Why Medical Child Support Is Important – and Complex
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Historical Perspectives

As a nation we pride ourselves on our devotion to children. As the courts charged with resolving cases that involve separated, divorced, and non-marital families, protecting the best interests of the children affected is our job— and our commitment. Providing health care coverage for children is crucial. Without coverage, children are less likely to have access to health care services, including preventive care such as immunizations and vision and hearing screening. Healthy children learn better. Ensuring access to health care is also sound public policy. Healthy children decrease public health care costs long term. Delayed care due to lack of coverage creates a domino effect— increasing costs of care and increasing lifelong problems for children without access to care.

According to the Census Bureau:¹

- In 2006, the number of uninsured increased from 44.8 million to 47.0 million.
- The percentage and number of children under 18 years old without health insurance increased to 11.7 percent and 8.7 million in 2006.

Defining responsibility for health care coverage or for defraying the costs of public benefits in child support cases has long been a requirement of the Federal/State/local Child Support Enforcement Program, created under Part D, Title IV of the Social Security Act (and hence referred to as the “IV-D Program”). Beginning with the Child Support Amendments of 1984,² State IV-D agencies were required to petition for medical support in certain IV-D cases in which such coverage is available at reasonable cost. By Federal law and regulation, the cost is considered “reasonable” when and if it was available through the support obligor’s employment.³

During the last two decades, changes were made to strengthen the medical child support component of the IV-D program. For example, the Omnibus Budget Reconciliation Act of 1993 ("OBRA ’93")⁴ amended the Employee Retirement Income Security Act of 1974 ("ERISA"), creating the Qualified Medical Child Support Order ("QMCSO").⁵ Every employer group health plan must honor a properly prepared QMCSO that requires a plan participant to provide coverage for a dependent child. And a new ERISA §1908 required States to enact laws prohibiting employers and insurers from denying enrollment of a child due to factors such as that a child was born out of wedlock, not claimed as a dependent on the employee’s tax return, or lived outside the service area. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA" or "welfare reform")⁶ changed the basic medical support rules. Health care coverage became a requirement to be included in all child support orders.⁷

¹ See pages 18-19, Census Bureau information available online at http://www.census.gov/prod/2007pubs/p60-223.pdf
² Pub. L. 98-378
³ 45 CFR §§ 302.80, 303.30 and 303.31 (1990)
⁴ Pub. L. 103-66
⁵ "A QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an ‘alternate recipient’s’ right to receive benefits for which a participant or beneficiary is eligible under a group health plan, and which satisfies certain additional requirements contained in ERISA section 609(a).” 65 FR 82128. Available online at http://frwebgate.access.gpo.gov/cgi-bin/getpage.cgi?dbname=2000_register&position=all&page=82128
⁶ Pub. L. 104-193
⁷ See, McKenzie, Dana K. & Susan F. Paikin, “A Complete History of Medical Child Support – Slightly Abridged!” 20 Delaware Lawyer, 20(2), (Summer 2002) and the summary of key historical legislative and regulatory provisions later in this document.
Still, research showed that medical child support was not as effective as hoped. Custodial parents provided coverage almost twice as often as noncustodial parents, particularly in families at lower income levels; and for children not living in two-parent households, securing health care coverage that is affordable, accessible, and comprehensive remained problematic.

One factor is that the costs of providing health insurance have skyrocketed. According to The Kaiser Family Foundation and Health Research and Educational Trust, 2007 Annual Employer Health Benefits Survey, the growth of health care premiums relative to the rest of the economy appears to be placing significant strains on employers. In 2007, the average cost of an employer sponsored family health insurance policy was $12,106 a year; the average employee contribution toward such family coverage was $273/month. Although growth in health insurance premiums has slowed in each of the last four years, it continues to outpace inflation and average wage growth by wide margins. Since 2000, the percentage of employers offering health benefits has fallen from 69% to 60%, with small firms offering coverage at a much lower rate than firms with over 200 employees.

Higher wage workers, full-time workers, and workers in union firms or government are more likely to be offered coverage. Even when employers provide health care coverage, the cost sharing has increased, first through increases in deductibles and co-payments, and more recently in the form of new plan types—Preferred Provider Organizations (PPOs), Point of Service (POS) plans, and catastrophic coverage. Thus, some employer-based health care coverage—considered reasonable under Federal regulations—may be deemed just too expensive given an obligor’s wages or may reduce unacceptably the cash, non-medical child support order.

Several further key changes in Federal law provide context to how medical child support now comes before courts:

- Title XXI of the Social Security Act, the State Children’s Health Insurance Program (“SCHIP”), was enacted to meet the needs of uninsured children in low income families.
- The Child Support Performance and Incentive Act of 1998 (“CSPIA”) established a Medical Child Support Working Group (“MCSWG”) to study the issue and report back to the Secretaries of Labor and Health and Human Services. The Working Group’s full report, 21 Million Children’s Health: Our Shared Responsibility (June 2000) contains 76 recommended changes to Federal statute, regulation and practice. Designed to enhance the ability of children in the IV-D system to access health care coverage or provide supplementary cash support, many of these recommendations form the linchpin to subsequent legislative and programmatic changes.

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10 Between spring of 2006 and spring of 2007, premiums increased an average of 6.1% for employer-sponsored plans while workers’ earnings increased 3.7% and inflation increased 2.6%. Id at p.1
11 Id at p.3, Exhibit D.
12 In 2007 Congress reauthorized SCHIP until 2009.
The National Medical Support Notice14 ("NMSN") was developed and promulgated pursuant to CSPIA, which also amended ERISA so that the NMSN is deemed to be a QMCSO. The State IV-D agency issues the NMSN to enforce the health care coverage provisions of IV-D child support orders.15

Deficit Reduction Act of 2005 ("DRA")16
This legislation contained several changes critical to how medical child support is established and enforced. First, medical support is more broadly defined and may include health care coverage, including the payment of health insurance premiums, co-payments and deductibles, as well as payment of the child's medical expenses. Second, in lieu of looking exclusively at an obligor who has employer-provided health care benefits, all child support orders must include a provision for medical support to be provided by either or both parents. Third, the IV-D agency must enforce a medical support order against a noncustodial parent and, at state option, may enforce such an order against the custodial parent if health care coverage is available to the obligated parent at reasonable cost.17

Proposed regulations covering both the DRA and some recommendations of the MCSWG were issued on September 20, 2006.18 Comments received are under review and final regulations will be issued.19 As the final rules have not issued, the following discussion considers the proposed regulations and recommendations from the MCSWG.

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14 The Departments of Labor and HHS jointly promulgated the NMSN. The form is available online at http://www.acf.hhs.gov/programs/cse/forms/OMB-0970-0222.pdf
15 See sections 466(a)(19) of the Social Security Act. Department of Labor guidance clarifies that “the specific requirements contained in section 609(a)(5)(C) of ERISA will not apply with respect to a Notice that is not issued by IV-D Agency, and that only Notices issued by IV-D Agencies will be deemed QMCSOs. … However, a Notice received from a source other than a IV-D Agency may be valid for purposes of enrolling a child. Plan administrators are advised that such orders are ‘medical child support orders’ as defined in ERISA section 609(a)(2)(B), that the procedures mandated by section ERISA 609(a)(5)(A) and (B) remain applicable with respect to such orders, and that if such orders satisfy the ERISA requirements, they are QMCSOs.” 65 Fed. Reg. 82136 (12/27/00).
16 Pub. L. No. 109-171
17 See 42 USC §666(a)(19) and 29 USC §1169 note.
What to Consider When Setting Medical Child Support Orders

Parents share the responsibility to provide for their children, including providing health care. Courts must consider both the custodial and noncustodial parent as a source for health care insurance that is comprehensive, accessible, and affordable. Private coverage is the clear first choice. Where private coverage is not available, SCHIP is an option. This program varies greatly State by State. For example, Pennsylvania offers SCHIP enrollment to all uninsured children in the Commonwealth, regardless of income. There is generally a low enrollment fee. There may also be Medicaid eligibility. This public coverage is not meant to absolve the parents of responsibility, but rather to serve as an option if health insurance is not available or does not provide coverage as extensive as Medicaid provides. If health insurance is not available at reasonable cost, an alternative monetary contribution from the parents toward Medicaid costs is an option. Not all States collect premiums or fees from the custodial or noncustodial parent to reimburse Medicaid costs when there is no affordable private health care coverage available. Judges will need to determine if their State has such statutory authority.

Every State must have and use numeric child support guidelines as the presumptive correct amount of child support. These guidelines apply to the calculation of all child support orders in the State, not just IV-D cases. Proposed regulations broaden the current requirement. Guidelines would be required to address how parents will provide for the child’s health care needs “through health insurance and/or cash medical support in accordance with [45 CFR] §303.31(b) of this chapter.” The order should require private health insurance coverage if it is accessible to the child and available to either parent at reasonable cost. If such coverage is not available, the order should include cash medical support until such time as health insurance, that is accessible and reasonable in cost, becomes available. As described above, each State’s child support guideline must look to both parents for both the insurance and the apportionment of these costs or cash medical support between them. Each State is free to decide how this is done but must address the issues of affordability and accessibility—concepts raised by the MCSWG.20

**Affordability** – The existing Federal IV-D program standard for affordability is coverage available through the child support obligor’s employer. 21 Million Children’s Health discusses in-depth why an employer-sponsored health care policy may be too expensive to require enrollment. Adopting the MCSWG recommendations, the proposed regulation defines the reasonable cost criteria as five percent of the obligated parent’s gross income21 but allows a “reasonable alternative income-based numeric standard” defined in a State’s guidelines. Judges must look to their State’s child support guidelines for the applicable standard. The affordability measure may be applied to the cost of health insurance and to cash contributions ordered to meet the child’s health care needs.

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20 The recommended third concept – comprehensive coverage is not explicitly addressed in the proposed regulation. The MCSWG considered coverage comprehensive when it meets the child’s basic needs.

21 The five percent standard recommended by the MCSWG parallels the SCHIP statutory standard for the maximum a custodial parent would be required to pay toward coverage for children enrolled in the program.
Accessibility – With the increase in HMOs and localized coverage, the issue of accessibility has grown more critical. Coverage that is not accessible to the child provides little or no benefit—particularly when measured against the high cost. The MCSWG recommended a standard that a provider is within 30 miles or reached in 30 minutes, or other alternate State standard. It recommended that the obligated parent’s work history also be considered. For example, a parent who works only part of the year may not have coverage that is reasonably accessible to the child year-round. The proposed Federal medical support regulations would require each State to define accessibility; each State adopts its own standard. Accessibility is a major issue in interstate child support cases. This is a key reason why—should all factors be equal—the MCSWG recommends that the insurance available to the custodial parent be preferred.

While private coverage provided by either or both parents is preferred, judges should consider public coverage where no private health care coverage is accessible or available at reasonable cost to either parent. Under such circumstances, the IV-D agency must seek cash medical support as an alternative. The five percent gross income (or alternative State) threshold would apply also to cash medical support and the order should be written in a manner that health insurance coverage is ordered whenever accessible insurance becomes available at reasonable cost, preferably without returning to court for a modified support order.

Approaches to Medical Support in Child Support Guidelines

State child support guideline models generally incorporate one of several options for addressing medical support. For health insurance, States generally either deduct the cost of the policy from the paying parent’s income before calculating the cash support obligation or add the premium cost to the base support obligation and apportion between the parents.22 Uninsured medical costs are usually considered as encompassed by the child support ordered (and therefore the responsibility of the custodial parent) or added on and apportioned. The latter category generally encompasses extraordinary medical expenses. What rises to the “extraordinary” level again varies by State. Some States set a threshold total amount. Others relate extraordinary to a single illness or treatment, again measured by a cost threshold. Several guidelines treat such expenses as a reason to deviate from the guideline itself.

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The necessity of setting reasonable cost and accessibility standards will likely cause a comprehensive evaluation of how children’s health care expenses are and should be covered under a State’s child support guideline. One issue discussed by both the MCSWG and the proposed regulations is the priority of withholding between cash and medical child support. The concern raised was that the combination of these withholdings will exceed the federal Consumer Credit Protection Act (CCPA) limits (or a lower threshold a State may have enacted). The MCSWG advises the employer that in such situations, the priority sequence of withholding should be: current child and spousal support; health insurance premiums or cash medical support; arrears; then any other child support obligations, such as costs and fees. Where the child has medical needs that warrant placing health insurance or cash medical support first, the court may enter an order changing this priority.

*It is important to note that nothing in these proposed changes require States to change a guidelines approach that deducts medical insurance costs “off the top.”*

**Medical Support and Modification of Child Support Orders**

Where an existing support order does not address medical support, the court must address the issue when a modification petition has been filed. Additionally, Federal regulations require the IV-D agency to identify orders without medical support provisions. Such orders must then be reviewed and adjusted if there is evidence that health insurance may be available to either parent and the facts warrant modification. States must have written criteria in place. Given how rapidly health insurance coverage costs can increase, a consideration for courts will be whether and how to expedite modification of orders when the cost of coverage changes.

**Setting Medical Support**

Your State may have developed a decision matrix or other tool to guide courts in determining how medical support should be addressed in child support orders. The following decision matrix is based on the work of the Medical Child Support Working Group. It is consistent with the recent statutory changes made by the Deficit Reduction Act of 2005 and will assist courts in thinking through the establishment of medical support orders. Because State laws, State child support guidelines, and public medical insurance programs for children vary, the chart focuses on information the decision-maker should have when addressing medical support in all child support orders.
## Determining Medical Child Support

**CP** = Custodial Parent  
**NCP** = Noncustodial Parent

<table>
<thead>
<tr>
<th>Case ID</th>
<th>IV-D</th>
<th>Non-IV-D</th>
<th>Initiating State</th>
<th>Responding State</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP Name</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>NCP Name</td>
<td></td>
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</tbody>
</table>

### 1. Is private health insurance coverage available to the child through a parent (or step-parent, if applicable)?

**NO**

### 2. Is appropriate coverage available to the **CP**?

- **A.** What is the cost of the premium? $ ___________
- **B.** Is this amount reasonable?  
  - State Standard: [or MCSWG = 5% of gross income of paying parent]
  
- **C.** Is coverage accessible?  
  - Defined by State law, or provider is within 30 miles or 30 min.

- **D.** Is coverage comprehensive?  
  - Yes | No

**Plan__________________________**

**YES**

### 3. Is appropriate coverage available to the **NCP**?

- **A.** What is the cost of the premium? $ ___________
- **B.** Is this amount reasonable?  
  - State Standard: [or MCSWG = 5% of gross income of paying parent]

- **C.** Is coverage accessible?  
  - Defined by State law, or provider is within 30 miles or 30 min.

- **D.** Is coverage comprehensive?  
  - Yes | No

**Plan__________________________**

### 4. Additional provisions:

- Order to IV-D agency (In IV-D case agency sends NMSN to employer.)
- Advise of any change in health insurance coverage: ________________________________
- Pay cash medical support to: ________________________________________________

Prepared By ___________________________  Date ___________________________
Federal Statutes on Medical Support

- **Medicare/Medicaid Antifraud and Abuse Amendments of 1977**: Established a medical support enforcement program under which States could require Medicaid applicants to assign to the State their rights to medical support. IV-D and Medicaid agencies were allowed to enter into cooperative agreements to enforce medical child support obligations.

- **Child Support Amendments of 1984**: Added section 452(f) to the Social Security Act, which mandates that the Secretary issue regulations requiring IV-D agencies to secure medical support information and to obtain and enforce medical support in the form of health care coverage from the NCP, when available at reasonable cost (reasonable cost is defined as employer-related or other group health insurance). Regulations also required States to incorporate children’s health care needs into child support guidelines calculations.

- **ERISA (1974)**: Enacted to protect employer-provided pension and health benefits and to encourage employers to establish such plans. The law is important for child support because it preempts State law in this area. It imposes requirements regarding information that must be provided to plan participants and standards of conduct for those who manage the plans. 29 U.S.C. §1169(a)

- **Omnibus Budget Reconciliation Act of 1993 (OBRA)**: Removed some of the impediments to obtaining medical coverage for a child born out-of-wedlock or not living in the parent’s home:
  - Required State law to prohibit discriminatory health care coverage
  - Created Qualified Medical Child Support Orders (QMCSOs) for use with respect to self-insured employers subject to ERISA. A QMCSO is an order for medical support that creates the right for the child (alternative recipient) to receive benefits under an ERISA group plan.
  - Required State law allowing an employer to deduct the cost of premiums from the employee’s pay

It required each State to pass a law requiring an employer to enroll a child in an employee’s group health plan when courts order the employee to provide health insurance coverage for the child but the employee fails to provide the coverage.

- **Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform or PRWORA)** amended the Social Security Act (42 U.S.C. §666(a)(19)(A)) to require States to obtain an order for health care coverage in all orders established or enforced by the IV-D agency (which had previously only been required in public assistance cases).

- **Child Support Performance and Incentive Act of 1998 (CSPIA)**: Section 401 strengthened enforcement by requiring the Departments of Health and Human Services (HHS) and of Labor (DOL) to develop the National Medical Support Notice (NMSN). Both HHS and DOL have regulations governing the use of the NMSN: 45 CFR 303.32; 29 CFR 2590. The CSPIA amendments mandates the use of the NMSN in all IV-D cases where the NCP is required to provide health coverage and the employer is known.
Federal Statutes on Medical Support CONTINUED

- **Federal Employees Health Benefits Children’s Equity Act of 2000** was enacted October 30, 2000, and amended section 8905 of Chapter 5 of the United States Code (5 U.S.C. §8905) by adding a new sub-section 8905(h) to enable the Federal Government to enroll an employee and his or her family in the Federal Employees Health Benefits Program (FEHBP) when a State court, or administrative authority, orders the employee to provide health insurance coverage for a child of the employee but the employee fails to provide the coverage.

  If the plan in which the employee is enrolled does not provide full benefits and services in the location in which the child resides, or if the employee fails to change to a self and family enrollment in a plan that provides full benefits and services in the location where the child resides, the employing agency shall change the coverage of the employee to a self and family enrollment in the option that provides the lower level of coverage under the Service Benefits Plan.

- **Deficit Reduction Act of 2005**: Effective October 1, 2005, sections 452 (f) and 466(a)(19) of the Social Security Act (42 U.S.C. §§652(f) and 666(a)(19)) are amended to require States to enact laws that establish procedures where orders in all IV-D cases will include medical support to be provided by one or both parents. Regulations are to be developed that require States to enforce orders against NCPs and, at State option against CPs, whenever health insurance is available at reasonable cost. Also includes a definition of medical support that may include health care coverage (under a plan, for example, including the payment of premiums, co-pays, and deductibles) and payment of medical expenses incurred.

Current Federal Regulations on Medical Support

- **45 CFR 303.30**: Securing medical information – If the IV-A or IV-E agency doesn’t provide it, and the IV-D agency can get it, the IV-D agency shall obtain the following information and provide it to the Medicaid agency:
  - Title IV-A case number, Title IV-E foster care case number, Medicaid number or the individual’s Social Security number;
  - Name of noncustodial parent;
  - Social Security number of noncustodial parent;
  - Name and Social Security number of child(ren);
  - Home address of noncustodial parent;
  - Name and address of noncustodial parent’s place of employment;
  - Whether the noncustodial parent has a health insurance policy and, if so, the policy name(s) and number(s) and name(s) of person(s) covered.

- **45 CFR 303.31**: Securing and enforcing medical support obligations. This regulation specifies that health insurance is considered reasonable in cost if it is available to the NCP through employment-related or other group health insurance. It requires the agency to request a medical support order in assistance cases unless the CP has coverage other than public coverage.
Current Federal Regulations on Medical Support CONTINUED

- **45 CFR 303.32:** States are mandated to pass laws to use the NMSN for employer-based enrollment in health care coverage. States must use the NMSN to give notice to employers and must send it within two days of entry of the person in the State Directory of New Hires; the employer must send the NMSN to the plan administrator within 20 days, and must make deductions for premiums. Also contains employer notice requirements. The DOL companion regulation is 29 CFR 2960.609-2.

- **45 CFR 302.56:** Guidelines – Must provide for children’s health needs, through health insurance coverage or other means.

- **45 CFR 302.80:** State Plan requirement for medical support enforcement – the IV-D agency may secure and enforce medical support obligations under a cooperative agreement between the IV-D agency and the State Medicaid agency but must secure medical support information and establish and enforce medical support obligations as required in 303.30 and 303.31.


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 Deficit Reduction Act of 2005 (DRA) changes and some of the MCSWG recommendations. Comments were received and final regulations will be issued. The proposed regulations:

- Define health insurance and cash medical support and where health insurance is considered to be reasonable in cost.
- Require IV-D agencies to petition for medical support in all support orders. [State law requires all orders include medical support.]
- Require that States consider both parents as a source of medical support.
- Define reasonable cost as five percent of gross income, or at State option, some other income-based numeric standard defined in the State’s guidelines.
- Provide that State must define whether health insurance is accessible (coverage must be accessible to the child).
- Establish a priority for cash child support over medical where there are insufficient funds to pay both.
- Provide case closure guidance for child-only Medicaid cases.
- Include medical support provisions for State self assessment and Federal substantial compliance audits.
Delayed care due to lack of coverage creates a domino effect—increasing costs of care and increasing lifelong problems for children without access to care.