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RESEARCH MEMO

TIC INTERNATIONAL CORPORATION

TO: MANAGERS, CONSULTANTS, OTHER PROFESSIONALS

FROM: DAVID LIVINGSTON, DIRECTOR OF RESEARCH

RE: **DOL ISSUES *COMPLIANCE ASSISTANCE GUIDE* FOR HANDLING OF CHILD MEDICAL SUPPORT ORDERS BY GROUP HEALTH CARE PLANS**

-- SEE ATTACHMENT FOR CERTAIN COMPLIANCE MATERIALS

BACKGROUND

From time to time contributing employers and group health care plan administrators may receive what is called a *National Medical Support Notice* from a State court or some other State child support agency. This Notice, if qualified, requires plans to provide continuing health care coverage to the child of a noncustodial parent in the event of a divorce or legal separation and is referred to as a child medical support order.

Until recently these orders took many different forms and formats in different states which, in turn, created some confusion in their processing by group health care plans. In **October 2001** a new standardized national form became effective for all states receiving Medicaid funds from the federal government. This Notice imposes certain requirements on state child support agencies and on ERISA group health plans.

On August 4, 2003 the Employee Benefit Security Administration (EBSA) of the Department of Labor (DOL) published on its website, a *Compliance Assistance Guide For Qualified Medical Child Support Orders* which tells State and group health plans everything they need to know (and more!) about how to handle the new *National Medical Child Support Notice* (NMCSN). This guide answers general questions about medical child support orders, the role of State child support enforcement agencies in obtaining coverage for children, and the responsibility of group health care plan administrators in processing and implementing such orders.

Anyone involved with the processing of child medical support orders should download and review this Guide in its entirety as soon as possible at:
www.dol.gov/ebsa/publications/qmcso.html

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The purpose of this Research Memo is to highlight some of the major requirements imposed on group health plans for handling child medical support orders by answering such questions as:

1. What is a qualified medical child support order (QMCSO)?

2. What is the national medical child support notice (NMCSN)?

3. What is the plan administrator's responsibility when he receives a NMCSN)?

4. What coverage does a group health care plan have to provide under a NMCSN?

Before answering these questions, there is a discussion below regarding the need to explain the new NMCSN to contributing employers in a multiemployer health plan situation in order to avoid some confusion. A sample letter, newsletter, or article is attached to this Memo for this purpose.

Also attached to this Memo is Part B which is the form that must be completed by someone at the fund office, in consultation with fund counsel, and then returned to the issuing State child support agency or State court.

POSSIBLE CONFUSION FOR CONTRIBUTING EMPLOYERS

The new national medical support notice will go a long way toward simplification and clarification of child medical support orders processed by group health plans. But for contributing employers in a multiemployer health plan, it will probably introduce some confusion because the employer is the party most likely to initially receive the NMCSN from a State court or State agency and will be asked to complete Part A. The State spends most of its time initially generating information about a noncustodial parent's employment history and current employment situation so that a medical child support order is often sent first to the address of the noncustodial parent's last employer or former employer.

Part A asks the employer questions about the noncustodial parent's current eligibility and coverage under the plan. This may work for single employer plans but not for multiemployer plans. Under a multiemployer health plan a contributing employer generally does NOT know what the eligibility of each employee is or if health care options are available under the plan what option(s) may have been elected by a particular employee. Generally only the multiemployer plan fund office is likely to have this information. In effect, Part A is a futile request in a multiemployer plan situation (although the employer should answer whatever questions he can for his own records).

Part B is a section which must be completed by the group plan administrator (i.e., the fund office) and the employer bears a responsibility for making sure that the administrator receives Part B within 20 business days after receipt of the NMCSN.

The primary reason for Part A is to get the employer to agree to withhold the appropriate premium from the noncustodial parent's wages to pay for the child's medical support. But this is not possible in a multiemployer plan situation since premiums are rarely withheld from wages to pay for a participant's coverage or coverage for his or her dependents. Moreover, unlike a single employer plan, dependent coverage under a multiemployer plan does not usually require a separate premium or self-payment (except under COBRA). Dependent coverage under a multiemployer plan is usually automatic and occurs as soon as the participant earns initial eligibility. Eligibility is almost always based on hours worked and employer contributions made or by self-payments. At any rate, it would not be surprising for a contributing employer who reviews Part A to wonder what this new notice is all about and to call the fund office to find out!

For this reason **it would be advisable to communicate as soon as possible** with every contributing employer to a multiemployer health plan regarding the existence of the NMCSN and how it should be handled. This may be accomplished with a separate letter to each participating employer or an article in the fund's monthly newsletter or the employer association's newsletter. **A SAMPLE IS ATTACHED FOR CONSIDERATION BY FUND COUNSEL.**

In the sample the employer is instructed to simply send **the entire notice (Part A and Part B) immediately** to the fund office with a promise that the fund office will take care of getting whatever is required back to the State court or agency and to the custodial parent and alternate payee. Employers should be relieved to have the fund office pick up this responsibility and can have confidence that the national notice will be properly implemented.

1. WHAT IS A MEDICAL CHILD SUPPORT ORDER (MCSO)?

According to the answer to Q1-3 of the *Compliance Guide* **(page 3)**:

> A Medical Child Support Order is a judgment, decree, or order (including an approval of a property settlement) that: (1) is made pursuant to State domestic relations law (including a community property law) or certain other State laws relating to medical child support (see Q1-8); and (2) 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.

Such an order is often issued by a State court but it may also be issued by some other State (or even County) child support agency.

2. WHAT IS A NATIONAL MEDICAL CHILD SUPPORT NOTICE (NMCSN)?

Until the year 2000 a Medical Child Support Order took different forms with many states designing and using their own forms. All too often the form used was incomplete or needed further clarification before the administrator of a group health plan (or fund office staff) could

determine whether or not the order was a "qualified" order. This meant additional contacts with the State and additional work by fund office staff before the order could be processed.

In recognition of this problem, the DOL appointed a special Task Force in 1993 to see if a NMCSN could be created so that processing of such notices could be simplified and expedited. Such a notice was released in 2001 with **an effective date of October 1, 2001.**

States are required to adopt certain State laws to help implement the national notice. To date about 35 states have done so. Some delays have occurred because State legislatures have not been in session or have not yet been able to gear up for changes in their computer systems to accommodate the new notice. Eventually it is expected that all states will come on board because failure to do so may mean a loss of Medicaid funds under federal law.

3. WHAT IS A GROUP HEALTH PLAN REQUIRED TO DO WHEN IT RECEIVES A NMCSN?

It is up to the plan administrator (i.e., the fund office and fund counsel in the case of a multiemployer plan) to determine whether or not a child medical support order is "qualified" (just as it is the job of a pension plan administrator to determine whether or not a domestic relations order is "qualified.") Completion of **Part B** of the notice entitled "Plan Administrator Response" is designed for this purpose (see attachment).

According to the answer to Q1-11 on **page 5**, a NMCSN "must be deemed to be a qualified medical child support order pursuant to ERISA 609(a)(5)(C) …if the Notice is appropriately completed." (emphasis added) In other words, the NMCSN must be given considerable deference as a qualified medical child support order if it is appropriately completed by a State court or State agency. To be considered "appropriately completed," the Notice must contain:

- Name of the issuing State agency
- Name and last known mailing address of an employee who is the participant under the plan.
- Name and last known mailing address of each alternate recipient(s) – child or children of the participant to whom the order applies.
- A reasonable description of the type of coverage to be provided for the child (or children) or the manner in which such coverage is to be determined: and
- The period of time for which the coverage must be provided.

The plan administrator may return the Notice to the appropriate state agency if there is any information missing or if any of the information needs further clarification before the plan can make a determination as to whether or not the Notice is qualified.

In addition to determining the qualified status of a child medical support order, the plan administrator must 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 a qualified order. Subsequently the administrator must notify those parties of its determination. (Q1-10, page 5)

For this reason **it is essential** that every group health care plan adopt (if it has not done so already) a set of procedures describing what steps the plan will take to determine whether a child medical support order is qualified, who is involved in that determination, how soon the alternate recipient will be informed about that determination, and what appeal may be available.

How Much Time Does A Plan Administrator Have To Make A Determination?

According to the answers to Q1-11 and Q2-4 (**pages 5 and 12**), plan administrators must determine whether a medical support order is qualified **"within a reasonable period of time"** after receiving the order. The Guide concedes that automatic approval is not required and that on occasion, a NMCSN "may be incomplete or unclear" and that a plan needs adequate time to review the Notice.

Nevertheless, the maximum period of time allowed for the plan administrator to complete Part B of the Notice is "40 business days after the date of the Notice." (emphasis added – Q2-4, **page 12**)

If a plan administrator determines that the Notice is appropriately completed, the administrator is required to treat the Notice as a QMCSO. In that case the plan administrator **must inform the State agency** that issued the Notice when coverage under the plan of the child named in the Notice will begin and **must provide the custodial parent of the child** (or his legal representative) 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.** (Second paragraph, Q2-4, **page 12**)

If the participant is not yet enrolled or there is more than one option available under the plan for coverage of the child, the plan administrator must also use Part B to notify the State court or State agency of that fact and inform the agency of the available options for coverage. If the State court or agency for child medical support does not respond **within 20 business days** and the plan has a "default option" the plan administrator may enroll the child in the default option. (Third paragraph in answer to Q2-4, **page 12**)

4. WHAT COVERAGE MUST THE PLAN PROVIDE?

If the order is a qualified order, the plan is required to provide the same coverage to the child specified in the order as would be provided to any other child of a participant under the terms of the plan. Nothing more, nothing less! **According to the answer to Q1-7 on page 4 of the Guide:**

> 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 described in Q1-8 below.

The exemption cited in Q1-8 may prove troublesome for certain plans. The answer to Q1-8 indicates that when issuing a NMCSN, the states must have in force certain state laws regarding child medical support. For example, a state must have laws which (among other things):

> … 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; (emphasis added - Q1-8, **page 4**)

Notice here the specific reference to "health insurers" and "health insurance" which may be interpreted to mean that State laws mandating benefits for the child of an unmarried parent or to a child living outside of the service area would apply to insured plans only and NOT to self-funded plans. Presumably application to self-funded plans would be preempted by ERISA.

However, the legislative history related to the national medical child support notice refers to the state requirements being applicable to "all group health plans." Moreover, the Supreme Court recently ruled that self-funded plans are in the "business of providing health insurance" if the risks and costs are spread over a large number of participants (see *Benefit News Briefs 2003-26*, 6/26/03, the Kentucky case on **pages 2-5**).

Some self-funded multiemployer plans do not extend coverage to the child of an unmarried parent. As a result, a self-funded multiemployer plan may find itself in conflict with a State child support agency on this issue. However, this situation may be unlikely to occur very often because there are usually other state-sponsored health programs, including Medicaid, designed to provide coverage for such children.

Notice that the requirement for a State law requiring coverage for the child outside of the normal service area of the plan is qualified later on in the answer to Q1-20, **page 7**, dealing with HMOs:

> … 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 (i.e., 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. (Q1-20, **page 7**)

In summary, it is reasonable to expect that from time to time there may be some differences between what the State thinks is required in the way of coverage under a self-funded plan and what the plan itself thinks it is required to do under ERISA. Hopefully such differences can be resolved without having to run to federal court.

Is A Plan Allowed To Impose Waiting Periods For Coverage Under A Child Support Order?

YES, according to the answer to Q1-15, **page 6**, which states:

> An employee who has not yet satisfied a plan's generally applicable waiting period [for coverage under the plan], 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 support order.

The answer to Q1-15 goes on to specify the plan's obligation under these circumstances which is to determine if the order is qualified and "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."

Although plans do not routinely estimate dates that each participant may become eligible for coverage under the plan, it may be appropriate to devise some system for "red-flagging" when it is likely that a child covered under a QMSCO will first qualify for coverage under the terms of the plan (i.e., when the noncustodial parent is likely to first become eligible).

CONCLUDING OBSERVATIONS

The Department of Labor has probably done group health plans a favor by developing a national medical child support notice and mandating its use by State courts and State agencies. With the use of a standard notice, there should be less confusion among interested parties as to what their responsibilities are for continuing to provide health coverage to the child of a divorcee or someone legally separated and some savings of the time required for review of child support orders regarding their qualified status.

As noted earlier, a contributing employer may be a bit confused for a while if he receives the Notice but that confusion can be easily eliminated by alerting contributing employers about the new Notice and instructing them to forward it immediately to the fund office. (See sample letter or article attached to this Memo.)

In conclusion, it should be noted that the plan has **no enforcement responsibilities** relative to the child medical support order. Its job is limited to providing the coverage it has agreed to provide under the terms of the "qualified" order. This means that a plan may terminate coverage if premiums or self-payments are not paid on time to the plan or if the participant fails to maintain his eligibility under the terms of the plan. Of course, the State enforcement agency should be immediately informed about such termination of coverage so that it can take prompt action with the interested parties.

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For Use in a Letter, Newsletter, or Article Format

TO: CONTRIBUTING EMPLOYERS TO XYZ FUND

FROM: BOARD OF TRUSTEES

SUBJECT: NEW NATIONAL MEDICAL CHILD SUPPORT ORDERS

From time to time you may receive what is called a *National Medical Support Notice* from a State court or a State child support enforcement agency. This notice generally requires a noncustodial parent to provide continuing health coverage for a child (or children) for some specified period of time in the event of a divorce or legal separation. You are receiving this notice because you probably were the last employer of the noncustodial parent.

Part A of the notice is intended for employer's to fill out. It asks questions about the noncustodial parent's eligibility for health care benefits and if eligible, requests the employer to withhold the applicable health care premium from the employee's paycheck for child medical support. Apparently no one thought about a multiemployer health care plan situation where employers generally do not deduct health care premiums from a paycheck but contribute cents per hour to a common fund. Moreover, in most cases, a contributing employer does not know what an employee's current eligibility status is. **Consequently completion of Part A by a contributing employer is NOT feasible.**

The employer is responsible, however, for forwarding **Part B** to the health care plan administrator, that is, to the fund office. This must be done in not less than 20 days (preferably earlier) after the date of receipt.

In order to avoid any confusion and to expedite correct processing of a national medical support notice if you receive one, MAIL THE ENTIRE NOTICE IMMEDIATELY (<u>BOTH PART A AND PART B</u>) TO THE FUND OFFICE. NO FURTHER ACTION IS NEEDED ON YOUR PART! THE FUND OFFICE WILL TAKE CARE OF ANY FURTHER PROCESSING AND WILL SEND THE REQUIRED INFORMATION TO THE APPROPRIATE STATE CHILD SUPPORT AGENCY.

Thank you very much for your cooperation.

(SUBJECT TO REVIEW BY FUND COUNSEL.)