

# CLASP

CENTER FOR LAW AND SOCIAL POLICY

## PROPOSED MEDICAL CHILD SUPPORT REGULATIONS

by Paula Roberts  
October 20, 2006

Children need health care coverage for both routine and critical care. Children in single parent families often obtain such coverage through job-related health insurance available to their custodial parent. If such coverage is not available, their non-custodial parent may provide coverage pursuant to a court or administrative medical support order. In cases where the state child support (IVD) agency establishes or enforces the order, the non-custodial parent may be required to provide such coverage if it is available at “reasonable cost”—i.e. if the coverage is available through employment. If neither parent has coverage, the child may be enrolled in Medicaid or in the state’s version of the State Children’s Health Insurance Program (SCHIP). See 42 USC §652(f) and 666(a)(19), as well as 45 CFR §§302.56 and 303.31.

There are a number of problems with this basic scheme. Among them are:

- If the custodial parent or his/her current spouse (i.e. a step-parent) carries the children’s coverage, the entire cost of both the coverage and any related co-payments, deductibles, and uninsured expenses is likely to be born by the custodial parent’s household. It is unfair to impose this burden solely on this household.
- If the non-custodial parent is required to provide coverage, the cost may be quite high, as, despite the federal regulations, employment related coverage may not be reasonable in cost. Moreover, if the parents live at some distance from one another, the coverage may not be accessible to the child. In this scenario, children obtain costly coverage that is not useful to them.
- Employers may receive orders for both cash and medical support that require them to deduct more from their employee’s paycheck than is allowed under the Consumer Credit Protection Act (CCPA). The result may be a loss of health care coverage, a loss of cash support, or both—depending on how the employer responds. There is no uniform national policy for employers to follow in this situation.

In the Child Support Performance and Incentive Act of 1998, Congress created the Medical Child Support Working Group (MCSWG) to examine these and other issues related to medical child support. The MCSWG issued its report to Congress in June 2000. It recommended nearly eighty changes in federal statute, regulation, and practice, change that would improve the current system and ensure that all children in the child support

system had access to some form of health care coverage.<sup>1</sup> Congress has enacted many of the statutory changes recommended by the MCSWG.<sup>2</sup>

Recently, Congress made even more changes in the law. Under the Deficit Reduction Act of 2005 (DRA), effective October 1, 2005:

- all orders enforced by the state child support enforcement agency must include a provision for medical support,
- the state may look to either or both parents to provide such support, and
- the state child support agency may enforce a medical support order against both custodial and non-custodial parents.

In addition, the new law contains a definition of “medical support” that includes both health insurance and payment for other medical expenses incurred on behalf of a child. As a result, if appropriate health insurance is available to either parent, states will be required to establish an order requiring that the children be placed on such coverage with appropriate cost sharing. States will also be able to enforce such orders against both custodial and non-custodial parents. If health insurance is not available, states can pursue cost-sharing of the expenses associated with the child’s medical care. These changes in the law will be codified in 42 USC § 652(f), 42 USC §666(a)(19), as well as 29 USC § 1169 note.

The MCSWG also recommended a number of regulatory changes to accompany any new legislation. Issues of particular concern included the cost of health care coverage, accessibility of the ordered coverage to the child, and adequacy of the ordered coverage. On September 20, 2006, the Administration for Children and Families of the Department of Health and Human Services issued proposed regulations to cover both the DRA changes and the MCSWG recommendations. *71 Fed. Reg.* 54965- 54973. Interested people and organizations can submit comments on these regulations but must do so by November 2006. Instructions on how to submit comments can be found in the Federal Register notice.

Below is a description of the proposed changes.

Child Support Guidelines. Every state must have and use numeric guidelines for establishing child support orders. These guidelines apply in all cases, not just those using the state’s child support enforcement (IVD) program. 42 USC § 667. Current regulations require that the guidelines “provide for the child(ren)’s health care needs, through health insurance coverage or other means.” 45 CFR §302.56(c)(3). The proposed regulations would change this to require that the guidelines “address how the parents will provide for the children’s health care needs through health insurance coverage and/or through cash medical support in accordance with §303.31(b) of this chapter.”

---

<sup>1</sup> See *21 Million Children’s Health: Our Shared Responsibility*, available at [www.acf.dhhs.gov/programs/cse/](http://www.acf.dhhs.gov/programs/cse/).

<sup>2</sup> For details of the changes made between 2000 and 2005 see Paula Roberts, *Medical Support Enforcement: The Federal Scene (2005)*, available at [www.clasp.org](http://www.clasp.org).

Thus, states will have to revisit their guidelines to make sure that health care coverage available to *both* parents is considered. If coverage is available, it should be ordered and the associated costs (premiums, co-pays, deductibles) divided between the parents. If no coverage is available, then the non-custodial parent may be ordered to provide cash to offset the child's health care costs. Exactly how this is to be done is left up to the state. 71 *Fed. Reg.* 54,967. However, the reference to §303.31(b) means that the state guidelines must consider both affordability and accessibility (issues discussed below).

Definition of Cash Medical Support. The DRA requires that, if health insurance is not available to a parent, a cash medical support award be considered. The proposed regulations define "cash medical support" as "an amount ordered to be paid toward the cost of health insurance provided by a public entity or by another parent through employment or otherwise or for other medical costs not covered by insurance." Proposed 45 CFR §303.31(a)(1).

Under this scheme:

- If the *non-custodial parent* has access to private health insurance from any source (including a step-parent or other family member) and that coverage is deemed to be the most appropriate for the child, the non-custodial parent will be ordered to include the child in the coverage and pay any associated premiums. The cash support award may be adjusted downward to take into account that the non-custodial parent is bearing this cost; whether and how to make such an adjustment will be determined under the state child support guidelines.
- If the *custodial parent* has access to private health insurance from any source (including a step-parent or other family member) and that coverage is deemed to be the most appropriate for the child, the custodial parent will provide coverage and the non-custodial parent may be required to pay some or all of the associated costs. In this case, the child support order will increase to include the amount of this cash contribution.
- If *neither* parent has access to private health insurance, the child is (or is ordered to be) enrolled in public coverage (Medicaid, SCHIP, or some other government sponsored health care coverage program), and there are costs associated with that program, then the non-custodial parent may be asked to contribute toward these costs.
- If neither parent-based nor public health care coverage is available, then the non-custodial parent may be asked to provide a cash contribution toward the children's health care expenses.
- If the child has access to public or private coverage but also has uncovered needs, then the non-custodial parent may be required to contribute toward the cost of these needs.

Definition of Health Insurance. The proposed regulations also provide a new definition of "health insurance." This is important because many types of employer-sponsored health care coverage are not strictly "insurance." The regulatory definition acknowledges this and defines insurance broadly, as including "fee for service, health maintenance organization, preferred provider organization, and other types of coverage which is

available to either parent, under which medical services could be provided to the dependent child(ren).” Proposed 45 CFR §303.31(a)(2).

Definition of Reasonable Cost. As noted above, current regulations define all employer-related health insurance to be reasonable in cost. Moreover, if coverage is not available (or is of limited scope) and the non-custodial parent is to provide a cash contribution toward the child’s health care expenses, there is no limit on how much he/she can be required to contribute. Under the proposed regulations, this would change. The new definition would cover both the cost of health insurance and any cash contribution toward the child’s medical expenses: “Cash medical support or private health insurance is considered reasonable in cost if the cost to the obligated parent does not exceed five percent of his or her gross income, or, at State option, a reasonable alternative income-based numeric standard defined in the State child support guidelines adopted in accordance with §302.56(c).” Proposed 45 CFR §303.31(a)(3). Thus, unless and until a change in the guidelines is made, a parent would not be required to contribute more than five percent of his/her gross income toward health care costs. If a State wishes to adopt either a higher or a lower numeric standard, it may do so—but only by amending its child support guidelines.<sup>3</sup>

One recommendation of the MCSWG that is missing here is a limit on contributions toward the cost of coverage from low-income individuals. The MCSWG regarded as a “best practice” that no parent whose net income is at or below 133 percent of the federal poverty level should be ordered to provide private health care coverage unless such coverage was available to that parent at no cost.<sup>4</sup> Advocates may want to cover this point in their comments or in their advocacy with the state around medical support issues.

Another concern is that it is not clear whether the 5 percent limit applies to the total cost of coverage or to the cost of the children’s coverage. In most employment-based coverage, the employee must enroll in order to cover his/her dependents. If an employee has not enrolled, he/she will have to do so in order to obtain coverage for the children. Since there is a substantial difference between the cost for an individual and the cost for covering the individual plus dependents, this could be an issue. For example, if an individual can obtain coverage for \$100 per month, adding dependents coverage might bring the cost to \$400 per month. The additional cost attributable to the children is then \$300 per month. Does the 5 percent apply to \$300 or \$400? This needs to be clarified in the final regulation.

Definition of Accessible Coverage. Proposed 45 CFR §303.31(b) lays out the duties of the state child support (IVD) agency in regard to medical support. Consistent with the provisions and definitions discussed above, the proposed subsection (b)(1) requires the agency to petition the court or administrative agency responsible for setting the award to

---

<sup>3</sup> The five percent standard was recommended by the MCSWG since the SCHIP statute used that standard for the maximum that a custodial parent could be required to pay toward SCHIP coverage for his/her children. Recommendation 9. Further background can be found at *21 Million Children, supra*, pp. 3-6 to 3-16.

<sup>4</sup> Recommendation 10. Discussion on this point can be found at *21 million Children, supra*, pp.3-14 to 3-16.

include, in all new or modified orders, health insurance that is available to the obligated parent at reasonable cost. However, this regulation also requires that the coverage be *accessible* to the child. What constitutes “accessible” is left to the state to define.

The commentary accompanying the proposed regulations suggests two parts to the definition: geographic access and likelihood that coverage will last for a certain period of time. The MCSWG had recommended that geographic access be determined by a 30 miles/30 minutes standard. It also recommended that coverage be sought only if, based on the obligated parent’s work history, coverage was likely to be in place for at least one year. Under the MCSWG proposal, states would have the option to adopt different standards if they felt conditions in their state warranted.<sup>5</sup> Rather than adopt the MCSWG standard, the proposed regulations allow every state to decide how to define “accessibility.”

There are pros and cons to this approach. Because state conditions vary, it may be best to let each state determine what works best. However, this could pose a problem in interstate cases: State A may issue an order for coverage that state B would not deem accessible but would still have to enforce. This is an issue on which advocates may wish to comment. One approach might be to suggest that this regulation parallel the proposed regulation on reasonable cost, in which a standard is set but states are free to adopt an alternate standard. This yields some consistency across states, while leaving room for variation if a state feels strongly that it has a better alternative. In this scenario, the regulations could adopt the MCSWG standard but allow a different definition at state option.

Alternate Coverage Provisions. Proposed 45 CFR §303.31(b)(2) deals with the child support agency’s responsibility when private health insurance that is accessible and reasonable in cost is not available to either parent at the time the order is entered or modified. In these cases, the agency must petition for cash medical support until such time as accessible coverage that is reasonable in cost becomes available.

Presumably, this is where the definition of “cash medical support,” found at proposed 45 CFR §303.31(a)(3) and discussed above, would come into play. The order would require a cash contribution not to exceed five percent of the obligated parent’s gross income and include a provision that private coverage is to be obtained if and when accessible coverage that is reasonable in cost becomes available to either parent. This latter provision would obviate the need to return to court and modify the order when appropriate coverage comes into being.

Modifying Orders. Proposed 45 CFR §§303.31(b)(3) and (b)(4) require state child support agencies to identify orders that do not address children’s health care needs, and to seek review and adjustment of those orders if—pursuant to written criteria established by the state—there is evidence that health insurance may be available to either parent, and the facts are sufficient to warrant a modification.

---

<sup>5</sup> Recommendation 8. For more discussion of the issues in this area see *21Million Children, supra*, pp. 3-6 to 3-16.

Once implemented, this should yield more modifications outside the regular three-year modification cycle. However, there is a good deal of state discretion here, and advocates may want to work with their states to make sure a thoughtful process is implemented. What exactly this process will be depends on the state. While some states have access to highly automated health insurance data bases, which can be easily matched with existing orders to discover available coverage, many states do not yet have this capacity. Some states highly restrict the facts on which an order can be modified; others do not have such restrictions. There will be substantial variation on how much can be accomplished here.

Notifying the Medicaid Agency. Proposed 45 CFR §§303.31(b)(5) and (6) relate to interactions with the Medicaid agency. Under these proposed regulations, the state child support agency would be required to inform the Medicaid agency whenever a new or modified medical support order is entered for a child who has applied for or receives Medicaid. Additionally, the state child support agency would have to communicate periodically with the Medicaid agency to determine if there have been lapses in health insurance coverage for Medicaid applicants or recipients.

Priority of Withholding. Proposed 45 CFR §303.32 amends the National Medical Support Notice (NMSN) to include a provision telling employers what to do if the combined withholding on one or more orders exceeds the amount that can be withheld under the CCPA limits for that employee. Under the proposed scheme, current child and spousal support come first. Thereafter, health insurance premiums or cash medical support are to be withheld. Next comes arrears, followed by any other child support obligations (e.g. interest, litigation costs). In cases in which the child has medical needs that make health care coverage even more important than cash support, the court/administrative agency entering or modifying the order can provide for a different scheme (i.e. health insurance premiums come first), and the employer would be informed of this.

This scheme will help employers determine how to handle, without a lot of fuss, orders that exceed the CCPA limits. It appears that once the withheld funds reach the child support agency, the agency will be able to distribute them in accordance with 42 USC §657. This could be a different allocation than the one used by the employer and might benefit the custodial family.

Failure to define “Comprehensive Coverage”. The MCSWG recommended that a baseline be established for what constitutes acceptable coverage.<sup>6</sup> A major reason for this recommendation is that children with any private coverage are ineligible for SCHIP. If the court or administrative agency orders coverage that is inadequate, the child will be unable to access SCHIP benefits even if he/she meets all other eligibility criteria. 42 USC §§1397aa(a) and 1397bb(b)(3)(C). However, the proposed regulations do not include such a provision, as the agency decided that this issue should not be addressed in federal regulations. 71 Fed. Reg. 54969. Advocates might want to comment on this omission, especially in light of the SCHIP implications.

---

<sup>6</sup> Recommendation 8. For a fuller discussion see *21 Million Children, supra*, pp. 3-7 to 3-10.  
*Center for Law and Social Policy*