Minnesota Medical Support Workgroup

Final Report
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DRAFT

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Contents

I. Background

During the 2000 session, legislation was passed requiring the Department of Human Services, in conjunction with the Commissioner's Advisory Committee, to study and make recommendations for improving the Minnesota medical support statutes. Chapter 372 of the 2000 Session Laws reads,

> [Medical Support Recommendations.] The commissioner of human services, in consultation with the commissioner's advisory committee, shall study and make recommendations for changes to the medical support statutes under Minnesota Statutes, chapter 518. The commissioner shall consider the medical support recommendations from the federal medical support workgroup created in the Federal Child Support Performance and Incentive Act of 1998, Public Law Number 105-200, section 401. The commissioner shall submit legislative recommendations to the chairs of the senate judiciary committee and the house civil law committee by January 15, 2001.

The Department convened a Medical Support Workgroup to act as a subcommittee of the Commissioner's Advisory Committee and carryout this task. The Workgroup first met in July 2000, with membership from a wide variety of stakeholders and perspectives on this issue, including child support, health plans, health care providers, the private bar, employers, Medical Assistance/MinnesotaCare, and custodial and noncustodial parents.

A number of issues or problems with current medical support policy have surfaced in recent years. Some issues are specific to the IV-D child support system, but others extend to all child support-eligible families. For example:

- Federal and state laws do not adequately address when medical coverage may be deemed affordable, or how to balance affordability with comprehensiveness.
- The income determination for a parent's contribution to medical support differs from the income determinations for the other two components of child support (basic support and child care support).
- Within the IV-D system, we do not have clear guidance on how to manage cases in which both parents have an obligation for medical support, and how to enforce these orders.

The Workgroup has attempted to address these and other issues in the recommendations outlined below.

II. National Medical Child Support Working Group

A. Overview

The National Medical Child Support Working Group was convened by the U.S. Departments of Labor and Health and Human Services at the direction of Congress in the Child Support Performance and Incentive Act of 1998. The charge to the National Working Group was to identify the barriers to effective establishment and enforcement of medical support and solutions for addressing those barriers. The report from this National Working Group was published in June 2000.[1]

B. Outdated Assumptions and a New Paradigm for Medical Support

The National Working Group began their work by addressing the fact that many of the assumptions that underlie the current national medical support model are outdated. For example, we used to assume that custodial parents are not employed and therefore do not have access to health care coverage. To the contrary, the National Working Group found that over 75 percent of all custodial parents were employed in 1995, and that in "single-parent households with incomes over 200 percent of poverty, more than 60 percent of children are covered by family health coverage provided by the custodial parent."[2]

Another outdated assumption of our medical support model is that employer-based coverage is always reasonable in cost. Indeed, both federal and state laws define "reasonable" as any coverage provided through an employer. Even when subsidized by an employer, an employee's share of the premium for family coverage may be unaffordable. According to Department analysis of data from the Minnesota Health Economics Program, a full-time worker in Minnesota earning $12/hour spends approximately 4.6 percent of their gross income for the children's portion of the premium. A full-time worker earning $7/hour spends approximately 8.1 percent of their gross income for the children's portion of the premium.[3]

Finally, we can no longer ignore geographic distance in setting medical support obligations. As cited by the National Working Group, over 25 percent of all noncustodial parents live in a different state from their children, and an additional 20 percent live in the same state, but not the same county or city.[4] With the increased reliance on HMO's and managed care plans in the health care system, there may be limitations on provider choice that make distance a critical issue, and highlight the need to consider accessibility when private coverage options are weighed.

The National Working Group produced a set of recommendations creating a new paradigm for medical support based on revised assumptions. This paradigm is summarized by the following principles:

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[1] Available: www.acf.dhhs.gov/programs/cse/rpt/medrpt

[2] National Medical Child Support Working Group (2000) "21 Million Children's Health: Our Shared Responsibility." U.S. Departments of Labor and Health and Human Services. Page 2-10.

[3] Child Support Enforcement Division, 2000, "Medical Coverage and Costs: What is currently being spent?" (unpublished – handout from the Medical Support Workgroup meeting, 9/27/00).

[4] National Medical Child Support Working Group (2000) "21 Million Children's Health: Our Shared Responsibility." U.S. Departments of Labor and Health and Human Services. Page 2-13.

1. It is in the best interest of both children and the nation that the maximum number of children have access to health care coverage.

2. Parents share primary responsibility for meeting children's needs. When one or both parents can provide comprehensive, accessible, and affordable health care coverage, that coverage should be provided to the child.

3. Coverage available to both parents should be considered in setting a medical support obligation. When both parents are able to provide appropriate coverage, coverage through the custodial parent should be preferred.

4. When determining whether to pursue private coverage, the cost should be considered. Coverage may be deemed reasonable if it does not exceed 5 percent of a family's gross income. Neither custodial nor noncustodial parents with incomes near the poverty line should be expected to provide private coverage, unless it is available at no cost.

5. Geographic accessibility and a parent's anticipated stability of employment and/or coverage should be factors in considering whether to pursue private coverage.

6. The child support program should work in close conjunction with Medicaid/SCHIPs to ensure that children who have access to private coverage obtain such coverage, and those who are eligible for publicly-subsidized coverage are covered by Medicaid or SCHIPs.[5]

[5] National Medical Child Support Working Group (2000) "21 Million Children's Health: Our Shared Responsibility." U.S. Departments of Labor and Health and Human Services.

III. Minnesota Medical Support Workgoup

A. Membership

The Department sought membership for the Workgroup that represented the variety of stakeholder perspectives in the health care and child support community. We also considered the representation of the National Working Group as a model for our membership.

Members:

Linda Aaker, University of Minnesota Student Legal Services
Christa Anders, Department of Human Services Child Support Enforcement Division, Workgroup Chair
Stephen Arnott, Arnott Law Firm, Minnesota State Bar Association - Family Law Section
Claudia Brewington, Brewington Consulting, custodial parent representative
Barry Bloomgren, Hennepin County Collections Services
Honorable Jim Clark, District Court Judge, Ramsey County
Honorable Susan Cochrane, Referee, Hennepin County
Tom Ehrlichmann, Children's Defense Fund
Arnie Engelby, Resource Center for Fathers and Families
John Gross, Department of Commerce
Kathie Henry, Department of Human Services Health Care Programs
Carolyn Jones, Minnesota Chamber of Commerce
Kathy McDonough, Legal Services Advocacy Project
Jodie Metcalf, Magistrate, Office of the State Court Administrator
Jenny Nystrom, Dakota County Human Services
Janet Olstad, Department of Health
Robin Rowen, Insurance Federation of Minnesota
Michael Scandrett, Minnesota Council of Health Plans
Martin Swaden, Swaden Law Offices
Jan Taylor, Department of Human Services Benefit Recovery
Dr. Steve Vincent, Cedar Riverside People's Center
Theresa Walton, Ramsey County Attorney's Office

Alternates:

Jayne Barnard McCoy, Mid Minnesota Legal Assistance
Pat Dault-Beauchane, Department of Human Services Benefit Recovery
Cathryn Edwall, Swaden Law Offices
Aurelia Gordon, Department of Commerce
Kathryn Kmit, Minnesota Council of Health Plans
Jim Losinski, Department of Commerce
Deb Wagner, Department of Human Services Health Care Eligibility and Access
Emily Williamson, Children's Defense Fund

Other Participants:

Cheryl Hogoboom, Ramsey County Child Support

Child Support Enforcement Division Staff:
Jen Augustson
Bill Dustin
Joy Grant
Lisa Richards
Julie Voigt

B. Role and Organization

The primary charge to the Workgroup was to carryout the legislative mandate of studying issues related to medical support and presenting recommendations to the 2001 Legislature. The Workgroup functioned as a subcommittee of the Commissioner's Advisory Committee for Child Support Enforcement. The Commissioner's Advisory Committee advises the Child Support Enforcement Division on the administration of the state's child support program. The recommendations from the Workgroup must be considered by the Commissioner's Advisory Committee.

The Workgroup first met on July 17, 2000, and agreed to meet bi-weekly in order to fulfill their charge. The Workgroup used the report of the National Working Group as a study guide for analyzing issues and developing recommendations, and also submitted other issues critical to their constituencies for discussion. Staff prepared summary documents of current law and potential changes, and presented other data and analysis as needed. Members gathered input from their constituencies and brought this information back to the Workgroup.

C. Guiding Values

As the Workgroup began its work, it developed and refined a set of principles or values to serve as a guide for their work. It should be noted that these values were developed prior to the release of the National Working Group's report. They are strikingly similar to the principles defined by the National Working Group, providing compelling support for the future direction of medical support. The values are as follows:

1. All child support-eligible children will have some basic threshold of medical coverage. Basic coverage is coverage that provides a minimum level of preventive, emergency, acute and chronic medical and dental care.

2. We will maximize the number of children that have the most appropriate medical coverage possible, such that it helps them achieve their highest potential. Factors to be considered in assessing appropriateness include comprehensiveness, accessibility, children's specific medical needs, and parents' ability to contribute. We recognize the importance of quality health care for a child's development and ability to succeed.

3. We will implement an equitable and rational method for parents to share all medical costs.

4. To the extent possible, we will minimize public costs and make efficient use of family and private resources in providing medical coverage for children.

5. In addition to the traditional responsibilities of establishing and enforcing medical support orders, the IV-D agency can and should do what it can to facilitate medical coverage of children. This might include such things as informing parents of a particular health plan, referring them to a public assistance program, or providing direct access to medical coverage.

6. The IV-D incentive structure should support these values.

7. Medical support needs to be addressed in every order establishing or modifying child support, and needs to be easy to understand, modify and enforce. Medical support orders should accommodate the shifting availability of medical coverage options.

IV. Recommendations

Over the course of nine meetings, the Workgroup has arrived at a number of recommendations for improving the establishment and enforcement of medical support and adapting the National Working Group recommendations to Minnesota. These recommendations, as summarized and discussed below, reflect the general consensus of the Workgroup.

A. Identifying Available Coverage

Employer-based or dependent only or union-based.

✓ **Private coverage is the first choice.**

As expressed in their guiding values, Workgroup members share a common interest in ensuring that all child support-eligible children have access to medical coverage. The National Working Group's recommendations indicate a preference for identifying available *private* coverage, with public coverage as a second choice. This is consistent with the Workgroup value that we should minimize public costs in providing medical coverage for children. The Workgroup also agreed that private coverage options available to *both* custodial and noncustodial parents should be taken into account. As such, the Workgroup recommends that *all private coverage options, including, but not limited to, employer or union-based coverage available to either parent, dependent-only coverage purchased in the private market, or coverage available through a stepparent, domestic partner, and/or grandparent, be considered prior to consideration of public coverage for the child.*

✓ **Medical coverage information request forms should be simplified; the Department of Human Services should increase outreach to health plans and employers about the importance of this information.**

Employers and health plan administrators can play a key role in identifying available private coverage for children and soliciting the information necessary to appropriately establish medical support obligations. Currently, the IV-D child support agency sends a form to employers or health plan administrators requesting information about available coverage, such as whether dependent coverage is available, and if so, the cost of dependent coverage and whether the employer subsidizes a portion of the cost.

A survey of county child support offices was conducted to determine whether there are problems with these requests to employers and health plan administrators. Based on the results, *the Workgroup recommends that efforts be made to simplify the form(s)*. They agreed that it is not necessary to identify sanctions for noncompliance by employers and health plans, but that in exchange, they should continue to provide the information free-of-charge. *The Workgroup also recommends increased outreach to health plans, self-insured providers and employers* about the importance of making information about their coverage available and other requirements.

✓ **If neither parent has appropriate private coverage available, public coverage should be considered.**

While appropriate private coverage is the first choice, if it is not available, public coverage is the second choice. The ultimate goal is to ensure that children have medical

coverage. Minnesota is fortunate to have public health care programs that support this goal. Medical Assistance is available for children under age two with family incomes up to 280 percent of poverty, for children ages 2 to 5 with family incomes up to 133 percent of poverty, and for children ages 6 to 15 with family incomes up to 100 percent of poverty. MinnesotaCare is available for children with family incomes up to 275% of poverty. The Workgroup recommends that *courts may order parents to apply for Medical Assistance or MinnesotaCare if they are not already enrolled and it seems to be a viable option.*

✓ **The Workgroup supports legislative efforts to extend MinnesotaCare to more children.**

Consistent with its guiding value that all child support-eligible children have access to medical coverage, the Workgroup strongly supports legislative efforts to eliminate barriers to MinnesotaCare for income-eligible children, including insurance barriers and the 4-month waiting period. The Workgroup also supports efforts to lower the cost of MinnesotaCare for some families, capping contributions at five percent of family income. One member questioned whether this recommendation was within the scope of the Workgroup. It was the belief of the other members that this is consistent with the Workgroup's recommendations regarding affordability and with recommendations from the National Working Group regarding State Children's Health Insurance Programs. The Workgroup offers support for the National Working Group's recommendations to streamline application processes, eliminate waiting periods, remove insurance barriers when available insurance is not accessible or affordable, and improve communication between child support agencies and public health care programs.

✓ **Child support agencies should help inform parents about Medical Assistance and MinnesotaCare.**

The National Working Group has recommended that IV-D child support agencies play a greater role in informing parents about public coverage options and/or facilitating enrollment. While the Workgroup is hesitant to expand the duties of child support workers without further analysis and planning, they do agree that child support agencies are well-positioned to provide outreach to families, and *recommend that child support agencies help inform parents about Medical Assistance and MinnesotaCare.* This may be accomplished by making applications available to parents, providing contact information for either program, or other means.

B. Appropriate Coverage and the Decision-Making Process

✓ **Medical coverage should be evaluated for appropriateness before being ordered; appropriate coverage is that which is accessible, affordable, comprehensive and in the best interests of the child.**

The National Working Group recommended that prior to ordering coverage for a child, three factors be considered in assessing whether or not that coverage is appropriate. Those factors include *accessibility, affordability, and comprehensiveness* of the coverage. The Workgroup has adopted these factors, as well as a fourth factor – *best interests of the child.* These factors are defined below.

In order to apply these factors and determine whether coverage is appropriate, the National Working Group developed a "Decision Making Matrix" (Appendix B) outlining the steps in deciding which parent should carry the coverage. The Workgroup adopted the underlying principles of the matrix, including the principle that if both parents have available coverage of equal accessibility, reasonableness, and quality, the custodial parent should be the first choice for obtaining the coverage. As noted by the National Working Group, designating the custodial parent as the carrier of coverage for the child eases the processing of claims and insurance information.

Members acknowledged that parents often have only one option for coverage available, or that parents are able to agree to the coverage they prefer, and therefore the matrix may not always be needed. The decision-making process for determining whether coverage is appropriate will be simplified in these cases.

✓ **Coverage is accessible if services are provided within 30 minutes or 30 miles of the child's residence.**

Coverage is appropriate only if the service providers covered are geographically accessible to the child and custodial parent. The Workgroup approved the standard for accessible coverage adopted by the National Working group. *Coverage is accessible if the covered child can obtain services from a health plan provider with reasonable effort by the custodial parent; specifically, within 30 minutes or 30 miles of the child's residence.* This standard is used by the federal Medicaid program, and is also required of health maintenance organizations in Minnesota Statute 62D.124. While this standard may not be compatible with patient-provider distances in rural areas, the 30 minute/30 mile accessibility standard would serve as rebuttable presumption. The Workgroup also adopted the accessibility standard Minn. Stat. 62D.124 creates for specialty care – 60 minutes or 60 miles from the child's residence.

The National Working Group highlighted another element of accessibility – the stability of coverage. Many parents have temporary or seasonal employment that makes coverage available some months of the year and not others. Other parents have an employment history of frequent job changes that may indicate instability in employer-based coverage. The National Working Group recommends that coverage be assessed for whether it can be expected to remain available for at least one year.

✓ **Parents with incomes above 150 percent of the federal poverty guideline have an ability to contribute to medical support for their child(ren). An affordable contribution is equal to five percent or less of their gross income.**

The Workgroup reviewed recommendations from the National Working Group intended to ensure that parents' contributions to medical support are affordable. The first issue the Workgroup addressed was the income level below which a parent could not be expected to contribute to medical support for the child. The National Working Group recommended a level of 133 percent of the federal poverty guidelines for consistency with Medicaid eligibility. Some members wondered if this threshold was too low, noting that national recommendations regarding Children's Health Insurance Programs have

suggested that the threshold at which families could be expected to contribute to the cost of coverage should be 150 percent of poverty. The expected benefits of raising the threshold include (1) more realistic orders, which are therefore more likely to be paid; and (2) allowing low-income parents to meet other expenses for the child and him or herself. For these reasons, *the Workgroup has recommended that parents with gross income below 150 percent of the federal poverty guidelines should not be expected to contribute to medical support.*

The second issue addressed by the Workgroup was how to define a reasonable contribution to medical support. Current federal and state law define "reasonable" as any coverage provided through an employer. This does not reflect the reality of employer-based coverage, which may in fact be unaffordable to employees, and does not establish a standard for cash contributions to medical support. The National Working Group recommended that coverage that does not exceed five percent of a parent's gross income should be deemed reasonable. This standard is used by the federal Children's Health Insurance Programs as the maximum amount parents should be expected to contribute to premiums, co-pays and deductibles. The Workgroup adopted this standard, recommending that for parents with incomes *up to 275 percent of federal poverty guidelines, it shall be presumed that they can contribute up to five percent of adjusted gross income*[6] *to medical support.* The five percent applies to medical support for children subject to the order, rather than per child or across cases. The manner in which to allocate this five percent of gross income between the components of medical support, specifically premiums and unreimbursed expenses, required further delineation and is discussed below under "Allocating Medical Costs Between Parents."

Of final note, Workgroup members discussed whether these tests of ability to contribute and affordability should be applied to adjusted gross income or net income. For consistency with the MinnesotaCare program, the Shared Responsibility guidelines proposal, and relevant federal programs, members agreed to use gross income for these determinations.

✓ **Coverage must include at least medical and hospital coverage, and provide for preventive, emergency, acute and chronic care.**

The National Working Group has recommended that comprehensive coverage must include at least medical and hospital coverage, and provide for preventive, emergency, acute and chronic care. The Workgroup agreed that coverage should include these elements, and that this consideration, along with the other factors of appropriateness, should replace the current use of the Number Two Qualified Plan standard (Minn. Stat. 62E.06, Subd. 2). While not every affordable health plan will include each of these elements, particularly preventative care, the Workgroup believes it is in the best interests of the child to pursue such coverage. In assessing comprehensiveness of coverage when

[6] For the purposes of this report, adjusted gross income means gross income minus (1) self-employed business expenses, (2) prior child support orders being paid, and (3) an allowance for the basic needs of other residential dependents. Deduction (3) has been defined in the proposed Shared Responsibility model to include children for whom the parent has a legal duty of support, not of this action or of another child support obligation, and who spend at least 50% of overnights with the parents over the course of a calendar year.

more than one plan is available, the National Working Group recommended that the following factors also be considered: basic dental coverage, orthodontics, eye glasses, contact lenses, mental health services and substance abuse treatment. The Workgroup adopted this language.

✓ **The best interests of the child should be considered in selecting coverage for the child, and should include an examination of the child's special medical needs.**

The Workgroup determined that in considering whether coverage is appropriate, a child's special medical needs should be considered. Unable to arrive at a single definition of "special medical needs" since the scope may be vast, the Workgroup agreed to add a fourth factor to consider, "best interests of the child," and to define best interests as including a child's special medical needs.

✓ **Current accessible coverage should be maintained; the determination of whether coverage is appropriate need only occur when the child is not presently enrolled in coverage.**

As recommended by the National Working Group, the Workgroup agrees that *if a child subject to the order is already enrolled in accessible private coverage, it shall be presumed that the current coverage will be maintained*, unless the parents agree otherwise or a motion is brought before the court to request a change in coverage. They also recommend that *the determination of whether or not appropriate coverage is available shall be exercised only for those cases in which the child is not presently enrolled in coverage or when requested by a parent.* To extend this determination to all cases would be administratively burdensome.

C. Allocating Medical Costs Between Parents

✓ **Parents should share health care premiums in proportion to their adjusted gross incomes.**

The Department of Human Services has conducted a two-year review of the child support guidelines to determine their application and appropriateness in meeting the needs of children. Through analysis of research and data, and the work of a Guidelines Review Advisory Task Force, the Department has developed a new child support guidelines model called the Shared Responsibility Model. The most recent version of the model is attached in Appendix C. Under this model, the responsibility for each component of child support – basic support, child care support, and medical support – is shared by parents based on their proportionate share of total adjusted gross income. The Workgroup agreed that prorating medical costs based on each parent's share of combined income makes it more likely that each parent is contributing within his or her means, and is the most equitable way to distribute costs. The Workgroup also supports the Shared Responsibility model's elimination of the current statutory deduction for the cost of dependent health insurance coverage in the income determination for child support. Currently, once an obligor's medical support obligation is determined, it is subtracted from income before setting the basic support amount. If the medical support obligation is modified, it has a ripple effect through the rest of the order – basic support must then be

modified, as well as child care support because of the deduction of basic support from income in setting child care support. This circular determination of support has proven to be cumbersome. Separating the determinations by eliminating the income deduction for dependent health insurance will significantly simplify order establishments and modifications.

✓ **The Workgroup recommends two options for determining affordability of coverage and allocating unreimbursed costs.**

The National Working Group recommended that a parent's medical support contribution of 5 percent or less of gross income could be deemed affordable, but did not specify how to account for both premiums and unreimbursed expenses within the 5-percent standard. In order to delineate how to determine whether coverage was affordable under the five percent test and allocate costs between parents, the Workgroup developed a flow chart to depict the necessary steps (Appendix D). The steps outlined in the flow chart only apply to cases in which the parents have met the ability-to-contribute test (150 percent of federal poverty guidelines).

When specific premium costs from private health coverage are known, the first step is to allocate the premium between the parents based on their proportionate share of combined income. The second step is to determine whether each parent's proportionate share of the premium is less than or equal to four percent of their respective adjusted gross incomes. If both parents meet this test, the coverage is deemed affordable and may be ordered. The parent who is not ordered to carry the coverage will contribute to the cost of coverage in proportion to their share of combined income. Each parent is also presumed able to contribute an additional one percent of adjusted gross income for unreimbursed expenses for the children subject to the order.[7] Unreimbursed expenses include the child's reasonable and necessary health-related expenses that are not reimbursed by insurance and that are in addition to the cost of the premium. They may include deductibles, co-pays, and expenses for orthodontia, eye glasses, or over-the-counter products. The one-percent standard was derived from expenditure data on what Minnesota parents spend on unreimbursed medical expenses.[8] The flat amount ordered would be capped at an amount equal to one percent of the median family income in Minnesota, or approximately $56/month.

If either parent's share of the premium does not meet the four percent of gross income affordability test, the court may order one parent to carry more of the burden if it will not result in extreme hardship. They may also order an additional one percent of adjusted gross income for unreimbursed expenses for the children subject to the order.

There was considerable discussion about ordering a flat amount for unreimbursed expenses. Currently, unreimbursed expenses are allocated between parents as a

[7] Expenses beyond 1% of gross income could be defined as extraordinary expenses to be allocated between parents based on their proportionate share of income.

[8] JobsNOW Coalition, 1998, "The Cost of Living in Minnesota." Minnesota parents spend an average of $30/month on out-of-pocket health care expenses for one child. This is one percent of the gross monthly earnings of a full-time worker earning $12/hour.

percentage, not a dollar amount. The percentage is based on the parent's proportionate share of net income. Parents are expected to share information regarding the unreimbursed expenses and reimburse one another without the intervention of the public authority or a court. If a parent fails to reimburse another parent, the requesting parent may seek public authority and/or court intervention.

In a survey of county child support offices, staff reported mixed experiences with the current collection of these expenses. For some counties and the parents with whom they work, the process works well. Other counties indicated the process is complicated and burdensome and that many custodial parents do not request and receive reimbursement of expenses to which they are entitled. The one-percent allotment would set aside a certain dollar amount for the custodial parent to apply toward unreimbursed expenses, and may reduce substantially the administrative efforts of county child support programs that currently expend resources attempting to enforce these obligations. A judicial referee and member of the Workgroup noted that ordering a flat one-percent for unreimbursed expenses would significantly reduce her workload, minimizing the accounting and paper work she must process before ordering payments between parents. She also acknowledged that some parents would still prefer the current, more labor-intensive, process.

Other workgroup members expressed concern with ordering a flat amount for unreimbursed expenses. From the private bar's experience, unreimbursed expenses claimed by a custodial parent are typically "big ticket" items – i.e. orthodontia – and the total cost will be significantly greater than the one-percent amount. Members questioned whether ordering one percent of gross income would limit parties' abilities to collect beyond that amount. Others expressed concern that this may represent a "windfall" to some custodial parents that do not incur unreimbursed expenses.

Based on the mixed reaction to the proposal to order an additional one percent of adjusted gross income for unreimbursed expenses, the Workgroup developed both a Plan A and a Plan B for legislative consideration. *Under Plan A*, a parent's share of the premium is measured against the four percent of adjusted gross income affordability standard, and if met by both parents, the coverage is ordered. An additional one percent of combined adjusted gross income is apportioned between the parents and ordered for unreimbursed expenses. Extraordinary expenses would be defined as exceeding the one percent of adjusted gross income ordered and would be apportioned between parents as a percentage in the same manner as unreimbursed expenses under the current statute. *Under Plan B,* the premium affordability standard is raised to five percent and all unreimbursed expenses are proportionately allocated between parents as a percentage in the same manner as under the current statute.

- ✓ **Parents should share unreimbursed and/or extraordinary medical expenses in proportion to their adjusted gross income.**

As stated above, the Workgroup recommends that health care premiums be shared by parents in proportion to their adjusted gross income. This is consistent with the Shared Responsibility guidelines proposal and should be applied to the allotment of

unreimbursed and/or extraordinary medical expenses as well, depending on whether Plan A or Plan B above is adopted. However, the Workgroup agreed that the enforcement of medical support orders could be simplified by having parents share unreimbursed and/or extraordinary expenses equally. Therefore, *the Workgroup recommends that if the Shared Responsibility guidelines proposal is brought forward as legislation, unreimbursed and/or extraordinary expenses should be prorated in the same manner as applied to the other components of child support. If it does not go forward, the Workgroup recommends that unreimbursed and/or extraordinary expenses be shared equally between parents.*

✓ **Parents may claim reimbursement from the other parent for unreimbursed expenses up to two years from the date of service.**

The Workgroup recommends that a statute of limitations on claiming unreimbursed expenses be incorporated into statute. The Workgroup considered related statute of limitations for guidance. Insurance companies must honor claims from Medical Assistance for up to three years after the service was provided. Members agreed that it generally takes insurance companies up to one year to process a private claim, and that an additional year to seek a contribution from the other parent is reasonable. Therefore, *the Workgroup recommends that parents may submit unreimbursed or extraordinary expenses to the other parent for their contribution up to two years (twenty-four months) from the date the service for which reimbursement is sought was provided.*

✓ **When appropriate coverage is unavailable, the noncustodial parent contributes the lesser of five percent of his or her adjusted gross income or the premium amount he or she would pay if enrolling in MinnesotaCare with the child(ren) subject to the order.**

Under current law, where private coverage is not available, a noncustodial parent is often ordered to contribute at least $50 per month to either be retained by the public authority for reimbursement of public coverage costs or by the custodial parent for medical expenses. There was some indication among Workgroup members that this amount neither reflects what a noncustodial parent can afford, nor the amount in medical expenses the custodial parent is likely to incur.

Under the flow chart for determining affordability and allocating costs, when coverage or premium amounts are unavailable, or the premium amount is unaffordable under either Plan A or Plan B above, the noncustodial parent is ordered to contribute the lesser of five percent of his or her adjusted gross income or the premium amount he or she would pay if enrolling in MinnesotaCare with the child(ren) subject to the order. The use of the MinnesotaCare sliding fee schedule was developed by the Guidelines Review Project as a way of extending the standard of an affordable contribution to medical coverage from one policy area to another, and as a way to treat custodial and noncustodial parents equally. The five-percent of adjusted gross income or the MinnesotaCare premium represents a contribution towards medical costs incurred by the custodial parent. If the custodial parent receives Medical Assistance or MinnesotaCare on behalf of the child(ren), this amount would be retained by the state to reimburse public coverage costs.

The custodial parent will not be ordered to obtain private health coverage. However, the court may order the custodial parent to apply for public coverage.

✓ **When premium or public coverage information is not available at the time of establishment, the judge or magistrate may leave the record open and order the parents to provide the information.**

Members expressed concern that there will be a significant percentage of cases in which premium information is not available at the time of a hearing, or cases in which the parents or court are not certain that the child is eligible for public coverage. *The Workgroup recommends that if premium or public coverage information is not available at the time of establishment, but the parents are present at the hearing, the judge or magistrate may leave the record open and order the parents to provide the information.* If both parents are not present and a default order will be entered, in the interest of judicial economy, the noncustodial parent may be ordered to contribute either five percent of his or her adjusted gross income or the the premium amount he or she would pay if enrolling in MinnesotaCare with the child(ren) towards medical costs incurred by the custodial parent.

✓ **If adding a child to family coverage results in no additional cost, the cost of medical coverage for the child subject to the order is zero.**

The cost of dependent coverage is the cost to the carrying parent to either add the child to single or family coverage or enroll in dependent-only coverage. The Workgroup discussed what the designated cost of dependent coverage is if a parent already has family coverage and adding the child to family coverage does not increase the parent's actual cost of that coverage. Should the other parent be expected to contribute to the cost of the family coverage? The Workgroup agreed that at the point in time of providing medical coverage for the child subject to the order, there is no cost to the parent already maintaining family coverage and therefore there is no cost to allocate between parents. Therefore, the *Workgroup recommends that if family coverage is already available and being carried and to add the child subject to the order results in no additional cost to the parent, the cost of medical coverage for the child subject to the order is zero.* However, if a parent is ordered to carry dependent coverage and does not have family coverage at that time, but has other dependents eligible for the coverage, the cost of dependent coverage would be the full cost to add family coverage.

✓ **A noncustodial parent's basic support payment should be offset by a custodial parent's contribution to medical support.**

The National Working Group reported that in a majority of states, a noncustodial parent's basic support payment is offset by a custodial parent's contribution to medical support in order to ease enforcement of medical support obligations. For example, if a custodial parent must contribute $50 to the medical coverage carried by the noncustodial parent, the noncustodial parent's basic support payment would be reduced by $50. The offset provides for an "automatic" enforcement of the custodial parent's obligation to contribute to medical support. One potential problem with the offset is that if the noncustodial parent doesn't carry the insurance, the custodial parent is left with a reduced child support payment. The Workgroup decided it was preferable to base policy decisions on

the assumption that parents will comply with their child support obligations, and therefore recommends *that a noncustodial parent's basic support payment should be reduced by a custodial parent's contribution to medical support or the child(ren) subject to the order.*

D. Medical Support Orders

✓ **Certain information and determinations must be included in every medical support order.**

The National Working Group recommended that specific items be included in every medical support order. The Workgroup agreed that court orders must be thorough and that boilerplate language should be developed. The Workgroup recommends that the following items be included in orders and specified in statute:

(1) whether appropriate health care coverage for the child is available and if so, which parent shall maintain health care coverage;
(2) the type of health care coverage, including the particular health plan if more than one is available, and whether dental coverage is available through the same or a separate health plan;
(3) the cost of premiums and how the cost is allocated between the parents;
(4) how unreimbursed expenses will be allocated between the parents, and how the unreimbursed expenses will be collected by parents who are not reimbursed their appropriate share;
(5) if both parents are required to provide health care coverage, which coverage is primary and which is secondary;
(6) the circumstances under which the obligation to provide health care coverage will shift from one parent to the other; and
(7) a cost-of-living adjustment under section 518.641.

✓ **A cost-of-living adjustment should be applied to medical support.**

The final item that every medical support order must provide for, a cost-of-living adjustment, is a departure from current law. The Workgroup agreed that a cost-of-living adjustment acknowledges that medical costs go up from year to year. It may limit the need for modifications of orders, reducing the burden on courts and child support workers. It is also a guaranteed adjustment to medical support that is not dependent on a parent's actions. *The Workgroup recommends applying COLA to medical support, using the same CPI measure as used for basic support, with the presumption that the adjusted medical support order does not exceed the five percent affordability standard. When a medical support COLA is contested, the decision-maker should consider actual costs of coverage. The issue of which parent has appropriate dependent health insurance may also be reopened at the time of the COLA hearing.*

✓ **"Conditional" orders**

Workgroup members also expressed an interest in using "conditional" orders for medical support. Conditional orders would specify more than one option for medical support, thereby creating flexibility for the constantly changing situations that families encounter

in maintaining coverage. The conditional language would also assist counties as they enforce the orders. There are some concerns of due process with conditional orders, but members found the concept to be worth pursuing. Two Workgroup members representing the private bar agreed to draft proposed language that could be used informally by private attorneys and that child support agencies could potentially use in their proposed orders. (Appendix E).

E. National Medical Support Notice

The National Medical Support Notice is a standard form to be sent to employers and health plans for enrolling a child in court ordered medical coverage. The Notice was created in the Child Support Performance and Incentive Act of 1998 in order to streamline the administrative work of employers and health plans, no longer requiring them to know the nuances of each state's form and laws. The National Working Group made recommendations for improving the proposed Notice and for its implementation, and final federal regulations will be issued in the near future for a October 2001 implementation due date.

✓ **Minnesota statutes should include a provision regarding the requirements of the National Medical Support Notice.**

If appropriately completed according to ERISA's requirements, the Notice is deemed a qualified medical child support order under ERISA, 29 U.S.C. § 1169(a). When a plan administrator receives the Notice, they must (1) notify the public authority whether coverage is available to the child under the plan's terms and, if so, whether the child is covered under the plan and the effective date of the coverage or, if necessary, what steps to be taken to effectuate the coverage; and (2) provide the public authority or custodial parent as appropriate with a description of the coverage and any documents necessary to effectuate coverage. *The Workgroup recommends that Minnesota statutes include a provision detailing this information about the National Medical Support Notice* so that employers and child support officers do not need to refer to federal law for the requirements of the notice.

The Workgroup was advised by a staff member of the National Working Group in the federal Office of Child Support Enforcement that the Notice is intended for use only by IV-D child support agencies, and only for court ordered coverage of the noncustodial parent. According to the federal Office, use of the Notice to enroll a child in custodial parent coverage was discussed but rejected, due to anticipation that enrollment by custodial parents would not require a Notice.

✓ **The public authority should receive COBRA notification.**

The National Working Group has recommended that IV-D agencies, in addition to the custodial parent, receive COBRA notification. Workgroup members noted that it seems consistent with our goal of IV-D agencies playing a greater role in ensuring that children have coverage. Therefore, the Workgroup recommends that statute specify that the public authority, as well as the custodial parent, shall be provided with COBRA notification.

F. Enforcement

✓ **The IV-D child support agency should enforce orders to carry or contribute to medical coverage equally against both custodial and noncustodial parents.**

Historically, child support agencies were established as representatives of custodial parents in enforcing child support orders. That role shifted to one in which the public authority represents neither parent; instead, the focus is on the responsibility to enforce the order. However, we do not, in state law, have the authority to enforce an obligation against a custodial parent. With a new emphasis through the National Working Group on looking to both parents for medical coverage availability, there may be instances in which it would be necessary for some type of enforcement action to be taken against a custodial parent for failure to comply with a medical support order. *The Workgroup agreed that the IV-D agency should enforce court orders requiring either parent to obtain coverage and/or requiring either parent to contribute to the cost of coverage.*

The Workgroup agreed that this change in enforcement policy requires a cautious approach. Federal law will need to change in order for many of the standard enforcement mechanisms to be used against custodial parents. In addition, many enforcement remedies are not tailored to medical support or orders to carry coverage. The Workgroup agreed that the one enforcement remedy specifically tailored to medical support enforcement, automatic income withholding, should be extended to a custodial parent where an offset to support is not available to automatically enforce the custodial parent's obligation to contribute to medical support. Evaluation will be necessary to assess whether further enforcement actions are necessary and appropriate.

✓ **Before enforcement action is taken, the public authority must verify the reason for noncompliance and modify the order, if appropriate.**

A flow chart was developed for a proposed enforcement scheme (Appendix F). Under the proposal, a parent ordered to enroll a child in appropriate health coverage shall verify that they have applied for the coverage to the public authority within 30 days of the date of the court's order. A parent who fails to enroll a child or who subsequently loses dependent coverage shall notify the public authority of the reason that the child is not enrolled in the court-ordered coverage. The National Working Group has specified some appropriate reasons to modify an order, and these could be outlined in IV-D policy. The Workgroup recommends that an emphasis be placed on modifying the order, if appropriate.

✓ **If a parent is ordered to carry coverage and fails to do so, that parent is presumed liable for all medical costs for the child and they shall be enforced accordingly.**

If a parent has not carried coverage as ordered, that parent is presumed liable for all medical costs for the child resulting from coverage not being provided, whether he or she is a custodial or noncustodial parent. These costs may be collected and enforced in a process similar to the current process for collecting unreimbursed expenses. A requesting parent may serve the liable parent with an affidavit of expenses and notice of intent to enforce. If a hearing is requested, the court will determine liability. If a hearing is not requested, the expenses become a judgment by default and are enforced accordingly. The

current practice of adding the expenses as arrears for the noncustodial parent, and increasing income withholding by 20% of basic support, is extended to the custodial parent under the proposal. If a custodial parent is liable for medical expenses, the first action taken is to reduce arrears owed to the custodial parent by the noncustodial parent. If arrears do not exist, the basic support obligation would be reduced by 20% until the medical arrears are paid. If a basic support obligation does not exist, income withholding would be instituted against the custodial parent's wages, or a payment agreement would be established if income withholding is not available.

✓ **Orders to contribute to coverage should be enforced through an offset of the basic support obligation, income withholding, or a payment agreement.**

If a custodial parent is ordered to contribute to coverage, the Workgroup has recommended that the contribution should be subtracted from the noncustodial parent's basic support obligation, as discussed above. The order should still specify the medical obligation, but for payment and collection purposes the basic support is offset by this amount. If a basic support obligation does not exist, either parent may be subject to income withholding, or a payment agreement if income withholding is not available. The Workgroup noted that enforcement policy will need to address whether an order for medical support should be enforced against a custodial parent if the noncustodial parent is not paying basic child support.

G. Modifications

✓ **The court may modify a medical support order without re-opening other issues of the child support obligation; the factors specified in statute to denote a substantial change in circumstances for modification should be amended to include (1) surpassing the Consumer Credit Protection Act limits and (2) health care coverage as ordered is no longer appropriate.**

On numerous occasions, the Workgroup expressed a desire to simplify the modification process, particularly for medical support obligations. Medical coverage availability, cost, accessibility, etc., may change often for parents, and even if they agree to the change in coverage, the order needs to be modified so that it can be enforced accordingly. The Workgroup discussed making forms available to parties for a simple Stipulation and Order. However, they acknowledged that any major simplification of the modification process could lead to a loss of due process. *The Workgroup does recommend that in modifying a medical support order, the court should not need to consider all other child support components, as required under current law.* This change is primarily made possible by the elimination of the income deduction for the cost of dependent health care coverage from the determination of support, as discussed previously.

The Workgroup also made recommendations for improving the standards for modification. At the recommendation of the National Working Group, the Workgroup agreed that *the delineation of a substantial change in circumstances under Minn. Stat. § 518.64, subd. 2(b) should include surpassing Consumer Credit Protection Act limits.* They also recommend that the factor of health care coverage being no longer available as

a justification for a substantial change in circumstances be substituted with the factor that *the health care coverage may no longer be appropriate*. This factor is consistent with the medical support recommendations requiring appropriate coverage and takes into account changes to coverage that may affect appropriateness: accessibility, affordability, comprehensiveness and best interests of the child.

H. Funding

The National Working Group has recommended increasing federal financial participation in the IV-D program funding for medical support from 66 percent to 90 percent for a five year period in order to encourage IV-D to aggressively pursue medical support. Federal law has also authorized the development of a medical support incentive measure to reward states for improvements in this area. The National Working Group recommends that the new incentive, once developed, be implemented at the end of the five-year increased federal financial participation funding period.

✓ **Minnesota's $50 medical support incentive payment to counties for medical support enforcement should be expanded to include nonpublic assistance cases and cases in which the custodial parent carries the insurance.**

One of the guiding values of the Workgroup is that the IV-D incentive structure should reflect the values and recommendations of the Workgroup. The primary incentive awarded to counties in the area of medical support is for actions taken to enforce a noncustodial parent's order to carry dependent health coverage. For cases in which the custodial parent receives Medical Assistance or MinnesotaCare on behalf of the child, counties receive a $50 incentive payment for each person for whom coverage is identified and enforced.

The Workgroup's foremost value is making sure that all children have medical coverage. As such, a medical support incentive should reward counties for getting coverage for children in both public assistance and nonpublic assistance families, through both custodial and noncustodial parents, and through either private or public coverage. The current incentive does not accomplish this.

The Workgroup recommends revising the current $50 medical support enforcement incentive to include both public assistance and nonpublic assistance cases, and be rewarded for coverage attained for the child regardless of which parent is ordered to carry insurance. This recommendation will be accommodated within the current incentive budget, and the incentive payment should remain at $50 until budget concerns require a reconsideration of the amount.

✓ **Minnesota should await the change in federal law before barring recovery of birthing expenses covered by Medical Assistance.**

The National Working Group has recommended that federal law be changed to bar IV-D child support agencies from recovering birthing expenses covered by Medical Assistance from noncustodial parents. The Workgroup recommends that Minnesota await the change in federal law before baring recovery in state law.

I. Future Work

The Workgroup recommended a few areas for future research and planning. Some or all of these ideas could be explored further through the Section 1115 planning grant the Department has received from the federal Office of Child Support Enforcement.

- ✓ Expanding Minnesota's New Hire Reporting law to allow the collection of medical coverage information.
- ✓ Reviewing how to provide IV-D children with coverage where private and public coverage are not available. This analysis might include an exploration of providing access to a private health plan for IV-D children or allowing noncustodial parents to buy-in to MinnesotaCare.
- ✓ Developing/maintaining a database of employers who offer dependent coverage.
- ✓ Reviewing the link between child support and participation in MinnesotaCare and its effects on application rates.

APPENDIX B

National Working Group's Decision-Making Matrix

Decision Matrix for Tribunal Use (To Determine Appropriate Coverage for a Child Not Currently Enrolled in Any Coverage)			
Step	**Situation**		**Action**
1	Is private coverage *available*?		
	custodial parent: YES	noncustodial parent: YES	Go to Step 2
	custodial parent: NO	noncustodial parent: YES	Go to Step 2
	custodial parent: YES	noncustodial parent: NO	Go to Step 2
	custodial parent: NO	noncustodial parent: NO	Custodial parent enrolls in Medicaid/SCHIP, or other available coverage
2	Does the child have *access* to coverage?		
	custodial parent: YES	noncustodial parent: YES	Go to Step 3
	custodial parent: NO	noncustodial parent: YES	Go to Step 3
	custodial parent: YES	noncustodial parent: NO	Go to Step 3
	custodial parent: NO	noncustodial parent: NO	Custodial parent enrolls in Medicaid/SCHIP, or other available coverage
3	Is *cost* reasonable?		
	custodial parent: YES	noncustodial parent: YES	Go to Step 4
	custodial parent: NO	noncustodial parent: YES	Noncustodial parent enrolls
	custodial parent: YES	noncustodial parent: NO	Custodial parent enrolls
	custodial parent: NO	noncustodial parent: NO	Custodial parent enrolls in Medicaid/SCHIP, or other available coverage
4	Does one parent have better coverage?		
	YES: custodial parent's coverage is better		Custodial parent enrolls
	YES: noncustodial parent's coverage is better		Noncustodial parent enrolls
	NO: coverage is of equal quality		Custodial parent enrolls, unless a special determination is requested

APPENDIX C

Shared Responsibility Child Support Guideline Worksheet

December 2000 - FOR DISCUSSION ONLY

Number of children for whom support is being determined: ____

DETERMINING PARENTAL RESPONSIBILITY:

	Obligor	***Obligee***	***Combined***
Income:			
1. Gross monthly income	_____	_____	
Deductions:			
2. Self-employment business expenses:	_____	_____	
3. Prior orders being paid:	_____	_____	
4. Total deductions (Line 2 + Line 3)	_____	_____	
Adjusted gross income:			
5. Monthly adjusted gross income (Line 1 – Line 4):	_____	_____	

Parents' share of responsibility: *Complete Line 6, 7, or 8-10 as appropriate.*

If Obligor's adjusted income (Line 5) is ***below $1000****, reserve child care support and medical support, and establish basic support as follows:*

6. For 1-2 children: Obligor's Line 5 X .10 or $50/mo[1] _____

7. For 3+ children: Obligor's Line 5 X .12 or $75/mo[1] _____

DO NOT COMPLETE THE REMAINDER OF THE WORKSHEET FOR OBLIGORS AT THIS LEVEL OF INCOME.

If Obligor's adjusted income (Line 5) is ***at least $1000****, apportion responsibility for meeting children's needs as follows:*

8. Deduction for other legally dependent children residing with the parent (Chart 1): _____ _____

9. Remaining monthly income available for child support (Line 5 minus Line 8): _____ + _____ = _____

10. Each parent's proportionate responsibility:
    Obligor's Line 9 ÷ Combined Line 9: _____
    Obligee's Line 9 ÷ Combined Line 9: _____

[1] Enter the greater of the two amounts

MEETING THE NEEDS OF THE CHILD(REN):

	Obligor	*Obligee*	*Combined*
Order for basic support:			
11. Shared responsibility for children's living expenses: (Table 1):[2]			_____
12. Proportionate responsibility of each parent: *Obligor:* Obligor's Line 10 X Line 11:	_____		
Obligee: Obligee's Line 10 X Line 11:		_____	
Order for child care support:			
13. Shared responsibility for child care costs:[3]			_____
14. Proportionate responsibility of each parent: *Obligor*: Obligor's Line 10 X Line 13:[4]	_____		
Obligee: Obligee's Line 10 X Line 13:		_____	
Order for medical support: *Complete Lines 15-19 or Line 20 as appropriate*			
If at least one parent has appropriate insurance[5] available:			
15. Cost of children's medical and dental insurance premium:			_____
16. Cost of children's ordinary uninsured medical and dental expenses (Combined Line 9 X .01):			_____
17. Cost of children's extraordinary uninsured medical and dental expenses:[6]			_____
18. Total shared responsibility for children's medical needs (Lines 15 + 16 + 17):			_____
19. Proportionate responsibility of each parent: *Obligor:* Obligor's Line 10 X Line 18:	_____		
Obligee: Obligee's Line 10 X Line 18:		_____	
If neither parent has appropriate insurance available:			
20. Obligor's adjusted share of children's medical needs:[7]	_____		

[2] For purposes of completing Line 11, limit the parents' combined monthly income available for child support (Combined Line 9) to no more than $15,000.

[3] Enter the actual cost of work-related and education-related child care

[4] If obligor is low-income, enter the lesser of (1) the monthly copayment obligor would make if he/she were receiving child care assistance appropriate to his/her monthly income available for child support as reported on Line 9, or (2) the obligor's proportionate contribution to child care costs as calculated on line 14.

[5] "Appropriate insurance" means medical insurance which is comprehensive, accessible, affordable, and in the best interest of the child/ren as defined by the Minnesota Medical Support Workgroup.

[6] Enter monthly medical and dental expenses which exceed ordinary medical expenses as calculated on Line 16.

[7] Enter the lesser of (1) the children's portion of the monthly premium the Obligor would pay if he/she were receiving MinnesotaCare assistance appropriate to his/her monthly income (Line 9), so long as the obligor's income does not exceed MNCare eligibility limits; or (2) 5% of Obligor's monthly income (Line 9).

CHART 1 – CONTRIBUTION TO BASIC NEEDS OF OTHER CHILDREN

Number of children	Parent's share of their basic needs
1	$244
2	$426
3	$578
4	$710
Each additional child	+ $100 per child

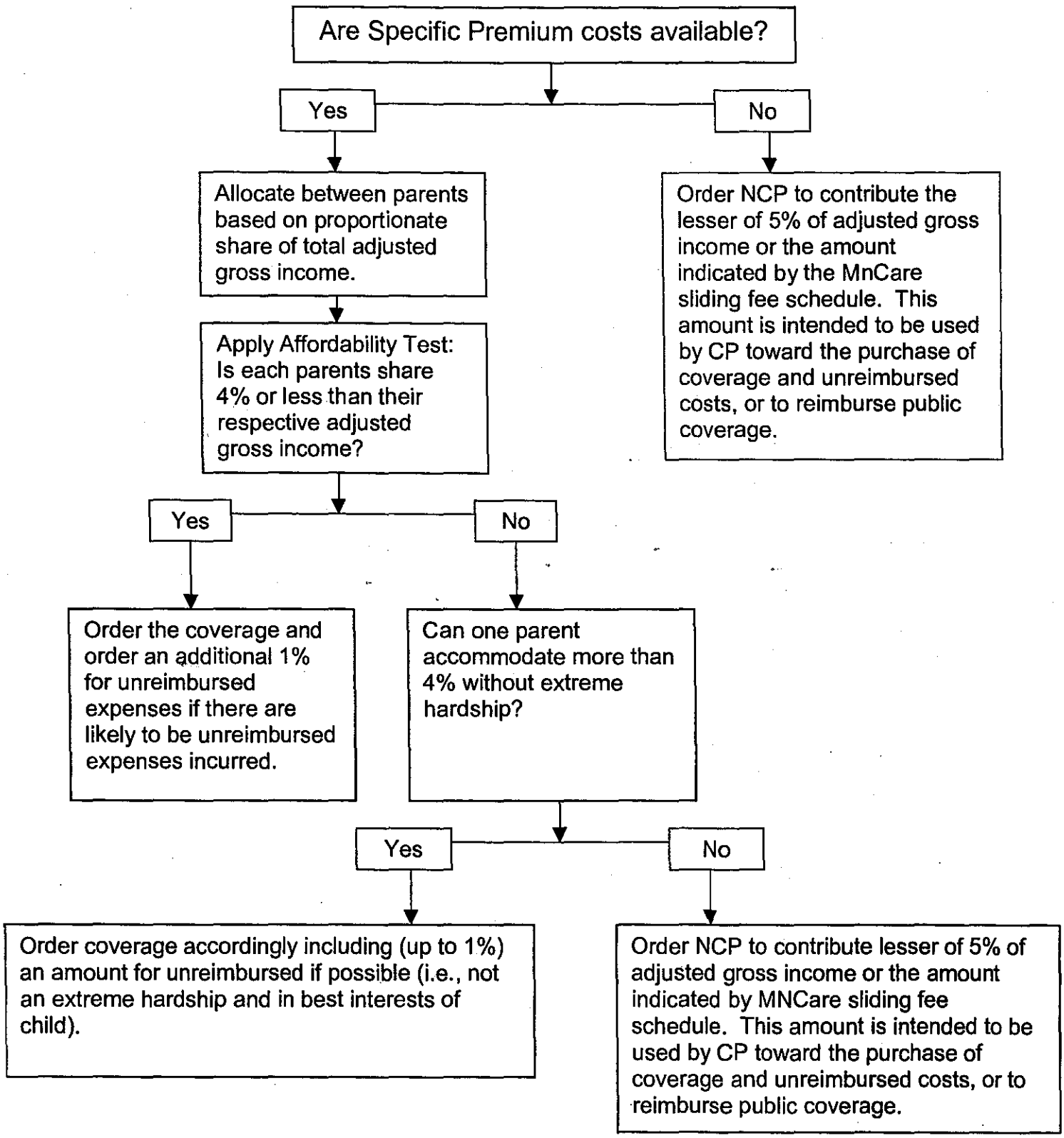
TABLE 1 – PARENTS' SHARED RESPONSIBILITY FOR BASIC SUPPORT

Note: *This table is under development in consultation with the US Department of Agriculture. It will be based on USDA data showing what parents at varying income levels spend on children, but adjusted to reflect the fact that some expenses are duplicated when children spend time in two households*

APPENDIX D

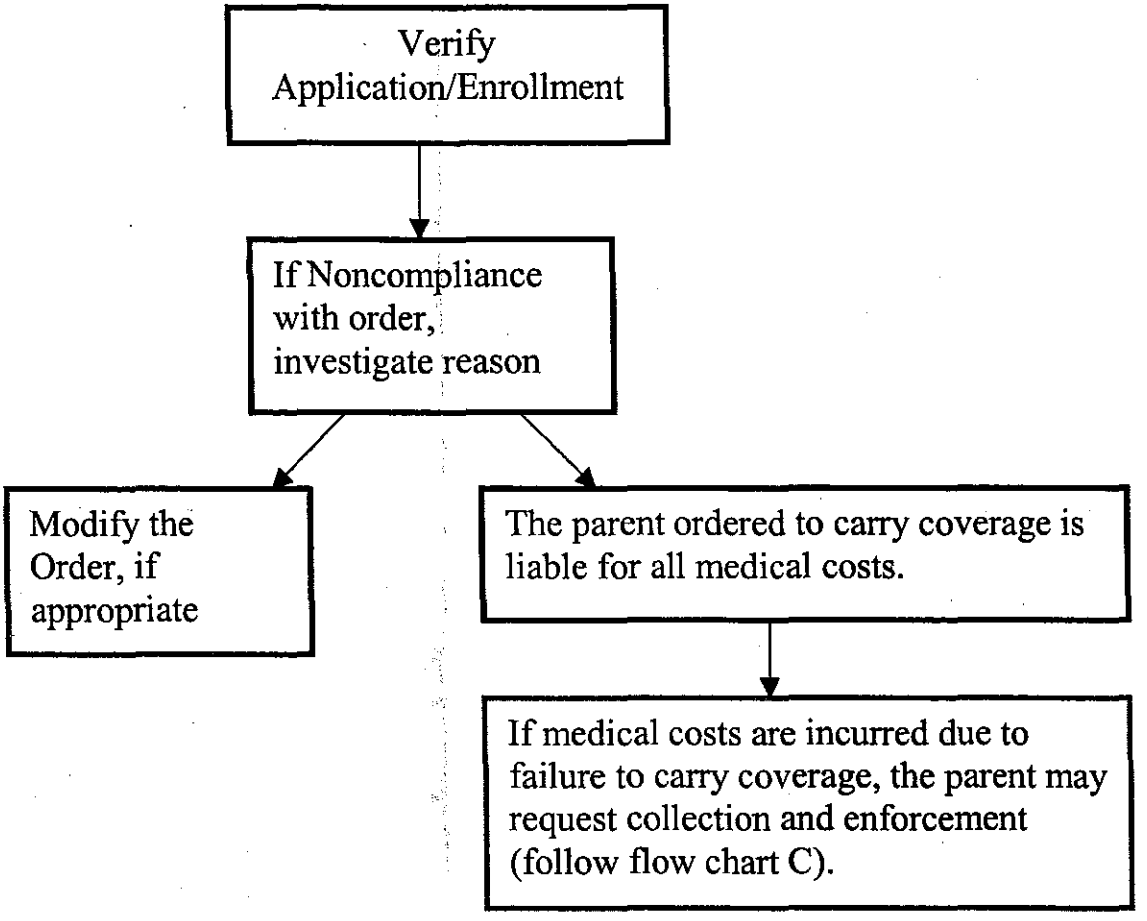
Determining Affordability and Allocating Costs

(For use following a determination that the parents have incomes greater than 150% of the federal poverty level and therefore have an ability to contribute to medical support).



APPENDIX F
Enforcement Flow Charts

A. Enforcing an Order to Carry Coverage



B. Enforcing an Order to Contribute to Coverage

1. If a basic support obligation exists, offset by contribution to medical coverage.

2. If no basic support obligation exists, establish income withholding if available.

3. If no basic support obligation exists and income withholding is not available, establish a payment agreement.

C. Enforcing Unreimbursed Expenses