

**IMPLEMENTING THE NATIONAL MEDICAL SUPPORT NOTICE:
INSIGHTS FROM STATE EXPERIENCES**

September 2002

As directed by Congress in the Child Support Performance and Incentive Act of 1998, the National Medical Support Notice (NMSN) was promulgated by the U.S. Departments of Health and Human Services and Labor after extensive consultation among diverse stakeholders through the Medical Child Support Working Group.¹ Now that the notice is in use in some states, a limited examination of implementation approaches can be made. These findings are based primarily on National Women's Law Center (NWLC) interviews of IV-D agency officials in several states that have been using the NMSN for approximately one year, and on a NWLC review of the legislation of the approximately 30 states that have passed implementation legislation.

As many states are in the initial implementation stages, it is too early to measure the effect of the notice on children's enrollment in employer-based health care plans by quantitative analysis. However, it is possible to share insights and suggestions based on the experiences of both states that have been using the notice for approximately one year and states in earlier stages of implementation.

- **Implementation was not difficult for states with automated or state-wide medical support orders.**

These existing program components are a good predictor of ease of implementation. Not surprisingly, states with automated medical support orders experienced a smooth transition to use of the NMSN. In states with existing state-wide medical support orders that were not yet automated, the transition was also easy; the NMSN merely replaced an existing document.

- **Coalition-building and outreach to employers increased employer acceptance.**

States that engaged in extensive coalition-building and employer-outreach activities prior to use of the NMSN report fewer complaints from employers than other states. Many states initiated the implementation process with outreach efforts aimed at notifying employers and other groups about the NMSN, striving to increase those groups' understanding of the entire medical support process and their recognition of the notice.

¹ For the Working Group's discussion of the National Medical Support Notice and its other recommendations on improving the enforcement of medical support, see *21 Million Children's Health: Our Shared Responsibility - The Medical Child Support Working Group's Report* (2000), available at http://www.acf.dhhs.gov/programs/cse/rpt/medrpt/Full_Report.pdf [hereinafter *21 Million Children's Health*].

Forums for employers on child support issues that included sessions on the notice, as well as medical support training for court personnel, have informed hundreds of stakeholders. IV-D agencies reached large numbers of employers by including news of the notice in state department of labor publications and by distributing written materials directly to state employers. Collaboration between employer-related groups, employers, the IV-D agency and other groups resulted in effective outreach efforts both early in the process and once the notice was in use.

- **Nevertheless, agencies and employers identify some barriers to smooth transition.**

The length of the NMSN has been cited as an obstacle to easy implementation of the notice. IV-D agencies identify as a primary obstacle the expense of mailing a lengthy form with each applicable medical support order. Some employers have similarly objected to both the length of the notice and accompanying instructions and to the fact that a single employer may receive multiple sets of instructions (attached to different orders) within a very short period of time.

If agencies and employers are objecting to lengthy documents that contain only required instructions and explanations of relevant state law as required by federal regulation, different delivery mechanisms should be considered. For example, the instructions and relevant law could be delivered to the employer on an annual or semi-annual basis rather than with each individual order. That information could also be provided online through the agency's website. These measures would minimize direct costs and employee time. However, these alternatives may not be permissible under current federal rules and policies. Collaboration with the federal Office of Child Support Enforcement should explore separating the individual case aspects of the notice from the boilerplate instructions that are uniformly applicable throughout each state.

Employers also have requested that the IV-D agency meet the requirement of providing contact information by including a matching name and telephone number of an agency official, and ensuring that the contact will be available and willing to answer employer questions about the notice.

- **Some state IV-D officials believe that lack of employer sanctions may lead to lack of compliance.**

Federal law does not require that states impose employer sanctions for failure to comply with the NMSN, but states are authorized to do so.² Almost half of the states that recently passed implementation legislation either created employer and plan administrator sanctions for noncompliance with the notice or expanded existing sanctions to apply in the NMSN context. These states added or applied codified

² See National Medical Support Notice, 65 Fed. Reg. 82154, 82159 (Dec. 27, 2000) (comment 2 to Section 303.32(c)(3)).

sanctions or penalties such as holding employers or plan administrators liable for accumulated premium payments³ or medical expenses incurred⁴ during the time the child should have been enrolled in a health care plan. Some states without relevant employer and plan administrator sanctions are concerned that the lack of sanctions will be an obstacle to successful enforcement.

- **Cost of health care coverage is a primary concern to parents and a principal consideration in the selection of a health care plan.**

Now that the NMSN is in use, other problems with health care coverage selection are coming to the forefront. One IV-D agency reported receiving complaints from both custodial and non-custodial parents since beginning to use the notice. The non-custodial parents indicated that they would prefer to enroll the children lower-cost health care plans. Some custodial parents also were concerned that the high cost of health care coverage would adversely affect the cash support they receive, although that state notes that other custodial parents have expressed relief that their children finally have health care coverage.

The current definition of when health care coverage is available at “reasonable cost” assumes that the cost of employer-related or other group coverage is reasonable. The definition fails to consider how much of a non-custodial parent’s income may be required to pay for the health coverage. Consequently, the cost of coverage may constitute a large part of the support order, reducing the amount of cash support provided to the child or increasing the non-custodial parent’s total obligation, depending on the manner in which the state takes the cost of coverage into account. As recommended by the Working Group, federal legislation or regulation should amend this definition to allow states to develop income-based standards of “reasonable cost.”⁵

The issue of cost particularly arises when multiple health care plans are available to the child. OCSE regulations state that when an employer’s plan administrator indicates that more than one coverage plan is available to the child, the “[s]tate agency, in consultation with the custodial parent, must promptly select from available plan options....”⁶ The agency’s role in selecting a plan is also identified in the plan administrator’s section of the actual notice.

Almost half of the states that have passed NMSN implementation legislation addressed the issue of multiple available health care plans. Of those states, seven

³ See, e.g., H.B. 02-1055, 63rd Gen. Ass., Reg. Sess. (Colo. 2002), Sec. 6 (codified at Colo. Rev. Stat. § 26-13-121.5(11) and applying existing Colo. Rev. Stat. § 14-14-112(5)).

⁴ See, e.g., Cal. Fam. Code § 3768(a) (2001); S.F. 3114, 82nd Leg., Reg. Sess. (Minn. 2002), Sec. 10 (codified at Minn. Stat. § 518.171, Subd. 4(d)).

⁵ See *21 Million Children’s Health* at Ch. 3.

⁶ See 45 C.F.R. § 303.32(c)(8) (2001).

articulated statutory guidelines about which plan to choose.⁷ Those guidelines generally reflect the priorities of accessibility, cost and comprehensiveness – priorities recommended by the Working Group in the decision matrix it developed to assist in health care plan selection.⁸ These state statutory guidelines generally base the decision on the plans’ cost and their geographic accessibility to the child. These states may receive fewer complaints from parents, and those IV-D agencies will likely need to spend less time on cases in which multiple plans are available than agencies in states without articulated guidelines.

As more states integrate the notice into their medical support programs, additional guidance and suggestions will be available, but these early lessons should assist other states as they implement the NMSN.

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⁷ See, e.g., H.F. 2395, 79th Gen. Ass., Reg. Sess. (Iowa 2002), Sec. 7 (codified at Iowa Code § 252E.5(9)(g)); H.B. 1224, 2001-2002 Leg., Reg. Sess. (Ga. 2002), Sec. 7 (codified at Ga. Code Ann. § 19-11-27(g)(7)).

⁸ The Working Group went into additional detail about plan selection by preparing for situations in which one, both or neither parent could enroll the child in health care coverage that was accessible, affordable and comprehensive. See *21 Million Children’s Health* at Ch. 3.