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.

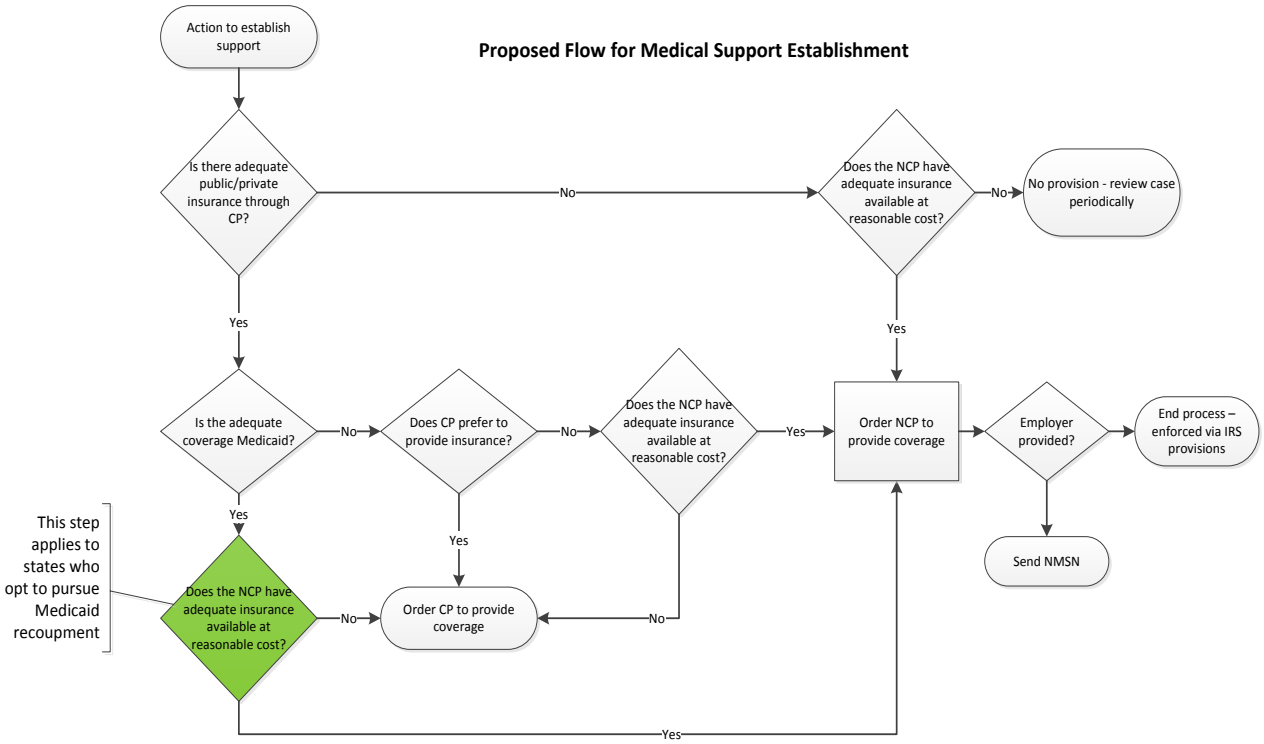
Where the child is on Medicaid, it may make sense to order both parents to provide medical support. This would ensure that the CP would understand his/her responsibility to keep the child ensured and would obviate the need to transfer the tax deduction to the NCP. In that way, if the CP experienced an 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