Employer's Guide to Qualified Medical Child Support Orders

Benefits & Human Resources Consulting

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Section 1 – Introduction

This guide to Qualified Medical Child Support Orders (QMCSOs) was created to provide a basic, but practical, summary of the major QMCSO rules as of August 1, 2021. It provides information on:

- QMCSO administrative requirements
- QMCSO enrollment, disenrollment, and employee contribution requirements
- Summary applicable requirements other than QMCSO rules
- Sample procedures and documents

We also include a few general comments on consulting issues such as insurer rules or employer administrative concerns.

What this guide does **NOT** do:

- It does not include consulting advice such as whether a particular medical child support order is a QMCSO.
- It does not include a broad discussion of other federal (or state) laws that impact benefits provided through QMCSOs such as ERISA, COBRA, or HIPAA Privacy and Security.
- It does not provide legal advice.

Private employers – both for profit and nonprofit – are required to comply with QMCSOs and National Medical Support Notices (NMSNs). Employers, including nonfederal governmental and church employers, are also required to comply with NMSN requirements. Requirements for QMCSOs and NMSNs are similar, but not identical. Both are discussed in this guide.

This guide is intended to provide a basic, working knowledge of QMCSO rules. It is not an exhaustive discussion of all of the Department of Labor (DOL) rules or nuances. It is intended to be a starting point; more detailed research may be required in specific areas.

Section 2 – Definitions

Basic Definitions

Under ERISA, a **"qualified medical child support order"** means a medical child support order:

> (1) Which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under a group health plan, and
>
> (2) With respect to which the requirements [regarding information to be included in a qualified order] and [regarding restrictions on new types or forms of benefits] are met.

A **"medical child support order"** is any judgment, decree, or order (including approval of a settlement agreement) which:

> (1) Provides for child support for a child of a participant under a group health plan or provides for health benefit coverage for such a child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under such plan, or
>
> (2) Is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act with respect to a group health plan, if the judgment, decree, or order (a) is issued by a court of competent jurisdiction or (b) is issued through an administrative process established under state law and has the force and effect of law under applicable state law.

If a medical child support order is "qualified," it is a QMCSO. A medical child support order is "qualified" when the plan administrator determines that the order contains the correct, necessary information and does not require any type or form of benefits, or benefit option, not otherwise provided under the applicable health plan (except to the extent that those obligations are necessary under applicable state law).

A **"National Medical Support Notice"** (NMSN) may also be a QMCSO, and in fact, a correctly completed NMSN is deemed to be a QMCSO.

National Medical Support Notices are standardized medical child support orders used by state child support enforcement agencies to obtain group health coverage for children. An "appropriately completed" NMSN is deemed to be a QMCSO, and a group health plan subject to ERISA must comply with it. Under federal law, state and local governmental plans and church plans that are not otherwise subject to ERISA must also comply with NMSNs.

An "appropriately completed" NMSN is a notice that includes the following information: (1) the name of an issuing State child support enforcement agency; (2) 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 (3) the name and mailing address of each child covered by the Notice. The 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 NMSN are not included as long as the NMSN 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, then the NMSN should not fail to be "appropriately completed" solely because of those omissions.

An **"alternate recipient"** is any child of a participant in a group health plan who is recognized under a medical child support order as having a right to enroll under the plan with respect to the participant.

"Participant" is not a defined term for purposes of QMCSOs. However, other parts of ERISA define a participant as "any employee or former employee of an employer…who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer…or whose beneficiaries may be eligible to receive any such benefit." Generally, this means "employees in, or reasonably expected to be in, currently covered employment." Thus, the scope of the term "participant" would include employees who are eligible for a plan but who are not currently enrolled.

The QMCSO provisions apply to **"group health plans"** subject to ERISA. For this purpose, a "group health plan" generally is a plan that (1) is sponsored by an employer or employee organization (or both) and (2) provides "medical care" to employees, former employees, or their families. ERISA does not generally apply to plans maintained by: federal, state, or local governments; non-electing churches; or employers providing benefits solely for purposes of complying with applicable state workers compensation or disability laws. However, the Child Support Performance and Incentive Act (CSPIA) of 1998 requires church plans to comply with QMCSOs and NMSNs, and state and local government plans to comply with NMSNs.

"Medical care" means amounts paid for: (1) the diagnosis, cure, mitigation, treatment or prevention of a disease; (2) the purpose of affecting any structure or function of the body; (3) transportation primarily for or essential to such care or services; or (4) for insurance covering such care or services. Thus, the definition includes many benefits in addition to major medical benefits (e.g., dental and vision plans, health FSAs, health reimbursement arrangements (HRAs), and employee assistance plans (EAPs)). However, the definition does not include any plan that substantially provides for "qualified long-term care services."

Section 3 – Administration

Federal law requires that health plans comply with certain administrative requirements for QMCSOs. Those requirements include written procedures that address how to determine whether a medical child support order is qualified and what steps to take upon receipt of a medical child support order. The main administrative requirements based upon receipt of a medical child support order are addressed below.

Use of Written Procedures

Each group health plan must establish reasonable procedures to determine whether medical child support orders are QMCSOs and to administer the provision of benefits under those orders. The procedures must: (1) be in writing; (2) provide that each person specified in a medical child support order as eligible to receive benefits under the plan will be notified of such procedures (at the address included in the order) promptly upon the plan's receipt of the order; and (3) permit an alternate recipient to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a medical child support order. The representative may be a custodial parent, a state agency, or another designated individuals.

Generally, the procedures should include a qualification checklist for the plan administrator to use when reviewing medical child support orders and form notification letters for advising plan participants and alternate recipients (see **Section 6 – Sample QMCSO Procedures**). As a best practice, a plan administrator may also wish to prepare a sample of a QMCSO that is not defective to provide to an alternate recipient when the plan receives a defective order.

Receipt of a Medical Child Support Order

When a plan first receives a medical child support order, the plan administrator must promptly notify the participant and the alternate recipient that it received the order and provide information about the plan's procedures for determining whether the order is a QMCSO. As a best practice, plan administrators may satisfy the notice requirement by including a copy of the plan's QMCSO procedures with the notice of receipt of the order. Within a reasonable period of time after receiving the order, the plan administrator must determine whether the order is a QMCSO and then notify the participant and the alternate recipient of the decision and provide any forms required in order to "effectuate coverage." These notices are subject to ERISA's disclosure rules and thus must be provided using "measures reasonably calculated to ensure actual receipt." Generally, this involves the use of first-class mail.

Receipt of a NMSN

A NMSN contains two parts that are used by state agencies to obtain health coverage for children based on certain events. Part B, the "Medical Support Notice to Plan

Administrator," is a form that includes specific information about the state agency, the child to be covered, the employee, the type of coverage the child is to be enrolled in, and the employer. This form is completed by the state agency and sent to the plan administrator. Part A, the "Notice to Withhold for Health Care Coverage," includes information about the state agency, the child to be covered, and the employee. That part is completed by the state agency and sent to the employer and directs the employer enroll specified child(ren) and make appropriate payroll deductions. Part B contains a form to be completed by the plan administrator and returned to the state agency along with instructions for the plan administrator. Part A contains a form to be completed by the employer and includes instructions for the employer. Parts A and B are included in the Appendix in the DOL's QMCSO guide which is available at: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/qualified-medical-child-support-orders.pdf. Please note that the DOL's guide was last updated in 2020.

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

If the NMSN is a QMCSO, then the plan administrator must inform the state agency that issued the Notice when coverage under the plan for the child named in the Notice will begin. The plan administrator also must 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, and 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, then the plan administrator must also use the Plan Administrator Response to notify the agency of that fact, and identify 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.

Necessary Information for Qualification

A medical child support order must contain the following in order for the order to become a QMCSO:

> (1) The name and last known mailing address of the participant and alternate recipient. Note: The order may contain the name and mailing address of a state or local official for the mailing address of any alternate recipient;

(2) A reasonable description of the type of health coverage to be provided to each alternate recipient (or the way to determine which coverage is included); and

(3) The time period to which the order applies.

The order may not require a plan to provide any type of benefit, or any option, not otherwise provided under the plan, except to the extent necessary to meet the requirements of applicable state law.

Potential Issues

Following are examples of problems that may arise when administering QMCSOs. These are only samples of common problems, not an exhaustive list.

Employee is not eligible for plan participation

Employers may receive medical child support orders for children of individuals who are not eligible to participate in the benefits listed on the order. For example, a plan may receive a medical child support order for a part-time employee, who is not eligible for coverage under the plan terms. When a plan receives a medical child support order for a child of an ineligible employee, the plan is not required to provide coverage for the child.

In addition (though not likely for applicable large employers subject to the Employer Mandate under the Patient Protection and Affordable Care Act (ACA)), an Order or Notice may seek enrollment for a child in a plan that does not otherwise provide coverage for dependent children. In that case, the employer is also not required to enroll the child.

The employee is eligible, but not enrolled when the medical child support order is received

The plan administrator must determine if the order is a QMCSO and, if so, provide coverage to the child. If the employee is eligible to participate in the plan, the child must be covered. If, as a condition for covering dependents, the employee must be enrolled, then the plan must enroll both the employee and child. In addition, a cafeteria plan document may be drafted to permit election changes to add a dependent child pursuant to a QMCSO (and an employee if the employee is not already enrolled) if the addition would otherwise require a mid-year election change. However, plan sponsors must verify that their cafeteria plan (or Section 125 plan) documents address such situations before allowing an employee to change his or her salary reduction agreement to reflect the change in coverage. Otherwise, the employee should pay for the coverage on a post-tax basis until the next opportunity to make a salary reduction agreement change.

QMCSO seeks retroactive coverage

QMCSOs cannot require any new benefits. Thus, if an order would require coverage for a child that would differ from that provided to non-alternate recipient children, such as retroactive coverage in cases other than birth, then the plan is not required to comply. However, a plan may choose to provide retroactive coverage, but if it does so, it should obtain written assurances from any applicable insurer or stop loss insurer that the alternate recipient's claims will be covered during the period of retroactive coverage. Note that, while the insurer may permit retroactive coverage, the cafeteria plan may not. In that case, coverage may be paid for after tax.

Medical Child Support Order is not technically complete

Generally, plan administrators may wish to adopt a "substantial compliance" approach through which the administrator accepts technically deficient orders where all the material facts can be determined - such as factual identifying information that the plan administrator has or can easily obtain from the custodial parent, the participant, or the state child support enforcement agency. For example, the employee's address may be missing from the order, but if the plan administrator can easily obtain the employee's address from employment records or by contacting the employee, then the administrator may choose to approve the order as "qualified" rather than denying it for a technical deficiency. As a best practice, when a plan administrator approves a QMCSO based upon "substantial compliance," he or she should obtain a written insurance from the plan's insurer or stop lossinsurer, as applicable, that the child's claims will be covered.

Section 4 –Enrollment, Disenrollment, and Contributions

Enrollment

The QMCSO rules do not contain a “hard and fast” rule about how soon an alternate recipient must be enrolled. However, Section 1908 of the Social Security Act requires that, when a child is enrolled in a plan pursuant to a court or administrative order, the enrollment be made without regard to open enrollment restrictions. The DOL takes the position 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 such 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.

If a plan has multiple options, its QMCSO procedures should address how to choose. For example, if a major medical plan has three options – PPO 1, PPO 2, and an HMO, then the plan’s QMCSO procedures could provide that if an otherwise-qualified order does not designate one of the three options (and does not indicate how to choose), the plan administrator will qualify the order and enroll the alternate recipient in the same option as the employee if the employee is already enrolled. The plan could also designate the PPO 1 option as the “default option” so that if the employee is not enrolled, the plan administrator will send the employee, the alternate recipient, and any relevant state agency information about all three options with a notice that the employee and alternate recipient will be enrolled in the PPO 1 option (i.e., the default option) unless one of the other options is selected within a specific period of time such as 20 business days. Without applicable procedures (or other selection methods), the plan might have to reject an order that does not designate one of the three options or indicate how the choice is to be made.

Disenrollment

A plan may dis-enroll an alternate recipient at the same time and under the same conditions as it can dis-enroll other dependents under the plan. For example, if the plan terminates coverage when a participant terminates employment, and neither the participant nor the alternate recipient elect COBRA continuation coverage, then the plan may discontinue coverage for the alternate recipient. Likewise, if the plan ceases to provide coverage for dependents who are over the age of 26, then the coverage of an alternate recipient who is over the age of 26 may be terminated (assuming that continuation coverage is not elected). If there is a change in the order/notice that makes the custodial parent (or another party) responsible for providing coverage, then the plan may dis-enroll the alternate recipient but only if the plan has written confirmation that the other party is responsible and the other party has actually enrolled the child for coverage.

Contributions

ERISA does not address the premium amount that may be charged for an alternate recipient provided coverage pursuant to a QMCSO. However, it would be reasonable to assume that if an employee is already covered under family coverage and the family coverage premium does not increase based upon the number of family members, then no additional premium is necessary. However, if an employee is enrolled in employee-only coverage, and the plan has a different premium for family coverage, then it would also be reasonable for a plan to increase the employee's salary reduction (or after-tax deduction, if applicable) amount to cover the cost of family coverage. Generally, the plan should follow its premium cost structure, regardless of whether a child is an alternate recipient.

Sometimes, a question will arise about who should pay for the coverage. Typically, the medical child support order will 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 noncustodial 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.

An employee may pay for coverage provided to a child subject to a QMCSO on a pre-tax basis if the child is eligible for tax-free coverage. Under the ACA, an employee's child who is under age 27 as of the end of the taxable year, whether or not the child qualifies as the employee's tax dependent (i.e., as a qualifying child or qualifying relative) or as an Internal Revenue Code Section 105(b) dependent, is eligible for tax-free coverage. To be a Code Section 105(b) dependent, an individual must meet most, but not all, of the requirements to be a "qualifying child" or a "qualifying relative" under Code Section 152.

Further, a cafeteria plan document may be drafted to permit mid-year election changes to add a dependent child pursuant to a QMCSO (and an employee if the employee is not already enrolled). However, the cafeteria plan (or Section 125 plan) written plan document must contain language permitting the change. Otherwise, the employee should pay for the coverage on a post-tax basis until a new pre-tax salary reduction election may be made, such as at annual enrollment. Note that under the cafeteria plan rules, an employee may change his or her salary reduction agree to reflect *termination* of coverage for a child if: (1) an order requires the spouse, former spouse, or other individual to provide coverage for the child; and (2) that coverage is, in fact, provided.

Potential Issues

Following are examples of problems that may arise when administering enrollment, dis-enrollment, or employee contributions related to QMCSOs. These are only samples of common problems, not an exhaustive list.

Employee has not yet met applicable waiting period requirements

If an employee has not yet met an applicable waiting period requirement, after determining that a medical child support order is a QMCSO, the plan administrator should follow applicable procedures so that the child will begin receiving benefits upon the employee's completion of the waiting period. The plan is not required to provide coverage for the child or the employer prior to completion of the applicable waiting period.

Employee has not yet completed a measurement period

If an employer uses the look-back method to determine full-time employee status for purposes of plan eligibility and an employee has not yet completed the initial measurement period and is not in a current stability period, then the plan should have procedures that would allow for the employee and alternate recipient to enroll in coverage during a stability period if the employee is deemed to be a full-time employee for a subsequent stability period.

QMCSO requires different coverage than employee currently has

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. The plan could also permit the employee to remain enrolled in the option originally selected and permit the alternate recipient to be enrolled in the option specific in the order. However, if this route is chosen, the plan should obtain written assurances from any applicable insurer or stop loss insurer that any claims related to the alternate recipient will be covered.

QMCSO does not include termination date

A plan may dis-enroll an alternate recipient at the same time and under the same conditions as it can dis-enroll other dependents of participants under the plan, so even if the QMCSO does not state a termination date, the plan may terminate coverage at the time it would for any other dependent child. For example, if the plan terminates coverage when a participant terminates employment, and neither the participant nor the alternate recipient elects COBRA continuation coverage, then the plan may discontinue coverage for the alternate recipient. Likewise, if the plan ceases to provide coverage for dependents who are over the age of 26, then the coverage of an alternate recipient who is over the age of 26 may be terminated (assuming that continuation coverage is not elected).

Employee cannot pay for coverage through salary withholding due to federal or state withholding limitations

If an employer cannot deduct the additional contribution required to provide coverage to the child under the terms of the plan due to federal or state withholding limitations, the employer should notify the custodial parent and the child support enforcement agency, if an 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. But some states require that medical support premiums be withheld before computing the maximum to withhold under the CCPA. **See the Income Withholding Requirements matrix** for information on state withholding priorities and other withholding information.

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.

Section 5 – Other Federal and State Laws

In addition to the QMCSO/NMSN rules, employers faced with QMCSOs must be aware of the potential application of other state and federal laws.

State law

Certain state laws may be enforced through QMCSOs. For example, states cannot receive federal Medicaid funds unless they have in place specific state laws relating to medical child support. States must have laws that:

> (1) 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;
>
> (2) Require a health insurer to enroll a child pursuant to court or administrative order without regard to the plan's open enrollment restrictions;
>
> (3) Require employers and insurers to comply with court or administrative orders requiring a parent to provide health coverage for a child; and
>
> (4) 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.

Federal laws

QMCSOs are also impacted by certain federal laws, including ERISA reporting and disclosure requirements, COBRA, Section 125 cafeteria plan rules, and HIPAA Privacy and Security requirements.

ERISA

Plan documents should reflect QMCSO requirements, including information such as the definition of a medical child support order. An alternate recipient may request a copy of the plan documents, so it is important to address QMCSOs in those documents. Further, alternate recipients are considered to be "participants" for purposes of the ERISA disclosure requirements even though they are otherwise treated as "beneficiaries;" thus, plans are required to distribute SPDs, SMMs, SMRs, and SARs (as applicable) to alternate recipients. SBCs must be provided to applicants and enrollees before enrollment or re-enrollment. Generally, the necessary documents should be provided to the alternate recipient and the custodial parent or guardian. In addition, DOL regulations require a group health plan's SPD to contain the plan's QMCSO procedures or a statement indicating that participants and beneficiaries may obtain a copy of the plan's QMCSO procedures from the plan administrator without cost. Moreover, plans should also include information about coverage eligibility for alternate

recipients in their SPDs, which would likely impact eligibility language, language related to termination of coverage, and, potentially, language related to continuation coverage.

COBRA/Continuation Coverage

Because a child covered by a group health plan pursuant to a QMCSO is a beneficiary under the plan, a child covered pursuant to a QMCSO is therefore a "qualified beneficiary" with the right to elect continuation coverage under COBRA. Thus, if a plan is subject to COBRA and if the child loses coverage as a result of a qualifying event, then the child must be extended the option to selection COBRA continuation coverage.

Alternate recipients (or their legal representatives) will also have an obligation to notify a plan in case of certain qualifying events, such as reaching age 26. Thus, although plans are not required to provide an Initial (General) COBRA Notice to an alternate recipient because that notice is only required to be provided to the employee and any applicable spouse, a plan may wish to provide the notice to the alternate recipient to provide the alternate recipient with information about his or her COBRA rights and any applicable deadlines or procedures.

As qualified beneficiaries, alternate recipients have separate and independent rights to elect COBRA continuation coverage if they lose coverage as a result of a qualifying event. In other words, an alternate recipient can elect COBRA coverage even if the employee-parent is also eligible for such coverage but does not elect it. For example, if the COBRA qualifying event is the employee's termination of employment, the alternate recipient may elect continuation coverage even if the former employee does not. Like other qualified beneficiaries, an alternate recipient is entitled to a COBRA Election Notice if he or she loses coverage as a result of a qualifying event. If the child lives at an address different from the employee's (as is sometimes the case), then the plan administrator must send a separate COBRA Election Notice to the child at the other address for the child.

A plan that is not subject to COBRA should review any applicable continuation coverage provisions and treat alternate recipients as it would treat any other child.

HIPAA Privacy and Security Issues

Generally, there are two important times to determine whether the HIPAA Privacy and Security rules apply – before receiving an order and after receiving an order. State agencies and alternate recipients may request information prior to the issuance of a medical child support order. The DOL's position is that the custodial parent or agency would be entitled to receive, at the pre-order issuance stage, an SPD, relevant plan documents, and a description of the particular coverage options (if any) selected by the participant. Providing SPDs and relevant plan documents would not involve the disclosure of protected health information, so disclosure of those documents would not involve the HIPAA Privacy or Security rules. Typically, employers can retrieve

enrollment information from employment records instead of health plan records. If the enrollment information is obtained from employment records, then the HIPAA Privacy and Security rules do not apply.

The HIPAA Privacy rule allows a health plan to respond to requests for information made by a state agency or alternate recipient prior to the issuance of a medical child support order. Additionally, a medical plan administrator may disclose protected health information in response to a NMSN. Employers should note, however, that the necessary information may be contained in the participant's employment records. Therefore, responding to such inquiries may not invoke HIPAA responsibilities, although HIPAA does permit a response if necessary.

Once a plan receives a QMCSO, any disclosures required under the QMCSO would be permitted under the HIPAA Privacy rule provision that allows uses and disclosures of PHI that are required by law. Thus, related disclosures would be subject to the HIPAA Privacy and Security rules, but would be permitted. However, the plan administrator may condition release of any information on receiving sufficient confirmation that the request is made in connection with a child support proceeding. Plan administrators may assume that the request is in connection with a child support proceeding if the request is made by a state child support agency. In addition, the plan administrator should follow any applicable HIPAA privacy policies and procedures that may apply if any information must be obtained directly from the health plan. Note that if protected health information is disclosed in response to a court order or QMCSO process, the disclosure should be documented for the employee.

The ACA

The use of measurement and stability periods for eligibility will complicate an employer's response when an employee may be eligible for coverage at a future date because of a stability period, but is not eligible for coverage at the time a QMCSO is received, either because the employee is in a stability period as a non-full-time employee or is in an initial measurement period and has not yet had his or her status determined. However, if an employee is not eligible for coverage, but may become eligible at a later date, the plan administrator should so indicate in documents responding to the QMCSO.

Further, employers are not required to determine whether coverage meets an affordability test under the ACA before enrolling a child. If a child support agency sends an NMSN, then the employer has to use the child support definition of reasonable cost, not the the ACA's affordability test.

Section 6 – Sample QMCSO Procedures

Caution: These sample documents are for a hypothetical organization, and they may not apply to your factual situation. They are provided here for illustrative purposes only and may not be used "as is" for any purpose. If you wish to use these samples as a starting point for your own documents, advice of legal counsel is recommended.

I. Determination and Handling of Qualified Medical Child Support Order (QMCSO)

A. Individuals Authorized to Make QMCSO Determinations

The Plan Administrator designated the following individuals as authorized to determine whether an Order is a QMCSO and conduct any necessary actions to fulfill the Plan's obligations with respect to a QMCSO:

[Insert job title of employee(s) fulfilling obligation such as Director of Human Resources, Benefits Administrator, etc.]

B. Upon receipt of a National Medical Support Notice:

1. Upon receipt of the Notice, provide written acknowledgment of receipt of the Notice to the participant (employee) and alternate recipient (child) named in the order (and their legal representatives, if applicable); and

   [Insert method to acknowledge (e.g., Use Form Letter Acknowledging Receipt of an Order or Notice)]

   Also provide a copy of the Plan's written QMCSO procedures to the participant and alternate recipient named in the Notice (and their legal representatives, if applicable).

   [Insert method (e.g., Attach a copy of these procedures to the Letter)]

2. Determine if the Notice qualifies as a QMCSO. It should include the following:

   a) The name and address of the child (or a state official's name and address);
   b) The name and address of an employee enrolled in or eligible for enrollment in the plan; and
   c) The name of the agency issuing the NMSN.

   Note: A properly completed National Medical Support Notice always qualifies as a QMCSO.

3. If the named "employee" is not an employee of the Organization, or if the Plan does not have dependent coverage, or if the named employee is not in a class of employees eligible for coverage, check the appropriate boxes on the Employer's Response (Part A) and return to the appropriate state agency within 20 business days.

If none of the above apply, forward Part B of the Notice to thePlan Administrator.

4. Within a reasonable time after the date on the Notice (the time limit of 40 business days should be used as the outside window for notification), notify the participant,

alternate recipient, state agency, and any other parties identified in the Notice (legal representatives, etc.) that:

The Notice qualifies as a QMCSO, or

The Notice does not qualify as a QMCSO.

Use the spaces indicated on the Notice (The Plan Administrator Response to Part B) to provide this information. Please note that the NMSN form was revised in 2011 to include a new section addressing waiting periods longer than 90 days or waiting periods based on a requirement other than elapsed time (e.g., an hours worked requirement).

5. If the Notice qualifies as a QMCSO, **[insert applicable procedures (e.g., HR Administrator will fill out a Benefits Change Form on behalf of the participant to add the alternate recipient. (If reasonable, request that the participant sign the change form; if unable to obtain signature, attach the Notice to the change form as documentation for the participant's file.))]**

6. Provide the applicable parties with the following information:
   - The effective date of the child's coverage;
   - A description of the coverage (e.g., medical summary, dental summary, vision summary, EAP summary and SPDs) (as applicable);
   - Any forms necessary to enroll in the plan (and any necessary steps to enroll); and
   - ID card(s) – (if applicable).

C. Handling any Order other than a National Medical Support Notice.

1. Upon receipt of the Order, provide written acknowledgment of receipt of the Order to the participant (employee) and alternate recipient (child) named in the order (and the legal representative(s), if applicable); and

   [Insert process to respond (e.g., Use Form Letter Acknowledging Receipt of an Order)]

   Also provide a copy of the Plan's written QMCSO procedures to the participant and alternate recipient named in the Order (and their legal representatives, if applicable).

   [Attach a copy of these procedures to the letter.]

2. Determine if the Order qualifies as a QMCSO (use the Checklist in Section X):

   - Is the order a court judgment, order or decree that (1) provides for child support or a health benefit coverage for a child of a participant under a group health plan pursuant to a state domestic relations law, which relates to benefits under the plan; or (2) that enforces a state law related to medical child support under Section 1908A of the Social Security Act?

- Does it include the name and last-known mailing address of each alternate recipient? (The order may substitute the name of a state official or name a guardian or other representative to receive notices.)
- Does it provide a reasonable description of the coverage to be provided?
- Does the order state the period of coverage?
- Is the child eligible for coverage under the eligibility terms of the plan?
- Does it require the plan to pay benefits that are not available?
- Do any required employee contributions exceed applicable state and federal withholding limits?

3. Within a reasonable time after the date on the Order (the time limit of 40 business days should be used as the outside window for notification), notify the participant, alternate recipient, and any other parties identified in the Order (legal representatives, etc.) that:

   - The Order qualifies as a QMCSO, or
   - The Order does not qualify as a QMCSO

   [Insert process (e.g., Use Organization's Letter Accepting Medical Child Support Order as a QMCSO, or the Organization's Letter Rejecting Medical Child Support Order as a QMCSO, to provide this information.)]

4. If the Order qualifies as a QMCSO, **[insert job title]** will **[insert action to be taken (e.g., fill out a Benefits Change Form on behalf of the participant to add the alternate recipient, or an Enrollment form if the employee is eligible but not currently participating. (If reasonable, request that the participant sign the change form; if unable to obtain signature, attach the Order to the change form or enrollment form, as appropriate, as documentation for the participant's file.))]**

5. If the Order qualifies as a QMCSO, provide the applicable parties with the following information:

   - The effective date of the child's coverage;
   - A description of the coverage (e.g., medical summary, dental summary, vision summary, EAP summary (as applicable) and SPDs);
   - Any forms necessary to enroll in the plan (and any necessary steps to enroll); and
   - ID card(s) – (if applicable).

II. Handling Designated Representatives

If an alternate recipient designates a representative to receive copies of notices that are sent to him or her with respect to an Order or coverage under the health plan, include them in all mailings as required by the QMSCO.

When adding the child as a dependent under the employee's record, if the address for the child defaults to the employee's address – change the child's address to reflect the proper address for which requested materials should be sent. Any other designated representatives should be sent any requested materials manually.

III. Handling Disputes

The parties, or their legal counsel, have the right to submit written comments regarding the determination of an Order's or a Notice's status as a QMCSO within 30 days of the date of the determination. The Plan Administrator shall consider the written comments and make a final determination as to the status of the Order or Notice. If the Plan Administrator does not receive any written comments within the 30-day period, the determination will become final.

IV. Handling Resubmitted Orders and Notices

If the Plan Administrator determines that an Order or a Notice does not meet the requirements of a QMCSO, the parties or applicable state agency may submit a revised Order or Notice to attempt to correct any deficiencies. If a revised Order or Notice is submitted, the Plan Administrator will review the Order or Notice as if it were a newly submitted Order or Notice. If an order was initially found to be nonqualified and the parties later corrected any deficiencies, the Order may be resubmitted to the Plan. The corrected Order must be approved again by the court or administrative agency in order for it to be qualified.

V. Obtaining Additional Information

The Plan Administrator should also seek the following information:

- The name and address of the alternate recipient's custodial parent, legal guardian, or other legal representative to whom SPDs and other plan-related information should be provided.
- A completed enrollment form (if required under the plan(s)).
- A Change in Status form if required under the plan(s)).
- The name and address of any individual the Plan may have to reimburse for the alternate recipient's expenses.
- The name and address of any person other than the participant responsible for paying for the alternate recipient's coverage.

VI. Providing Additional Information

If someone other than the plan participant must pay for the alternate recipient's coverage, the Plan Administrator shall communicate how and when payments should be made.

VII. Providing Coverage for the Alternate Recipient

A. Alternate Recipient entitled to same coverage as other dependent children.

Unless the QMCSO provides otherwise, an alternate recipient should be given the same coverage provided to other dependent children under the plan(s). For example, if dependent children are covered under a medical plan and a dental plan, alternate recipients are entitled to coverage under both the medical and dental plan.

B. Alternate Recipient entitled to receive applicable required disclosures.

The alternate recipient should also be provided with all applicable required disclosures such as an SPD, the Summary of Benefits and Coverage (SBC), a summary of material modification, a summary annual report, and all required group health plan notices (e.g., an annual Women's Health and Cancer Rights Act notice, Medicare Part D Notice, etc.).

These items should be provided to the alternate recipient's custodial parent, guardian, or other authorized representative. If the alternate recipient is an adult or emancipated minor under state law, any such items should be provided to both the alternate recipient and, as applicable, the alternate recipient's custodial parent, guardian, or other authorized representative.

C. Handling enrollment.

1. Effective date of coverage.

After the Plan Administrator approves a QMCSO, the alternate recipient will be enrolled in the plan(s) **[insert appropriate date (e.g., the first of the following month)]**, or as of a later date if so required by the QMCSO. If the participant is not yet eligible for coverage (waiting period not fulfilled or initial measurement period not complete), then the coverage for the alternate recipient will be effective as soon as the participant is eligible for coverage. Upon the effective date of coverage, the Employer will then change, if necessary, the participant's payroll deductions corresponding to the new level of coverage for including the alternate recipient under the Plan.

2. Handling enrollment when necessary forms not provided.

The Plan Administrator will enroll the alternate recipient in the coverage indicated by the QMCSO. If the QMCSO does not specify, the Plan Administrator will enroll the alternate recipient in the same coverage as the Plan participant, or the default coverage (as described below) if the participant is not currently enrolled.

The Plan Administrator shall provide the appropriate parties with enrollment/election forms. The Plan Administrator shall also notify the parties that if a response is not received within a specified time period (e.g., twenty (20) business days), the alternate recipient will be enrolled in the default option (as described below).

Upon the effective date of coverage, the Employer will then change, if necessary, the participant's payroll deductions corresponding to the new level of coverage for including the alternate recipient under the Plan.

3. **Handling enrollment when participant is not already enrolled in the plan(s).**

If an employee is eligible for coverage under the Plan(s), but is not enrolled,QMCSO that is not an NMSN, the employee will also be enrolled in the coverage indicated in the QMCSO, or if the QMCSO does not specify coverage, the employee and the alternate recipient will be enrolled in a default level of coverage. The default level of coverage shall be **[insert level of coverage such as Core PPO Plan, medical plus dental, etc.]**.

Upon the effective date of coverage, the Employer will then change, if necessary, the participant's payroll deductions corresponding to the new level of coverage for including the alternate recipient under the Plan.

4. **Handling election changes at annual enrollment.**

Neither the statute nor DOL guidance prohibits an employee from dropping coverage for themselves or their dependents at open enrollment. However, the plan's responsibility is to comply with the court or state order and ensure the alternate recipient is enrolled for the period specified in the order, regardless of the employee's wishes. Therefore, the employee should not be allowed to drop coverage if the employee's enrollment is required to permit coverage for the alternate recipient.

D. Determining coverage when multiple plan options exist.

If the QMCSO is not a National Medical Support Notice and the applicable plan(s) has more than one level of coverage (e.g., PPO vs. HMO, etc.), but the QMCSO does not specify the level of coverage or the manner in which coverage should be determined, the Plan Administrator shall enroll the alternate recipient in the same option(s) that the participant is enrolled in. If the participant is not enrolled in an option, the Plan Administrator shall enroll the alternate recipient (and employee if necessary) in the default option.

If the QMCSO is a National Medical Support Notice, the Plan Administrator shall follow the instructions regarding plans with multiple coverage options in the Notice to determine the appropriate coverage. The Plan Administrator shall provide the appropriate parties with information about the options and provide them with any necessary forms to make an election. The Plan Administrator shall also notify the parties that if a response is not received within a specified time period (e.g., twenty (20) business days), the alternate recipient will be enrolled in the default option as follows**: [insert default option such as PPO Medical Plan Option #1 and dental coverage].**

VIII. Handling required employee contributions when the contribution withholding would exceed applicable state and federal withholding limits.

When the Employer must increase a plan participant's required contributions to provide coverage for an alternate recipient, the Employer must determine whether the additional (or new) required contribution will exceed applicable state or federal limits.

If the QMCSO is a National Medical Support Notice, the Notice should specify the limitations.

If the QMCSO does not specify the limits, the Employer must be certain that withholdings do not exceed the limits under the Consumer Credit Protection Act (CCPA). Under this Act, if an employee is supporting a spouse or dependent child (other than the alternate recipient), the Employer may not withhold more than 50% of the employee's disposable weekly earnings. If the employee is not supporting a spouse or dependent child (other than the alternate recipient), the Act prohibits the employer from withholding more than 60% of the employee's disposable weekly earnings.

The Employer must also review applicable state wage withholding limitations and comply accordingly with those limitations.

If the cost of coverage is more than the amount that can be withheld, coverage need not and should not be extended unless contributions are made from another source – such as the custodial parent or a state agency.

If the required contribution cannot be withheld because of the above limitations, the custodial parent and any applicable child support agency must be notified. (If the QMCSO is a National Medical Support Notice, the Notice will contain a form in Part A of the NMSN for these purposes.)

However, the participant may voluntarily agree to withholding in excess of the federal and state limitations. Any such agreement must be in writing and signed by the participant.

IX. Handling COBRA for an Alternate Recipient

If a COBRA Qualifying Event occurs, an alternate recipient should be treated the same as any other Qualified Beneficiary and offered COBRA continuation coverage.

The appropriate notices should be sent to both the alternate recipient and the alternate recipient's custodial parent or other legal representative. As applicable, appropriate notices shall include an Election Notice, a notice of ineligibility for COBRA, a notice of early termination, and any other relevant form. It is not necessary to provide the alternate recipient (or the alternate recipient's representative) with an Initial (General) Notice, but the Plan Administrator may do so as a best practice.

If the only available address for the alternate recipient is a state or local agency, the Plan Administrator should contact the agency to determine where applicable notices should be sent.

X. Checklist for Completing QMCSO Procedures

1. Initial Receipt of Order or Notice:

Employee's Name (Last, First, Middle)	
Employee's Soc. Sec. Number	
Date Order or Notice Received	
Date Acknowledgement Sent	
Coverage employee currently enrolled in	Medical _____ Vision_____ Dental _____ Other _____ (specify)

Alternate Recipient(s):

Name	Date of Birth	Address	Social Security Number	Time Period for Which Order Applies

2. Determination of whether the Document qualifies as a Medical Child Support Order

a. Determine the following

Item	Yes	No
Is the document a court order, judgment, or decree (may include an approval of a settlement agreement)?		
Does the order, judgment, or decree provide for child support or health benefit coverage for an employee covered under a group health plan, or an employee eligible for coverage under a group health plan?		
Is the order, judgment, or decree made subject to state domestic relations law?		
Does the order, judgment, or decree relate to benefits under an organization health plan (e.g., medical, dental, vision, hearing, prescription drugs, etc.)?		

b. If the answer to all of the questions above is "yes" or if it is a NMSN, continue to Section 3. If the answer to any of the questions is "no" and it is not an NMSN, seek review by legal counsel.

If review by legal counsel is necessary:

Date sent to legal counsel for review:	
Date legal review received:	
Legal counsel's determination:	QMCSO _____ Not a QMCSO _____

3. Assessment of Order:

Is the Order a National Medical Support Notice? Yes _____ No _____

(If "yes" complete section "a" below. If "no," skip to section "b" below.

a. Determine the following:

Item	Yes	No
Does the Notice contain the name and address of the child, or name and address of a state official?		
Does the Notice contain the name and address of an employee who is enrolled in the Plan, or the name and address of an employee who is eligible for enrollment in the Plan?		
Does the Notice contain the name of the issuing agency?		
Does the Notice contain all other information required by the instructions on the Notice?		
Does the Notice identify the underlying child support order?		
Do any required employee contribution withholdings exceed federal or state limits (when considering other current withholdings such as child support)?		
If any required employee contributions will exceed federal or state limits, will the employee voluntarily agree to excess withholding?		

b. If the Order is not a National Medical Support Notice, determine the following:

Item	Yes	No
Does the Order include the name and last-known mailing address of each alternate recipient (or state official)?		
Does the Order include the name and last-known address of an employee who is enrolled in the Plan, or name and last-known address of an employee who is eligible for enrollment in the Plan?		
Does the Order name a guardian or other representative for the alternate recipient(s) who is to receive copies of notices for alternate recipients? *(optional)*		
Does the Order provide a reasonable description of the coverage to be provided?		
Does the order state the time period for which the Order applies?		
Is the child eligible for coverage under the Plan(s)?		
Does the order require the Plan to provide benefits not available under the Plan(s)?		
Do any required employee contribution withholdings exceed federal or state limits (when considering other current withholdings such as child support)?		
If any required employee contributions will exceed federal or state limits, will the employee voluntarily agree to excess withholding?		

c. Upon completion of the items above, prepare a Response to the Parties

For National Medical Support Notices, complete the Plan Administrator Response portion (Part B) of the Notice. For Orders other than National Medical Support Notices, complete either the Letter Accepting a Court Order as a QMCSO or the Letter Rejecting a Court Order as a QMCSO, as appropriate. Also, the Plan Administrator shall provide a copy of the Plan SPDs, SBCs, any forms or documents necessary for coverage to begin, and information regarding submission of claims to the custodial parent, other designated representative of the alternate recipient, or appropriate state agency. Use the charts that follow to document actions taken.

Item	Date	N/A	Yes	No
National Medical Support Notice Employer Response				
Letter Accepting a Court Order as a QMCSO				
Letter Rejecting a Court Order as a QMCSO				
SPD(s) provided?				
Enrollment/change of status form provided?				
Information regarding submission of claims provided?				

Response completed by:	
Party(ies) to whom SPDs sent:	
Date of receipt of response, if any, from party(ies):	
Description of further action, if any:	

d. Enrollment of Alternate Recipient:

Item	Date	N/A	Yes	No
Was alternate recipient enrolled in Plan prior to receipt of QMCSO?				
Has participant's employee contribution been changed?				
If withholding will exceed federal and/or state limitations, have the parties been notified?				
Is employee currently enrolled in the Plan?				
If employee is not currently enrolled in the Plan, when will employee be eligible to enroll?				

Item	Date	N/A	Yes	No
Have all appropriate enrollment/change in status forms been received?				

e. Additional Information:

Alternate Recipient	Date of Enrollment	Name and address of person to whom reimbursements may be made/Plan information furnished

Copies of the National Medical Support Notice forms and additional information on QMCSOs are available on the Department of Labor's website at:

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/qualified-medical-child-support-orders.pdf.

XI. Model Documents

Letter Acknowledging Receipt of Medical Child Support Order

[You must customize any items marked in red font; delete any items that do not apply.]

[Date]

[Plan Participant]
[Address]

[Alternate Recipient (Child) and/or Designated Representative named in QMCSO (may be custodial parent, guardian, or state agency)] [include each Alternate Recipient]
[Address]

Dear [Plan Participant] and [Alternate Recipient and/or Designated Representative]:

On [insert date], we received a [(medical child support order) (National Medical Support Notice)] relating to coverage for (Alternate Recipient(s) under the [insert name of applicable health plan or plans] as (a child) (children) of (Plan Participant). We are reviewing this [insert (order) if the document is a medical child support order; insert (Notice) if the document is a National Medical Support Notice] to determine if it is a "qualified medical child support order" (QMCSO), as defined under a federal law often referred to as "ERISA." During our review, we will determine whether [Plan Participant] is eligible for health benefits under the [insert name of Plan/s] and review the terms of the [(order) (Notice)] to determine if it meets the Plan's(s') requirements and applicable law. We have enclosed a copy of our procedures used to determine whether orders are QMCSOs and to administer benefits under QMCSOs.

We will provide you with written notice of our preliminary determination, and if we find that the [order] [Notice] is not a QMCSO, we will advise you as to what corrective steps are necessary. Within 30 days after the date of the notice providing you with our preliminary determination, you (or your attorney) may submit written comments regarding our preliminary determination. After considering any comments received, we will make a final determination as to whether the [order] [Notice] is qualified. If we do not receive any comments within that 30-day period, the preliminary determination will become final without further notice from us.

Please advise us if your current mailing address changes. In addition, please advise us if [Alternate Recipient(s)] wish(es) to designate a representative to receive copies of notices that are sent to him/her/them relating to this order or benefits are provided subject to qualification of the applicable (order)(Notice). Your cooperation is appreciated.

Gallagher

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Sincerely,

[Insert representative for Plan]
Plan Administrator
[Name of Plan/s]
Enclosure (copy of QMCSO procedures)
cc: (Participant's Attorney, if any)
(Alternate Recipient's Attorney, if any)
(State Agency, if any)

Gallagher

Insurance | Risk Management | Consulting

Letter Accepting Medical Child Support Order as Qualified

[You must customize any items marked in red font; delete any items that do not apply. Replace items in blue font with the appropriate information.]

[Date]

[Plan Participant]
[Address]

[Alternate Recipient (Child) and/or Designated Representative named in QMCSO (may be custodial parent, guardian, or state agency)] [include each Alternate Recipient]
[Address]

Dear [Plan Participant] and [Alternate Recipient and/or Designated Representative]:

The [insert name of Plan(s)] reviewed the medical child support order received on [insert date] related to coverage for [insert names of all Alternate Recipients]. We have determined that the order is a valid Qualified Medical Child Support Order (QMCSO) as defined under a federal law called ERISA.

[Insert appropriate paragraph (Choice #1 or Choice #2) based upon whether child is currently enrolled.]

[Choice # 1: Child not currently enrolled.]

Coverage for [insert names of all Alternate Recipients] will [begin on _____ (insert date)] [not begin until a completed enrollment form has been received by the Plan Administrator and any other requirements for plan coverage have been met].

[Choice # 2: Child already enrolled in plan coverage.]

According to our records, [insert names of Alternate Recipients] (is) (are) currently covered under the [insert name of Plan(s)] as (an) eligible (dependent) (dependents) of [insert name of employee]. No changes to coverage will occur at this time. Please note that coverage under the [insert name of Plan(s)] will only continue to be effective for the period of time and under the conditions established by the Plan terms.

If your contact information changes, please let us know by contacting [insert Plan Administrator contact information]. Also, please let us know if information related to [insert names of all Alternate Recipients] should be forwarded to any additional parties such as a designated representative or state official.

Gallagher

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Sincerely,

[Insert representative for Plan]
Plan Administrator
[Name of Plan/s]
Enclosure (copy of QMCSO procedures)
cc: (Participant's Attorney, if any)
(Alternate Recipient's Attorney, if any)
(State Agency, if any)

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Letter Rejecting Medical Child Support Order as Invalid

[You must customize any items marked in red font; delete any items that do not apply. Replace items in blue font with appropriate information.]

[Date]

[Plan Participant]
[Address]

[Alternate Recipient (Child) and/or Designated Representative named in QMCSO (may be custodial parent, guardian, or state agency)] [include each Alternate Recipient]
[Address]

Dear [Plan Participant] and [Alternate Recipient and/or Designated Representative]:

The [insert name of Plan(s)] reviewed the medical child support order received on [insert date] related to coverage for [insert names of all Alternate Recipients]. We have determined that the order is not a valid Qualified Medical Child Support Order (QMCSO) as defined under a federal law called ERISA.

The order is not qualified as a QMCSO for the following reasons:

[Insert reasons order is not qualified (e.g., The Order does not provide a reasonable description of the benefits to be provided; The Order requires benefits that the Plan does not provide).]

Because the order does not meet the requirements of a QMCSO, [insert names of all Alternate Recipients] will not be added to coverage under the Plan at this time. You have the right to submit written comments in response to this determination. You must submit your comments within (30) days of the date of this letter. Comments must be submitted to: [Insert contact information for Plan Administrator, including mailing address and/or email address].

If the Plan Administrator does not receive comments from you within (30) days of the date of this letter, the determination that the order is not a QMCSO will become final. If you do not intend to make any comments, you may notify the Plan Administrator at the address noted above. If you provide comments, the Plan Administrator will consider those comments and provide a final determination upon the conclusion of the comment review.

If your contact information changes, please let us know by contacting [insert Plan Administrator contact information]. Also, please let us know if information related to

[insert names of all Alternate Recipients] should be forwarded to any additional parties such as a designated representative or state official.

Sincerely,

[Insert name of representative for Plan]
Plan Administrator
[Name of Plan/s]
Enclosure (copy of QMCSO procedures)
cc: (Participant's Attorney, if any)
(Alternate Recipient's Attorney, if any)
(State Agency, if any)