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The Affordable Care Act Update

A. AFFORDABLE CARE ACT (ACA) OVERVIEW

1. **General Overview as it Applies to Child Support:**

   a. 900 page federal act – No mention of child support
   b. Mandates minimum essential healthcare coverage for children
   c. Healthcare exchanges through federal system or individual state system (Minnesota chose individual state system - MNsure)
   d. Tax subsidies and tax penalties

2. **Visual Framework of the Affordable Care Act:**

   Mandates on employers, plans, and individuals
   + Tax subsidies
   + Medicaid expansion
   + Healthcare marketplace
   + Tax enforcement and penalties
   The Affordable Care Act

3. **Mandates:**
   a. Employer Mandate – Employers are required to provide minimum essential coverage that is affordable for full-time employees.[1]
   b. Plan Mandate – Healthcare coverage plans must provide minimum essential coverage. Other features of plan mandates under the ACA include:
      - Children can be covered through age 25
      - No pre-existing conditions exclusions
   c. Parent Mandate – Parents are responsible for covering themselves and their tax dependent children. Parents must have minimum essential coverage in place, qualify for an exemption, or pay a tax penalty. The parent who claims the child as a tax dependent for federal taxes is responsible to prove that the child has coverage. There are exemptions.
      - Parents can provide minimum essential coverage can be provided through employer or union coverage, including COBRA, Retiree, Self-insured, and TRICARE.

[1] Under the ACA, 30 hours per week = full-time

- Minimum essential coverage can also be provided through the Healthcare Exchange, which in Minnesota is MNsure, as follows:
  - MNsure private coverage
  - MNsure private coverage with subsidies
  - Medical Assistance (public coverage)
  - MinnesotaCare (no longer available for children)

  MNsure, as a Healthcare Exchange is simply a portal to eligibility, financial assistance, and plan options.
- In addition to the above, Medicare is an option for those who qualify.
- Also, there is still the option to purchase individual, family or dependent only, coverage directly through individual insurance providers (i.e. Medica, HealthPartners, BlueCross, Preferred One) without going through the Healthcare Exchange.

d. Tax Penalties on Individuals – There are IRS tax penalties for failure to ensure minimum essential coverage.

4. **Exemptions** – Exemptions from the individual mandates include religious objections, federally recognized Indian Tribes, incarcerated individuals, people who don't have affordable coverage available, people who have a short coverage gap, people who have other hardships.
   a. Hardship Exemption – A parent will be exempt from tax penalties if they are the parent that claims the child on federal taxes but the other parent is ordered to provide healthcare coverage and fails to do so; but only if the child has been deemed not eligible for Medicaid.
   b. Example of Hardship Exemption – If Parent A is ordered to carry healthcare coverage for the child and fails to do so, and if Parent B claims the child on his/her taxes, Parent B is subject to an IRS penalty for failure to ensure healthcare coverage for the child. Parent B can apply for a hardship exemption in this type of situation. To apply for a hardship exemption, Parent B must for apply for MA on the Healthcare Exchange and be denied as eligible for MA.

5. **Financial Assistance is Available** – Financial assistance is available to families and individuals with incomes below 400% of the federal poverty guidelines. Not all financial assistance available under the ACA is "public assistance" or public assistance that requires a referral to child support (IV-D). Forms of financial assistance include:
   a. Premium Tax Credits (PTCs) – PTCs are subsidies (not public assistance) available based on household size and Modified Adjusted Gross Income (MAGI). The purpose of PTCs are to make premiums through MNsure or other state Marketplaces or the Federal Healthcare Exchanges affordable. PTCs are only available to the parent who claims the child dependency exemption.
   b. Advanced Premium Tax Credits – Advanced premium tax credits are available for the purchase of private plans through the Healthcare Exchange. They are not considered public assistance and do not require a referral to child support. They are a cost sharing subsidy to reduce costs paid by the insured.

c. Expanded Medicaid – There is also expanded eligibility for public assistance programs through Medicaid, which may require a referral to child support.

6. **The County's Role regarding Taxes** –
   a. IRS Tax Penalty – The IRS tax penalty is not a county enforcement tool. If a parent is responsible to ensure that the child has healthcare coverage and fails to do so, the IRS tax penalty is between the parent and the IRS.
   b. IRS Dependency Exemption – The county will not address which parent should get the tax exemption in its pleadings or motions, but this issue may come up in hearings or settlement negotiations. The county should be prepared to alert the parents and court to the consequences of the tax penalties and hardship exemption (that the parent who claims the child must ensure that the child has healthcare coverage in place or is subject to tax penalties). If parties want to share the tax exemption every other year, the county should alert, but not object.[2]
   c. IRS Verification of Coverage Form – The county will not distribute or collect the IRS tax form from the parties. However, the county may be asked by a party to provide verification as to whether healthcare coverage is in place for the child, or where to find the form. The county should be prepared to provide verification to the parent (not to the IRS), and to provide information to the parent as to where they can find the IRS form.

B. PROGRAMS, SYSTEMS, INTERFACES

1. **Relevant Medical Programs** –
   a. Medical Assistance – Medical Assistance (MA) can be based on MAGI (Modified Adjusted Gross Income) and Non-MAGI (age or disability). The ACA (and thus Minnesota) expanded MA eligibility in Minnesota on January 1, 2014. Child support referrals are required and child support is assigned when children receive MA.
   b. MinnesotaCare – Before January 1, 2014, MinnesotaCare was a form of public assistance. As such, a referral to child support was required and child support was assigned. After January 1, 2014, MinnesotaCare is still technically public assistance, but serves a different population that does not include children. Thus, a referral is not required and child support is not assigned (because there are no children on the program). After January 1, 2015, MinnesotaCare becomes the basic health plan (BHP) offered in Minnesota, and is no longer considered public assistance.

[2] There may be advantageous financial reasons for sharing the tax exemption or for allowing NCP to claim it when paid in full. Other than alerting the parties and the court to the issues associated with having the tax dependency exemption with the parent who is not responsible for providing the health care coverage, the county does not have a role in deciding this issue.

2. **Relevant Systems** –
   a. MNsure – MNsure is Minnesota's Healthcare Exchange (marketplace), Minnesota's public assistance and financial assistance eligibility system, and Minnesota's case management system for MAGI cases and eventually for non-MAGI cases. MNsure is not a program, insurance, or a "type of coverage."
   b. MAXIS – Minnesota's former (still exists for some cases) case management system for MA cases.
   c. PRISM – Minnesota's child support case management system.
   d. MMIS – Secondary financial system for benefits, not a robust system for case management.

3. **Interfaces** – Federal IV-D system certification requires each state to have the healthcare system interface with the child support system. The purpose of the interface is for referrals, updates, "Good Cause" status, and "Safe At Home" addresses. There has been an interface between MAXIS and PRISM to provide information and updates on cases IV-A refers to IV-D. At the time of publication of these materials, the interface between MNsure and PRISM is not yet operational.

C. DECISIONS BASED ON TEMPORARY LACK OF INTERFACE

1. **Generally** – As stated above, the interface between MNsure and PRISM is not yet operational as to the medical portion of the case. Decisions on how to handle the medical portion of cases depend on which system MA was opened.[3]

2. **DHS Decisions with County Input** – DHS Child Support and DHS Healthcare have been making decisions with county input on how to handle cases while the interface is not operational. As of the date of this document:
   - MAXIS referrals will continue through CRDL,
   - New cases opening in MNsure will not have a referral sent to Child Support until there is an operational interface,
   - Counties will reserve medical support for cases where up-to-date information about receipt of MA is not available, and
   - Counties will not request past medical support and reimbursement for any time in which support was reserved due to the lack of an operational interface.

[3] There are three ways that MA is opened: (1) MA cases opened only on MNsure and not in MAXIS, (2) MA cases now open on MAXIS that have not transitioned to MNsure, and (3) MA cases originally opened on MAXIS that have transitioned to MNsure.

3. **<u>Decisions Made Based on Three Groups of Cases</u>** – The decision makers are working on decisions based on three distinct groups of cases:

Group	Type of MA	System	Status in PRISM	Interface Status
*Group 1	Interim MA cases (former MNC with kids)	Opened in MAXIS, transitioned to MNsure	NPA or CCC (Flipped from MNC)	No interface
**Group 2	New MA cases	Opened in MNsure, not in MAXIS	Not on PRISM unless party applies for services (NPA)	No interface
***Group 3	Existing MA cases	Opened in MAXIS, exists in MAXIS still	Medical status correct	Interface works (for now)

***Group 1- Interim MA (former MNCare with kids cases)**

- Lost interface as of 1/1/2014
- PRISM flipped cases to NPA or CCC on 1/1/2014, and no MA open

****Group 2 - New MA cases opened on MNsure only:**

- No interface established yet
- MA cases exist only on MNsure, not MAXIS
- Child Support may or may not know about these cases
- If the parties open on MFIP or CCA at a later time, a referral will be received with the open programs, but no MA open

*****Group 3 - Existing MA cases on MAXIS:**

- MA cases will exist on MAXIS until the cases transition to MNsure
- The MAXIS interface will work correctly
- Transition from MAXIS to MNsure for most MA cases will occur at recertification time (or through batching)
- If the interface is not operational at the time of transition, MA will close; PRISM will flip cases to NPA, CCC or MFIP only. No MA will be open on PRISM

4. **<u>Working Cases without an Interface</u>** –

***Group 1 – Interim MA (former MinnesotaCare with kids cases):**

- Counties should have worked through worklists and cases in January 2014
- No new MinnesotaCare case referrals to child support
  - Children should no longer be open on MinnesotaCare
- Cases should be worked as NPA or CCC depending on PRISM case type

****Group 2 – New MA cases opened on MNsure only:**

- If there is no referral or NPA application, there is no case on PRISM
- Most MA cases are not supposed to open new on MAXIS, but some new MA cases are opening new on MAXIS, so counties will continue to receive some new referrals through MAXIS (additional children, non-MAGI or "emergency situation" cases)
- IV-D may get NPA applications. If the client indicates that they are on MA:

- Waive $25 application fee and suppress 2% cost recovery fee; do not suppress the $25 federal fee. The cost recovery fee should be suppressed for 12 months at this time. CSED will review the decision to suppress the cost recovery fees on these cases whenever more information is available. See the Cost Recovery Fee topic, Supervisor Override section of SIR MILO for more information.
- Establish child support based on NPA status.
- If there is no indication that either party has insurance or if parties bring verification of MA open to the hearing:
  - medical support may be ordered
  - medical support can be reserved
- No retroactive medical support (past medical) for any time in which medical support was reserved due to the lack of an operational interface.

***Group 3 – Existing MA cases on MAXIS:**

- Cases continue to be updated in MAXIS until they transition to MNsure. Because the cases are updated in MAXIS and have not transitioned to MNsure, counties should continue to work cases in PRISM "business as usual" until transition.
- As they transition, MA will close and PRISM will determine case type depending on what other programs are open.
- Business as usual establishing and enforcing medical support on MA cases that exist in MAXIS until transition to MNsure.
  - For reserved cases, a modification motion will be necessary at the time the interface is operational and referrals begin again.
  - Consider using conditional language so that charging can be suspended after the transition to MNsure until the interface is operational.
  - Consider using medical support addendum to allow for review hearings on medical support only.

5. **Processes to Consider for Court Actions** – Getting clear language in the court order and entering a CAAD note to reflect that the basis for the reservation of the medical support obligation is because of the interface issues are essential. Envision a future generation of CSOs conducting a review of the case a decade from now, who may be able to see at that time that MA was in place for the child even though we cannot identify that today. If they do not have a clear court order or a clear CAAD note to reflect why MA was reserved, if there is a conditional order to charge when public assistance is in place, they may decide to tack on arrears that the county, the parties, and the court intended to be waived.
   a. Reservation due to Lack of Interface – Sample Language to Consider: "Effective January 1, 2014, due to automated data sharing issues between the state medical assistance computer system(s) and the state child support computer system, the county may have limited or no information available regarding the status of medical public assistance after December 31, 2013. The county is unable to determine whether a

contribution to public coverage is appropriate or, if so, to calculate the appropriate contribution to the cost of public coverage."

b. Conditional Order – Sample Conditional Language to Consider: "Beginning 00/00/0000, [NCP Name] shall pay ongoing medical support of $X.XX per month for any month public coverage is in place. When public coverage is not in place, the ongoing medical support is suspended."

c. Review Hearing Addendum – Dakota County has also developed a medical support addendum that is attached to orders where medical support is reserved due to the lack of an interface (and thus lack of verifiable information) which allows any party to file a medical support only modification motion, or for the county to set the matter on for review hearing for medical support only in lieu of a formal motion at such time as the public assistance is verifiable (see attachment).

6. **Rationale for Decisions Made Thus Far** –
   - Without an operational interface between MNsure and PRISM, the placement and expenditures for MA for the child cannot be verified. The government cannot collect money from a citizen without proof of expenditures. In a risk benefit analysis, it was decided that it is better to not collect when the government might be able to collect than risk collecting when the government should not.
   - It is also unknown whether MA can keep collections made by child support if medical support is collected and MA is not verifiable. If not, it would be time consuming, risky, and expensive to refund collections.
   - Without an interface, child support cannot get updates about good cause, status changes, and additional family members, or about when MA is expended.
   - It is important to protect the integrity of the decisions made by DHS Healthcare and DHS Child Support and ensure consistent treatment of all families in the same situation statewide.
   - The bottom line - this appears to be a cost of a major systems upgrade.

7. **Trust and Rely on the PRISM Code for Medical** – While the interface is not operational, for medical support issues, if PRISM reflects an NPA program code, the case must be treated as an NPA case even if MAXIS shows that MA is open. If the PRISM code is MAO, treat the case as a medical assistance only case. If the PRISM code is NPA, treat the case as a non-public assistance case.
   a. NPA Cases – For NPA cases (cases that start out or flip from MAO to NPA or CCC due to the lack of an interface):
      i. If party applies for NPA services and receipt of MA can be verified, the $25 application fee will be waived and the 2% cost recovery fee will be manually suppressed.
      ii. If the child support worker notices or a party contacts the county, and receipt of MA can be verified, the $25 application fee will be waived and the 2% cost recovery fee will be manually suppressed.

D. UPDATES

1. **MinnesotaCare Sliding Fee Scale Gone** – The MinnesotaCare sliding fee scale has been replaced with a MinnesotaCare premium table. The new table tops out at $50 for a single child's premium.

2. **Three Groups Update** –
   - Group 1 cases are already all closed. PRISM no longer has any cases coded "MinnesotaCare."
   - The number of cases in Group 2 continues to grow, as more people apply for MA on MNsure.
   - The number of Group 3 cases remains steady.

3. **Retroactive Medical Assistance** – Referrals should no longer be sent from MAXIS to PRISM. However, cases were sent and quickly followed by a closing trigger before MA policy provided clarification to the county financial workers. If you receive one of these cases, it is referred in error.

4. **Legislative Ideas** – This year's legislative ideas aim to address some of the issues raised by the ACA implementation in Minnesota. They include:
   - Removing references in child support statutes to MinnesotaCare
   - Providing additional definitions of medical coverage, public assistance and full-time work (for the purpose of imputing income) to conform with the ACA
   - Creating a medical-only modification process as a streamlined way to modify tax credit and coverage issues
   - Removing the obligation to reimburse MA if an NCP is eligible for MA

5. **Former MinnesotaCare Conversion** – Parents who were formerly on MinnesotaCare are currently on Interim MA (IMA). The state is in the process of converting these cases, and their associated children who might be receiving Medical Assistance through MAXIS to MNsure. As the children close on MAXIS, child support officers will receive closing codes saying the children are eligible for MNsure. (See handout for more details.)

6. **Interface Update** – The PRISM team continues to work with the larger MNsure team to determine the priority of a MNsure-PRISM interface.

7. **SIR Page Update** – DHS-SIR now contains a page with all the updates CSD has issued about the MNsure interface and the ACA.

E. INTERSECTION OF MINNESOTA LAW AND THE AFFORDABLE CARE ACT

1. **ACA vs. Minnesota Law** – While the ACA and current state child support law have some shared public policy objectives, they offer different points of view:

Affordable Care Act Law	Minnesota State Law
Obtain coverage	Obtain coverage and contribution
Enforce with tax consequences	Enforce by court action
Tax household relationships	Appropriateness of coverage (hierarchy of coverage)

2. **Hierarchy of Coverage Generally** – Minnesota law "prefers" that one parent provide coverage after certain considerations (Minn. Stat. § 518A.41, subd. 4). Minnesota law generally looks at continuity of coverage, appropriateness of coverage, and with whom the child lives (which may or may not be the same parent who has the child dependency exemption). The ACA requires the parent with the dependency exemption to ensure minimal essential coverage. The preferences under current state law do not explicitly consider or depend on the dependency exemption.

3. **Hierarchy of Coverage – MN Law Simplified** –
   a. Child already covered – Continue coverage, unless someone requests otherwise and the court orders otherwise
   b. Child not covered – Who has coverage?
      - One parent – that parent provides coverage.
      - Both parents – who has the more appropriate coverage? If the same, preference for custodial parent.
      - Neither Parent – court can order the custodial parent to apply for public coverage.
   c. If the child receives public coverage – The noncustodial parent must contribute an amount towards the cost of the public coverage, and if eligible, this cost is based on the sliding fee scale for MinnesotaCare.

4. **Cost of Coverage** – The cost of coverage is still a relevant consideration under both Minnesota law and the ACA. However, with the ACA:
   Different percentages
   Are applied to different measures of income
   For different purposes

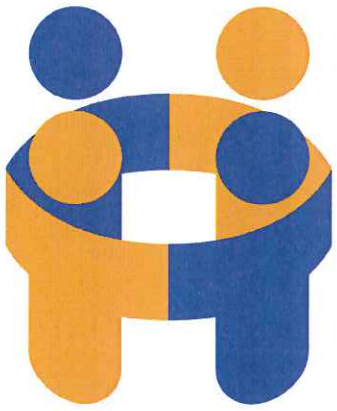
The following chart illustrates the differences in costs between Minnesota Law and the ACA:

	Percentage	Income	Purpose
Minnesota Law	5%	Gross Income	Order Coverage?
ACA–Individual	8%	Household Income	Avoid Penalty?
ACA–Large Employer	9.5%	Household Income	Employer Plan Affordable?

5. **Cost of Coverage-MN Law Simplified** –
   - Contribution towards the premium
   - PICS %
   - Allocation based on situation for parent ordered to provide the coverage:
     - Parent has no additional cost to add child
       - No allocation
     - Parent has other children that will be covered
       - Allocation of full dependent share
     - Parent must enroll him or herself to get child covered
       - Allocation of dependent share only
   - Contribution towards public coverage
     - Sliding fee scale if eligible

6. **Cost of Coverage – Household Composition Differences** –
   a. Minnesota Law – Household composition is not relevant in the Minnesota Child Support Guidelines. The Income of an adult child or new spouse or significant other is not considered in a guidelines calculation.
   b. ACA – Household composition is relevant in the Affordable Care Act. Who is in the household determines whose income applies towards eligibility. "Household" means people who are considered a unit for purposes of determining eligibility. Household size is especially important for Advance Premium Tax Credits because every dollar change in income affects the expected premium contribution of the family and therefore the tax credit they will receive.

7. **What is a "Child?"** – There are some differences in how the ACA defines a child and how Minnesota law defines a child. Under the ACA, a parent can provide coverage through age 25. Under Minnesota law, child support (including medical support) continues until child turns 18 or 20 if still attending secondary school, with some limited exceptions. If the court orders health care coverage through age 25, IV-D child support enforcement stops at emancipation (unless the case has some of the limited exceptions). If a parent needs to enforce medical support after emancipation, they will have to do so outside of the IV-D child support system (thus outside of the Expedited Process). The ACA does not change the IV-D requirement of having a "child" on the case (except when continuing to collect arrears).



Child Support
Directors Association

California Affordable Care Act Child Support Workgroup Report

July 10, 2013

Presented by the Child Support Directors Association of California

This report is written by HMS under contract with, and based on information and direction from, the Child Support Directors Association of California (CSDA) to lead a multi-disciplinary group though an analysis resulting in a set of specific recommendations relative to the integration of the Affordable Care Act of 2010 and California's Child Support program. This report is based on assumptions and examples that may be only applicable to the California Child Support Program, and may not apply or be relevant to other programs, situations, or contexts. HMS is a publicly traded company (NASDAQ: HMSY) and is the strategic source for innovative cost containment solutions that benefit government and commercial healthcare program. The views expressed are solely those of the CSDA and do not necessarily reflect the views of HMS.

CSDA

Executive Summary

Currently, there are over 17 million children in the Child Support Program, and Child Support Enforcement Programs across the country play a vital role in determining if and how these children have health coverage. The passage of the Patient Protection and Affordable Care Act (ACA) in March 2010 has resulted in a number of stakeholders focusing resources and efforts to meet what has been a longstanding goal of Child Support programs—ensuring that children have healthcare coverage. As a result, it is critical that Child Support programs be fully engaged in ACA policy discussions and rulemaking in order to ensure that the needs of child support eligible children are met and those families in non-traditional structures are treated equitably.

The Child Support Directors Association of California (CSDA) took a proactive approach to this charge by forming a multi-disciplinary workgroup (the California Affordable Care Act Child Support Workgroup) that included representatives from CSDA, local child support agencies (LCSAs), CA State Department of Child Support Services (DCSS), Administrative Office of the Courts (AOC), and the Federal Office of Child Support Enforcement (OCSE).

The objectives of the Workgroup included the following:

» Review the ACA for its impact on California's Child Support Program including state, local, and court-based operations;

» Lead the development of a comprehensive matrix of issues identified;

» Lead the development of a written gap analysis of major points where the ACA intersects with California's Child Support Program;

» Lead the development of recommendations or actions required to either implement or mitigate the issues identified; and

» Examine and make recommendations on the "Future Role of the Medical Child Support program" at the national level in establishing and enforcing medical support orders as the ACA becomes operationalized.

Project consultants from HMS Consulting were hired to assist the Workgroup in this effort. Over a five-month period, a series of Workgroup meetings and conference calls were held to accomplish the objectives outlined above.

Key Recommendations

Based on the analysis conducted by the California Affordable Care Act Child Support Workgroup a series of recommendations were developed and separated into two parts: (1) actions needed within the California program and (2) actions needed at the national level to align and support the common goals of the ACA and Child Support.

Recommended actions needed within the California Child Support Program:

1. Do not seek legislative changes prior to the January 2014 ACA implementation date.
2. Do not seek to amend current state laws unless federal child support regulations are amended.
3. Encourage Center for Medicare & Medicaid Services (CMS) and Department of Treasury to work closely with the Federal Office of Child Support Enforcement (OCSE) and state child support programs when developing ACA-related regulations or guidance in consideration of the added layer of complexities that families within the Child Support Program face.
4. Encourage tracking of federal regulations as they relate to the ACA and potential impact on the California Child Support Program, and encourage active participation at the national level to share California related experience and perspective.
5. Direct efforts to Federal Office of Child Support Enforcement (OCSE) and other state child support programs offering comments to encourage examination of individual states' policy regarding the potential impact to child support caseloads under Medicaid Expansion requirements.
6. Direct efforts to California Department of Child Support Services (DCSS) and the California Department of Health Care Services offering comment and recommendations regarding the importance of collaboration for both programs. Include LCSA participation in collaboration meetings.
7. Support ongoing collaboration and shared initiatives between DCSS and the California Health Benefit Exchange and include Local County Child Support Agency (LCSA) participation in collaboration meetings.
8. Establish collaborative workgroup with AB1058 commissioners and family law judges to encourage consistent application and standardization when medical support orders are established or modified after the implementation of the ACA.
9. Child Support Directors Association of California (CSDA) should lead the development of statewide LCSA training on the ACA and intersections with Child Support Program to support informed customer service after the implementation of the ACA.
10. Child Support Directors Association of California (CSDA) should lead the development of a work plan for the creation of FAQ and/or outreach materials to support program staff as they interface with parents, legal professionals, employers, Exchanges, and other child support stakeholders.

Recommended actions needed at the national level:

1. Create a national medical support workgroup to study and determine collaboratively the future of medical child support prior to the issuance of new program regulations.

Conclusion

As this report demonstrates, there is a common goal between the ACA and the Child Support Program to increase healthcare coverage for children and families. The Child Support Program has a history of meeting new challenges with innovation and success. The program has achieved this by keeping the well-being of the children and families served at the core of all decisions. The Child Support Directors Association of California (CSDA) believes that the Child Support Program will rise to the challenge and lead the country in the creation of a new medical support model that improves the well-being of children and families.

The Child Support Directors Association of California respectfully offers this report to the child support community to support the search for this solution.

CSDA

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CSDA

Introduction

Medical Child Support" is the legal provision of medical, dental, prescription and other healthcare expenses and can include provisions to cover health insurance costs as well as cash payments. The first connection between medical support and child support came in 1977 as an attempt to recoup the costs of Medicaid to public assistance cases under Title XIX of the Social Security Act. Today, federal law and regulations require states to provide for children's healthcare needs by obtaining health insurance or by other means. Health insurance responsibility can now be placed with either parent, and major initiatives have been undertaken during the past 30 years to improve medical coverage for children in the Child Support Program. The enactment of the 2010 Affordable Care Act (ACA) has significantly impacted the U.S. healthcare system and its participants; however, there are still many questions regarding its impact on the millions of families and dependents that are members of the Child Support system. Recent guidance issued by the Federal Office of Child Support Enforcement (OCSE) has indicated that the role of the program may experience a dynamic shift in agencies' responsibilities.

California was the first state to enact Exchange legislation following passage of the ACA. Covered California™, California's version of its state-based health insurance Exchange, is a marketplace where legal residents of the state of California can purchase healthcare coverage. During the month of October 2013, Covered California™ will "go-live" for open enrollment, offering qualified health insurance coverage plans (QHP) for review through the Covered California™ portal. Starting in January 2014, legal residents of California will be eligible to purchase health coverage. In addition, new government programs will offer financial assistance to lower the cost of health insurance including tax credits and cost-sharing subsidies.

Federal, state, and local government stakeholders are collectively attempting to analyze the impact that enactment and implementation of the ACA will have on programs they are entrusted to administer. Because the ACA essentially creates a mandate for each individual to secure health insurance for him or herself and minor child(ren), and creates new duties on government, employers, and individuals, it is important that California's Child Support Program work in collaboration with other stakeholders to evaluate the ACA's impact on the program.

In response, the Child Support Directors Association of California (CSDA) established a joint Workgroup to conduct an analysis of the ACA and its impact on California's Child Support Program. Specifically, the Workgroup was charged with identifying all areas where the implementation of ACA intersects the Medical Child Support Program and conduct an analysis on those intersection points to determine the potential impact where the program does not align and to provide short-term and long-term recommendations.

Workgroup members included the federal Office of Child Support Enforcement (OCSE) including Region IX, the State Department of Child Support Services (DCSS), the Administrative Office of the Courts (AOC), and local county Child Support agencies (LCSA).

This report examines the intersections between the ACA and Medical Child Support requirements and identifies where the two programs do not align or may conflict, such as:

» Setting different standards of compliance in obtaining and maintaining health insurance coverage for IV-D case participants—Custodial Parent (CP) and Non-custodial Parent (NCP)—leading to confusion and potential ACA and medical child support compliance issues

» Potential loss of uniformity in the application of medical child support operating procedures across LCSA and family law courts

» Setting different health insurance enrollment standards for employers as they attempt to comply with ACA and medical child support requirements on behalf of their employees and dependents

Found in this report is an ACA & Child Support Matrix the Workgroup developed that identifies the 18 major intersections in an easy to read, side-by-side format.

In order to prepare for final recommendations, the Workgroup prepared 14 Gap Analyses of the intersections identified in the Matrix. (Some intersections are combined within a single Gap Analysis.) The Gap Analyses are independent studies of specific intersections and provide background and comment on potential legal conflicts, program role conflicts, policy and procedural impacts, and increased need for communication across programs. Each Gap Analysis offers an individual set of recommendations from the Workgroup.

As a final step, the Workgroup examined and made recommendations on the "Future Role of the Medical Child Support program" at the national level in establishing and enforcing medical support orders as the ACA becomes operationalized.

The report concludes with the Workgroup recommendations separated into California focus and National focus, including:

» How the California state and local child support enforcement agencies should proceed to prepare short-term mitigation strategies over the next 12-18 months as the ACA is operationalized in California.

» How federal, state, and local Child Support programs should proceed to develop a long-term strategy regarding the future of medical child support and its role within the mission of the Child Support Program to improve the program's impact and effectiveness.

Workgroup

The California Child Support Affordable Care Act Workgroup (Workgroup) was created in February 2013 by the Child Support Directors Association of California (CSDA) on behalf of its members to study and understand the Affordable Care Act (ACA) and the potential impact on California's Child Support Program.

The CSDA was established in 2001 as a non-profit association to represent the local child support directors of California's 58 counties. The Association strives to be of service to local child support agencies (LCSA) in their effort to ensure children and families have the financial, medical, and emotional support required to be productive and healthy citizens in our society.

The Workgroup was charged with creating a report that summarized their activities, findings, and recommendations by July 10, 2013 for submittal to CSDA Board for final approval. CSDA contracted with HMS to provide consulting services, facilitate Workgroup discussions and analysis, and to assist with the development of a final report.

The Workgroup met together in person six times and held five supplemental conference calls between February and June 2013. The group studied a variety of reference documents, reviewed federal and state guidance and regulations, and met with subject matter experts on the ACA, Health Insurance Benefit Exchanges, Medicaid, and the Child Support Program. The reference section of this report identifies many of these documents. As with any major piece of legislation the regulatory landscape is constantly evolving. During the Workgroup's 5-month deliberations, numerous proposed and final regulations and guidance documents were released for consideration and analysis. The last release considered by the Workgroup came on June 26, 2013: CMS final regulation "Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions." Workgroup documents were housed and produced on the Central Desktop document hosting website.

Workgroup membership was established by CSDA and included a balance of 10 representatives from LCSAs representing large and small counties from different regions within the State. Workgroup leadership and oversight was provided by David Oppenheim, CSDA Executive Director, and Chairperson Kathy Sokolik, Director, Santa Cruz/San Benito Regional.

The Workgroup also included Ad hoc participants from the California Department of Child Support Services (DCSS), Administrative Office of the Courts (AOC), and Region IX HHS Administration for Children and Families (ACF). Ad hoc participants attended the Workgroup meetings in an advisory capacity. The recommendations in this report are those of CSDA and may not necessarily reflect those of the organization the Ad hoc members represent.

Workgroup Roster

» Lori Cruz – *Deputy Director, Los Angeles County*
» Natalie Dillon – *Assistant Director, Yolo County*
» Kari Gilbert – *Director, Fresno County*
» Tim Hirschberg – *Attorney, Ventura County*
» David Oppenheim – *Executive Director, CSDA*
» Julie Paik – *Director, Sonoma County*
» Terrie Porter – *Director, Sacramento County*
» Iliana Rodriguez – *Director, San Mateo County*
» Tex Ritter – *Director, Sierra/Nevada Regional*
» Kathy Sokolik – *Director, Santa Cruz/San Benito Regional*
» Sharon Wardale-Trejo – *Director, Merced County*

Ad Hoc Participants

» Michael Wright – *Supervising Attorney/Program Manager, Judicial Council of California—Administrative Office of the Courts*
» Elise Wing – *Acting Regional Program Manager, Region IX HHS Administration for Children and Families*
» Vickie Contreras – *Deputy Director, State DCSS*
» Charles Mullinaux – *Associate Governmental Program Analyst, Department of Child Support Services*
» Jonathan Burris – *Department of Child Support Services*
» Lori Norman – *Staff Services Analyst II, Merced County*

Guest Attendees – Subject Matter Experts

» Jennifer Burnszynski – *Director, Division of Technical Assistance Office of Child Support Enforcement (OCSE)*
» David Maxwell Jolly – *Chief Operations Officer at California Health Benefit Exchange*
» Diane Stanton – *Special Consultant for External Affairs, Covered California*
» Arika Pierce – *Division Vice President, Federal Government Relations, HMS*
» Dana Robbins – *Analyst, State Government Relations, HMS*

HMS Contract Support

» Barbara Saunders – *Vice President, Child Support Services, HMS*
» Whitney Warrick – *Senior Manager, Federal Government Relations, HMS*

CSDA would like to thank all the Workgroup members and Ad Hoc participants for their commitment and service to the project. The findings and recommendations will serve to improve child support services provided to the children and families of California.

CSDA

California Child Support Program

Established under Title IV-D of the Social Security Act, the Office of Child Support Enforcement (OCSE) provides the administrative and regulatory oversight of the program and states manage and operate the services provided directly to families.

In California, the Child Support Program is state-supervised and county-administered. The California Department of Child Support Services (DCSS) was established by AB 542[1] and AB 196[2] to be the agency responsible for the oversight and management of the California Child Support Program.

Child Support services are mandated for recipients of CalWorks and available to the general public through a network of 51 county and regional child support agencies referenced as Local Child Support Agencies (LCSAs). LCSAs provide services to approximately 1.4 million children and families. LCSAs locate noncustodial parents, establish paternity, establish and enforce support orders, modify support orders, and collect and pay out child support payments.

The California Child Support Program is the largest in the nation, serving approximately 10% of the nation's child support cases.

The following March 2013 published statistics were provided to the Workgroup from DCSS:

Total Number of Cases	1,318,705
Number of Current Assisted Cases	361,199
Number of Formerly Assisted Cases	657,262
Number of Never Assisted Cases	300,244
Number of Cases without Medical Support Ordered	852,411

The following is point-in-time data as of April 2013 and represents California IV-D caseload data provided to the Workgroup by DCSS. Data may not include all instances of public and private insurance. Summary data includes what the program knew at that point in time:

Number of Children in CA IV-D caseload	1,381,121
Number of Children in CA IV-D caseload with public coverage only	636,332
Number of Children in CA IV-D caseload with private coverage only	138,583
Number of Children in CA IV-D caseload with a combination of both	173,169
Number of CA IV-D caseload with no known coverage	433,037

[1]Assem. Bill 542, 1998-1999 Reg. Sess., ch. 480, (Cal. 1999).
[2]Assem. Bill 196, 1998-1999 Reg. Sess., ch. 478, (Cal. 1999).

CSDA

Affordable Care Act Background

Introduction

The Affordable Care Act (ACA) was signed into law on March 23, 2010. The law seeks to increase access to affordable health insurance beginning in 2014 through a comprehensive set of provisions focused on expanding coverage, controlling healthcare costs, and improving the healthcare delivery system.

In order to level set the conversation and understand how the ACA interacts with the Child Support Program, the Workgroup spent their initial meetings hearing from experts on the ACA. In these meetings, the entire ACA was analyzed and discussed by Workgroup members and consultants in order to effectively understand which sections of the ACA would have an impact on the Child Support program as implementation nears.

The Workgroup found, with regard to the Child Support Program, the law does not contain any language that makes direct changes to the program; however, there are number of sections within the new law that will potentially impact the future of child support. As a result of these meetings, the Workgroup decided to further analyze the following four key sections of the ACA that were determined to have an effect on the Child Support Program: the Individual Mandate, Employer Requirement, Medicaid Expansion, and Health Insurance Exchanges.

- **Individual Mandate: Requires that all Americans maintain a minimum level of health insurance coverage or pay a penalty (with some exceptions)**
- **Employer Requirements: Requires that large employers provide affordable insurance to full-time employees or pay penalties**
- **Medicaid Expansion: Allows states to expand their Medicaid populations with significant federal assistance**
- **Health Insurance Exchanges/Marketplaces: Requires that each state establish a health insurance Exchange where certain individuals and businesses can purchase affordable private health insurance**

As with any legislation of this magnitude, the law has been met with a number of setbacks, regulation modifications, and subsequent changes. However, after overcoming a number of legal challenges at both the state and federal level, the ACA continues to be the law of the land. States and the federal government are moving at a swift pace to implement these new requirements on time—most of which have a January 1, 2014 deadline.

This portion of the report provides a high-level overview of the four sections of the ACA that the Workgroup determined would have the most impact on the Child Support Program.

Individual Mandate

Section 1501 of the ACA requires most individuals to maintain minimum essential coverage for themselves and their dependents or pay a penalty. Under the law, minimum essential coverage is defined as coverage under a government-sponsored plan, eligible employer coverage, individual coverage, and grandfathered health plans.

The law provides some exemptions from the mandate penalty, which apply to members of certain religious sects, unlawfully present individuals or those with a nonresident alien status, incarcerated individuals, members of Indian tribes, individuals who have suffered a financial hardship, and individuals who do not have access to affordable minimum essential coverage. This exemption applies to individuals whose required contribution for the lowest-cost self-only coverage is not more than 8% of his or her household income. Additionally, if an individual meets one of the exemption requirements, they must still pay the penalty for their dependents who lack coverage, unless the dependents also qualify for an exemption. Furthermore, with regards to the affordability exemption as it relates to dependents, the required contribution under the employer's health plan is affordable if the employee's required contribution for the lowest-cost option that would provide minimum essential coverage to his or her family members (i.e., family plan) is not more than 8% of his or her household income.

Employer Requirements

The ACA also includes a provision that subjects large employers—defined as those with at least 50 full-time employees or full-time equivalents—to penalties if they do not offer affordable health coverage. While the provision does not mandate that an employer offer health insurance to their employees, the ACA imposes penalties on large employers if they do not offer affordable health coverage that provides a minimum level of coverage to their full-time employees, or if at least one of their full-time employees obtains a premium credit through the newly established health insurance Exchange. However, large employers are not subject to a penalty if their full-time employees are eligible for Medicaid or CHIP.

Under the employer provisions of the ACA, employer-sponsored coverage is considered affordable if the employee's required contribution for self-only coverage does not exceed 9.5% of the employee's household income for the taxable year. The Internal Revenue Service (IRS) has provided a safe harbor for employers to use the employee's W-2 income for this calculation since most employers do not readily have information on an employee's household income. Additionally, employers have the flexibility to designate certain measurement or look-back periods (up to 12 months) during which they will calculate whether a worker is full-time or not. Moreover, the affordability of coverage for the employee's dependents is based on the same test of self-only coverage (alternatively, the individual mandate uses the required contribution for family coverage).

Medicaid Expansion and Medi-Cal

The ACA requires all states to expand their Medicaid program to all individuals (including childless adults) earning up to 133-138% of the Federal Poverty Level (FPL). Under this provision, the federal government will pay 100 percent of the cost of all newly eligible Medicaid recipients in the state from 2014 to 2016. The federal government's share will decrease to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, with the share further reducing to 90 percent beginning in 2022[3].

The June 2012 Supreme Court decision, however, deemed the Medicaid expansion requirement provision in the ACA unconstitutional, leaving the decision of whether to pursue Medicaid expansion to the individual governors and state legislators. As of this writing, approximately 23 states and the District of Columbia have decided to expand their Medicaid programs. A number of other states are still weighing their decision. The federal government is allowing states to make their expansion decision at any time with no deadline.

Following the passage of the ACA, California was one of the first states to embrace healthcare reform and immediately began work on implementation. Specifically, in November 2010, the Centers for Medicare and Medicaid Services (CMS) approved a California proposal to make several major changes to Medi-Cal, California's Medicaid program administered by the state Department of Health Care Services (DHCS), and to expand county-based coverage programs for low-income, uninsured residents under what is called a "Bridge to Reform" waiver. This waiver allows state officials to pursue fundamental program changes intended to improve health outcomes, curb spending growth, and prepare the State for the sizeable expansion of Medi-Cal expected in 2014 under the ACA.

Currently, approximately 8.3 million Californians are covered by Medi-Cal, and more than one million new enrollees are expected beginning in 2014. Additionally, children who are currently in the Healthy Families Program—which will be eliminated by 2014—began transitioning into the Medi-Cal program at the beginning of 2013. It is expected that more than 850,000 children will make this transition. Further, another 240,000 to 510,000 Californians who are currently eligible, and not enrolled in the program are expected to enroll by 2019 due to increased awareness of coverage options provided by the ACA[4].

After much debate as to whether California Governor Jerry Brown would adopt a county-based or state-based approach for Medi-Cal expansion, Governor Brown released his budget revision in May 2013, which proposes a statewide approach under which the state would expand its existing state-administered Medi-Cal program to cover the expansion population.

[3]The Commonwealth Fund, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, by T. S. Jost, July 2010
[4]See http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidCHIP-Eligibility-Final-Rule-Fact-Sheet-Final-3-16-12.pdf

Health Insurance Exchanges and Covered California

The creation of online marketplaces, also known as health insurance Exchanges, was included in the ACA as a means to increase individual access to health insurance by providing consumers with a structured marketplace to purchase health coverage. These Exchanges may be established in one of three ways:

» **A state-based Exchange where the state is responsible for creating and managing its own Exchange**

» **A state partnership Exchange where the state chooses to partner with the federal government to run the Exchange**

» **A federally-facilitated Exchange where the Department of Health and Human Services (HHS) manages the Exchange solely**

At the time of this writing, 17 states have declared a state-based Exchange, 7 states are planning to run a partnership Exchange, and 27 are defaulting to the federal Exchange.

The ACA requires that the Exchanges be operational in every state by January 1, 2014, with the initial open enrollment beginning on October 1, 2013. Additionally, the ACA provides certain requirements for the establishment of Exchanges, while leaving other choices to up to the states[5]. Further, for those individuals who may not be able to afford a health plan in an Exchange, coverage will be subsidized for individuals in families with income between 100-400% of the Federal Poverty Level (FPL) who are not eligible for Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer-sponsored insurance. The ACA also states that any qualified health plan offered on the Exchange must also be offered as a corresponding child-only plan—open to those individuals who have not yet turned 21 at the start of the plan year—at the same level of coverage.

California was the first state to pass Exchange legislation following passage of the ACA. Covered California™, California's version of its state-based health insurance Exchange, is a marketplace where legal residents of the State can buy health coverage. According to the Covered California™ site, as of 2014, approximately 2.6 million Californians will qualify for federal financial assistance and an additional 2.7 million who do not qualify for assistance will benefit from guaranteed coverage through Covered California™ or through an insurance company in the individual market. An estimated 2.3 million California residents will enroll in a health plan through Covered California™ by 2017. Starting in October 2015, Covered California™ will be open to employers with 100 or fewer full-time equivalent employees.

[5]The Lewin Group, *Medi-Cal Facts and Figures: A Program Transforms*, May 2013.

CSDA

ACA & Child Support Matrix

Upon concluding the study of the ACA and identifying the four key sections from the Act that will have a major impact on the Child Support Program, the Workgroup created an ACA & Child Support Matrix. The Matrix allowed the Workgroup to identify the intersections between the ACA, federal regulations, Office of Child Support Enforcement (OCSE) regulations, and California medical child support laws so that each section could be clearly defined and laid out in an easy-to-read table.

The ACA & Child Support Matrix (Matrix) can be found in Appendix A and is designed in the following way:

Sections

» Individual Mandate: Requires that all Americans maintain a minimum level of health insurance coverage or pay a penalty (with some exceptions)

» Employer Requirements: Requires that large employers provide affordable insurance to full-time employees or pay penalties

» Medicaid Expansion: Allows states to expand their Medicaid populations with significant federal assistance

» Health Insurance Exchanges/Marketplaces: Requires that each state establish a health insurance Exchange where certain individuals and businesses can purchase affordable private health insurance

Columns

» Column 1: Includes the provision of the ACA and/or related US code that the Workgroup determined may intersect or impact the Child Support Program delivery of medical child support services. The language in this column is taken directly from the ACA as originally passed in March 2010.

» Column 2: Includes relevant federal regulations or guidance from the Administration that clarifies or amends the law as written in the ACA in column 1.

» Column 3: Includes any Code of Federal Regulation (CFR) or guidance from OCSE that identifies the medical child support regulation that is most closely related to the ACA provision identified in Column 1.

» Column 4: Includes the most relevant California Family code or guidance regarding OCSE regulations identified in Column 3.

» Column 5: Identifies the intersection between the ACA and Child Support. The Workgroup further categorized these intersections based on the potential impact to the related medical child support service:

  » Establishing a Medical Support Order (MSO)

  » Enforcing an MSO

  » Case maintenance

  » Other

The completed Matrix, found in Appendix A, identifies 18 specific intersections that the Workgroup concluded will impact the Child Support Program's delivery of medical child support services.

CSDA

Gap Analysis

Once the Matrix was completed, the Workgroup prepared 14 Gap Analyses based on the 18 major intersections identified in the Matrix. Some intersections were combined into a single Gap Analysis as the discussion and conclusions were parallel.

The Gap Analyses were created by the Workgroup as independent studies of specific intersections, providing background and comment on potential legal conflicts, program role conflicts, policy and procedural impacts, and the need for communication across programs. The Workgroup broke down the analysis into two major categories:

» **Regulations: Identification and discussion of where federal and California Child Support regulations intersect, with a specific ACA section from the Matrix, and potential resolutions or recommendations**

» **Operations: Identification and discussion of where California local business practices, California Child Support Automated System (CCSAS) processes, and forms/documents intersect with a specific ACA section, and the potential resolution or recommendations**

Each Gap Analysis offers its own individual set of recommendations from the Workgroup. As part of the decision-making process, each recommendation was weighed against the impact to California's Child Support Program:

- Current law and regulation
- Implementation timelines
- Funding
- LCSA workload
- Automation
- Local business practice for the family courts and LCSA

The Gap Analyses are numbered sequentially to link back to the Matrix for easy reference. They are located in Appendix B – Gap Analyses and briefly described as follows:

Individual Mandate – The five gap analyses under this section identify and discuss where parents may experience conflict in meeting their ACA and Child Support program responsibilities and provide mitigation strategies of increased collaboration with family law courts along with the development of LCSA training and materials for outreach.

1. *Tax Exemption*: Under the ACA, the individual responsibility provisions require each individual to have minimum essential coverage or pay a penalty. The individual who could claim the dependent on their federal income tax return is responsible for maintaining coverage for the dependent. Within the Child Support Program, which parent has the federal tax exemption does not play a significant part in the determination of who could be ordered to obtain healthcare coverage under federal child support regulations. The implementation of the ACA, adds a layer of complexity and possible conflict for individuals who are trying to meet both their personal responsibilities and medical support obligations under very different legal constraints.
2. *Coverage Source*: While Child Support benefit requirements align with the ACA and Covered California minimum essential coverage requirements, Child Support and the ACA do not clearly align regarding the coverage source for maintaining coverage. States are allowed to revise their definition of medical support to include public healthcare coverage, but it is at the point of establishing the medical support order that states face complex issues in the determination of which parent (or both) should be ordered to provide the heathcare coverage.
3. *5% v. 8%*: Under the ACA for an individual or their dependent, the affordability exemption from obtaining coverage is defined as no more than 8% of household income. In California, the test for determining if the cost of healthcare coverage is reasonable is 5% of gross income. With the implementation of the ACA, having different standards for exemptions to obtaining coverage may lead to confusion and uncertainty for parents with child support cases, employers, LCSAs, and the courts. The Workgroup examined several income scenarios, found in Appendix C, to compare the different income standards and the possible impact to child support obligations. The Workgroup determined that California's definition of "reasonable" for child support purposes is already codified in California Family Code and meets the current federal requirements. Without knowing what the future plans will be for the medical child support program at the federal level, redefining affordability would be premature on the part of the California Child Support Program.
4. *Coverage Gaps*: Under the ACA, a gap in coverage that lasts less than three months qualifies as a short coverage gap and the individual will be exempt from any penalties. In the Child Support Program, once a National Medical Support Notice (NMSN) has been served on an employer, it is the employer's responsibility to maintain the coverage under NMSN requirements and report changes to coverage to the child support agency. For parents ordered to provide health insurance there are no penalties for gaps in coverage if employer-sponsored insurance (ESI) is not available, reasonable, or accessible. Allowing short coverage gaps that last less than three months places the Custodial Parent (CP) at risk of a tax penalty if the Non-custodial Parent (NCP) is ordered to maintain coverage and fails to do so. For parents involved in child support cases, having "maintaining coverage" requirements that differ may lead to confusion and uncertainty.
5. *Tax Penalty*: Under the ACA, an individual is liable for the shared responsibility payment (tax penalty) of his/her dependent if he/she claims or may claim the dependent on his/her federal income tax return. Under the Child Support Program it is the ordered parent's responsibility to ensure that the dependent has healthcare coverage. It is a common scenario within the Child Support Program for the Custodial Parent (CP) to have the tax exemption and the Non-custodial Parent (NCP) who has the obligation to provide the insurance coverage. If the NCP fails to provide insurance coverage, the CP is at risk of having to pay a tax penalty. Federal guidance released on June 26, 2013 clarified that for a CP in the above scenario where the NCP has not enrolled the dependent in healthcare coverage, the CP would be eligible to claim a hardship exemption.

Employer Requirements – The two gap analyses found in this section identify and discuss employers' new ACA requirements and how this may impact child support caseloads and interactions with employers in regards to meeting NMSN requirements.

6. ***Employer Requirements***: Under the employer mandates, the ACA imposes an excise tax on large employers who fail to offer affordable coverage to their full-time employees. In regards to the Child Support Program, employers will still be required to honor National Medical Support Notices (NMSNs) and enroll an employee's dependent if state law requirements of available, reasonable, and accessible are met. For the California program, it is anticipated that employers will be contacting local Child Support agencies seeking clarification regarding their responsibilities in relationship to the ACA mandates and NMSN requirements. In addition, parents may confuse the employer mandate to offer coverage to an employee and dependents up to the age of 26 and their medical support responsibilities until the age of emancipation and increase their contacts with the child support agency seeking clarification on their responsibilities.
7. ***Employer Reporting***: Employers will be required to file annual reports with the IRS identifying each full-time employee and describing the coverage they offer to full-time employees and their dependents. Employers must also provide a statement to each full-time employee with information about the coverage available to the employee. Whether this data would prove to be useful to child support programs is unclear and will need to be studied as final reporting requirements are determined and reported data is gathered.

Medicaid Expansion – The four gap analyses found in this section identify and discuss the new mandates state Medicaid agencies are responding to and how this may impact child support caseloads and increased opportunities for collaboration.

8. ***Medicaid Expansion Overview***: For states that implement Medicaid Expansion, respective Child Support Medical-Only referrals will increase. California was one of the first states to adopt Medicaid Expansion requirements. Already offering Medicaid eligibility up to 250% of poverty level for families/dependent, the California Child Support Program does not anticipate a significant increase in the IV-D caseload due to new federal Medicaid expansion regulations.
9. ***MAGI:*** The ACA makes the tax concept of Modified Adjusted Gross Income (MAGI) the basis for determining affordability of healthcare for individuals and their dependents. Under the ACA for an individual or their dependents, the affordability exemption from obtaining coverage is defined as no more than 8% of household income. MAGI income is the total of all types of income including within the household. In California, the test for determining if the cost of healthcare coverage is reasonable is 5% of a parent's gross income. The application of different income sources between the ACA and the Child Support Program are particularly striking. The ACA definition draws in all members of an individual's household. The Child Support Program is specifically focused only on the income of the individual who is a party to the child support case. The basis of the Child Support Program is to provide services to parents who live apart from their children. Income from new spouses or other household members including non-married relationships is intentionally disregarded. With the implementation of the ACA, having different standards for exemptions to obtaining coverage may lead to confusion and uncertainty for parents with child support cases, employers, LCSAs, and the courts.
10. ***CHIP Reauthorization***: Funding for CHIP through September 30, 2015 (an additional two years compared to current law), continues the authority for the program through 2019, and requires states to maintain eligibility standards for children in Medicaid and CHIP through 2019. CHIP-eligible children who cannot enroll in the program due to federal allotment caps must be screened to determine if they are eligible for Medicaid and if not would be eligible for tax credits in a plan in the state Exchange. California has already begun to transition Healthy Family participants (Medi-Cal/CHIP) as part of statewide preparation for completing full Medicaid Expansion by January 2014.

11. ***Enrollment Simplification***: While the Child Support Program was not specifically cited in the ACA as one of the mandated agencies under the enhanced coordination and communication requirements, HHS over the last several years has worked to create opportunities to improve information sharing, system integration, and program coordination among Center for Medicare and Medicaid Services (CMS), Administration for Children and Families (ACF), and the Food and Nutrition Services (FNS), with the goal of expanding access and improving outcomes. Having continued access to Medi-Cal eligibility data will assist child support-related case tracking and maintenance of effort. This data will also assist child support agencies in locating newly eligible adults party to a child support case.

Health Insurance Exchange – The three gap analyses found in this section describe the development of Exchanges and the intersections where parents may access the exchange to purchase healthcare coverage for their dependents and also may obtain tax credits and subsidies to offset the cost of the insurance. Also included are Workgroup comments and discussion on the increased opportunities for collaboration between the Child Support Program and Exchanges.

12. ***Health Insurance Exchange Overview***: In 2010, California was the first state in the nation to enact legislation to implement the provisions of the federal Affordable Care Act by creating a healthcare marketplace—Covered California™. Covered California™ will offer child-only qualified health plans. Premium tax credits and cost-sharing subsidies are available for eligible individuals who purchase child-only plans. With Covered California™ in the final preparations to begin open enrollment in October 2013, the California Child Support Program has ready access to information and resources to study the impact of the ACA on the program in order to make informed decisions about the future of providing medical support services to the child support caseload. Collaborative relationships with Covered California™ and state/local Child Support programs are firmly established and discussions of shared initiatives have begun.
13. ***Tax Credits***: Premium tax credits are available to individuals and families with incomes between 100% of the federal poverty level ($23,550 for a family of four) and 400% of the federal poverty level ($94,200 for a family of four) who purchase coverage in the health insurance Exchange in their state. To receive the credits, individuals must be U. S. citizens or lawfully present in the United States. They cannot receive premium tax credits if they are eligible for other "minimum essential coverage," which includes most other types of health insurance such as Medicare or Medicaid, or employer- sponsored coverage that is considered adequate and affordable. Only individuals who may claim a dependent for federal tax purposes are eligible to receive a premium tax credit. This may place an ordered parent in a child support case at a financial disadvantage if they attempt to comply with a medical support order by obtaining coverage through a health insurance Exchange.
14. ***Exchanges—Streamlining Enrollment:*** Covered California™ will provide the access for individual family members to apply for health insurance affordability programs with each family member having a unique Client Identification Number (CIN). This practice will allow each family member to maintain continuity of coverage because the system can accommodate moving between public and private coverage options according to changes in status or qualifying events (pregnancy, recently unemployed, turned 65, etc.). Additionally, this capability will accommodate unique family dynamics such as one family member with employer-sponsored coverage, another on a Covered California™ qualified plan with a premium subsidy, and a child receiving Medi-Cal. Access to Exchange data may assist local California Child Support agencies in meeting not only medical child support requirements, but also may aid in location efforts. The Child Support Program provides services to individuals from all income levels. Unlike most social service programs, eligibility is not based on income. Officials from DCSS and California's Health Benefit Exchange have started discussions about outreach initiatives to parents receiving child support services regarding the benefits of the health insurance Exchange.

Summary of Recommendations

The Workgroup's gap analysis recommendations are California program-specific. As an early adopter of the ACA, California is on schedule to begin open enrollment in October of 2013 and to meet the January 2014 implementation requirements. CSDA members have a strong sense of urgency to prepare responsibly on behalf of their staff, customers, and interested stakeholders to meet the challenges that will impact the medical support services that are currently provided across the State as the ACA is implemented.

The recommendations provide a roadmap on how the California state and local Child Support enforcement agencies should proceed to prepare short-term mitigation strategies over the next 12-18 months as the ACA is operationalized in California. It should be noted that some recommendations were repeated across Gap Analyses.

The full details and justification for each recommendation can be found in the Gap Analyses provided in Appendix B. A summary of the recommendations is available on the following page.

The recommendations for the California program were a high priority for the Workgroup. They were thoughtfully researched and carefully deliberated by the group. The Workgroup urges CSDA membership and other interested California stakeholders to begin immediately and establish the suggested collaboration workgroups. It is also important to develop ACA training for LCSAs and outreach materials for courts, case participants, employers, and agency staff. With open enrollment through the Exchanges to begin in October 2013, preparations must begin now. The Workgroup has already created a work plan for outreach materials and has developed early stage drafts of call scripts for LCSA staff, as well as FAQs. These drafts have been made available to CSDA as a suggested starting point for further development.

	Recommendation	Applicable Gap Analysis
1	No short term legislative change are required prior to the January 2014 ACA implementation date.	1-14
2	No changes to current state laws unless federal regulations are amended.	1-14
3	Encourage CMS and IRS to work closely with OCSE and state child support programs when developing ACA related regulations or guidance in consideration of the added layer of complexities that families within the Child Support Program face.	5
4	Encourage tracking of federal regulations as it relates to the ACA and potential impact on the California Child Support Program and encourage active participation at the national level to share California related experience and perspective.	5
5	Share comments with OCSE and other state child support programs to encourage examination of individual states' policy regarding the potential impact to child support caseloads under Medicaid expansion requirements.	8
6	Share comments and recommendations with DCSS and the California Department of Health Care Services regarding the importance of collaboration for both programs. Include LCSA participation in collaboration meetings.	11
7	Support ongoing collaboration and shared initiatives between DCSS and the California Health Benefit Exchange and include LCSA participation in collaboration meetings.	14
8	Establish collaborative workgroup with AB1058 commissioners and family law judges to encourage consistent application and standardization when MSOs are established or modified after the implementation of the ACA.	1-5,9-13
9	CSDA lead development of statewide LCSA training on the ACA and intersections with Child Support Program to support informed customer service after the implementation of the ACA.	1-14
10	CSDA lead development of a work plan for the creation of FAQ and/or outreach materials to support program staff as they interface with parents, legal professionals, employers, Exchanges, and other child support stakeholders. Establish a collaborative workgroup with DCSS.	1-14

CSDA

Future of Medical Child Support

As a final charge, the Workgroup examined the Future Role of the Medical Child Support Program in establishing and enforcing medical support orders as the ACA becomes operationalized. Informal discussions have already begun at the federal level, and four broad policy options have been identified by the child support community. As described more fully below, the Workgroup has discussed the impact of each of these options and the long-term impact each could have on medical child support going forward.

Historical Overview of Medical Child Support

While medical child support requirements have always been a part of the IV-D program, the service delivery complexities have historically caused this service to appear slightly removed from the core mission of the Child Support Program: to locate parents, establish paternity, establish orders, and collect support. Furthermore, because medical support enforcement has never been a part of the child support incentive program, improvements to medical child support services are often not a top priority at either the federal or the state level.

Improvements to the effectiveness of medical child support, however, have been attempted in the past. For example, in 1998, the Child Support Incentive Act (CSPIA) strengthened and expanded the program's duties, emphasizing the importance of not only establishing medical support orders but also securing private healthcare coverage for children[6]. CSPIA standardized the communication between Child Support agencies and employers with the development of a National Medical Support Notice (NMSN). The use of the NMSN was required for all state programs and employers, and Plan Administrators were required to accept the notice as a Qualified Medical Support Order (QMSO).

As part of CSPIA, a medical support working group was established, and in 2000 published their report to Congress[7]. Explained in further detail in the CRS report to Congress, *Medical Child Support: Background and Current Policy*[8], the medical support working group report identified impediments to the effective enforcement of medical child support and offered 76 recommendations for the development of a comprehensive medical child support system.

These recommendations included shifting the focus to both parents sharing the primary responsibility to meet their children's healthcare needs, streamlining the process for establishing and enforcing medical support orders, and establishing performance measures and incentives for states to support program outcomes.

[6]P.L. 105-200 the Child Support Performance and Incentive Act of 1998.

[7]Department of Health and Human Services, Administration for Children and Families, Office of Child Support Enforcement, *21 Million Children's Health: Our Shared Responsibility*, the Medical Child Support Working Group, June 2000.

[8]CRS Report R43020, *Medical Child Support: Background and Current Policy*, by Carmen Solomon-Fears, March 21, 2013.

Subsequently, in July 2008, OCSE released AT-08-08 transmitting the release of the final rule, *Child Support Enforcement Program-Medical Support*[9], which included many of the medical support workgroup's recommendations. The final rule:

» Defined cash medical support

» Required that all support orders in the IV-D program address medical support

» Required that states consider health insurance available to either parent

» Redefined health insurance that is available at "reasonable cost"

» Required health insurance coverage to be "accessible"

» Allowed states to close child-only Medicaid cases under certain circumstances

» Made changes to federal substantial-compliance audit and state self-assessment audit to address medical support requirements

Though CSPIA also required HHS to develop a medical support incentive measure based on a state's effectiveness in establishing and enforcing medical support orders, this final rule did not include a medical support incentive measure. As referenced in greater detail in the CSR report to Congress, *Medical Child Support: Background and Current Policy*, HHS did report to Congress in 1999 that a medical support incentive measure could not be set due to limited and invalid data.

Since that time, state Child Support programs continued implementation of the 2008 medical support requirements with varying degrees of success, hampered by lack of funding, competing priorities, and the complex issues surrounding the establishment and enforcement of medical support orders. According to the latest report to Congress, medical support was provided in only 32.9% of child support cases in which medical support was ordered[10].

[9]AT-08-08 Final rule; Child Support Enforcement Program, Medical Support.

[10]FY2011 Preliminary Report-Table P-33. OCSE, October 2012

With the passage of the ACA in March 2010, OCSE has issued guidance to state Child Support programs in the form of Action Transmittals (ATs) and Policy In Question (PIQs) in recognition of the difficulties states faced in implementing all of the required medical child support provisions. The guidance relieved states from making new investments in medical support enforcement to comply with regulatory requirements, allowed states greater flexibility, and encouraged collaboration with regards to the implementation of the ACA until it is determined if further legislative or regulatory changes may be necessary to update medical child support policy. The relevant ATs and PIQs listed below are available in the reference section at the end of this report:

» AT-10-02 SUBJECT: Holding States Harmless from Penalties for Failure to Comply with Medical Support Final Rule State Plan Requirements

» AT-10-10 SUBJECT: State Child Support Enforcement Program Flexibility to Improve Interoperability with Medicaid and CHIP

» AT-11-10 SUBJECT: Notice of changes to the OCSE-157 Form regarding Medical Support

» PIQ 12-02 SUBJECT: Partnering with other programs, including outreach, referral, and case management activities

With the release in April 2013 of the National Child Support Strategic Plan FY 2010–2014[11], Medical Child Support still remains on OCSE and child support stakeholders' priority list as one of the eight strategies to carry out the mission of the Child Support program and improve the program's impact and effectiveness.

Secure access to healthcare coverage or medical support for children[12]:

» Update medical child support policy and programmatic practices to improve access to healthcare coverage for children and their parents, and ensure child support agencies have the resources to meet their responsibilities

» Ensure that child support agencies have efficient access to necessary and appropriate private and public health coverage data

» Eliminate barriers and emphasize collaboration among child support, Medicaid, CHIP, state health Exchanges, and Indian Health Services

» Educate legislators and policymakers regarding the evolving role of child support in securing health coverage for children

[11]National Strategic Plan 2010 - 2014 OCSE, April 2013

[12]National Strategic Plan 2010 - 2014 OCSE, April 2013

Medical Child Support Policy Option Discussion

Over the years, there have been numerous attempts through regulation to strengthen medical child support and remove impediments to increasing the number of children in the IV-D system with healthcare coverage. Despite continued efforts at both the federal and state levels, securing and maintaining medical coverage for children is resource-intensive and complex, resulting in only small incremental gains for the program.

The passage of the ACA allows the opportunity to examine, once again, the role best suited for the Child Support Program. Following a guiding principle that all children should have healthcare coverage at the forefront and using the findings from the Matrix and Gap Analyses discussed in earlier sections, the Workgroup examined the possible role of medical child support post-ACA implementation.

Across the country, federal and state child support stakeholders are currently reviewing four broad policy options for considerations.

The following are the Workgroup's comments regarding the four potential policy options:

» None of Our Beeswax – IV-D program would no longer have responsibility for establishing or enforcing medical support orders

- » Over the long run, relieves the Child Support Program of a significant body of work that isn't incentivized
- » Allows agencies to realign staff to focus on current performance measures
- » Does not promote the goal of ensuring that all children have medical coverage; there are gaps in the ACA—some children would not have coverage
- » Wouldn't have to align child support provisions with the ACA provisions around affordability, availability, type of coverage, and enforcement related to the individual mandate
- » Relieves employers of meeting medical support requirements, which may be different from or in addition to the ACA/IRS requirements
- » Could eliminate or limit cost recovery opportunities through third party liability (TPL) for Medicaid, and lead to less opportunity for cost avoidance
- » Allows for an easier customer service message with less confusion
- » Child support role is shifting to serving the entire family. Ending all medical support program responsibilities will cause parents in IV-D caseload to seek assistance from other agencies that may not understand the complexities of their needs

» Show Me the Money – IV-D program's primary role would be to establish guidelines that allocate the dependent healthcare costs into appropriate financial orders

» Small cost of medical already built into CA income shares model ($100-$300 annually)

» Must determine whether to build cost of coverage into the child support obligation calculation, or add it as a separate obligation

» May positively impact Medi-Cal cost recovery efforts

» 45 CFR302.55 Medicaid incentive payments to states is a possible funding stream (15% of amount collected)

» Could be as simple as adding a set percentage to all NCP orders

» Orders would still need to address unreimbursed medical expenses (usually 50/50)

» IV-D program's strength is collecting money

» This option may simplify the process in the long run

» Heavy lift would be initial development of guidelines calculation

» Any increase in the amount of child support ordered will affect state performance in current and arrears collections

» Would OCSE consider excluding cash medical orders from performance measurements?

» Any increase in the amount of child support ordered may impact collectability of orders

» Increasing the dollar amount to families allows for flexibility in decision-making for custodial parent

» Got Coverage? – IV-D program would cede most of its responsibilities to the IRS but would retain its traditional role of providing medical support services for parents who are exempt from ACA mandates

» New role would also include ensuring that children are covered by accessing various data sources to determine if coverage has been obtained

» This option would not necessarily include enforecement. For example, if coverage is not identified, provide outreach to parents

» IV-D responsibilities and performance expectations would need to be clearly defined

» Establishing data exchanges and matching procedures with Medi-Cal, IRS, and Exchanges presents technical challenges and would require major system resources

» Exception-based services can be complex to standardize across states and/or counties

» Would be difficult to track and monitor

» May be resource-intensive depending on federal requirements

» **Full Treatment** – The IV-D program would retain its current support responsibilities

» This option would likely include full implementation of many facets of the 2008 regulations

» Require data matching to monitor for ongoing coverage

» Require full enforcement. Dependent must be covered with either public healthcare coverage, Employer-Sponsored Insurance (ESI), or a qualified health plan (QHP) obtained through an Exchange

» Align with the ACA at state option where possible

» May cause interstate issues

» Very resource-intensive

» Would require stronger collaboration with Exchange to develop interface to assist in medical support order enforcement

In addition, the Workgroup identified the following considerations that must also be included for all four of the policy options under discussion:

» Knowledgable insiders within the child support community do not think it is likely that Congress would full eliminate medical support or healthcare coverage considerations from the program

» OCSE is not projecting any final regulatory changes for at least 12-18 months

» Child support program has a lot to offer in supporting the goals of the ACA:
  - » *Expertise*
  - » *Best practices*
  - » *Automation*
  - » *Data*
  - » *Access*

» Any change would involve developing a strategy for existing medical support orders and new orders, which would increase complexity

» Would states be required to have a standardized approach?

» Any change will be complex with a long implementation period (2-4 years or more)

» In all cases, changes would have to be made in the following areas:

- » *State laws*
- » *Systems*
- » *Forms and documents*
- » *Guidelines*
- » *Websites and materials*
- » *Reporting*
- » *Training*

» Would OCSE provide support through increased funding to states to implement changes?

» Will states be incentivized to meet "new" medical support program requirements?

After careful consideration and study, the Workgroup concluded that each of the suggested models presents its own unique set of challenges. It is still unclear at this early stage of ACA implementation whether child support customers are best served if the Child Support Program plays a very active front line role in ensuring healthcare coverage for children in the IV-D caseload, or a support role to other agencies and programs designated by the ACA to ensure healthcare coverage for children. ACA implementation across the country over the next 12-15 months will be at a frantic pace. As an early adopter of the ACA, California is well positioned to meet its implementation goals and time frames, while other states may not be so fortunate. Because the ACA offers states flexibility in such things as Medicaid expansion and whether to set up their own state Exchange or use the federal Exchange, program uniformity may vary greatly across the country. These variations will affect child support-related program decisions.

As experienced by this workgroup during deliberations, through the remainder of 2013 and into 2014, ongoing releases of federal guidance and final regulations will continue to be transmitted, necessitating program adjustments and shifts in priorities. In addition, HHS will be deep in the process of assisting states in their implementation plans as well as implementing the federal Exchange. The IRS will be preparing for new data collection from employers and health insurance Exchanges, as well as establishing procedures for the assessment of possible tax penalties in 2015. Data from tax penalties will most likely not be available until well beyond 2015.

For these reasons, the Workgroup recommends that no final decision regarding the future of medical child support be made until ACA implementation is further along and there is experience and data to support changes to regulations and procedures.

The Workgroup strongly recommends that a coordinated commitment begin immediately with OCSE, state IV-D programs, and other child support stakeholders to develop a strategy that balances and aligns the mission of the medical child support program with the ACA. The Workgroup acknowledges that OCSE, a number of states, and child support-affiliated associations have begun similar discussions and are in early stages of deliberation and study. As this report points out, even without any regulatory changes, states need to prepare for open enrollment beginning October 2013 and its impact on customers and current medical support operating procedures.

The Workgroup recommends that OCSE establish a workgroup, much like the 2000 Medical Support Workgroup. The new workgroup should seek and forge partnerships with a variety of organizations from both the public and private sector to develop short- and long-term solutions regarding the future role of medical child support.

The following is a summary of the Workgroup's Future of Child Support recommendations:

- **No final decision regarding the future of medical child support should be made until ACA implementation is further along and there is experience and data to support changes to regulations and procedures.**
- **OCSE should establish a National Medical Child Support Workgroup**
  - Workgroup members should include a balance of:
    - US Department of Health & Human Services Administrators
    - State IV-D Directors
      - Large and small states
      - Regional balance
      - Agencies from states that are early adopters of the ACA
    - Local County IV-D Directors
    - Tribal Program Directors
    - State Medicaid Directors
    - Organizations representing Child Support Professionals
    - Judiciary and/or Legal Professionals
    - Trade and Industry Representatives
    - Child Advocacy Organizations
    - Health Benefit Exchange Representatives
    - Employers
    - Plan Administrators
  - National Medical Child Support Workgroup Charge
    - Study the intersections between ACA and medical child support requirements
    - Identify barriers to effective medical child support
    - Provide ongoing guidance to states for short-term solutions pending formal regulatory changes
    - Provide recommendations for the creation of a new medical child support model that address
      - Balance and alignment with ACA
      - Amending relevant law to reduce barriers
      - Funding
      - Automation
      - State flexibility
      - Reasonable implementation timeframes
      - Guidance on procedures for managing medical support orders established prior to any regulatory changes

CSDA Responds to the Challenge

The Child Support Program promotes parental responsibility so children receive financial, medical, and emotional support from both parents even when they live in separate households. Nationally, the program supports a fourth of the nation's children (17 million) from all socioeconomic backgrounds. The California Child Support Program is the largest in the nation providing services to approximately 1.4 million children and families. To increase healthcare coverage for children, state Child Support programs are required to establish and enforce medical support orders for their caseload.

In an effort to increase access to affordable health insurance nationally, Congress passed the ACA, which provides a comprehensive set of provisions focused on expanding coverage, controlling healthcare costs, and improving the healthcare delivery system. Many of the expansion provisions from the ACA will be implemented in January 2014. These provisions will directly impact the children and families that are being served by the Child Support Program. This report is CSDA's response to the challenges state and local programs will be facing.

In February 2013, the CSDA established an Affordable Care Act Child Support Workgroup made up of local California Child Support agency representatives as well as Ad hoc members from state DCSS, the Administrative Office of the Courts, and federal Child Support program experts. Over a five-month period the Workgroup analyzed numerous reference documents, reviewed federal and state guidance and regulations, and met with subject matter experts on the ACA, Medicaid (Medi-Cal), and health insurance Exchanges. The Workgroup created an ACA & Child Support Matrix to capture 18 key intersections between the new law and the Child Support program. Next, the Workgroup developed detailed gap analyses based on the intersection points to define the identified areas of impact and to support the Workgroup's final recommendations.

After thorough deliberation the Workgroup separated the recommendations into two parts: (1) actions needed within the California program and (2) actions needed at the national level to align and support the common goals of the ACA and Child Support.

The California-specific recommendations focus on how state and local agencies should proceed to prepare short-term mitigation strategies over the next 12-18 months. Provided in detail in this report are recommendations that offer mitigation strategies to:

- Support families in the IV-D program as they adjust to new individual mandates under the law
- Encourage collaboration with family law courts to develop interim solutions that support custodial and non-custodial parents as they navigate to comply with their medical support obligations and their ACA responsibilities
- Encourage continued collaboration between state and local child support agencies with California Health Benefit Exchange and state Health and Human Service agency to support the implementation of the ACA and the goals of the California Child Support Program
- Encourage tracking of federal regulations as it relates to the ACA and potential impact on the California Child Support Program and encourage active participation at the national level to share California-related experience and perspective
- Develop ACA training for LCSA staff so they may be better informed when responding to the needs of local IV-D cases
- Encourage increased collaboration with DCSS to develop FAQs and other outreach materials to support program staff as they interface with parents, legal professionals, employers, Exchanges, and other child support stakeholders

The national recommendations focus on how federal and state Child Support programs should proceed to develop a long-term strategy regarding the future of medical child support and its role within the mission of the Child Support program. The recommendation calls for the formation of a national medical support workgroup to study and determine collaboratively the future of medical child support prior to the issuance of new program regulations.

As this report demonstrates there is a common goal between the ACA and the Child Support Program to increase healthcare coverage for children and families. While the methods taken to achieve this goal may be different, the Workgroup emphasizes that this link must be kept at the forefront of any discussion as efforts are made to align the programs.

The Workgroup believes it is too soon to make substantive program changes at both the state and national level. Rather this report strongly urges that federal and state decision-makers begin immediately to establish a multidisciplinary workgroup to gather data and study trends as the ACA becomes operationalized.

The Workgroup firmly believes there is a role for the Child Support Program that can support the implementation of the ACA. The Child Support Program has a history of meeting new challenges with innovation and success. The program has achieved this by keeping the well-being of the children and families served at the core of all decisions. CSDA believes that the Child Support Program will rise to the challenge and lead the country in the creation of a new medical support model that improves the well-being of children and families.

The Child Support Directors Association of California (CSDA) respectfully offers this report to the child support community to support the search for this solution.

CSDA

Reference Documents

AT-08-08 - Final Rule: Child Support Enforcement Program Medical Support

AT -11-10 – **SUBJECT**; Notice of changes to the OCSE-157 Form regarding Medical Support

AT-10-10 - **SUBJECT**: State Child Support Enforcement Program Flexibility to Improve Interoperability with Medicaid and CHIP

AT-10-02 - **SUBJECT**: Holding States Harmless from Penalties for Failure to Comply with Medical Support Final Rule State Plan Requirements

California Laws Pertaining to Medical Support and Health Insurance Assignment Orders – created by the ACA and Child Support Workgroup June 2013

CFR & Medical support code cites – created by the ACA and Child Support Workgroup June 2013

CMS **Notice of proposed rulemaking SUBJECT**: Medicaid, Children's Health Insurance, Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing., 78 Federal Register 4593 (22 January 2013) pp. 4593-4724

CMS SUBJECT: Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage Federal Register 78 Federal Register 22. (1 February 2013) pp.17900-17901

CMS Final Regulation Titled; Patient Protection and Affordable Care Act: Exchange Functions Eligibility for Exemptions: Miscellaneous Minimum Essential Coverage Provisions, Published June 26, 2013

CMS guidance SUBJECT: Guidance on Hardship Exemption Criteria and Special Enrollment Periods. Published June 26, 2013

Fact Sheet: Visualizing Health Policy. American Medical Association. Kaiser Family Foundation. March 2013

Frequently Asked Questions; California Health Benefit Exchange. Covered California, 2013. Print

Health Care Reform in Depth: Information for California Counties, UCDAVIS Extension, Center for Human Services. March 19, 2013

Health Plans & Rates for 2014: Making the Individual Market in California Affordable. Covered California, 2013. Print

Internal Revenue Service. *Questions and Answers on Employer Shared Responsibility Provisions under the Affordable Care Act.* 28 December, 2012

Maxwell Jolly, David. Cover California Overview. Presentation to the CSDA Annual Child Support Conference. Anaheim, CA. May 2013

Moore, Amy. IRS Clarifies Family Health Coverage Mandates. Health Plans, Welfare Plans Covington & Burling LLP, 25 February 2013

Office of Child Support Enforcement. National Strategic Plan 2010 – 2014. April 2013

Patient Protection and Affordable Care Act; Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions; Notice of proposed rulemaking, 45 CFR Parts 155 and 156 78 Federal Register 22 (1 February 2013) pp. 7348-7371

Hennepin County's "Cheat Sheet" on MNSure Transition ver. 8/18/14

Information and Processes for cases transitioning, "closing" or, opening on Medical Assistance (MA).

IVE and Non-IVE Medical will continue to be administered in MAXIS for the foreseeable future. thus there are no changes to current process in Intake or Enforcement, including Interstate cases.

Auto-Newborn MA - Effective immediately (6/1/14), if a COMA auto-newborn CRDL is received, please close the case using 950 Case Opened in Error. If a paper application is received and you discover that a/the child on the application is an "auto-newborn" on MAXIS do not ask the HSR to complete a referral through MAXIS. Instead, open the case as NPA, waive the application fee, and suppress the cost recovery fee.

MNsure IBM Curam Date	Program – Case Type	Case Type Information	CS access to info	PRISM Program Code	How to proceed if PRISM Program Code = NPA - **Intake**	How to proceed if PRISM Program Code = NPA - **Enforcement**
Beginning August 1, 2014	Former MNCare Family Cases	Cases that were formerly MNC that auto-converted to "Interim MA" effective 1/1/14	Former MNC cases are currently administered in MMIS – do not use MMIS or ECF information to establish or enforce these cases	NPA or Other PA Program Code if opened on other assistance. IF the case has another PA Program code (MFP, DWP, CCC, etc.) establish/enforce as usual.	Review IVD application – if applicant selected Medical Services Only AND you have not commenced an action please, set the case aside until further instruction. If applicant selected full services OR, you have already commenced an action please read on. Case should be handled as any other NPA case: • Send a Notice of Continued Services • CP may opt to close case • If formerly in sanction and CP continues to not cooperate treat as NPA case that does not cooperate Exceptions to NPA treatment: • Cost recovery fee should be suppressed and set a 6 month fee eligibility review date. *Extend for 12 months more upon review date. Absent knowledge of available/affordable private insurance pleadings should contain the following paragraph in appropriate location –	Case should be handled as any other NPA case: • Send a Notice of Continued Services • CP may opt to close case Exceptions to NPA treatment: • Cost recovery fee should be suppressed and set a 6 month fee eligibility review date. *Extend for 12 months more upon review date. Refer to CSED Helpdesk Message 5445 for complete instructions on what and how to enforce. Interstate Initiating – follow the above instructions as you make/respond to requests based on CSNET interface alerts/inquiries. Interstate Responding – enforce according to other State's request.

					"Due to MNsure technical issues the County has no information regarding the status of medical public assistance. The County requests that the issue of medical support be reserved until medical public assistance information becomes available. The County waives any claim for medical public assistance reimbursement until further motion." Interstate Initiating – follow all of the above; however, absent knowledge of available/affordable private insurance your pleadings should simply indicate that the matter of medical support should be reserved. Do not add any information regarding interface issues. Interstate Responding – abide by the other State's petition and pursue what is requested.	
MNsure IBM Curam Date	Program – Case Type	Case Type Information	CS access to info	PRISM Program Code	How to proceed if PRISM Program Code = NPA - **Intake**	How to proceed if PRISM Program Code = NPA - **Enforcement**
January 1, 2014	New MA cases	Did not receive MA in last quarter of 2013. Applied for and qualified for MA through MNsure	None - All info regarding case will be housed in IBM Curam system	NPA	There will be no interface, no referrals for these cases. Clients may apply for IVD services. • If an applicant indicates current receipt of MA case should be opened as NPA and the application fee should be waived • Cost recovery fee should be suppressed and set a 6 month fee eligibility review date. *Extend for 12 months more upon review date. Process case as any other NPA case in terms of basic support. Absent knowledge of available/affordable private insurance pleadings should contain the following paragraph in appropriate location –	Case should be enforced as any other NPA case EXCEPT that the Cost Recovery Fee should be suppressed and set a 6 month fee eligibility review date.*Extend for 12 months more upon review date. IF there's an existing order (case did not come from Intake) please refer to CSED Helpdesk Message 5445 for complete instructions on what and how to enforce. Interstate Initiating – follow the above instructions as you make/respond to requests based on CSNET interface alerts/inquiries. Interstate Responding – enforce according to other State's request.

					"Due to MNsure technical issues the County has no information regarding the status of medical public assistance. The County requests that the issue of medical support be reserved until medical public assistance information becomes available. The County waives any claim for medical public assistance reimbursement until further motion." Interstate Initiating – follow all of the above; however, absent knowledge of available/affordable private insurance your pleadings should simply indicate that the matter of medical support should be reserved. Do not add any information regarding interface issues. Interstate Responding – abide by the other State's petition and pursue what is requested.	
MNsure IBM Curam Date	Program – Case Type	Case Type Information	CS access to info	PRISM Program Code	How to proceed if PRISM Program Code = NPA - **Intake**	How to proceed if PRISM Program Code = NPA - **Enforcement**
January 1, 2015 – December 31, 2015	Existing MAO cases	Received MA prior to January 1, 2014	MAO cases will continue to be administ-ered in MAXIS/MMIS until their recert date. At recert they will close and flip to NPA.	MAO	**No change to current process until case flips to NPA at recertification UNLESS applicant has requested Medical Services Only and no action has been commenced – set those cases aside.** Once case flips to NPA (could be anytime beginning 1/1/15) Case should be handled as any other NPA case: • Send a Notice of Continued Services • CP may opt to close case • If formerly in sanction and CP continues to not cooperate treat as NPA case that does not cooperate	**No change to current process until case flips to NPA at recertification.** Once case flips to NPA (could be anytime beginning 1/1/15) Case should be handled as any other NPA case: • Send a Notice of Continued Services • CP may opt to close case Exceptions to NPA treatment: • Cost recovery fee should be suppressed and set a 6 month fee eligibility review date.

					Exceptions to NPA treatment: • If an applicant indicates current receipt of MA case should be opened as NPA and the application fee should be waived • Cost recovery fee should be suppressed and set a 6 month fee eligibility review date. Absent knowledge of available/affordable private insurance pleadings should contain the following paragraph in appropriate location – "Due to MNsure technical issues the County has no information regarding the status of medical public assistance. The County requests that the issue of medical support be reserved until medical public assistance information becomes available. The County waives any claim for medical public assistance reimbursement until further motion." Interstate Initiating – follow all of the above; however, absent knowledge of available/affordable private insurance your pleadings should simply indicate that the matter of medical support should be reserved. Do not add any information regarding interface issues. Interstate Responding – abide by the other State's petition and pursue what is requested.	Please refer to CSED Helpdesk Message 5445 for complete instructions on what and how to enforce. Interstate Initiating – follow the above instructions as you make/respond to requests based on CSNET interface alerts/inquiries. Interstate Responding – enforce according to other State's request.

Summary of Differences Between Minnesota Laws and the Affordable Care Act

	Purpose	Coverage Required	Age of Child	Coverage Responsibility	Child Tax Exemption	Household Composition	Cost/ Affordability	Who may be Penalized
MN	Obtain and enforce coverage and a contribution towards costs through the courts	Appropriate: • Comprehensive • Accessible • Affordable • Special Needs	Child support continues until child turns 18 or 20 if still attending secondary school, unless court finds individual is incapable of self-support due to a disability or incapacity	Hierarchy of coverage as set forth in MN statutes • Continuity • Appropriate • Best available through employer/union • Who the child lives with	• Not addressed in IV-D cases, but Child Support Magistrates can address the issue if raised by one of the parties • There are reasons parties may want to share the child tax exemption • Default is to Custodial Parent	Consideration only of the parent of the joint child's income (no step-parents, other adults living in the home or adult children's income considered)	Reasonable - No more than 5% of the gross monthly income of the party ordered to carry the coverage (based on Federal IV-D Law)	Parent ordered to carry who does not: • 100% of unreimbursed and uninsured medical expenses • Enforcement remedies including contempt
ACA	Obtain coverage and enforce through IRS	Minimum essential coverage	Coverage can continue for a "child" through age 25	Parent who claims the child on taxes must ensure minimum essential coverage	Parent who claims the child on taxes must ensure minimum essential coverage or get an exemption, file a form with the IRS, and is subject to an IRS penalty for failing to do so	People considered a unit for purposes of determining eligibility (can include step-parents, other adults living in the home or adult children's income)	• Individual - 8% of household income • Employer - 9.5% of household income	Parent who claims the child on taxes is subject to a tax penalty if child not covered, unless the parent gets an exemption

Melissa Rossow, Ramsey County Attorney's Office, September 2014

TIME TO RE-THINK MEDICAL SUPPORT:

Impact of the Affordable Care Act on Child Support

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December 13, 2013

Introduction

With the Affordable Care Act (ACA) taking full effect, it is time to re-think medical support, which has been an essential but frustrating component of the child support program. The ACA creates a new enforcement structure for health insurance which will make some of our traditional efforts counter-productive, but also provides new options for health care insurance for children, custodial parents (CPs), and even non-custodial parents (NCPs). States should take action now to maximize the potential to improve health care for their families. At the same time, they should take advantage of the unique opportunity to reduce employer burden and significantly increase the efficiency of their programs by re-focusing their medical support activities on maximizing access to coverage, while limiting enforcement to the small minority of cases that will need and want our help.

The New Sheriff in Town

As we all know, an integral part of the ACA is the requirement that every citizen, with few exceptions, obtain health insurance through an employer, the government, or the individual marketplace -- where health insurance marketplaces will improve access. The enforcer of the mandate will be the IRS. The IRS role can supplant our medical support function in most cases, but also has the potential to conflict with the traditional enforcement approach in the child support program.

IRS enforcement will be driven by tax household relationships rather than our focus on custodial and non-custodial parents. Thus the IRS will expect that whoever claims a child as a tax deduction will be responsible for providing health insurance. For most of our cases, that will be the custodial parent, but there are some instances (discussed below) in which the non-custodial parent will claim the deduction and will be held responsible by the IRS for providing health insurance. Where the custodial parent has remarried, one scenario will be that the step-parent will file taxes on behalf of the entire household, and will thus be required to provide health insurance for the child.

Where we are enforcing medical support against an NCP, and where that NCP is claiming the child as a deduction, our enforcement efforts will overlap those of the IRS (although enforcement mechanisms and remedies are different). At first blush, this argues that we should work to align the tax deduction with the party that has primary responsibility for

medical support, usually the NCP. Unfortunately, that solution may actually be harmful to the CP due to another provision of the ACA, which we discuss below.

An even stickier problem arises when we are enforcing medical support against the NCP, but the CP claims the tax deduction. In that instance, if the NCP fails to provide insurance for at least nine out of the twelve months in a given year, the IRS will seek to enforce a penalty against the CP. The CP can petition for a hardship exemption, but this is not a hassle-free process. We also discuss this problem in more detail below.

The on-scene arrival of the IRS changes the ground rules dramatically. At minimum, this will greatly complicate our efforts to enforce medical support, but in all too many cases, it will create conflicts where we are trying to enforce against the NCP and the IRS is proceeding against the CP. This leads to a logical question: should we not consider withdrawing entirely from medical support and deferring to the IRS? As tempting as that prospect might be, it would ignore two compelling considerations: 1) we still have a statutory responsibility to provide medical support services; and 2) there will be a significant minority of cases that fall between the cracks of ACA coverage and will need our help getting health insurance coverage for the child.

Better Coverage for Kids

Even before enactment of the ACA, available government-sponsored health insurance for kids (and pregnant women) was pretty good. Medicaid has been available at the lowest income levels, and State Children's Health Insurance (SCHIP) programs extend coverage for kids (and sometimes pregnant women) up to 160 – 400 percent of the federal poverty level (FPL), depending on the state.

Under the ACA, no-cost or subsidized insurance options extend to much higher levels than most Medicaid or SCHIP programs. Advance Premium Tax Credits (APTC), together with an important but little-known program called cost sharing, are available up to 250 percent of the FPL. Advance Premium Tax Credits alone are available up to 400 percent of FPL: currently $78,120 for a household of three and $94,200 for a household of four.

The Urban Institute estimates 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) have incomes less than 400 percent of poverty, implying

eligibility for government assistance with health insurance through Medicaid, SCHIP, or ACA insurance subsidies.1 Under Action Transmittal AT 10-10, OCSE has indicated that government-sponsored health insurance counts as medical support under federal policy.

For the first time, then, all but a fraction of our cases will have access to high-quality, accessible, affordable, and reliable health care through government-paid or subsidized insurance. From the standpoint of our kids, this will be a preferable alternative to inconsistent or unavailable health coverage provided through a parent's employer or a policy bought on the open market.

Mind the Gaps

The Urban Institute estimate is slightly optimistic in that it does not account for certain gaps in eligibility for ACA health insurance subsidies. The most notorious is the employer-coverage-affordability test. A parent is not eligible for ACA health insurance subsidies (cost-sharing and APTC) if they have access to employer-sponsored insurance that is affordable.

The well-known Catch-22 is that affordability is defined based on single coverage: if employee-only insurance costs less than 9.5 percent of an employee's gross income, the employer coverage is deemed to be affordable. This is true even if family coverage through the same employer greatly exceeds 9.5 percent of income. With the average cost of family coverage exceeding $1,000 per month, and with many employers not contributing to those premiums, it is quite possible for family coverage to cost 20 – 25 percent of income or more. In that case, a family will be denied access to a marketplace for subsidized insurance despite the high cost of dependent's coverage.

Thus a CP can be shut out of employer coverage due to prohibitive cost, yet be denied access to the ACA insurance subsidies administered through the marketplaces (exchanges). This group of cases will most definitely benefit from active medical support enforcement by IV-D agencies. There will be other groups of cases that will not have access to government-sponsored insurance or subsidies, including those with incomes too

[1] 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.

high, CPs that are part of another tax household (remarried or living with parents), and CPs who do not meet citizenship or immigration requirements. These, too, will likely need and want IV-D assistance in getting health care coverage for children through traditional medical support processes.

Watch the Deduction

Under the ACA, responsibility for providing health insurance follows the tax household. That is, whichever parent (or other person such as grandparent or step-parent) claims the tax deduction for the child must provide health insurance, pay a penalty, or obtain an exemption. In most cases, the custodial parent claims the deduction and would therefore have responsibility for providing health insurance in the eyes of the IRS. This directly conflicts with the prevailing practice in the IV-D program, which usually looks to the non-custodial parent for medical support.

In some states, however, it is common practice in divorce cases for the NCP to receive the benefit of the deduction, either by agreement of the parties or by court order. In such situations, an NCP's medical support order will align with the IRS requirement. Failure by the NCP to provide health insurance can lead to enforcement by the IV-D agency and a penalty by the IRS.

In a few situations, it may have been the practice for the NCP and CP to claim the deduction in alternate years. It is highly advisable to discontinue such a practice because this means that responsibility to provide health insurance under IRS rules will also shift between the parents each year.

If the CP claims the deduction but the IV-D program is pursuing the NCP for medical support, the CP still meets his/her obligation if the NCP does in fact cover the child. However, if the NCP does not provide health insurance consistently, defined as at least nine out of the twelve months in the tax year, then the CP will either have to pay a penalty or file for and receive a hardship exemption. While the rules for hardship exemptions can vary in the sixteen states that operate their own marketplaces, within federally-operated marketplaces, the CP can receive a hardship exemption if there is a valid medical support order in place and the child has been denied coverage for Medicaid and CHIP. Most states are likely to follow this same rule.

First Do No Harm

There is a real prospect that enforcing a medical support obligation against the NCP will cause more harm than good for many children in our caseloads. For too many cases, it will result in less consistent health insurance than the CP could obtain through government sources (or his/her own employment or a step-parent's employment). Moreover, failure of an NCP to meet their obligations, willingly or not, can expose the CP to possible penalties if they have claimed the tax deduction, or at least the hassle of filing for an exemption.

A worse consequence, however, is that ceding the tax deduction to the NCP disqualifies the CP from obtaining ACA subsidies for the child through a federal or state marketplace. Some states might try to align their medical support orders with IRS penalties by asking the court to assign the tax deduction to the NCP, especially when it is of limited economic value to the CP. Failing to align the tax deduction with the medical support obligation sets up a conflict between the IRS mandate and the IV-D medical support remedies.

However, if the NCP is assigned the tax deduction, yet fails to provide compliant insurance, the CP will be barred from obtaining ACA insurance subsidies for the child because a basic eligibility requirement is that the child be part of the tax household. If income is low enough, the CP can still obtain Medicaid or SCHIP, but if income is too high for those programs, the CP will be unable to get an affordable policy under the new ACA programs.

Even if the CP is assigned the deduction, but the NCP fails to provide compliant insurance, the CP will have to apply for a hardship exemption to avoid IRS penalties. Depending on the state, this is likely to be a burdensome process. Since one of the requirements for obtaining a hardship exemption in the federal marketplaces is that the child not be eligible for Medicaid or SCHIP, the CP will need to file a Medicaid/SCHIP application for the child and receive a formal denial before a hardship exemption will be considered.[2]

The point is that states electing to continue their traditional approach of ordering NCPs to provide medical support are likely to create unintended negative consequences for CPs. A

[2] Centers for Medicare and Medicaid (CMS), Guidance on Hardship Exemption Criteria and Special Enrollment Periods, June 26, 2013.

better approach will be to re-focus their efforts on determining whether the CP can obtain reliable health insurance for the child through public or private sources, then initiating medical support enforcement against NCPs only for that fraction of CPs not otherwise able to obtain affordable and adequate coverage through Medicaid, SCHIP, employers, or the ACA marketplaces.

NCPs Can Get Covered 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. NCPs in particular often have difficulty getting good coverage because they are generally not eligible for Medicaid and a diminishing number of employers provide affordable health insurance, especially in lower income 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 without dependent children since most states already cover children and their parents. Thus, in the 27 states opting for Medicaid expansion, single adults (and couples without children) will be eligible for Medicaid at incomes up to 138 percent of the federal poverty level: $15,856 per year for a single adult in 2013. Above this income level, single adults can qualify for ACA premium subsidies through their state marketplace up to 400 percent of the federal poverty level: $45,960 per year in 2013.

It would 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 of FPL, and even at 35 hours per week is at 115 percent of FPL. Most remarkably, a single adult at full-time minimum wage is eligible for a health insurance plan through an ACA marketplace that will cover 94 percent of their 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 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 will provide almost total coverage.

Many child support agencies have taken a more proactive approach with NCPs in recent years, helping them with job services and other referrals where indicated. Educating NCPs on new health insurance options represents an extension of this approach in which we buttress their efforts to support their children. 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, we can change lives while furthering our mission to help children.

Limitations of Traditional Medical Support

A response to the ACA should consider the current limitations of traditional medical support. We know what is good about medical support. It provides health insurance for many children and it both recovers and avoids costs for Medicaid (and to a much lesser extent, SCHIP). Moreover, there are still statutory requirements for IV-D agencies to establish medical support orders and pursue medical support in appropriate cases.

However, medical support is very unsatisfying for most child support agencies. The most significant issue is that the substantial time and resources expended on medical support yield only limited results. Generally child support agencies establish a medical support obligation in every ordered case, then pursue every NCP (with few exceptions). Agencies send lengthy National Medical Support Notices (NMSNs) to every verified employer and assess the responses to determine whether the NCP has access to health insurance for the child through the employer, and whether that insurance is affordable (and usable due to possible geographic limitations).

The question is: what proportion of children ultimately receives employer-sponsored (or more rarely individual insurance policies) as a result of these extensive and time-consuming activities? Regrettably, there are no reliable national statistics on this subject, but the answer is most likely well under 25 percent of the cases. And this number has been declining through the years as employer-sponsored insurance has become less available and less affordable.

A recent report from California's Child Support Directors' Association indicated that only 10 percent of IV-D children in that State are covered by private coverage only, and that another 13 percent are covered by a mix of public and private insurance.3 Note that those covered by private insurance include cases in which the CP provides the insurance. If all our efforts to obtain private coverage for our children get results in only 10 – 25 percent of all IV-D cases, it calls into question whether many of the resources expended on this effort could not be more usefully deployed elsewhere. We could re-focus the staff and IT and printing and postage costs on improving results for core IV-D functions, or expanding complementary services for parents.

Another limitation of medical support is that most orders are indeterminate on their face. That is, it is not possible from looking at an order to know whether a parent is actually required at that moment to provide health insurance coverage. A common form of a medical support order is: the parent is ordered to provide health insurance coverage for the child if it is available from an employer at reasonable cost. This contrasts with a financial child support order that must be stated as a sum-certain, which provides unambiguous clarity in the requirement. If medical support orders were reserved for situations in which agencies have already determined that insurance is in fact available at reasonable cost, they would be easier to enforce.

A related issue is that medical support as structured is flawed by the lack of timely and accurate information about loss of medical coverage. On the financial side, we know when an obligor stops paying because all payments are channeled through SDUs. In contrast, there is no equivalent system for notifying us when health care coverage lapses. Medicaid agencies do not notify child support agencies when they detect terminations of third party coverage. Agencies must rely on reports by CPs, or on indirect enforcement methods such as issuing new NMSNs and medical support withholdings when an NCP changes employers.

With medical support being effective in such a limited number of cases, it makes sense under the ACA to consider a more selective approach: focusing our efforts on that fraction of cases where the CP does not have access to adequate and affordable health insurance through his/her own employment or through the array of coverage options under the

[3] California Child Support Directors Association, *California Affordable Care Act Child Support Workgroup Report*, prepared by HMS, July 10, 2013.

ACA. These cases will mostly be the ones that fall between the cracks of ACA coverage, or that are unable to qualify due to high incomes or some other reason. Such cases will want and need our assistance, and will be more likely to yield positive results.

Carpe Annum

OCSE is giving states latitude to work out their own adaptations to medical support given enactment of the ACA (Action Transmittal AT 10-02). OCSE has stated the intention to wait until the effects of the ACA on child support are better understood before providing formal guidance to the states. Thus it may be another year or two before OCSE develops a formal position, which would imply at least three to four years before regulations can be developed and issued given the long cycle time for their gestation.

The federal latitude creates opportunities for states to develop approaches that best fit their own needs and circumstances. Indeed, how states respond to the ACA will likely affect OCSE's ultimate position on these issues.

The opportunity at hand is for states to:

- Require the custodial parent to provide health care coverage in most cases and encourage custodial parents to claim the tax exemption for the child (see Appendix I)
- Default most medical enforcement activities to the new sheriff in town4
- Re-define their primary medical support role as ensuring that the children and their parents, specifically including the NCP, have access to adequate, affordable, and reliable health care coverage

4 We recognize that the IRS will have its limitations as an enforcer. Penalties are weak and are not imposed until the following tax year. In addition, we do not know how many years it will take the IRS to become effective in its new role. However, avoiding conflicts with the IRS enforcement role is important to avoid confusion and discrediting both enforcement processes. In addition, by defaulting to the IRS to enforce against what most frequently will be the custodial parent, child support agencies can reserve their most powerful tools for the minority of NCPs for which it will be appropriate to pursue medical support.

- Increase cash support for CPs by minimizing the number of NCPs required to provide health insurance (which increases cash support by not applying the attendant credit toward cash support in most states)
- Require a cash contribution from the NCP to share in the cost of subsidized premiums where appropriate
- Modify existing medical support orders over time
- Re-focus medical support enforcement activities targeted toward NCPs on that small fraction of cases where the children do not otherwise have access to good health care coverage

This last group will consist primarily of existing medical support cases depending on private insurance, cases that fall between the cracks of the ACA, and cases with incomes too high to qualify for government subsidies.

The best option for many custodial parents will be to acquire insurance for the child through an ACA marketplace where they will be able to qualify for premium subsidies. Mostly this will consist of CPs with incomes in the 200 – 400 percent of federal poverty level (FPL) bracket, since those with lower incomes generally qualify for Medicaid, or they can qualify their children for SCHIP. (The 200 – 400 percent of FPL bracket corresponds this year to an income range of $31,020 to $62,040 for a two person family, and from $47,100 to $94,200 for a four-person family).

However, even with subsidies, health insurance will have significant cost, ranging from 6.3 to 9.5 percent of household income in that bracket. As a result, it will be reasonable to require a contribution by the NCP toward the unsubsidized cost. In most states, this contribution can be appropriately calculated through the existing child support guidelines. But instead of requiring establishment and enforcement of a medical support obligation through the NCP, a contribution toward ACA-subsidized insurance will be just a component of cash support, enforced as part of the overall cash support obligation.

Note that if the child qualifies for CHIP, the CP is likely to be eligible for ACA insurance subsidies for his/her own coverage. This most likely includes cost-sharing (assistance with co-pays and deductibles) as well as premium subsidies.

By following the strategy outlined above, states will realize major benefits:

- ***Better health insurance coverage for children.*** By focusing on ensuring that children have access to the best coverage, public or private, states will improve their well-being.
- ***Fewer resources spent on unproductive medical support.*** Limited staff and IT capabilities can be re-directed toward core IV-D functions and/or complementary activities such as NCP employment services.
- ***More effective targeted medical support.*** Those cases that need and want our medical support enforcement services will benefit from improved cooperation and better results. These are likely to involve NCPs with higher income levels where employment is more stable and affordable health insurance is more likely to be available.
- ***Reduced employer burden.*** A major benefit will be reduced employer burden. Instead of sending NMSNs to every verified employer, states can send them only to selected employers in those limited cases where medical support is being actively pursued.
- ***Better coverage for NCPs.*** Referring NCPs to adequate and affordable coverage will help them stay healthy and provide for their children, while improving their view of the child support agency.

The strategy outlined here roughly equates to the "Got Coverage" option presented by Jennifer Burnszynski of OCSE. It is a proactive strategy with broad benefits for children, their parents, employers, and IV-D agencies. The impact of this strategy on state policies for obtaining medical support orders is discussed further in Appendix I.

Transitioning to this approach involves many challenges, and these challenges will vary by state. States will have to review their own statutes and procedures, as well as their system interfaces and relationships with Medicaid agencies. The approach will require a major change in mindset of child support staff and re-education of our NCPs and CPs. Converting existing medical support orders to this approach may be the biggest challenge of all. However, the benefits of this approach far outweigh these costs, and states who start early will gain the most.

It is possible under existing guidance for states to continue their traditional medical support enforcement strategy. The primary rationale would be to maximize cost-recovery for Medicaid if that is deemed to be practical and cost-effective. However, following such a strategy requires a major effort to align IV-D medical support enforcement with ACA insurance requirements. It risks creating widespread confusion on the part of IV-D families, staff, and employers. It is likely to yield questionable benefits even while requiring ongoing dedication of major resources. Worst of all, it risks taking actions that result in more harm than good in all too many cases. Overall, this does not seem to be an attractive option.

Doing nothing is an even worse option given the potential for conflicts with the IRS enforcement role, missed opportunities for improving insurance arrangements for children and their parents, and the potential for massive confusion concerning specific parental responsibilities to provide insurance. States need to develop some kind of coherent strategy for adapting to the ACA.

States will be better off if they seize the year and craft their own solution to the ACA and medical support. By reducing the scope of medical support enforcement, they will free up resources for other critical activities. By reducing employer burden, they will earn political good-will and make a small contribution to improving the economy. By limiting medical support enforcement to cases that need and want the service, they will get better results for cases where they do perform this function. Most importantly, by focusing on ensuring the best coverage for children and their parents, regardless of source, they will further contribute to the well-being of the children we serve, while helping their parents to thrive and actively perform their responsibilities.

The impact of the ACA is too important an issue to ignore. OCSE has delegated the initial response to the states: another example where states will serve as laboratories of democracy. This is a unique opportunity for states to craft solutions that work most effectively for their particular circumstances, and further improve their services for the benefit of the children, their parents, employers, and the agencies themselves.

APPENDIX
ACA Impact on Medical Support Orders

AT 10-02 holds states harmless from penalties for failure to comply with medical support requirements, but it specifies that "…state agencies continue to provide medical support enforcement services in compliance with all statutory requirements, including Sections 452(f) and 466(a)(19) of the Act." Section 452(f) requires the Secretary to issue regulations to enforce medical support against either the non-custodial or custodial parent (or possibly both).

Section 466(a)(19) is more specific: "… all child support orders enforced pursuant to this part shall include a provisions for medical support for the child to be provided by either or both parents…" It continues that the medical support shall be enforced, where appropriate, through the use of the National Medical Support Notice. It appears, then, that states are required to continue ordering medical support, notwithstanding the hold harmless provisions of AT 10-02.

Custodial Parent Medical Support Orders

To implement the strategy recommended in the body of this paper requires, in most cases, that the custodial parent be ordered to provide medical support through a public or private health insurance program. If the child is not eligible for Medicaid or SCHIP, this will protect the CP's ability to access an ACA marketplace for insurance subsidies. It will also enable the CP to focus on obtaining the best coverage for the child through Medicaid, SCHIP, an ACA marketplace, or through employer-sponsored insurance available to the CP or a step-parent. The IV-D agency could then defer to the IRS for enforcement, rather than actively enforcing against the CP.

When a support order is established or modified, the IV-D agency should determine whether the CP has already acquired health insurance for the child. If not, the agency can make the appropriate referral to the Medicaid agency or ACA marketplace for assistance. The CP will be able to apply for health insurance through either source and determine eligibility for Medicaid, SCHIP, or ACA insurance subsidies. If the CP already insures the

child through his/her own employment or that of a step-parent, this can be encompassed under a medical support order.

Under guidelines effective in most states, the NCP will be required to contribute a proportionate share of health insurance premiums incurred for the child (through the ACA marketplace or employer-sponsored insurance), and that contribution will be added to cash support. If the CP is ordered to provide health insurance, it makes sense to align this responsibility with IRS-enforced health insurance mandate by having the CP claim the tax deduction for the child.

Non-Custodial Parent Medical Support Orders

NO MEDICAID ELIGIBILITY

There will be a limited number of situations where the best option for a child's health insurance will be through an NCP's employer-sponsored insurance. The best example is where the NCP has stable employment and is already providing insurance for the child. Other situations will arise where the CP is unable to get affordable and adequate health insurance through public or private sources because his/her employer-sponsored insurance meets the affordability test for single coverage, but is excessively costly for dependents' coverage. Alternatively the CP's income may be too high, or the CP may not able to access coverage through a public program for other reasons.

In such cases, it is appropriate to order the NCP to obtain health care coverage for the child if it is available through the employer at a reasonable cost. Then the IV-D agency can initiate a NMSN, establish through the existing process whether the coverage can actually be provided, and order the employer to do so.

MEDICAID ELIGIBILITY

If a child is eligible for Medicaid, some states may wish to continue using medical support as a cost-recovery tool and seek to order the NCP to provide medical support. Where that occurs, the child can continue receiving Medicaid, with the Medicaid agency pursuing the NCP-provided policy to recover some (or all) of the child's health care costs.

It is questionable whether this use of medical support enforcement is cost-effective since non-residential parents of low-income children eligible for Medicaid have a high probability of being low-income themselves, with minimal access to affordable employer-sponsored health insurance. However, it is theoretically possible for the child support program to pursue medical support in these cases even while pulling back on others.

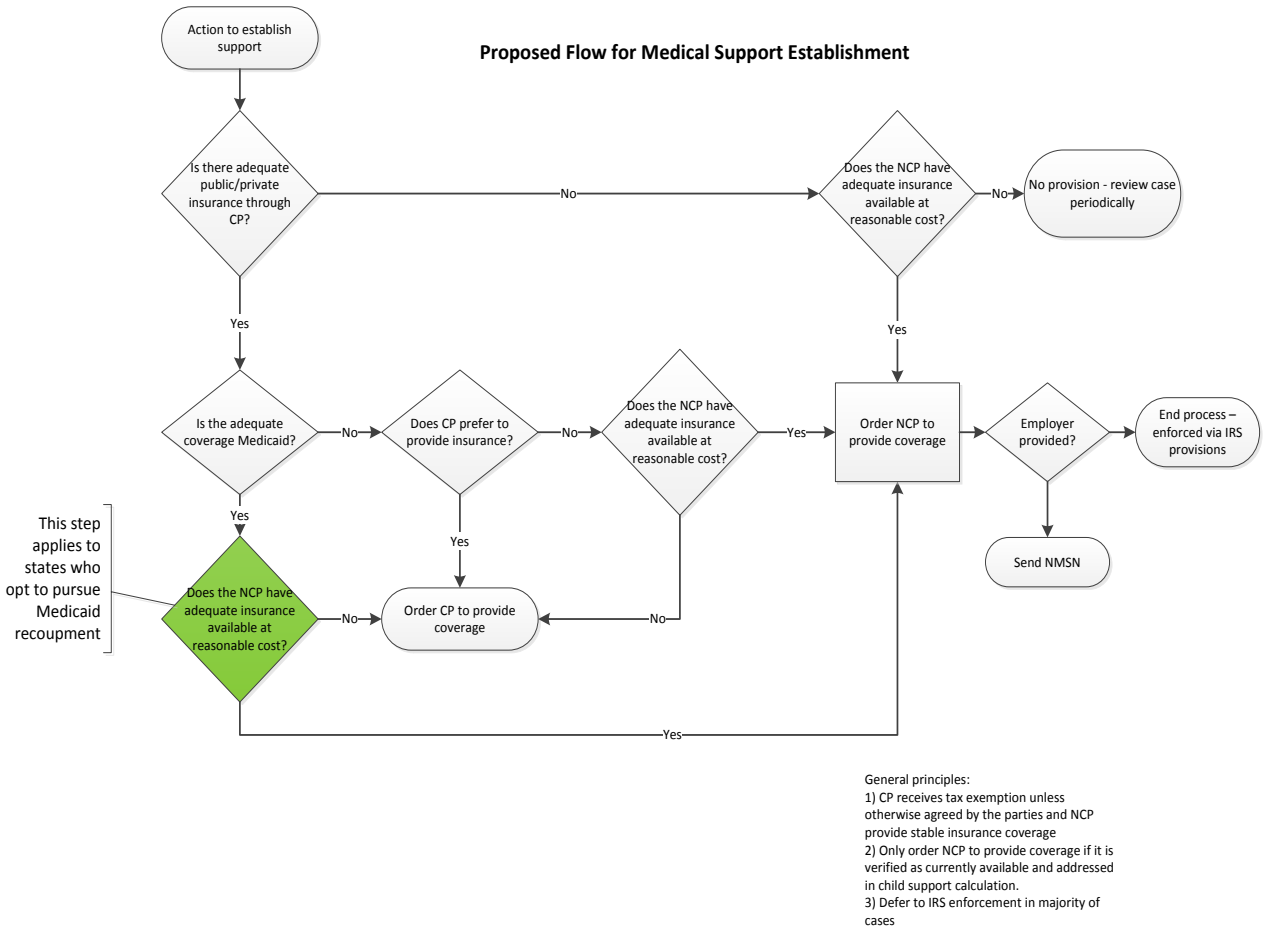
Where the child is on Medicaid, it may make sense to order both parents to provide medical support. This would ensure that the CP would understand his/her responsibility to keep the child ensured and would obviate the need to transfer the tax deduction to the NCP. In that way, if the CP experienced an increase in income such that the child was no longer eligible for Medicaid or SCHIP, he/she could still access insurance subsidies for the child through the ACA marketplace.

Existing Medical Support Orders

Current medical support orders will be unaffected by ACA implementation until they are reviewed and modified. As each current child support order comes up for review, IV-D agencies should follow the same procedure as for establishment of new orders, except that in cases where the NCP is providing insurance for the child, it will be important to ensure that any changes in responsibility do not interrupt coverage. In addition, it will be important to review which parent is claiming the tax deduction (normally the CP unless transferred to the NCP by agreement or court order) and ensure it is being given to the CP unless there are written arrangements for the NCP to claim the deduction and assume full responsibility for the health insurance.

Summary

In most cases, it will make most sense to order the custodial parent to provide a child's health insurance through a public program or the CP's (or step-parent's) employer. The NCP will be ordered to provide health insurance coverage only when a stable source can be identified, and/or the CP is unable to obtain adequate and affordable insurance on his/her own. This is a major paradigm shift for the IV-D program, but will provide improved coverage for children while lessening administrative burdens on IV-D agencies and employers. Below is a flow diagram depicting how medical support obligations will be established under this strategy.


Proposed Flow for Medical Support Establishment
Action to establish support
Is there adequate public/private insurance through CP?
No
Does the NCP have adequate insurance available at reasonable cost?
No
No provision - review case periodically
Yes
Yes
Is the adequate coverage Medicaid?
No
Does CP prefer to provide insurance?
No
Does the NCP have adequate insurance available at reasonable cost?
Yes
Order NCP to provide coverage
Employer provided?
End process – enforced via IRS provisions
Send NMSN
Yes
Yes
This step applies to states who opt to pursue Medicaid recoupment
Does the NCP have adequate insurance available at reasonable cost?
No
Order CP to provide coverage
No
Yes
General principles:
1) CP receives tax exemption unless otherwise agreed by the parties and NCP provide stable insurance coverage
2) Only order NCP to provide coverage if it is verified as currently available and addressed in child support calculation.
3) Defer to IRS enforcement in majority of cases

Medical Support in Today's Child Support Guidelines and The Affordable Care Act

First and foremost, this article does not —and cannot— provide a clear direction for medical child support under the Affordable Care Act (ACA) (only Congress and rule makers can). What this article does is describe how states currently address medical support in their child support guidelines and how these provisions compare to ACA provisions. In short, this article documents "what is" with the hope that policymakers use it to find the appropriate path for medical child support in the future.

Introduction

As recently pointed out by Federal Office of Child Support Enforcement (OCSE) Commissioner Vicki Turetsky, despite the major changes caused by the ACA, the child support community

…will continue to keep doing what we are doing—what our statute directs us to do, which is to provide for child health care coverage in child support orders.[1]

The federal statute[2] makes no mention of medical support within the guidelines, but federal regulation does. Specifically, federal regulation requires that a state's child support 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 of this chapter.[3]

Section 303.31 requires state child support agencies to petition the court to include an order for private insurance— if it is accessible to the child and reasonable in cost to the parent providing the private insurance— in newly established or modified child support

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[1] Turetsky, Vicki (August 2013). "What Is Our Medical Support Road Map?," *Child Support Report*. Retrieved from: http://www.acf.hhs.gov/sites/default/files/programs/css/csr1308.pdf

[2] Nonetheless, the guidelines regulation helps states meet the statutory requirements for state child support agencies to "…petition and enforce medical support included as part of a child support order, whenever health care coverage is available to the noncustodial parent at a reasonable cost. . ." and, for "all child support orders . . . [to] include a provision for medical support for the child to be provided by either or both parents, and shall be enforced, where appropriate, through the use of the National Medical Support Notice. . ." The guidelines provision is contained in Title IV-D §467(a) of the Social Security Act (42 U.S.C. 651 et seq) while the other provisions are contained in §452(f) and 466(a)(19), respectively. Retrieved from: http://www.ssa.gov/OP_Home/ssact/title04/0467.htm

[3] Title 45, Public Welfare, C.F.R § 302.56(c)(3). Retrieved from: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=d829d9fb6969a2402303f45c14097e61&r=PART&n=45y2.1.2.1.3#45:2.1.2.1.3.0.1.28

orders.[4] Section 303.31 also defines health insurance and cash medical support and provides for state discretion in their definitions of "accessible" and "reasonable cost."

State Provisions for Medical Support

All states provide for medical support in state statute, administrative rule, court rule, or a combination For example, Iowa provides that:

> The court shall order as medical support for the child a health benefit plan if available to either parent at the time the order is entered or modified. A plan is available if the plan is accessible and the cost of the plan is reasonable.[5]

The medical support provisions of most states are similar to those of Iowa except that the term "health insurance" is typically used instead of "health benefit." Few states use the term "healthcare coverage," which is actually what is in federal statute.[6]

State definitions of a health benefit/insurance are generally broad and mimic what is in federal regulation.[7] The broad wording often encompasses more than a parent's employer-sponsored insurance. For example, it encompasses insurance available from union membership in most states or insurance available through a step-parent in a few states. In all, states vary in the scope and depth of their definitions. Based on the author's knowledge, no state explicitly identifies health insurance marketplaces (i.e., the exchanges) as a health benefit/insurance, although most states have a blanket phrase that includes other types of coverage. Insurance available from an exchange could be interpreted as coverage through a state's blanket phrase.

The author also knows of no state medical support provisions that define Medicaid or CHIP as a health benefit/insurance. To the contrary, Minnesota (which uses the term, "healthcare coverage" in its guidelines) explicitly excludes any form of public coverage in its definition.[8] Texas and New York take another unique approach. Although they prioritize private insurance as the source of the child's medical support, Texas guidelines provide that if the court finds that neither parent has accessible insurance available at a reasonable cost, the court shall order the custodial parent to apply for Medicaid/CHIP on the child's behalf.[9] New York has a similar provision. In general, however, it is rare for a state's child support guidelines to provide that a parent can be ordered to apply for Medicaid or CHIP.

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[4]Title 45, Public Welfare, C.F.R. § 303.31. Retrieved from: http://www.ecfr.gov/cgi-bin/text-idx?SID=d829d9fb6969a2402303f45c14097e61&node=45:2.1.2.1.4&rgn=div5#45:2.1.2.1.4.0.1.16

[5] IA Code §252.E.1A.3 Retrieved from: http://search.legis.state.ia.us/nxt/gateway.dll/ic?f=templates&fn=default.htm

[6] The Social Security Act (42 U.S.C. 651 et seq). Title IV-D §452(f) and 466(a)(19). Retrieved from: http://www.ssa.gov/OP_Home/ssact/title04/0452.htm

[7] Title 45, Public Welfare, C.F.R. § 303.31 (a) (2). Retrieved from: http://www.ecfr.gov/cgi-bin/text-idx?SID=d829d9fb6969a2402303f45c14097e61&node=45:2.1.2.1.4&rgn=div5#45:2.1.2.1.4.0.1.16

[8]MN Statutes Ch. 518A. Retrieved from: https://www.revisor.leg.state.mn.us/statutes/?id=518A.41

[9] For example, see Texas Title 5, Chapter 154, Sec. 154.182 (b-2). Retrieved from: http://www.statutes.legis.state.tx.us/Docs/FA/htm/FA.154.htm

Orders to Provide Insurance

Most states wrap the provision to carry insurance for the child into the financial child support order, although there are a few states that require two separate orders: one for financial child support, and one for health insurance and/or the child's uninsured medical expenses. In all, many child support orders contain provisions requiring one or both parents to provide health insurance for the child. Although national counts conflict, there are indisputably millions of child support orders with provisions for medical child support, specifically, orders that require parents to provide health insurance coverage for the child.[10]

Most states will order private insurance even if it is not available to either parent at the time the child support order is established. These orders typically provide that in the future, if private insurance becomes available to a parent, the child shall be enrolled in that insurance if it is accessible and reasonable in cost. Figure 1 shows examples of this type of standardized language from two states.

Figure 1: Examples of Standardized Language that Provides the Child Shall Be Enrolled in the Parent's Health Insurance if Insurance Becomes Available in the Future	
California11	The parent ordered to pay support The parent receiving support must (1) provide and maintain health insurance coverage for the children if available at no or reasonable cost and keep the local child support agency informed of the availability of the coverage (the cost is presumed to be reasonable if it does not exceed 5% of gross income toad a child); (2) if health insurance is not available, provide coverage when it becomes available; . . .
Vermont12	Private health insurance is currently unavailable to either parent at a reasonable cost. If private health insurance becomes available to either parent at a reasonable cost, that parent shall be responsible for providing and maintaining health insurance for the minor child(ren). Either parent may request a hearing to determine whether the cost of health insurance is reasonable.

The use of such language helps states meet the federal statutory timeline for issuing a National Medical Support Notice (NMSN) once a parent's employer is identified from the state's directory of new hires. It also facilitates swift enrollment of a child in a parent's employer-sponsored insurance when a parent changes employment without having to

[10] The data reports based on the Current Population Survey (CPS) and the Federal Office of Child Support Enforcement (OCSE), albeit different measurement methods and of different populations, range from 3.6 million to 6.7 million awards that include an order for insurance. The CPS data is available from: Grall, Timothy, (2011). *Custodial Mothers and Fathers and Their Child Support: 2009*. Current Population Reports P60-240, U.S. Census, Washington, D.C. p. 11.Retrieved from: http://www.census.gov/prod/2011pubs/p60-240.pdf. The OCSE data is available from: U.S. Department of Health and Human Services, Office of Child Support Enforcement, (2013), *Office of Child Support Enforcement FY 2010 Report*, Washington, D.C. Table 36, Retrieved from: http://www.acf.hhs.gov/programs/css/resource/fy2010-annual-report-table-36

[11] Judicial Council of California. *Stipulation and Order (Government)*. Form FL-625 [Rev. July 1, 2011]. Retrieved from: http://www.courts.ca.gov/documents/fl625s.pdf

[12] State of Vermont Superior Court. *Child Support Order.* Form 802. Retrieved from: https://www.vermontjudiciary.org/eforms/Form%20802.pdf

modify the order. The NMSN is essentially a qualified medical child support order requiring that the employer enroll the child in the parent's employer-sponsored insurance even if the child does not reside with the insured parent, the parents were never married, or the parent does not claim the child as dependent for tax purposes.[13]

Obviously, the parent ordered to provide insurance through a medical child support order may not be the same parent that faces the ACA penalty for not maintaining healthcare coverage for the children. ACA provides that the parent claiming the child as a dependent for federal income tax purposes is the parent responsible for obtaining and maintaining healthcare coverage for the child. Exacerbating this issue is that some child support orders (and child support guidelines such as Arizona's[14]) provide that the nonresidential parent will claim all or some of the children as dependents for tax purposes. The federal government has recently released new rules that can relieve these situations.[15] Specifically the rule allows an exemption from the penalty if:

> . . .a child who has been determined ineligible for Medicaid and CHIP, and for whom a party other than the party who expects to claim him or her as a tax dependent is required by court order to provide medical support. We note that this exemption should only be provided for the months during which the medical support order is in effect . . . .

Definitions of Accessible and Reasonable-Cost Insurance

Since 2008, federal regulation provides that states consider whether the insurance is accessible to the child and the cost of the insurance is reasonable.[16] Specifically, the cost of the child's health insurance is deemed reasonable if it does not exceed 5 percent of the parent's gross income, but a state may develop its own income-based standard that is appropriate for its state. The federal regulation was in response to escalating health insurance premium costs and the affordability of premium costs. The five-percent threshold was borrowed from the Child Health Insurance Program (CHIP), in which federal regulations provide that the CHIP cost-sharing (e.g., premiums and co-pays) cannot exceed five-percent of the CHIP family's income.

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[13] More information about qualified medical support orders can be found at the U.S. Department of Labor (n.d.) *Qualified Medical Child Support Orders*, Retrieved from: http://www.dol.gov/ebsa/publications/qmcso.html

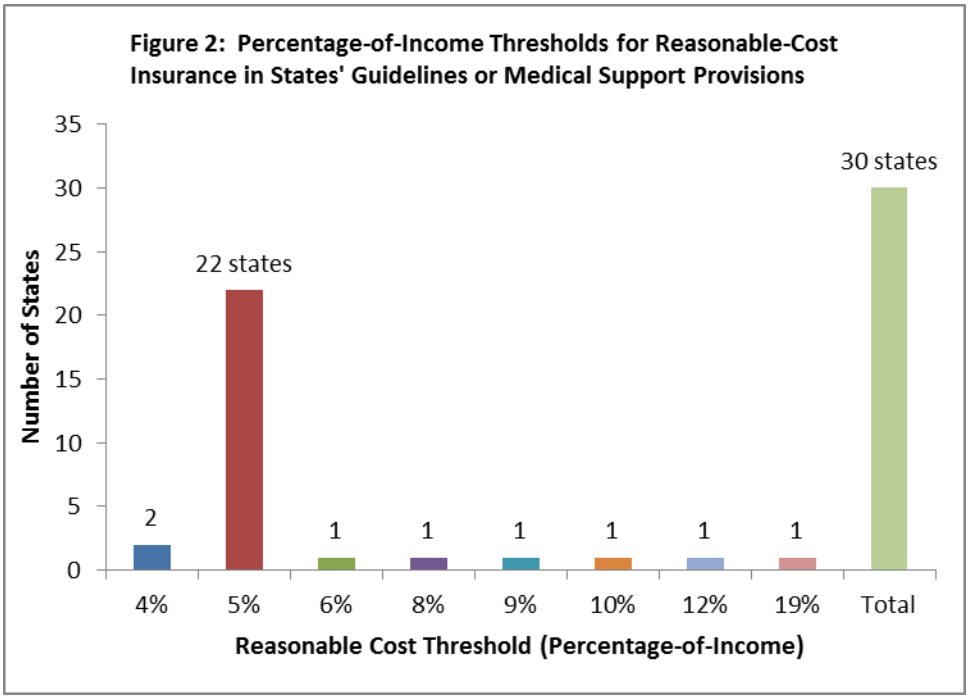
[14] Arizona Supreme Court (2011). *Administrative Order 2011-46*. p. 21. Retrieved from: http://www.azcourts.gov/Portals/31/GuideSched10072011.pdf

[15] Cohen, Gary (June 26, 2013). "Guidance on Hardship Exemption Criteria and Special Enrollment Periods." [Online.] Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, Retrieved from: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/exemptions-guidance-6-26-2013.pdf

[16] U.S. Department of Health and Human Services Administration for Children and Families (ACF), (2008), "Child Support Enforcement Program; Medical Support: Final Regulation." *Federal Register*, Vol. 73 , No. 140 (July 21, 2008, pp. 42416-42442). Retrieved from: http://www.gpo.gov/fdsys/pkg/FR-2008-07-21/html/E8-15771.htm

As of 2010, 23 state guidelines or medical support provisions provide a definition for accessible insurance.[17] The definitions vary among states. Some are very specific definitions (e.g., consider the number of miles or minutes between the child's primary residence and primary healthcare provider).

As of January, 2013 30 states have adopted a percentage-of-income based standard for determining whether the cost of a child's health insurance is reasonable to the parent providing the insurance. As shown in Figure 2, most states have adopted the five-percent threshold and a few states have adopted lower or higher percentages. Some states with net-income guidelines relate their threshold to net income rather than gross income (e.g., South Dakota). There are also several states that use gross income for the reasonable-cost threshold, but define gross income for the calculation of financial child support differently (e.g., New York).



The reasonable-cost percentages in state medical support provisions are generally less than the effective maximum cost of coverage through healthcare exchanges (i.e., 9.5 percent of modified adjusted gross income)[18] and 8 percent, which is the threshold for exemption from the ACA penalty for non-compliance with mandatory insurance.[19] Nonetheless, it is important to note that the reasonable-cost percentages apply to the

[17] In some states, the medical support provisions are separate from statute. Iowa is a case in point. Its guidelines are set by court rule but its medical support provisions are in statute.
[18] A good summary of the ACA provisions is provided by the Kaiser Family Foundation, (2013) *Focus on Healthcare Reform: Summary of the Affordable Care Act.* Retrieved from http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf
[19] See Kaiser Family Foundation (n.d.), *The Requirement to Buy Coverage Under the Affordable Care Act* for a simple explanation of the penalty. Retrieved from: http://kff.org/infographic/the-requirement-to-buy-coverage-under-the-affordable-care-act/

child's share of the insurance premium, whereas the ACA percentages relate to the premium for an individual or an entire family. So, for medical child support purposes, if a single parent obtains insurance for two children, the children's share of the premium is the difference between the costs for single and family coverage. Historically, since cost information about single and family coverage is often unavailable, many state guidelines provide that the child's share of the premium can be determined by prorating the premium across the number of covered individuals. An unexpected benefit of the healthcare exchanges is that the automated calculators that have a data field for family size can ease the calculation of the child's share of the premium.

Cash Medical Support

The 2008 medical support rules call for child support agencies to petition for cash medical support when accessible private health insurance is not available to parents at a reasonable cost. It also defines cash medical support:

> [A]n 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.[20]

States' interpretations and applications of cash medical support vary widely. As of 2010, the guidelines or medical support provisions in 16 states provide an explicit definition of cash medical support. Several states provide that cash medical support is to be paid to the state Medicaid agency when the child is enrolled in Medicaid. Some of these states (e.g., Iowa, Ohio, and Texas) also routinely order and collect this type of cash medical support. Among these states, Texas stands out for its substantial collections. In 2006, Texas collected over $10 million in cash medical support to offset Medicaid costs.[21] Ordering cash medical support that is distributed to the Medicaid agency, however, is not the norm among states.

States also fulfill the cash medical support requirement through their base guidelines amounts because they include some of the child's medical expenses.[22] In addition, states have fulfilled the requirement by ordering the parents to share in the financial responsibility of any out-of-pocket medical expenses incurred for the child.

Out-of-Pocket Healthcare Expenses

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[20] Title 45, Public Welfare, C.F.R. § 303.31(a)(1). Retrieved from: http://www.ecfr.gov/cgi-bin/text-idx?SID=d829d9fb6969a2402303f45c14097e61&node=45:2.1.2.1.4&rgn=div5#45:2.1.2.1.4.0.1.16

[21] Greg Abbott, (n.d.) *How the AG Helps Parents Meet Their Children's Medical Needs*, Texas Attorney General. Retrieved from: https://www.oag.state.tx.us/agency/weeklyag/2006/0306csd_medical.pdf.

[22] This approach appears to be consistent with federal regulations. See response to comment 1 on p. 42419, U.S. Department of Health and Human Services Administration for Children and Families (ACF), (2008), "Child Support Enforcement Program; Medical Support: Final Regulation." *Federal Register*, Vol. 73 , No. 140 (July 21, 2008, pp. 42416-42442). Retrieved from: http://www.gpo.gov/fdsys/pkg/FR-2008-07-21/html/E8-15771.htm

Most state guidelines provide for two types of out-of-pocket healthcare expenses. One type is a nominal amount of out-of-pocket healthcare expenses that is included in the base guidelines formula or child support schedule. It is intended to cover routine and ordinary healthcare expenses that are typical for children (e.g., co-pays for well visits and some over-the-counter medicines such as cough syrup). Over half of the states include $100 or $250 per child per year or a similar amount for these expenses in their base guidelines calculation. The other type is for extraordinary, out-of-pocket healthcare expenses. This includes recurring expenses (e.g., asthma treatments) or future expenses if they occur (e.g., the out-of-pocket expense for an emergency room visit). Most state guidelines prorate these expenses between the parents. If they are recurring and known at the time of order establishment, the nonresidential parent's prorated share is added to the base award amount. For future expenses, the order will state each parent's percentage share (e.g., the custodial parent is responsible for 50 percent and the nonresidential parent is responsible for 50 percent). The parent incurring the expense notifies the other parent to recoup that parent's share directly. If the other parent does not pay, the out-of-pocket expenses can be reduced to a judgment, and only then can child support enforcement actions be taken. Some state guidelines (e.g., Michigan and Texas) impose timeframes and other requirements for reporting and recouping out-of-pocket healthcare expenses.

Full implementation of ACA will change the amount of out-of-pocket medical expenses that families typically incur for their children. The change will vary by income level. Children covered by Medicaid will have no expense and some higher income families with private healthcare coverage will face high deductibles. Medicaid assesses no premiums, co-pays, or other cost sharing for children's health services. ACA provides that beginning in 2014, the maximum out-of-pocket limits for most qualified plans will be $12,700 for families.[23]

More children will be eligible for Medicaid beginning in 2014. Over a half million children alone will be newly eligible in 2014 because ACA expands Medicaid eligibility for older children from 105 to 138 percent of the federal poverty level (FPL).[24] As of 2014, Medicaid income eligibility will range from 138 to 380 percent of FPL (about $37,000 to $74,000 per year for a family of three) depending on the state and age of the child.[25]

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[23] Andrews, Michelle (July 9, 2013). "In Addition To Premium Credits, Health Law Offers Some Consumers Help Paying Deductibles And Co-Pays," *Kaiser Health News*. Retrieved from: http://www.kaiserhealthnews.org/features/insuring-your-health/2013/070913-michelle-andrews-on-cost-sharing-subsidies.aspx

[24] Prater, Wesley (2013). *Aligning Eligibility for Children: Moving the Stairstep Kids to Medicaid.* Kaiser Family Foundation, Menlo Park, California. Retrieved from: http://kff.org/report-section/aligning-eligibility-for-children-moving-the-stairstep-kids-to-medicaid-issue-brief/

[25] The Henry J. Kaiser Family Foundation, (n.d.) "Medicaid and CHIP Income Eligibility Limits for Children at Application, Effective January 1, 2014: *State Health Facts*, Retrieved from: http://kff.org/health-reform/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-at-application-effective-january-1-2014/

States' CHIP income eligibility thresholds are often slightly higher than Medicaid's. States may assess nominal premiums, co-pays, or other cost sharing for CHIP. A recent study using 1999 data found that 72.9 percent of all child support-eligible children are Medicaid or CHIP eligible, and the proportion is even higher (81.3 percent) among child support-eligible children lacking health insurance.[26] Another study using 2009 data found that 63 percent of IV-D custodial-parent families and 17 percent of non-IV-D custodial-parent families receive Medicaid.[27] The study did not note the percentage enrolled in CHIP. National data, however, shows that 84.8 percent of all children eligible for Medicaid or CHIP in 2011 were indeed enrolled.[28]

Low-income families ineligible for Medicaid or CHIP may be eligible for ACA cost-sharing subsidies that will reduce deductibles, co-payments, co-insurance and total out-of-pocket expenses. High-income families, however, may face relatively high deductibles. The extent to which out-of-pocket healthcare expenses on behalf children will reach these limits is unknown. ACA prohibits cost sharing for many preventive healthcare services, so out-of-pocket healthcare expenses will be less if the children are generally healthy and do not use emergency room services or need other healthcare services subject to cost sharing.

Healthcare Expenses in the Calculation of the Award

In all, there are four ways that healthcare expenses affect the amount of the child support award. One way is the amount of ordinary, out-of-pocket healthcare expenses included in the child support schedule. States that include none of these expenses generally have lower child support schedules than those that do. As identified earlier, most states include some healthcare expenses in their base guidelines formula or schedule.

Another way is the treatment of the cost of providing insurance for the child. Most state guidelines prorate the actual cost of the child's health insurance between the parents and add or subtract the prorated amount to the base guidelines amount. If the custodial parent pays the premium, the total amount owed by the nonresidential parent is more than the base support calculation. If the nonresidential parent pays the premium, the final award amount is less than the base support calculation. There are also twelve state guidelines that deduct the premium from the parent's income. In effect, a larger premium reduces the amount of income available for financial child support.

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[26] McMorrow, Stacey, et.al. (2011), *Health Care Coverage and Medicaid/CHIP Eligibility for Child Support Eligible Children*, Research Brief prepared for the U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Urban Institute, Washington, D.C. Retrieved from http://aspe.hhs.gov/hsp/11/HealthCare-ChildSupport/rb.pdf.

[27] Lippold, Kye and Sorensen, Elaine (2013). *Characteristics of Families Served by the Child Support (IV-D) Program: 2010 Census Survey Results*, Urban Institute, Washington, D.C. p. 6. Retrieved from: http://www.acf.hhs.gov/programs/css/resource/characteristics-of-families-served-by-the-child-support-iv-d-program-2010

[28] Insurekidsnow.gov (n.d.), *Medicaid/CHIP Participation Rates.* Retrieved from: http://www.insurekidsnow.gov/professionals/reports/index.html

The third and fourth ways consist of provisions for cash medical support and the child's uninsured medical expenses, which were discussed previously. Specifically, orders for cash medical support can add to the nonresidential parent's financial obligation. Orders for recurring, uninsured medical expenses can also add to the nonresidential parent's financial obligation. In practice, however, few orders are adjusted for recurring medical expenses. This trend may reflect that the child does not have a known medical condition or that there are significant recurring medical expenses at the time that the order is established. Nonetheless, orders for future uninsured medical expenses are of concern particularly in cases in which the children are covered by insurance plans with high deductibles. If these orders go unpaid, there will be a greater need for child support enforcement.

Conclusions

In general, medical child support provisions in state guidelines are based on pre-ACA statutes and regulations and on outdated data regarding medical costs. Some of the regulations affecting child support guidelines actually stem from federal statutes that are detailed requirements for the establishment and enforcement of IV-D medical support orders while the child support guidelines apply to all orders regardless of IV-D status. OCSE promises new regulations, but their release is still pending. A complete review (and possible overhaul) of both federal statutes and regulations affecting medical child support is warranted. A clear federal direction is needed before states can revamp their medical child support provisions. Millions of children and parents are affected by medical child support orders. They deserve orders that are just and appropriate for their individual case circumstances, including their actual access to affordable and quality healthcare coverage, as well as appropriate for the new healthcare landscape of the post-ACA world.

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