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FAILURE TO THRIVE: THE CONTINUING POOR HEALTH OF MEDICAL CHILD SUPPORT

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June 2003

INTRODUCTION

Access to health care coverage is critically important to a child's well-being. Insured children are far more likely than their uninsured peers to have access to regular health care. Their children's access to health care is also important to parents. When their children lack health care coverage, parents are worried, scared, and stressed.[1] For these reasons, the majority of parents enroll their children in health care coverage, even when there are substantial costs associated with such coverage.

Parents obtain this coverage in one of two ways. The majority (about 69 percent) cover their children through private insurance. This may come from an employer-sponsored health care plan (65 percent) or through private non-group coverage (4 percent). The bulk of children who obtain their coverage this way are from families with incomes above the poverty line. The other way in which children access coverage is through public programs such as Medicaid, the State Children's Health Insurance Program (SCHIP), Medicare, and CHAMPUS (which covers military dependents). Almost 18 percent of children are covered through one of these programs.[2] However, a large number of children lack coverage. An estimated 9.2 million children (13 percent of all children) are uninsured. Some of these children could be enrolled in employer-based private coverage available through one of their parents.[3] Many others are eligible for public programs, especially Medicaid or SCHIP.[4]

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[1] A discussion of the research on the importance of having health care coverage for children as well as its benefits to their parents can be found in Dana Hughes and Sandy Ng, *Reducing Health Disparities among Children: The Role of Insurance Expansions,* THE FUTURE OF CHILDREN, Vol. 13, No. 1, (Spring 2003). This document can be viewed at www.thefutureofchildren.org/pubs.

[2] John Holahan, Lisa Dubay, Genevieve Kenney, *Which Children are Uninsured and Why*, THE FUTURE OF CHILDREN, *supra*, Figure 1, p. 57. These percentages are for 2000.

[3] It has been estimated that between 2 and 18 percent of custodial parent families that currently lack employer-sponsored health insurance could obtain coverage through a non-custodial parent. Laura Wheaton, NON-RESIDENT FATHERS: TO WHAT EXTENT DO THEY HAVE ACCESS TO PRIVATE

To the extent that these children are in single-parent families, the state child support enforcement program could assist them in obtaining coverage. The child support system could do this in two ways. *First,* it could make sure that adequate, stable, accessible, affordable private coverage available though one of the child's parents is ordered. Any new or modified child support order should require a parent with access to such coverage to enroll the child, and allocate any associated costs for premiums, co-payments, and deductibles between the parents. The state child support agency also needs to follow-through with enforcement of the order, making sure that the child is actually enrolled and that the custodial parent has access to all needed information and claim forms. *Second,* when it appears that neither parent has access to private coverage, the state child support agency can provide information to the custodial parent about public coverage, and help the custodial parent enroll the child in such coverage.

While some states are moving in this direction, most are not. There are a variety of reasons for this. On the private coverage side, the federal government has failed to update the standards under which states determine whether to seek private health care coverage; has not provided states any financial incentive to seek medical support; and has failed to timely implement federal requirements for the enforcement of orders. On the public coverage side many states have failed to steer children to public coverage in appropriate cases and have not taken advantage of the opportunity to use public dollars to pay for the premiums associated with private coverage, even when this would be cost-effective. Each of these issues—as well as innovative state responses—is discussed below. However, to full understand the issues, it is important to comprehend the nature of the child support program and its role in medical child support. So, we begin with an overview of this system.

A BRIEF DESCRIPTION OF THE STATE CHILD SUPPORT ENFORCEMENT PROGRAMS

In 1975, Congress added Title IV-D to the Social Security Act.[5] Under this law, states receive substantial federal funding to operate child support programs that meet detailed federal requirements. Program services are available to all single parents through

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HEALTH INSURANCE?, Urban Institute Report to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC, (2000). Another 7 percent may have access to such coverage through their custodial mother. Laudan Aron, HEALTH CARE COVERAGE AMONG CHILD SUPPORT ELIGIBLE CHILDREN, A Report Submitted to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC, (December 2002), p. 23. These documents can be obtained at http://aspe.hhs.gov/hsp/hspparent.htm.

[4] Holahan, et al., *supra.* The authors estimate that 52 percent of all uninsured children are eligible for Medicaid and another 25 percent are eligible for SCHIP. Id. Figure 6, p. 67.

[5] 42 USC § 651 et seq. If states operate their programs in accordance with detailed federal norms, the federal government will pay 66 percent of the basic program costs. Id. § 655. In addition, states must operate acceptable child support enforcement programs in order to receive federal block grant funds for their Temporary Assistance for Needy Families (TANF) programs. Id. § 603(a)(2).

a simple application process. However, families who receive cash assistance through the Temporary Assistance for Needy Families (TANF) program or health care coverage through the Medicaid program do not have to file an application: they automatically receive services. Families who do not receive public assistance or Medicaid can be asked to pay an application fee of up to $25, but families receiving public assistance or Medicaid are not subject to this fee.[6]

All state child support programs must provide the following:

- *Parent Locator Services*. Every state has a State Parent Locator Service (SPLS), which has the capacity to look through a variety of automated databases, such as state employment service and motor vehicle records.[7] In addition, the state has access to the Federal Parent Locator Service (FPLS), which allows the state to obtain information from federal databases such as the Social Security Administration. Moreover, all employers must report their new hires to the State New Hire Registry. This information is then passed on to the FPLS for inclusion in the Federal New Hire Registry. Through these mechanisms, a state can obtain information about a non-custodial parent's current address, employment status, and income. As described below, this information can be used in setting a support order.

- *Paternity Establishment.* If paternity is at issue, the state program will assist parents in establishing their children's paternity through a voluntary acknowledgment process or through court action.[8]

- *Obtaining and Periodically Modifying Support Orders*. Child support orders must establish periodic cash support and address the children's health care needs.[9] If private health care coverage is available to the non-custodial parent through employment or membership in a group (e.g., a union), then the non-custodial parent will be ordered to enroll the children in that coverage. The order may also address how the parents are to share the burden of any significant co-payments or deductibles under the policy.

  Once set, orders can be periodically reviewed and adjusted. This process is called modification, and each state has its own rules about how frequently and under what circumstances a modification can be obtained. Most commonly, modifications are sought when there has been a substantial change in the non-

[6] Id. § 654(6)(B). TANF and Medicaid recipients are also exempt from other fees and costs associated with the child support program. 45 CFR §§ 302.33(a)(1)(ii) and 302.33(a)(3).
[7] See 42 USC §§ 654(8), 654a (e), 654a (f) and 45 CFR § 302.35 for more details on how this system works.
[8] For a description of the detailed federal requirements in this area, see 42 USC § 666(a)(5).
[9] Every state has numeric guidelines for setting and periodically modifying support orders pursuant to 42 USC § 667. Unless the court finds that use of the guidelines would yield an amount of support that is unjust or inappropriate, the guidelines must be used to set the support order. If a deviation is allowed, then the court must explain on the record why a deviation was granted and how this serves the best interests of the child. 45 CFR §§ 302.56(f) and (g).

custodial parent's financial circumstances. An increase in income can result in a higher order while a decrease in income may yield a reduction in support. If health insurance is no longer available or becomes available, a modification can also be sought to adjust the order in light of this change.

- *Enforcement of Cash Support.* The state's child support program has a variety of tools available to enforce cash support orders.[10] The most frequently used methods, however, are income withholding and federal tax intercept. If a non-custodial parent is employed, at the time the support order is set, the court will also issue an income withholding order. This order will tell the non-custodial parent's employer the amount of support that has been ordered and that this amount is to be withheld from the employee's paycheck and sent to the state's child support distribution unit.[11] This unit will record payment and distribute the money.[12] If the non-custodial parent gets behind in payment, arrears accumulate. The state can certify these arrears for collection by the Internal Revenue Service through an intercept of any tax refund owed to the non-custodial parent.[13]

- *Enforcement of Medical Support.* If the non-custodial parent is required to enroll the children in dependent's health care coverage and does not voluntarily do so, the child support agency will send a National Medical Support Notice (NMSN) to the non-custodial parent's employer. The employer must honor the notice, withhold any applicable premiums from the employee's wages, and send the NMSN on to the health care plan administrator. Within 40 business days, the plan administrator must enroll the children, and provide the custodial parent (or the state child support agency) with a description of the plan and any documents necessary to effectuate coverage.[14]

In fiscal year 2002, the state child support programs processed over 16 million cases and collected $20.1 billion in cash support.[15] When the child support program fulfills its mission, families—especially low-income families—obtain substantial benefits.[16] Child support is especially significant to families leaving welfare. About 42

[10] Most of these are described in 42 USC §§ 654 and 666. They include the imposition of liens on real and personal property, revocation of professional and recreational licenses, suspension of driver's licenses, passport revocation, and credit agency reporting.
[11] Each state now operates a central collection and distribution system pursuant to 42 USC § 654b. How the funds collected by this unit are distributed is governed by 42 USC § 657.
[12] 42 USC § 666(b) describes in detail what this process looks like. There is also a standardized form that states use to inform employers. Failure to honor an income withholding order makes the employer responsible for the payment and can subject the employer to a fine. 42 USC § 666(b)(6)(B).
[13] 42 USC § 664 describes this process in detail.
[14] Beginning on October 1, 2001, a standardized form was to be used to inform employers and health care plan administrators about the existence of a medical support order. This form and its use are discussed in more detail *infra*.
[15] CSE FY 2002 PRELIMINARY DATA REPORT, (April 29, 2003), available at www.acf.dhhs.gov/proj/cse/pubs/2003.
[16] When poor families receive cash support, that support constitutes more than a quarter of the family's yearly income. Elaine Sorensen and Chava Zibman, *To What Extent Do Children Benefit From Child Support?,* Discussion Paper 99-11, Assessing the New Federalism: An Urban Institute Program to Assess Changing Social Policies (2000). These families average $2,000 a year in support payments.

percent of children in single-parent families who have left welfare receive child support. These funds provide 30 percent of their family income. On average, this amounts to $2,562 per year.[17]

However, the state programs are considerably less successful in obtaining private health care coverage for children. Less than 50 percent of the child support orders in the state system contain a provision for private health care coverage. Even worse, less than 20 percent of those with orders for private coverage actually obtained that coverage.[18]

Congress has recognized this failure. In 1998, it established a Medical Child Support Working Group (MCSWG) to investigate the problem and develop solutions. This group was made up of representatives of the Department of Labor, the Department of Health and Human Services, state child support agencies, Medicaid and SCHIP programs, employers, human services and payroll professionals, sponsors and administrators of group health plans, child advocacy organizations, and organizations representing child support programs. In June 2000, the MCSWG issued its report, identifying major issues and potential solutions.[19] To date, most of its recommendations have not been acted on.

ISSUES RELATING TO PRIVATE HEALTH CARE COVERAGE

To be useful to a child, private health care coverage must be available, stable, accessible, and affordable. As detailed below, current federal policy and regulations do not adequately address these issues. Moreover, states currently lack a financial incentive to pursue private health care coverage, despite a four-year-old Congressional directive that a medical child support incentive payment system be developed.

Issue 1. The Failure of the Federal Law and Regulations to Include Consideration of Health Care Coverage Available to Custodial Parents in the State Child Support Agencies' Decision-Making Process.

The Problem: Federal law and regulations are deficient in *two* respects. If the custodial parent is already providing private health care coverage for herself and the children, federal regulations do not require state child support agencies to inquire whether private coverage is available through the non-custodial parent. This means that even if the custodial parent is bearing the full cost of premiums, co-payments and deductibles—without assistance from the non-custodial parent—the child support agency will take no

[17] Sorensen and Zibman, *supra.*

[18] Office of Child Support Enforcement, ANNUAL STATISTICAL REPORT FOR FISCAL YEARS 1999 AND 2000 (2002), available at www.acf.dhhs.gov/programs/cse/pubs/2002/reports/datareport . See Tables 24 and 48.

[19] The Medical Child Support Working Group, 21 MILLION CHILDREN'S HEALTH: OUR SHARED RESPONSIBILITY, Report to the Hon. Donna Shalala, Secretary of the Department of Health and Human Services and the Hon. Alexis Herman, Secretary of Labor, (June 2000). This report is available at www.acf.dhhs.gov/programs/cse/pubs.

action.[20] Cash support, which is not calculated with these costs in mind, will have to be used to pay health care costs. As a result, a child may have private health care coverage but live in poor housing or lack adequate food or clothing.

In addition, if the child is not enrolled in private coverage through a custodial parent, the state agency is not required to look into dependant's health care coverage that might be available to through the custodial parent. The state need only consider coverage available through the *non-custodial* parent.[21]

Recognizing this, the MCSWG recommended that federal law and regulations be changed to require states to look at coverage available to **both** parents. Indeed, the very first recommendation of the MCSWG was:

> HHS should require each State to maximize the enrollment of children in private health care coverage: the first recourse should be appropriate private coverage of *either parent.*[22].

To enable the child support agencies to determine whether either parent had coverage, the MCSWG further recommended that parents be required to provide information about potential private coverage at the time the order was being established or modified. Specifically:

> 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.[23]

Moreover, as the MCSWG saw it, the coverage available to the *custodial parent* might be preferable. The MCSWG developed a decision matrix for making determinations about private health care coverage when only one parent has access to acceptable coverage. In that case, whichever parent has the coverage should provide it. However, if both parents have access to acceptable coverage, then (absent special circumstances) the decision maker should order the coverage available through the custodial parent:

> If...it is determined that accessible, affordable, comprehensive coverage is available to both parents, then coverage available to the custodial parent

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[20] See, PIQ-02-03 (December 20, 2002), p. 8, Question and Answer 20 for HHS most recent pronouncement on this issue. This document is a memo from Sherri Z. Heller, Commissioner of the Office of Child Support Enforcement, to State IV-D Directors and Regional Program Mangers and is entitled *Medical Support Enforcement Policy Clarifications*. It can be found on the worldwide web at www.acf.hhs.gov/programs/cse/pol/piq-02-03.htm.

[21] 42 USC § 652(f) and 45 CFR §§ 303.31(b) and (c).

[22] 21 MILLION CHILDREN'S HEALTH, *supra*, p. 3-3 (emphasis added).

[23] Id., p. 3-5. The MCSWG also recommended that states use existing databases that provide information about the types of coverage available through employers in their states, and develop supplemental information as well. Id., Recommendation 4.

> should be ordered unless (1) either parent expresses a preference for coverage available through the non-custodial parent; or (2) the non-custodial parent is already carrying dependents' 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.[24]

There are several reasons for looking primarily to custodial parent coverage. It is easier for the custodial parent to obtain plan information and claim forms and resolve any disputes about coverage. It also prevents a problem that concerns many custodial parents: they submit claims for reimbursement and the plan sends the payment to the non-custodial parent. That parent then fails to give the money to the custodial parent who paid the bill.

In addition, such coverage is far easier to enforce in most cases. The decision maker simply has to increase the amount of cash support to be collected, and the custodial parent can use that extra amount to pay whatever premiums or other costs are associated with the coverage.[25] The child support agency does not then have to go through the complex process of enforcement of an order against the non-custodial parent (described in more detail below).[26]

Action to Date: The changes in federal law and regulations endorsed by the MCSWG have not been made. Limited guidance was provided to states in December 2002 via PIQ-02-03.[27] Several questions in this document relate to what happens if the custodial parent is providing or is ordered to provide health care coverage for the child.

Innovative State Practices: While the federal government has not responded to the MCSWG recommendations, some states have moved ahead. A notable example is New York State, which recently enacted laws incorporating the MCSWG ideas.[28] Under this legislation, courts are to consider health care coverage available to both parents in making their determination about health care coverage. If the child is already covered by one of the parents, that coverage is to remain in place unless either parent requests a change. If the child is not presently covered and only one of the parents has access to coverage, that parent is to be ordered to enroll the child. If both parents have available coverage, then the court can order either or both to provide coverage. In making the

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[24] Id. Recommendation 13, p 3-20.

[25] The reasoning behind the preference for custodial parent coverage is further elaborated at pp. 3-17 to 3-20 of 21 MILLION CHILDREN, *supra*.

[26] PIQ-02-03, *supra*, p. 7, Question 21, addresses the rare case in which the custodial parent is ordered to provide coverage and fails to enroll the child. In that case, the child support agency can enforce the order against that parent. Federal funding is available for that activity.

[27] PIQ-02-03, *supra*, pp. 7-8.

[28] This bill was passed by the legislature and signed by Governor Pataki in October 2002. Its provisions are codified in N.Y. FAM. CT ACT § 416 (2003) and N.Y. DOM.REL. LAW § 240 (2003).

decision, the court is to consider the cost and comprehensiveness of the parents' respective benefit packages and the best interests of the child. Irrespective of who carries the coverage, the cost is to be prorated between the parties. Thus, if the custodial parent is or will be providing coverage, the non-custodial parent will contribute to the cost of this coverage.

New Jersey is also moving in this direction. That state recently completed a feasibility study of model review and adjustment practices for medical support obligations. As part of this effort, the state developed a set of guidelines for addressing private health care coverage issues. The guidelines include looking at health care coverage available to both parents. When all things are equal, coverage available to the custodial parent is preferred and should be ordered under its proposed guideline.[29]

Minnesota has also been active in this area. That state convened its own Medical Support Work Group to evaluate the recommendations of the MCSWG and consider their applicability in Minnesota.[30] The Work Group agreed that coverage available to both parents should be considered when addressing the child's health care needs.[31]

Issue 2. The Failure of the Federal Law and Regulations to Consider Accessibility When Deciding Whether to Seek Private Coverage Available Through the Non-Custodial Parent.

The Problem: Private health care coverage available to the custodial parent is generally accessible to the child even if the plan coverage has a limited service area, as is the case with many HMOs. However, this is not necessarily the case with non-custodial parent coverage, particularly if that coverage is provided through managed care. For example, HMO coverage in California may be utterly useless to a child living in Massachusetts. Likewise, coverage available in Upstate New York may be too far away to be useful to a child living in New York City. Since managed care is now the norm and only 40 percent of non-custodial fathers live in the same city or county as their children, this can be a serious problem.[32]

The situation is particularly distressing when application of the rigid rule about ordering private coverage available though employment regardless of cost (discussed below) comes into play. Non-custodial parents can be ordered to pay for expensive coverage that is not even useful to their children. Then, either the parent pays excessive

[29] A FEASIBILITY STUDY OF REVIEW AND ADJUSTMENT FOR MEDICAL SUPPORT AND CHIP COLLABORATION, (December 2002), Exec. Summary, p. 2. This report was submitted by Alisha Griffin, Assistant Director of the New Jersey Department of Human Services, Division of Family Development, Office of Child Support and Paternity Programs to the US Department of Health and Human Services, Office of Child Support Enforcement pursuant to a Special Improvement Project Grant No. 90F 10028/01.

[30] The state's legislature authorized the creation of this body in Chapter 372 of the 2000 Session Laws.

[31] MINNESOTA MEDICAL SUPPORT WORK GROUP FINAL REPORT, (DECEMBER 2000), p. 12. The work group also recommended that coverage available through a step-parent, grandparent, or domestic partner be considered before referring the child to public coverage. This report is available on the state's child support website at www.dhs.state.mn.us/ecs/ChildSupport/Reports.

[32] Wheaton, *supra*, Executive Summary, p. 3.

amounts of support or the children get less cash support for their other needs and the children still have no useful health care benefits.

The MCSWG addressed this issue as well. It recommended that federal regulations be developed defining "accessible" coverage and that it be made clear that coverage that is not accessible should not be ordered.[33] The MCSWG developed the following advice in designing a definition of "accessible":

> 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 to the non-custodial 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 is not available within these constraints, the coverage should be deemed inaccessible.

The MCSWG went on to state that, in light of the geographic differences in states, some flexibility should be provided so that states would also have the option of using the standards for accessibility that they use to administer programs such as Medicaid.[34]

Finally, the MCSWG cautioned that to be deemed accessible, the coverage should be stable. It does no good to order health care coverage by a parent who is sporadically or seasonally employed. By the time the paperwork is done, the parent is likely no longer working for the employer through whom the coverage was to be obtained. In this regard, the MCSWG suggested that the decision maker should determine that it can reasonably be expected that the health care coverage will remain effective for at least one year, based on the employment history of the parent who is to provide the coverage.[35]

Action to Date: No action has been taken on this recommendation of the MCSWG. In addition, the federal Office of Child Support Enforcement (OCSE) has made it clear that states cannot obtain a waiver of the existing regulation in order to implement a different definition.[36]

Innovative State Practice: As noted above, New Jersey has recently developed a model medical child support guideline. In this process, it devised a definition of "accessible coverage" as well as a definition of "stable coverage." Its definition of "accessible coverage" is similar to that of the MCSWG with its emphasis on the

[33] 21 MILLION CHILDREN, *supra*, Recommendation 8, p. 3-10.
[34] Id.
[35] Id.
[36] PIQ-02-03, *supra,* p. 7, Question 19.

accessibility of primary care. Coverage is accessible if "…a plan provider is located within the State of New Jersey and the covered child can obtain services from the provider within 10 miles or 30 minutes from the child's residence. If primary care services are not available within these parameters, the coverage will be deemed inaccessible."[37]

New Jersey also included a notion of "stable coverage" that is the same as that recommended by the MCSWG. Health care coverage is to be deemed stable if it can reasonably be expected to remain effective for at least one year, based on the employment history of the parent who is to provide coverage.[38]

Minnesota has also recommended an approach similar to that of the MCSWG. Consistent with the state's Medicaid and HMO program regulations, a 30 minute/30 mile standard for basic care and a 60 minute/60 mile standard for specialty care were deemed appropriate by its Medical Support Workgroup. Since this may not be workable in rural areas, the Workgroup suggested that this be a rebuttable presumption.[39]

Issue 3. The Failure to Update the Regulatory Definition of "Reasonable Cost."

The Problem: Existing federal regulations define all employment-related or group health care coverage as being reasonable in cost without regard to whether this is actually so.[40] If, in fact, there are substantial premium costs related to the coverage, this inflexible rule can cause major problems for both parents and children. The problem is particularly acute when the non-custodial parent has low income.

To understand this issue, a little background on child support guidelines is helpful. As noted above, pursuant to federal requirements, every state has numeric guidelines for setting cash child support.[41] There is substantial variation between states in both the kinds of guidelines used and the size of the obligation imposed.[42] There is, however, concern that some state guidelines require a disproportionately large payment from low-income non-custodial parents.[43]

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[37] A FEASIBILITY STUDY, *supra*, Section II, p. 11.
[38] Id.
[39] MINNESOTA MEDICAL SUPPORT WORKGROUP, *supra*, p. 14.
[40] 45 CFR § 303.31(a)(1).
[41] 42 USC § 667.
[42] For a discussion of this issue see Laura Morgan and Mark Lino, *A Comparison of Child Support Awards Calculated Under States' Child Support Guidelines with Expenditures on Children Calculated by the U.S. Department of Agriculture*, FAMILY LAW QUARTERLY 33:1, (Spring 1999).
[43] Some states have special rules for setting awards in these cases; others do not. Some states are flexible about the amount ordered, while others have mandatory minimums. Even in states with minimum orders, there is wide variation in the definition of "minimum." For example, Utah has a presumptive minimum award of $20 a month, while in New Jersey the presumptive minimum can be as high as $179 a month. Department of Health and Human Services, Office of the Inspector General, STATE POLICIES USED TO ESTABLISH ORDERS FOR LOW INCOME NON-CUSTODIAL PARENTS, OEI-05-99-00391, (July 2000). See, also Elaine Sorensen, HELPING POOR NON-RESIDENT DADS DO MORE, (2002), Urban Institute.

In addition to providing for cash support, child support guidelines are supposed to address the child's health care needs.[44] Here again, there is a good deal of state variation. However, if the family is receiving services from the state's child support program and the non-custodial parent has access to group or employment-based dependent's health care coverage, the state agency must—at a minimum—seek an order that requires that parent to enroll the children in that coverage.[45] As noted above, federal regulations presume that the cost is reasonable.[46]

The combination of cash and health care premiums can yield an order that is beyond a parent's ability to pay. The non-custodial parent may then become destitute. That parent might also quit his or her job and disappear, leaving the child without an involved parent and with neither cash support nor health care coverage. Alternatively, the court might lower the cash support in order to obtain health care coverage for the child through the non-custodial parent. The child will then have private insurance but there will be less money available to meet the child's other needs. Moreover, especially in interstate cases, even if affordable coverage is available, it may be inaccessible to the child. (See discussion above.) In that case, the child will have less income to meet his/her basic needs, and still lack effective health care coverage. This presents families and decision makers with a real dilemma.

The MCSWG also addressed this issue.[47] It noted that at the time the reasonable cost regulation was adopted, a majority of employers offered dependent's health care coverage to their employees at little or no cost.[48] Unfortunately, this is no longer the case. Not only do fewer and fewer employers offer dependents health care coverage but the cost to the employee when such coverage is available can be enormous.[49] This is especially true for low-wage workers. Indeed, the average employee contribution to the cost of dependent's coverage ($1,724-$1,936 per year depending on the type of coverage)[50] is nearly 50 percent of the average child support received ($3,700 per year).[51]

Moreover, at the time this regulation was adopted, public coverage through Medicaid was in its infancy and SCHIP did not exist. If private coverage was not obtained, it was likely that the child would be uninsured. Faced with a choice between no

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[44] 45 CFR § 302.56(c)(3).
[45] This is a somewhat confusing area because the statutes were written in contemplation that on or around October 1, 2001 every state would be using the new National Medical Support Notice. This has not happened, so it is unclear what the legal requirement is. Compare 42 USCA § 652(f)(West Supp. 2003) with 42 USCA § 652 note Amendment of Subsec. (f). (West Supp. 2003).
[46] 45 CFR § 303.31(a)(1).
[47] 21 MILLION CHILDREN, *supra*, pp. 3-11 to 3-16.
[48] This explanation was offered as justifying the regulation at 53 Fed. Reg. 36016-17 (Sept.16, 1988).
[49] The General Accounting Office (GAO) estimates that in 1980, 51 percent of employers who offered dependent's coverage fully subsidized the cost; by 1993, only 21 percent did so. United States General Accounting Office, PRIVATE HEALTH INSURANCE: CONTINUED EROSION OF COVERAGE LINKED TO COST PRESSURES, GAO/HEHS-97-122, (1997), p. 35.
[50] These are 1996 numbers and come from the Employee Benefits Research Institute, EBRI DATA BOOK ON EMPLOYEE BENEFITS, as quoted in 21 MILLION CHILDREN, *supra*, p. 3-11.
[51] United States Census Bureau, CHILD SUPPORT FOR CUSTODIAL MOTHERS AND FATHERS 1997, P60-212, (2000), Table 5.

health care coverage and the possibility of coverage available through a non-custodial parent, public policy favored coverage. Medicaid is now available to poor and near-poor children and those not eligible for Medicaid may be eligible for SCHIP. (See discussion below.)

Therefore, the MCSWG recommended that new regulations be promulgated. Specifically:

> 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…. If the cost of providing private coverage does not exceed 5 percent of the gross income of the parent who provides the coverage, then the cost should be deemed reasonable.[52]

Action to Date: No action has been taken on this MCSWG recommendation to date.

Innovative State Practices: Despite the federal regulation, some states have adopted definitions of "reasonable cost" more in line with the concept endorsed by the MCSWG. For example, Washington State has a long-standing rule that a decision maker does not have to order the non-custodial parent to pay for coverage if the premiums exceed 25 percent of the parent's basic cash support obligation.[53] Colorado does not require the decision maker to order coverage if the premium exceeds 20 percent of the non-custodial parent's gross income.[54] More recently, New Jersey endorsed a version of the standard recommended by the MCSWG. Under that standard, health care coverage would be deemed affordable if it does not cost more than 5 percent of the net income of the parent who provides coverage. Moreover, parents whose net income is below 200 percent of poverty would not be required to provide coverage unless it was available to them at no cost.[55]

Minnesota's Workgroup adopted a slightly different approach. It recommended that parents with gross income below 150 percent of poverty not be expected to contribute to medical support. Parents with income between 150 and 275 percent of poverty would be expected to contribute up to 5 percent of adjusted gross income to medical support.[56]

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[52] 21 MILLION CHILDREN, *supra*, Recommendation 9, p. 3-14. The MCSWG also noted that it would be a good practice for states not to order coverage available through a parent whose income was below 133 percent of poverty unless the coverage was available at no cost. Id., Recommendations 10 and 11. The rationale for these rules is derived form the Medicaid and SCHIP programs that define as reasonable asking a parent to pay no more than 5 percent of gross income toward the cost of coverage and require no contribution from those with income below 133 percent of poverty. See Id., pp 3-14 to 3-15.

[53] WASH. REV. CODE § 26.09.105(1)(1999).

[54] COL. REV. STAT. § 14-10-115(g)(1999).

[55] A FEASIBILITY STUDY, *supra*, Section II, p. 11.

[56] MINNESOTA MEDICAL SUPPORT WORKGROUP, *supra*, p. 15.

Many other child support professionals would like to move in this direction. Consensus has emerged that federal regulations should be changed to allow states that wish to do so to adopt either the standard endorsed by the MCSWG or another income-based numeric standard. Such a standard would allow state child support agencies to concentrate their efforts on creating enforceable orders and prevent the creation of unenforceable orders.[57]

Issue 4. The Lack of a Financial Incentive for States to Seek Private Coverage.

The Problem: There is an old adage that "You get what you pay for." When states are provided with financial incentives to improve their child support performance, they generally respond. For this reason, Congress created an incentive payment system that rewards states for improving their performance in establishing paternity, establishing support orders, collecting current support, obtaining payments on arrears, and being cost-efficient.[58] The legislation that created this incentive payment system also required that the Secretary of HHS, in collaboration with state child support directors and representatives of children eligible for child support, develop an incentive payment measure for establishing and enforcing medical support.[59] This 1998 legislation required that a report on this issue be submitted to Congress no later than October 1, 1999.

Action to Date: A Medical Support Incentive Work Group (MSIWG) was convened by the Secretary of HHS pursuant to this legislation. However, it was unable to develop a recommendation due to a lack of data. In light of this, HHS sought an extension of time in which to obtain the data and develop the measure.[60] Eventually, a reconstituted MSIWG was convened and—in September 2001—recommended that the Secretary not develop a medical support performance measure for incorporation into the incentive system. Again noting the lack of data, the second MSIWG recommended that a measure be developed, but not for incentive payment purposes.[61] To date, the Secretary has not acted on this report. Hence, a recommendation to Congress has not been made and there remains no incentive payment for medical support activities.

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[57] See *Revised Definition of Reasonable Cost* statement prepared by the National Child Support Enforcement Association (NCSEA), the National Women's Law Center (NWLC), the Eastern Regional Interstate Child Support Enforcement Association (ERICSA) and the Center for Law and Social Policy (CLASP), a copy of which is available from the author. The position of NCSEA and ERICSA is based on resolutions adopted by the Board of Directors of each organization. In addition, the National Council of Child Support Directors has endorsed this approach in a letter from Pauline Burton to Senator Max Baucus dated June 25, 2002. A copy of this letter is also available from the author.

[58] 42 USC § 658a.

[59] Pub. L. 105-2000, Title II, § 201(d) which is set out as a note to 42 USCA § 658a (West Supp. 2003).

[60] U.S. Department of Health and Human Services, REPORT TO THE CONGRESS ON THE DEVELOPMENT OF A MEDICAL SUPPORT INCENTIVE FOR THE CHILD SUPPORT ENFORCEMENT PROGRAM, (June 23, 1999), available at www.acf.dhhs.gov/programs/cse/rpt/dc199125a.

[61] Medical Support Incentive Work Group, MEDICAL SUPPORT: MEASURING THE PERFORMANCE OF STATE IVD AGENCIES, report to the Office of Child Support Enforcement, Administration for Children and Families, U.S. Department of Health and Human Services, (September 2001).

Innovative State Practices: At least two states have developed their own medical support incentive structure. Minnesota has a county-based child support program. Counties receive a $50 payment for each child participating in the state's Medicaid program for which private coverage through a non-custodial parent is identified and enforced. This money is to be reinvested in the child support program and cannot be used to supplant county funds.[62] California provides a $50 per case incentive payment to local child support agencies that obtain new private health care coverage or restore lapsed coverage.[63]

Issue 5. Failure to Timely Implement the National Medical Support Notice

The Problem: Once an order for health care coverage is issued, the affected parent must enroll the child in available coverage. If that parent fails to do so, the other parent or the child support agency will have to enforce the order. Until recently, the mechanism for doing this was extremely cumbersome.

Pursuant to federal statute, all states have laws that require employers and insurers to enroll a child in health care coverage when the employee-parent of that child has been ordered to provide coverage for the child and that parent has failed to do so voluntarily, and the other parent or the state's child support enforcement agency requests enrollment.[64] However, the nature of the document that triggers the employer's/insurer's obligation to act has been unclear. Unless the document met very specific (and often idiosyncratic) conditions, employers would often refuse to honor medical support orders sent to them by child support agencies.[65] Moreover, there were no time-frames in which employers were required to act, and no real mechanism for resolving disputes about the validity of the order were available.

To address these problems, Congress enacted legislation requiring the Secretaries of Labor and HHS to develop and promulgate a National Medical Support Notice (NMSN).[66] Congress required all state agencies to use this document once it was promulgated. The legislation contemplated that all states would be using the NMSN by October 1, 2001 or—at the latest—by the end of first legislative session to occur after that date, if state legislation was needed.[67] It also required employers to honor any NMSN that was regular on its face[68] and send it to the appropriate plan within 20 business days.[69] Finally, employers were required to notify the state child support agency if the employee

[62] MINN. STAT. § 256.9791, (2002).The Minnesota Medical Support Workgroup recommended that this be expanded so that counties receive a $50 incentive payment for *every child* for whom the child support program obtains private coverage, *whether through a custodial or a non-custodial* parent. MINNESOTA MEDICAL SUPPORT WORKGROUP, *supra*, p. 25.
[63] Due to California's budget situation, this bonus program is currently not being operated.
[64] 42 USC § 1396g-1.
[65] In order to be enforceable, the notice to the employer had to meet the requirements of a Qualified Medical Child Support Order (QMCSO). This often required individual tailoring of orders and prevented efforts to automate the issuance of the orders. See, discussion at 21 MILLION CHILDREN, *supra*, p. 4-2.
[66] 42 USCA § 651 note (West Supp. 2000).
[67] Id. § 666(a)(19)(B)(i).
[68] 29 USC § 1169(a)(5)C)(ii).
[69] 42 USC § 666(a)(19)(B)(ii).

was terminated.[70] This alerts the agency of the need to enforce medical support against any new employer using the NMSN.

Action to Date: A draft NMSN was issued for public comment on November 15, 1999. Changes were made in response to comments from the MCSWG, as well as the public, and the final NMSN was issued on December 27, 2000.[71] While this was somewhat later than the target date suggested by the MCSWG,[72] states had time to enact laws and procedures by October 1, 2001—the implementation date contemplated by the federal statute and federal regulations.[73] Nonetheless, few states implemented on or around that target date. In fact, as of April 4, 2003, almost half the states were not yet using the NMSN.[74]

In those states that are using the NMSN, new federal regulations specify that the forms must be sent to the employer within two business days after the date of entry of the obligated parent's name in the state's New Hire Directory.[75] Employers must transfer the NMSN to the appropriate plan administrator within 20 business days of the date of the NMSN.[76] Thereafter, both the state and the employer must keep in touch. The state must notify the employer when there is no longer a medical support order in effect or when the state agency is no longer responsible for enforcing the order.[77] The employer must notify the state agency if the employee is terminated.[78]

Innovative State Practices: California was the first state to use the new NMSN. It issued regulations[79] and conducted training for staff and reports few problems with using the new form. Connecticut has just obtained authorizing legislation. In preparation, however, the state's child support agency conducted an extensive outreach campaign to

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[70] Id. § 666(a)(19)(B)(iv).
[71] Both HHS and the Department of Labor had to issue regulations to implement the new form and they did so simultaneously. The full text of both sets of regulations can be found at 62 Fed. Reg. 82-82176 (December 27, 2000). Due to the change in Administrations, there was a slight delay in the effective date of the regulations. However, they did become effective on March 27, 2001. See, Action transmittal 01-05 (April 2, 2001) available at www.ach.hhs.gov/programs/cse/pol/at-01-05.
[72] The MCSWG recommended that the final NMSN be issued by September 1, 2001, to give states time to prepare for implementation. Recommendation 29, 21 MILLION CHILDREN, *supra*, pp. 4-8.
[73] 45 CFR § 303.32(d). The regulations say that the NMSN procedures must be used effective October 1, 2001, or, if later, close of the first day of the first calendar quarter that begins after the close of the first regular session of the state legislature that begins after October 1, 2001. For most jurisdictions, that date has passed.
[74] Twenty-four jurisdictions are not using the NMSN. They are Arkansas, Connecticut, District of Columbia, Guam, Idaho, Louisiana, Massachusetts, Mississippi, Nebraska, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Tennessee, Texas, Vermont, Virginia, and Washington. A chart detailing this information is available at www.acf.hhs.gov/programs/cse/newhire/employer/contacts.
[75] 45 CFR § 303.32(c)(2).
[76] Id. § 303.32(c)(3).
[77] Id. § 303.32(c)(7).
[78] Id. § 303.32(c)(6). Additional guidance on some of these issues is provided in PIQ-02-03, *supra,* pp. 1-5.
[79] CAL.CODE REGS. Tit. 22, § 116118.

employers to familiarize them with the new process, prepared extensive explanatory materials, and provided a good deal of information online.[80]

PUBLIC COVERAGE ISSUES

Children who cannot obtain private health care coverage may be able to obtain coverage from a publicly subsidized program such as Medicaid or SCHIP. Medicaid provides comprehensive health care coverage to a variety of low-income children and adults.[81] In recent years, Congress has placed special emphasis on providing Medicaid coverage to children; children under age six from families with income under 133 percent of poverty and older children with family income below 100 percent of poverty must be covered. In addition, states may cover pregnant women and infants with incomes below 185 per cent of poverty through their Medicaid programs. Finally, states must provide Transitional Medical Assistance (TMA) to families leaving Temporary Assistance for Needy Families (TANF).[82] In most cases, families will receive these services without paying premiums, co-payments, or deductibles. However, participants in Medicaid must usually assign to the state any rights they have to private health care coverage and (in the absence of good cause) cooperate with the state in pursuing those rights.[83] To this end, they are automatically served by the state's child support enforcement program.[84] If the child support agency can obtain an order for coverage and/or enforce an existing order, that coverage is the child's primary coverage. Medicaid will pay for uncovered expenses.

More recently, Congress created SCHIP, which provides federal funds to states so that they can offer health care coverage to even more children. They can do this by expanding their Medicaid programs, creating separate SCHIP programs, or both.[85] With this flexibility, 16 states expanded their Medicaid programs, 15 set up separate programs, and 20 adopted a mixed approach.[86]

This is significant because there are some major differences between Medicaid and SCHIP. Unlike Medicaid, SCHIP does not contain a child support assignment or

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[80] For more on Connecticut's effort, see www.ctchildsupport.com/. There is a subsection with the latest information about Connecticut's efforts to facilitate implementation of the NMSN as quickly as possible.

[81] The income and asset rules vary somewhat by state. A full discussion of the current rules can be found in Guyer, *Health Care for Working Families After Welfare Reform,* 34 CLEARINGHOUSE REV. 563-577, (2001).

[82] This transitional benefit is provided to families that participated in both TANF and Medicaid, who lose their TANF eligibility due to earnings or child support. Those who leave due to earnings may receive up to 12 months of TMA, while those who leave due to child support receive 4 months of TMA. 42 USC § 1396r-6(a).

[83] 42 USC § 1396k(a). If a parent does not cooperate, the children are covered but the parent is not. For more on this issue, see Paula Roberts, RETHINKING THE MEDICAID CHILD SUPPORT COOPERATION REQUIREMENT, (May 2003), available at www.clasp.org in Child Support and Low-Income Fathers.

[84] Id. § 654(4)(A)(i)(III).

[85] Id. § 1397aa.

[86] See, Judith Wooldridge, Ian Hill, Mary Harrington, Genevieve Kenney, Corinna Hawkes, and Jennifer Haley, INTERIM EVALUATION REPORT: CONGRESSIONALLY MANDATED EVALUATION OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM, (February 26, 2003) p. 6. This is available at http//:aspe.hhs.gov/health/schip/interimrpt/index.htm.

cooperation requirement. If a child is enrolled in SCHIP, the family may be using the services of the state's child support enforcement program, but this is not necessary. In addition, if the child is enrolled in a separate SCHIP program, there may be premiums, co-payments and deductibles associated with the coverage. The amount varies by state, but there is a federal limit. The total of premiums, co-payments, and deductibles cannot exceed 5 percent of the custodial parent's income.[87]

In short, depending on how the state has chosen to structure its SCHIP program, the eligibility rules, conditions of participation, and costs for Medicaid and SCHIP may be the same or they may be quite different.

Issue 1. Failure to Build Consideration of Medicaid and SCHIP into the Medical Support Decision-Making Process.

The Problem: If private health care coverage is not available through either parent, the child is uninsured but still has health care needs. In many cases, this problem could be addressed by enrolling the child in Medicaid or SCHIP. In fact, one study estimates that enrolling uninsured, child support-eligible children in Medicaid or SCHIP could reduce the share of these children who are uninsured from 15 percent to 3 percent.[88] To do this, the state could build consideration of these alternatives into its child support process and have the decision maker require that the child be enrolled in Medicaid or SCHIP(if eligible) when private coverage is not available. Consideration could also be given to having the non-custodial parent contribute to any premiums, co-payments, or deductibles associated with SCHIP coverage if the state in which the child is to be enrolled has a separate SCHIP program that imposes these costs. This would spread the cost more equitably between the parents, and between parents and the state.

The MCSWG made a recommendation that this be considered a "best practice" and that HHS should encourage states to move in this direction. The MCSWG recommended that:

> 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 SCHIP.[89]

Action to Date: No action has been taken on this MCSW recommendation.

Innovative State Practices: Some states have, however, adopted this concept and incorporated it into their laws. In Texas, if private health care coverage is not available through either parent, the court will order the non-custodial parent to apply for coverage through the Texas Healthy Kids Corporation.[90]

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[87] Id. § 1397cc(e)(3)(B). See, also 42 CFR § 457.15 and 42 CFR § 457.560.
[88] Laudan Aron, *supra,* p. 39.
[89] 21 MILLION CHILDREN, *supra,* Recommendation 15, p. 3-24.
[90] TEX. CODE § 154.182(b)(4).

In Connecticut, the law requires Family Support Magistrates to order a parent to enroll the child in the state's SCHIP program (called HUSKY B) if private coverage is not available to either parent at reasonable cost.[91] Either parent can be ordered to enroll the child in HUSKY B, and, to facilitate this, the SCHIP statute specifically allows a non-custodial parent to apply for his/her children. If the order requires enrollment in HUSKY B, there is a continuation of the case so the parent ordered to apply can do so, and the eligibility determination can be completed. If the custodial parent is the one ordered to enroll the children and does so successfully, the non-custodial parent will be ordered to contribute to the premiums.[92]

In addition, New York has recently passed legislation under which, if private health care coverage is not available to either parent, the court will order the custodial parent to apply for SCHIP. If the child is found eligible, the court will prorate the associated costs between the parents.[93]

Issue 2. Failure to Use the Child Support Agency in the Medicaid and SCHIP Outreach Process.

The Problem: A state may not wish to issue orders that require enrollment in Medicaid or SCHIP. However, that does not mean it should ignore the problem of uninsured children in the child support system. There are still important steps a state can take.

It has been estimated that 66 percent of uninsured child support-eligible children are eligible for Medicaid, and another 15 percent are eligible for SCHIP.[94] In other words, the child support system serves a substantial number of uninsured children who could obtain coverage through one of the public programs. A major reason for this is lack of information: almost one-third of the parents of eligible but un-enrolled children reported that they had not heard of Medicaid or SCHIP. Another 10 percent had difficulty with the enrollment process.[95] The child support agency could provide parents with information about these programs and assist them in the enrollment process.

The MCSWG also recommended this step:

[91] CONN. GEN. STAT. § 17B-745(A)(2)(a)(2003).
[92] Presentation by Lynne Fender, Senior Research Associate, the Urban Institute, at a workshop entitled State Innovations in Medical Child Support Cross-Program Coordination, at the Eastern Regional Child Support Enforcement Association Conference, Philadelphia, Pennsylvania, April 29, 2003.
[93] FAM CT. ACT § 416(e) (2)(iii).
[94] Laudan Aron, *supra*, p 39. The numbers may be slightly higher as this study only considered children living with their custodial mothers.
[95] Holahan, et al., *supra,* p. 5-6. See, also United States general Accounting Office, MEDICAID DEMOGRAPHICS OF NONENROLLED CHILDREN SUGGEST STATE OUTREACH STRATEGIES, GAO/HEHS-98-93, (March 1998), p. 2, identifying lack of information about the programs as a reason so many qualified children were not enrolled in Medicaid.

> 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.[96]

Action to Date: When SCHIP was enacted, the Commissioner of OCSE sent a message to all state child support enforcement program directors urging them to be involved in SCHIP outreach activities.[97] However, it was never made clear that this was an allowable activity for which federal funding was available. As a result, many states were reluctant to become aggressively involved in these efforts.

Innovative State Practices: Nonetheless, some states found creative ways to provide information to parents. Montana notifies custodial parents of the availability of SCHIP. The letter it sends out describes the program and tells how to apply, including how to obtain a mail-in application.[98] Arizona also informs parents about SCHIP. Further, if the Arizona child support agency discovers, in its attempts to enforce a medical support order, that the non-custodial parent lacks health care coverage, the custodial parent is given a 1-800 number to obtain information about the state's medical services. California is reconfiguring its child support program, and plans to install terminals in its child support offices so families can apply online for Medicaid and SCHIP right from the child support office.[99] Virginia links its child support homepage to information about Medicaid, including online application procedures.[100]

Issue 3. Failure to Take Advantage of the Presumptive Eligibility Process.

The Problem: There is usually a lapse of time from the date a family applies for Medicaid/SCHIP and the date an eligibility determination is made. During this time, the child is uninsured. To address this problem, Congress allowed states to designate certain programs that already have information about a family and its income to make "presumptive eligibility" determinations at the time of Medicaid application. These determinations are in effect until the Medicaid agency has time for a more thorough review and makes a regular eligibility determination. For example, Head Start programs, Child Care and Development Block Grant programs, and Women, Infants, and Children (WIC) nutrition agencies may be authorized to make such determinations.

Given that it, too, has information about the family, its income, and its assets, the state child support agency would be a natural addition to this list. Indeed, the MCSWG

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[96] 21 MILLION CHILDREN, *supra*, Recommendation 16, p. 3-25.
[97] Dear Colleague Letter 97-91 (December 6, 1997) from Commissioner David Gray Ross to all IV-D Directors.
[98] A copy of the letter is available online at www.dphhs.state.mt.us/about_us/divisions/child_support_enforcement/additional/childrens_health_insurance_program.
[99] California Child Support Services letter 02-03 (January 18, 2002).
[100] See, http://www.dss.state.va.us/benefit/index.

recommended that it be added to the list of those able to make presumptive eligibility determinations.[101]

Action to Date: In response, Congress amended the Medicaid statute and included child support agencies (including tribal agencies) in the list of those allowed to conduct presumptive eligibility determinations.[102] However, OCSE has determined that making presumptive eligibility determinations is not a child support function and is thus ineligible for child support funding. The associated costs would have to be born by the Medicaid or SCHIP program.[103] This is a complicated process and, therefore, no state has used this authority.

Issue 4. Failure to Creatively Use the Child Support Process to Identify and Pay for Cost-Effective Private Coverage for Medicaid-Eligible Children.

The Problem: Sometimes a parent has access to private health care coverage but the cost is prohibitive. The child may then be enrolled in Medicaid. It is possible that it would be less expensive for the state if the child were enrolled in the private coverage. For example, the employee's share of the premium might be less than what the state pays an HMO for the child's Medicaid coverage. In that case, it would be prudent for Medicaid to pay the private coverage premium.

Action to Date: States are allowed to operate premium assistance programs under federal law. They may also obtain a waiver to develop such a program pursuant to the Health Insurance Flexibility and Accountability Act.[104]

Innovative State Practices: Iowa started such a program in 1991. In 1995, it was joined by Pennsylvania and Texas. In 1998, Illinois, Massachusetts, and Oregon began operating premium assistance programs. They were joined by Wisconsin in 1999. Maryland and New Jersey followed suit in 2001 and Rhode Island's program was started in 2002. Some of the programs use Medicaid funds, some use both Medicaid and SCHIP, and others use state dollars. Some programs are quite large: Pennsylvania has enrolled 19,500 and Massachusetts has enrolled over 10,000. Others are quite small: Wisconsin serves 62 families and New Jersey serves 119 families.[105] Some require a substantial employer contribution, while others do not. For example, Massachusetts and New Jersey require a 50 percent employer contribution toward the premium, while Rhode Island has no minimum employer contribution.[106] However, it does not appear that these programs have actively tried to integrate with the child support process.

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[101] 21 MILLION CHILDREN, *supra,* Recommendation 17, pp.3-26.
[102] Pub. L. 106-554,§1(a)(6)[708(a)(2), codified at 42 USC §1396r-1a(b)(3).
[103] PIQ-02-03, *supra*, pp.5-6, Question 16.
[104] A more detailed discussion of the law and the various state options is found in Claudia Williams, A SNAPSHOT OF STATE EXPERIENCE IMPLEMENTING PREMIUM ASSISTANCE PROGRAMS (April 2003). This report was prepared under a contract with the Centers for Medicare and Medicaid Services and is available on the web at http://cms.hhs.gov/schip.
[105] Id., p. 6.
[106] Id., p. 7.

CONCLUSION

There is a good deal that could be done to significantly reduce the number of child support-eligible children who are without health care coverage. Some of these children could be enrolled in private coverage, while others are eligible for public coverage through Medicaid or SCHIP. There are both good ideas and proven strategies for enrolling more of these children. However, there remain substantial barriers in federal law, regulations, and policies that actively discourage states from moving aggressively in this area. Both Congress and the Department of Health and Human Services need to do more to remove these barriers so that fewer children will be uninsured.