to explore health care coverage available to both parents.

- The Working Group developed a "decision matrix" that provides guidance to decision makers when

deciding which health care coverage is the most appropriate—affordable, accessible, comprehensive—to order. This matrix considers private insurance available to both parents and grants decision makers flexibility to order parents to seek public coverage where no private health care plan is found to be appropriate. These important recommendations provide structured and equitable treatment to all children.

- The Working Group recommends that the Federal regulation that deems all employment-related or group-based coverage to be reasonable in cost should be replaced with a standard based on the cost of coverage relative to income of the parent who provides the coverage. If the cost of providing private coverage does not exceed five percent of the gross income of the parent who provides coverage, then the cost should be deemed reasonable.

- The Working Group makes recommendations to improve coordination between IV-D and Medicaid and SCHIP, including adding IV-D as an agency that can engage in presumptive eligibility for Medicaid enrollment.

- The decision maker needs information about health care plans that are available to both parents to determine where there is access to private health care coverage, and how to allocate costs and draft the medical support order. Therefore, the Working Group recommends that States develop discovery mechanisms that require parents to disclose information about health care coverage to ensure the best available health care choice is ordered. In addition, the Working Group recommends further study of automated sources that would provide improved information sharing and data exchange.

- The Working Group recommends that SCHIP eligibility not be denied where a child is enrolled in private insurance but the health care benefits are not geographically accessible.

Streamline Process for Enforcement

- During its deliberations, the Working Group provided significant feedback and input on the National Medical Support Notice. The suggested changes make the Notice more "user friendly" for IV-D personnel, employers, and plan administrators. The Notice of Proposed Rule Making (NPRM) on the Notice, proposed in November 1999, provides a uniform tool for States to inform employers to enroll noncustodial parents' children in an employer-sponsored group health plan. The standardized form has two parts. After an employer receives the entire Notice, the employer retains Part A and sends Part B to the appropriate group health plan. In addition, the Working Group provides recommendations to improve the implementation and use of the Notice through education and outreach strategies.

- The Working Group makes recommendations on the Medical Support Incentive and funding for these new medical support activities. Enhanced Federal Financial Participation (FFP) to jump-start these medical support activities is the key. In addition, the Working Group recommends that two years be afforded to the Medical Incentive Workgroup to finalize the measure, using this time to obtain data not currently available. The incentive would be in place in the third year and States would begin collecting and reporting the data necessary to calculate the incentive. Full implementation of the medical support performance measure would begin at the

end of five years, at which time the enhanced FFP would end.

- The Working Group recommends that the priority of child support be: cash support, then health care premiums and current medical support, then arrears, with flexibility.

- The Working Group recommends that State child support enforcement agencies should not pursue recoupment of pregnancy and birth-related costs in Medicaid cases.

- The Working group recommends research examining potential cost savings to Medicaid as a result of the greater role of IV-D in accessing private health insurance and a special grant project testing the use of innovative health care delivery models for child support-eligible children, such as the Sacramento IV-D Kids program.

- The Working Group recommends amending relevant laws to eliminate—or at least reduce—barriers. In addition to looking at the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Social Security Act, there are important recommendations to review tax policy in several areas to make the Internal Revenue Code more consonant with health care policy.

Organization of Report

This Report will assist policy makers in developing technical and substantive changes to statutes and regulations. It will provide best practice information to States and employers.

The Report is organized into nine chapters. The first two chapters provide an overview and background. Chapter 1 addresses the scope of the problem and Chapter 2 provides an overview of the current system from the perspective of the Child Support Enforcement Program (IV-D), as well as from the perspective of the employer and plan community. This Chapter lays out not only the requirements and suppositions built into current law but also offers a new paradigm for ensuring health care coverage for all child support-eligible children.

A critical step in child support is establishing the child support order. Chapter 3 offers a detailed analysis and comprehensive reform of both how health care is included in a child support obligation and how that order is drafted. Chapter 4 discusses the enforcement tool for IV-D medical support orders, the National Medical Support Notice. Chapter 5 is a broader discussion of enforcement of the health care provisions in a child support order. Chapter 6 is a macro discussion of system coordination. Funding of child support activities directly related to medical support can be found in Chapter 7. Chapter 8 identifies additional strategies and research required to ensure ongoing improvements in assuring health care coverage for children in single parent

families. Finally, Chapter 9 provides a brief Postscript/Conclusion to the Report.

Future

The Working Group's recommendations are designed to create an easier, more cost effective, and comprehensive medical child support enforcement system. Suggested strategies and laws will move our society a long way down the road to ensuring that children are protected from the health care consequences of family dissolution. Finally, although it is the Working Group's goal that this Report frame the focus and future direction of medical child support enforcement within the IV-D program, it is our hope that the consensus built here will also provide a model for sorting through the complex interplay of competing interests and move as a society to ensure health and well-being to all America's children.

Table of Recommendations

Page

Recommendation 1 (Federal Regulation) 3-3
The HHS should require each State to maximize the enrollment of children in appropriate health care coverage; the first recourse should be appropriate private coverage of either parent. ("Appropriate coverage" is defined in Recommendation 8.)

Recommendation 2 (Federal Regulation) 3-4
Each State's child support guidelines should show how the cost of health care coverage will be allocated between the parents.

Recommendation 3 (Federal Regulation) 3-5
Each State should develop mechanisms that require both parents to disclose information about actual and potential private health care coverage in order to help the decision maker determine whether private coverage is available to either parent.

Recommendation 4 (Federal Regulation) 3-5
States should use existing automated databases providing information about private health care coverage available through employers or use insurers' databases. Such databases need not contain information about the types of benefits offered, only whether dependent coverage is offered by an employer. For further details about the development of or modification to such databases, see Recommendation 64.

Recommendation 5 (Federal Guidance) 3-6
To further expand the ability of IV-D agencies to obtain information about actual and potential health care coverage available to both parents, OCSE should inform these agencies that §466(c)(1)(C) gives the agencies the authority to request health care benefits information from employers before they establish a medical support order. In conjunction with this, the DOL should inform plan administrators subject to ERISA that they must respond to such IV-D requests when they are made for the purpose of drafting a Qualified Medical Child Support Order (QMCSO). (See Recommendation 29.)

Recommendation 6 (Federal Legislation) 3-7
If the child is presently enrolled in either parent's private health care coverage and the coverage is accessible to the child, that coverage should be maintained. If, however, one of the parents has more appropriate coverage (as determined in accord with Recommendation 8 through Recommendation 11) and either parent requests that the child be enrolled in this plan, the decision maker shall determine whether or not to maintain the existing coverage based upon the best interests of the child.

Recommendation 7 (Best Practice) 3-9
DOL and HHS should request the NAIC to encourage insurance providers with limited coverage areas to enter coordination agreements under which children who are covered under a geographically inaccessible plan can obtain services from a plan that is geographically accessible to them. Child support enforcement should publicize the availability of such plans and encourage States to take into account the possibility that out-of-area coverage may be available when assessing whether a particular plan is accessible to the child.

Recommendation 8 (Federal Regulation)...3-10
If a child is not enrolled in private coverage, the decision maker shall determine whether one or both parents are able to obtain *appropriate* coverage for the child based on three factors: (1) comprehensiveness of the plan, (2) access to services, and (3) affordability. Each factor should be assessed individually and then considered together in accord with Recommendation 13.

If a child has special needs, the decision maker should consider this circumstance in conjunction with the needs of the primary plan member and other dependents (see Recommendation 12).

Coverage is *comprehensive* if it includes at least medical and hospital coverage; provides for preventive, emergency, acute, and chronic care; and imposes reasonable deductibles and co-payments. In determining which coverage is more comprehensive when both parents have such coverage, the decision maker should consider the following: basic dental coverage, orthodontics, eyeglasses, mental health services, and substance abuse treatment.

Coverage is *accessible* if the covered children can obtain services from a plan provider with reasonable effort by the custodial parent. When the only health care option available through the noncustodial parent is a plan that limits service coverage to providers within a defined geographic area, the decision maker should determine whether the child lives within the plan's service area. If the child does not live within the plan's service area, the decision maker should determine whether the plan has a reciprocal agreement that permits the child to receive coverage at no greater cost than if the child resided in the plan's service area. The decision maker should also determine if primary care is available within the lesser of 30 minutes or 30 miles of the child's residence. If primary care services are not available within these constraints, the coverage should be deemed inaccessible. In lieu of the 30 miles/30 minutes standard, States may adopt an alternative standard for time and distance, such as the standard that the State uses to administer programs such as Medicaid managed care services or to regulate managed care provider networks.

In determining accessibility, the decision maker should also assess whether one can reasonably expect the coverage to remain effective for at least one year, based on the employment history of the parent who is to provide the coverage.

Reasonable cost should be assessed based on Recommendation 9 through Recommendation11.

Recommendation 9 (Federal Regulation)...3-14
The Federal regulation that deems all employment-related or group-based coverage to be reasonable in cost should be replaced with a standard based on the cost of coverage relative to the income of the parent who provides the coverage. Except as noted in Recommendation 10 and Recommendation 11, if the cost of providing private coverage does not exceed five percent of the gross income of the parent who provides coverage, then the cost should be deemed reasonable.

Recommendation 10 (Best Practice) 3-15
No parent whose net income is at or below 133 percent of the Federal poverty level should be ordered to provide private coverage, unless that parent has access to private coverage that does not require an employee contribution to obtain coverage.

Recommendation 11 (Best Practice) 3-15
No parent whose resident child is covered by Medicaid, based on that parent's income, should be ordered to provide private coverage, unless the parent has access to private coverage that does not require an employee contribution to obtain coverage.

Recommendation 12 (Federal Guidance) 3-16
The decision maker must consider a child's special medical needs when deciding which form of private or public coverage is appropriate under Recommendation 8 through Recommendation 11. HHS should identify governmental agencies that are currently studying issues involving children with special needs and should coordinate with these agencies in the development of a common definition of "special needs" children. HHS should provide guidance to State IV-D agencies on how best to use the decision making matrix set out in Recommendation 13 when a special needs child is involved.

HCFA should require Medicaid agencies to identify whether there is a special needs child in any case they refer to the IV-D program pursuant to the child support cooperation requirement of the Medicaid program.

Recommendation 13 (Federal Legislation)..3-20

After determining that a child is not enrolled in private health care coverage, and that at least one parent could enroll the child in private coverage, the decision maker should determine which plan is most *appropriate* for the child (as defined in Recommendation 8) by evaluating the plan(s) in the following manner:

Step 1. Determine whether the child has access to the services provided under the coverage.

Step 2. Determine whether the cost of the coverage is reasonable.

Step 3. Determine whether the coverage is comprehensive.

Step 4. If, after following steps 1-3, the decision maker finds that only the *custodial* parent has accessible, affordable, and comprehensive coverage, that coverage should be ordered, with appropriate allocation of cost, as determined by the State child support guidelines. (See Recommendation 2)

If, after following steps 1-3, the decision maker finds that only the *noncustodial* parent has accessible, affordable, and comprehensive coverage, that coverage should be ordered, with appropriate allocation of cost, as determined by the State child support guidelines. (See Recommendation 2)

Step 5. If, after following steps 1-3, it is determined that accessible, affordable, comprehensive coverage is available to both parents, then coverage available to the custodial parent should be ordered unless (1) either parent expresses a preference for coverage available through the noncustodial parent; or (2) the noncustodial parent is already carrying dependent's coverage for other children, either under a child support order for those children or because the children reside in his current household, and the cost of contributing toward the premiums associated with the custodial parent's coverage is significant. If either of the exceptions applies, the decision maker should make an assessment of what is in the best interests of the child and order coverage accordingly.

If neither parent has family health coverage, see Recommendation 14 and Recommendation 15.

Recommendation 14 (Best Practice) 3-22

When neither parent has access to private health care coverage at reasonable cost but a step-parent does, enrolling the children in the step-parent's coverage should be considered *under certain conditions*. These conditions are: (a) the coverage is accessible to the children; (b) the step-parent is willing to provide such coverage; and (c) there are no employer/insurer constraints for enrollment of the child.

When these conditions are met, the parent who is married to the step-parent should be ordered to provide health care coverage for the children. The order should specify that this obligation may be met by enrolling the children in the step-parent's health care coverage. Moreover, the order must make it clear that if the obligated parent and the step-parent later commence proceedings for a separation or divorce, the obligated parent has responsibility for obtaining information about the cost and availability of COBRA coverage for the children and enrolling the children in this coverage. The order should also specify that if COBRA (or other) coverage is not available or affordable, the obligated parent must immediately seek modification of the medical provisions of the child support order. As an alternative, the custodial parent should seek publicly-funded coverage in order to minimize any lapse in coverage for the children.

Recommendation 15 (Best Practice) 3-24

When neither parent can provide comprehensive, accessible, affordable private health care coverage, the decision maker should explore the possibility of providing coverage to the child through Medicaid or the SCHIP. If the child is ineligible for Medicaid or SCHIP, the decision maker should explore whether there is any available lower-cost, child-only plan, such as Sacramento IV-D Kids.

Recommendation 16 (Federal Legislation).. 3-25

To facilitate enrollment of eligible children in public coverage, Federal law should require State IV-D agencies to: (1) provide parents with information about the Medicaid and SCHIP programs, as well as any other subsidized coverage that may be available to the child; and (2) refer the family to the appropriate program for possible enrollment.

Recommendation 17 (Federal Legislation).. 3-26

Congress should amend §1920A of the Social Security Act to include IV-D agencies among the "qualified entities" that may enroll children in Medicaid for a presumptive eligibility period, based on preliminary information that indicates that the child is income-eligible for Medicaid.

Recommendation 18 (Federal Guidance) 3-26
Provided that Congress amends the Social Security Act to allow State IV-D agencies to presumptively enroll children in Medicaid, OCSE and HCFA should strongly encourage all States to exercise this option or to take other steps to facilitate Medicaid enrollment, including placing Medicaid or SCHIP staff in IV-D offices, providing application forms to potentially eligible families, and arranging eligibility appointments.

Recommendation 19 (Best Practice, Federal Legislation) 3-28
Part A (Best Practice): States should grant authority to the decision maker to order the noncustodial parent to contribute toward the State cost of providing coverage under Medicaid and SCHIP. Provided, however, no contribution should be ordered from any noncustodial parent whose net income (as defined by the State to determine Medicaid eligibility) is less than 133 percent of poverty.

Part B (Federal Legislation): Congress should amend §467 of the Social Security Act to provide that the amount the noncustodial parent may be ordered to contribute toward the monthly cost of coverage under Medicaid or SCHIP shall be the *lesser* of: (1) the estimated cost of enrolling the child in Medicaid or SCHIP; (2) five percent of the noncustodial parent's gross income; or (3) the amount indicated by a sliding fee schedule, developed by the State, which takes into account ability to pay and average Medicaid/SCHIP costs for dependent children.

Recommendation 20 (Federal Legislation).. 3-31
Congress should amend Title IV-D of the Social Security Act to preclude State IV-D agencies from attempting to recover Medicaid-covered prenatal, birthing, and perinatal expenses from the noncustodial parent.

Recommendation 21 (Federal Regulation) 3-32
The States should give the decision maker authority to order either or both parents to contribute toward: (1) the cost of any co-payments, deductibles, or costs associated with the ordered health care coverage; and (2) any uncovered medical expenses incurred by the child.

Recommendation 22 (Federal Regulation).. 3-33
To the extent that unreimbursed costs are not included in the State's basic child support guideline formula, those costs should be apportioned *pro rata* between the parties.

Recommendation 23 (Best Practice) 3-33
Since the extent of unreimbursed costs is unknown at the time an order is established, each State should develop protocols that permit the court or administrative agency to reduce such expenses to a judgment based on the language of the order. These protocols should include time limits for the parent who has paid the expenses to claim reimbursement and time limits for the obligated parent to pay these expenses, as well as simple pro se procedures for making or contesting such claims. The protocols should also include procedures to enforce collection from the noncustodial parent.

Recommendation 24 (Best Practice) 3-34
State child support guidelines should require that the medical support provisions of a child support order for private or public health care coverage clearly explain the obligation of each parent in meeting the child's health care needs. Although not necessary to be qualified under §609(a) of ERISA, orders should address, as fully as possible, each of the following issues:The party (custodial or noncustodial parent) responsible for obtaining public or private health care coverage

- The type of coverage to be obtained
- The cost of premiums and the manner in which each parent will contribute to those premiums
- The type of uncovered expenses for which the parties will share costs
- The specific manner in which each parent will contribute to the cost of uncovered expenses
- The designation of primary and secondary coverage in any case in which both parties are to provide health care coverage
- The circumstances under which the obligation to provide health care coverage for the child will shift from one parent to the other

Recommendation 25 (Federal Guidance) 3-35
To facilitate implementation of Recommendation 24, the DOL and HHS should develop model language regarding health care coverage for inclusion in child support orders. The model language, which would not be mandatory, would alert attorneys, child support workers, and court personnel to common issues that should be addressed in such orders.

Recommendation 26 (Technical Assistance) 3-35
Following adoption of the recommendations of the Medical Child Support Working group, DOL and HHS should provide training and technical assistance to courts to facilitate implementation of the recommendations, particularly those relating to the decision-making matrix and enrolling children in Medicaid and SCHIP.

Recommendation 27 (Federal Guidance) 4-4
DOL and HHS should: (1) make it clear that the Notice is deemed to be a Qualified Medical Support Order only if issued by IV-D agencies, and (2) explain how the QMCSO process works for private parties. (See Recommendation 25.)

Recommendation 28 (Technical Assistance) 4-5
The DOL and HHS should collaborate with State IV-D agencies and organizations representing employers, plan administrators, and payroll agents to develop automated State IV-D systems that can produce the National Medical Support Notices and distribute these Notices and their responses to affected parties.

Recommendation 29 (Federal Regulation) 4-8
HHS and DOL should publish the National Medical Support Notice in final form no later than September 1, 2000 to allow States sufficient time to implement automated processes by October 1, 2001.

Recommendation 30 (Education/Technical Assistance) 4-9
The DOL and HHS should develop strategies to educate and reach out to all categories of constituents who have a need for, or interest in, the National Medical Support Notice, including the following categories of constituents:

- American Bar Association
- State and Local Bar Associations
- State Courts
- Private Attorneys
- American Payroll Association
- Child Support Organizations (NCSEA, ERICSA, WICSEC)
- National Coordinating Committee for Multi-employer Plans
- AFL-CIO
- International Foundation of Employee Benefit Plans
- Association of Private Pension and Welfare Plans
- ERISA Industry Committee
- Society of Professional Benefit Administrators
- National Association of Insurance Commissioners

- Society for Human Resource Management
- Native American Tribes
- Federal Government
- Military
- Faith-Based Organizations
- State and local governments

Recommendation 31 (Education and Technical Assistance) 4-9
DOL and HHS should reach out to courts and administrative authorities to educate them regarding the Notice and the health coverage data required for completion.

Recommendation 32 (Education/Technical Assistance)... 4-9
The DOL and HHS should draft an easy-to-understand booklet similar to HHS's *The Employer's Desk Guide to Child Support* and DOL's booklet on *Qualified Domestic Relations Orders (QDRO) under ERISA*. The booklet should explain the National Medical Support Notice and the DOL's views and interpretations of ERISA's Qualified Medical Child Support Order (QMCSO) provisions.

Recommendation 33 (Federal Guidance) 4-9
The DOL should inform employers, insurers, and plan administrators that when a noncustodial parent carries health care coverage for a child, and the provider of services or the custodial parent of such child submits the claim, 42 USC §1396g(a)(5) requires the insurer to pay the person or entity that submits the claim to the same extent the employee is entitled to be paid.

Recommendation 34 (Technical Assistance) 4-10
The DOL and HHS should develop and make available to States a suggested model "Notice of Release" that State IV-D agencies may issue to employers when a noncustodial parent's obligation to provide health care coverage terminates.

Recommendation 35 (Federal Legislation).. 4-11
Congress should enact legislation requiring health care plans to send a copy of any COBRA notice related to a child's loss of health coverage to the State IV-D agency *if* the health care plan received any QMCSO, including the National Medical Support Notice for that child, from the IV-D agency.

Recommendation 36 (Federal Regulation) 4-12

If some or all of the options under a health care plan are limited to specified geographic service areas, such as those covered by specific zip codes, then:

- The plan administrator should indicate that geographic restrictions apply and should provide information that would make it possible for the IV-D agency to determine whether the coverage is accessible to a child (see Recommendation 8.).
- The plan administrator should be instructed to enroll the child—unless the IV-D agency requests that a child not be enrolled—even if the only available plan coverage is geographically limited and the child is outside the plan's service area.

Recommendation 37 (Federal Regulation)..4-12

If the plan administrator cannot determine a child's zip code or location from the Notice because a Substitute Official's address is used, the plan administrator should be instructed to contact the IV-D agency and provide sufficient information to permit the agency to decide whether or not the coverage is accessible as defined in Recommendation 8.

Recommendation 38 (Best Practice) 4-12

In situations in which the IV-D agency is advised that a choice is required with regard to plan options, the agency should do the following:

- If there is a Medicaid assignment in effect, the IV-D agency should consult with the custodial parent and the Medicaid agency, review the State's treatment of coverage under child support guidelines, choose the appropriate option consistent with the best interests of the child, and notify the plan.
- If there is no Medicaid assignment in effect, the IV-D agency should contact the custodial parent regarding the options, review such options in light of the State's treatment of coverage under the child support guidelines, ascertain the custodial parent's choice, and notify the plan.

Recommendation 39 (Federal Regulation)..4-13
If an employee is in a waiting period that will expire within 90 days after the receipt date of the Notice, then the plan administrator should: (1) determine whether the Notice is a qualified order, and (2) notify the IV-D agency and the parents of the date on which coverage will begin.

If the waiting period expires more than 90 days after the receipt of the Notice, or if the duration of the waiting period is determined by some measure other than the passage of time (for example, the completion of a certain number of hours worked), then once the plan administrator has determined that the Notice is a qualified order, the plan administrator would describe the waiting period on the portion of the Notice returned to the IV-D agency (Part B), and the employer would notify the plan administrator when the employee is eligible to enroll in the plan and when a NMSN is in effect with respect to one or more children of the employee. The plan administrator then notifies both parents.

Recommendation 40 (Best Practice/Guidance/Technical Assistance/ Notice Comments) 4-14
Where the court determines that a pattern of misappropriation of insurance payments exists, the court may, at its discretion, order the insurer to pay all claims for reimbursement directly to the provider of services. This provision should be binding on all parties.

Recommendation 41 (Technical Assistance) 4-14
The DOL and HHS should work with agencies that administer health plans for Federal workers and the military (OPM and DOD) to develop procedures that will recognize the Notice as a means to enroll children in their plans. (See Recommendation 42 and Recommendation 43.)

Recommendation 42 (Federal Legislation)..4-14
Congress should enact legislation that would allow Federal agencies to enroll Federal employees and their dependents in the Federal Employees Health Benefits Program without the employee's consent if the employee is ordered to provide such coverage for his or her dependent(s).

Recommendation 43 (Federal Regulation)..4-14
Congress should enact legislation to allow the U.S. military to enroll its employees and their dependents in Tri-Care without the employee's consent if the employee is ordered to provide such coverage for his or her dependents.

Recommendation 44 (Federal Legislation)..5-5
When the decision maker requires the custodial parent to provide coverage for the children, the parent should verify that the children have been enrolled within a reasonable time, to be determined by the State. When the child support enforcement agency provides enforcement services, and the children are not enrolled as ordered, the child support enforcement agency should take appropriate steps to enforce the order against the custodial parent. However, any notice that is sent to the parent should ask the custodial parent to contact the child support enforcement agency if she did not provide health care coverage because of some financial difficulty, a change in employment, other change in circumstances, and/or the noncustodial parent's failure to comply with an order that required him/her to pay a portion of the premium.

Recommendation 45 (Federal Regulation)..5-6
The Secretaries of HHS and DOL should request the Department of Commerce to review the current provisions of the Consumer Credit Protection Act, which specifies limits on wage garnishment for family support payments, 15 U.S.C. §167(b)(2)(A) and (B). The Department should clarify whether the lower wage garnishment applies only to individuals who have an order to support a spouse or one or more children outside of their households and are also supporting a spouse and/or child within their household.

Recommendation 46 (Best Practice) 5-7
The current Federal wage-withholding limits should be maintained, but the Federal OCSE should advise the States that they can set lower limits, as long as they are not so low that they make it impossible to order the parent to provide health care coverage, in addition to child support, when it is available at reasonable cost.

Recommendation 47 (Best Practice) 5-8
In any case where the amount of the parent's current child support payments exceeds Federal wage withholding limits, the decision maker should examine the calculation of the noncustodial parent's disposable income to determine whether the parent is reducing their disposable income through excessive withholding or other reductions in gross income that are not contemplated by the Consumer Credit Protection Act (CCPA).

Recommendation 48 (Best Practice) 5-9
If the cost of providing private health care coverage increases a parent's child support obligation so that the amount exceeds Federal wage-withholding limits, the decision maker should have the authority to direct the custodial parent to apply for the Medicaid or SCHIP. If the child is found eligible, the decision maker may require the noncustodial parent to contribute toward the cost of coverage consistent with Recommendation 19.

Recommendation 49 (Federal Regulation)..5-11
A Federal policy on the priority of allocation by employers of funds collected through wage withholding should be promulgated. Employers should first attribute withheld funds to current cash support (alimony and child support), then to health care premiums and other current medical support, then to arrears (cash or medical) and then to other obligations. Decision makers should have the flexibility under State law to deviate on a case-by-case basis and provide that health care premiums will be paid first when that is in the best interest of the child.

Recommendation 50 (Federal Guidance)..6-4
HCFA should continue to encourage joint Medicaid/SCHIP applications to streamline the application process.

Recommendation 51 (Federal Guidance)..6-6
HCFA should provide guidance to States to make children who lose health care coverage pursuant to a medical support order an exception to the SCHIP "crowd out" provision by eliminating the waiting period for these children. In particular, guidance would include eliminating the waiting period when the custodial parent loses court- or agency-ordered dependent health coverage due to the noncustodial parent's failure to comply with an obligation to reimburse the custodial parent for the premiums.

Recommendation 52 (Federal Regulation)...6-7
HCFA should issue SCHIP regulations that allow a child to be eligible for SCHIP if the child is enrolled in a group health plan but does not have reasonable access to care under that plan.

Recommendation 53 (Federal Guidance)..6-8
HCFA should provide guidance to States that IV-D-eligible children are also eligible to participate in SCHIP if private health care coverage is available to them but they are not enrolled in such coverage because the services available through that coverage are not appropriate—that is, they are not accessible, comprehensive, or affordable as those terms are defined in Recommendation 8.

Recommendation 54 (Administrative Action)..6-10
The Secretary of HHS should convene a Working Group to develop protocols for implementing the recommendations concerning the enrollment of IV-D children in public rather than private health care coverage, particularly in interstate cases. This group should be comprised of staff from OCSE, HCFA, the Office of the Secretary, State Child Support, Medicaid, and SCHIP agencies as well representatives of other appropriate agencies and the courts.

Among the tasks of this Working Group should be: (1) determining the feasibility and advisability of developing and mandating the use of a standard notification system to transmit information between the State courts, child support enforcement agencies, and Medicaid and SCHIP agencies; (2) assessing the feasibility of each State creating a IV-D/Medicaid/SCHIP database to facilitate a standardized system for information exchange; and (3) exploring the possibility of administrative simplification between the IV-D, Medicaid, and SCHIP programs.

Recommendation 55 (Best Practice) 6-11
State child support enforcement and SCHIP agencies should establish effective ways of communicating with each other.

Recommendation 56 (Best Practice) 6-12
In IV-D cases, when coverage is provided through Medicaid or SCHIP and information provided by the parties or obtained through New Hire Reporting indicates that private dependent health care coverage may now be available, it should be determined whether that coverage is appropriate for the child (as defined in Recommendation 8). If private dependent health care coverage is available and appropriate, the order should be modified as needed and a National Medical Support Notice should be sent to the employer and the child should be enrolled.

Recommendation 57 (Technical Assistance) 6-14
State IV-D agencies, as well as the Federal OCSE, should monitor, evaluate, and report on current State initiatives related to the development of State databases and computer matches with other sources of information about private coverage. Where States have developed these matches, it is essential that the matched information be shared with the IV-D agency. If certain States have obtained successful results through these matches, Child Support Enforcement should hold them up as a best practice. (See Recommendation 5.)

Recommendation 58 (Federal Legislation)..6-16
Congress should repeal §1902(a)(25)(F) of the Social Security Act to allow State Medicaid agencies to cost-avoid claims where the third party coverage is derived through a noncustodial parent's obligation to provide medical coverage.

Recommendation 59 (Federal Guidance) 6-17
DOL and HHS should request the IRS to confirm that a child enrolled in a plan pursuant to a QMCSO would be considered a "dependent child" for purposes of the COBRA provisions, and therefore would be considered a "qualified beneficiary." In the event that such a child would not be considered a "qualified beneficiary," COBRA should be amended to provide that such children are qualified beneficiaries.

Recommendation 60 (Federal Guidance/Federal Legislation) 6-21
DOL and HHS should request the IRS to provide interpretive guidance regarding whether the expiration of the period covered by the Qualified Medical Child Support Order is a COBRA qualifying event in ERISA §603(5) (a dependent child ceasing to be a dependent child under the generally applicable requirements of the plan). This interpretation would make it possible for the child support enforcement agency or custodial parent to elect COBRA continuation coverage to prevent a child from losing coverage for these reasons. If the current statute does not permit this interpretation, we recommend that Congress amend §603(5).

Recommendation 61 (Federal Regulation) 6-21
The DOL should issue regulation(s) that make it clear that ERISA §701(f)(1)(C)(ii) (special enrollment for individuals losing other coverage) permits a child to be specially enrolled in a new plan, after prior coverage obtained through a Qualified Medical Child Support Order (QMCSO) is terminated, if the coverage ends during the period covered by the order or at the end of the period covered by the order. This would permit a child to enroll in other available coverage provided by either parent, if coverage is terminated for some reason related to the medical support order.

Recommendation 62 (Federal Legislation).. 6-21
Congress should amend ERISA §701(f)(2)(A)(iii) to include children enrolled pursuant to a QMCSO among the categories of dependents who, if certain other requirements are met, must be given special enrollment rights.

Recommendation 63 (Federal Legislation).. 6-23
Provided that Congress makes the following changes to §1908 of the Social Security Act (42 U.S.C. §1396g-1), Congress should also amend §1908 to state explicitly that the laws it requires States to pass as a condition of participation in the Medicaid program apply to all children (regardless of whether they are eligible for assistance under the State Medicaid plan), and should amend §609 of ERISA to incorporate the requirements of the amended §1908. The necessary changes are:

- Clarify that a child who is in enrolled in a group health plan pursuant to a court or administrative order could be disenrolled under circumstances under which other dependent children would lose coverage (for example, elimination of family health coverage for all employees in the same business unit or job category).

- Amend §1908(a)(1) to provide that, if there is no QMCSO, a child would be enrolled only if the participant enrolls or consents to the enrollment of the child.

Recommendation 64 (Federal Regulation)..6-24
The term "family health coverage" should be defined in regulations and guidelines to include health coverage that provides benefits to dependents, including a dependent-only policy.

Recommendation 65 (Federal Legislation)..7-6
Congress should amend Federal law to provide for 90 percent enhanced Federal Financial Participation to State IV-D agencies for a five-year period to facilitate the implementation of the Title IV-D medical support requirements, contained in §401 of CSPIA 1998, and additional Federal requirements that result from the Working Group's recommendations. This funding may be capped.

Recommendation 66 (Federal Legislation)..7-8
Congress should amend Federal law to require that the medical support incentive measure is developed in conjunction with the implementation of CSPIA 1998 §401 requirements and additional requirements that may be imposed by law or regulation, based on the recommendations of the Working Group. The measure should also take into account the findings of the research and demonstration grants undertaken by States and funded by HHS.

Recommendation 67 (Federal Legislation)..7-10
Congress should amend Federal law to require HHS to publish the medical support performance incentive measure in final form within three years of the date the 90 percent FFP goes into effect. Implementation of the medical support performance incentive measure shall begin upon publication, including the collection and submission by the States to OCSE of all data necessary to calculate the measure. The medical support performance incentive measure shall be included in the calculation of incentive payments due States beginning 2 years after publication. This five-year time period shall run concurrent with that set forth in Recommendation 65.

Recommendation 68 (Research and Demonstration)...7-11
HHS should study the savings and cost avoidance to the Medicaid program when IV-D secures and enforces a medical child support order for private insurance for Medicaid-eligible children. HHS should also study alternate methodologies to supplement funding for the child support enforcement program based on such Medicaid program savings and avoided costs. If HHS does not have sufficient funds to meet the cost of such a study, it should seek an additional appropriation from Congress.

Recommendation 69 (Research and Demonstration)....................................8-4

The Federal OCSE should conduct a study of the 11 States that ask employers to submit health care coverage information as part of their New Hire Reporting process. The study should analyze the costs and benefits of these efforts from the point of view of employers and States, consider the privacy issues raised by such an information exchange, and identify any precautions taken to protect the privacy of case participants. The results shall be communicated to the States and to the Congress.

If HHS does not have sufficient resources available to fund these studies and/or demonstration projects, the agency should seek an additional appropriation from Congress.

Recommendation 70 (Research and Demonstration)....................................8-6

HHS should undertake projects that will examine various aspects of the intersections of child and medical support enforcement. These projects will encourage States to implement the Working Group's recommendations and promote further innovations to expand health care coverage for children. The projects may be, but should not be limited to, §1115 demonstrations and Child Support Enforcement State program improvement grants projects. These grants might examine issues such as:

- States' efforts to coordinate health care coverage availability between the Child Support, Medicaid, TANF, and SCHIPs programs
- Best practices in establishing and enforcing private family health coverage
- How automation/technologies can be used to improve medical child support enforcement and save tax dollars
- States' creative use of cross-program funding to promote medical support enforcement including, but not limited to, SCHIP block grant funds, PRWORA-related Medicaid matching funds, Federal TANF or States' maintenance of effort funds (MOE), and other block grant funds
- The availability of private family health coverage to IV-D families with an emphasis on access, cost, and comprehensiveness of family health coverage
- State-specific demographic and economic variables that impact performance and States' ability to improve medical support enforcement performance

If HHS does not have sufficient resources available to fund these studies and/or demonstration projects, the agency should seek an additional appropriation from Congress.

Recommendation 71 (Research and Demonstration)..8-10

The HHS should seek Congressional appropriation to fund demonstration projects for a minimum of three to five years to encourage states to adopt public-private partnership health care models for children who are eligible for IV-D services. The HHS should provide information to the States regarding how to establish a public-private model (such as Sacramento IV-D Kids) that is combined with SCHIP/Medicaid program to make private insurance available for individual children at a group rate. Model programs will have features such as the following:

- State IV-D Agencies will gain access to the SCHIP provider pool, making the SCHIP's benefits, including dental and vision, accessible to a pool of children eligible for child support services at the reduced rate created by the increased population pool.

- The target group will be children served by State child support enforcement agencies, regardless of income level, who do not have reasonable access to employer-provided insurance due to cost, access, continuity of coverage or other reasons.

- Facilitators for the Model program will be stationed in family law courts, who will enroll children for coverage at the time the order for support is entered. The facilitator will communicate with the third-party administrator, who will facilitate all subsequent transactions between the third-party SCHIP and the children.

- The efficacy of the court facilitator's role in the Model program will be evaluated separately and as part of the whole Model. The separate evaluation will focus on the facilitator's effectiveness in making families aware of various available health care programs and enrolling children in the most appropriate and cost-effective programs.

- If the noncustodial parent's income is higher than the SCHIP-based eligibility cut-off, a wage assignment for the full insurance premium will be issued. However, since the overall pool of children would include children covered by SCHIP, Medicaid, and the Model program, the "full premium" could be substantially less than the group rate secured by the IV-D Kids Program alone. If the noncustodial parent's income and assets make the children ineligible for SCHIP, then the noncustodial parent will be able to buy into the equivalent of the SCHIP program by paying the premium required under the Model program.

- Since the medical premium will be part of the child support order, a separate health care application process will not be needed.

- Coordinating the third-party administrators of the Model program and the SCHIP program will create a system that provides children with seamless health care coverage throughout the life of the order, regardless of changes in the parents' income levels.

Recommendation 72 (Federal Legislation)..8-11
The Administration should convene a national policy and coordination group that will act through the Federal agencies to provide oversight on health care programs that affect children. The policy group should establish a mechanism or process to encourage dialogue and ensure coordination on health care program issues, especially those impacting children. This process will ensure that interested groups, such as Child Support Enforcement, providers, and payers, help in developing and implementing national objectives concerning health care coverage for children. The group will help ensure that policies, objectives, guidelines, and regulations are consistent, and that these initiatives are designed with consideration for their impacts on all affected parties.

Recommendation 73 (Administrative Action)...8-12
All Federal and State regulatory agencies should develop mechanisms for reviewing proposed health care programs and mandates and incorporating programs and mandates for subsequent periodic review.

Review mechanisms should focus on:

- Research designed to obtain information about how proposed programs or mandates may conflict with existing programs or mandates, especially those that will impact children.

- Establish standards and goals for initiatives and mandates. For example, the number of uninsured children has been reduced by 20 percent (+/-).

- Periodically review established programs, in accordance with standards and goals, such as the goal of cost-effectiveness, and determine whether and to what extent programs are achieving their intended purposes. For example, child support enforcement agencies should determine whether the numbers of uninsured parents and children have been reduced or whether parents' obligations to provide health care coverage are being met.

Recommendation 74 (Technical Assistance) 8-14
The HHS should collaborate with the DOL, Department of Education, and other Federal agencies involved in health care, health care benefits, child support, and tax policies, to develop consumer education programs in order to help contain health care costs.

These consumer education programs could be promoted through tax incentives, grants, private foundation awards, and advocacy groups. The programs would focus on:

- The availability and types of health care programs available to children (and would target the parents of uninsured children)
- Consumer education that will allow the market to help control health care costs, such as developing literature on efficacy and cost of generic and brand-name drugs
- Civic health education, screening and preventive programs, civic risk education programs, and healthful life-styles programs.

Recommendation 75 (Legislative Action)..8-15
Amend Tax Code to Extend Exclusion: The exclusion from income for health care costs under §105 and §106 should be extended to step-parents, grandparents, and other individuals who accept responsibility for obtaining or providing health care coverage for children, regardless of whether the child qualifies as a dependent of that individual under other provisions of the tax code.

Recommendation 76 (Administrative Action)..8-16
The Administration should establish an interagency group to evaluate the impact of tax and health care policy on the provision of children's health care coverage. This group, drawn from the Federal Departments of Treasury, Health and Human Services, and Labor should recommend and help develop tax laws that support the goal of securing health care coverage for all children.

- The interagency group should consider the impact of tax and health care policies upon health care costs, medical insurance costs, and children's access to health care services, with special emphasis on those children who live with a single parent.
- In order to reduce heath care costs and make medical insurance more affordable, the interagency group should consider granting tax incentives to preventive programs, such as health and safety programs.
- The interagency group also should evaluate tax and health care policies, with an aim to proposing legislation and developing regulations that promote individual awareness and responsibility for improving health and reducing health risks. The group might recommend Federal tax incentives for programs that promote proper diet, self-administered care, and exercise programs for diabetic children.

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