

FINAL REPORT:

*A FEASIBILITY STUDY OF REVIEW AND ADJUSTMENT FOR  
MEDICAL SUPPORT AND CHIP COLLABORATION*

GRANT NUMBER: 90F10028/01

CHILD SUPPORT DEMONSTRATION AND SPECIAL PROJECTS  
SPECIAL IMPROVEMENT PROJECTS  
ACF SIP ANNOUNCEMENT OCSE 99 SIP-1  
PRIORITY AREA: OTHER REVIEW AND ADJUSTMENT OF MEDICAL SUPPORT ORDERS

DECEMBER 16, 2002

*Submitted to:*

U.S. Department of Health and Human Services  
Administration for Children and Families

Services

Office of Grants Management  
Office of Child Support Enforcement

Paternity Programs

Attention: Mary Nash  
370 L'Enfant Promenade, SW  
4<sup>th</sup> Floor West  
Washington, D.C. 20447

*Submitted by:*

Alisha Griffin, Assistant Director  
New Jersey Department of Human

Division for Family Development  
Office of Child Support &

P.O. Box 716  
Trenton, New Jersey 08625

## Table of Contents

# Table of Contents

Acknowledgement.....	TOC-3
<i>Section 1: Executive Summary</i>	
Introduction .....	I-1
Key Considerations .....	I-2
Conclusion.....	I-6
<i>Section II: Medical Support Guideline</i>	
Project Context.....	II-1
Existing Legal Framework .....	II-3
Medical Child Support Work Group Report.....	II-5
Selected State Approaches .....	II-7
Proposed Medical Support Guideline .....	II-11
Anticipated Guideline Implementation Issues.....	II-28
<i>Section III: Proposed Review and Modification Process</i>	
New Coordinated Approach.....	III-1
Basis for Review and Modification .....	III-5
Case Selection.....	III-6
Review Process .....	III-7
Post-Review Notice and Challenge.....	III-10
Order Entry and Enforcement.....	III-11

Anticipated Implementation Issues ..... III-15

Conclusion ..... III-19

*Section IV: Test Results in Support of Proposed Guideline and Process*

Introduction .....IV-1

Guide for Interpreting Case Samples .....IV-2

Summary and Next Steps .....IV-4

## **Acknowledgement**

We would like to acknowledge that the work done under this project was completed by Cathleen Bennett of Policy Studies, Inc. through a State contract and funded by a Federal Special Improvement Project Grant awarded to New Jersey.

Section I  
Executive Summary

# Section I

## Executive Summary

### INTRODUCTION

---

In March 1999, the Medical Child Support Working Group was formed under the Child Support Performance and Incentives Act of 1998<sup>1</sup> to study and provide recommendations on how to improve the enforcement of medical support obligations for children. At the time of the Working Group's formation, the Secretary of the Department of Health and Human Services, Donna Shalala, announced her intention for the group to coordinate with the State Children's Health Insurance Program (SCHIP). The intent behind coordinating with SCHIP was to improve the entry and enforcement of medical support orders by allowing non-custodial parents under court order to apply for and provide medical coverage for the child under SCHIP.

In August 2000, the New Jersey Department of Human Services, Division of Family Development, Office of Child Support and Paternity Programs (OCSPP) was awarded a Special Improvement Project Grant to conduct a feasibility study of model review and adjustment procedures for medical support obligations with an emphasis on collaboration with the New Jersey FamilyCare Program<sup>2</sup>. This study explored the efficacy of using a Medical Support Facilitator during the review and modification process to determine the most appropriate healthcare coverage (private vs. public) for a child. The study utilized a test environment to examine the potential impact of ordering the non-custodial parent to meet his/her obligation to provide the Medical Support Facilitator-determined health coverage through the payment of cash medical support to the State Disbursement Unit. Because the amount of medical support ordered is income dependent, a cash medical support guideline was developed as part of this study. The focus of the study was on results – increasing the number of children with medical support orders, increasing the number of children with either private health care coverage or FamilyCare coverage, and enforcing that obligation through income withholding. The study examined the feasibility of automating the collection of the medical support obligation through income withholding and distributing the premium payments to the Medical Support Facilitator-determined coverage provider – either the private provider or to FamilyCare. The study also resolved the issue of using collected medical support to help offset the FamilyCare capitation fee if the amount of medical support collected exceeded the premium cost (as in the case where the Medical Support Facilitator preliminarily determines that the child is eligible for the FamilyCare \$0 premium program).

This project recognized that the New Jersey Child Support Program has enjoyed its greatest successes where it has automated and streamlined processes. Consequently, this project emphasized “sum-certain” orders for cash

---

<sup>1</sup> Pub. L. 105-200.

<sup>2</sup> FamilyCare provides free or low-cost health insurance for uninsured parents with income up to 200% of the federal poverty level.

medical support, with the amount of the order to be set according to income-based guidelines. The simplicity of this approach is two-fold: (1) the non-custodial parent is required to make all payments through the State Disbursement Unit (SDU), thus allowing OCSPP to track compliance readily, and (2) missed payments will be collected through automated collections remedies. This project specifically addressed the need for collaborative methods to ensure not only that medical support orders are entered but also, that orders entered are enforceable.

## **KEY CONSIDERATIONS**

---

### ***PROPOSED MEDICAL SUPPORT GUIDELINE***

Four principles guided the development of the proposed medical support guideline:

- 1) The goal of a medical support guideline is to provide quality healthcare coverage for more children served by the IV-D program.
- 2) Healthcare coverage for children served by the IV-D program must be appropriate. Appropriate healthcare coverage is comprehensive, accessible, stable, and affordable.
- 3) Private healthcare coverage is the preferred coverage for children in the IV-D program.
- 4) Both parents are responsible for healthcare coverage. When all things are equal, the preference is for the custodial parent to carry the coverage.

During the development of the proposed guideline, the following issues were addressed and resolved:

- Definition of “comprehensive coverage”
- Definition of “accessible coverage”
- Definition of “stable coverage”
- Definition of “affordable coverage”
- Withholding limitations posed by the CCPA
- FamilyCare enrollment limitations
- Healthcare for children with special health needs

- Non-custodial parents with multiple child support orders
- Multiple non-custodial parents per custodial parent household

We recommend that other states consider these issues when developing their own medical support guideline.

Following resolution of these issues, the proposed medical support guideline, consisting of seven steps, was developed. The first step requires the Medical Support Facilitator to determine if private healthcare coverage is available from one or both parents or from a stepparent. The second step requires the Medical Support Facilitator to determine if the available private coverage is appropriate, based on the criteria of comprehensibility, accessibility, stability, and affordability. The third step requires the Medical Support Facilitator to preliminarily determine if a child is eligible for enrollment and, if eligible, to enroll the child in a public health program in those cases where private coverage is not available or is not appropriate. The fourth step requires the Medical Support Facilitator to allocate responsibility for premium payments, if such premiums are necessary to obtain the healthcare coverage. The fifth step requires the Medical Support Facilitator to include unreimbursed healthcare expenses for the child, as necessary, in the medical support order. The sixth step requires the Medical Support Facilitator to designate primary and secondary plan providers, if appropriate. The seventh step requires the Medical Support Facilitator to draft the medical support provisions of the child support order.

In developing the proposed medical support guideline, the following implementation issues were anticipated and addressed:

- Means of collecting medical support order payments
- Enforcing a medical support order against a custodial parent
- Processes for assigned vs. non-assigned support orders
- Priority of withholding
- Foregoing recovery of prenatal and birth expenses
- Medical support payments and federal incentive measures
- Statutory, regulatory, and administrative changes

The resolution of these issues helped inform the development of the proposed process for review and modification of medical child support orders. Again, it is suggested that other states consider these issues in creating and implementing their own medical support guidelines.

## ***PROPOSED REVIEW AND MODIFICATION PROCESS***

A medical support order may be reviewed and modified without re-opening other issues of the child support obligation, provided that there is showing of at least one of the following six factors:

- 1) A parent's earnings have substantially increased or decreased, raising issues concerning the appropriateness of the existing healthcare coverage.
- 2) The needs of the parent or child(ren) have substantially increased or decreased.
- 3) Receipt of Temporary Assistance for Needy Families(TANF).
- 4) A change in the cost of living for either parent as measured by the federal bureau of statistics, any of which makes the terms unreasonable and unfair.
- 5) Extraordinary medical expenses of the child not provided for in the order.
- 6) The addition of, or a substantial increase or decrease, in work-related or education-related childcare expenses of the custodial parent.

Cases eligible for review will be drawn from and distributed in an Automated Child Support Enforcement System (ACSES) report. The report will contain all cases where the review date is equal to or greater than 15 months, reflecting the realities of today's skyrocketing health care costs that are typically passed on to the insured on an annual basis. If a review is warranted, a Financial and Medical Support Information Sheet must be completed and returned within 10 days. Orders will be reviewed by a Medical Support Facilitator to determine if there is a 20% change in the amount of financial and medical child support ordered when the child support guidelines are applied and to determine if the ordered medical support is comprehensive, affordable, accessible, and stable in accord with the proposed Medical Child Support Guideline.

Where more than one private healthcare coverage option is available, the Medical Support Facilitator will assist the custodial parent in identifying the most appropriate option. Where private coverage is not available or appropriate, the Medical Support Facilitator preliminarily makes a determination of a child's eligibility for FamilyCare. When the most appropriate coverage option is identified, the Medical Support Facilitator will calculate the required premium and will apply the proposed medical support guideline to that amount to assure affordability. When the amount of medical support is determined, an order for cash medical support will be drafted.

Medical support will be collected through income withholding as well as directly from the non-custodial parent and will be distributed to the plan administrator. Because this process is automated, the ACSES tickler will notify the

Medical Support Facilitator in the event of non-payment. To assure seamless coverage, after one payment is missed, the Medical Support Facilitator will notify the custodial parent of the non-payment and its impact on coverage. The custodial parent will be apprised of the right to apply for FamilyCare, which could be a reduced fee or no fee, depending on the household financial picture. Both automated matches and other communication methods with FamilyCare will enhance collaboration and cooperation on IV-D cases that are preliminarily determined eligible for FamilyCare.

During the development of the proposed review and modification process, the following issues were addressed and resolved:

- Considering both parents, and step-parents, as sources of potential healthcare coverage
- Uninsured or extraordinary medical expenses
- Availability of primary and secondary coverage options
- Process, if child currently has private coverage
- Sum-certain vs. general coverage orders
- Effect of a family violence indicator on medical support payments

We recommend that other states consider these issues when developing their own medical support processes.

In addition, in developing the proposed review and modification process, the following implementation issues were anticipated and addressed:

- Obtaining available private healthcare coverage options from the parents
- Using medical support facilitators
- Ensuring seamless healthcare coverage for children in the IV-D program
- Collecting multiple FamilyCare premium payments for a single household
- Using the proposed medical support guideline within the context of the National Medical Support Notice

## **CONCLUSION**

---

This study revealed that performance in the key areas of medical support establishment and enforcement can be enhanced through improved review and adjustment of support order processes. Enhanced performance can be obtained through automated process efficiencies. This study revealed that implementation of the proposed medical support guideline and of the proposed review and modification procedures would garner the following key benefits:

- Increased medical support establishment on review and adjustment cases.
- Streamlined processes for establishing medical support orders.
- Increased percentage of cases with medical support orders.
- Increased proportion of cases complying with medical support orders.
- Automated enforcement of medical support orders.
- Enhanced communication and cooperation between OCSP and FamilyCare.
- Increased enrollments in FamilyCare.

Simply put, the proposed cash medical support guideline considers issues of affordability, accessibility, stability, and comprehensiveness prior to the issuance of an order so that enforceable orders are established. Lastly, our study indicates that cash medical support orders ease enforcement burdens significantly because they allow for greater consistency in enforcement through automated means.

Section II  
Medical Support Guideline

## Section II

### Proposed Medical Support Guideline

#### PROJECT CONTEXT

---

Expanding a child's access to accessible, affordable, and comprehensive health coverage continues to be a major public policy goal in New Jersey. In New Jersey, 13.3% of all children under the age of 18 do not have health insurance.<sup>3</sup> Alarming, figures show that 33% of New Jersey's children under the age of 18 reside in households below 200% of the poverty level, and of these most at-risk children, more than 25% do without health insurance coverage.<sup>4</sup> This statistic is disturbing in light of the initiatives that New Jersey has undertaken to improve access to affordable, comprehensive coverage. "The initiatives include reforms of the individual and small group health insurance markets, subsidized health coverage through Health Access, Medicaid expansion to 185% of the Federal Poverty Level for pregnant women and infants, Medicaid's move to managed care, and the implementation of NJ [Family]Care."<sup>5</sup>

The number of uninsured children in New Jersey would decrease if all children receiving IV-D services had enforceable orders for medical support established. "Children growing up in divorced, never-married, or separated families are at a greater risk than other children of not having health care coverage."<sup>6</sup> The child support community is uniquely positioned to facilitate access by these children to health care coverage. It is too well known that lack of health insurance has a profound effect on access to health care, including routine care such as immunizations and emergency care for injuries.<sup>7</sup> "Healthy insured children perform better in school because they are less likely to suffer from treatable conditions – such as asthma, ear infections and vision problems – that interfere with classroom participation and attendance."<sup>8</sup> Thirty-seven percent of long-term uninsured children have no doctor visits throughout the year.<sup>9</sup>

Despite this damaging social trend, with its severe adverse consequences for the children involved, there is emerging only lately a recognition of the critical role that the Child Support Program can play in reducing the incidence of non-insurance. Although pursuit of private coverage has been a child support requirement since the Child Support

---

<sup>3</sup> Covering Kids, A National Health Access Initiative for Low-Income Uninsured Children, *New Jersey Child Health Coverage Statistics*, 2001 (citing Urban Institute, 2000).

<sup>4</sup> Id.

<sup>5</sup> New Jersey Department of Health & Senior Services, Family Health Services, *2001 Annual Report: Maternal and Child Health Services, Title V Block Grant Program*, July 2001.

<sup>6</sup> The Medical Child Support Work Group's Report to the Honorable Donna E. Shalala and the Honorable Alexis M. Herman, *21 Million Children's Health: Our Shared Responsibility*, x (2000).

<sup>7</sup> General Accounting Office, *New Strategies to Insure Children*, (Washington, DC: US General Accounting Office, GAO/HEHS-96-35, January 1996) 3; Linda J. Blumberg and David W. Liska, *The Uninsured in the United States: A Status Report*, (Washington, DC: The Urban Institute, April 1996).

<sup>8</sup> Covering Kids, A National Health Access Initiative for Low-Income Uninsured Children, *Background for Researchers and Policymakers*, 2001.

<sup>9</sup> The Southern Institute on Children and Families, *Child Health Coverage*, 2001; Ron Pollack, Cheryl Fish-Parchman, and Barbara Hoenig, *Unmet Needs: The Large Differences in Health Care Between Uninsured and Insured Children*, (Washington, DC: Families USA, 1997).

Amendments of 1984, the regulations promulgated pursuant to this statute have hindered the establishment of enforceable orders for medical support through an outmoded definition of “reasonable cost.”<sup>10</sup> This definition has created unenforceable medical support orders since “most uninsured children live in working families that cannot afford to pay for health care coverage, even when offered through their employers. The premiums are just too expensive.”<sup>11</sup>

As a step forward in coping with the issue of uninsured children, the Child Support Performance and Incentives Act of 1998 ordered the formation of the Medical Child Support Work Group under the auspices of the Secretaries of the Department of Health and Human Services and the Department of Labor.<sup>12</sup> The Medical Support Work Group was charged with delivering a report that identified and resolved impediments to enforceable medical child support orders. In developing model processes for review and adjustment for medical support orders, New Jersey reviewed and, in some instances, incorporated the findings and recommendations of the Medical Support Work Group. New Jersey also assessed approaches to medical child support utilized by other states. The Medical Support Work Group and other states that are proactively addressing the medical support issue have urged the need for close coordination with the State Children’s Health Insurance Program (SCHIP).<sup>13</sup> SCHIP provides funding to the states, enabling them to begin or expand the provision of health care coverage to uninsured children of low-income families.<sup>14</sup> SCHIP is a mechanism for ensuring that low-income children are given the same guarantees of effective and efficient health care in a manner coordinated with other sources of health benefit coverage for children.<sup>15</sup>

## EXISTING LEGAL FRAMEWORK

---

Child support enforcement was controlled by the states until the mid-1970s when Congress passed the Social Services Amendments of 1974 and created the first federally mandated child support enforcement program.<sup>16</sup> Prior to the passing of the Social Services Amendments, Congress had regulated health benefit plans regardless of whether benefits were provided through the purchase of insurance, from the sponsor or from general plan assets.<sup>17</sup> Then, in 1977, the Medicare-Medicaid Anti-Fraud and Abuse Amendments established medical support programs wherein states could require Medicaid recipients to assign to the states their rights to medical support.<sup>18</sup>

---

<sup>10</sup> 45 CFR 303.31(a) defines health insurance as “reasonable in cost if it is employment-related or other group health insurance, regardless of service delivery mechanism.”

<sup>11</sup> Covering Kids, A National Health Access Initiative for Low-Income Uninsured Children, *Background for Researchers and Policymakers*, 2001.

<sup>12</sup> *21 Million Children’s Health: Our Shared Responsibility*, x.

<sup>13</sup> The Balanced Budget Act of 1997. Pub. L. 105-33.

<sup>14</sup> The Balanced Budget Act of 1997. Pub. L. 105-33.

<sup>15</sup> IM-01-07. Office of Child Support Enforcement. (August 30, 2001).

<sup>16</sup> Pub. L. 93-647. Congress created Title IV-D of the Social Security Act to establish the Child Support Enforcement Program under then Secretary of Health, Education and Welfare (now Health and Human Services).

<sup>17</sup> The Employee Retirement Income Security Act of 1974 (ERISA). Pub. L. 93-406.

<sup>18</sup> Pub. L. 95-142.

However, the Child Support Enforcement Amendments of 1984 were the primary tool that enhanced child support enforcement mechanisms and expanded federal oversight in obtaining uniformity among state programs. This legislation required states to petition for the establishment of medical support in addition to cash support awards, provided that medical support is available at reasonable cost.<sup>19</sup> “Reasonable cost” is defined as health insurance that “is employment-related or other group health insurance, regardless of service delivery mechanism.”<sup>20</sup> Clearly, legislators were demonstrating that providing for the medical needs of children was an important aspect of a parent’s duty to support his/her child.<sup>21</sup>

The Family Support Act of 1988 extended the presumptive application of child support guidelines to all child support decisions.<sup>22</sup> This law emphasized a parent’s duty to work and support their children. In 1989, Congress made it possible for Medicaid benefits to continue for four months upon a family’s loss of Aid to Families with Dependent Children eligibility as a result of child support payments collection.<sup>23</sup>

Continuing through the 1990s, Congress enacted laws that attempted to strengthen the establishment and enforcement of medical child support orders. A first significant step occurred with the passage of the Omnibus Budget Reconciliation Act of 1993 (OBRA ‘93), which amended the Employee Retirement Income Security Act of 1974 (ERISA) by requiring covered group health plans to provide benefits pursuant to medical child support orders that satisfy the statutory requirements of qualified medical child support orders.<sup>24</sup> OBRA ‘93 also provided medical support enforcement mechanisms, including the garnishment of wages, salary, and other income. In addition, OBRA ‘93 required states to enact legislation prohibiting employers and insurers from denying enrollment of a child under a parent’s family plan.<sup>25</sup> Employers were restricted from excluding children because of such factors as the child’s legitimacy, the parent’s failure to claim the child as a dependent on his or her Federal income tax return or because the child did not live with the non-custodial parent in the health plan coverage area.

However, until 1996, IV-D agencies were required only to *petition* for the inclusion of medical support in new and modified support orders when health care coverage was available to the non-custodial parent through employer-related or other group health insurance. In enacting the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), Congress mandated that all child support orders include a provision for health care coverage.<sup>26</sup> Further, PRWORA mandated IV-D agencies to provide notice of existing medical support orders to employment-related coverage plans and required the plan administrators to enroll qualified children, unless the parent contested the enrollment.

---

<sup>19</sup> Pub. L. 98-378.

<sup>20</sup> 45 CFR 303.31(a).

<sup>21</sup> The conference report on the Child Support Amendments of 1984 included a statement from conferees stating that the best long-term solution in achieving medical care coverage for all families was the use of private insurance made through one parent’s employment. See Henry, Michael R. and Victoria S. Schwartz, A Guide for Judges in Child Support Enforcement. Second Edition. U.S. Department of Health and Human Services.

<sup>22</sup> Pub. L. 100-485

<sup>23</sup> The Omnibus Budget Reconciliation Act of 1989. Pub. L. 101-239.

<sup>24</sup> The Omnibus Budget Reconciliation Act of 1993. Pub. L. 103-66.

<sup>25</sup> *Id.*

<sup>26</sup> Pub. L. 104-193. States were also required to operate a Title IV-D child support program to remain eligible for TANF funding.

Yet, perhaps the most sweeping reforms regarding medical support occurred with the passage of the Child Support Performance and Incentive Act of 1998 (CSPIA).<sup>27</sup> CSPIA mandated several important steps be taken to improve medical support enforcement within child support enforcement programs.<sup>28</sup> CSPIA directed the joint creation and dissemination of a National Medical Support Notice by the Department of Health and Human Services and the Department of Labor. The National Medical Support Notice is issued by state IV-D agencies as an automated method for medical child support enforcement. CSPIA directed the Department of Health and Human Services and the Department of Labor to develop and jointly issue interim and final regulations for the transmission of the National Medical Support Notice by state IV-D agencies to employers.<sup>29</sup> These regulations require plans to ensure that the federal Consumer Credit Protection Act (CCPA) limits are not breached.<sup>30</sup> Although the CCPA sets the uppermost limits, states are permitted to offer more protection to an obligor via lower withholding limits.

## **MEDICAL CHILD SUPPORT WORK GROUP REPORT**

---

The Medical Support Work Group's mandate to identify impediments to the establishment and enforcement of medical support orders included the charge to provide recommendations on removing the barriers to effective medical support enforcement by state child support agencies. In June 2000, the Medical Support Work Group issued *21 Million Children's Health: Our Shared Responsibility*.<sup>31</sup> The Medical Support Work Group listened to testimony, conducted research and met with panelists to achieve its 76 recommendations for the new framework of medical support establishment and enforcement within the IV-D program.<sup>32</sup> The Medical Support Work Group's goal was to ensure appropriate utilization of private health care coverage and to establish public coverage as "the payer of last resort."<sup>33</sup> The Medical Support Work Group established a new, streamlined, cost-effective model for medical support establishment and enforcement.

Six principles guided the Medical Support Work Group in its development of a new medical child support paradigm.<sup>34</sup> The six principles are:

- 1) The number of children in single-parent households with health care coverage must be increased.

---

<sup>27</sup> Pub. L. 10-200. See implementation regulations at 29 CFR 2950 & 45 CFR 303.32.

<sup>28</sup> Pub. L. 10-200, 1998. As noted, this piece of legislation called for the formation of a Medical Support Work Group by the Secretaries of Health and Human Services and Labor to issue a report on the impediments to the enforcement of medical support.

<sup>29</sup> The National Medical Support Notice was issued on December 27, 2000 and took effect March 27, 2001. This document is to be utilized as by state child support enforcement programs in enforcing medical support orders. Additionally, the Support Notice is to be identified as a qualified medical support order under ERISA by health care administrators. 29 CFR 2590; 45 CFR 303.32.

<sup>30</sup> CCPA limits the percentage of an obligor's income that may be withheld for purposes of child support payments. Up to sixty percent of an employee's disposable earnings if the employee does not have another family and is current on support payments may be withheld. If an employee supports two families, the maximum amount that may be withheld is fifty percent. 15 U.S.C. Section 1671 *et seq.* See also 29 CFR 870.

<sup>31</sup> *21 Million Children's Health*, Executive Summary.

<sup>32</sup> *21 Million Children's Health*, xiii.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

- 2) Private coverage is the preferred means of coverage, where appropriate. If private coverage is not affordable, accessible, or comprehensive enough, public coverage is an appropriate alternative.
- 3) Where all is equal, the custodial parent is the preferred source for health coverage for the child.
- 4) Coverage must be affordable (*i.e.*, the cost of premiums should not exceed 5% of a family's gross income).
- 5) Coverage must be accessible (*i.e.*, services provided under a plan must be geographically accessible).
- 6) Coverage must be both comprehensive and seamless.

These guiding principles recognize that many of the assumptions that underlie the existing medical child support framework are outdated. Most apparent is the outmoded definition of employer-based coverage as per se reasonable in cost.<sup>35</sup> Even where dependent care coverage is available through the workplace, it is financially out of reach for low-wage families because the premiums are too expensive.<sup>36</sup>

Because of rising health care costs, employers have tended to reduce coverage or to increase the amount of the employee's contribution. For example, from 1988 to 1996, the per capita cost for employers to obtain employee coverage rose by eight percent, while employee contributions to those costs increased by 18 percent. During the same time period, the median earnings of American households increased less than two percent.<sup>37</sup>

The Medical Support Work Group also addressed the traditional assumption that custodial parents are not employed and do not have access to employer-based health insurance.<sup>38</sup> Indeed, research shows that more than 75% of all custodial parents were employed in 1995 and that in "single parent households with incomes over 200 percent of poverty, more than 60 percent of children are covered by family health coverage provided by the custodial parent."<sup>39</sup> The Medical Support Work Group noted that neither the custodial nor the non-custodial parent enjoy stable, continuous employment with the same employer.<sup>40</sup> Data reveals that the median employee

---

<sup>35</sup> 45 CFR 303.31(a)(1); *21 Million Children's Health*, 2-11.

<sup>36</sup> Covering Kids, A National Health Access Initiative for Low-Income Uninsured Children, *Background for Researchers and Policymakers*, 2001; *21 Million Children's Health*, 2-12.

<sup>37</sup> *21 Million Children's Health*, 2-12 (citing Ellen O'Brien and Judith Feder, *How Well Does the Employment-Based Health Insurance System Work for Low-Income Families?* Kaiser Commission on Medicaid and the Uninsured (September 1998), 5; John McNeil, *Changes in Median Household Income: 1969 to 1996*, U.S. Bureau of the Census (July 1998), 23-196, Table 5b).

<sup>38</sup> *21 Million Children's Health*, 2-10.

<sup>39</sup> *Id.* (citing Lydia Scoon-Rogers, *Child Support for Custodial Mothers and Fathers: 1995*, Census Bureau Current Population Reports (March 1999), 60-196). See also General Accounting Office, *New Strategies to Insure Children*.

<sup>40</sup> *21 Million Children's Health*, 2-10.

tenure per employer is less than four years.<sup>41</sup> More telling are studies which show that the median length of time for a wage assignment is 11 months, suggesting even less stability among obligor parents.<sup>42</sup>

The Medical Support Work Group emphasized the importance of coverage that is geographically accessible, challenging conventional wisdom that held that distance does not matter.<sup>43</sup> The increased preponderance of and reliance on managed care plans brings the issue of geographic accessibility to the forefront. This holds especially true in the child support arena where more than 25% of all non-custodial parents reside in a different state from their children and where an additional 20% of all non-custodial parents live in a different county or city from their children even when residing in the same state.<sup>44</sup>

Because child support guidelines tend to be predicated upon these outdated assumptions, private coverage opportunities for children on the IV-D caseload are not maximized. The Medical Support Work Group recommended a model for medical child support accounts for the changing labor market, family structure, health care delivery systems, and social welfare policies of today. The Medical Support Work Group recognized that transition to this model will require close coordination and collaboration between child support, public health coverage programs, and the private sector.

## **SELECTED STATE APPROACHES**

---

In developing an understanding of contemporary medical support establishment and enforcement practices, various state practices were reviewed to ascertain the range of procedures employed and to determine what specific improvements could bolster medical support efforts in order to achieve comprehensive, inclusive health care coverage for all children on the IV-D caseload. Certain patterns were observed during this analysis. Foremost, establishment of a medical support order does not necessarily mean that a child is actually enrolled in a health insurance plan.<sup>45</sup> Further, studies show that some state child support programs fail to consistently petition for the inclusion of health coverage in support orders while others fail to enforce the orders once established. “State medical support enforcement has been spotty at best.”<sup>46</sup> The failure of state child support agencies to effectively pursue medical support for children has cost federal and state governments approximately \$122 million dollars in

---

<sup>41</sup> *Id.* See also Bureau of Labor Statistics, *Employee Tenure in 1998*.

<sup>42</sup> *21 Million Children's Health*, 2-10 (citing Anne Gordon, *Income Withholding, Medical Support, and Services to Non-AFDC Cases After the Child Support Amendments of 1984*, Volume 1, Mathematica Policy Research, Inc. (1991)).

<sup>43</sup> *21 Million Children's Health*, 2-13.

<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> Child Support Enforcement Incentive Payment Proposal, 1997: Hearing on Child Support Enforcement Incentive Payment Proposal Before the Subcomm. on Human Resources of the House Comm. on Ways and Means (statement of Nancy Ebb, Senior Staff Attorney with the Children's Defense Fund). For a report of her testimony see <http://waysandmeans.house.gov>. She testified that according to data collected by the Office of Child Support Enforcement in fiscal year 1994, 58 percent of support orders established included health insurance. This number was up from 46 percent in 1991. However, only 32 percent of the orders modified in this same time included health insurance, decreasing from 35 percent previously.

expenditures.<sup>47</sup> Nonetheless, some states have piloted or established comprehensive medical support systems. Some of the best practices learned from these programs are introduced below.

## *CALIFORNIA*

Sacramento County has made low-cost, private health insurance available for IV-D children since 1996.<sup>48</sup> Sacramento County has developed a program for non-custodial parents to obtain medical insurance. This program has served over 500 children, generating more than \$450,000 in public savings.<sup>49</sup> More importantly, these children now have comprehensive health care coverage, which was previously lacking. Eligibility for this initiative is contingent upon a court order requiring the non-custodial parent to provide health coverage for the dependent children, as well as the Family Support Division having enforcement responsibility over the case. Should a non-custodial parent fail to provide proof of coverage, he or she may be ordered to provide coverage through the IV-D program. A withholding order may be entered directing an employer to withhold premium payments, which are then forwarded to the programs' third-party administrator.

## *CONNECTICUT*

In Connecticut, the court will enter a medical support order for minor children if health insurance is available through an employer for a reasonable cost. The court also may order either the custodial or the non-custodial parent to apply for and maintain coverage for the child through Connecticut's "H.U.S.K.Y. Health Plan."<sup>50</sup> HUSKY provides free or subsidized premiums for private insurance to children up to 300 percent of the federal poverty level and allows families above that income to buy into the program. Finally, Connecticut's guidelines provide for the allocation of un-reimbursed medical costs between the parties.

## *ILLINOIS*

Illinois requires that health care coverage be addressed whenever a support order is established, modified or enforced. Illinois Public Act 86-649 provides for medical support enforcement remedies that exceed federal requirements. Illinois has mandated that when medical care coverage is available through the non-custodial parent's

---

<sup>47</sup> *Id.*

<sup>48</sup> See Best Practices and Good Ideas in Child Support Enforcement 2000. Office of Child Support Enforcement. Full the full report, see <http://www.acf.dhhs.gov>.

<sup>49</sup> The Bureau of Family Support Services negotiated with two private companies to provide insurance coverage for the IV-D children under rates comparable to that of county health plans. Therefore, where non-custodial parents fail to obtain coverage when ordered to do so, insurance is available through the IV-D program.

<sup>50</sup> H.U.S.K.Y. is the acronym for Healthcare for Uninsured Kids and Youth, which is Connecticut's public health insurance programs for those under 19 years of age.

employer, the employer must enroll the dependent children in the insurance plan and deduct any premiums directly from the employee's wages.<sup>51</sup> Moreover, employers cannot exclude a child from coverage where the child does not reside with the employee. This system even permits the custodial parent to sign insurance claims and forward them to the insurer for processing.

## *MASSACHUSETTS*

Massachusetts makes provision for medical support in its wage assessment forms. Under Massachusetts' guidelines, the cost of medical insurance is deducted from the child support order. The wage assignment order increases if the non-custodial parent fails to provide the child with health insurance.<sup>52</sup> It is policy in Massachusetts that in ordering child support, the court shall determine whether the non-custodial parent has health insurance available on a group plan or other insurance available at a reasonable cost that may be extended to the dependent children for whom support is ordered.

## *MINNESOTA*

Medical support in Minnesota may include dependent health and dental insurance coverage or cash payments to cover incurred medical expenses.<sup>53</sup> Minnesota requires that the medical assistance recipients assign to the county of residence any rights the recipient has under employment related or private health care coverage, any rights the recipient has under automobile injury coverage, and any rights to payments from third parties for medical care for the recipient and any dependents. Additionally, recipients must cooperate fully with the county in any legal action brought against a third party for medical expenses and also must cooperate with the establishment of paternity.<sup>54</sup> A recipient may be removed from medical assistance for failure to keep the Child Support Enforcement Division apprised of known information.

Current law provides that all court orders for child support must include medical support.<sup>55</sup> Moreover, since January 1, 1994, all court orders regarding child support require such support to be paid through income withholding even if the obligor is willing and/or has been making those payments directly.<sup>56</sup> These notices are deemed "automatic", as employers must commence income withholding immediately upon receipt of the document whether forwarded from the employee, Child Support Enforcement Division or the courts.<sup>57</sup>

---

<sup>51</sup> IM-91-1 Office of Child Support Enforcement. September 5, 1991.

<sup>52</sup> IM-91-01. Office of Child Support Enforcement . September 5, 1991.

<sup>53</sup> See Office of the Ramsey County Attorney at <http://www.co.ramsey.mn.us>.

<sup>54</sup> *Id.*

<sup>55</sup> *Id.*

<sup>56</sup> See Economic and Community Support: Employer's Guide to Minnesota Child Support Laws at <http://www.dhs.state.mn.us>. Minnesota also requires authorizes income withholding for child support, childcare support and spousal maintenance.

<sup>57</sup> IM-91-1. Office of Child Support Enforcement. September 5, 1991.

Employers must provide medical coverage information to the custodial parent as well as the child support agency. Should an employer willfully fail to comply with a medical support withholding order, the employer may be obligated for medical expenses incurred by a dependent during the time period the dependent was eligible to be enrolled in the coverage plan, obligated for any premiums incurred as a result of the employer's failure to comply, and/or may face a finding of contempt with a \$500 fine.

Finally, employers must keep all dependents enrolled in coverage until notified by the child support agency that coverage can be terminated or until the employee has provide proof that medical support is no longer ordered. Should disenrollment be caused by the employee's failure to pay the premium, employers must provide written notice to the custodial parent thirty days prior to the expiration of the policy.

## ***WASHINGTON***

During the past 15 years, Washington has altered dramatically the manner in which medical support is handled by IV-D staff.<sup>58</sup> Washington requires medical support to be included in all new and modified orders. The child support agency requires the non-custodial parent to provide proof of enrollment in employment-based health insurance. If the non-custodial parent fails to provide such proof within twenty days, the employer is served notice to enroll the child in the health insurance plan and is instructed to withhold premiums. This insurance coverage applies to the child regardless of the child's place of residence. Should the employer fail to comply with the notice, fines are imposed.

In efforts to automate and streamline the medical support process, Washington modified its forms; it clarified non-custodial parent instructions and communicated with the non-custodial parent regarding necessary reciprocal information. Further, Washington's automated system used for case management to record pertinent medical support information was modified. Washington also established formal communications with the Medicaid Third-Party Liability unit and created a liaison position to work between the two offices. Washington provides for the co-endorsement of third party payments to prevent obligors from receiving payments due to the state agency for paid medical services.<sup>59</sup> Finally, Washington strengthened its outreach and training aspects to inform employers of the importance of medical support.

## **PROPOSED MEDICAL SUPPORT GUIDELINE**

---

---

<sup>58</sup> In the area of medical support, Washington received an efficiency rating of zero for the Office of Child Support Enforcement program-results audit for fiscal year 1987. However, in the next review period, from July – September 1991, the state received a rating of ninety-eight percent.

<sup>59</sup> IM-91-01.

## ***BACKGROUND***

In 1998, Congress directed the creation of the federal Medical Child Support Work Group, a thirty-member group jointly established by the Secretaries of Health and Human Services and Labor. The Medical Support Work Group's charge was to submit a report to the Secretaries "identifying the impediments to the effective enforcement of medical child support and recommending solutions to those impediments." The Medical Support Work Group issued their final report *21 Million Children's Health: Our Shared Responsibility*,<sup>60</sup> in June 2000. We incorporated many of the Medical Support Work Group's assumptions, findings, and recommendations into the development of New Jersey's medical support guideline.

## ***PRINCIPLES FRAMING PROPOSED MEDICAL SUPPORT GUIDELINE***

In creating this proposed guideline, four basic principles focused our emphasis and informed our policy choices. These four principles, together with an abbreviated explanation, are set forth below.

- 1. The goal of a medical support guideline is to provide quality healthcare coverage for more children served by the IV-D program.*

The proposed guideline emphasizes the quality of the healthcare available to children in the IV-D program and considers the practical implications of medical support orders on parents and children. Private coverage is given priority over public coverage options – but only when it meets the criteria under the proposed guideline. A medical support obligation for private coverage that is ordered and complied with, but that does not provide adequate healthcare coverage for the child, is of little or no benefit to the child. In fact, such an order can actually harm the child's opportunities for access to other medical coverage. With this in mind, our goal was to obtain more and better healthcare coverage for more children served by the IV-D program.

- 2. Healthcare coverage for children served by the IV-D program must be appropriate. Appropriate healthcare coverage is comprehensive, accessible, stable, and affordable.*

The Medical Support Work Group identified medical support orders that resulted in inadequate or inappropriate coverage as one of the main obstacles to the provision of quality healthcare services for children receiving child support. In response to this, the Medical Support Work Group devised a simple matrix for determining appropriate healthcare coverage under a medical support order. The matrix focused on the consideration of four primary factors: comprehensibility, accessibility, stability, and affordability. These factors have been incorporated into New Jersey's proposed guideline. However, the definitions for these factors have been amended to comply with New Jersey law and to respond to geographic and socioeconomic characteristics of New Jersey's IV-D caseload.

---

<sup>60</sup> The executive summary and text of the Medical Support Work Group's complete report are available at <http://www.acf.dhhs.gov/programs/cse/rpt/medrpt/index.html>.

Healthcare coverage is **comprehensive** if it includes at least medical and hospital coverage, provides for preventive, emergency, acute, and chronic care, and imposes reasonable deductibles and co-payments.

Healthcare coverage is **accessible** if a plan provider is located within the State of New Jersey and the covered child can obtain services from the provider within 10 miles or 30 minutes from the child's residence. If primary care services are not available within these parameters, the coverage will be deemed inaccessible.

Healthcare coverage is **stable** if it can reasonably be expected to remain effective for at least one year, based on the employment history of the parent who is to provide the coverage. Parents with sporadic or seasonal employment are not good candidates to provide employer-sponsored coverage.

Healthcare coverage is **affordable** if it does not cost more than five percent of the net income of the parent who provides the coverage. Parents whose net income is at or below 200 percent of the federal poverty level will not be ordered to pay for private or public coverage, unless that parent has access to private coverage that does not require an employee contribution. Likewise, no parent who lives with a child who is Medicaid-eligible based on that parent's income will be ordered to pay for private coverage, unless the parent has access to private coverage that does not require an employee contribution.

*3. Private healthcare coverage is the preferred coverage for children in the IV-D program.*

Federal and state law and regulations previously have focused entirely on private healthcare coverage available from the non-custodial parent. No state formally has linked medical child support orders with public healthcare programs. New Jersey's proposed guideline considers public as well as private healthcare coverage options for children in the IV-D program. However, the first choice for coverage remains private healthcare coverage, assuming the criteria for appropriate coverage are met.

*4. Both parents are responsible for healthcare coverage. When all things are equal, the preference is for the custodial parent to carry the coverage.*

New Jersey is one of 27 jurisdictions in the nation that currently considers both parents as sources of healthcare coverage for children in the IV-D program. The Medical Support Work Group ratified this approach to medical support in their recommendations, arguing that the custodial parent is the more convenient and appropriate parent to be in charge of healthcare coverage for the child, even if the non-custodial parent is responsible for some or all of the child's healthcare costs. This logic was incorporated into the proposed guideline, which directs the medical support facilitator (MSF) to favor the custodial parent, when all factors are otherwise equal.

These general principles provided the framework for the proposed medical support guideline and the accompanying decision matrix.<sup>61</sup>

---

<sup>61</sup> See Appendix A, Medical Support Decision Matrix.

## *SIGNIFICANT ISSUES ADDRESSED DURING GUIDELINE DEVELOPMENT*

In addition to the principles enumerated above, certain aspects of New Jersey law and policy also provided direction for development of the proposed medical support guideline. Below are several focal points that required consultation with New Jersey law and/or administrative policy or necessitated public policy decisions. We recommend that other states consider these issues when developing their own medical support guideline.

### Comprehensive Coverage

The Medical Support Work Group reported that some healthcare plans are so limited that they do not even meet the child's basic needs. In fact, enrollment in these plans could actually hinder the child from obtaining adequate medical coverage under, for instance, a state Children's Health Insurance Program (SCHIP), because public healthcare programs are typically limited to children with no other coverage. To be comprehensive, the Medical Support Work Group recommended that coverage include at least medical and hospital coverage, provide for preventive, emergency, acute, and chronic care, and impose reasonable deductibles and co-payments. If more than one plan is available, the plans should be compared by considering basic dental coverage, orthodontics, basic vision care, mental health services, and substance abuse services. We incorporated this definition into New Jersey's guideline.

### Accessible Coverage

Accessibility is a major concern when setting a medical support order for healthcare coverage. In today's healthcare environment, many Health Maintenance Organizations (HMOs) serve only limited geographic "network" areas, and nearly all plans limit services to particular doctors who are considered "in-network." Costs, including co-pays and deductibles, to see a physician or specialist "out of area" or "out of network" can be significantly higher. Since non-custodial parents may live a significant distance away from their child and the custodial parent, private coverage available to them through an employer sponsored plan may not be reasonably accessible to the child. Some healthcare insurers have reciprocity agreements with providers in other states or regions. These agreements may enable some non-custodial parents to provide adequate coverage for their children, even at a great distance. In many situations, however, the non-custodial parent's available private insurance will simply not be a practical alternative for the child because of accessibility issues, and other coverage possibilities will need to be examined.

The Medical Support Work Group concluded that "children should not be enrolled in any limited provider plan whose services/providers are not accessible to them, unless the plan can provide financial reimbursement for alternate service providers."

The Medical Support Work Group defined accessible providers as those that could be reached within 30 minutes or 30 miles. In developing New Jersey's proposed guideline, consideration was given to New Jersey's "bedroom

community” status (*i.e.*, New Jerseyans maintain a household in the state but are employed in either New York City or Philadelphia); the urban, suburban, and rural nature of the state; the regionalization of the state; the limitations of available public transportation; and the impact of traffic congestion. With these considerations in mind, accessible coverage was defined as coverage that is within the State of New Jersey and can be reached within 10 miles or 30 minutes of the child’s residence. This criterion accounts for the realities that most public transportation in New Jersey’s cities will travel approximately 10 miles outside the urban center, and that a 30-minute ride on public transportation to reach necessary services is not unusual for low-income clients. The in-state aspect of this criterion accounts for prohibitively high transportation costs that can be incurred by traveling to out of state for healthcare treatment that is within the 10 miles or 30 minutes parameter, such as to New York City or Philadelphia. For instance, it was estimated that a short driving trip from suburban New Jersey to New York City for a doctor appointment could easily generate transportation costs close to \$30, when tunnel tolls, parking, and gasoline are accounted for. For this reason, an in-state provider network is favored in our guideline.

The “accessibility” criteria is a rebuttable presumption that can be overcome at the request of the custodial parent, who presumably will be responsible for transporting the child to medical appointments. For example, a custodial parent may desire the child to continue seeing a pediatrician or specialist who is not located within the criterion’s parameters and can accommodate the time, travel, or cost required to access the provider. In such a case, there is no practical reason to require the child to begin treatment with a different provider. Thus, there is a rebuttable presumption characteristic to the accessibility criterion.

### **Stable Coverage**

Experience has taught that just because healthcare coverage is available at the time an order is entered does not mean it will be available or affordable by the time the paperwork is completed. Some parents have access to dependent healthcare coverage but lose the coverage shortly after the order is entered. Parents with seasonal employment, those whose hours of employment vary at different times of the year (such as construction workers), and those who frequently change jobs may not be able to provide consistent, stable healthcare coverage through their employer. The Medical Support Work Group recognized the issue of stability and recommended that it be one of the primary considerations when determining appropriate medical coverage under a child support order. This recommendation has been incorporated into the proposed guideline’s criteria.

### **Affordable Coverage**

The Medical Support Work Group considered several approaches to ensuring that medical support orders were set at reasonable amounts. The Medical Support Work Group’s main concern was that if medical support orders are set too high, “cash support will be substantially reduced, leaving the custodial parent without enough money to supply the child’s basic needs.” Further, if medical support orders are set high and the cash support order is not adjusted downward to reflect the additional healthcare contribution, “poorer non-custodial parents will pay an unreasonably high portion of their income as support,” possibly even in violation of the federal Consumer Credit

Protection Act. Therefore, our goal was to obtain healthcare coverage for children without reducing cash support awards or creating more poor non-custodial parents.

The Medical Support Work Group examined two general approaches to setting medical support orders. One calculates reasonable cost relative to the cash support award, and the other determines reasonable cost with reference to the gross income of the parent providing the coverage. The Medical Support Work Group ultimately recommended the second approach and suggested that states define reasonable cost for healthcare coverage under a medical support order as that which does not exceed five percent of the gross income of the parent providing the coverage. New Jersey's child support guideline is based on the parents' net incomes, which is calculated as gross incomes minus prior child support obligations, taxes, union dues, etc. Although in agreement with the Medical Support Work Group's analysis, the proposed guideline adopts net income to reflect New Jersey's use of net income in the child support guideline. The expectation is that this will simplify the medical support calculation, account for the existence of multiple orders, and also result in a more reasonable health care contribution.

Some of the models examined by the Medical Support Work Group calculated reasonable costs with reference to a percentage of the basic support obligation, rather than a percentage of the obligor's income. In evaluating the Medical Support Work Group's approach, several policy considerations argued strongly in favor of the percentage of income approach. First, to set the limit as a percentage of income places the calculation "above the line" – in other words, the calculation is made without reference to the total obligation amount. Because of this, a custodial parent is less likely to view the medical support amount as a subtraction from the basic cash support order. Second, because New Jersey's child support guidelines are based on the combined incomes of both parents with obligations split proportionally, it made sense to deduct the medical support contribution from the parents' incomes in identical proportions.

As suggested by the Medical Support Work Group, an income level floor for medical support obligations was created. The Medical Support Work Group recommended that no parent whose income is below 133 percent of the federal poverty level should be required to contribute to private insurance coverage. Under the proposed guideline, no parent whose net income is at or below 200 percent of the federal poverty level will be ordered to contribute to private coverage premiums. Likewise, no parent with a net income below 200 percent of the federal poverty level will be ordered to contribute to SCHIP enrollment payments. This second floor is based on the FamilyCare eligibility guidelines for 2001, which do not require a premium contribution for families below this level. Finally, no parent who lives with a child who is Medicaid-eligible based on that parent's income will be ordered to contribute to private coverage premiums. Parents in this category will only be ordered to participate in coverage that does not require an employee contribution or to enter into a public health plan.

Also considered was the circumstance in which a custodial parent might prefer private coverage that does not meet the affordability requirements of the guideline and where the custodial parent is willing to contribute the difference between what the non-custodial parent could be ordered to pay and the actual cost of the coverage. This circumstance is perhaps most likely to occur when the court is considering a step-parent's offer of coverage but deems the coverage too costly to be borne by the non-custodial parent. In this circumstance, the proposed

guideline permits the custodial parent to request the more expensive coverage. The subsequent medical support order would require a greater contribution by the custodial parent in order to offset the difference in cost between the chosen plan and one that satisfied the affordability criteria for the non-custodial parent. It is recognized that these situations will not lend themselves to automated processing, but the expectation is that they will be relatively few in number.

### Withholding Limitations

The federal Consumer Credit Protection Act (CCPA) limits the percentage of an obligor's income that may be withheld for child support purposes.<sup>62</sup> Under the CCPA, if the obligor supports only one family, the maximum amount that may be withheld for child support purposes is 60 percent of his disposable income. If an obligor supports more than one family, the maximum amount that may be withheld is 50 percent. Both of these amounts may be increased by five percent, to 65 percent and 55 percent respectively, if the obligor's child support payments are in arrears for at least 12 weeks.

The CCPA sets the uppermost limits on what may be withheld, but states are permitted to create lower limits to offer obligors more protection. According to the Medical Support Work Group, 18 states have laws that lower the federal limits on withholding for child support purposes. New Jersey's withholding law incorporates the federal limits by reference and does not create new limits for withholding.<sup>63</sup>

States also differ in their approach to applying the lower CCPA limits for subsequent family obligations. Some states require that the obligor be living with and contributing to the support of a subsequent family in order for that obligation to be considered under the state's CCPA limits. Other states recognize subsequent family obligations regardless of whether the obligor actually resides with the subsequent family. The Medical Support Work Group analyzed Congressional legislative history and concluded that Congress had intended that the lower withholding limits apply to non-custodial parents who are supporting a second family *in their own household*. Based on this, the Medical Support Work Group recommended that this interpretation be adopted nationally.

In New Jersey, the lower CCPA limits are triggered by *any* subsequent family obligation, regardless of whether the non-custodial parent resides with the subsequent family. In developing the proposed medical support guideline, a change in New Jersey's approach based on the Medical Support Work Group's recommendation was contemplated. However, New Jersey's current standard was retained because from a practical and financial standpoint, it was found immaterial whether the obligor actually resides with his subsequent family. Furthermore, the Medical Support Work Group consulted Congressional legislative history from 1977, when the nature of child support enforcement was very different, and non-custodial parents were typically viewed as adversaries rather than partners in the child support program. New Jersey takes the position that a medical support guideline should focus on pragmatic solutions to healthcare coverage, rather than function as a punitive measure against non-custodial parents.

---

<sup>62</sup> 15 U.S.C. §1671, *et seq.*; 29 CFR 870.

<sup>63</sup> N.J. STAT. 2A:17-56.11(a) (2001).

## FamilyCare Enrollment Limitations

New Jersey's SCHIP program is an extension of the state's Medicaid program, and the State operates both programs under the umbrella program of FamilyCare. In 2001, FamilyCare provided healthcare coverage to families under 350 percent of the poverty level, with a sliding premium and co-pay scale based on income and family size.<sup>64</sup> Six different plan varieties are available. Premiums and co-pays range from a \$0 monthly premium/\$0 co-pay to a \$100 monthly premium/\$35 co-pay.

Most state CHIP programs have limitations on enrollment based on availability of private insurance coverage. Limitations on enrollment in New Jersey's FamilyCare program are not triggered unless the household in which the child resides has an income greater than 100% of the federal poverty level -- \$14,630 annually or \$1,219 monthly for a family of three. Even so, there are some exceptions for enrollment in FamilyCare for children with access to private coverage who are living in households with incomes above 100% of the federal poverty level. FamilyCare does require that eligible children be uninsured for the previous six months prior to enrollment in the FamilyCare program. This requirement will be waived for children in the IV-D program whose private healthcare insurance lapses or ceases while they are under a medical support order.

## Children with Special Health Needs

The Medical Support Work Group acknowledged the importance of considering the medical, mental, and social service needs of children with special health needs (CSHNs). Because CSHNs are at greater risk for chronic illness and disabilities, special attention must be paid to their routine preventive and acute care. Medical support guidelines must be responsive to the needs of these children and provide flexibility for the decision-maker to accommodate those needs. It is possible, for instance, that for some families with severely ill or disabled children healthcare coverage might preempt cash support as the primary need of the child. With this in mind, the proposed medical support guideline requires consideration of the needs of CSHNs when evaluating the comprehensibility of a plan.

The Medical Support Work Group stressed the value of a common definition of CSHNs, but did not provide one. Therefore, it was necessary to create or borrow a definition of a CSHN in order to incorporate this consideration into the proposed guideline. Research revealed that the federal Maternal and Child Health Bureau, Division of Services for Children with Special Health Needs, has devised a definition of a CSHN that was subsequently adopted and endorsed by the American Academy of Pediatrics for universal application in all states and all federal programs. Under this definition, " 'children with special health needs' include all children who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related

---

<sup>64</sup> See New Jersey FamilyCare Income Guidelines.

services of a type or amount beyond that required by children generally.” This definition is incorporated into New Jersey’s proposed guideline. In addition, FamilyCare will assist in the identification of CSHNs. CSHNs referred to the child support agency from FamilyCare will be specifically flagged for attention.

### **Non-Custodial Parents with Multiple Support Orders**

Non-custodial parents with multiple child support and medical support orders can complicate the application of a medical support guideline because the multiple obligations diminish the amount of obligor income available for garnishment under the CCPA. If a medical support order has to compete with another child support order for available income in the garnishment process, it is likely to be left unmet, and the children left uninsured. New Jersey’s Child Support Guidelines address multiple child support orders by subtracting existing child support obligations from gross income before computing the current child support amount based on net income. This guideline policy is driven by the concern that child support order amounts reflect actual income available for child support. Therefore, by basing the proposed medical support guideline on the Child Support Guideline’s definition of net income, multiple orders specifically are accounted for in the proposed medical support guideline. In practice, this will mean that prior medical support order amounts will be included in the amounts subtracted before determining child support obligations for subsequent children.

A second problem arises in situations in which a non-custodial parent with multiple orders is covering some but not all of his nonresidential children under his private healthcare plan. While it is likely that the non-custodial parent could enroll additional children at no cost – since most plans breakdown by “Family” coverage or “Employee plus Children” coverage – the difficulty arises in allocating the single enrollment fee across all the medical support orders so that the non-custodial parent’s contribution is calculated into each of the orders. To ensure that this happens, New Jersey plans to have the medical support facilitator (MSF) review all medical support orders against a non-custodial parent during the proposed review and modification process. Private coverage fees paid by the non-custodial parent will be subject to cost-sharing among all the orders. This procedure follows the New Jersey practice of recognizing and factoring in prior child support order amounts and guarantees that a non-custodial parent receives credit in each medical support calculation.

### **Multiple Non-Custodial Parents per Custodial Parent Household**

Medical support orders can be complicated further by situations in which a custodial parent shares children in her household with more than one non-custodial parent. One goal of the proposed medical support guideline is to make the provision of healthcare as straightforward and simple as possible, which is particularly important in such cases as these. Therefore, the proposed guideline was developed with the principle that, if it is both possible and appropriate, all children within one household should share the same type of healthcare coverage. This would greatly simplify paperwork and logistics for the custodial parent, enabling the children, for example, to have a single pediatrician.

Obviously, in some circumstances this will not be possible – such as when a stepparent will not agree to voluntarily cover a stepchild under his employer-based plan. In other situations, it will not be appropriate – such as when one child has special or chronic health needs, say a physical disability or asthma, and that child has access to coverage that is more comprehensive than the coverage available to his or her siblings. When no special health needs exist and all aspects of the plans available to a group of siblings residing together are otherwise equal, a plan that would permit enrollment of all of them is preferred. For instance, if the custodial parent has appropriate healthcare coverage available through an employer, then it would be ideal to have all the children enrolled in that coverage, assuming the guideline criteria are met.

FamilyCare places some limitations on enrollment of children who have access to private coverage through a parent. With some limited exceptions, if a household has FamilyCare coverage, a child with private health coverage will not be included in the household's FamilyCare coverage unless the household has an income of 100% or less of the federal poverty level.

An additional consideration prompted by multiple non-custodial parents is the question of premium payments. If a non-custodial parent covers his own child under his own healthcare plan, then payment of premiums is straightforward and clear. If the custodial parent covers all the children under her own healthcare plan, then the cost of adding the children to the plan is shared among the non-custodial parents. Complications arise when public healthcare plans are used, which typically cover a “household” rather than an individual child. In these circumstances, if one child in the household is enrolled in a public health plan – such as FamilyCare – the other children may be added for no additional cost. Therefore, it would be prudent to enroll all the children if any of the children need public coverage, even if the other children are also enrolled in private plans (giving them double coverage and improving the comprehensibility of their coverage). Under the proposed guideline, if a child is enrolled in both private and public plans, the private plan will be designated the primary provider of coverage and the public plan the secondary provider.

Another complication that arises with multiple non-custodial parents and public healthcare plans is the payment of fees or other charges. Co-pays or office visit charges under these plans are treated as unreimbursed expenses in the proposed guideline. Additionally, some public healthcare plans, such as FamilyCare, require a monthly or annual premium or enrollment fee. In constructing the proposed guideline, it was considered that one monthly premium payment would cover an entire household of children, including those with different non-custodial parents. This situation begged the question of which non-custodial parent(s) should be required to make premium payments. It was decided that, for the purposes of the medical support guideline calculation, each child in the household should be treated as if the other children did not exist. In other words, it was assumed that each child required the full monthly premium amount towards FamilyCare coverage. Therefore, all non-custodial parents of children in a single household relying on FamilyCare coverage would be required to make the full FamilyCare premium payment. This policy serves three purposes. First, it aids the goal of ensuring seamless healthcare coverage for all children, because multiple payments will guarantee household coverage even if one non-custodial parent misses a payment or makes a partial payment. Second, it ensures that each non-custodial parent shoulders an equal share of responsibility for his or her children in the household. In other words, no non-custodial parent carries the medical support responsibility

for another person's child simply because that child resides in the same household as his own. Third, this policy contributes to the State's efforts to offset its capitation rate for FamilyCare coverage. Payments received in excess of necessary premium amounts will be retained by the state to offset capitation costs.

Under the Income Shares child support guideline model, a basic child support obligation that represents the child's needs is determined. That support amount is then apportioned between the custodial parent and non-custodial parent, in proportion to their incomes, with the custodial parent's share presumed to be spent on the child and the non-custodial parent's share reduced to a cash support obligation. The proposed medical support guideline follows this basic premise of the Income Shares philosophy. The non-custodial parent's contribution will be a cash obligation for necessary enrollment premiums. The custodial parent's contribution will consist of necessary co-pays for provider visits and prescriptions. Extraordinary or unusual expenses will be apportioned as discussed in the section titled "Uninsured or Extraordinary Medical Expenses".

### ***MEDICAL SUPPORT GUIDELINE***<sup>65</sup>

*Step 1: Determine if private healthcare coverage is available from one or both parents.*

Both parents should be considered as sources for healthcare coverage. If neither parent has private coverage available through their employer, the medical support facilitator should consider coverage under a stepparent's employer-provided healthcare coverage. Coverage under a stepparent should only be used if:

- The coverage meets the criteria for appropriateness outlined in Step 2 of this guideline,
- The step-parent is willing to provide the coverage and provides written verification of such willingness, and
- There are no employer constraints on enrolling the child in the plan.

If a Family Violence Indicator is present in the case file or evidence of domestic violence exists, any healthcare coverage available through the non-custodial parent or the non-custodial parent's spouse should be automatically deemed inappropriate. Only coverage available through the custodial parent, the custodial parent's spouse, or a public agency should be considered. The medical support order should be a cash support order payable to the custodial parent through the child support agency or state disbursement unit.

**If private coverage is not available, proceed to Step 3.**

*Step 2: Determine if the available private coverage is appropriate, based on the criteria of comprehensibility, accessibility, stability, and affordability.*

---

<sup>65</sup> This narrative version is illustrated visually in the decision matrix in Appendix A.

In order to be appropriate, a private healthcare plan must be:

- 1) Comprehensive
- 2) Accessible
- 3) Stable
- 4) Affordable

If private coverage is available through more than one source (for example, both the non-custodial parent and the step-parent have available coverage), each available private plan should be evaluated for appropriateness and compared for quality of coverage.

- *Comprehensive* coverage includes at least medical and hospital coverage, provides for preventive, emergency, acute, and chronic care, and imposes reasonable deductibles and co-payments.

When comparing available plans for comprehensibility, the following inclusions should be considered: basic dental coverage, orthodontics, eyeglasses, mental health services, and substance abuse treatment.

If the child subject to the medical support order suffers from special health or medical needs, those needs should be given significant weight when evaluating the comprehensiveness of available coverage. A child with special health needs is one who has, or is at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also requires health and related services of a type or amount beyond that required by children generally.

If none of the available plans is appropriate on its own, but two or more of the plans together would provide appropriate coverage for the child, the plans should be considered jointly and evaluated for comprehensibility, accessibility, and cost as though they were a single plan. In this situation, special attention should be paid to whether the combined cost of obtaining primary and secondary coverage is reasonable under these guidelines.

- *Accessible* coverage delivers services from plan providers within the State of New Jersey and within 10 miles or 30 minutes from the children's residence.

This criterion may be waived if the custodial parent wishes that the child have access to providers outside this coverage area, is willing and able to transport the child to such appointments, and use of the providers will result in no additional cost to the non-custodial parent.

If an available plan has geographic or “network” limitations that place it outside the parameters of this criterion, the plan’s managers should be consulted to determine whether the healthcare plan has a reciprocal operating agreement with a provider that would meet this criterion.

- *Stable* coverage is coverage that can reasonably be expected to remain effective for at least one year, based on the employment history of the parent who is to provide the coverage.

If the parent who will be providing the coverage is engaged in seasonal employment (such as a camp counselor), employment that increases or decreases depending on the time of year (such as a construction worker or fisherman), or sporadic employment (the parent frequently changes jobs), the parent’s coverage should be deemed inappropriate as a primary coverage option for the child.

- *Affordable* coverage does not cost more than five percent of the net income, as defined by the New Jersey Child Support Guidelines, of the parent who provides the coverage.

If the non-custodial parent cannot contribute the amount of his or her share to obtain the healthcare coverage under consideration without surpassing the withholding limits imposed by New Jersey law and the CCPA, the coverage should be deemed unaffordable.

No parent with a net income at or below 200 percent of the federal poverty level should be ordered to contribute to private coverage premiums. The coverage under consideration should be deemed unaffordable, unless it does not require an employee contribution. Likewise, no parent with a net income below 200 percent of the federal poverty level should be ordered to contribute to FamilyCare enrollment payments.

No parent who lives with a child who is Medicaid-eligible based on that parent’s income should be ordered to contribute to private coverage premiums. The coverage under consideration should be deemed unaffordable, unless it does not require an employee contribution.

If the custodial parent requests a coverage option that does not meet this affordability criterion, and the custodial parent is willing to contribute the difference between the more expensive coverage option and one that is deemed reasonable under this guideline, the decision-maker may order such coverage. The non-custodial parent should be ordered to contribute an amount equal to the premiums for coverage that satisfies the affordability criteria above. The custodial parent should be ordered to contribute the difference necessary to enroll the child in the more expensive coverage option.

If more than one private healthcare plan is appropriate, the plan with coverage better suited to the individual needs of the child should be selected.

If more than one private healthcare plan is appropriate and the plans are relatively equal in all respects, the plans should be selected in the following priority:

- 1) The plan available through the custodial parent.
- 2) The plan available through a stepparent with whom the child primarily resides.
- 3) The plan available through the non-custodial parent.
- 4) The plan available through a stepparent with whom the child does not primarily reside.

**If private healthcare coverage is appropriate, proceed to Step 4.**

**If private healthcare coverage is not appropriate, proceed to Step 3.**

*Step 3: If private coverage is not available or appropriate, determine the child's eligibility for enrollment in a public healthcare program. If eligible, the child should be enrolled.*

If private coverage is deemed unavailable or inappropriate, the medical support facilitator should preliminarily determine if the child is eligible for a public healthcare plan, such as FamilyCare. Children subject to a child support order should be screened first for eligibility under FamilyCare Plan A (Medicaid) and enrolled if eligible. Children who are deemed ineligible for Plan A should be screened for eligibility for the other FamilyCare plans and enrolled in an appropriate plan if eligible. The medical support facilitator should determine the required cash medical support that should be ordered. The draft order also should require the custodial parent to enroll the child in FamilyCare. In the event of non-enrollment, enforcement action can be taken against the custodial parent.

*Step 4: Allocate responsibility for premium payments, if such premiums are necessary to obtain the healthcare coverage.*

The parent's cost of enrolling the child in a private or public healthcare plan should be deducted from the paying parent's net income prior to calculation of the child support award under the Child Support Guidelines.

*Step 5: Include unreimbursed healthcare expenses for the child, as necessary, in the medical support order.*

Unreimbursed healthcare expenses for the child in excess of \$250 per year should be added to the basic child support obligation if they are predictable and recurring. Unreimbursed healthcare expenses for the child in excess of \$250 per year that are not predictable should be shared by the parents in proportion to their relative incomes as incurred.

Healthcare costs that are not included in the support award should be paid directly to the parent who made or will make the expenditure or directly to the healthcare provider. The medical support order should clearly state the method and recipient of such payments.

*Step 6: Designate primary and secondary plan providers, if appropriate.*

If the child is to have both primary and secondary plan coverage, specific designation must be made regarding which plan is primary and which is secondary. If the child is to be enrolled in two private plans, the one that best fits the above criteria shall be designated the primary healthcare plan provider, and the other plan shall be designated the secondary healthcare plan provider. If the child is to be enrolled in a private plan and public plan, the private plan shall be designated the primary healthcare plan provider, and the public plan shall be designated the secondary healthcare plan provider.

*Step 7: Draft the medical support provisions of the child support order.*

The medical support section of a child support order should address each of the following issues as fully as possible:

- Party (custodial parent, non-custodial parent, or step-parent) responsible for enrolling the child in public or private healthcare coverage;
- Type of coverage to be obtained;
- Total amount necessary for current coverage to be obtained under the desired plan and the amount each parent will contribute;
- Specific manner in which each parent will contribute to the enrollment premiums, noting the presence of any Family Violence Indicators and necessary precautions in accordance with those indicators;
- Type of unreimbursed expenses for which the parties will share costs;
- Specific manner in which each parent will contribute to the cost of unreimbursed expenses;
- Actions the party providing the coverage must take to notify the other party and the IV-D agency of changes affecting the child's healthcare coverage, such as separation from the providing employer, income ineligibility for public programs, or significant changes in the nature or costs of the coverage;

- Designation of primary and secondary coverage in any cases in which more than one party is to provide for healthcare coverage; and
- Circumstances under which the obligation to provide healthcare coverage for the child will shift from one parent to another.

## **ANTICIPATED GUIDELINE IMPLEMENTATION ISSUES**

---

As the proposed medical support guideline was developed, several aspects of the guideline that will require special attention during the implementation process were identified. Again, it is suggested that other states consider these issues in creating and implementing their own medical support guidelines.

### ***MEANS OF COLLECTING MEDICAL SUPPORT PAYMENTS***

Because of the variety of payees that need to receive medical support payments, payment collection and processing is one of the most difficult logistical issues for implementation of a cash medical support guideline.

An early identified issue was the question of how to distribute medical support payments for employer-based health plans if the amount was obtained through income withholding. Since the employer is responsible for both withholding the income and diverting employee health plan contributions to the insurer, it was considered having those payments go directly from the employer to the insurer. It was quickly realized, however, that this process was deficient for several reasons. First, it creates two classes of payors – those that pay their medical support obligations through New Jersey’s Centralized Collections and are subject to all the automated tracking and enforcement mechanisms available from Centralized Collections, and those who are not. Second, it was realized that without the automated features of Centralized Collections payment processing, tracking payments and ensuring non-custodial parents’ compliance would be very labor intensive. Third, this payment process inhibits full maximization of federal incentive money for the State: If medical support payments for private coverage, which are likely to be the most consistent and expensive, are not processed through Centralized Collections, OCSPP will have difficulty verifying the payments in order to include them in the calculations necessary for federal incentive measurements, such as the amount of current support paid. Fourth, this process would actually create additional work for the employer, as the accounting department would have to withhold from the employee’s paycheck the full obligation amount, then cut two separate checks – one to Centralized Collections for the financial support amount and a second to the health plan for the medical support amount.

For the foregoing reasons, a payment process will be adopted whereby all medical support payments will be processed by Centralized Collections and premium payments forwarded to the appropriate insurer, whether private or public. Therefore, regardless of the origin of the payment, the medical support amount will be processed by

Centralized Collections and the appropriate premium sent to the private health plan provider or to FamilyCare. This process ensures that all payments are tracked by automated means, allowing OCSPP to rely on automated enforcement flags and permitting OCSPP to strengthen its position with regard to federal incentive measures. Furthermore, because OCSPP can rely on automated means to notify the agency of lapses in payments, seamless coverage for New Jersey's children, which is one of the primary goals of our medical support program, can be better ensured.

We recognize that some private insurers and employers may be initially uncomfortable with employee contributions being distributed from Centralized Collections instead of through the employer directly to the plan provider. We have identified this issue as one requiring additional research during the implementation phase.

Another collections issue is the frequency of premium payments. In New Jersey, some FamilyCare plans do not require premiums while others require monthly premiums, similar to private health plans. Monthly premiums simplify the medical support orders and our collection techniques, as we do not have to contend with pro-rated or lump sum annual premiums. States whose SCHIP programs rely on annual premiums will need to consider this factor when setting collection policies and procedures.

If a plan provider receives payment prior to the child's completed enrollment, the provider will be instructed to hold the payment, pending completion of the child's enrollment application. If the application is not completed within 30 days, the provider will be instructed to notify the medical support facilitator. The medical support facilitator will contact the custodial parent to ascertain the reason for her failure to enroll the child and to facilitate enrollment.

It is likely that for a small number of cases, small increases in healthcare premiums will result in a breach of the CCPA limits, particularly for obligors subject to multiple medical and child support orders. Because employers cannot withhold money in excess of the CCPA limits, these situations could result in unnecessary lapses in healthcare coverage and/or the accrual of child support arrearages. As these situations arise, the medical support facilitator will review medical support orders for low-income obligors and examine lower cost options, such as FamilyCare. For moderate and high-income obligors who possess the necessary assets to make the payments despite the CCPA limitations, we plan to examine direct payment methods, such as an automated bill pay system or a bill pay booklet, as well as the tax intercept program. Under these payment structures, the non-custodial parent will pay the child support agency directly and the agency will forward the premium payments to the plan providers as needed.

### ***ENFORCING A MEDICAL SUPPORT ORDER AGAINST A CUSTODIAL PARENT***

Some state child support officials have expressed reservations about the propriety of a child support agency enforcing a medical support order against a custodial parent. The need for such action could arise, for instance, in a case in which the court orders the child to be enrolled in a public healthcare plan and directs the custodial parent to enroll the child if eligible. New Jersey consistently has taken the position that both parents are responsible for

supporting and ensuring the well-being of their children. This position is illustrated by the selection of the Income Shares guideline model and the current policy of considering both parents as sources of healthcare coverage. The adoption of a State policy preventing or inhibiting the enforcement of a medical support order against a custodial parent would undermine the purposes and goals of the proposed medical support guideline and would likely leave thousands of New Jersey's children unnecessarily uninsured. Therefore, the custodial parents' responsibility with regard to medical support will be enforced. Given that New Jersey is a judicial state for child support actions, the plan is to rely on court authority, through contempt procedures, to enforce orders against custodial parents.

### ***PROCESSES FOR ASSIGNED VS. NON-ASSIGNED SUPPORT ORDERS***

The concept of potentially different guideline processes for medical support orders attached to assigned support versus those attached to orders for unassigned support is addressed. Some child support administrators have suggested that the IV-D agency should determine the appropriate coverage only in cases in which the child support is assigned to the state. In cases of unassigned child support, the decision would be left to the custodial parent. After careful consideration, it was determined that the child support agency should conduct the "appropriateness" evaluation for all assigned cases. In unassigned cases, however, the custodial parent would have primary responsibility for selecting the appropriate coverage, except that her choice would be subject to the reasonable cost and stability requirements of the proposed guideline. Under this process, the custodial parent would rightly have responsibility and authority to select the desired coverage but would not be able to create an undue hardship for the non-custodial parent in so doing.

### ***PRIORITY OF WITHHOLDING***

As more and more child support orders include medical support components, employers and states will be faced with the necessity of prioritizing the distribution of available cash support payments among competing child support obligations. Anticipating this, it was decided to adopt the priority favored by several child support administration organizations (including the Eastern Regional Interstate Child Support Association, or ERICSA). Under the proposed guideline, employers in New Jersey would be directed to withhold and assign money in the following order of priority:

- 1) Current financial support
- 2) Current medical support
- 3) Financial support arrears
- 4) Medical support arrears.

## ***FOREGOING RECOVERY OF PRENATAL AND BIRTH EXPENSES***

Implicit in this priority list is the recommendation that New Jersey forego the attempted collection of birthing costs and prenatal care in IV-D cases. This policy is based on current realities of the child support system, as well as federal policies in this area. Child support administrators across the country acknowledge that birthing costs are very difficult to recover, in part because those who owe the birthing costs are frequently low-income fathers. Furthermore, collection of birthing costs from low-income men creates a dynamic in which the birthing cost debts compete with the need for payment of current support and adequate financial reserves for the obligor.

Of perhaps even greater concern, healthcare officials argue that policies to recover such costs cause low-income women to avoid necessary prenatal care, resulting in a high incidence of infants with low birth weight or other disabilities and greater costs to society for the care of these infants. In 1985, the National Academy of Science, Institute of Medicine issued a report, *Preventing Low Birthweight*, which identified an extremely high correlation between low birth weight and inadequate prenatal care. The report calculated that savings of \$3.39 could be realized for every \$1.00 of public funds expended on health care. Likewise, *For the Children of Tomorrow*, a report issued by the Southern Governors' Regional Task Force on Infant Mortality arrived at the same conclusion. That report calculated an estimated cost savings of \$2.00-\$10.00 for each public dollar spent on prenatal care.

Based on these studies and others, Congress amended the Medicaid Act in 1990 to remove the "support cooperation requirement" which mandated that low-income pregnant women cooperate with authorities to assist the Medicaid program in recovering the pregnancy-related costs incurred by the mother and child. This amendment created the "Poverty Level Pregnant Women" (PLPW) program. In enacting the PLPW program, Congress expressly observed that the application of these requirements to women seeking prenatal care "discourage[d] many of them from seeking benefits that would give them access to early prenatal care."

From a fiscal standpoint, Congress acknowledged that the PLPW program's "support cooperation" exemption would necessarily increase the expenditure of public funds for prenatal health care to the extent that the unwed fathers of children born to PLPW recipients would no longer be liable to pay for these expenses. Congress concluded, however, that the financial benefits gained from the decrease in medical expenses associated with caring for low birth weight and physically impaired infants far outweighed the financial benefits that might be achieved from enforcing the support cooperation requirements. As the Health Care Finance Administration observed when it implemented the "exemption" regulations:

[B]y removing impediments to prenatal and postpartum care, the provisions implemented by this [support cooperation exemption] are expected to reduce infant mortality and save money that would otherwise be spent on costly services such as neonatal intensive care.<sup>66</sup>

---

<sup>66</sup> See OCSE DCL-93-12 (HCFA final rule – PLPW eligible for Medicaid).

The arguments surrounding the PLPW program were found persuasive in the child support context as well. Therefore, it was decided to propose a policy in New Jersey of not pursuing birth-related costs for women receiving IV-D services.

### ***MEDICAL SUPPORT PAYMENTS AND FEDERAL INCENTIVE MEASURES***

It is recognized that characterizing medical support as a cash support obligation will have consequences for the State under the federal incentive measures, particularly the “amount of current support paid” measure. Some commentators have raised concerns that casting medical support as a cash support obligation will negatively impact the State’s performance under this measure when non-custodial parents fail to make medical support payments. This argument was evaluated, and it was concluded that, based on this rationale, the fiscally advisable choice would be not to order medical support at all, because under the current federal measures, it will always count as current support owed. Furthermore, if the proposed medical support guideline is reasonable and properly applied, it should not create additional hardship for those individuals already struggling to pay their child support.

### ***STATUTORY, REGULATORY, AND ADMINISTRATIVE POLICY CHANGES***

It is recognized that some aspects of this proposed medical support guideline will necessitate changes in statutory, regulatory and administrative law. The recommendations inherent in this guideline were based on a determination of the best public policy and practices in the medical support area. The focus is pragmatic and outcome-oriented. It is anticipated that lawmakers will share our enthusiasm and dedication to create a medical support structure for the State of New Jersey that is affordable, practical, and beneficial.

---

Section III  
Proposed Review and Modification Process

## Section III

### Proposed Review and Modification Process

#### **NEW COORDINATED APPROACH**

---

##### ***INTRODUCTION***

The new coordinated approach is designed to provide seamless coverage for children so that they have continuous healthcare coverage. The major objectives of a new coordinated approach are to:

- Identify eligible uninsured children.
- Remove barriers to enrollment and enroll children in appropriate coverage – private insurance or FamilyCare.
- Monitor premium payment and enrollment status through automated means to ensure seamless coverage. As circumstances change, health care coverage will be reviewed and modified, if necessary, to ensure that children remain covered under the most appropriate private insurance or public program.

As noted in the proposed guideline, this coordinated approach will seek to enroll children in private health insurance where such insurance is comprehensive, stable, affordable, and accessible. This will require the coordinated efforts of child support agencies, courts establishing medical child support orders, and employers to ensure that private insurance coverage is identified and that the children are enrolled as soon as possible. A Medical Support Facilitator would be placed within the court handling child support cases to review cases and make a determination of the appropriateness of private health insurance. A medical support questionnaire will be distributed in order to collect information on potential coverage and determine appropriateness. A sophisticated automated information system would be used to facilitate the identification of health insurance alternatives and the process of selecting among the alternatives. If private health insurance is appropriate, an order for medical support would be obtained, the employer and health insurance provider would be notified, the children would be enrolled, and continued eligibility and enrollment would be monitored.

Where private health insurance coverage is not available or not appropriate, the Medical Support Facilitator will preliminarily determine FamilyCare eligibility. Medical Support Facilitators will be uniquely suited to this task because they will have access to information on the children's healthcare coverage and the parent's income, employment, and other financial information. Under this approach, the Medical Support Facilitator will be able to use web browser software to determine the children's potential eligibility for FamilyCare. If the child(ren) is eligible, FamilyCare information will be made available to the parents, the application forms will be generated automatically, and finally, expedited eligibility decisions coordinated with FamilyCare. Mechanisms for automated information

exchange between OCSPP and FamilyCare will be created so that children can be enrolled promptly in the appropriate healthcare coverage with minimal or no delays or disruptions. Streamlining and simplifying the application process would further expedite the enrollment process.

Continued monitoring of cases will ensure that, as family and employment information changes, appropriate health coverage for the children is maintained. To facilitate this, information will be shared between OCSPP, FamilyCare, and the courts responsible for ensuring that child support orders provide health care coverage.

### ***SIGNIFICANT ISSUES ADDRESSED DURING PROCEDURES DEVELOPMENT***

#### **Considering Both Parents and Step-Parents as Sources of Potential Coverage**

New Jersey is one of 27 jurisdictions that currently consider both parents as sources of potential healthcare coverage. This approach greatly improves the opportunity of children receiving IV-D services to obtain quality healthcare coverage. The Medical Support Work Group supported this position, recommending that all states adopt policies directing that both parents be considered for the provision of healthcare coverage.

The Medical Support Work Group also addressed the issue of private coverage available through stepparents. The spirit of this recommendation has been incorporated into the proposed. Under New Jersey's proposed medical support guideline, children may be enrolled in private coverage available through a step-parent if:

- 1) The criteria of appropriateness is met.
- 2) The stepparent is willing to provide such coverage and provides written verification of such consent.
- 3) There are no employer/insurer constraints for enrollment of the child. This will further maximize the use of private insurance for children in the IV-D program. If the above requirements are met, the medical support order will contain a provision ordering the stepparent to enroll the child in his or her health plan, as consented to. The actual order is necessary to create the cash obligation for the noncustodial parent and to allow the child support agency to accurately identify responsibility for enrollment.

#### **Uninsured or Extraordinary Medical Expenses**

Family healthcare plans do not usually cover all health-related costs. Basic and ordinary medical expenses, such as band-aids and aspirin, are trivial, and costs for those items are built into the basic support obligation. However, unreimbursed and extraordinary medical expenses, particularly those generated by an acute or chronic illness or injury, can account for a significant portion of a child's healthcare expenses.

New Jersey is one of seven states that creates a threshold for consideration of unreimbursed healthcare expenses, and one of 23 states with a formula for allocating the costs. In New Jersey, unreimbursed healthcare expenses for a child in excess of \$250 per year are added to the basic obligation if they are predictable and recurring. Healthcare expenses for a child that exceed \$250 per year that are not predictable are shared by the parents in proportion to their relative incomes as incurred. This is the approach favored by the Medical Support Work Group and recommended in its final report.

### **Availability of Primary and Secondary Coverage Options**

In some circumstances it may be advisable for the Medical Support Facilitator to determine a child be covered through two separate private health plans. This usually occurs because each offers desired coverage options but neither provides comprehensive coverage on its own. Frequently the secondary coverage may be necessary to provide coverage for specific needs but is not appropriate for basic coverage because it does not meet the required criteria of the guideline. For example, the Medical Support Facilitator may order secondary coverage when the child requires enhanced prescription services, psychological services, or specialized vision care not available under the non-custodial parent's plan. The need for secondary coverage must be weighed, of course, against the cost of carrying the secondary coverage.

Secondary coverage is also desirable when it can be obtained at no additional cost. For instance, if both the custodial and non-custodial parent maintain private family coverage for themselves and their subsequent families, they can typically add their shared child to their family plans without an increase in their premiums. In this instance, a Medical Support Facilitator may order the double coverage even if one or both parent's plan would be adequate and comprehensive on its own, simply to provide additional provider options and services for the child.

Child support guidelines have traditionally ignored the possibility of primary and secondary healthcare coverage, resulting in medical support orders that do not clearly identify insurance liability and parental responsibility. We specifically include a separate consideration for secondary coverage in the proposed guideline. Also, regardless of the circumstances prompting a double coverage order, medical support orders should plainly state which plan is to be the primary coverage and which the secondary coverage for the child.

### **Process if Child is Currently Enrolled in Private Coverage**

Under the proposed medical support guideline outlined in Section II, a child currently enrolled in a private, employer-sponsored healthcare plan would not be subject to the guideline criteria unless the custodial parent raised issues of accessibility or comprehensibility, e.g. if the child has special health needs that are not currently being adequately addressed. If the available coverage is not accessible because the non-custodial parent lives and receives the coverage out of state, the guideline criteria would be applied. Also, if FamilyCare was selected as the appropriate coverage option, the child would be permitted to apply without compliance with the standard six-month uninsured waiting period.

## Sum-Certain vs. General Coverage Orders

Child support experts disagree as to whether medical support orders should be sum-certain – “You must pay \$50 per month in medical support” – or only coverage specific – “You must secure healthcare coverage for your child under your employer’s plan.” After considering both approaches and consulting members of the New Jersey judiciary for their insights, a hybrid approach was developed. New Jersey medical support orders will direct the parent or parents to enroll the child in a particular type of coverage, will state the cost of the coverage per month for the current plan year, and will note that the coverage costs can be expected to increase.<sup>67</sup>

If the coverage increases become too burdensome, one or both of the parents may request a modification. If one or both of the parents fails to fulfill their portion of the obligation to provide coverage and the coverage lapses, the child support and FamilyCare agencies will intervene and perform the functions outlined below in the section on ensuring seamless coverage. This approach was decided on based on the desire to use automated collection and disbursement means, which cannot be done with a general coverage order, and concerns that orders not require yearly modification, which would be necessary with sum-certain orders.

## EFFECT OF A FAMILY VIOLENCE INDICATOR ON MEDICAL SUPPORT PAYMENTS

During discussions about the medical support review and modification process, it was quickly realized the potential danger medical support orders could create for victims of domestic violence. Medical paperwork typically contains a vast amount of private information, such as social security numbers, home and billing addresses, etc. If a violent non-custodial parent is ordered to enroll his child in his employer-sponsored health plan, he is likely to receive this type of information concerning his child and the custodial parent in an Explanation of Benefits (EOB) form from his health plan. This creates a very vulnerable situation for the custodial parent and child who may be seeking to distance themselves or even hide from the non-custodial parent.

With this in mind, a separate procedure for families victimized by domestic violence has been created. Under this process, if a Family Violence Indicator exists or any other evidence of domestic violence is present, a cash medical support order will be issued, and the custodial parent will be directed to enroll the child in a coverage option not provided by the non-custodial parent or the non-custodial parent’s spouse. The non-custodial parent’s and/or spouse’s employer-sponsored coverage will be deemed automatically inappropriate and not considered as a viable coverage option. Only coverage available through the custodial parent, the custodial parent’s spouse, or a public agency will be considered.

## **BASIS FOR REVIEW AND MODIFICATION**

---

A medical child support order may be reviewed and modified without re-opening other issues of the child support obligation. In addition to the six factors listed below that denote a substantial change in circumstances and warrant

---

<sup>67</sup> An example of a medical support order is included in Appendix B.

a review of both the financial and medical support parts of an order, the medical child support order may be reviewed if the current order surpasses federal Consumer Credit Protection Act limits or if health care coverage as ordered is no longer appropriate.

A review of the financial and medical support provisions of an order may be conducted simultaneously. The terms of a financial or medical child support order may be modified upon a showing of one or more of the following:

- 1) A parent's earnings have substantially increased or decreased, raising issues concerning the appropriateness of the existing healthcare coverage.
- 2) The needs of the party or child(ren) has substantially increased or decreased.
- 3) Receipt of assistance under TANF.
- 4) A change in the cost of living for either party as measured by the federal bureau of statistics, any of which makes the terms unreasonable and unfair.
- 5) Extraordinary medical expenses of the child not provided for in the order.
- 6) The addition of work-related or education-related child care expenses of the custodial parent or a substantial increase or decrease in existing work-related or education-related child care expenses.

From a medical support perspective, if any of these six conditions are demonstrated, a rebuttable presumption will arise that there has been a substantial change in circumstances and that the terms of the current medical child support order are unreasonable and unfair, provided that the medical child support order is not enforceable, and that the ordered health coverage is not available to the child through the parent ordered to provide the coverage.

## **CASE SELECTION**

---

On a monthly basis, the Automated Child Support Enforcement System (ACSES) will produce and forward to the Medical Support Facilitator a report entitled *Cases Needing Medical Support Order Review*.<sup>68</sup> This report will contain all cases where the review date on ACSES is equal to or greater than 15 months. This 15-month time frame reflects the realities of today's skyrocketing health care costs, which typically are passed through to the insured on an annual

---

<sup>68</sup> This is a modified CS694-01. The report will be modified to shorten the review date time frame from 36 to 24 months and will limit the selection criteria to medical support.

basis. The Medical Support Facilitator will be required to review the cases to determine if an adjustment is warranted. A review will not be conducted when:

- In a TANF case, there has been a determination of good cause.
- In a IV-E case, the Division of Youth and Family Services has made a determination of good cause and neither party has requested a review.
- It is determined that the most recent medical support order or last review is less than 12 months old.
- There is no valid address for one or both parties.
- The medical support order is not a New Jersey order.
- It is determined that it would not be in the best interest of the child.

## **REVIEW PROCESS**

---

*Step 1: Initiating review and modification of the medical support order.*

In TANF and IV-E Foster Care cases, a review will be conducted automatically every 15 months. In all other cases, both the custodial and the non-custodial parent will be given notice of their right to request a review. If, in response to the notice, one of the parties requests a review, the Medical Support Facilitator will review the request and inform the parties that either:

- No review will be conducted, providing the reason why, or
- A review is warranted and will commence.

*Step 2: The custodial parent and the non-custodial parent must provide income and health insurance information.*

If a review is warranted, both the custodial parent and the non-custodial parent must complete a Financial and Medical Support Information Sheet.<sup>69</sup> The Financial and Medical Support Information Sheet, which asks the parents to provide income, employment, and health insurance coverage options, must be returned within 10 days. If the requesting party fails to return the Financial and Medical Support Information Sheet, the review will be terminated for failure to cooperate. The IV-D client in non-public assistance cases also will be required to sign the *Authorization to Review Support*.

---

<sup>69</sup> See Appendix C, Financial and Medical Support Information Sheet.

*Step 3: The Medical Support Facilitator will assure the venue is appropriate.*

If the Medical Support Facilitator receives a request for a review but is not located in the county of venue, the case will be referred by the Medical Support Facilitator in receipt of the review request to the county of venue for appropriate action. The party requesting the review should be notified in writing of the transfer of his/her review request.

*Step 4: The Medical Support Facilitator will determine if a modification is warranted.*

Orders will be reviewed to determine if there is a 20% change in the amount of financial and medical child support ordered when the child support guidelines are applied and to determine if the ordered medical support is comprehensive, affordable, accessible, and stable in accord with the Medical Child Support Guideline.<sup>70</sup>

Employment, income, and health coverage information provided by the custodial and non-custodial parents, as well as information gathered from other sources (*i.e.*, New Hire Reporting, Wage Reporting, etc.), will be used to review the order. When all needed information is obtained, calculations using both parents income, the New Jersey Child Support Guidelines, and the New Jersey Medical Support Guidelines will be formulated to determine the anticipated financial support and medical support order amount. An adjustment can be sought on cases with a 20% change. An adjustment will not be sought when it is not in the best interest of the child.

*Step 5: The Medical Support Facilitator will determine which healthcare coverage is appropriate for the child.*

Using medical support software and based on the proposed medical support guideline criteria of comprehensibility, accessibility, stability, and affordability, the Medical Support Facilitator will determine which healthcare coverage is appropriate for the child. The Medical Support Facilitator will first examine private coverage options. If all of the private coverage options available fail to meet the proposed guideline criteria or if the cost would exceed withholding limits under the Consumer Credit Protection Act, the Medical Support Facilitator will look to public healthcare options. First, the Medical Support Facilitator will use the medical support software to determine the child's eligibility for Medicaid. If the child is not Medicaid eligible, the Medical Support Facilitator will determine if the child meets other FamilyCare plan eligibility requirements using the medical support software. Based on this analysis, the Medical Support Facilitator will make a recommendation regarding appropriate healthcare coverage for the child and that recommendation will be converted into the medical support order.

*Step 6: Termination of Review Process*

In accordance with OCSE PIQ-9403, if a request to terminate a review by the requesting party is received, notice shall be provided to the other party advising them that the review will be terminated unless they object within 10 days.

---

<sup>70</sup> See Appendix D, Guidelines Worksheet.

*Step 7: The Medical Support Facilitator will obtain a medical support order.*

After the Medical Support Facilitator has determined the coverage option and the cash medical support amount that the non-custodial parent will be obligated to pay, the Medical Support Facilitator will file the necessary papers to obtain a modified medical support order that includes the non-custodial parent's contribution.

*Step 8: Time Frame for Completing Review and Modification*

The review and modification process shall be completed within 180 days of initiating the review. The 180-day time frame begins:

- When it is determined that a review shall be conducted, or
- When both parents are located and their location is verified.

*Step 9: The Medical Support Facilitator will coordinate the issuance of the National Medical Support Notice to the employer or other enrollment functions and arrange for the coverage to be explained to the family.*

Once the modified medical support order is issued, the Medical Support Facilitator will note the details in the case file. If necessary, the Medical Support Facilitator also will complete and send the National Medical Support Notice to the employer. Any questions or concerns the employer has in the future would be forwarded to the Medical Support Facilitator for attention. If private coverage was not available or not appropriate and public coverage will be used instead, the Medical Support Facilitator will use automated eligibility and enrollment software to enroll the child in the appropriate FamilyCare plan. Once the coverage is established, the Medical Support Facilitator will explain to the custodial parent the basic requirements of the plan. For more specific coverage information, the custodial parent will be directed to the appropriate coverage provider. Any questions concerning the medical support order that the custodial parent has in the future will be directed to the Medical Support Facilitator for attention.

*Step 10: Enforcement of Cash Medical Support Enforcement and Monitoring of Enrollment*

Medical support will be collected through income withholding and will be distributed to the plan administrator. Because this process is automated, ACSES tickler will notify the Medical Support Facilitator in the event of non-payment. To assure seamless coverage, the Medical Support Facilitator will notify the custodial parent of the non-payment and its impact on coverage. The custodial parent will be apprised of the right to apply for FamilyCare, which could be a reduced fee or no fee, depending on the household financial picture. Both automated matches and other communication methods with FamilyCare will enhance collaboration and cooperation on IV-D cases that are preliminarily determined eligible for FamilyCare.

If a child covered by a medical support order is disenrolled from a health plan, that health plan will be required to report that disenrollment to the Medical Support Facilitator. The Medical Support Facilitator will contact the custodial parent to determine why disenrollment took place and identify steps necessary to re-enroll the child in that or another health plan. This scenario is necessarily over-simplified and does not capture the various permutations that actual cases will have. It is intended for illustration purposes only.

## **POST-REVIEW NOTICE AND CHALLENGE**

---

Upon completion of a review, a written notice shall be issued to both the custodial and non-custodial parents by regular and certified mail to the address of residence. The notice shall advise of the new amount of medical child support. The notice also will include a *Consent to Modify Order*. The notice will inform both parties that if they agree with the review findings, they may avoid a court appearance by signing the *Consent* and returning it within 30 days. The notice will advise the parties that if they disagree with the findings, they have 30 days to challenge the findings. A challenge may only be filed if the information on which the determination was made is incorrect or incomplete. The challenge must be in writing. The parties also will be advised that the medical child support amounts may be adjusted by the court if they do not challenge the recommended award within 30 days.

If a challenge is filed, the party filing the challenge must provide documentation to support the basis for the challenge. If documentation is provided, the case will be referred for review and, if appropriate, the filing of a motion for court action. A case will be referred when the Medical Support Facilitator conducting the review is unable to determine if the case qualifies for a modification or if a court hearing has been requested by one of the parties. In cases where a conflict of interest exists between the Medical Support Facilitator and the involved parties, a *Conflicts Facilitator* will be retained to process and resolve the case review.

## **ORDER ENTRY AND ENFORCEMENT**

---

In cases where the custodial parent and non-custodial parent agree with the review determination and return the *Consent to Modify Order* within the 30-day time frame without challenge, the Medical Support Facilitator will refer the case to the appropriate Probation Division for enforcement. Included in the referral will be the following documents:

- Request for review
- Financial and Medical Support Information Worksheet
- Employer letters

- Wage reporting verifications
- Medical Support Guideline worksheet
- Certification in Support of Request for Modification of Financial and Medical Child Support Order
- Any other pertinent information

Medical Child Support Orders entered must comply with the requirements of a qualified medical child support order as described in the federal Employee Retirement Income Security Act of 1974 (ERISA), as amended by the federal Omnibus Budget Reconciliation Act of 1993 (OBRA). Every medical child support order for private coverage must:

- Expressly assign or reserve the responsibility for maintaining health insurance for the minor children and the division of uninsured medical and dental costs; and
- Contain the names, last known addresses, and social security numbers of the parents of the dependents, unless the court prohibits the inclusion of an address or social security number and orders the parents to provide their addresses and social security numbers to the administrator of the health plan. The court shall order the parent with the better group dependent health and dental insurance coverage or health insurance plan to name the minor child as beneficiary on any health and dental insurance plan that is available to the parent on:
  - A group basis, or
  - Through an employer or union.

If the court finds that dependent health insurance does not meet the Medical Support Guideline's affordable, accessible, comprehensive, and stable criteria, the court shall order the custodial parent to apply for FamilyCare coverage.

If the court finds that the available dependent health insurance does not pay all the reasonable and necessary medical expenses of the child, including any existing or anticipated extraordinary medical expenses, and the court finds that the non-custodial parent has the financial ability to contribute to the payment of these medical expenses, the court shall require the non-custodial parent to be liable for all or a portion of the medical expenses of the child not covered by the required health plan. Extraordinary medical expenses include, but are not limited to, necessary orthodontia and eye care, including prescription lenses.

If, upon completion of the Medical Support Guideline Worksheet, the court finds that the parties have the financial ability to contribute to the cost of medical expenses for the child, including the cost of insurance, the court shall

order the custodial and non-custodial parent to each assume a portion of these expenses based on their proportionate share of their total net income. A copy of the medical child support order, together with the direct income withholding order, shall be forwarded to the non-custodial parent's employer or union. The employer or union must, in turn, forward a copy to the health insurance carrier.

Upon entry of an order, the Probation Division will enforce the award for cash medical support through direct income withholding, provided that federal Consumer Credit Protection Act limitations are not exceeded. All monies collected through direct income withholding will be forwarded to Centralized Collections for accounting. Centralized Collections will distribute the cash medical support collected to the appropriate entity, making premium payments on the non-custodial parent's behalf to either the private health plan or FamilyCare. Orders for medical support are enforceable against both the custodial and non-custodial parent.

The cash medical support order is binding on the employer or union and the health insurance plan. In the case of a non-custodial parent who changes employment and is required to provide health coverage for the child, a new employer that provides health care coverage shall enroll the child in the non-custodial parent's health plan upon receipt of the National Medical Support Notice. The employer must comply with the terms of the medical support order by forwarding cash medical support to Centralized Collections. If the non-custodial parent contests the child's enrollment in the new employer-provided plan, the enrollment will remain in place during the time period in which the obligor contests the withholding.

An employer or union that is included under ERISA may not deny enrollment based on exclusionary clauses. Upon application of the non-custodial parent pursuant to a medical support order, the employer or union and its health insurance plan must enroll the minor child as a beneficiary in the group insurance plan. Withheld premiums must be forwarded to Centralized Collections, which will distribute the funds to the appropriate plan. If the employer or union offers more than one plan, the Medical Support Facilitator will assist the parents with selecting the appropriate plan for the child. If the non-custodial parent is not enrolled in a health insurance plan, the employer or union shall also enroll the non-custodial parent in the chosen plan if enrollment of the non-custodial parent is necessary in order to obtain dependent coverage under the plan. Enrollment of dependents and the non-custodial parent shall be immediate and not dependent upon open enrollment periods.

An employer or union that willfully fails to comply with the medical support order is liable for:

- Any health expenses incurred by the dependents during the period of time the dependents were eligible to be enrolled in the insurance program, and
- Any other premium costs incurred because the employer or union willfully failed to comply with the order.

An employer or union that fails to comply with the medical child support order is subject to contempt and is also subject to a fine of \$500 to be paid to Centralized Collections. The collected fine will be distributed to the custodial parent in non-public assistance cases and to the appropriate public authority in public assistance cases.

Failure of the non-custodial parent to execute any documents necessary to enroll the dependent in the group health insurance plan will not affect the obligation of the employer or union and group health insurance plan to enroll the dependent in a plan. Information and authorization provided by the child support program or by the custodial parent is valid for the purposes of meeting enrollment requirements of the health plan.

A minor child that a non-custodial parent is required to cover as a beneficiary is eligible for insurance coverage as a dependent until further order of the court. The health insurance carrier or employer may not disenroll or eliminate coverage for the child unless:

- The health carrier or employer is provided satisfactory written evidence that the court order is no longer in effect, or
- The child is or will be enrolled in comparable health coverage through another health insurance plan that will take effect no later than the effective date of the disenrollment, or
- The employer has eliminated family health coverage for all of its employees, or
- The required premium has not been paid by or on behalf of the child. However, if disenrollment or elimination of coverage of a child is based upon nonpayment of premium, the plan must provide 30 days' written notice to the custodial parent prior to the disenrollment or elimination of coverage.

The signature of either parent of the insured dependent is a valid authorization to a health plan for purposes of processing an insurance reimbursement payment to the provider of the medical services or to the parent who has prepaid for the medical services. The health plan shall send copies of all correspondence regarding the insurance coverage to both parents. When an order for dependent insurance coverage is in effect and the non-custodial parent's employment is terminated, or the insurance coverage is terminated, the health plan shall notify the custodial parent within ten days of the termination date with notice of conversion privileges.

When an order for dependent insurance coverage is in effect, the non-custodial parent's employer or union shall release to the custodial parent or the child support program, upon request, information on the dependent coverage, including the name of the health insurance carrier. The employer, union, or health plan shall provide the custodial parent with insurance identification cards and all necessary written information to enable the custodial parent to utilize the insurance benefits for the covered dependents. The Probation Division is authorized to release to the non-custodial parent's health insurance carrier or employer information necessary to obtain or enforce medical support.

A non-custodial parent who fails to maintain medical insurance for the benefit of the child(ren) as ordered or fails to provide other medical support as ordered is liable to the custodial parent for any medical expenses incurred from the effective date of the court order, including health insurance premiums paid by the custodial parent because of the non-custodial parent's failure to obtain coverage as ordered. Proof of failure to maintain insurance or

noncompliance with an order to provide other medical support constitutes a showing of increased need by the custodial parent and provides a basis for a modification of the financial and medical child support order.

Payments for services rendered to the dependents that are directed to the non-custodial parent, in the form of reimbursement by the health carrier, must be endorsed over to and forwarded to the custodial parent when the reimbursement is not owed to the non-custodial parent. A non-custodial parent retaining insurance reimbursement not owed to him/her may be found in contempt of this order and held liable for the amount of the reimbursement. Upon written verification by the health insurance carrier of the amounts paid to the non-custodial parent, the reimbursement amount is subject to all enforcement remedies available to the child support program, including income withholding. Probation Divisions may use all remedies available for the collection and enforcement of financial support for the collection and enforcement of medical support.

## **ANTICIPATED IMPLEMENTATION ISSUES**

---

### ***ACCESSING INFORMATION ABOUT AVAILABLE PRIVATE COVERAGE PLANS***

Some states have access to existing automated databases that contain information about private healthcare coverage available through employers. Other states have access to insurers' databases. New Jersey has limited access to this type of information. Some information is gathered through the State's Paternity Opportunity Program, but this information represents healthcare options only at the time at which paternity is established. New Jersey will change to its data collection and form generation software to begin gathering private healthcare information on a regular, timely basis through its review and modification process. In addition, New Jersey will begin to create a database of insurers from information gathered from the National Medical Support Notice, which will obtain the healthcare coverage options information directly from the non-custodial parent's employer. This is a time-consuming and costly mechanism since the National Medical Support Notice is an 11-page document. Automated alternatives for distribution and collection of the National Medical Support Notice Information are being explored, and it is recommended that other states take advantage of other automated avenues. The State of New Jersey also urges the federal government to create a national database of healthcare plans, their coverage details, and their coverage areas, similar to the National New Hire Directory. With private coverage information available prior to a hearing, the Medical Support Facilitator will be positioned to utilize the proposed guideline and new approach as envisioned.

### ***USING MEDICAL SUPPORT FACILITATORS***

Many child support officials have voiced concerns about the wisdom of having child support agencies evaluate different healthcare plans and make determinations regarding appropriate coverage options for children in the IV-D program. The Medical Support Work Group expressed some misgivings in this area and devised a decision matrix (very similar to the proposed guideline above) to assist child support officials in conducting these analyses. After careful consideration, it was decided best to separate the healthcare functions from the traditional child support duties. Experience has shown that child support agencies do not typically perform as well on tasks that diverge from traditional child support duties. Therefore, the new approach to medical support that centers on the use of a Medical Support Facilitator has been developed. The Medical Support Facilitator will be someone having knowledge of the healthcare industry, as well as FamilyCare procedures and regulations. The Medical Support Facilitator could possibly be co-located in a family court or a child support office. It is hoped that the use of a Medical Support Facilitator will be piloted in one or two New Jersey counties.

### ***ENSURING SEAMLESS COVERAGE FOR CHILDREN IN THE IV-D PROGRAM***

The child support and healthcare communities agree that seamless coverage is a key element of any successful approach to medical support for children. To address this, a two-prong procedure to close the loopholes through which uninsured children might slip has been developed.

The crux of the first prong is the requirement that providers must notify the child support office when coverage for a child under a medical support order has ceased or been diminished. In a private plan situation, if coverage ceases or diminishes due to selections made by the non-custodial parent, the Medical Support Facilitator will follow up to ensure that the child is still receiving appropriate coverage, as ordered under the proposed medical support guideline.

The second prong activates if coverage ceases due to job separation. In this instance, the child support office also will receive a second constructive notice of such cessation as medical support withholding payments will no longer be forwarded to Centralized Collections and the case will begin accruing arrearages. Similarly, the second prong activates if medical support is paid through a direct payment method (without withholding).

To avoid lapses in coverage, when two months of medical support arrears accrue, the custodial parent will receive a notice from the child support office advising that coverage is terminating due to non-payment of medical support. The notice will encourage the custodial parent to contact FamilyCare to explore coverage options at a reduced or no

premium rate. In such instances, the Medical Support Facilitator will also ensure that the custodial parent receives information about COBRA and any other private coverage options available to the child.

FamilyCare will provide interim assistance for IV-D children whose coverage ends. FamilyCare caseworkers will use the proposed medical support guideline to examine public and private plan options currently available to the child and facilitate enrollment if necessary. If private coverage is available and appropriate but not affordable for the custodial parent, the FamilyCare Premium Support Program will be considered. Under the Premium Support Program, FamilyCare will subsidize private coverage payments with a minor contribution (determined by a formula) by the custodial parent if such coverage is deemed more cost effective than direct coverage under FamilyCare. The child support agency will be notified of subsequent enrollment or changes in premiums and/or coverage.

### ***COLLECTING MULTIPLE FAMILYCARE PREMIUMS FOR A SINGLE HOUSEHOLD***

State agencies administering the SCHIP program may not be equipped to accept and reconcile multiple SCHIP premiums for a single household, since one premium is sufficient to cover all the children residing in the household. To this end, OCSPP worked with FamilyCare to ensure its preparedness for receipt of multiple payments from different non-custodial parents for coverage of children residing in the same household. FamilyCare is prepared and able to accept and credit these multiple payments. Furthermore, FamilyCare also is prepared to accept and credit partial medical support payments. If all the partial payments do not cover the single premium necessary for the household's coverage, FamilyCare will notify the custodial parent and request that she contact FamilyCare to explore the possibility that the household may be eligible for a different FamilyCare plan with a lower premium.

### ***INCORPORATING THE NMSN INTO THE NEW PROCESS***

The National Medical Support Notice (NMSN), as mandated by federal law and regulation, is sent to employers and acts as a qualified enrollment and withholding notice for private healthcare coverage. The National Medical Support Notice directs employers to immediately enroll the child subject to a child support order if only one employer-sponsored plan is offered and the necessary premium may be withheld from the obligor's income without exceeding the CCPA limits. The National Medical Support Notice is meant as an information-gathering tool and enrollment order for medical support. The National Medical Support Notice was designed to facilitate prompt enrollment of IV-D children, but its rigidity creates some difficulty for application of New Jersey's proposed medical support guideline and review process. Our proposed approach relies on obtaining complete information on all potential coverage options *before* a plan is selected. Therefore, the National Medical Support Notice's requirement of immediate enrollment, without consideration of the appropriateness of the coverage, is contrary to the goals of the proposed approach. Because use of the National Medical Support Notice is federally mandated,

New Jersey cannot create exceptions to the requirements of the National Medical Support Notice or alter it in any way.

Under New Jersey's proposed approach, all employer-sponsored coverage will be considered, but may not be deemed appropriate. In order to support implementation of the approach, New Jersey will need to create processes to circumvent the immediate enrollment requirement of the National Medical Support Notice. For this reason, a process is envisioned whereby employers of the non-custodial parent, custodial parent, and step-parents (if step-parent consent is obtained) are required to submit complete health plan information prior to the medical support hearing. This information will be solicited from the employers using a form different from the National Medical Support Notice. The Medical Support Facilitator will conduct the medical support guideline analysis using the information provided and make a recommendation to the court. The National Medical Support Notice will be sent to an employer if private coverage is ordered but will not be used if public coverage is the appropriate option.

## **CONCLUSION**

---

The goal of the medical support provision in Title IV, Part D of the Social Security Act is to expand health care coverage to as many children as possible, ensuring that the first resort is private health coverage, rather than FamilyCare. In recognition of this, the model guideline and processes developed as part of this SIP reflect that private coverage is the first option to pursue with FamilyCare acting as second.

The major objectives of this new coordinated approach are to:

- Identify eligible uninsured children.
- Remove barriers to enrollment and enroll children in appropriate coverage – private insurance, Medicaid or SCHIP.
- Monitor enrollment to ensure seamless coverage. As circumstances change, health care coverage will be reassessed and modified, if necessary, to ensure that children remain covered under the most appropriate private insurance or public program.

The new coordinated approach is designed to have a Medical Support Facilitator ensure seamless, continuous healthcare coverage for children. First, this coordinated approach would have the Medical Support Facilitator seek to enroll children in private health insurance where such insurance is comprehensive, affordable, stable, and accessible. This would require the coordinated efforts of child support, the courts, and employers to ensure that private insurance coverage is identified and that the children are enrolled as soon as possible. Protocols were developed to make inquires for information on potential coverage and determine appropriateness. A sophisticated

electronic information system would be used to facilitate the identification of health insurance alternatives and the process of selecting among the alternatives. If private health insurance is appropriate, an order for cash medical support will be obtained, the employer and health insurance provider would be notified, the children would be enrolled, and continued eligibility and enrollment would be monitored.

Where private health insurance coverage is not available or not appropriate, the Medical Support Facilitator will preliminarily determine eligibility for FamilyCare, using web browser software. The Medical Support Facilitator is uniquely suited to this task because he already has access to information on the children's healthcare coverage options and the parents' income, employment, and other financial information. Mechanisms for automated information exchange between OCSPP and FamilyCare will be created so that children can be promptly enrolled in the appropriate healthcare coverage with minimal or no delays or disruptions. Streamlining and simplifying the application process would further expedite the enrollment process. Where appropriate, an order for cash medical support will be entered in the amount of the premium and/or to assist with the capitation rate.

Continued monitoring of cases will ensure that, as family and employment information changes, appropriate health coverage for the children is maintained. To facilitate this, information will be shared between OCSPP, FamilyCare, and Family Court to ensure that child support orders provide health care coverage. It is recognized that, for the child support program to effectively enforce medical support orders, highly automated processes must be utilized to effectively provide services to the IV-D caseload. This sentiment is consistent with the objective of using high-volume, automated enforcement techniques to enforce medical support obligations in the same fashion as financial support obligations.

Section IV  
Test Results in Support of Proposed Guideline & Process

## Section IV

### Test Results in Support of Proposed Guideline and Process

#### INTRODUCTION

---

This study included the sampling of hypotheses in a test environment.<sup>71</sup> The test environment was created with an extract of cases from the Automated Child Support Enforcement System (ACSES) and with an extract of cases from the Medicaid System. Because neither ACSES nor the Medicaid System record income information, the largest issue confronted in testing the hypotheses was accurately estimating income. Income information was backed into only for public assistance cases since New Jersey is an income shares state, which made it difficult to accurately estimate income for non-public assistance cases. After matching the extracts from the systems and ensuring clean data, our test environment was established.

To help inform and solidify New Jersey's proposed guideline and particularly the question of "reasonable" cost, the sample was tested against the New Jersey model, which provides that private coverage is not affordable if the premium exceeds 5% of the non-custodial parent's (NCP) net income, and against the other following models for "reasonable" cost:

- Washington model (WA): no coverage if premium is greater than 25% of the non-custodial parent's basic child support obligation.
- Maine model (ME): no coverage if premium is greater than 15% of the non-custodial parent's cash support obligation.
- Colorado model (CO): no coverage if premium is greater than 20% of the non-custodial parent's gross income. *Note:* because we did not have gross income information, we used estimates of net income and a ceiling of 15%.

Using these models, the samples indicate coverage options are appropriate under the limitations of the various models.

#### GUIDE FOR INTERPRETING CASE SAMPLES

---

---

<sup>71</sup> See Appendix E, Test Environment Results.

## *INCOME AND OBLIGATION DATA*

The case results shown in Exhibit E can best be interpreted and understood with the following information. The proposed guideline was tested by creating sample cases with a certain number of children, ranging from one child, to four to six children, and by allowing for a monthly income and obligation that ranged from minimum to average to median to high. The monthly income and obligation amounts used in the sample cases were representative of data in the test environment. The weekly obligation amounts in the test environment reflected:

- Minimum weekly obligations of \$115 or less
- Average weekly obligations of \$116-\$231
- High weekly obligations of \$232-\$692

The weekly incomes in the test environment reflected:

- Minimum weekly incomes of \$328.05 or less
- Average weekly incomes of \$391.09-\$798.75
- High weekly incomes of \$1,219.71-1,745.00

Using this data, the sample case rows for income and child support obligations were completed. The samples in the monthly obligation row reflect the total child support and cash medical support obligation, based on premiums for that plan, owed by the non-custodial parent.

## *HEALTHCARE COVERAGE OPTIONS*

The proposed guideline and new approach require the Medical Support Facilitator to look to private coverage first and to determine if private coverage is appropriate utilizing the proposed guideline criteria. Private coverage options utilized in the sample are:

- PPO: Preferred Provider Option, employer-offered plan; medical coverage plus dental; \$100 premium.  
*Note:* The employer-offered Out of Area Option is also \$100/month premium; therefore it mirrors the PPO in effects.

- POS: Point of Service Option, employer-offered plan; medical coverage plus dental; \$94 premium.

If private coverage is not appropriate or is not available, the Medical Support Facilitator will look to FamilyCare options. FamilyCare offers a variety of plans:

- Family Care Plan A or B, or Medicaid, \$0 premium
- Family Care Plan C, \$15 premium
- Family Care Plan D, \$30 premium
- Family Care Plan D, \$60 premium
- Family Care Plan E, \$100 premium

Using this data, the sample case rows for PPO, POS, and FamilyCare were completed. The sample cases indicate whether coverage could be ordered under each type of plan that is available to the child.

### *CCPA LIMITS*

The samples address whether cash medical support can be obtained without violating CCPA limits. If the non-custodial parent supports only one family, which is the recipient of the child support check, the maximum amount that may be withheld is 60% of his net income. To survive this limit, the total obligation amount (child support + medical support) must be less than .6 of the NCP's net income. If the non-custodial parent supports more than one family, including the one which is the recipient of the child support check, the maximum amount that may be withheld is 50% of his net income. To survive this limit, the total obligation amount (child support + medical support) must be less than .5 of the NCP's net income. If the total child support and cash medical support ordered survives CCPA limits, the sample indicates "yes." As the samples indicate, CCPA limits were rarely breached, suggesting that the 5% of net income criteria is sound.

### *ECONOMIC STATUS INDICATOR*

The economic status indicator demonstrates what the percentage of poverty will be for the non-custodial parent, based on net income after the total child support and cash medical support obligation has been paid. The percentage of poverty was calculated by dividing income after payment of child support and medical support by \$716. \$716 is the 2001 Federal Poverty Guideline for one person. Once more, the economic status indicators show that the proposed guideline affordability criteria is fair; it will not leave the non-custodial parent in dire financial difficulties.

## ***SAMPLE CONCLUSIONS***

Case examples and data<sup>72</sup> demonstrate that CCPA limits are a very limited consideration for New Jersey because the limitations were rarely breached. Comparison of the New Jersey guideline to Washington, Maine, and Colorado demonstrates the following:

- Functionally, New Jersey’s medical support guideline mirrors the Washington guideline limit and is very close to the Maine guideline limit.
- Application of Colorado’s guideline shows that Colorado’s approach makes it the outlier because the New Jersey guideline allows for more remaining income.
- Poverty levels are significantly affected by the inclusion of the medical support order and by the different premium levels.

## **SUMMARY AND NEXT STEPS**

---

### ***TEST ENVIRONMENT SUMMARY***

The following tables summarize the findings from the test environment. Table 1 depicts the number of cases eligible for each FamilyCare plan and the number of cases found not eligible for FamilyCare. It reveals the appropriate premium based on maximum non-custodial parent annual income and number of children.

**Table 1: Family Care (n=1,607)**

<b>Plan</b>	<b>Number</b>	<b>Percentage of Total</b>
-------------	---------------	----------------------------

---

<sup>72</sup> See Appendix E, Test Environment Results.

<b>Plan A - \$0 premium</b>	1,357	84.4%
<b>Plan B - \$0 premium</b>	66	4.1%
Plan C - \$15 premium	109	6.8%
Plan D	47	2.9%
\$30 premium	27	1.7%
\$60 premium	8	.5%
\$100 premium	12	.7%
Do not qualify for FamilyCare	28	1.7%

Table 2 depicts whether each case “qualifies” for coverage under each of the State models based either on monthly obligation or monthly net income, and premium for each plan. The data reveals that both the New Jersey and Maine models are less likely to find PPO and POS “reasonable” in cost for the 1,607 cases in the sample. However, the Washington model would find PPO and POS reasonable in cost for 15% of the sample, and the Colorado model would find PPO and POS reasonable in cost for 55.2% of the sample. Given that FamilyCare is a New Jersey program, we examined only the New Jersey proposed guideline in relation to FamilyCare requirements. This revealed that 1,579 of the cases would qualify for FamilyCare – the majority for Plan A/Medicaid. This indicates that any cash medical support collected will be applied to the FamilyCare capitation fee, requiring that FamilyCare be prepared to accept these distributions from Centralized Collections.

**Table 2: Cases that Qualify for Each Model/Plan (n=1,607)**

	<b>WA Model</b>	<b>ME Model</b>	<b>CO Model</b>	<b>NJ Model</b>
--	-----------------	-----------------	-----------------	-----------------

<b>PPO</b>				
<i>Number</i>	242	71	887	81
<i>Percentage</i>	15.1%	4.4%	55.2%	5.0%
<b>POS</b>				
<i>Number</i>	304	79	887	96
<i>Percentage</i>	18.9%	4.9%	55.2%	6.0%
<b>FamilyCare</b>				
<i>Number</i>				1,579
<i>Percentage</i>				98.3%
Plan A				1,357
Plan B				66
Plan C				109
Plan D				47
\$30				27
\$60				8
\$100				12

With the test environment established and the cash medical support guideline’s definition of “reasonable cost” applied, FamilyCare cost recovery generated by the transition to a cash medical support guideline was estimated. Our testing indicates that 88.5% of the child support current assistance cases would qualify for either FamilyCare Plan A or Plan B, both of which are \$0 premium plans, and that any sums collected by OCSPP would be applied to the capitation rate. FamilyCare members of New Jersey’s Medical Support Work Group estimated cost recovery of approximately \$3,120,000 annually from the child support current assistance caseload. This estimate was based on recovering \$50 annually from the eligible

current assistance cases, which results in an increase of only \$4.16 per month in the ordered amount. Sums recouped from child support's eligible former assistance cases generated \$15,406,700 in FamilyCare recovery. This estimate was based on recovering a \$100 annually per former assistance case (which results in an increase of \$8.33 per month in the ordered amount). The total costs recovered by OCSPP for FamilyCare through the application of a cash medical support guideline are estimated at \$18,526,700.

Table 3 depicts the remaining non-custodial parent net monthly income after paying monthly child support obligation and cash medical support for each model/plan. These average incomes were only calculated for non-custodial parents who qualified for each plan/model. Refer to table 2 for n sizes.

**Table 3: Average NCP Monthly Net Income AFTER Payment of Child Support and Medical Premium**

	WA Model	ME Model	CO Model	NJ Model
<b>PPO</b>	\$1,601.75	\$3,193.46	\$914.61	\$3,079.54
<b>POS</b>	\$1,466.92	\$2,983.00	\$920.61	\$2800.58
<b>FamilyCare</b>				\$604.86
Plan A				\$489.47
Plan B				\$1,041.90
Plan C				\$1,212.09
Plan D				\$1,914.54
\$30				\$1,616.83
\$60				\$2,000.50
\$100				\$2,527.08

Table 4 depicts the average monthly obligation, before cash medical support, for cases that qualify for each model.

**Table 4 – Average Monthly Obligation (before medical premium) for  
Cases that Qualify for Each Model/Plan**

	<b>WA Model</b>	<b>ME Model</b>	<b>CO Model</b>	<b>NJ Model</b>
<b>PPO</b>	\$693.39	\$1,184.95	\$384.10	\$1,067.93
<b>POS</b>	\$630.12	\$1,130.29	\$384.10	\$993.69
<b>FamilyCare</b>	\$244.16	\$244.16	\$244.16	\$244.16
Plan A	\$205.53	\$205.53	\$205.53	\$205.53
Plan B	\$388.10	\$388.10	\$388.10	\$388.10
Plan C	\$431.31	\$431.31	\$431.31	\$431.31
Plan D	\$723.30	\$723.30	\$723.30	\$723.30
\$30	\$588.05	\$588.05	\$588.05	\$588.05
\$60	\$753.46	\$753.46	\$753.46	\$753.46
\$100	\$1,007.50	\$1,007.50	\$1,007.50	\$1,007.50

## *NEXT STEPS*

This study revealed that performance in the key areas of medical support establishment and enforcement can be enhanced through improved review and adjustment of support order processes. To implement the proposed guideline and new approach, legislative, regulatory, and procedural changes and enhancements must occur within OCSPP, FamilyCare, and Family Court. Effected areas include:

- Court Rules (incorporate proposed medical support guideline)
- Child Support enabling legislation (authority to collect cash medical support, authority to enforce against the custodial parent, limiting liability of Medical Support Facilitators)
- Memoranda of Understanding (with FamilyCare; addressing preliminary eligibility determination process, cost savings/recovery and sharing of those funds, increasing enrollments)
- Cooperative Agreements (Family Court, Probation Divisions, Boards of Social Services, new approach for medical support, performance measures, responsibilities)

These changes must be the result of consensus arrived at by a cross-agency working group. However, a study is not as telling as implementation, and these changes should not occur until a pilot has taken place. To further determine how best to approach medical support on a statewide basis, study results should be tested at one or two pilot locations. The pilot locations should be agreed to by the working group. Once a pilot has been implemented successfully, the necessary legislative, regulatory, and statutory changes should be identified and addressed. At that time, the following technology issues will need to be resolved:

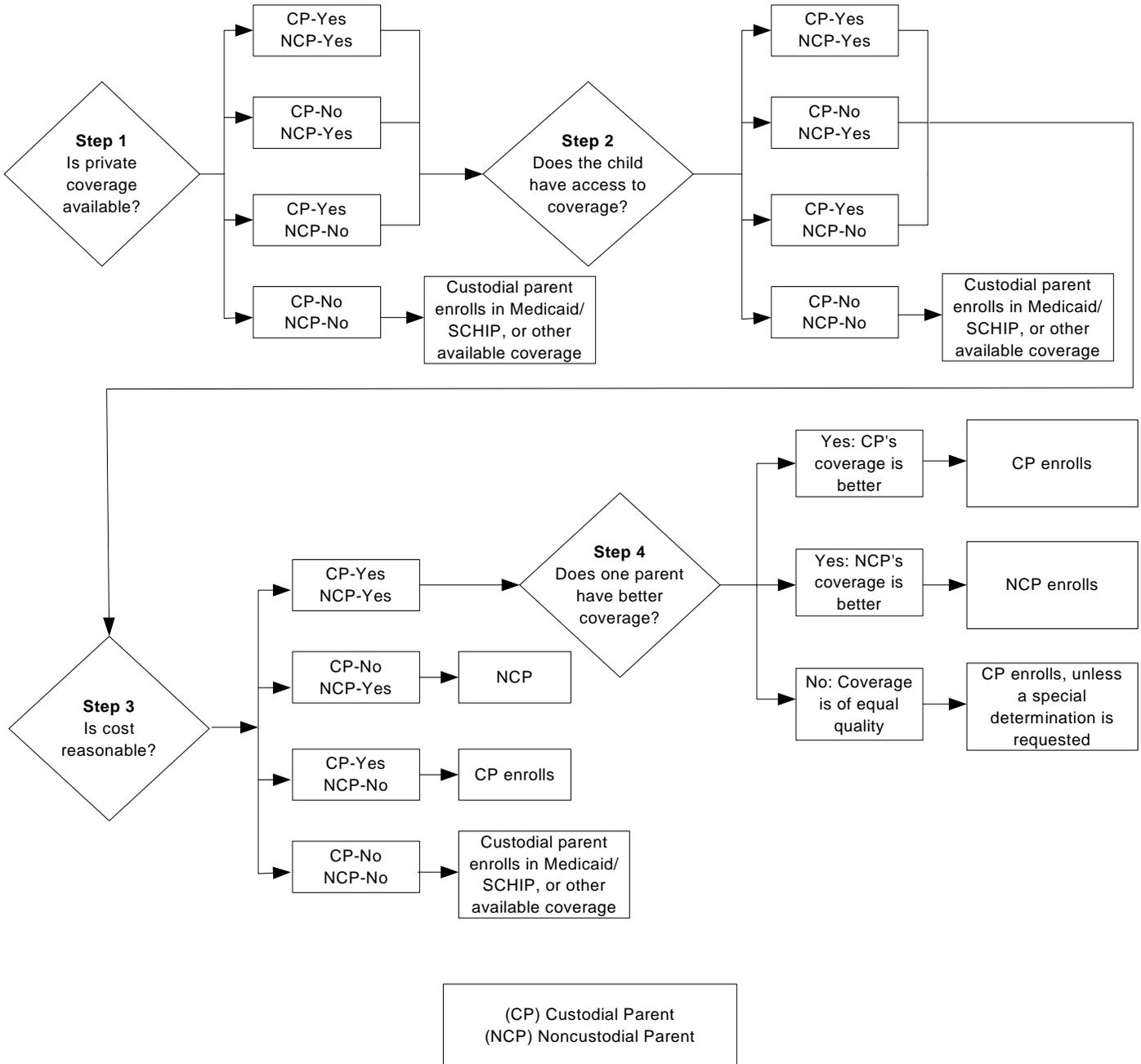
- Developing a medical insurer database
- Creating forms generation software
- Automated communication links with partner agencies
- Centralized collections receipt and distribution of cash medical support

We expect that as the study is piloted, a number of other issues will need resolution. In Sections II and III of this study, we anticipated and explored some of these issues. However, we recognize that the list is not exhaustive. Pilot implementation will cause this list to grow and may impact on some decisions that have already been reached.

Appendix A  
Decision Matrix

# Decision Matrix for Tribunal Use

(To Determine Appropriate Coverage for a Child Not Currently Enrolled in Any Coverage)



Appendix B  
Draft Financial and Medical Support Order

PLAINTIFF VS. DEFENDANT	<b>SUPERIOR COURT OF NEW JERSEY</b> <i>Chancery Division-Family Part</i>				
<input type="checkbox"/> Obligor <input type="checkbox"/> Obligee <input type="checkbox"/> Obligor <input type="checkbox"/> Obligee	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><b>COUNTY OF</b></td> <td style="width: 50%;"><b>CIVIL ACTION ORDER</b></td> </tr> <tr> <td></td> <td style="text-align: center;"><b>Page 1 of 2</b></td> </tr> </table>	<b>COUNTY OF</b>	<b>CIVIL ACTION ORDER</b>		<b>Page 1 of 2</b>
<b>COUNTY OF</b>	<b>CIVIL ACTION ORDER</b>				
	<b>Page 1 of 2</b>				

HEARING DATE ____/____/____	WELFARE/U.I.F.S.A. #	PROBATION ACCOUNT # CS	DOCKET #
--------------------------------	----------------------	---------------------------	----------

Attorney for Plaintiff: \_\_\_\_\_ Attorney for Defendant: \_\_\_\_\_

This matter having been opened to the court by:  Plaintiff  Defendant  County Welfare Agency  Probation Division  Family Division for an ORDER:

IT IS HEREBY ORDERED THAT: The obligee shall pay support for the spouse named above and/or support for the child(ren) named below:

CHILD'S NAME	BIRTH DATE	CHILD'S NAME	BIRTH DATE
1.		4.	
2.		5.	
3.		6.	

PATERNITY of child(ren) (# above) \_\_\_\_\_, is acknowledged by defendant, and an ORDER of paternity is entered.

Financial Support shall be paid through the Probation Division in the county in which the obligor resides, by income withholding, in the amount of:

			+		=		payable		effective	
<i>Financial Support</i>	<i>Medical Support</i>	<i>Spousal Support</i>		<i>Arrears Payment</i>		<i>Total</i>		<i>Frequency</i>		<i>Date</i>

ARREARS are to be calculated by the Probation Division based upon amounts and effective date noted above.

ARREARS, indicated in the records of the Probation Division, are \$ \_\_\_\_\_ as of \_\_\_\_/\_\_\_\_/\_\_\_\_.

GROSS WEEKLY INCOMES of the parties, as defined by the Child Support Guidelines, upon which this FINANCIAL SUPPORT ORDER is based:  
 PLAINTIFF = \$ \_\_\_\_\_ DEFENDANT = \$ \_\_\_\_\_

NET INCOME of the parties, as defined by the Medical Child Support Guidelines, upon which this MEDICAL SUPPORT ORDER is based:  
 PLAINTIFF = \$ \_\_\_\_\_ DEFENDANT = \$ \_\_\_\_\_

INCOME WITHHOLDING to satisfy both the financial and medical support is hereby ORDERED on current and future income sources, including:  
 Name of Income Source: \_\_\_\_\_ Address of income source: \_\_\_\_\_

OBLIGOR SHALL, however, make payments AT ANY TIME the full amount of financial and medical support and/or arrears are not withheld.

**MEDICAL INSURANCE** coverage for the child(ren) is hereby **ORDERED** to be provided by the Obligor. The obligor shall maintain the employment or union-based health care coverage for the benefit of the children named above. The obligor shall continue this coverage until no longer allowed under the policy. If coverage becomes unavailable, the obligor shall notify the obligee and the Probation Division. If the obligor has replacement coverage through a new employer or union, the obligor shall secure such coverage for the benefit of the above named children. Written evidence of any insurance coverage ordered under this section must be provided within thirty (30) days of obtaining insurance coverage. If insurance coverage is currently in place, verification must be provided within thirty (30) days of this order. If no replacement coverage is available, or if such replacement coverage fails to meet the requirements of the Medical Child Support Guideline, the obligor shall continue to make cash medical support payments to the Probation Division. In the event that replacement coverage available through the obligor's employer or union fails to meet the requirements of the Medical Child Support Guideline, medical insurance coverage for the child(ren) is hereby **ORDERED** to be provided by the Obligor through either an employment or union-based plan or through application to New Jersey FamilyCare.

**MEDICAL INSURANCE** coverage for the child(ren) is hereby **ORDERED** to be provided by the Obligor. The obligor shall maintain the employment or union-based health care coverage for the benefit of the children named above. The obligor shall continue this coverage until no longer allowed under the policy. If coverage becomes unavailable, the obligor shall notify the Probation Division. If the obligor has replacement coverage through a new employer or union, the obligor shall secure such coverage for the benefit of the above named children. If no replacement coverage is available, or if such replacement coverage fails to meet the requirements of the Medical Child Support Guideline, the obligor shall make application to New Jersey FamilyCare to ensure seamless coverage for the children named above. Written evidence of any insurance coverage ordered under this section must be provided within thirty (30) days of obtaining insurance coverage. If insurance coverage is currently in place, verification must be provided within thirty (30) days of this order.

PLAINTIFF

VS.

DEFENDANT

PAGE 2 OF 2

DOCKET # \_\_\_\_\_

HEARING DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**BLOOD/GENETIC TESTING** to assist the court in determining paternity of the child(ren) (# \_\_\_\_\_) is hereby **ORDERED**. The county welfare agency in the county of residence of the child shall bear the cost of said testing, without prejudice to final allocation of said costs. If defendant is later adjudicated the father of said child(ren), defendant shall reimburse the agency for the costs of said tests, and pay financial child support and medical child support retroactive to \_\_\_\_/\_\_\_\_/\_\_\_\_.

**AN EMPLOYMENT SEARCH** must be conducted by the Obligor. Written records of at least # \_\_\_\_\_ employment contacts per week must be presented to the Probation Division. If employed, proof of income and the full name and address of employer must be provided to the Probation Division.

This matter is hereby **RELISTED** for hearing on \_\_\_\_/\_\_\_\_/\_\_\_\_ before \_\_\_\_\_. A copy of this **ORDER** shall serve as the summons for the hearing. No further notice for appearance shall be given. Failure to appear may result in a default order, bench warrant, or dismissal.

**THIS ORDER IS ENTERED BY DEFAULT.** The obligor was properly served with notice for court appearance on \_\_\_\_/\_\_\_\_/\_\_\_\_, failed to appear, and is in violation of litigant's rights for failure to comply with the financial and medical support **ORDER** (Service noted below). A payment of \$ \_\_\_\_\_ shall be required to purge the warrant. Said payment shall be applied to the arrears.

**SERVICE** upon which this order is based:

Personal Service       Certified Mail:       Refused       Regular Mail (not returned)       Other:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_       Returned Unclaimed       Signed by: \_\_\_\_\_

**FUTURE MISSED PAYMENT(S)** numbering \_\_\_\_\_ or more may result in the issuance of a warrant, without further notice or hearing for the arrest of the obligor.

**A LUMP SUM PAYMENT OF \$ \_\_\_\_\_** must be made by the obligor by \_\_\_\_/\_\_\_\_/\_\_\_\_, or a bench warrant for the arrest of the obligor will issue.

This complaint is hereby **INACTIVATED**, pending \_\_\_\_\_.

This complaint/motion is hereby **DISMISSED**, without prejudice, as \_\_\_\_\_.

Order of Financial and Medical Support is hereby **VACATED** effective \_\_\_\_/\_\_\_\_/\_\_\_\_, as \_\_\_\_\_. Arrears, if any, as calculated by the Probation Division, prior to the effective date, shall be paid at the rate and frequency noted on page number one of this **ORDER**.

It is further **ORDERED**:

Additional Page(s) attached: # \_\_\_\_\_, # \_\_\_\_\_

**TAKE NOTICE** that all provisions stated on the reverse of page 1 are to be considered part of this **ORDER**.

I waive my right to hearing in this matter and **CONSENT** to entry of an **ORDER** of all provisions noted herein. I enter my consent freely and voluntarily. I understand all terms and conditions of this **ORDER**.

Plaintiff \_\_\_\_\_ Attorney \_\_\_\_\_

Defendant \_\_\_\_\_ Attorney \_\_\_\_\_

Welfare Rep. \_\_\_\_\_ Family Div. Rep. \_\_\_\_\_  
(Witness)

Copies provided to above at conference.

Copies to be mailed to the parties.

So **ORDERED** by the Court:

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Judge \_\_\_\_\_ Signature \_\_\_\_\_ J.S.C.

Appendix C  
Medical Support Questionnaire

## Sample Language for Medical Support Questionnaire

### **Private Medical Insurance Information**

Does your employer or union offer health coverage: Yes  No .

If yes, what is the monthly cost for health insurance coverage for **yourself only**: \$\_\_\_\_\_.

What is the monthly cost for **family** health insurance coverage: \$\_\_\_\_\_

Do you have health insurance coverage **currently in place**: Yes  No .

If yes, what type: Self  Family . Cost per month: \$\_\_\_\_\_

If you have family health coverage in place, name the dependants covered and how they are related to you:\_\_\_\_\_

### **Private Dental Insurance Information**

Does your employer or union offer dental coverage: Yes  No .

If yes, what is the monthly cost for dental insurance coverage for **yourself only**: \$\_\_\_\_\_.

What is the monthly cost for **family** dental insurance coverage: \$\_\_\_\_\_

Do you have dental insurance coverage **currently in place**: Yes  No .

If yes, what type: Self  Family . Cost per month:\$\_\_\_\_\_

If family dental coverage is in place, name the dependants covered and how they are related to you:\_\_\_\_\_

Does the other parent currently have any insurance coverage in place for the child(ren) of this action: Yes  No .

If yes, describe the type (health and/or dental) and name of insurance company:

---

If both parents have health and/or dental insurance available, which plan is the better choice and why:

---

### **Required Documentation**

Attach documentation of the cost of health/dental insurance that you now carry or which is available to you or your minor child(ren) through your employer or union. Include the policy number, the name of the plan, and the cost of the plan for both self and dependent coverage.

Provide any additional information such as a summary of plan benefits, plan coverage area, your length of service with your current employer, and the city, county, state of your employment.

### **FamilyCare Insurance Information**

Do you receive FamilyCare: Yes  No

If yes, what is your monthly co-pay: \$\_\_\_\_\_.

If yes, which plan do you belong to? \_\_\_\_\_.

Do you receive Medical Assistance: Yes  No

If yes, is it for yourself, your children, or both: \_\_\_\_\_.

Appendix D  
Guidelines Worksheet

**CHILD SUPPORT GUIDELINES - SOLE PARENTING WORKSHEET**

Case Name:

County:

vs.  
Plaintiff  
Defendant

Docket #:

Number of Children:

Custodial Parent is the: ( ) Plaintiff  
( ) Defendant

<b>All amounts must be weekly</b>	<b>Custodial</b>	<b>Non-Custodial</b>	<b>Combined</b>
<b>Gross Income</b>			
1. Gross Taxable Income			
1a. Mandatory Retirement Contribs	(-)	(-)	
1b. Alimony Paid	(-)	(-)	
1c. Alimony Received	(+)	(+)	
2. Adjusted Gross Taxable Income			
2a. Federal, State, and Local Taxes	(-)	(-)	
2b. Prior Child Support Orders	(-)	(-)	
2c. Mandatory Union Dues	(-)	(-)	
2d. Other Dependent Deduction	(-)	(-)	
<b>Net Income</b>			
3. Net Taxable Income			
4. Health Insurance Premiums Paid for Child. Medical support shall not be ordered if: -- net income is equal to or less than 200% of the PG (Poverty Guideline), or -- the parent lives with a child who is Medicaid-eligible based on that parent's income, unless coverage does not require parental contribution. Medical support shall not be ordered in an amount that exceeds 5% of a parent's Net Income (Line 7).	(-)	(-)	
5. Unreimbursed Health Care. Expenses in excess of \$250 per year that are predictable and recurring.	(-)	(-)	
6. Non-Taxable Income ( )	(+)	(+)	
7. Net Income			
<b>8. Percentage Share of Income</b>	%	%	Must equal 100%
<b>9. Basic Child Support Amount</b>			
<b>Total Child Support Contributions from Parents</b>			
10. Total Net Work-Related Child Care			(+)
11. Total Health Insurance Premium Paid for Child			(+)
12. Total Unreimbursed Health Care Expenses. Expenses in excess of \$250 per year that are predictable and recurring.			(+)
13. Total Other Extraordinary Expenses	<b>IF LINE 13 IS</b>		(+)

	<b>ZERO, STOP. Benefit apportionment is substituted for support.</b>		
14. Total Government Benefits for the Child			
15. Total Amount of Child Support for Child			
<b>Each Parent's Share of Total Child Support Contributions</b>			
16. Each Parent's Share of Financial Obligation			
17. Net Work-Related Child Care	(-)	(-)	
18. Other Extraordinary Expenses Paid	(-)	(-)	
19. Credit for Visitation Variable		(-)	
20. Net Financial Support Obligation			
<b>Dependent Deductions</b>			
21. Financial Support Order w/Other Dependent Deduction	<b>If neither parent is requesting a dependent deduction, go to Line 24.</b>		
22. Financial Support Order w/o Other Dependent Deduction			
23. Adjusted Financial Child Support Order			
<b>Each Parent's Share of Total Medical Support Contributions</b>			
24. Total Health Insurance Premium Amount			
25. Total Unreimbursed Health Care Expenses			(+)
26. Total Medical Support Contributions			
27. Each parent's share of total medical support contributions. Medical support shall not be ordered if: -- net income is equal to or less than 200% of the PG (Poverty Guideline), or -- the parent lives with a child who is Medicaid-eligible based on that parent's income, unless coverage does not require parental contribution. Medical support shall not be ordered in an amount that exceeds 5% of a parent's Net Income (Line 7)			
<b>28. Obligor Self-Support Reserve Test</b>	<b>If result is greater than 105% of the PG for one person or if CP net income is less than the PG, enter Line 20 or Line 23 amount on Line 27. If NCP L24 income is less than the PG and CP income is greater than the PG, go to Line 26.</b>		

**Final Child Support Order Amount**

29. Obligor Parent's Maximum Child Support Obligation.  
Enter result here and on Line 30.

30. Financial Child Support Order.

31. Cash Medical Child Support Order.

**COMMENTS, REBUTTALS, AND JUSTIFICATIONS FOR DEVIATIONS**

1. This financial and medical child support order was ( )  
was not ( ) based on the child support guidelines.

2. If this child support order (Lines 30 or 31) deviates from  
the amount suggested by the child support guidelines, enter  
the amount ordered:

3. The child support guidelines were not used or the child  
support award was adjusted because:

4. The following court approved extraordinary expenses  
were added to the basic support obligation:

5. Percentage of visitation time:

The Custodial Parent's percentage of time with the child  
is %

The Non-Custodial Parent's percentage of time with the  
child is %

6. Additional Notes:

Prepared by

Title

Date

Appendix E  
Data Summaries

## Sample Cases with One Child

### Case 1A - Minimum Income/Minimum Obligation

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$433.33			
Monthly Obligation	\$21.67			
<b>PPO Premium</b>	<b>\$100.00</b>			
Qualifies under model	___	___	___	___
CCPA 60% limit				
CCPA 50% limit				
Income after child support and medical premium				
<b>POS Premium</b>	<b>\$94.00</b>			
Qualifies under model	___	___	___	___
CCPA 60% limit				
CCPA 50% limit				
Income after child support and medical premium				
<b>Family Care Premium (Plan A)</b>	<b>\$0.00</b>			
Child support and medical	\$21.67			
Income after child support and medical	\$411.66			
% of 2001 Poverty Guideline	57%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
CCPA 60% limit				
CCPA 50% limit				
Income after child support and medical premium				

### Case 1B - Minimum Income/Average Obligation

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$433.33			

Monthly Obligation	\$108.52				
<b>PPO Premium</b>	<b>\$100.00</b>				
Qualifies under model	___	___		___	___
CCPA 60% limit					
CCPA 50% limit					
Income after child support and medical premium					
<b>POS Premium</b>	<b>\$94.00</b>				
Qualifies under model	___	___		___	___
CCPA 60% limit					
CCPA 50% limit					
Income after child support and medical premium					
<b>Family Care Premium (Plan A)</b>	<b>\$0.00</b>				
Child support and medical	\$108.52				
Income after child support and medical	\$324.81				
% of 2001 Poverty Guideline	45%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___		___	___
CCPA 60% limit					
CCPA 50% limit					
Income after child support and medical premium					

**Case 1C - Median Income**

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$801.67			
Monthly Obligation	\$195.00			
<b>PPO Premium</b>	<b>\$100.00</b>			
Child support and medical	\$295.00			
Income after child support and medical	\$506.67			
% of 2001 Poverty Guideline	71%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___

<b>POS Premium</b>	<b>\$94.00</b>				
Child support and medical	\$289.00				
Income after child support and medical	\$512.67				
% of 2001 Poverty Guideline	72%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___		___	___
<b>Family Care Premium (Plan A)</b>	<b>\$0.00</b>				
Child support and medical	\$195.00				
Income after child support and medical	\$606.67				
% of 2001 Poverty Guideline	85%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___		___	___

**Case 1D - Qualifies for Family Care Plan D at \$60 Premium**

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$2,470.00			
Monthly Obligation	\$589.33			
<b>PPO Premium</b>	<b>\$100.00</b>			
Child support and medical	\$689.33			
Income after child support and medical	\$1,780.67			
% of 2001 Poverty Guideline	249%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___		___
<b>POS Premium</b>	<b>\$94.00</b>			
Child support and medical	\$683.33			
Income after child support and medical	\$1,786.67			
% of 2001 Poverty Guideline	250%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			

Qualifies under model	___	___	___	___
<b>Family Care Premium (Plan D)</b>	<b>\$60.00</b>			
Child support and medical	\$649.33			
Income after child support and medical	\$1,820.67			
% of 2001 Poverty Guideline	254%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___

### Case 1E - High Income

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$12,566.67			
Monthly Obligation	\$2,200.00			
<b>PPO Premium</b>	<b>\$100.00</b>			
Child support and medical	\$2,300.00			
Income after child support and medical	\$10,266.67			
% of 2001 Poverty Guideline	1434%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>POS Premium</b>	<b>\$94.00</b>			
Child support and medical	\$2,294.00			
Income after child support and medical	\$10,272.67			
% of 2001 Poverty Guideline	1435%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>Family Care Premium</b>	<b>Does not qualify</b>			
Child support and medical	#VALUE!			
Income after child support and medical	#VALUE!			
Within CCPA 60% limit	#VALUE!			
Within CCPA 50% limit	#VALUE!			

Qualifies under model	___	___	___	___	___
-----------------------	-----	-----	-----	-----	-----

## Sample Cases with Two Children

### Case 2A - Minimum Income/Average Obligation

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$433.33			
Monthly Obligation	\$151.42			
<b>PPO Premium</b>	<b>\$100.00</b>			
Qualifies under model	___	___	___	___
CCPA 60% limit				
CCPA 50% limit				
Income after child support and medical premium				
<b>POS Premium</b>	<b>\$94.00</b>			
Qualifies under model	___	___	___	___
CCPA 60% limit				
CCPA 50% limit				
Income after child support and medical premium				
<b>Family Care Premium (Plan A)</b>	<b>\$0.00</b>			
Child support and medical	\$151.42			
Income after child support and medical	\$281.91			
% of 2001 Poverty Guideline	39%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
CCPA 60% limit				
CCPA 50% limit				
Income after child support and medical premium				

### Case 2B - Average Income

	WA Model	ME Model	CO Model	NJ Model
--	----------	----------	----------	----------

NCP Net Monthly Income	\$931.67				
Monthly Obligation	\$329.33				
<b>PPO Premium</b>	<b>\$100.00</b>				
Child support and medical	\$429.33				
Income after child support and medical	\$502.34				
% of 2001 Poverty Guideline	70%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___		___	___
CCPA 60% limit					
CCPA 50% limit					
Income after child support and medical premium					
<b>POS Premium</b>	<b>\$94.00</b>				
Child support and medical	\$423.33				
Income after child support and medical	\$508.34				
% of 2001 Poverty Guideline	71%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___		___	___
CCPA 60% limit					
CCPA 50% limit					
Income after child support and medical premium					
<b>Family Care Premium (Plan A)</b>	<b>\$0.00</b>				
Child support and medical	\$329.33				
Income after child support and medical	\$602.34				
% of 2001 Poverty Guideline	84%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___		___	___
CCPA 60% limit					
CCPA 50% limit					
Income after child support and medical premium					

**Case 2C - Qualifies for Family  
Care Plan D at \$30 Premium**

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$2,751.67			
Monthly Obligation	\$949.00			
<b>PPO Premium</b>	<b>\$100.00</b>			
Child support and medical	\$1,049.00			
Income after child support and medical	\$1,702.67			
% of 2001 Poverty Guideline	238%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>POS Premium</b>	<b>\$94.00</b>			
Child support and medical	\$1,043.00			
Income after child support and medical	\$1,708.67			
% of 2001 Poverty Guideline	239%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>Family Care Premium (Plan D)</b>	<b>\$30.00</b>			
Child support and medical	\$979.00			
Income after child support and medical	\$1,772.67			
% of 2001 Poverty Guideline	248%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___

**Case 2D - Qualifies for Family  
Care Plan D at \$100 Premium**

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$3,856.67			
Monthly Obligation	\$1,256.67			
<b>PPO Premium</b>	<b>\$100.00</b>			
Child support and medical	\$1,356.67			
Income after child support and medical	\$2,500.00			

% of 2001 Poverty Guideline	349%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___	___	___	___
<b>POS Premium \$94.00</b>					
Child support and medical	\$1,350.67				
Income after child support and medical	\$2,506.00				
% of 2001 Poverty Guideline	350%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___	___	___	___
<b>Family Care Premium (Plan D) \$100.00</b>					
Child support and medical	\$1,356.67				
Income after child support and medical	\$2,500.00				
% of 2001 Poverty Guideline	349%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___	___	___	___

### Case 2E - High Income

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$8,406.67			
Monthly Obligation	\$2,119.00			
<b>PPO Premium \$100.00</b>				
Child support and medical	\$2,219.00			
Income after child support and medical	\$6,187.67			
% of 2001 Poverty Guideline	864%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>POS Premium \$94.00</b>				
Child support and medical	\$2,213.00			
Income after child support and medical	\$6,193.67			
% of 2001 Poverty Guideline	865%			

Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___	___	___	___
<b>Family Care Premium</b>	<b>Does not qualify</b>				
Child support and medical	#VALUE!				
Income after child support and medical	#VALUE!				
Within CCPA 60% limit	#VALUE!				
Within CCPA 50% limit	#VALUE!				
Qualifies under model	___	___	___	___	___

## Sample Cases with Three Children

### Case 3A - Minimum Income/Average Obligation

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$433.33			
Monthly Obligation	\$177.67			
<b>PPO Premium</b>	<b>\$100.00</b>			
Qualifies under model	___	___	___	___
CCPA 60% limit				
CCPA 50% limit				
Income after child support and medical premium				
<b>POS Premium</b>	<b>\$94.00</b>			
Qualifies under model	___	___	___	___
CCPA 60% limit				
CCPA 50% limit				
Income after child support and medical premium				
<b>Family Care Premium (Plan A)</b>	<b>\$0.00</b>			
Child support and medical	\$177.67			
Income after child support and medical	\$255.66			
% of 2001 Poverty Guideline	36%			
Within CCPA 60% limit	___			

Within CCPA 50% limit	___				
Qualifies under model	___	___		___	___
CCPA 60% limit					
CCPA 50% limit					
Income after child support and medical premium					

### Case 3B - Median Income

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$758.33			
Monthly Obligation	\$325.00			
<b>PPO Premium</b>	<b>\$100.00</b>			
Child support and medical	\$425.00			
Income after child support and medical	\$333.33			
% of 2001 Poverty Guideline	47%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>POS Premium</b>	<b>\$94.00</b>			
Child support and medical	\$419.00			
Income after child support and medical	\$339.33			
% of 2001 Poverty Guideline	47%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>Family Care Premium (Plan A)</b>	<b>\$0.00</b>			
Child support and medical	\$325.00			
Income after child support and medical	\$433.33			
% of 2001 Poverty Guideline	61%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___

### Case 3C - Qualifies for Family

**Care Plan C**

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$2,210.00			
Monthly Obligation	\$910.00			
<b>PPO Premium</b>	<b>\$100.00</b>			
Child support and medical	\$1,010.00			
Income after child support and medical	\$1,200.00			
% of 2001 Poverty Guideline	168%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>POS Premium</b>	<b>\$94.00</b>			
Child support and medical	\$1,004.00			
Income after child support and medical	\$1,206.00			
% of 2001 Poverty Guideline	168%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>Family Care Premium (Plan C)</b>	<b>\$15.00</b>			
Child support and medical	\$925.00			
Income after child support and medical	\$1,285.00			
% of 2001 Poverty Guideline	179%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___

**Case 3D - High Income**

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$7,930.00			
Monthly Obligation	\$2,392.00			
<b>PPO Premium</b>	<b>\$100.00</b>			
Child support and medical	\$2,492.00			
Income after child support and medical	\$5,438.00			
% of 2001 Poverty Guideline	759%			
Within CCPA 60% limit	___			

Within CCPA 50% limit	___				
Qualifies under model	___	___	___	___	___
<b>POS Premium</b>					
	<b>\$94.00</b>				
Child support and medical	\$2,486.00				
Income after child support and medical	\$5,444.00				
% of 2001 Poverty Guideline	760%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___	___	___	___
<b>Family Care Premium</b>					
	<b>Does not qualify</b>				
Child support and medical	#VALUE!				
Income after child support and medical	#VALUE!				
Within CCPA 60% limit	#VALUE!				
Within CCPA 50% limit	#VALUE!				
Qualifies under model	___	___	___	___	___

## Sample Cases with Four through Six Children

### Case 4A - Average Income - Four Children

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$1,148.33			
Monthly Obligation	\$541.67			
<b>PPO Premium</b>				
	<b>\$100.00</b>			
Child support and medical	\$641.67			
Income after child support and medical	\$506.66			
% of 2001 Poverty Guideline	71%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>POS Premium</b>				
	<b>\$94.00</b>			
Child support and medical	\$635.67			
Income after child support and medical	\$512.66			

% of 2001 Poverty Guideline	72%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___	___	___	___
<b>Family Care Premium (Plan A)</b>					
Child support and medical	\$0.00				
Income after child support and medical	\$541.67				
Income after child support and medical	\$606.66				
% of 2001 Poverty Guideline	85%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___	___	___	___

**Case 4B - Qualifies for Family Care Plan C - Four Children**

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$2,816.67			
Monthly Obligation	\$1,256.67			
<b>PPO Premium</b>	<b>\$100.00</b>			
Child support and medical	\$1,356.67			
Income after child support and medical	\$1,460.00			
% of 2001 Poverty Guideline	204%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>POS Premium</b>				
Child support and medical	<b>\$94.00</b>			
Income after child support and medical	\$1,350.67			
Income after child support and medical	\$1,466.00			
% of 2001 Poverty Guideline	205%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>Family Care Premium (Plan C)</b>				
Child support and medical	<b>\$15.00</b>			
Income after child support and	\$1,271.67			
Income after child support and	\$1,545.00			

medical					
% of 2001 Poverty Guideline	216%				
Within CCPA 60% limit	___				
Within CCPA 50% limit	___				
Qualifies under model	___	___		___	___

**Case 5A - Median Income -  
Five Children**

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$866.67			
Monthly Obligation	\$442.00			
<b>PPO Premium</b>	<b>\$100.00</b>			
Child support and medical	\$542.00			
Income after child support and medical	\$324.67			
% of 2001 Poverty Guideline	45%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>POS Premium</b>	<b>\$94.00</b>			
Child support and medical	\$536.00			
Income after child support and medical	\$330.67			
% of 2001 Poverty Guideline	46%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>Family Care Premium (Plan A)</b>	<b>\$0.00</b>			
Child support and medical	\$442.00			
Income after child support and medical	\$424.67			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
Child support and medical	\$442.00			
Income after child support and medical	\$424.67			
% of 2001 Poverty Guideline	59%			
Within CCPA 60% limit	___			

Within CCPA 50% limit	___				
Qualifies under model	___	___		___	___

**Case 6A - Minimum Income -  
6 Children**

	WA Model	ME Model	CO Model	NJ Model
NCP Net Monthly Income	\$736.67			
Monthly Obligation	\$377.00			
<b>PPO Premium</b>	<b>\$100.00</b>			
Child support and medical	\$477.00			
Income after child support and medical	\$259.67			
% of 2001 Poverty Guideline	36%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>POS Premium</b>	<b>\$94.00</b>			
Child support and medical	\$471.00			
Income after child support and medical	\$265.67			
% of 2001 Poverty Guideline	37%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___
<b>Family Care Premium (Plan A)</b>	<b>\$0.00</b>			
Child support and medical	\$377.00			
Income after child support and medical	\$359.67			
% of 2001 Poverty Guideline	50%			
Within CCPA 60% limit	___			
Within CCPA 50% limit	___			
Qualifies under model	___	___	___	___