Employee Name:_____

Date:_____ **Completed by:** _____

Checklist for Assessing Whether an Order or Notice Is a QMCSO (Include with QMCSO Procedures)

Federal law requires group health plans to honor the terms of a qualified medical child support order (QMCSO). The determination as to whether a court order or National Medical Support Notice is "qualified" is made by the employer [employee benefits department]. This checklist will help determine whether an order or Notice meets the requirements of a QMCSO in accordance with federal law.

This checklist sets out the items that must be present for an order or Notice to be a QMCSO. The employer [employee benefits department] should complete this checklist as soon as possible after receiving such an order or Notice. If all items are present, the parties (including the issuing agency, in the case of a National Medical Support Notices) must be notified that the order is a QMCSO. If one or more items are not present, the parties (including the issuing agency, in the case of a National Medical Support Notices) must be notified that the order is not a QMCSO. The order or Notice should be considered to be qualified if it is in substantial compliance with the required items.

Complete a separate checklist for each plan to which the order or Notice applies.

The term "you" or "your" in this checklist refers to the employer [employee benefits department].

☐ **1. Is the Document a Medical Child Support Order?**

The order must be a judgment, order, or decree (including approval of a settlement agreement) that:

(a) provides for child support or health benefit coverage for a child of a participant under a group health plan, is made under state domestic relations law, and relates to benefits under the plan; or

(b) enforces a state law relating to medical child support described in Section 1908A of the Social Security Act (which requires states to enact certain medical child support laws in order to receive federal Medicaid funds – applies to Vermont).

The order may be issued by a court of competent jurisdiction or through an administrative process that has the force and effect of law under applicable state law. The order may be a National Medical Support Notices. Agreements made by the parties but not formally approved by a court are not acceptable.

A note on revised orders: If an order was initially rejected as not qualified and the deficiencies are later corrected by the parties, a revised order may be submitted to the plan. However, the revised order must have been formally approved by the court or administrative agency to be qualified.

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☐ **2. If the Order Is a National Medical Support Notice, Does It Include the Following?**

A properly completed National Medical Support Notices will automatically qualify as a QMCSO if all of the specified information is filled out. This is because such Notices are prepared using a standard form that was jointly developed by the DOL and HHS. The instructions on the Notice should be followed in evaluating whether the Notice constitutes a valid QMCSO order qualifies and for providing an appropriate response to the issuing agency and the other parties. In general, a Notice must include-

- the name and address of the child (a state official's name and address may be substituted for the address of the child);
- the name and address of an employee who is enrolled in the plan or eligible for enrollment; and
- the name of the issuing agency.

In addition, the Notice must identify an underlying child support order and may not require benefits for an alternate recipient who is at or above the age at which dependent children are no longer eligible for coverage under the plan or where the employee is in a class of employees that is not eligible for the plan. The form of the Notice is designed so as to automatically satisfy the other requirements of a QMCSO (i.e., items 3.b, c, and e below).

☐ **3. If the Order Is Not a National Medical Support Notice, Does It Meet the Following Requirements?**

☐ *a. Does the Order Include All Necessary Names and Addresses?*

The order must include the names and last-known mailing addresses of the participant and each alternate recipient (i.e., each child of the participant who is recognized under the order as having a right to enroll under a group health plan with respect to the participant). (In some cases, there may be multiple alternate recipients.) However, the order may substitute the name and mailing address of an official of a state or political subdivision for the mailing address of an alternate recipient. An order may also designate a guardian or other representative of an alternate recipient (for example, the custodial parent or another adult who cares for the minor child) to receive copies of notices that are sent to an alternate recipient with respect to an order.

Although the law requires the order to state the parties' names and addresses, an order that misstates factual identifying information (e.g., the order misstates a name or omits an address) should not be rejected if you can readily determine or access the correct information.

Employee Name:_____

Date:_____ **Completed by:** _____

☐ *b. Does the Order Provide a Reasonable Description of the Coverage to Be Provided?*

In general, the order should either provide a reasonable description of the type of coverage to be provided by the plan to each alternate recipient or indicate the manner in which the type of coverage is to be determined. To the extent that the order identifies a plan or type of coverage for which there is only one benefit option, this requirement is met. An order would also satisfy this requirement by designating the alternate recipient's coverage to be the same as the coverage elected each year by the participant/parent. An order that identifies a plan or type of coverage with multiple options may also designate the option in which the alternate recipient is to be enrolled or the manner in which an option is to be chosen.

In the absence of such a designation under an otherwise-qualified order that applies to a plan with multiple options, the employer [employee benefits department] should enroll the alternate recipient in the same option as the employee if the employee is enrolled in the plan. Otherwise, the employer [employee benefits department] may follow procedures similar to those in the National Medical Support Notice. That is, the employer [employee benefits department] may, instead of rejecting the order, provide the parties with information about the available options and direct them to make a selection. If the plan has a default option, the employer [employee benefits department] may also notify the parties that the alternate recipient and employee will be enrolled in this option if a response is not received within a specified time period (e.g., 20 business days).

It is acceptable for an order to refer to an outdated or informal plan name, or not to name a plan. The plan's letter to the parties regarding whether the order is a QMCSO should state the proper name of the plan(s) covered by the order.

☐ *c. Does the Order Identify the Period to Which It Applies?*

While the order must indicate the period to which it applies, it need not include a specific ending date. For example, it is acceptable for an order to indicate that it expires when the child attains a certain age, such as 19, or upon the employee's ineligibility for coverage (if earlier). The period during which the order is effective might also be inferred from the context of the order. Note that coverage under a QMCSO need not continue beyond the age for which coverage is available for dependent children generally.

☐ *d. Is the Child Eligible for Coverage Under the Plan?*

The order may not override other plan provisions generally applicable to dependents or dependent children coverage. For example, a child may not qualify for coverage under the plan because-

- the child does not meet the plan's definition of "dependent child" because of age;
- the plan does not provide dependent coverage for children; or
- the employee is not eligible to participate in the plan (due to part-time status, termination of employment, etc.). (Note that an employee who is eligible for coverage but is not enrolled must be enrolled if necessary for an alternate recipient to have coverage pursuant to a QMCSO.)

☐ *e. Does the Order Require the Plan to Provide Benefits Not Available Under the Plan?*

The order may not require a plan to provide a type or form of benefit or option not otherwise provided, except as necessary to comply with the requirements of a state law relating to medical child support described in Section 1908A of the Social Security Act. For example, an order cannot require a plan that provides only medical benefits to provide dental benefits to an alternate recipient. Similarly, an order cannot require a waiver of a plan's cost-sharing provisions or coverage for specific conditions, supplies, or services not otherwise covered.

☐ **4. Does Any Required Employee Contribution Exceed Applicable State and Federal Withholding Limits?**

A determination must be made as to whether any required employee contribution toward the coverage exceeds applicable state and federal limits. If the order is a National Medical Support Notice, the limitations should be specified in the Notice. Otherwise, an employer [employee benefits or payroll department] must ensure that it is not requiring the employer to withhold amounts for coverage that exceed the maximum amount permitted under the Consumer Credit Protection Act (CCPA). Under the CCPA, an employer cannot withhold more than (a) 50% of the employee's disposable weekly earnings where the employee is supporting a spouse or dependent child (other than the potential alternate recipient); or (b) 60% of the employee's disposable weekly earnings where the employee is not supporting a spouse or other child. Applicable state-law wage withholding limitations, which may be even more restrictive than the CCPA, must also be reviewed.

Where the cost of coverage exceeds the amount that can be withheld, coverage need not (and should not) be extended (unless contributions are made from another source-

e.g., a state agency). If the amount required to pay for the child's coverage cannot be withheld, the custodial parent (as well as the child support enforcement agency, if one is involved) should be notified. (The National Medical Support Notice includes a form to be used for notifying the agency of the inability to withhold sufficient funds due to withholding limitations.) The custodial parent and/or agency may be able to modify the employee's other support obligations in order to allow for sufficient withholding to pay for the child's coverage. The participant may also voluntarily consent in writing to withholding in excess of applicable limitations.