COMPLIANCE OVERVIEW

Qualified Medical Child Support Orders—FAQs

The Employee Retirement Income Security Act (ERISA) requires employer-sponsored group health plans to extend health care coverage to the children of a parent-employee who is divorced, separated or was never married when ordered to do so by state authorities.

Generally, a state court or agency may require an ERISA-covered health plan to provide health benefits coverage to children by issuing a medical child support order. The group health plan must determine whether the medical child support order is "qualified." This type of order is referred to as a Qualified Medical Child Support Order (QMCSO). In addition, a state child support enforcement agency may obtain group health coverage for a child by issuing a National Medical Support Notice (NMSN) that the group health plan determines to be qualified.

The Departments of Labor (DOL) and Health and Human Services (HHS) have provided answers to frequently asked questions (FAQs) about QMCSOs and NMSNs. This Compliance Overview includes select FAQs from the DOL and HHS on medical child support orders.

LINKS AND RESOURCES

- DOL FAQs on medical child support orders, including QMCSOs and NMSNs
- HHS' FAQs for employers on NMSNs
- National Medical Support Notice and Instructions, to be completed by a state child support agency

QMCSO Determination

- The administrator of a group health plan is required to determine whether a medical child support order is "qualified."
- The administrator must make this determination within a reasonable period of time pursuant to written procedures that have been adopted by the plan.

"Qualified" Status

- To be "qualified," a medical child support order must include certain identifying information.
- The order may not require a plan to provide any type or form of benefit not otherwise provided under the plan, except to the extent necessary to meet state law requirements.
- A properly completed NMSN must be treated as a QMCSO.

Qualified Medical Child Support Orders

What types of plans are subject to the QMCSO provisions?

The QMCSO provisions apply to "group health plans" subject to ERISA. For this purpose a "group health plan" generally is a plan that both:

- Is sponsored by an employer or employee organization (or both); and
- Provides "medical care" to employees, former employees or their families.

"Medical care" means amounts paid: for the diagnosis, cure, mitigation, treatment or prevention of a disease; for the purpose of affecting any structure or function of the body; transportation primarily for or essential to such care or services; or for insurance covering such care or services.

ERISA does not generally apply to plans maintained by federal, state or local governments, churches and employers solely for purposes of complying with applicable workers compensation or disability laws. However, provisions of the Child Support Performance and Incentive Act (CSPIA) of 1998 require church plans to comply with QMCSOs and NMSNs, and state and local government plans to comply with NMSNs.

What is a QMCSO?

A QMCSO is a medical child support order that:

- Creates or recognizes the right of an alternate recipient to receive benefits for which a participant or beneficiary is eligible under a group health plan, or assigns to an alternate recipient the right of a participant or beneficiary to receive benefits under a group health plan; and
- Is recognized by the group health plan as "qualified" because it includes information and meets other requirements of the QMCSO provisions.

In addition, a properly completed NMSN must be treated as a QMCSO.

What is a medical child support order?

A medical child support order is a judgment, decree or order (including an approval of a property settlement) that:

- Is made pursuant to state domestic relations law (including a community property law) or certain other state laws relating to medical child support; and
- Provides for child support or health benefit coverage for a child of a participant under a group health plan and relates to benefits under the plan.

Must a medical child support order be issued by a state court?

No. Any judgment, decree or order that is issued by a court of competent jurisdiction or an administrative agency authorized to issue child support orders under state law (such as a state child support enforcement agency) that provides for medical support of a child is a medical child support order.

Who can be an alternate recipient?

Any child of a participant in a group health plan who is recognized under a medical child support order as having a right to enrollment under the plan with respect to such participant is an alternate recipient.

What information must a medical child support order contain to be considered a "qualified" order?

A medical child support order must contain the following information in order to be qualified:

- The name and last known mailing address of the participant and each alternate recipient (the order may substitute the name and mailing address of a state or local official for the mailing address of any alternate recipient);
- A reasonable description of the type of health coverage to be provided to each alternate recipient (or the manner in which such coverage is to be determined); and
- The period to which the order applies.

What other requirements must a medical child support order meet in order to be considered "qualified"?

An order may not require a plan to provide any type or form of benefit—or any option—not otherwise provided under the plan, except to the extent necessary to meet the requirements of certain state laws.

What state laws relating to medical child support can be enforced by a QMCSO?

At the time that the QMCSO provisions were added to ERISA, Congress also added Section 1908 to the Social Security Act. Section 1908 says that states cannot receive federal Medicaid funds unless they have specific state laws in place relating to medical child support. States must have laws that:

- Require health insurers to enroll a child under his or her parent's health insurance, even if the child was born out of wedlock, does not reside with the insured parent or in the insurer's service area, or is not claimed as a dependent on the parent's federal income tax return;
- Require a health insurer to enroll a child pursuant to court or administrative order without regard to the plan's open season restrictions;
- Require employers and insurers to comply with court or administrative orders requiring the parent to provide health coverage for a child; and
- Require insurers to permit a custodial parent to file claims on behalf of his or her child under the non-custodial parent's health insurance and to make benefit payments to the custodial parent or health care provider.

What may a QMCSO do to enforce these state medical child support laws?

If a QMCSO refers to these state laws or requires a plan to comply with the substantive requirements contained in the state laws, the plan must comply with them. For instance, a QMCSO may require a plan to enroll a child before the plan's next open enrollment period.

Who determines whether a medical child support order is qualified?

The administrator of the group health plan is required to determine whether an order is qualified. The administrator is required to make this determination within a reasonable period of time pursuant to reasonable written procedures that have been adopted by the plan. The administrator must first notify the participant and the alternate recipient when the plan receives a medical child support order and must give them copies of the plan's procedures for determining whether it is qualified. The administrator must notify those parties of its determination whether or not the order is qualified.

How long may a plan administrator take to determine whether a medical child support order (other than a NMSN) is qualified?

Plan administrators must determine whether a medical child support order is qualified within a reasonable period of time after receiving the order. What is a reasonable period will depend on the circumstances. For example, an order that is clear and complete when submitted should require less time to review than one that is incomplete or unclear. The NMSN provisions contain separate, specific time limits on the processing of the notice by employers and plan administrators.

If an order names an employee who is not enrolled in the plan, but is eligible to enroll, can the order be a medical child support order within the meaning of the QMCSO provisions?

Yes. An employee who is eligible to enroll is a participant in the plan. Thus, the order is a medical child support order.

In the case of an employee named in a medical child support order who is not enrolled, what is the plan's obligation?

The plan administrator must determine if the order is qualified, and, if so, provide coverage to the child. If the employee is eligible to participate in the plan, the child must be covered. If the employee must be enrolled as a condition for covering his or her dependents, the plan must enroll both.

If an order names an employee who has not yet satisfied the plan's generally applicable waiting period, can the order be a medical child support order within the meaning of the QMCSO provisions?

Yes. An employee who has not yet satisfied a plan's generally applicable waiting period (such as requiring that the person be employed for a certain number of days or work a certain number of hours before being eligible for benefits) is also a participant in the plan, and the order is a medical child support order.

In the case of an employee named in a medical child support order who has not satisfied the plan's generally applicable waiting period, what is the plan's obligation?

The plan administrator must determine if the order is qualified. If the order is qualified, the administrator should have procedures in place so that the child will begin receiving benefits upon the employee's satisfaction of the waiting period.

If a group health plan does not provide any dependent coverage, may a medical child support order require the plan to provide coverage for a child of a participant pursuant to a QMCSO?

No. A medical child support order is not qualified if it requires a plan to provide a type or form of benefit or option not otherwise available under the plan. An order may not require a plan to provide dependent coverage when that option is not otherwise available under the plan.

In determining whether a medical child support order is qualified, is the plan administrator required to determine whether the order is valid under state law?

No. A plan administrator generally is not required to determine whether the issuing court or agency had jurisdiction to issue an order, whether state law is correctly applied in an order, whether service was properly made on the parties or whether an individual identified in an order as an alternate recipient is in fact a child of the participant.

Is a plan administrator required to reject a medical child support order as not qualified if the order fails to include factual identifying information that is easily obtainable by the administrator?

No. In many cases, an order that is submitted to the plan may clearly describe the identity and rights of the parties, but may be incomplete only with respect to factual identifying information within the plan administrator's knowledge or easily obtained through a simple communication with the alternate recipient's custodial parent, the participant or the state child support enforcement agency. For example, an order may misstate the names of the participant or alternate recipients and

the plan administrator can clearly determine the correct names, or an order may omit the addresses of the participant or alternate recipients and the plan administrator's records include this information. In that case, the plan administrator should supplement the order with the appropriate identifying information, rather than rejecting the order as not qualified.

What is a "reasonable description" of the type of coverage to be provided to the child?

The order need only provide a coverage description that enables the plan administrator to determine which of the available options and levels of coverage should be provided to the child. For instance, if an order requires that a child be provided any coverage available under the plan, the plan administrator would determine the coverage available under the plan (for example, major medical, hospitalization, and dental) and provide that coverage to the alternate recipient. However, if the plan offers more than one type of coverage (for example, an HMO and a fee-for-service option), the order should make clear which should be provided or how the choice is to be made. If the order is unclear, the plan's procedures may direct the administrator to contact the submitting party, or may provide other selection methods similar to those established for the processing of NMSNs. If the plan does not have these types of procedures, the administrator may have to reject the order.

If a plan provides benefits solely through an HMO or other managed care organization with a geographically limited benefit area, is the plan required to create and provide comparable benefits to an alternate recipient who resides outside of the HMO's service area?

No. A medical child support order is not qualified if it requires a plan to provide a type or form of benefit that is not otherwise available under the plan. Requiring a plan that provides benefits solely through a limited-area HMO to provide benefits to alternate recipients outside of the HMO's service area (that is, on a fee-for-service or any other basis), would be requiring the plan to provide a form of benefit that the plan does not ordinarily provide. On the other hand, if the child is able to come into the HMO's service area for medical care, the plan would be required to provide benefits to the alternate recipient.

May a plan provide benefits to a child of a participant pursuant to a medical child support order that is not a qualified order?

ERISA does not prohibit the plan from providing this coverage pursuant to the terms of any medical child support order, regardless of whether the order satisfies the qualification requirements of Section 609(a), provided that the terms of the plan do not otherwise prohibit coverage of the child for any other reasons.

If a child is covered by a group health plan pursuant to a QMCSO, does the child have any rights to continuation coverage?

Yes. A child covered by a group health plan pursuant to a QMCSO is a beneficiary under the plan. The Internal Revenue Service (which has jurisdiction over questions related to continuation coverage) has informed the DOL that a child covered pursuant to a QMCSO is therefore a "qualified beneficiary" with the right to elect continuation coverage under COBRA, if the plan is subject to COBRA and if the child loses coverage as a result of a qualifying event.

When must a plan begin to provide coverage to an alternate recipient pursuant to a QMCSO?

The DOL believes that, following a determination that an order is qualified, the alternate recipient (and the participant, if necessary) must be enrolled as of the earliest possible date following that determination. For example, if an insured plan only adds new participants or beneficiaries as of the first day of each month, that plan would be required to provide coverage to the alternate recipient as of the first day of the first month following the determination that the order is qualified. As described previously, the state laws described in the Social Security Act require that when a child is enrolled in a plan pursuant to a court or administrative order, that enrollment be made without regard to open season restrictions.

What information should a group health plan make available to parties seeking to obtain health coverage for a child before the plan receives a medical child support order?

The DOL believes that Congress intended custodial parents and/or state child support enforcement agencies acting on the child's behalf to have access to plan and participant benefit information sufficient to prepare a QMCSO. Information important for that purpose would include the summary plan description, relevant plan documents and a description of any particular coverage options, if any, that have been selected by the participant.

The DOL believes that Congress did not intend to require parties seeking coverage of a child to first submit a medical child support order to the plan in order to establish rights to information in connection with a child support proceeding. However, a plan administrator may condition disclosure of such information on receiving information sufficient to reasonably establish that the disclosure request is being made in connection with a child support proceeding. A disclosure request from a state child support enforcement agency should be assumed to be made in connection with a child support proceeding.

What effect does an order that a plan administrator has determined to be a QMCSO have on the administration of the plan?

The plan administrator must act in accordance with the provisions of the QMCSO as if it were part of the plan. In particular, any payment for benefits in reimbursement for expenses paid by an alternate recipient or an alternate recipient's custodial parent or legal guardian must be made to the alternate recipient, custodial parent or legal guardian.

If a plan provides that dependents of participants must be enrolled in the same coverage and option as the participant, must an alternate recipient be enrolled in the same coverage and options in which the participant is enrolled?

Yes. Pursuant to Section 609, an alternate recipient under a QMCSO is treated as a beneficiary under the plan. Accordingly, the DOL believes that an alternate recipient is also treated as a dependent of the participant under the plan. (However, if a QMCSO specifies that an alternate recipient is to receive a particular level of coverage, or option, that is available under the plan, but the participant is not enrolled in the particular coverage or has not selected the particular option, the plan may be required to change the participant's enrollment to the extent necessary to provide the specified coverage to the alternate recipient.)

If the plan requires additional employee contributions or premiums for coverage of a child named in a QMCSO, who is obligated to pay that additional amount?

The medical child support order will ordinarily establish the obligations of the parties for the child's support. In most cases, the obligor under a medical child support order will be the non-custodial parent who is a participant in a group health plan and is responsible for the payment of any costs associated with the provision of coverage.

What is the plan's obligation in the event that the employer is unable to withhold from the participant's paycheck the employee contributions necessary to provide coverage to the child?

If federal or state withholding limitations prevent withholding from the participant's paycheck the additional contribution required to provide coverage to the child under the terms of the plan, the employer should notify the custodial parent (and the child support enforcement agency, if the agency is involved). Unless the employer is able to withhold the necessary contribution from the participant's paycheck, the plan is not required to extend coverage to the child. However, the custodial parent or the agency may be able to modify the amount of cash support to be provided, in order to enable the employer to withhold the required contribution to the plan. The participant may also voluntarily consent to the withholding of an amount otherwise in excess of applicable withholding limitations.

To whom should the plan pay benefits?

The plan should pay benefits to the alternate recipient, the custodial parent or the provider of health services to the child notwithstanding plan terms that may require benefit payments be made to the participant. In some instances, payment will be required to be made to the state child support enforcement or Medicaid agency.

When and under what conditions may a plan disenroll an alternate recipient?

A plan may disenroll an alternate recipient at the same time and under the same conditions as it can disenroll other dependents of participants under the plan. For instance, if the plan terminates coverage when a participant terminates employment, and neither the participant nor the alternate recipient elects COBRA continuation coverage, the plan may discontinue coverage for the alternate recipient.

National Medical Support Notices

What is the NMSN?

The NMSN is a standardized medical child support order that is to be used by state child support enforcement agencies to enforce medical child support obligations.

When is the NMSN sent to the employer?

Child support agencies send the NMSN to employers when appropriate. Specifically, when:

- A new child support order is issued requiring a parent to provide medical coverage;
- An existing order is modified;
- The parent(s) ordered to provide health care coverage has a change in employment; or
- It is not clear that the parent is complying with an existing order to provide coverage.

The NMSN is divided into two parts: Part A and Part B. Part A is a Notice to Withhold for Health Care Coverage and includes the employer response and instructions. Part B is a Medical Support Notice to the Plan Administrator and includes the plan administrator response and instructions.

What are a plan administrator's obligations upon receipt of a NMSN?

A plan administrator who receives a NMSN must review the notice and determine whether it is appropriately completed. The administrator must complete the Plan Administrator Response (included with Part B of the notice), indicating whether the notice is a QMCSO, and return it to the state agency that issued the notice within 40 business days after the date of the notice.

If the plan administrator determines that the NMSN is appropriately completed, the administrator is required to treat the notice as a QMCSO. The plan administrator must, in that case:

- Inform the state agency that issued the NMSN when coverage under the plan of the child named in the notice will begin; and
- Provide the custodial parent of the child (or, in some cases, a named state official) with information about the child's coverage under the plan, such as the plan's summary plan description, any forms or documents necessary to make claims under the plan, etc.

If the participant is not enrolled and there is more than one option available under the plan for coverage of the child, the plan administrator must also use the Plan Administrator Response to notify the agency of that fact, and inform them of the available options for coverage. If the agency does not then respond within 20 business days and the plan has a "default option," the plan administrator may enroll the child in the default option.

What is an "appropriately completed" NMSN?

An appropriately completed notice includes the following information:

- The name of an issuing state child support enforcement agency;
- The name and mailing address of the employee, enrolled or eligible for enrollment, who is obligated by a state court or administrative order to provide medical support for each named child; and
- The name and mailing address of each child covered by the notice (the name and address of a state or local official may be substituted for the address of the child).

A notice may be "appropriately completed" even if some items of information in the notice are not included, as long as the notice includes the information listed above. In addition, if any of the necessary information described above has been omitted but is reasonably available to the plan administrator, the notice should not fail to be "appropriately completed" solely because of that omission.

How does a NMSN satisfy the QMCSO requirements?

An appropriately completed notice satisfies the informational requirements of the QMCSO provisions by:

- Providing the name and last known mailing address (if any) of the participant and the name and mailing address of each child covered by the order;
- Having the child support enforcement agency identify either the specific type of coverage or all available group health coverage;
- Instructing the plan administrator that:
    - If a notice does not designate either specific type(s) of coverage or all available coverage, it should assume that all are designated;
    - If a group health plan has multiple options and the participant is not enrolled, the agency will make a selection after the notice is qualified; and
    - If the agency does not respond within 20 business days, the child will be enrolled under the plan's default option (if there is one); and
- Specifying that the period of coverage may end for the named child only when similarly situated dependents are no longer eligible for coverage under the terms of the plan, or upon the occurrence of events specified in the notice.

What if the non-custodial parent is not yet eligible to enroll because he or she has not satisfied the plan's generally applicable waiting period?

A plan administrator may not find a medical child support order, including a NMSN, to be not qualified solely because the participant is subject to a waiting period (such as one requiring a certain number of months or hours worked). A waiting period may, however, affect the procedures necessary for enrollment of the named child.

Assuming a NMSN otherwise meets the requirements to be a QMCSO:

- For short waiting periods (90 days or less remaining at the time of the plan administrator's receipt of Part B), the plan administrator qualifies the notice and waits until the expiration of the necessary time to enroll the child and notify the employer of the need, if any, to withhold from the employee's wages to provide coverage.
- For long waiting periods (greater than 90 days remaining at the time of the plan administrator's receipt of Part B, or the period is measured by other means, such as hours worked), the plan administrator should inform the employer of the waiting period and wait for notification from the employer of the employee's satisfaction of the waiting period.

What are the duties of an employer that has been notified of the qualification of a NMSN?

Following notification of qualification, the employer must determine if necessary employee contributions may be withheld from the employee's wages without violating any applicable withholding limits. Part A of the notice contains information for the employer regarding federal and state limitations on withholdings, any applicable withholding prioritization laws and the duration of the withholding obligation.

If withholding limits would prevent the employer from withholding the employee contributions necessary for coverage, the employer must use the Employer Response on Part A to notify the issuing IV-D Agency of its inability to withhold the necessary amounts. If the amounts necessary for coverage may be withheld, then the employer must initiate the withholding and transmit the withheld amounts to the group health plan to pay for the child's coverage.

Who pays for coverage provided pursuant to a NMSN?

The NMSN provides that the employee named in the notice is liable for any employee contributions required under the plan for enrollment of the children. However, if federal or state withholding limitations prevent the withholding of the required employee contributions from the employee's paycheck, the plan is not required to provide coverage to the child. The employer is required to notify the state agency if withholding limitations prevent the withholding of the required employee contributions.

Source: Departments of Labor and Health and Human Services