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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

45 CFR Parts 302, 303, 304, 305, and 308

RIN 0970–AC22

Child Support Enforcement Program; Medical Support

AGENCY: Administration for Children and Families, Department of Health and Human Services (HHS).

ACTION: Notice of Proposed Rulemaking (NPRM).

SUMMARY: These proposed regulations would revise Federal requirements for establishing and enforcing medical support obligations in child support enforcement program cases receiving services under title IV–D of the Social Security Act (the Act). The proposed changes would: require that all support orders in the IV–D program address medical support; redefine reasonable-cost health insurance; require health insurance to be accessible, as defined by the State; and make conforming changes to the Federal substantial-compliance audit and State self-assessment requirements.

DATES: Consideration will be given to comments received by November 20, 2006.

ADDRESSES: Send comments to the Office of Child Support Enforcement, Administration for Children and Families, 370 L'Enfant Promenade, SW., 4th Floor, Washington, DC 20447, Attention: Director, Division of Policy, Mail Stop: OCSE/DP. Comments will be available for public inspection Monday through Friday, 8:30 a.m. to 5 p.m. on the 4th floor of the Department's offices at the above address. A copy of this regulation may be downloaded from *http://www.regulations.gov*. In addition, you may transmit written comments electronically via the Internet: *http://www.regulations.acf.hhs.gov*.

FOR FURTHER INFORMATION CONTACT: Thomas G. Miller, OCSE Division of Policy, 202–401–5730, e-mail: *tgmiller@acf.hhs.gov*. Deaf and hearing impaired individuals may call the Federal Dual Party Relay Service at 1–800–877–8339 between 8 a.m. and 7 p.m. eastern time.

SUPPLEMENTARY INFORMATION:

Statutory Authority

This notice of proposed rulemaking is published under the authority granted to the Secretary of Health and Human Services (the Secretary) by section 1102 of the Social Security Act, 42 U.S.C. 1302. Section 1102 of the Act authorizes the Secretary to publish regulations, not inconsistent with the Act, that may be necessary for the efficient administration of the title IV–D program.

This proposed rule is also published in accordance with section 452(f) of the Act, as amended by section 7307 of the Deficit Reduction Act of 2005 (DRA of 2005), which directs the Secretary to issue regulations which require that State agencies administering IV–D programs ''enforce medical support included as part of a child support order whenever health care coverage is available to the noncustodial parent at reasonable cost.'' Section 7307 of the DRA of 2005 also added two additional sentences to section 452(f) of the Act: ''A State agency administering the program under this part [title IV–D] may enforce medical support against a custodial parent if health care coverage is available to the custodial parent at a reasonable cost, notwithstanding any other provision of this part [title IV–D].'' And: ''For purposes of this part, the term 'medical support' may include health care coverage, such as coverage under a health insurance plan (including payment of costs of premiums, co-payments, and deductibles) and payment for medical expenses incurred on behalf of a child.''

This proposed regulation is also published in accordance with section 466(a)(19) of the Act, as amended by section 7307 of the DRA of 2005, which requires States to have in effect laws requiring the use of procedures under which all child support orders enforced pursuant to title IV–D of the Act ''shall include a provision for medical support for the child to be provided by either or both parents.''

Background

In 2001, the Census Bureau estimated that 9.2 million of the nation's children under the age of 19 (12.1 percent) were without health insurance (*Children With Health Insurance: 2001*, Current Population Reports, U.S. Census Bureau, August 2003). Of all children, 52.4 million were covered through private health insurance. Ninety-three percent of the 52.4 million children were covered through an employer-sponsored plan (ESI) and 19.5 million had coverage through a government program. *Children With Health Insurance: 2001*, reports that the rate of uninsured children in 2001 was lower than reported in 1997, when Congress established the State Children's Health Insurance Program (SCHIP).

A more recent Census Bureau report, *Health Insurance Coverage in the United States: 2002* (Current Population Reports, U.S. Census Bureau, September 2003), found that the proportion of children who remained uninsured did not change from 2001 to 2002, despite an increase in the number and percentage of uninsured in the general population to 43.6 million people (15.2 percent) in 2002. It appears children were largely protected as a result of increased government-sponsored health insurance coverage through Medicaid, SCHIP and military health care (*Health Insurance Coverage: 2002*). While public coverage increased, the percentage of people covered by employment-sponsored health insurance (ESI) dropped in 2002, from 62.6 percent to 61.3 percent, driving an overall increase of 2.4 million U.S. residents who were uninsured during the entire year of 2002. Only for children did expanded public coverage offset the decrease in ESI.

The income disparity as to who does or does not receive ESI is widely documented. *Children With Health Insurance: 2001* estimates that 85 percent of children in families with incomes of at least 250 percent of the poverty level have ESI, compared with 51.3 percent of children in families with incomes between 133 and 200 percent of poverty level. In 2002 the coverage rate for households with incomes of $25,000 to $50,000 decreased 1.5 percentage points from 2001 rates (*Health Insurance Coverage: 2002*).

For children who live apart from one or both of their parents, securing private health care coverage or defraying the cost of public benefits has proven even more complex and burdensome. From its creation in 1975 Part D of title IV of the Act, the Child Support Enforcement Program (IV–D program), has been responsible for locating noncustodial parents; establishing paternity; establishing, modifying and enforcing child support orders; and collecting and distributing child support owed by the noncustodial parent. The initial focus of this Federal/State/local partnership was to secure reimbursement for Federal welfare expenditures from the noncustodial parents of these children.

The Child Support Enforcement Amendments of 1984 added a new section to the Act, requiring State IV–D agencies to petition for health care coverage in all IV–D cases in which

such coverage is available at reasonable cost. The Secretary of HHS defined ''reasonable cost'' by regulation at 45 CFR 303.31: The cost of health care coverage is reasonable if it is available through the child support noncustodial parent's employment.

Federal regulations require that the State child support guidelines must, at a minimum, ''provide for the child(ren)'s health care needs, through health insurance coverage or other means.'' (45 CFR 302.56(c)(3)). The mechanism for accomplishing this mandate is determined by each State. Generally, guidelines use one or a combination of the following methods: One parent is ordered to provide health insurance and the cost is deducted from his/her income before the support obligation is calculated or the cost of health insurance is added to the basic award and prorated between the parents. Where there is no ESI or there are significant uninsured or extraordinary medical expenses, States generally add an amount to the support award and apportion it between the parents or consider such expenses a basis to deviate from the guideline amount.

The Federal statute and regulations fostered cooperation between State IV–D and Medicaid agencies. Under 42 CFR 433.151, Medicaid State plans must provide for entering into cooperative agreements for enforcement of rights to and collection of third party benefits with, among other agencies, IV–D agencies. Child support program regulations required State child support agencies to notify Medicaid agencies when private family health coverage was obtained or discontinued for a Medicaid-eligible person, and authorized Federal financial participation for the cost of these services (45 CFR 304.20).

Seeking to remove legal impediments to securing private health care coverage from noncustodial parents of child support-eligible children, the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) amended the Employee Retirement Income Security Act of 1974 (ERISA), creating the Qualified Medical Child Support Order (QMCSO). Every employer group health plan must honor a properly prepared QMCSO that requires a plan participant to provide coverage for a dependent child (29 U.S.C. 1169(a)). OBRA '93 required States as a condition of Medicaid funding to enact laws prohibiting employers and insurers from denying enrollment of a child under a parent's health coverage plan due to various factors such as: The child's birth out-of-wedlock, failure to claim the child as a dependent on the parent's Federal income tax return, or the child's residence outside the insurer's service area or with someone other than the employee.

Medical child support was strengthened in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). This legislation mandated that all child support orders contain provisions for medical support. [The Child Support Performance and Incentive Act of 1998 (CSPIA) discussed below, later moved this requirement from section 466(a)(19) to section 452(f) of the Act. The DRA of 2005 moved the requirement back to section 466(a)(19) as noted under *Statutory Authority*.]

States also were required to provide a simple administrative process for enrolling a child in a new health plan using a notice of coverage. Section 609(a) of ERISA was amended to expand the definition of ''medical child support orders'' to permit certain administrative orders to be considered QMCSOs, rather than just court orders.

Recognizing that States' efforts to secure and enforce medical support orders against child support obligors had met with limited success and that significant problems remained, Congress enacted CSPIA. This law included even stronger provisions to improve medical support enforcement in the IV–D program. Further, the CSPIA directed the Secretaries of HHS and the Department of Labor (DOL) to establish a *Medical Child Support Working Group* (Working Group). The Working Group included thirty members representing: HHS and DOL, State child support directors, State Medicaid directors, employers (including payroll professionals), sponsors and administrators of group health plans defined by section 607(1) of ERISA, organizations representing children potentially eligible for medical support, SCHIP programs, and organizations representing child support professionals. The Working Group was asked to identify impediments to the effective enforcement of medical support by State IV–D agencies and make recommendations to the Secretaries to eliminate them.

A final report, *21 Million Children's Health: Our Shared Responsibility*, offered 76 recommendations broken into five categories: Federal Statute/Legislation; Federal Regulation/Guidance; Best Practice; Technical Assistance and Education; and Research and Demonstration. This proposed rule responds to several of the Working Group's key recommendations. The Secretaries of HHS and DOL jointly transmitted *21 Million Children* to the Congress on August 16, 2000.

CSPIA also directed HHS and DOL to develop and promulgate a *National Medical Support Notice (NMSN)*, to be issued by State IV–D agencies as a means of enforcing health care coverage provisions contained in child support orders. HHS and DOL issued the final rule on the NMSN jointly on December 27, 2000 (amending 29 CFR part 2590 and 45 CFR part 303) (65 FR 82154). All States have now implemented the NMSN. Under ERISA, an appropriately completed NMSN is deemed to be a QMCSO for the child, and the employer is required to comply with the Notice in a timely manner.

After review of *21 Million Children* and promulgation of the NMSN, OCSE consulted with a wide range of program stakeholders in 2001 and 2002, including State and local workers and administrators, national organizations, advocates and other parties interested in medical support enforcement. These consultations explored the feasibility and impact of the Working Group's recommendations, establishing which recommendations had wide support. Those included in the consultations were the National Governors Association (NGA), the National Conference of State Legislators (NCSL), the American Public Human Services Association (APHSA), the National Child Support Enforcement Association (NCSEA), the National Council of Child Support Directors (NCCSD), the Eastern Regional Interstate Child Support Association (ERICSA), and the Western Interstate Child Support Council (WICSEC).

Resolutions passed by NCSEA, NCCSD, and ERICSA urged OCSE to expand the definition of reasonable cost under 45 CFR 303.31 to include both parents and to decouple it from ESI. These organizations joined in the Working Group's conclusion that the definition ''deeming employment-related coverage to be *per se* reasonable'' in cost is an artifact of earlier decades when employment-related insurance was both widely available and more heavily subsidized by the employer. Therefore, there is broad support for eliminating the employer-tied definition of reasonable cost.

Additionally, the HHS study *Health Care Coverage Among Child Support-Eligible Children,* published in 2002 after the Working Group's Report, suggests that untapped employer-sponsored insurance through custodial mothers and their spouses might reduce the share of children without private health insurance more significantly than similar insurance through noncustodial

parents, for a variety of reasons, including availability, accessibility, cost and preference. ''Half of child support-eligible children living with their mothers are currently covered by [employer-sponsored] insurance. The sources of this coverage are as follows: the resident mother (26 percent), the noncustodial father (13 percent), a step-father (7 percent), and another adult in the child's household (4 percent),'' (*HHS, December 2002*). Another 6.7 percent appear to have access to employer-sponsored insurance (ESI) but are not covered. (Custodial fathers are more likely to either provide ESI or have access to it). Therefore, it appears that custodial mothers are the most important source of ESI for child support-eligible children living with their mothers, and provide more than one-quarter of those children with ESI. Indeed, the Working Group's decision matrix to determine appropriate health insurance coverage, presented in *21 Million Children,* contains a preference for using the custodial parent's (or step-parent's) health insurance.

Provisions of the Regulation

We propose amending parts 302, 303, 304, 305, and 308, as discussed below.

Part 302

Section 302.56—Guidelines for Setting Child Support Awards

Currently, under § 302.56(c)(3), the State guidelines for setting and modifying child support awards must provide for the child(ren)'s health care needs, through health insurance coverage or other means. We propose to amend § 302.56(c)(3) to require that guidelines ''address how the parents will provide for the child(ren)'s health care needs through health insurance coverage and/or through cash medical support in accordance with § 303.31(b) of this chapter.''

The recommendations of the Working Group grew from a fundamental understanding that parents share primary responsibility for their children's needs. The proposed regulation clarifies that the resources of *both* parents must be considered. The Working Group found that ''* * * only 27 States'' child support guidelines direct the decision maker to consider both parents as potential sources of health care coverage'' (*21 Million Children*).

The proposed language is purposely broad, ensuring that child support guidelines consider not only health insurance coverage that may be available from either, or both parents, but also how the parents will meet the child's health care needs when no insurance is available, when the cost of insurance is beyond the reasonable means of the parents, or where the cost is extraordinary or unreimbursed by insurance. It is possible that both health insurance coverage and cash medical support would be included in a support order. For example, where a custodial parent has access to maintain health insurance coverage for the parties' child, the noncustodial parent may be required to pay a share of the premium's cost. And each parent may be ordered to pay a fixed sum or a percentage of the cost of allergy shots, or orthodontic treatment or psychological counseling, not covered by insurance.

This regulation does not mandate that State guidelines label the payment of medical costs as a stand-alone item. States are free to incorporate health costs within an existing methodology, such as those described below, so long as the insurance and resources of both parents are considered. The sole limitation is that considerations of accessibility and affordability must be addressed in accordance with § 303.31(b), as proposed.

Currently, the health insurance premium to cover the child is generally either deducted from the income of the parent providing coverage or treated as an ''add on'' to the basic support obligation, which may be further apportioned. Uninsured and extraordinary medical expenses are usually either an ''add on'' or treated as a factor allowing deviation from the guideline amount.

The Working Group acknowledged the variation in approach. The elected methodology clearly affects the amount of the support obligation. These are policy choices left to each State. Each State should ensure that its child support guidelines address with specificity how the cash child support award would then ''* * * increase or decrease in order to account for health care premiums, and child support orders should clearly specify how such amounts are to be allocated between the parents'' (*21 Million Children*).

Part 303

As discussed below, we propose one change to case closure regulations at § 303.11, to address the circumstances under which a child-only Medicaid case receiving IV–D services may be closed.

The other proposed amendments to part 303 incorporate major recommendations of the Working Group. They shift the focus of providing health insurance from the non-custodial parent with an employer-related or other group plan, to either parent, to the extent that insurance coverage is accessible and available at reasonable cost. The amendments also broaden medical child support by specifically addressing cash medical support.

Section 303.11—Case Closure Criteria

Section 303.11(b)(11) states that in order to be eligible for closure, a case must meet the following criterion: ''In a non-IV–A case receiving services under section 302.33(a)(1)(i) or (iii), the IV–D agency documents the circumstances of the recipient of services's noncooperation and an action by the recipient of services is essential for the next step in providing IV–D services.''

Currently § 303.11(b)(11) allows case closure for noncooperation only for IV–D applicants (§ 302.33(a)(1)(i)) or *former* IV–A, IV–E foster care or Medicaid families (§ 302.33(a)(1)(iii)). States have complained about lack of cooperation by custodial parents of children in child-only Medicaid cases and the inability to either ensure cooperation or close the case.

If, in a child-only Medicaid case, the IV–D agency documents that the custodial parent has not cooperated and an action by the custodial parent is essential for the next step in providing IV–D services, we believe it would be appropriate, after meeting notice and waiting period requirements under § 303.11(c), for the IV–D agency to close the case under § 303.11(b)(11). We propose to authorize a State IV–D agency to close such cases for noncooperation by adding references in § 303.11(b)(11) to child-only Medicaid cases receiving services under § 302.33(a)(1)(ii), which requires IV–D agencies to provide services to non-IV–A Medicaid recipients. We do this by expanding the reference in this section to include the whole of § 302.33(a)(1). However, we continue to encourage State Medicaid agencies to refer cases to IV–D agencies when it is appropriate, and to develop criteria and procedures, in conjunction with State IV–D agencies, for appropriate referrals.

The proposed regulation would authorize States to close these cases using the Secretary's rulemaking authority under section 1102 of the Act to ensure efficient administration of his functions under section 452 of the Act. The Secretary is responsible under section 452(a)(1) for setting standards determined to be necessary to assure IV–D programs will be effective. Allowing States to close cases when the custodial parent is not cooperating with the IV–D agency will allow States to focus on cases in which the custodial parent is cooperating with the State in

its efforts to secure support for his/her children.

Section 303.31—Securing and Enforcing Medical Support Obligations

Section 303.31(a)

We have added a new paragraph (a)(1) to define cash medical support as ''an amount ordered to be paid toward the cost of health insurance provided by a public entity or by another parent through employment or otherwise, or for other medical costs not covered by insurance.'' This would include the cost of: (1) Premiums when health insurance is provided by another parent or through Medicaid or SCHIP; (2) medical care such as orthodontia not covered by available health insurance; or (3) medical costs when no reasonable or accessible insurance is available. A health insurance premium or cash medical support obligation is current support for purposes of distribution and allocation between cash child support and cash medical support, as discussed later in this preamble.

Currently, § 303.31(a)(2) specifies that health insurance includes fee for service, health maintenance organization, preferred provider organization, and other types of coverage under which medical services could be provided to dependent children of noncustodial parents. We propose to amend § 303.31(a)(2) by deleting reference to the noncustodial parent and referring instead to either parent to clarify that either parent could be ordered to provide health care coverage.

Under current § 303.31(a)(1), health insurance is considered reasonable in cost if it is available through an employment-related or other group health insurance, regardless of service delivery mechanism. We proposed to renumber this provision as § 303.31(a)(3) and to revise it as follows: ''Cash medical support or private health insurance is considered reasonable in cost if the cost to the obligated parent does not exceed five percent of his or her gross income or, at State option, a reasonable alternative income-based numeric standard defined in State child support guidelines adopted in accordance with § 302.56(c).'' We are using the Secretary's rulemaking authority under section 1102 of the Act to update an obsolete regulatory requirement to recognize the evolution of the health care system over the past decade, particularly with respect to availability of health insurance through the workplace. Use of 1102 authority to update this definition would eliminate the requirement for IV–D programs to consider health insurance available through employment to be reasonable in cost, and contribute to the State's and Secretary's responsibilities to operate effective programs.

A major focus of the Working Group's recommendations was redefining ''reasonable cost'' in existing regulations. Research completed after *21 Million Children* supported the Working Group's recommendation that it was appropriate to remove from the regulation the conclusion that health insurance through the noncustodial parent's employer is *de facto* available at reasonable cost. During its consultation process on the Working Group's recommendations, OCSE has been urged to change the existing regulation to provide a definition of reasonable cost that considers the parent's ability to pay.

The proposed rule changes in this Notice adopt the Working Group's conclusion that a new measure is required to ascertain whether private health insurance is ''reasonable in cost.'' For many, the cost of obtaining such coverage, even when offered by an employer, is beyond their reasonable means.

The trend over the last 20 years is significantly increased employee costs for ESI coverage. At the time the existing regulation was enacted, a majority of employers offered dependent health care coverage to their employees at little or no cost. A 1997 General Accounting Office report estimated that ''* * * in 1980, 51 percent of employers who offered dependent coverage fully subsidized the cost, but in 1993, only 21 percent of employers did so.'' The recent Census Bureau report, *Health Insurance Coverage in the United States: 2002,* reports that 30.8 percent of workers employed for firms with fewer than 25 employees are covered by their own ESI, compared with 68.7 percent of covered workers in firms with 1000 or more employees. Even within the few years since *21 Million Children* was published, the cost to employees has risen to more than 50 percent of the average child support received (U.S. Census Bureau, *Child Support for Custodial Mothers and Fathers 1997*).

State child support enforcement officials have been concerned that the cost of health insurance would dramatically and disproportionately reduce the cash child support award, leaving the custodial parent with insufficient funds to meet the child's daily living expenses, and/or so impoverish the noncustodial parent as to remove his or her incentive to work.

After considerable debate, the Working Group recommended that private health insurance coverage be deemed reasonable if the cost does not exceed five percent of the gross income of the parent who provides the coverage (*21 Million Children*). During the consultation process, OCSE was made aware that States, professional organizations and advocacy groups were engaged in considerable discussion over this recommendation and varied in their position. The main division was whether each State should be able to set the threshold for reasonableness under its own guidelines—as some already do—or whether the Working Group's five percent of gross income standard should be adopted.

Recently, two States have considered how best to handle medical support enforcement. A New Jersey grant project endorsed a standard of reasonableness measured against five percent of the net income of the person ordered to provide coverage. However, no coverage would be required from ''parents whose net income is at or below 200 percent of the Federal poverty level,'' unless the coverage is available at no cost to the parent. See *A Feasibility Study for Review and Adjustment for Medical Support and SCHIP Collaboration (Feasibility Study)*. New Jersey's report is available at *http://www.acf.hhs.gov/programs/cse/pol/dcl/dcl-03–10.htm*.

Minnesota's Medical Child Support Workgroup recommended that no contribution for medical support be required from parents with incomes below 150 percent of poverty. For those with net incomes between 150 and 275 percent of the Federal poverty level, five percent of adjusted gross income is ordered toward the cost of medical support. Minnesota's December 2002 Report is available at (*www.dhs.state.mn.us/ecs/ChildSupport/Reports*). The limitations on ordering a low-income parent to provide health insurance offered in both studies mirror, in concept, best practice recommendations in *21 Million Children:* Unless insurance is available from an employer without an employee contribution, enrollment should not be ordered against either a parent with income at or below 133 percent of the Federal poverty level or one whose child is covered by Medicaid due to the enrolling parent's income.

Proposed § 303.31(a)(3) is similar to the Working Group's five percent of gross income recommendation and clarifies that ''reasonable cost'' considerations apply where a tribunal is ordering health insurance coverage and/or cash medical support. However, this rule allows States the option of

adopting, as part of their child support guidelines under § 302.56, an alternate standard, *that is reasonable, income-based and numeric*. We appreciate that there are competing interests in establishing a reasonable cost standard and particularly welcome comments on this issue.

In addition, the proposed definition recognizes the possibility that one parent may have access to health insurance but the other parent may be ordered to bear a portion or all of the cost of the insurance. Therefore, the proposed regulation refers to the cost of private health insurance that does not exceed five percent of the *obligated* parent's gross income.

Section 303.31(b)

Currently, under § 303.31(b), the introductory text specifies that medical support enforcement services will be provided if rights to medical support have been assigned to the State as a condition of receiving Medicaid. We propose to amend the introductory text of § 303.31(b) by deleting the reference to assignment of medical support rights to the State since the IV–D agency must provide medical support enforcement services to all IV–D recipients.

Sections 303.31(b)(1)–(4)—Addressing Medical Support in Child Support Orders

To incorporate the concepts of including medical support (health insurance and/or cash medical support) in every order, we propose to revise § 303.31(b)(1)–(4).

Under existing § 303.31(b)(1), the IV–D agency is required to petition for medical support in a new or modified child support order if the noncustodial parent has health insurance available at reasonable cost, unless the custodial parent and child(ren) have satisfactory health insurance other than Medicaid. From consultations with our individual State partners, and as discussed later in this preamble, we believe there is a national consensus that simply ignoring the availability of health care through the custodial parent's employment is not in the best interest of children.

A second concern with the current rule is that it may require the noncustodial parent to pay for health insurance coverage that is not accessible to the child, due to distance or to plan restrictions that make it virtually worthless for the child. A Working Group Recommendation proposes a modification to Federal regulation: The decision-maker establishing or modifying a child support order must determine whether either the custodial or noncustodial parent is able to obtain *appropriate* health insurance coverage. If appropriate coverage is available, it is to be ordered. *Appropriateness* is based on three factors. The first, *affordability* or *reasonable cost*, has been discussed above and is included in these regulations.

The second component of ''appropriateness'' is *accessibility*. Health insurance has little or no value if the child does not have geographic access to the services provided by the coverage. Part of the Working Group's new paradigm for setting medical child support orders is that coverage should *not be ordered* where the services and providers are unavailable to the child in practical terms. The Working Group recommends that enrollment of a child in private health care coverage is not required unless the coverage is found to be: available for at least one year based on the work history of the parent providing coverage *and* with the child living within the geographic area covered by the plan or within 30 minutes or 30 miles of primary care services. The Working Group further suggests that States be permitted to enact an alternate standard.

OCSE agrees that health insurance should not be mandated when the covered child cannot use it. However, we found no consensus among our partners on how to define accessibility and concluded that this is not an area in which the Federal government should be prescriptive. Thus, the provisions contained in this proposed rule make it a State responsibility to define under what circumstances health insurance is ''accessible.''

States are free to incorporate a definition that addresses only geographic access to services or also to address the continuity problem recognized by the Working Group. There is no public consensus on whether and how to measure the value of private health insurance to a child when it is frequently disrupted. For example, New Jersey's proposed medical support guidelines do consider the stability of coverage based on whether it is likely to be in place for at least one year (*Feasibility Study*). Again, we concluded that this judgment is best left to the individual States.

The third component of ''availability'' that the Working Group recommends is whether the health insurance plan is *comprehensive*. We concluded that this third measure should not be explicitly addressed in Federal requirements, beyond the existing requirement in § 303.32(c)(8), relating to the NMSN, under which IV–D agencies must choose among insurance plans if more than one is available and the child is not yet enrolled as ordered.

The Working Group also concluded that parents have the primary responsibility to meet their children's needs, including health care coverage. When one or both parents can provide ''accessible and affordable health care,'' that coverage should not be replaced by the expenditure of public funds from either Medicaid or SCHIP (*21 Million Children*). Given the importance of medical support to the well being of children, we propose that each newly-established or modified order must directly address medical support, whether or not private health insurance is currently available. To petition for such relief is ineffective without a corresponding, comprehensive mechanism for determining how courts or administrative hearing bodies will allocate this responsibility between the parents, under some circumstances subsidized by public benefits.

Rather than looking exclusively to the noncustodial parent, private insurance available to both the custodial and noncustodial parent should be considered. And while section 452(f) of the Act only requires states to *enforce* medical support orders when the obligor is the noncustodial parent, section 466(a)(19) of the Act requires that States have in effect laws requiring the use of procedures under which all child support orders enforced under title IV–D of the Act ''shall include a provision for medical support for a child to be provided by either or both parents.'' States will be required to submit an amended State plan page providing assurances that laws and procedures require inclusion of medical support provisions in new and modified orders. Given both demographics and relative ease of use, the Working Group concludes that, quite opposite to the current rule, there should be a preference for coverage available to the custodial parent with financial contribution by the noncustodial parent. Not only does this expand the pool of available private health coverage but it also provides coverage that is generally more accessible to the custodian than that provided by the noncustodial parent.

Under proposed paragraph (b)(1), the State must petition the court or administrative authority to include private health insurance coverage in the support order if it is accessible to the child and available at reasonable cost to the obligated parent. If private health insurance is not available, then under proposed paragraph (b)(2), the IV–D agency must petition to include a provision for cash medical support in

all new and modified orders, to continue until accessible insurance becomes available at reasonable cost. As defined by proposed paragraph (a)(1), cash medical support includes not only payments to cover a child's uninsured medical expenses but also may include an amount to be paid toward the cost of health insurance provided through a government program, such as Medicaid or SCHIP, or privately by the other parent. For example, if a custodial parent of a child enrolled in SCHIP is required to pay a co-payment or premium for SCHIP, the cash medical support obligation of the noncustodial parent could be used to pay or reimburse the custodial parent for any co-payment or premium owed to SCHIP.

We are proposing paragraphs (b)(1) and (2) using the Secretary's rulemaking authority under section 1102 of the Act to increase the effectiveness of State IV–D programs and therefore allow for more efficient administration of the Secretary's responsibilities under section 452 of the Act. Incorporating the concept of accessibility of health care as well as providing for a cash medical support obligation in the absence of health insurance coverage will ensure an increase in the availability of health insurance coverage for children, and, if that is not possible, provide for cash medical support to contribute to the child(ren)'s medical needs.

As it is possible for an order to include both an order to pay health insurance and cash medical support, this regulation specifically authorizes States to address both health insurance coverage and cash medical support. For example, pursuant to § 303.31(b)(1), where the custodial parent had health insurance coverage available through his/her employer, the decision-maker could first determine that the insurance was both accessible to the child (as defined by the State) and that the obligated parent's cost was less than five percent his/her gross income (or another income-based numeric standard enacted by the State). The obligated parent could be the custodial parent, the noncustodial parent, or both parents, depending on the circumstances in the particular case, the State's guidelines, and how responsibilities are shared between the parties. If so, the child support order could require the custodial parent to enroll the child in the health insurance plan.

The support order could specify which parent is responsible for the cost of obtaining the coverage or allocate responsibility for costs between the parents. For example, should the custodial parent have access to health insurance, and the cost of the insurance does not exceed five percent of the noncustodial parent's gross income, the custodial parent could enroll the child(ren) and the State could order the noncustodial parent to pay cash medical support towards the cost of the employee's share of health insurance coverage by the custodial parent. It would be up to the State to determine how the premium is paid, directly by the noncustodial parent to the plan administrator or as reimbursement to the custodial parent should he or she have premiums withheld from his or her income.

The order should also address allocation of the cost of any uncovered expense—co-payments, deductibles, unreimbursed or extraordinary expenses. The same scenario applies where the noncustodial parent has accessible coverage, available at reasonable cost.

However, private insurance may be found to be unavailable where: neither parent has access to employer-sponsored or group coverage; the cost of enrollment exceeds five percent of the obligated parent's gross income (or other standard elected by the State); or the noncustodial parent's insurance is not accessible to the child. In such a case, a new or modified support order must contain a provision for cash medical support in lieu of health insurance, consistent with the state's guidelines. The amount of cash medical support must be reasonable as defined under paragraph (a)(3). The amount paid could be used to contribute to the cost of a government health insurance program and/or to cover a child's medical needs not covered by health insurance.

If no private health insurance is available, the cash medical support provision would continue until insurance becomes available and the order is modified accordingly. State law, guidelines, and procedures would determine the mechanism to modify the support order when private insurance becomes available (for example, using administrative adjustment, automatic modifications, or review and modification by the issuing tribunal).

We appreciate that there are competing interests in how States will accommodate these changes to establishing medical support. Will changes to State child support guidelines be required? How will cash medical support be designated? How will orders be modified once private health insurance becomes available? We particularly welcome comments on these issues.

Under current § 303.31(b)(2), the IV–D agency is required to petition for inclusion of medical support in a new or modified support order whether or not health insurance is available to the noncustodial parent at the time the order is entered or the children can be immediately added to the health care coverage. We propose to delete this section because under the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), an employer receiving a QMCSO, including a NMSN, is required to immediately enroll the child in the health plan, without regard to open enrollment periods. Therefore, because of the OBRA '93 requirement, children can be immediately added to the health care coverage and paragraph (b)(2) is no longer accurate.

Currently, under § 303.31(b)(3), the IV–D agency is required to establish written criteria to identify cases without a medical support order when there is high potential for obtaining medical support based upon evidence that health insurance may be available to the noncustodial parent at a reasonable cost. We propose to revise this section, changing ''cases'' to ''orders'', deleting the reference to the noncustodial parent, since either parent could provide health care coverage, and adding a cross-reference to § 303.8(d). Section 303.8(d) requires that the ''need to provide for the child's health care needs in the order, through health insurance or other means, must be an adequate basis under State law to initiate an adjustment of an order, regardless of whether an adjustment in the amount of child support is necessary.'' States are free to define their own criteria so long as, at a minimum, the State meets the requirement in § 303.8(d) and includes as criteria: evidence, such as from New Hire reporting or another database or reporting process that health insurance is now available to the obligated parent; and other facts, as defined by the State, and Federal review and adjustment requirements in § 303.8(d), that are sufficient to warrant modification of the order to include medical support.

Currently, under § 303.31(b)(4), the IV–D agency is required to petition the court or administrative authority to modify a support order to include medical support in the form of health insurance coverage when cases meet the modification criteria established by the State for inclusion of medical support. We propose in § 303.31(b)(4) to petition for medical support and to require the IV–D agency to petition the court or administrative authority to modify support orders to include medical support in accordance with the proposed regulation when cases meet the modification criteria for inclusion of medical support discussed above.

Sections 303.31(b)(5)–(b)(9), and (c)—Securing and Enforcing Medical Support Obligations

We propose deleting current §§ 303.31(b)(5), (7) and (9) that require the IV–D agency: to provide the custodial parent with ''information pertaining to the health insurance policy'' obtained under a support order; to enforce health insurance coverage ordered but not obtained; and to request that employers and health insurers inform the agency of lapses in coverage. Under OBRA '93, the plan administrator is required to provide information and forms regarding the child's coverage directly to the custodial parent. This requirement is included on the NMSN. Therefore, the requirement in paragraph (b)(5) for the IV–D agency to do so is no longer necessary. Since states are required to use the NMSN to enforce all orders for health insurance coverage under § 302.32, the separate requirement to do so under paragraph (b)(7) is unnecessary. The employer's responsibility to notify the IV–D agency when an employee-obligor's health insurance has lapsed under paragraph (b)(9) is contained in § 303.32(c)(6) and on the NMSN itself.

In accordance with the deletions of these sections, the remaining paragraphs have been renumbered. Existing paragraph (b)(6) becomes proposed (b)(5) and existing paragraph (b)(8) becomes proposed (b)(6).

Paragraph 303.31(c) continues to require that medical support services shall be provided to individuals eligible for services under § 302.33.

Section 303.32—National Medical Support Notice

Currently, under § 303.32(c)(4), employers must withhold any employee share of premiums and send any amount withheld directly to the insurance plan. States are required to allocate amounts available for income withholding across multiple orders under § 303.100(a)(5), recognizing that there may be insufficient funds to meet all of the orders/notices for withholding. Similar situations will occur where the employee's income is insufficient to meet the mandates to withhold both payments for health insurance premiums required by the NMSN and cash child support under an income withholding order.

Both the Working Group and our individual state partners with whom we discussed these issues raised concern that the cost of health insurance might adversely impact funds available for cash child support, particularly where the obligor is under a support order for more than one family. This proposed regulation incorporates an allocation priority presented in *21 Million Children*. Using our rulemaking authority under section 1102 of the Act, the proposed regulation places current cash child and spousal support first in priority, followed by health insurance and cash medical support, then arrearages, and finally other child support obligations. However, it affords the State decision-maker the opportunity to require a different allocation when the best interest of the child so dictates. Some existing State laws may need to be amended to meet this proposed requirement.

We propose to revise existing paragraph 303.32(c)(4) requiring the employer to withhold employee contributions for health coverage for the children and forward them to the plan. Proposed paragraph (c)(4) would require employers to:

''(i) Withhold any obligation of the employee for employee contributions necessary for coverage of the child(ren), and send any amount withheld directly to the plan; or (ii) Where there are insufficient funds available to meet the employee's contribution necessary for coverage of the child(ren) and also to comply with any withholding orders received by the employer under § 303.100 of this part, up to the limits imposed under section 303(b) of the Consumer Credit Protection Act (15 U.S.C. 1673(b)), the employer shall allocate the funds available in accordance with § 303.100(a)(5) and the following priority, unless a court or administrative order directs otherwise:

(A) Current child and spousal support;

(B) Health insurance premiums or current cash medical support;

(C) Arrearages; and

(D) Other child support obligations.''

This proposed hierarchy places health insurance premiums or current cash medical support before payment of arrearages because premiums and cash medical support are considered current support for distribution purposes.

Finally, under current § 303.32(d), the effective date for implementing the use of the NMSN is specified. We are deleting this paragraph as unnecessary because all States are using the NMSN. The remainder of § 303.32 is unchanged. Using the Secretary's authority to regulate under section 1102 of the Act to specify the appropriate allocation of available funds for health insurance premiums, current child support and current cash medical support will ensure consistency across State programs and therefore contribute to the effective operation of IV–D programs. This allocation formula responds, along with the National Medical Support Notice, to the Secretary's responsibility under section 452(f) of the Act to issue regulations governing the enforcement of medical support when included as part of a child support order.

Part 304

Section 304.20—Availability and Rate of Federal Financial Participation (FFP)

Currently, under § 304.20(b)(11), FFP is available for services and activities under approved IV–D State plans, including required medical support activities as specified in §§ 303.30 and 303.31. To include reference to the NMSN requirements in § 303.32, we propose to revise § 304.20(b)(11), to read as follows: ''Required medical support activities as specified in §§ 303.30, 303.31, and 303.32 of this chapter.''

Part 305

Section 305.63—Standards for Determining Substantial Compliance With IV–D Requirements

Currently, under § 305.63(c)(5), for the purposes of optional Federal audits to determine substantial compliance with State plan requirements, the State must provide certain specified required medical support services in at least 75 percent of the cases reviewed. We propose to add the requirements under § 302.32, the National Medical Support Notice (NMSN), to the program services subject to the substantial compliance audit because of the importance of ensuring that States meet Federal requirements for use of the NMSN.

We are using our rulemaking authority under section 1102 of the Act to include reference to the National Medical Support Notice requirements under § 302.32 in both the Federal audit authority under § 305.63 and the State self-assessment requirements in § 308.2 below. The Secretary may conduct audits, in accordance with section 452(a)(C) of the Act, when appropriate, to determine the effectiveness of State programs. These Federal audits and State self-assessments combine to ensure that States operate efficient and effective IV–D programs.

Part 308

Section 308.2—Required Program Compliance Criteria

Currently under § 308.2(e), for purposes of the State's annual self-assessment review and report, the State must evaluate whether it has provided certain specified required medical support services in at least 75 percent of the cases reviewed. We are adding reference to use of the NMSN as required in § 303.32 to the self-assessment process because we failed to

do so when the NMSN was finalized. States should determine as part of their annual self-assessments whether Federal requirements with respect to use of the NMSN are being met.

We proposed to revise § 308.2(e) by deleting current § 308.2(e)(2), (5), (6), and (7) since these required program compliance criteria refer to requirements in § 303.31 that have been deleted in the proposed regulation and to make the self-assessment requirements consistent with other changes to the medical support enforcement requirements made by this regulation. Proposed § 308.2(e)(1) would require a determination of whether the State is meeting its obligation to include medical support that is reasonable and accessible, in accordance with § 303.31(b) in at least 75 percent of new or modified support orders.

Under proposed § 308.2(e)(2), States are required to assess their own performance according to their criteria: ''If reasonable and accessible health insurance was available and required in the order, but not obtained, determine whether the National Medical Support Notice was used to enforce the order in accordance with the requirements in § 303.32 of this chapter.'' Current § 308.2(e)(4) requires States to report whether the State Medicaid agency was informed ''* * * that coverage had been obtained when health insurance was obtained,'' has been renumbered as proposed § 308.2(e)(3) and the cross-referenced section has been amended to cite § 303.31(b)(5), to comport with the changes elsewhere in these proposed regulations.

We propose to add a new § 308.2(e)(4) for States to assess their own performance with the use of the NMSN: ''Determine whether the State transferred notice of the health care provision, using the National Medical Support Notice required under § 302.32 of this chapter, to a new employer when a noncustodial parent was ordered to provide health insurance coverage and changed employment and the new employer provides health care coverage.''

Paperwork Reduction Act

Under the Paperwork Reduction Act of 1995, Public Law 104–13, all Departments are required to submit to the Office of Management and Budget (OMB) for review and approval any reporting or recordkeeping requirements inherent in a proposed or final rule. Interested parties may comment to OMB on these reporting requirements as described below. This NPRM contains changes to reporting requirements in Part 308, which the Department has submitted to OMB for its review.

Section 308.1(e) contains a requirement that a State report the results of annual self-assessment reviews to the appropriate OCSE Regional Office and to the Commissioner of OCSE. The information submitted must be sufficient to measure State compliance with Federal requirements for expedited procedures and to determine whether the program is in compliance with title IV–D requirements and case processing timeframes. The results of the report will be disseminated via ''best practices'' to other States and also be used to determine whether technical assistance is needed. The State plan preprint page for this requirement (page 2.15, State Self-assessment and Report) was approved by OMB on January 18, 2001, under OMB Number 0970–0223.

The revisions to section 308.2(e), which address securing and enforcing medical support, will slightly reduce the paperwork burden on States, by eliminating three information collection and reporting requirements because, under these proposed regulations, medical support will be included in all new and modified support orders, but the reduced paperwork burden would be negligible.

Respondents: State child support enforcement agencies in the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

This information collection requirement will impose the estimated total annual burden on the agencies described in the table below:

Information collection	Number of respondents	Responses per respondent	Average burden hours per response	Total annual burden hours
Section 308.1	54	1	3,866	208,764

The Administration for Children and Families (ACF) will consider comments by the public on the proposed information collection in order to evaluate the accuracy of ACF's estimate of the burden of the proposed collection of information. Comments by the public on this proposed collection of information will be considered in the following areas:

• Evaluating the accuracy of the ACF estimate of the burden of the proposed collection[s] of information, including the validity of the methodology and assumptions used;

• Enhancing the quality, usefulness, and clarity of the information to be collected; and

• Minimizing the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technology, e.g., permitting electronic submission of responses.

OMB is required to make a decision concerning the collection of information contained in these proposed regulations between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment is best assured of having its full effect if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment to the Department on the proposed regulations. Written comments to OMB for the proposed information collection should be sent directly to the following: Office of Management and Budget, Paperwork Reduction Project, 725 17th Street, NW., Washington, DC 20503, Attn: Desk Officer for the Administration for Children and Families.

Regulatory Flexibility Analysis

The Secretary certifies, under 5 U.S.C. 605(b), and enacted by the Regulatory Flexibility Act (Pub. L. 96–354), that these proposed regulations will not result in a significant impact on a substantial number of small entities. The primary impact is on State governments. State governments are not considered small entities under the Act.

Regulatory Impact Analysis

Executive Order 12866 requires that regulations be reviewed to ensure that they are consistent with the priorities and principles set forth in the Executive Order. These proposed rules provide solutions to problems in securing private health care coverage for children who live apart from one or both of their parents and the Department has determined that they are consistent with the priorities and principles set forth in the Executive Order.

These proposed regulations implement section 7307 of the Deficit Reduction Act of 2005, the Administration's proposal to require States to consider medical support available to either parent in establishing a medical support obligation, and to enforce medical support at their option when the obligated parent is the custodial parent. They also address certain recommendations of the Medical Child Support Working Group, which included public deliberation, and additional input from state and local IV–D administrators and other child support enforcement stakeholders.

There are no costs associated with these proposed rules. They do not introduce new requirements for including medical support in child support orders, a long-standing program requirement, but rather broaden States options for addressing the availability and accessibility of health care coverage. For example, by focusing on health insurance coverage available to either parent, these rules recognize that untapped employer-sponsored insurance through custodial mothers and their spouses might reduce the share of children without private health insurance. As discussed earlier in the preamble, an HHS study *Health Care Coverage Among Child Support-Eligible Children, 2002,* found that half of child support-eligible children living with their mother are currently covered by employer-sponsored insurance.

These regulations are significant under section 3(f) of the Executive Order because they raise novel policy issues and therefore have been reviewed by the Office of Management and Budget.

Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act requires that a covered agency prepare a budgetary impact statement before promulgating a rule that includes any Federal mandate that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more in any one year. The Department has determined that these proposed regulations would not impose a mandate that will result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of more than $100 million in any one year.

Congressional Review

These proposed regulations are not a major rule as defined in 5 U.S.C., chapter 8.

Assessment of Federal Regulations and Policies on Families

Section 654 of the Treasury and General Government Appropriations Act of 1999 requires Federal agencies to determine whether a proposed policy or regulation may affect family well-being. These proposed regulations will have a positive impact on family well-being as defined in the legislation, by providing greater access to health care coverage.

Executive Order 13132

Executive Order 13132 on Federalism applies to policies that have federalism implications, defined as ''regulations, legislative comments or proposed legislation, and other policy statements or actions that have substantial direct effects on the States, or on the distributions of power and responsibilities among the various levels of government''. These proposed regulations do not have federalism implications for State or local governments as defined in the Executive Order.

List of Subjects

45 CFR Part 302

Child support, Grant programs/social programs, Reporting and recordkeeping requirements.

45 CFR Parts 303 and 304

Child support, Grant programs/social programs, Reporting and recordkeeping requirements.

45 CFR Part 305

Child support, Grant programs/social programs, Accounting.

45 CFR Part 308

Auditing, Child support, Grant programs/social programs, Reporting and recordkeeping requirements.

(Catalog of Federal Domestic Assistance Programs No. 93.563, Child Support Enforcement Program)

Dated: February 16, 2006.

Wade F. Horn,

Assistant Secretary for Children and Families.

Approved: June 20, 2006.

Michael O. Leavitt,

Secretary, Department of Health and Human Services.

For the reasons discussed above, title 45 CFR chapter III is amended as follows:

PART 302—STATE PLAN REQUIREMENTS

1. The authority citation for part 302 continues to read as follows:

Authority: 42 U.S.C. 651 through 658, 660, 664, 666, 667, 1302, 1396a(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), 1396(k).

2. Amend § 302.56 by revising paragraph (c)(3) to read as follows:

§ 302.56 Guidelines for setting child support awards.

* * * * *

(c) * * *

(3) Address how the parents will provide for the child(ren)'s health care needs through health insurance coverage and/or through cash medical support in accordance with § 303.31(b) of this chapter.

* * * * *

PART 303—STANDARDS FOR PROGRAM OPERATIONS

1. The authority citation for part 303 continues to read as follows:

Authority: 42 U.S.C. 651 through 658, 660, 663, 664, 666, 667, 1302, 1396a(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), and 1396k.

§ 303.11 [Amended]

2. In § 303.11, amend paragraph (b)(11) by removing ''(i) or (iii)'' after ''§ 302.33(a)(1).''

3. Revise § 303.31 to read as follows:

§ 303.31 Securing and enforcing medical support obligations.

(a) For purposes of this section:

(1) Cash medical support means an amount ordered to be paid toward the cost of health insurance provided by a public entity or by another parent through employment or otherwise, or for other medical costs not covered by insurance.

(2) Health insurance includes fee for service, health maintenance organization, preferred provider organization, and other types of coverage which is available to either parent, under which medical services could be provided to the dependent child(ren).

(3) Cash medical support or private health insurance is considered reasonable in cost if the cost to the obligated parent does not exceed five percent of his or her gross income or, at State option, a reasonable alternative income-based numeric standard defined in State child support guidelines adopted in accordance with § 302.56(c).

(b) The State IV–D agency must:

(1) Petition the court or administrative authority to include health insurance that is accessible to the child(ren), as defined by the State, and is available to the obligated parent at reasonable cost, as defined under paragraph (a)(3) of this section, in new or modified court or administrative orders for support;

(2) If health insurance described in paragraph (b)(1) of this section is not available at the time the order is entered or modified, petition to include cash medical support in new or modified orders until such time as health insurance, that is accessible and reasonable in cost as defined under paragraph (a)(3) of this section, becomes available. In appropriate cases, as defined by the State, cash medical support may be ordered in addition to health insurance coverage.

(3) Establish written criteria to identify orders that do not address the health care needs of children based on—

(i) Evidence that health insurance may be available to either parent, and

(ii) Facts, as defined by State law, regulation, procedure, or other directive, and review and adjustment requirements under § 303.8(d) of this part, which are sufficient to warrant modification of the existing support order to address the health care needs of children in accordance with paragraphs (b)(1) and (2) of this section.

(4) Petition the court or administrative authority to modify support orders, in accordance with State child support guidelines, for cases identified in paragraph (b)(3) of this section to include health insurance and/or cash medical support in accordance with paragraphs (b)(1) and (b)(2) of this section.

(5) Inform the Medicaid agency when a new or modified court or administrative order for child support includes health insurance and/or cash medical support and provide the information referred to in § 303.30(a) of this part to the Medicaid agency when the information is available for Medicaid applicants and recipients.

(6) Periodically communicate with the Medicaid agency to determine whether there have been lapses in health insurance coverage for Medicaid applicants and recipients.

(c) The IV–D agency shall inform an individual who is eligible for services under § 302.33 of this chapter that medical support enforcement services will be provided and shall provide the services specified in paragraph (b) of this section.

4. Amend § 303.32 by revising paragraph (c)(4), and removing (d), to read as follows:

§ 303.32 National Medical Support Notice

* * * * *

(c) * * *

(4) Employers must:

(i) Withhold any obligation of the employee for employee contributions necessary for coverage of the child(ren), and send any amount withheld directly to the plan; or

(ii) Where there are insufficient funds available to meet the employee's contribution necessary for coverage of the child(ren) and also to comply with any withholding orders received by the employer under § 303.100 of this part, up to the limits imposed under section 303(b) of the Consumer Credit Protection Act (15 U.S.C. 1673(b)), the employer shall allocate the funds available in accordance with § 303.100(a)(5) of this chapter and the following priority, unless a court or administrative order directs otherwise:

(A) Current child and spousal support;

(B) Health insurance premiums or current cash medical support;

(C) Arrearages; and

(D) Other child support obligations.

* * * * *

PART 304—FEDERAL FINANCIAL PARTICIPATION

1. The authority citation for part 304 continues to read as follows:

Authority: 42 U.S.C. 651 through 655, 657, 1302, 1396a(a)(25), 1396b(d)(2), 1396b(o), 1396b(p), and 1396k.

§ 304.20 [Amended]

2. Amend § 304.20(b)(11) by removing ''§§ 303.30 and 303.31'' and adding ''§§ 303.30, 303.31, and 303.32'' in its place.

PART 305—PROGRAM PERFORMANCE MEASURES, STANDARDS, FINANCIAL INCENTIVES, AND PENALTIES

1. The authority citation for part 305 is revised to read as follows:

Authority: 42 U.S.C. 609(a)(8), 652(a)(4) and (g), 658A and 1302.

§ 305.63 [Amended]

2. Amend § 305.63(c)(5) by adding ''and § 302.32'' after ''under § 303.31''.

PART 308—ANNUAL STATE SELF-ASSESSMENT REVIEW AND REPORT

1. The authority citation for part 308 continues to read as follows:

Authority: 42 U.S.C. 654(15)(A) and 1302.

2. Amend § 308.2 by revising paragraph (e) to read as follows:

§ 308.2 Required program compliance criteria.

* * * * *

(e) *Securing and enforcing medical support orders.* A State must have and use procedures required under this paragraph in at least 75 percent of the cases reviewed. A State must:

(1) Determine whether support orders established or modified during the review period include medical support in accordance with § 303.31(b) of this chapter.

(2) If reasonable in cost and accessible health insurance was available and required in the order, but not obtained, determine whether the National Medical Support Notice was used to enforce the order in accordance with requirements in § 303.32 of this chapter.

(3) Determine whether the IV–D agency informed the Medicaid agency that coverage had been obtained when health insurance was obtained during the review period pursuant to § 303.31(b)(5) of this chapter.

(4) Determine whether the State transferred notice of the health care provision, using the National Medical Support Notice required under § 302.32 of this chapter, to a new employer when a noncustodial parent was ordered to provide health insurance coverage and changed employment and the new employer provides health care coverage.

* * * * *

[FR Doc. 06–7964 Filed 9–19–06; 8:45 am]

BILLING CODE 4184–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[DA 06–1757; MB Docket No. 05–111; RM–11200]

Radio Broadcasting Services; Cumberland Head, NY

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; dismissal.

SUMMARY: The Audio Division has dismissed the request of Dana J. Puopolo (''Puopolo'') to allot Channel 264A at Cumberland Head, New York. Puopolo filed a petition for rulemaking proposing the allotment of Channel 264A at Cumberland Head, as the community's first local FM transmission service. The proposal was dismissed for inability to provide useable service to the community due to destructive interference from Canadian Station CBF–FM.

FOR FURTHER INFORMATION CONTACT: Deborah Dupont, Media Bureau, (202) 418–2180.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's *Report and Order*, MB Docket No. 05–111, adopted August 31, 2006, and released September 5, 2006. The full text of this Commission decision is available for