MEDICAL SUPPORT 2.0:

Re-Positioning Medical Support in the Changing Landscape of Health Insurance

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July 27, 2018

Introduction

As the child support program has evolved, one of the continuing challenges for agencies has been how to ensure that a child has adequate medical coverage. The dwindling availability of affordable employer-sponsored insurance in conjunction with major expansions in public health insurance for children (and their parents) have drastically altered the ecosystem for medical support. Traditional medical support has been geared toward obtaining coverage for children through the employer or union of the non-custodial parent (NCP). However, as fewer employers offer family coverage, or even single coverage, and as the cost of family coverage has dramatically increased even when available, few NCPs can now provide stable and accessible coverage from employers or unions at a reasonable cost.

While options have become much more limited for obtaining stable, accessible, and affordable child health coverage from private sources through the NCP, public health insurance options have expanded. Medicaid, Children's Health Insurance Program (CHIP), and the Affordable Care Act (ACA) provide generally affordable coverage for children, and in most cases for their parents, up to 400 percent of the federal poverty level.

In recognition of this shift in realistic possibilities, the Flexibility, Efficiency, and Modernization Rule ("Final Rule") issued by the federal Office of Child Support Enforcement (OCSE) in December 2016, provided that public coverage is an allowable form of medical support in the Title IV-D child support enforcement program.[1] In January 2018, the CHIP program – along with Medicaid the most significant source of public health insurance coverage for children – was reauthorized for six years after a series of short-term extensions, and that six-year extension was lengthened to ten years in February 2018. Within the past year, efforts to repeal the Affordable Care Act were not successful, but tax legislation in December 2017 eliminated the ACA's individual mandate effective 2019. This removed a potential source of conflict between the ACA and medical support. Until the mandate is eliminated, the IRS enforces the health insurance requirement against the custodial parent if he/she claims the tax exemption for the child, while the child support program typically pursues the NCP to provide health insurance under its medical support provisions.

In the absence of explicit federal guidance, other than qualifying public coverage as an allowable form of medical support, most states have continued to pursue medical support with few if any changes. Yet, taken together, the declining availability of NCP-provided private insurance and the

[1] Action Transmittal 16-06, or *Federal Register* p. 93492, Volume 81, Number 244.

expansion of public coverage present the opportunity for states to streamline their medical support programs while providing more predictable and effective coverage for children and their parents.

This paper provides a more detailed description of these changes in the health insurance landscape and presents recommendations for achieving better health insurance coverage, while relieving IV-D programs and employers of unnecessary paperwork and expense. We call this approach Medical Support 2.0.

Dwindling Availability of NCP-Provided Health Insurance

When originally implemented, medical support was predicated on the notion that NCPs would typically have access to affordable health insurance through an employer, or in some cases through a union. In fact, medical support was initially deemed to be affordable if the NCP had access to health insurance through either of those sources, with no reference to the cost. As the years passed, this assumption became patently untenable and, in 2000, the Medical Child Support Working Group recommended that states establish affordability tests at five percent of NCP income. This recommendation was intended to ensure that the requirement for medical support, in conjunction with the requirement for cash support, was not onerous and did not materially diminish the amount of cash support that was ordered.[2]

In the years that have passed since the original requirement for medical support was established, health insurance costs have increased at a rate that greatly exceeds the overall rate of inflation. This has caused many employers to drop health insurance, to increase employee premiums, and/or reduce the value of employer-sponsored insurance by increasing employee out-of-pocket contributions such as copays, deductibles, and co-insurance. As a result, the availability of employer-sponsored health insurance to non-custodial parents has declined, and the availability of employer-sponsored health insurance that is affordable has declined even more. The decline in availability has stabilized somewhat since implementation of the Affordable Care Act, but the cost of employee premiums has made health insurance progressively less affordable.

As shown in Exhibit 1, only 53 percent of companies offered employer-sponsored insurance in 2017, based on a national employer survey by the Kaiser Family Foundation.[3] However, since most employees work for larger employers, 89 percent of workers are in companies that do offer health

[2] *21 Million Children's Health: Our Shared Responsibility. The Medical Child Support Working Group's Report*, submitted to U.S. Department of Labor and U.S. Department of Health and Human Services, June 2000, p. 3-28.

[3] Kaiser Family Foundation, *2017 Employer Health Benefits Survey*, https://www.kff.org/report-section/ehbs-2017-summary-of-findings/, September 19, 2017.

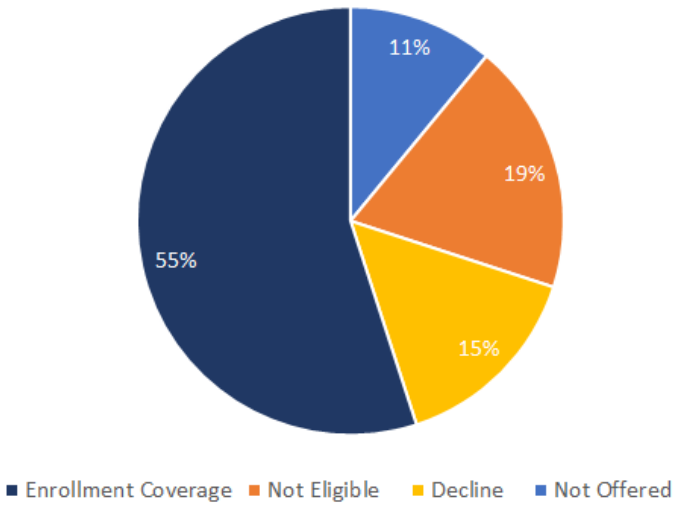
insurance. This suggests that availability of health insurance is much more widespread than implied by the statistic that only slightly more than half of employers actually offer health insurance.

Exhibit 1
Availability of Employer-Sponsored Insurance is Widespread (2017)

Unfortunately, the widespread availability significantly over-states how many employees obtain health insurance. As shown in Exhibit 2, below, only 55 percent of workers actually enroll. For 11 percent of employees, health insurance is not available, while an additional 19 percent are not eligible even though their employer offers it (probably due to waiting periods and part-time status). Another 15 percent decline coverage, most likely because of cost but in some cases because it may be available from another source (such as a spouse). [4]

[4] Kaiser Family Foundation, *2017 Employer Health Benefits Survey*.

Exhibit 2
But Only Limited Numbers of Workers Enroll
(2017)



However, even if coverage is available, paying for family premiums has become unaffordable for most NCPs. Most states have established quantitative tests for affordability of health insurance. Applying these affordability tests to median worker pay and comparing the amount available to pay for health insurance with average family premiums shows all too clearly why current employer policies are out of reach for most NCPs.

The federal Office of Child Support Enforcement (OCSE) website shows affordability tests for 32 states plus D.C. Of these:

- Five percent of net or gross income is the affordability test for 22 states plus D.C. This test follows the recommendation of the Medical Child Support Advisory Working Group.
- Eight percent of income is the affordability test for one state. This is similar to the affordability tests used in the ACA.
- Ten percent of income is the affordability test for three states.
- Other income levels are used for affordability tests in six states.

No information is presented for the remaining eighteen states.[5]

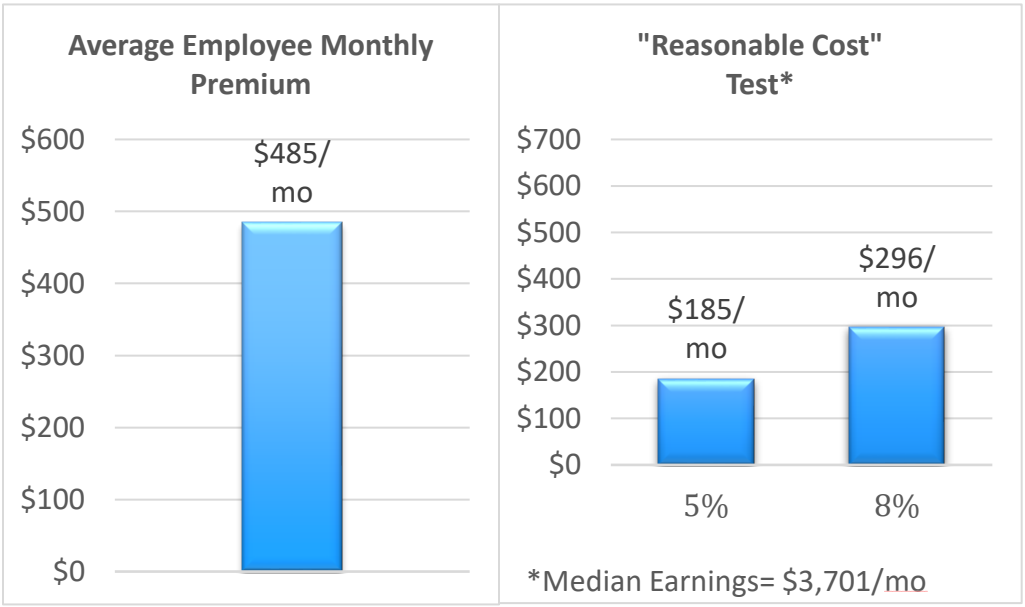
[5] https://ocsp.acf.hhs.gov/irg/irgpdf.pdf?geoType=OGP&groupCode=EMP&addrType=NMS&addrClassType=EMP

Exhibit 3, below, compares average family health insurance premiums with affordability tests applied to national median earnings. This comparison demonstrates how the average family health insurance premiums greatly exceed the ability to pay by workers with median earning levels.

As shown in the left-hand bar of Exhibit 3, the median earnings for all workers in the U.S. was $3,701 per month in 2017.[6] Moreover, given the demographics of the IV-D program, we would expect that well over half of all NCPs fall below this income level, so the national median earnings figure likely exceeds the median earnings level of most NCPs. The right-hand bars compare the amounts theoretically available to the median worker under the five and eight percent affordability tests with the average employee monthly premiums for family coverage. These average premium amounts are $485 per month.

As shown in this comparison, average employee premiums for family coverage are more than two and one-half times higher than a five percent affordability test. With an eight percent affordability test, the average family premium is still more than one and one-half times as high.

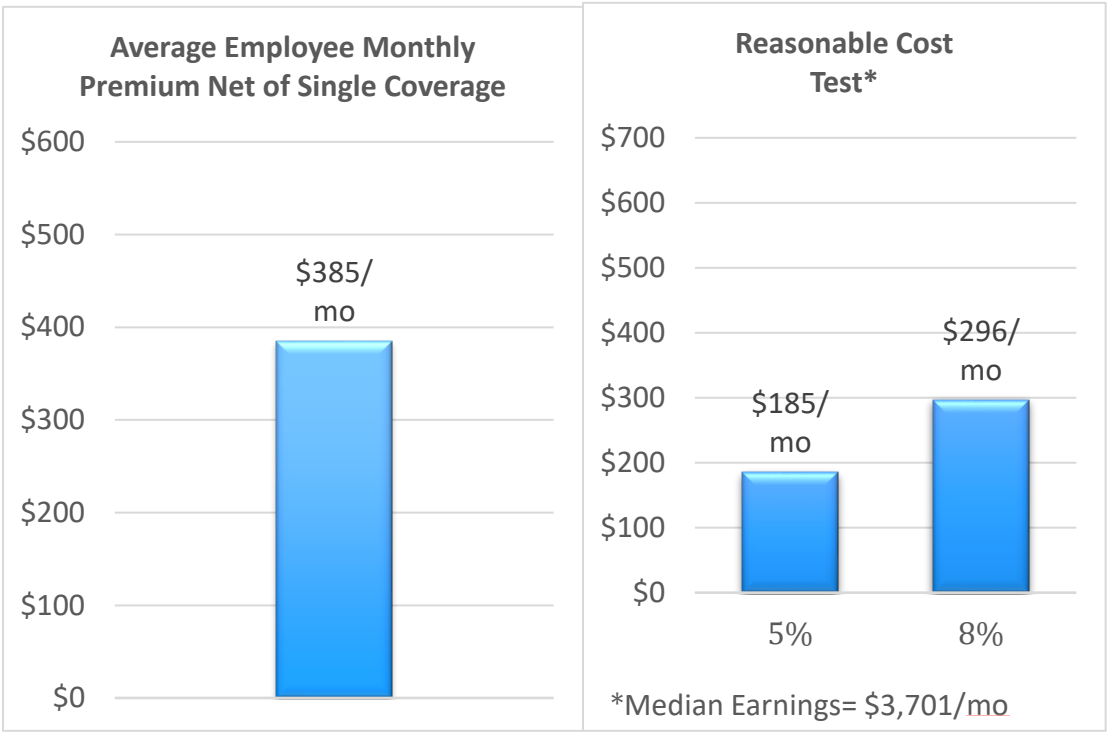
Exhibit 3
Even If Available, Family Insurance Premiums Greatly Exceed Affordability Tests for Most NCPs



6 U.S. Bureau of Labor Statistics, https://www.bls.gov/news.release/wkyeng.t01.htm. Figure cited is for fourth quarter 2017.

The affordability test is somewhat complicated, however, by the requirement in most states that the affordability test be applied to the incremental cost of covering the child(ren), relative to single coverage for the NCP, rather than to the total cost of family coverage. The average employee premium for single coverage in 2017 was $100 per month. As shown in Exhibit 4, subtracting that amount from the average employee premium for family coverage yields an estimated average of $385 per month for the incremental cost of adding family coverage. For the worker with median earnings, this estimated incremental cost is still more than twice as high as the five percent affordability test and 30 percent higher than the eight percent affordability test.

Exhibit 4
Even Incremental Family Premiums Greatly Exceed Affordability Tests



An additional consideration is that many NCPs change jobs frequently. Even if they have access to employer-sponsored health insurance that meets the reasonable cost test, their job tenure is often too short for that health insurance to be beneficial for the child(ren). Unpublished data from the U.S. Office of Child Support Enforcement indicates that the median length of an income withholding order is only five months. This is barely enough time in most cases for an agency to send a National Medical Support Notice (NMSN), obtain a response affirming available health insurance, and have the plan administrator sign a child up for health insurance. This short job tenure is another factor limiting the potential for NCPs to provide health insurance, even in those relatively few cases where it is available and affordable.

The bottom line is that only a small proportion of NCPs can provide health insurance for the child(ren) that is accessible, affordable, and stable. The data discussed above show that:

- Only slightly more than half of workers actually enroll in employer-sponsored insurance
- For most employed NCPs in the IV-D program, family health insurance is likely to be unaffordable even if available, and
- Even if family health insurance is available and affordable, the short job tenures of most NCPs further constrain the accessibility of the coverage, and certainly limit the stability of coverage that is needed to provide a meaningful benefit to the child(ren)

Unfortunately, there are no published national data on what proportion of NCPs in the IV-D program actually provide health insurance for the child(ren). Based on pieces of information from selected states, we believe that this proportion is only 10-15 percent, and probably closer to the lower figure. Further research would be useful on this point, but it is clear that children can no longer rely on NCPs to provide accessible, affordable, and stable health insurance through their employer or union except in a small fraction of cases.[7]

Expanded Availability of Public Coverage for Children (and Their Parents)

Although employer-sponsored health care has become less available and more expensive, government-sponsored health care has expanded – for both children and adults. Even before implementation of the Affordable Care Act (ACA), there was significant government-sponsored health insurance available for kids (and pregnant women). Medicaid has provided coverage at the lowest income levels, and State Children's Health Insurance (CHIP) programs have provided coverage for kids (and sometimes pregnant women) up to 175 – 400 percent of the federal poverty level (FPL), depending on the state. The ACA standardized Medicaid eligibility for children at 138 percent FPL. It also added a layer of coverage on top of CHIP, namely health insurance premium subsidies, that extend up to 400 percent FPL (See Exhibit 6, below, for various multiples of the 2018 Federal Poverty Level.)

The ACA has created a tiered structure for public health insurance for children. The three programs for child coverage are Medicaid, CHIP, and ACA premium subsidies.

7 Because the proportion of NCPs that actually provide health insurance for children is an important outcome of the child support program, we recommend that OCSE and states consider collecting this information.

- ***Medicaid*** – Medicaid has no premiums and comprehensive coverage, although wait times for treatment can be long because of limited participation by providers in some states. Under the ACA, Medicaid coverage for children is available up to 138 percent of FPL, or higher if the Medicaid program is integrated with CHIP.

- ***CHIP*** – CHIP is a major source of health insurance for children, especially for working poor and working households. State CHIP programs typically have nominal premiums and fairly comprehensive coverage. Income limits vary substantially. In some states the limits are as low as 175 percent of FPL, whereas in other states they reach as high as 400 percent of FPL.

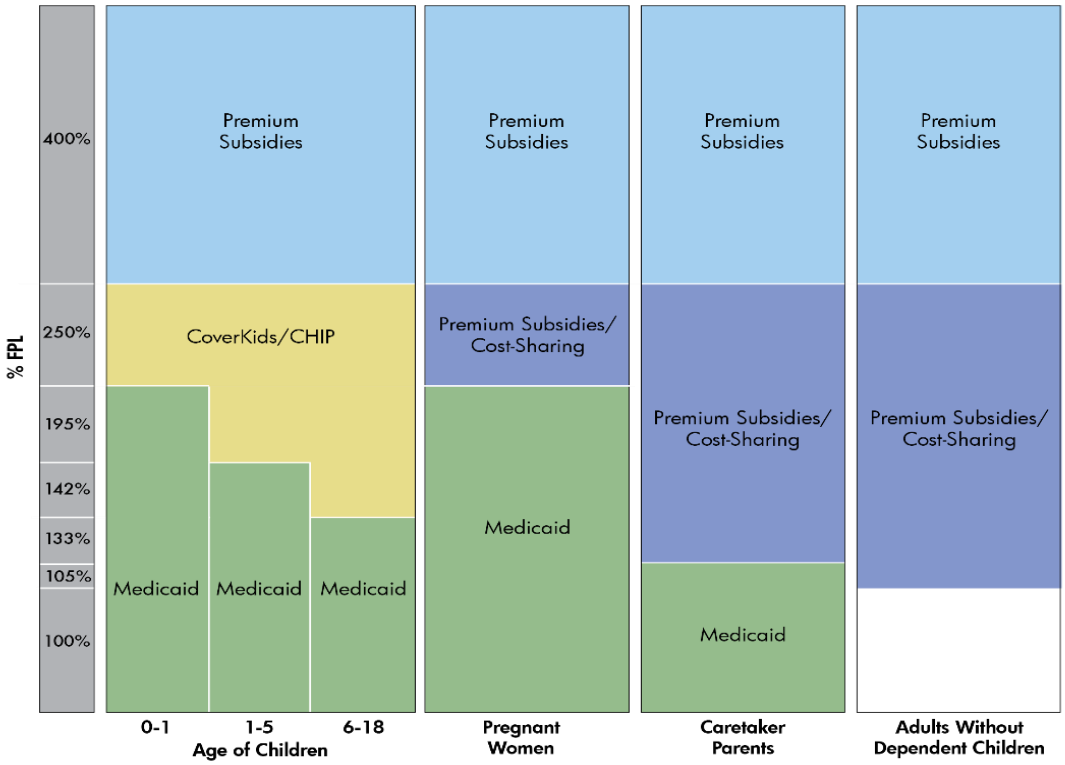
- ***ACA premium subsidies*** – these consist of Advance Premium Tax Credits (APTC) that provide monthly or annual tax credits that reduce the cost of health insurance for families with incomes up to 400 percent FPL. They also consist of a little-known program called Cost Sharing Reductions (CSRs) that subsidize out-of-pocket health insurance costs (co-payments, co-insurance, and deductibles) for households buying Silver Plans on the ACA Marketplace. CSRs are available from 100 – 250 percent FPL so do not apply to most children's coverage since CHIP programs typically cover up to 250 percent FPL or higher. While a Silver Plan covers an estimated 70 percent of health care costs, cost-sharing subsidies together with the Silver Plan cover up to an estimated 94 percent of health care costs.

The ACA implements a tiered structure for public health insurance for children. Thus, if a child is eligible for Medicaid, it is not eligible for CHIP. If it is eligible for CHIP, it is not eligible for ACA cost sharing or premium subsidies.

An example of how these programs are implemented in a state is depicted in Exhibit 5. This shows the structure of publicly available health insurance for Tennessee, which is a typical state without Medicaid expansion. As shown in the Exhibit, Tennessee provides Medicaid coverage for children up to 195 percent FPL for babies, 142 percent FPL for pre-school children, and 138 percent FPL for school-aged children. It provides CHIP up to 250 percent FPL. From 250 to 400 percent FPL, families are eligible for ACA subsidies (APTC only).

The absence of Medicaid expansion does not affect coverage available for children. Rather it limits the coverage available to adults. Thus, in Tennessee, caretaker parents are eligible for Medicaid only up to 105 percent FPL and adults without dependent children are not eligible for Medicaid. If Tennessee were a Medicaid expansion State, caretaker parents and adults without dependent children would be eligible for Medicaid up to 138 percent of FPL.

Exhibit 5
Health Care Coverage by FPL
Non-Medicaid Expansion State (Example: Tennessee)



For reference, Exhibit 6 shows the 2018 Federal Poverty Level by family size, and also shows increments of the Federal Poverty Level that correspond to key eligibility thresholds. For example, FPL for one person is $12,140 and FPL for three persons, such as a single parent and two children, is $20,780. In Tennessee, as one example, CHIP eligibility for a single parent with two children extends up to $51,950 (250 percent FPL). ACA premium subsidies extend up to $83,120 (400 percent FPL) although premium contributions would be 9.5 percent of income at that level, or $658 per month.

Exhibit 6
Federal Poverty Level 2018*

Household Size	100%	138%	200%	250%	300%	400%
1	$12,140	$16,753	$24,280	$30,350	$36,420	$48,560
2	$16,460	$22,715	$32,920	$41,150	$49,380	$65,840
3	$20,780	$28,676	$41,560	$51,950	$62,340	$83,120
4	$25,100	$34,638	$50,200	$62,750	$75,300	$100,400
5	$29,420	$40,600	$58,840	$73,550	$88,260	$117,680

*This version of the Federal Poverty Level covers the 48 contiguous states. FPL levels are higher for Alaska and Hawaii.

The CHIP program has strong bipartisan support, but it must be renewed periodically. Several times in the fall of 2017, the CHIP program was re-authorized with short month-to-month extensions. However, once cost estimates showed a positive fiscal impact for the program after elimination of the ACA mandate, it was extended for ten years. Thus, the survival of the CHIP program is no longer in doubt and it has sustained its role as a major source of health insurance coverage for children. Indeed, given the demographics of the IV-D caseload, Medicaid and CHIP are the most important sources of public coverage for children in the IV-D program.

Advance Premium Tax Credits alone are available up to 400 percent of FPL. Thus, children are eligible for subsidized health insurance coverage through the federal Marketplace or state marketplaces if they are above their state's eligibility ceiling for CHIP, but below 400 percent of FPL.

For a parent to be able to enroll a child in a Marketplace plan with ACA subsidies, the parent must claim the child as a tax dependent. Since the custodial parent is the default choice to claim the child, in most cases ACA subsidized insurance for the child is not available to the NCP. The issue of which parent claims the child as a tax dependent is now addressed in some states' child support guidelines and can also be negotiated between the parents.

Especially at eligibility levels above CHIP, the ACA requires large premium contributions from the parent: at income levels of 250 percent FPL and above, ACA premiums amount to 8.05 – 9.50 percent of a parent's income. As we discuss below, these premiums can be costly. As with premiums incurred with employer-sponsored insurance, it is important that they be considered in the guidelines calculation so that the parent carrying the coverage is not unfairly burdened.

There is also a well-known provision in the ACA that restricts its availability for family coverage subsidies, even within the specified income limits. ACA subsidies are not available to a parent if employer-sponsored insurance is available at "reasonable cost". However, "reasonable cost" is defined in terms of individual coverage – i.e. employer-sponsored insurance is deemed to be reasonable in cost if single coverage for the parent only costs less than eight percent of the parent's income. In such a case, neither the parents nor the children are eligible for ACA subsidies even if the cost of family coverage greatly exceeds that amount.

In a 2011 study published a year after enactment of the ACA, the Urban Institute estimated that 91 percent of all IV-D households (those receiving child support services through federally-funded child support programs pursuant to Title IV-D of the Social Security Act) had incomes less than 400 percent of poverty, implying eligibility for government assistance with health insurance through Medicaid, CHIP, or ACA insurance subsidies.[8] This estimate slightly overstates accessibility to public programs since other eligibility criteria must be met in addition to income, for instance the lack of access to "affordable" health insurance through an employer. However, the proportion of IV-D households with access to public coverage from one of these programs is not likely to be much lower than 90 percent.

For the first time, then, all but a fraction of IV-D children have access to high-quality, accessible, affordable, and reliable health care through government-paid or subsidized insurance. For most children, access to government-provided health insurance is not new because it comes from the long-standing Medicaid and CHIP programs. However, the ACA standardized requirements for minimum Medicaid coverage and added additional options above the upper limits of CHIP

[8] Stacey McMorrow, et al. *Health Care Coverage and Medicaid/CHIP Eligibility for Child Support Eligible Children*, ASPE Research Brief prepared by Urban Institute, July 2011.

eligibility. From the standpoint of the kids and their custodial parents, public coverage is often a preferable alternative to inconsistent or unavailable health coverage provided through a parent's employer or a policy bought on the open market.

Following enactment of the Affordable Care Act, the federal Office of Child Support Enforcement issued informal policy guidance indicating that government-sponsored health insurance counts as medical support under federal policy (Action Transmittal AT 10-10). This represented a significant change from prior policy that limited medical support to private sources of health insurance or cash. This guidance was formalized in the regulation entitled Flexibility, Efficiency, and Modernization in the Child Support Program ("Final Rule") issued on December 20, 2016. This rule added language to the medical support regulation as follows:

> **45 CFR Section 303.31 Securing and enforcing medical support obligations.**
>
> (2) Health care coverage includes fee for service, health maintenance organization, preferred provider organization, and other types of private health insurance and public health care coverage under which medical services could be provided to the dependent child(ren) [emphasis added].

This change to the rule makes it official that medical support can shift its focus to include the broad coverage available under public programs instead of being limited to private coverage that could be obtained through non-custodial or custodial parents.

Re-Positioning Medical Support

The dwindling opportunities for obtaining adequate health care from NCPs, in conjunction with the changes in federal rules allowing public coverage to count as medical support, create the opportunity for states to re-position their medical support programs. Such a re-positioning can include the following elements.

1. Pursue orders from NCPs only when an agency can document that the NCP can provide accessible, affordable, and stable health insurance for the child(ren).

2. In all other cases, order the CP to provide health insurance from private (if available) or public sources. In such cases, enforcement action would rarely be needed because: (i) the CP would be highly motivated to comply, (ii) the agency would not generally have information needed to directly enforce and (iii) at least to a degree, the order would be self-enforcing.

3. Make only determinate NCP orders: i.e. specify that the NCP should obtain coverage from a specific employer, union, or other source

4. Modify NCP orders if there is a change in availability or affordability of health insurance coverage

5. Make appropriate guidelines adjustments in recognition of the responsibility of the NCP or CP to provide coverage.

6. Encourage both parents to get adequate coverage for themselves so they can provide and care for the children.

7. Limit the use of NMSNs to cases where the agency has indications that adequate coverage is likely to be available.

This re-positioning would result in significant benefits for the children, their parents, employers, and child support agencies.

- Children would get better and more stable coverage

- Parents would be referred to the best coverage options

- Employers would have a reduced burden responding to NMSNs

- Agencies would be able to streamline their medical support enforcement functions

At least a few states shifted their approach to medical support following implementation of the ACA, but only some states – most likely a small minority – made significant changes in the absence of definitive federal guidance. However, with the publication of the "Final Rule", the stabilization of CHIP, and the dust apparently settling in terms of further modifications to the ACA, states should be able to move forward with these recommended changes with reasonable confidence that such changes will not be undermined by major federal policy shifts, at least in the near future.

In considering how to re-position medical support, a basic principle is that there must be a medical support order in each case. As stated in the Social Security Act, Title IV-D: "… all child support orders enforced pursuant to this part shall include a provision for medical support for the child to be provided by either or both parents …." [42 U.S.C. Section 666 (19)(A)]. This means that if a state determines that the NCP cannot provide accessible, affordable, and stable health insurance through

an employer or other means, then a state must order the CP (or both parents) to provide it.[9] The CP may be able to provide health insurance through private insurance in some cases (and in a few cases through a step-parent living in the home), but most of the time will rely on public coverage through Medicaid, CHIP, or ACA subsidies.

Note that the current regulation does not require an agency to seek private insurance when public coverage is available. It only requires that medical support be established. In this paper, we suggest that first priority still be given to private coverage where it is available and stable at reasonable cost. This reflects the historic recovery mission of the program and the desirability of reducing the cost of Medicaid, CHIP, or ACA subsidies in cases where private insurance is a suitable option for the child(ren). However, under the regulation, a state does not appear to be prohibited from prioritizing the best coverage available for the child, whether that coverage is public or private.

If the CP is ordered to provide health insurance coverage, there should be no need for the agency to pursue enforcement, except in rare cases. First, child support agencies lack the critical data required to enforce such an order without developing and administering cross-matches between IV-D cases and Medicaid/CHIP/ACA marketplaces and then supplementing these results with information on private insurance coverage from the CP. Second, voluntary compliance by the CP will be high given the broad availability of health insurance from public sources. Indeed, in our experience, most CPs have already enrolled in Medicaid or CHIP before applying for IV-D services. Third, if ordered to do so the CP has a strong motivation to obtain health insurance coverage because he or she will be liable for health care costs if health insurance coverage is not obtained. This liability means that any such order is substantially self-enforcing.

Since it is likely that under this proposal the preponderance of medical support orders will be the responsibility of CPs, such a change will relieve IV-D agencies of a large proportion of their medical support enforcement responsibilities.

A shift toward CPs as the primary medical support providers makes it even more critical that CP costs for health insurance and out-of-pocket health care costs be reflected in guidelines calculations. CPs would not incur such costs with Medicaid, and CHIP has only nominal premiums. However, if accessing the ACA marketplace or private coverage, the CP would likely incur substantial expenses for premiums as well as out-of-pocket costs. By recognizing such expenditures

9 While some states may order both parents to provide health insurance, our discussion focuses on ordering the CP to provide coverage when it is not available to the NCP at reasonable cost. This approach ensures that both parents (and the agency) understand which parent is responsible for providing health insurance at any given time.

under the child support guidelines, increased cash orders for the CPs would be one effect of implementing the recommendations in this paper.

One weakness of traditional medical support has been the widespread use of indeterminate orders. The most common form of a medical support order is to direct a parent to provide coverage "… if it is available at reasonable cost." The form of this order does not specify whether a parent should actually provide coverage. It just provides a basis for ordering an employer to sign the child(ren) up for coverage if it is available and its cost does not exceed the State standard for reasonable cost, based on receipt of a completed NMSN.

In the absence of definitive evidence from an employer or directly from the NCP, neither the agency nor the CP knows whether the NCP is required to provide health insurance at any given time. Contrast this with the determinate order for cash support in which the NCP is required to pay a specified amount for child support and compliance with that order is tracked monthly through a State Disbursement Unit. At any given time, compliance with the order (or lack thereof) is readily apparent and an enforcement remedy can be applied as appropriate.

Changing to determinate orders for NCP-provided medical support would specify that an NCP provide health insurance based on evidence that it is available from a specific employer or union, most likely the military, government, or a large employer with a generous benefits package. Compliance with such an order could be readily tracked by the CP. If compliance lapsed, the agency could initiate enforcement action or, in the case of a change in employers and loss of access to suitable health insurance, initiate a modification. Compliance with determinate orders would likely be higher than for indeterminate orders because the NCP would have a clearer understanding of his or her responsibilities. Determinate orders would be more satisfactory for the CPs because they would also create a clearer picture of the NCPs' obligations. They would be more satisfying for the judiciary and the agency because they would remove the ambiguity that accompanies indeterminate orders.

Determinate orders may not be required for CPs since the agency will need to enforce those orders only rarely, if at all. They can be left more open, but with the understanding that the CPs would be responsible for obtaining health insurance and maintaining it as circumstances change. Thus, to meet federal requirements that there be a medical support order in every case, the CP could be ordered to obtain health insurance from private or public sources.

For cases in which CPs are ordered to provide medical support, there would be no need for a state to issue NMSNs. The agency would not be proactively enforcing the order against the CP. In addition, since states do not track employment of CPs there would be no information available to

issue a NMSN. Federal regulations require states to issue NMSNs to enforce medical support "…where appropriate…" [45 CFR Section 303.32 (a)]. Given that states would need to issue NMSNs only in cases where NCPs have been ordered to provide health insurance, states could drastically reduce the volume of NMSNs that they issue.

Limiting issuance of NMSNs to cases in which NCPs have been ordered to provide health insurance poses a risk of missing some NCPs that find jobs with accessible and affordable health insurance for dependents even though their earlier employment did not provide that option. However, this risk needs to be weighed against the employer effort and agency expense that would be saved by no longer issuing the vast majority of NMSNs. Limiting NMSNs to NCPs that have access to affordable insurance would greatly reduce employer burden, which would be a desirable result, as well as reducing costs for the agency. The NMSN Parts A and B is ten pages long. The reduction in employer time would be great and the savings in agency printing and mailing costs would be considerable.

Cash Medical Can Still Be An Option

This approach does not preclude pursuit of cash medical by a state. Cash medical is defined 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." [45 CFR 303.31 (a)(1)]. The regulations require that states pursue cash medical support in the absence of available health care coverage from one of the parents. Under the approach recommended in this paper, either the NCP or CP will be ordered to provide medical support in all cases, so the mandate to pursue cash medical support will not apply.

In the regulations, cash medical support is defined either as an amount to be paid toward the cost of public health insurance or toward the other parent. In most cases, cash medical support paid to another parent is covered by the guidelines calculation, so this discussion will focus on use of cash medical to recover costs of public insurance.

If an NCP does not have access to accessible, affordable, and stable family insurance from an employer or other source, a state would order the CP to provide coverage. If the source of the coverage is Medicaid or CHIP, the NCP could be ordered to pay cash reimbursement to the state for part or all of the cost of that coverage. This would have the benefit of reducing the cost of those public programs.

The use of cash medical support does raise issues of fairness, collectability, and cost-effectiveness. Some may question a policy that collects funds from generally low-income obligors to reimburse Medicaid, for example, which is aimed at reducing the burden of health care costs for other low-

income recipients. Since cash support is not always collectible, cash medical ranks behind current support in priority so would have a lower collection rate than the base child support amount. Finally, collecting cash medical may be marginally cost-effective given the limited amounts involved and the effort entailed in setting and enforcing the orders, as well as accounting for the collections.

On the other hand, cash medical support orders ensure that NCPs make some contribution toward the publicly-borne cost of health insurance for the children. The contribution is usually low enough that it does not represent a particularly large burden. In a few states that proactively pursue cash medical support in this manner, collections are substantial and help offset the cost of Medicaid for children.

Given how little evidence there is on these issues, the decision to collect cash medical support as reimbursement for public programs is an appropriate policy issue for states. The point is that cash medical can be administered in conjunction with the other recommendations made in this paper. It could simply be an add-on to the basic child support order. The NCP would be ordered to provide cash medical support and the CP would be ordered to provide health insurance from a private or public source.

Broader Public Coverage Can Help Parents Too

While the primary focus of medical support enforcement is properly on the children, the children also benefit when their parents have access to affordable and adequate health insurance. Many human services agencies have adopted a two generation (2Gen) approach to their services, which suggests that child support should focus on the needs of the parents, as well as the children.

Under this philosophy, some agencies may wish to train their staff on referral options for health insurance for CPs since CPs need to be healthy so that they can care and provide for their children. If the child is on Medicaid, then many times the CP is signed up too. At higher income levels, CPs may be eligible for CHIP if they are pregnant. Otherwise ACA subsidies constitute the most important public option.

NCPs in particular often have difficulty getting good coverage because they are generally not eligible for Medicaid in non-expansion states. In addition, a diminishing number of employers provide affordable health insurance, especially for lower paying jobs. Yet such coverage can be instrumental in enabling NCPs to remain healthy enough to get and keep a job.

The Medicaid expansion provisions are targeted directly at adults since states already cover children. Thus, in the 32 states (plus D.C.) opting for Medicaid expansion so far, single adults as well

as caretaker parents, and couples without children are eligible for Medicaid at incomes up to 138 percent of the federal poverty level: $16,753 per year for a single adult in 2018. Above this income level, single adults can qualify for ACA premium subsidies through their state's marketplace up to 400 percent of the federal poverty level: $48,560 per year in 2018.

It might seem that low-income single adults are out of luck in states not opting for Medicaid expansion, but this is not entirely true. Eligibility for ACA premium subsidies extends down to 100 percent of poverty level, and low-income single adults above that threshold can qualify for substantial benefits.

A single adult working 40 hours per week at the federal minimum wage is at 131 percent FPL. Remarkably, a single adult at that earnings level is eligible for a health insurance plan through an ACA marketplace that will cover 94 percent of his/her health care expenses for $25 per month. The APTC limits premium costs at less than 150 percent of poverty to 2 percent of income ($25 per month at federal minimum wage) and the "cost-sharing program" provides help with co-pays and deductibles such that the modest premium covers almost all costs. Although $25 per month is not a trivial amount for a minimum-wage earner, it should be manageable and provides almost total coverage. Exhibit 7 demonstrates this calculation.

Exhibit 7
NCP Eligibility for ACA Health Insurance Plan
Non-Medicaid Expansion State

Health Care Assistance: Single Adult Federal Minimum Wage (40 hours/week)

Note: not eligible for Medicaid; assistance comes from APTC* and cost-sharing**

Example: $15,080/year ($7.25/hour full-time)
$1,257 per month (131% FPL)

APTC* eligibility: Premium $302/year @ 2% of income = $25/month

CSR** eligibility: Covers estimated 94 percent of health care costs

*Advance premium tax credits **Cost sharing reduction

Child support agencies have taken a more proactive approach with NCPs in recent years, helping them find employment and eliminate other barriers that prevent them from supporting their children. Educating NCPs on new health insurance options represents an extension of this approach. Many NCPs have unaddressed health care issues which can hamper their ability to

generate income to meet their own needs, let alone those of their children. By referring them to affordable and comprehensive health insurance, child support agencies can change lives while furthering their mission to help children. A suitable mantra can be: Get healthy. Get a job. Pay child support.

Conclusion: Re-Positioning Medical Support Emphasizes Realistic Coverage, Reduces Employer Burden, and Streamlines the IV-D Program

The dwindling availability to NCPs of employer-sponsored (or union-sponsored) insurance, along with the diminishing affordability of coverage that is available, leaves only a small proportion of NCPs with the capability of providing accessible, affordable, and stable health insurance for dependents. These circumstances render most traditional medical support orders ineffective since they traditionally require NCPs to provide health insurance "… if available at reasonable cost…." By permitting states to count public coverage as child support, the "Final Rule" enables states to chart a new course with medical support that emphasizes realistic requirements for medical support and the best coverage for children regardless of source.

This new course would emphasize determinate orders that clarify responsibilities of the parents and thereby improve accountability in providing health insurance coverage for children. The new course would have the following elements.

- Assess whether the NCP can provide accessible, affordable, and stable coverage from an employer, union, or other source. [10] If so, issue a determinate medical support order for the NCP to obtain coverage from that employer or union, or for the NCP to obtain coverage from another source in the event of a job change. The NCP order should be followed by issuance of a NMSN to the specified employer or union which would be ordered to provide such coverage. Our rough estimate is that approximately 10 percent of NCPs will be able to provide such coverage.
- If the NCP is not able to provide accessible, affordable, and stable coverage from an employer or some other entity, the CP should be ordered to provide coverage from a private or public source. This complies with a federal statutory requirement that there be a health insurance order in every case. In most cases, this means that coverage will come from Medicaid or CHIP. Less frequently the CP may have employer coverage, family coverage

10 Occasionally the NCP will be able to provide accessible, affordable, and stable coverage from an open-market individual policy or from the ACA Marketplace if the NCP has claimed the child as a tax exemption, but we expect that these would be relatively rare situations.

through a spouse, or coverage from the ACA marketplace or an individual policy purchased on the open market.

- The guidelines calculation should reflect the contributions of each parent toward the health insurance obligation, as well as any resulting out-of-pocket costs. In many cases, this will be expected to increase cash support for CPs.
- If the NCP is ordered to provide coverage through an employer or union and subsequently becomes unable to provide affordable coverage, then the order should be modified in accordance with the new circumstances.
- If the CP is ordered to provide health insurance, medical support enforcement can stop. Voluntary compliance will be high, and it will not be practical for the IV-D agency to enforce such orders. Moreover, a CP medical support order will be substantially self-enforcing since failure to obtain coverage will expose the CP to responsibility for payment of any actual health care costs that are incurred.
- Cash medical support can be ordered when the child is on Medicaid, if a state deems such to be appropriate.
- The CP and NCP can be referred for adequate and affordable health care coverage to assist them in staying healthy so that they can provide for and care for their child(ren).

Implementing these elements will enable states to reduce their resources devoted to medical support and improve other core services. Limiting issuance of NMSNs will reduce the burden on employers by cutting way back on the voluminous paperwork issued by child support agencies.

Will this approach lessen the provision of medical support by NCPs? At this point, it is impossible to know for sure, but a system that creates definite obligations tied to known employers (or other sources) may very well increase compliance because the obligations will be perceived as more reasonable and they will have more clarity. Coverage for the children should be improved because the orders will be more definitive, with both parents knowing their roles. This approach will streamline responsibilities for child support agencies and improve their credibility by eliminating vague and indeterminate orders. Given the new realities of health insurance and the opportunities afforded by broader public coverage and new federal rules, states will benefit from re-assessing their processes and adopting the principles of Medical Support 2.0.

Acknowledgments

This paper has benefitted greatly from prior review and thoughtful comments from the following individuals.

Lauren Antelo, Senior Social Science Analyst, Office of Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

James C. Fleming, Director, Child Support Enforcement, North Dakota Department of Human Services

Karen E. Hebert, Chief, Bureau of Child Support Services, New Hampshire Department of Health and Human Services

Michael R. Henry, Senior Vice President, Veritas HHS

David A. Price, President, Center for Public Policy Studies

Jane Venohr, Senior Researcher, Center for Policy Research

I would like to acknowledge their contributions and thank them for providing their considered input, which has enriched the final version of this paper. Of course, any opinions expressed in the paper are mine alone, as is responsibility for the final analyses and recommendations.