

**DEPARTMENT OF LABOR****Pension and Welfare Benefits Administration****29 CFR Part 2590**

RIN 1210-AA72

**National Medical Support Notice****AGENCY:** Pension and Welfare Benefits Administration, Labor.**ACTION:** Final rule.

**SUMMARY:** This document contains a final rule that promulgates a National Medical Support Notice to be issued by State agencies as a means of enforcing the health care coverage provisions in a child support order, and to be treated by plan administrators of group health plans as a qualified medical child support order under section 609(a) of Title I of the Employee Retirement Income Security Act (ERISA). Through this regulation, the Department of Labor (the Department) is implementing an amendment to section 609 (a) of ERISA, made by section 401 of the Child Support Performance and Incentive Act of 1998 (CSPIA), Pub. L. 105-200. This rule will affect group health plans, participants in group health plans, noncustodial children of such participants, and State agencies that administer child support enforcement programs.

**DATES:** The regulation is effective January 26, 2001.

**FOR FURTHER INFORMATION CONTACT:** David Lurie or Susan Rees, Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, (202) 219-8671 (this is not a toll-free number).

**SUPPLEMENTARY INFORMATION:****1. Background**

Under section 609(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), each group health plan, as defined in ERISA section 607(1), shall provide benefits in accordance with the applicable requirements of any "qualified medical child support order" (QMCSO). A QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan, and which satisfies certain additional requirements contained in ERISA section 609(a). An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a

group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. Section 514(b)(7) of ERISA also provides that ERISA preemption of State laws does not apply to QMCSOs and provisions of State law described in section 1908 of the Social Security Act (SSA) to the extent that they apply to a QMCSO.<sup>1</sup>

**2. The Child Support Performance and Incentive Act**

Congress enacted section 401 of the Child Support Performance and Incentive Act of 1998 (CSPIA) to amend both ERISA and the SSA. Section 401(b) of CSPIA directed the Secretaries of Labor and Health and Human Services to jointly develop and promulgate the Notice.

Section 401(c) of CSPIA amended section 466(a)(19) of the SSA (contained in part D of Title IV of the SSA) to require States to enact laws requiring the use of the Notice to enforce medical child support obligations of parents.<sup>2</sup> A State agency that administers a child support enforcement program pursuant to such laws (IV-D Agency or Issuing Agency) will be required to use the Notice to notify the employer of the

<sup>1</sup> Section 1908 of the SSA, 42 U.S.C. 1396g-1, conditions State eligibility for Medicaid matching funds on the enactment of certain specified State laws relating to medical child support. Under section 1908 States must enact laws under which insurers (including group health plans) may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child is born out of wedlock, not claimed as a dependent on the parent's tax return, or not in residence with the parent or in the insurer's service area. Section 1908 also sets out rules for States to require of employers and insurers when a parent is ordered by a court or administrative agency to provide health coverage for a child and the parent is eligible for health coverage from that insurer or employer, including a provision which permits the custodial parent or the State agency to apply for available coverage for the child, without regard to open season restrictions.

<sup>2</sup> This requirement is effective for each State on or after the later of October 1, 2001, or the effective date of laws enacted by the legislature of such State implementing the amendments to the SSA made by section 401 of CSPIA, but in no event later than the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after October 1, 2001. In the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature. Some States, therefore, may not have laws mandating the use of the Notice until 2003. Until that time, such States may continue to use medical child support orders other than the Notice.

noncustodial parent that a State court or administrative agency has issued a child support order providing for health care coverage. Under these laws, employers will be required to forward a portion of the Notice to the appropriate group health plan administrator and to withhold any necessary employee contributions.

Section 401(d) of CSPIA added a new subparagraph (C) to section 609(a)(5) of ERISA. Section 609(a)(5)(C) provides that if an administrator of a group health plan which is maintained by the employer of a noncustodial parent of a child, or to which such employer contributes, receives an appropriately completed Notice in the case of such child, and the Notice satisfies the conditions of paragraphs (3) and (4) of ERISA section 609(a), the Notice shall be deemed to be a QMCSO in the case of such child.

Section 401(a) of CSPIA mandated that the Secretaries of Labor and Health and Human Services jointly establish a Medical Child Support Working Group (the Working Group or MCSWG) whose purpose was to identify the impediments to the effective enforcement of medical support by IV-D Agencies and to submit a report to the Secretaries containing recommendations for appropriate measures to address such impediments. CSPIA section 401(a) requires the Secretaries to submit a report to Congress within two months of receipt of the Working Group's report that addresses the recommendations contained in the Working Group's report. CSPIA section 401(g) further requires the two Secretaries to submit a second report to Congress eight months later, regarding possible legislative changes.

**3. The Medical Child Support Working Group**

CSPIA specifically directed the Working Group, among other things, to make recommendations based on assessments of the form and content of the Notice as developed by the two Departments. The Working Group was composed of 30 members, who represented the Department and the Department of Health and Human Services (HHS), directors of State IV-D and Medicaid agencies, employers (including owners of small businesses) and their trade or industry representatives and certified human resource and payroll professionals, administrators and sponsors of group health plans (as defined in section 607(1) of ERISA), children potentially eligible for medical support, State medical child support programs, and

organizations representing State child support programs.

The Working Group held a series of nine meetings beginning in March of 1999. The initial meetings of the Working Group led the Departments to a more complete appreciation of the complexity of the issues involved in the development of the Notice. In the interest of developing a more useful Notice, the Departments decided to obtain additional input from the Working Group, which necessitated taking additional time in developing the Notice. Comments from the Working Group proved very helpful in the development of the proposed regulations issued by the Secretaries on November 15, 1999 (64 FR 62054, 62074).<sup>3</sup> In a meeting held June 8, 2000, the Working Group formally approved a Report to be submitted to the Secretaries. The Report contains 76 recommendations relating to medical child support enforcement, including recommendations concerning the proposed Notice.<sup>4</sup>

#### 4. The National Medical Support Notice

##### A. General

The Departments of Labor and HHS are jointly promulgating the Notice. The Notice has two parts, Part A, the "Notice to Withhold for Health Care Coverage," and Part B, the "Medical Support Notice to Plan Administrator." Also being published in the **Federal Register** today is a parallel regulation issued by the Office of Child Support Enforcement (OCSE), HHS, under sections 452(f) and 466(a)(19) of the SSA, 42 U.S.C. 652(f) and 666(a)(19), as amended by section 401 of CSPIA. That regulation, at 45 C.F.R. 303.32, in addition to promulgating the Notice, provides guidance to States on implementing the laws required by such sections. These laws describe the duties and obligations of employers and State agencies generally with respect to Part A of the Notice. The Department of Labor's regulation promulgated herein provides guidance to plan administrators for processing Part B of the Notice.

<sup>3</sup> In an effort to ensure that the statutorily mandated Notice facilitated IV-D Agency efforts to secure health care coverage for children, consistent with Congressional intent, and taking into account the views of the Working Group, the Department first promulgated the Notice as a proposed rulemaking rather than as an interim regulation as provided for in section 401(b)(5) of CSPIA.

<sup>4</sup> A copy of the Report is available in the Department's Public Disclosure Room for the Pension and Welfare Benefits Administration (PWBA), Room N5638, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The Report is also available at [www.pwba.dol.gov](http://www.pwba.dol.gov).

##### B. Part A—Notice to Withhold for Health Care Coverage

As described in the OCSE regulation, a State IV-D agency will issue the two-part Notice to an employer who maintains or contributes to a group health plan, and employs a noncustodial parent obligated by a child support order to provide medical support for his or her children. Part A, the "Notice to Withhold for Health Care Coverage" identifies the obligated employee as well as the child(ren) to whom the order applies. The Instructions to Employer inform the employer of its obligations (i) to transfer Part B of the Notice to the administrator of each group health plan to which the Notice applies within 20-business days of the date of the Notice, (ii) if the Notice is determined to be a QMCSO by the plan administrator, to determine whether Federal or State withholding limitations or prioritization rules permit the withholding from the employee's income of the amount required to obtain coverage for the children under the terms of the plan, (iii) if appropriate, to withhold from the income of the employee any contributions required under the group health plan for such coverage, and (iv) to transmit those amounts to the group health plan. Part A also includes an Employer Response, which the employer would use to notify the Issuing Agency if the employer does not maintain or contribute to a group health plan that offers family health care coverage or that the employee is among a class of employees that is not eligible for family health coverage under any plan maintained by the employer or to which the employer contributes, or if the individual is no longer employed by the employer.

The Instructions to Employer in Part A also notify the employer (i) of Federal and State limitations on withholding, (ii) of the obligation to comply with any applicable withholding prioritization law established by the State of the employee's principal place of employment and to notify the State agency which issued the Notice of the employee's termination of employment, (iii) of the duration of the withholding obligation, (iv) of sanctions that the employer might be subject to for failure to withhold as required by the Notice, and (v) that the employee is liable for any employee contributions required by the terms of the plan.

##### C. Part B—Notice to Plan Administrator

Part B of the Notice, the "Medical Support Notice to Plan Administrator," includes the same information as is contained in Part A. Part B and its

Instructions to Plan Administrator were developed to meet the requirements of CSPIA, as well as coordinate those requirements with the existing QMCSO requirements of ERISA section 609(a), because receipt by a plan administrator of Part B of this Notice is considered receipt of a medical child support order as defined in ERISA section 609(a)(2)(B). Part B was also developed to comply with the requirements placed on group health plans under State laws described in SSA section 1908, and to accommodate the requirements for State agencies to use automated processing of medical child support orders where possible.

Receipt of Part B of the Notice from the employer notifies the administrator of the group health plan that the named employee is obligated by a court or administrative child support order to provide medical support coverage for the named child(ren), and that the named employee is enrolled or eligible for enrollment under the plan maintained by or contributed to by the employer. The Notice is to be treated as an application by the Issuing Agency for health coverage for the child(ren) to the extent such application is required by the plan.

The Notice is designed to provide the information necessary for the plan administrator to determine, as required by section 609(a)(5)(A), whether the Notice is a QMCSO under section 609(a) of ERISA, and to enroll the child(ren) as dependent(s) in the group health plan. ERISA section 609(a)(5)(C) provides that if a plan administrator receives an appropriately completed Notice that satisfies the conditions of paragraphs (3) and (4) of section 609(a), the Notice shall be deemed to be a QMCSO.

The Plan Administrator Response of Part B is to be completed by the plan administrator and returned to the Issuing Agency and/or the parties, as appropriate, to inform them whether the Notice constitutes a QMCSO. If the Notice is qualified, the plan administrator is required to notify the Issuing Agency either that the child(ren) is/are currently or will be enrolled in coverage offered by the plan, and the date of enrollment, or, if the employee is not enrolled and there is more than one option available, inform the Agency of the options from which to elect coverage. Part B is also to be used to notify the Issuing Agency and the parties of certain waiting periods. In addition, Part B is to be used to notify the employer to determine whether any employee contribution necessary for coverage can be withheld from the employee's income. If the plan administrator determines that a Notice

received by the plan is not qualified, he or she is to complete the Response and identify the specific reason(s) why the Notice is not qualified, and is to notify the Issuing Agency and the parties.

### Discussion of the Comments

#### 1. General Responsibilities of the Parties

##### A. Time Periods

The Department received several comments related to the 40-business day period from the date of the Notice within which the employer and the plan administrator are to act on the Notice. Several expressed the view that the respective time periods are too long, and suggested that they should be shortened. One of these commenters explained that under State law, an employer or insurance carrier is required to enroll a child immediately upon receipt of a court order requiring such enrollment. One comment requested clarification regarding whether the 40-business day period to run from the date of receipt of a complete Notice by a plan administrator, or from the mailing date of the Notice.

In response, the time periods are specified in CSPIA. However, in order to coordinate the requirements contained in ERISA section 609(a)(5)(A)(ii) and section 609(a)(5)(C)(ii), the Notice also indicates that the plan administrator would be required to respond more quickly, if reasonable. The Department understands that there may be State insurance laws that will apply in medical child support enforcement with respect to insured plans, and assumes that both Federal and State law will be given effect wherever possible. In response to the last comment, under CSPIA, the period runs from the "date of the Notice." HHS has recommended, and the Department has adopted, the rule used for income withholding notices. Under this interpretation, the period runs from the date the Notice is issued by the IV-D Agency.

##### B. Confidentiality of Personal Information

Several commenters suggested that the Notice should include general language that warns the employer and plan administrator to safeguard confidential information. Commenters also suggested that the notification responsibilities described in the respective instructions should be drafted in a manner that would prevent any confidential information from being disclosed to either the custodial or noncustodial parent. With respect to the specific information content of the Notice, a commenter suggested that the

item in the Notice requiring the address of the custodial parent should instead automatically require the address of a substituted State official. Another suggested that the Notice should not include the addresses of either the custodial or noncustodial parent.

The Department believes the need for confidentiality, although arising in only a small proportion of medical child support enforcement cases, is a serious matter. However, the Notice is designed to put the State court issuing the support order or the IV-D Agency issuing the Notice in control of confidentiality, by permitting either to substitute the name and address of a State official for that of the child and/or custodial parent, where appropriate. Plan administrators are required to honor such substitutions by ERISA section 609(a)(3)(A), and the Department assumes that the employer and the plan administrator will respect this substitution, without specific instruction of the Notice to do so. Later arising confidentiality concerns may also be addressed by section 609(a)(5)(B)(iii) of ERISA, which permits the child to name a representative for receipt of notice from the plan.

The Department believes that these mechanisms work best with the countervailing considerations under ERISA—that the plan administrator is required to send notification of various events to the noncustodial parent whose eligibility for coverage is the basis of the Notice and from whose income any necessary employee contribution will be withheld. Further, absent circumstances that warrant confidentiality, it will be more efficient for both the plan administrator and the custodial parent to be in direct communication on matters such as updated plan information, resolution of benefit claims, reimbursement and other matters of ongoing plan administration.

##### C. Notification Requirements

Commenters requested guidance that would clarify how the Employer Response and the Plan Administrator Response would be used to satisfy the employer's and plan administrator's notification requirements to the Issuing Agency and the custodial and noncustodial parents. Commenters specifically suggested that the Employer Response and the Plan Administrator Response should be sent only to the Issuing Agency. One commenter expressed the view that notification to the custodial parent duplicates the State's duty to inform the custodial parent that coverage is obtained.

In response, the Department believes that the responsibilities of the employer and plan administrator to provide notifications to the Issuing Agency and the custodial and noncustodial parents as described in the Instructions to the Notice are based on the statutory requirements of CSPIA and ERISA. In implementing the Notice, the Department attempted to integrate overlapping notification requirements in order to make processing as efficient as possible. Therefore, Part A of the Notice provides that the employer need notify only the Issuing Agency if coverage is not available for one of the enumerated reasons on Part A, or, if, after the Notice is qualified, the employer determines that coverage is prevented because of State or Federal withholding limitations. In these instances, the Department understands that the Issuing Agency is responsible for notifying the child and/or parents.

In the draft Notice submitted by the Working Group to the Departments as part of its comments and included in an appendix in its Report to the Secretaries, it was suggested that other notification requirements based on CSPIA or section 609(a) of ERISA, such as of the receipt by the plan administrator of a medical child support order (or Notice) and of the qualification decision and basis, can be met by the plan administrator by sending Part B of the Notice to the parties as well as the Issuing Agency. Although this may be permissible, some members of the Working Group were concerned about confidentiality, and about whether use of Part B as a means of providing notifications would satisfy all other statutory obligations. Therefore the Notice as published herein does not provide that Part B can necessarily be used for all purposes.

##### D. Disclosure of Plan Information

Commenters suggested that the Notice should specify the employer's and the plan administrator's responsibilities with respect to disclosure of information related to the group health plan or plans covered by a Notice. Another commenter suggested that the regulation and Notice should clarify which disclosure requirements related to the Notice can be satisfied by use of separate documents such as a summary plan description (SPD). Another suggested that the plan administrator should be required to send the description of coverage only to the custodial parent (or substituted official, as appropriate), and not to the Issuing Agency. Several commenters noted that the space on the Plan Administrator Response allocated for a plan

administrator, following qualification, to provide certain information to the Issuing Agency is inadequate.

The Department believes that information on group health plans, including options available under such plans covered by a Notice, may routinely become available to the parties and the Issuing Agency earlier in the process than at the present. The Department understands that under State laws described in section 466(c)(1)(C) of the SSA, employers are required to provide plan information to a IV-D Agency in response to its request for such information. Further, after the issuance of the underlying support order, the Agency or the custodial parent or other representative of the child may request, and is entitled to receive from the plan administrator, sufficient information to understand the options available and to assist in appropriately completing the Notice. Further, upon receipt of Part B from the employer, the plan administrator is obligated to provide plan information to the child/custodial parent because receipt of the Notice triggers the plan administrator's obligation under ERISA section 609(a)(5)(A) to provide the plan's QMCSO procedures and any other information related to the qualification process to the parties. Lastly, under Part B of the Notice, the plan administrator may be obligated to provide information on options under the plan directly to the Issuing Agency if the employee is not enrolled in any option.

In response to the comments above, the Department has amended the Instructions to Plan Administrator in Part B to clarify that the plan administrator may fulfill the obligation to provide plan information by forwarding copies of the plan's SPD, provided that the SPD includes sufficient information concerning required contributions, benefit levels, and limitations (including geographic or service area limitations) of the plan or plan options. In general, in order to satisfy the requirements of CSPIA and ERISA section 609(a), information about the plan or plan options must be sent to the IV-D Agency as well as the child and custodial parent if requested. This clarification is intended to preserve the flexibility of the plan administrator to satisfy the requirement to provide adequate information in the most efficient and cost effective manner available based on the specific circumstances of the plan administrator. While this revision clarifies that the SPD may be used, it is not intended to prescribe or restrict the types of documents that may be used to satisfy

the objective of providing adequate information about the plan or plan options.

Other commenters requested that the Notice contain additional information. Several commenters suggested that the Plan Administrator Response in Part B should be modified so that when a plan administrator provides information following enrollment, it will include the group policy number and any other relevant information. Another commenter suggested that the Response should contain an item for the plan administrator to inform the Issuing Agency that enrollment forms have not been returned to the plan. Another commenter suggested that the Notice include an explicit coordination of benefits provision. Another commenter suggested that the Employer Response in Part A should be modified so that it can be used by an employer to notify the Issuing Agency if coverage pursuant to the Notice has lapsed for reasons such as termination of the employee's employment or elimination of family coverage by the employer.

The Department has determined that the Notice has as its purpose the establishment of a qualified order under which group health coverage will be provided to a child. Subsequent changes in enrollment or terminations, while perhaps events subject to notification requirements under Federal or State law, are beyond the scope of this Notice. The Department also recognizes that the Notice does not contain all information that may be useful to the parties. Rather, the Notice has been designed to alert the parties to new obligations and procedures, and to remain as streamlined as possible.

## *2. Specific Responsibilities To Be Satisfied Within Statutory Time Periods*

### *A. The Employer*

In general, the responsibilities of employers are described in the final regulation published today by OCSE. However one commenter asked the Department to reconsider the provision in the proposed regulation that only after a Notice is determined to be a QMCSO by the plan administrator would the employer test withholding limits and initiate withholding for contribution to the plan. Several comments suggested that the employer should test whether withholding limits would be exceeded prior to forwarding Part B to the plan administrator. According to these commenters, if withholding limits would be exceeded, the employer should notify the Issuing Agency and the custodial parent of the inability to withhold, and should not

send Part B to the plan administrator. These commenters expressed the view that this would result in more efficient administration of a Notice. Other commenters expressed concern that notification that coverage is available when amounts cannot be withheld to pay for such coverage may place a burden on plan administrators and, in some cases, certain State agencies. One commenter suggested that the plan administrator test for withholding as part of the qualification process.

In response to the last comment, the Department concluded that the plan administrator does not have the information or the authority to make income withholding or prioritization determinations. Further, the Departments, as well as the Working Group, also considered and rejected having the employer determine permissible income withholding within the 40-business day period, and prior to forwarding part B of the Notice to the plan administrator for qualification. It is the understanding of the Departments that it may not be feasible for the employer to attempt to determine whether the necessary withholding is possible prior to the time the plan administrator determines that the Notice is a QMCSO because the employer's payroll office or agent, which usually makes such determinations, often does not have information relating to the amount of employee contribution necessary to extend coverage to the child (ren). Also, where group health plans provide different options for coverage, not all options require the same participant contribution. If the employee is not enrolled, the plan administrator may be required to qualify a Notice before an option is selected by the Issuing Agency. In those cases, the employer initially may not have enough information on the amount of withholding required for coverage.

Although the Department recognizes that the procedure in the Notice may result in some delay between qualification and actual enrollment, the Department believes that qualification of the Notice as a QMCSO at the earliest possible time is most likely to result in more coverage for children. Further, with QMCSOs enforced outside the IV-D system (private QMCSOs), the determination concerning income withholding will necessarily take place after an order is qualified, because the order generally is relayed directly from the court or administrative agency to the plan administrator. Therefore, under the final regulation, as under the proposal, the employer's withholding determination takes place after the qualification of the Notice.

## B. The Plan Administrator

One commenter suggested that the regulation should specify or clarify what responsibilities the plan administrator must fulfill within the applicable 40-business day period. This commenter expressed the view that such clarification would assist IV-D Agencies in developing automated systems for sending inquiries to those plan administrators who do not fulfill their duties in a timely manner. One commenter suggested that the regulation should provide that the 40-business day period shall not run while a plan administrator does not have "complete" information. A commenter also suggested that to correspond with such guidance, the Notice should be modified to contain a space for the plan administrator to inform the Issuing Agency that it cannot satisfy its obligations within the 40-business day period because Part B is incomplete or there is insufficient information for it to determine if the named child can be covered by the plan. This commenter explained that some plans verify that a named child is eligible under the terms of the plan before qualifying an order.

In response, the Department believes that an appropriately completed Notice will have sufficient information for it to be deemed a QMCSO, although additional steps may need to be taken before the enrollment is effective. If a plan administrator receives Part B from the employer, the employer has already confirmed that group health coverage is available and that the employee who is the noncustodial parent is enrolled or eligible for enrollment, and, therefore, that the child is eligible under the Notice for enrollment under the plan (unless over the age limit for dependent coverage under the plan). In addition, both ERISA section 609(a) and State laws described in section 1908 of the SSA have eliminated a number of eligibility criteria that may have been an issue in the past, such as exclusions of children on Medicaid or Medicaid eligible or born out of wedlock, from the definition of "dependent." Therefore, the Department believes that qualification of the Notice can be accomplished well within the 40-business days provided by CSPIA.

### 3. Qualification by the Plan Administrator

#### A. Description of Coverage Provided in the Notice

The proposed regulation at section 2590.609-2(a) provided, as required by section 609(a)(5)(C) of ERISA, that an "appropriately completed" Notice that also satisfies the requirements of

paragraphs (3) and (4) of section 609(a) is deemed to be a QMCSO. The proposal provided in relevant part that a Notice is appropriately completed if it contains the name of an Issuing Agency, the name and mailing address of an employee who is a participant under the plan, the name and mailing address of one or more alternate recipient(s), and if the family group health care coverage required by the child support order is identified and available. One commenter expressed concern that the language in the proposal requiring that family group health care coverage must be "identified and available" might be interpreted as requiring the Issuing Agency to include the name and address of the plan. This commenter suggested that the Department substitute language that would lessen the likelihood of such a misinterpretation.

Several other comments were made regarding the identification of the type of coverage required in the proposed Notice. Commenters generally requested clarification that a "reasonable description" of the type of coverage as required by ERISA 609(a)(3)(B) would be satisfied by a description consisting of "any coverage available under the plan," and that the "type of coverage" provision in the Notice should be modified accordingly. Other commenters suggested that the "type of coverage" provision should be expanded so that an Issuing Agency may enforce orders that provide more specific types of coverage. Commenters suggested that this could be done by providing an exhaustive list of boxed-items that could be checked by the Issuing Agency or by providing empty lines for this purpose.

In response to these comments, the Department has clarified in the final regulation that a Notice is appropriately completed within the meaning of section 609(a)(5)(C) if it identifies an Issuing Agency and an employee of an employer, enrolled or eligible for enrollment in a group health plan sponsored by the employer or to which the employer contributes, who is a noncustodial parent obligated by a State court or administrative order to provide medical child support for one or more children named in the Notice, and also identifies the underlying support order. However, the Issuing Agency is not required to provide the name and address of a group health plan on a Notice because a Notice can be used to enforce a child support order that establishes a general obligation to provide health care coverage. In recognition, the Department has changed the Notice to provide a box to be checked by the Issuing Agency for

any available coverage. In addition, the Notice provides boxes for the Agency to select a particular type of coverage, although the number has not been increased from the proposal.

The Department also has added clarification in the final regulation as to how the Notice will satisfy the requirements of ERISA section 609(a)(3) and (a)(4). Under subparagraph (A) of section 609(a)(3) a QMCSO must include information identifying the employee and child. Subparagraph (B) requires a reasonable description of the type of coverage to be provided or the manner in which such coverage is to be determined, and subparagraph (C) requires a description of the period to which such order applies.

It is the view of the Department that the Notice satisfies ERISA section 609(a)(3)(A) by including the necessary identifying information in Part B that also satisfies the CSPIA requirement contained in section 609(a)(5)(C) of being "appropriately completed." The Department interprets ERISA section 609(a)(3)(B) as being met initially by having the Issuing Agency identify on the Notice some or all of the group health plan options to be considered. Upon receipt of the Notice, the employer will identify whether group health coverage with dependent coverage is available to this employee prior to forwarding part B of the Notice to the plan administrator. The final regulation now provides that if an employer offers a number of different types of benefits (e.g., dental, prescription) through separate plans and receives a Notice on which the Issuing Agency has not specified which or all are covered by the Notice, the employer should assume all, and forward copies of Part B of the Notice to each plan administrator. Further, if a Notice is received by the administrator of a group health plan with several options (e.g., a fee for services option and a managed care option) and the employee is not enrolled, the ERISA section 609(a)(3)(B) requirement will be satisfied because the Notice directs the plan administrator to obtain an election from the Issuing Agency after the Notice is qualified. Finally, ERISA section 609(a)(3)(C) is satisfied by the Notice specifying that the period of coverage may only end for the child(ren) when similarly situated dependents are no longer eligible for coverage under the terms of the plan, or upon the occurrence of certain specified events.<sup>5</sup>

<sup>5</sup> Section 1908(a)(2)(C) and (3)(C) of the SSA sets out rules for States to require that, when a child is provided health care coverage by a parent's insurer pursuant to a court or administrative order,

Under ERISA section 609(a)(4), a QMCSO cannot require a plan to provide new types or forms of benefits not otherwise provided under the plan, except to the extent necessary to meet the requirements of a State law described in section 1908 of the SSA. The Notice satisfies this section because it provides that the child(ren) will only be covered as dependents, or be enrolled only in an option provided under the plan available to other dependents, and the Instructions inform the plan administrator of the restrictions relating to section 1908 of the SSA.

The Department has made several small changes in the final regulation consistent with this discussion, as well as other small changes to simplify the Notice by removing guidance available to the parties elsewhere.

#### B. Other Qualification Matters

A commenter requested that the Notice should indicate which items to be completed by the Issuing Agency are essential for the effectiveness of the Notice with respect to the plan administrator. This commenter explained that an Issuing Agency might hesitate to provide some items of information listed in the Notice, such as child's social security number, or might not have an employer's EIN. Another suggested that the Department provide guidance regarding the omission of information that a plan administrator can reasonably obtain or determine. Another commenter suggested that, consistent with ERISA section 609(a)(3)(A), the Notice should clarify that a plan administrator may not fail to qualify a Notice solely because the address of a substituted official is entered in place of the address of the child (alternate recipient). Another commenter suggested that the Notice should include a statement that it serves as evidence of the underlying child support order. This commenter explained that including this statement is necessary to ensure that the medical support provisions of the underlying child support order can be implemented upon the receipt of the Notice without requiring any additional documentation.

Although the Notice provides for information designed to assist the parties, such as the EIN of the employer and social security numbers of the parties, not all of these items are necessary for the Notice to be

the child may only be disenrolled if the employer or insurer is provided satisfactory evidence that the order is no longer in effect, the child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment, or the employer eliminates family health coverage for all of its employees.

recognized as a QMCSO. As described above, the only information necessary on the Notice is the identity of the Issuing Agency, the identification of an underlying order providing for medical child support, and the names and addresses of the employee and the child(ren) (or substitutes where appropriate). It is the view of the Department that identification of the order on the Notice is sufficient evidence of the existence of the underlying support order. The plan administrator may take Part B of the Notice at face value, and is not obligated (nor should undertake under normal circumstances) to make an inquiry into the bona fides of a Notice or Order under state law. In addition, if any of the necessary information has been omitted but is reasonably available to the plan administrator, the Notice should not fail to be qualified solely because of such omission.

A commenter suggested that the final regulation should provide that a plan administrator would be deemed to have not breached its duties if such plan administrator has acted in good faith to comply with the regulation.

Under ERISA section 609(a)(6), if a plan administrator acts in accordance with the fiduciary standard of conduct in treating a medical child support order as being (or not being) a qualified medical child support order, then the plan's obligation to the participant and each alternate recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary. In addition, the Department believes that the Notice is designed to be presumptively qualified when it reaches the plan administrator. Therefore, in most cases, a plan administrator must pay benefits in accordance with the applicable requirements of an appropriately completed Notice.

#### C. Waiting Periods

The proposed Notice did not specifically address how the application of a waiting period would affect qualification and enrollment. The preamble accompanying the proposal provided in relevant part that "if Part B is appropriately completed, the plan administrator must treat the Notice as a QMCSO, even if there is a waiting period to enroll in the plan." Several commenters suggested that the regulations and the Notice should provide guidance regarding the responsibilities of the respective parties following notification to the Issuing Agency that enrollment is subject to a waiting period. Several commenters suggested that the Employer Response

should contain spaces for the employer to inform the Issuing Agency that the named employee is not eligible for coverage because of a waiting period, and to describe such waiting period.

Under section 701(b)(4) of ERISA, as added by the Health Insurance Portability and Accountability Act (HIPAA), a waiting period is the period that must pass with respect to an individual before the individual is eligible to be covered for benefits under the terms of the group health plan. The Department believes that under some circumstances, such as when an employer receives a Notice for a newly hired employee, or where the Notice requires enrollment of the employee for enrollment of the child, such waiting periods will apply to the employee and child. As under the proposed regulation, the Department believes that a Notice should be qualified regardless of the applicability of a waiting period. The MCSWG in Recommendation #39 of its Report suggested that the employer should be responsible for applications subject to a waiting period of 90 days or more, or if the waiting period is ascertained by some other means such as hours worked.

In response to public comments and concerns of the Working Group, the Notice clarifies that if more than ninety days remain of the waiting period, or if it is measured by some other means, the plan administrator qualifies the Notice, and returns Part B to the employer and the Issuing Agency without completing the enrollment. Upon notification from the employer of satisfaction of the period, the plan administrator completes the enrollment process. However, if the plan provides a waiting period of ninety days or less, or if ninety days or less remain of a longer waiting period, the plan administrator qualifies the Notice, and processes the enrollment, notifying the parties, including the Issuing Agency, of the effective date.

#### D. Notification to Issuing Agency of Multiple Enrollment Options

The proposed Notice provided that, following qualification, in the event that more than one enrollment option would be available to an alternate recipient, the plan administrator would use the Plan Administrator Response to notify the Issuing Agency of these options. The Agency would then choose the option in which the child(ren) would be enrolled.

Several commenters suggested that the Plan Administrator Response (and any corresponding Instructions) should be modified so that the notification to the Issuing Agency regarding multiple enrollment options also includes the

cost of dependent coverage for each option. These commenters explained that, in the event that limitations on withholding would prevent an employer from withholding sufficient amounts for contribution to a plan, information regarding cost of coverage would permit an Issuing Agency to address this problem by modifying the amount withheld for cash support or selecting an option that requires employee contribution within the limitations.

Additionally, some of these commenters suggested that the Plan Administrator Response (and any corresponding Instructions) should be modified so that notification regarding multiple enrollment options also includes a description of any service area limitations. Such information would permit the Issuing Agency to choose an option that could provide benefits to an alternate recipient.

The MCSWG in Recommendation #36 suggested that if some or all options under the plan are limited to specific geographic service areas, then (in addition to sending the Plan Administrator Response to the Issuing Agency) the plan administrator should provide information to the Agency that would allow that Agency to determine whether the coverage would be accessible to the child, although if the child is outside the plan's service area, the plan administrator should be instructed to enroll the child in the plan unless the Agency notifies the plan otherwise. The MCSWG suggested in Recommendation #37 that if the plan administrator cannot determine the child's zip code or location from the Notice, the plan administrator should be instructed to contact the Issuing Agency to obtain sufficient information to determine which options would be accessible to the child or to provide sufficient information to the Agency to make such a determination.

In response, the Department believes that the majority of these concerns will be alleviated because the addition of automatic enrollments in the final Notice decreases the likelihood that the Issuing Agency will need to select coverage. Furthermore, as discussed previously, the Department assumes that the parties, including the Issuing Agency, will have received adequate information regarding the required contributions, benefit levels, and limitations (including geographic limitations) of the plan or plan options, in the form of an SPD or other documents provided by the plan administrator. In general, the Department believes that the Notice will be used most efficiently when it remains as short and simple as possible, and

where the plan administrator has the flexibility to provide the needed information by supplying the appropriate existing documents rather than adding information to the Notice. Therefore, the Department believes that procedures in the final regulation and Notice will satisfy the concern of the Working Group, although the suggestion in Recommendation #36 was not specifically implemented.

With respect to Recommendation #37 of the MCSWG, the Department recognizes the need for information to be exchanged if an option is to be selected, but is reluctant to require the plan administrator to make a determination regarding accessible enrollment options. This determination is better placed with the Agency. Therefore the Department believes it is not appropriate to implement Recommendation #37 of the MCSWG.

#### E. Issuing Agency Responsibility To Choose Enrollment Option

The Department received several comments that expressed concern regarding the requirement that the Issuing Agency choose from among available options. Some of these comments explained that there may be inadequate staff to carry out this function, that such interaction may cause delays in enrollment, and that such interaction may hinder automation of the child support enforcement system. One commenter requested that the Issuing Agency not be made responsible for requiring the non-custodial parent to change coverage, unless Federal legislation is passed that would require States to include this requirement in the State child support enforcement plans. Several commenters suggested, as an alternative, that in the event multiple options are available, the plan administrator should contact one or both parents to choose an enrollment option. Another suggested alternative was that, in the event multiple options are available, the employer would provide the plan administrator with information regarding withholding limits (in this respect, Part A should be revised so that the Issuing Agency clarifies the limit) and costs of options, and the Notice should instruct the plan administrator to enroll the named child in the option that can be accommodated by the amounts that may be withheld in accordance with applicable withholding limits.

Others recommended that if the named employee is already enrolled in family coverage and the named child is in the plan's service area, then the plan administrator should be instructed to enroll the child in such coverage

without any further action by the Issuing Agency. There was also a recommendation that if a plan has a "default option" that it applies with respect to enrollment pursuant to a qualified medical child support order, then it should be permitted to follow that option if the Issuing Agency does not respond within 20-business days regarding its choice from among the available options.

Another commenter recommended that if the named child is currently enrolled as a dependent under the terms of the plan, but other options are available, the plan administrator would use the Plan Administrator Response to notify the Issuing Agency of the availability of options, and the child's enrollment would not change unless the Agency directs otherwise by returning enrollment forms.

In response, the Department understands that some medical child support orders are general in nature, in part because such orders may be used to obtain coverage from a succession of employers and/or group health plans. However, where a plan has only one option, there will be no need to make a selection. This is reflected in the final regulation. Further, in response to comments, under the final regulation, even if there are multiple options under the plan (e.g., a fee for services option and a managed care option), if the child is already enrolled, enrollment will continue unchanged. Also, based on the concerns expressed by State agencies, the final Notice does not provide the Issuing Agency with the opportunity to change the noncustodial parent's existing coverage. Therefore, if the employee is already enrolled in an option with dependent coverage, or with dependent coverage available, the plan administrator should enroll the child with no further action by the Issuing Agency. Thus, in most cases, coverage will be provided automatically, with no further involvement by the Issuing IV-D agency.

The Department recognized, however, that there needed to be some mechanism to implement Notices that are QMCSOs where the employee is not enrolled, the employer provides options under a group health plan, and no option is specified in the Notice. Because the Issuing Agency is enforcing one parent's child support obligations, the Department believes that it is not appropriate to permit either parent alone to choose the coverage. The Department also does not believe it is feasible to adopt the suggestion that the plan administrator choose the enrollment option because the

Department does not believe that the plan administrator should be required to make such discretionary choices regarding coverage. The Department, therefore, concluded that the choice should be made by the Issuing Agency on behalf of the child. Placing the decision with the Issuing Agency also may give that Agency the opportunity to adjust the cash/medical obligation, in order to make appropriate coverage available, and to take into account any assignment of rights to the Medicaid agency.

Lastly, the Notice now provides that if a group health plan offers options, and the employee is not enrolled, and the plan has a default option, the child should be placed in that option if the IV-D agency does not respond to the plan administrator within 20 business days. Even if the plan does not provide a default option, the Department understands that the OCSE regulations, also published today, are designed to ensure that the Issuing Agency will select an option promptly. However, in the event that the Issuing Agency does not, the plan administrator may wish to contact the Agency to ensure that each child is placed in appropriate coverage as soon as reasonably possible.

The Department recognizes that, under these procedures, delays after the Notice is deemed to be a QMCSO may occur in the rare instance that a plan does not have a default option and the Issuing Agency does not respond promptly. The Department also recognizes that this part of the process is not necessarily amenable to automation. This process nonetheless provides a child at least as great a chance of obtaining coverage as a child covered by a private QMCSO, or as a child receiving enforcement services under the State child support enforcement system that existed before CSPIA. With a private QMCSO, there is no mechanism, unless the parents agree, short of returning to the state court or administrative agency that issued the order, to choose between available options. Prior to CSPIA, furthermore, State agencies often had difficulty obtaining medical child support at all. Nevertheless, the Department is soliciting comments regarding approaches by which any remaining delays in providing coverage may be reduced or avoided.

#### 4. Enrollment in Coverage and Types of Benefits

##### A. Type of Coverage

One commenter requested guidance regarding whether a Notice would require a plan to provide dependent-

only coverage if it otherwise would not provide such coverage. Another requested clarification regarding whether a Notice could require enrollment of an employee and an alternate recipient in two separate plans. That commenter expressed the view that a Notice could require enrollment in only one plan.

Under ERISA section 609(a)(4), a QMCSO cannot require a group health plan to offer a type or form of benefit not otherwise provided under the plan, except as required by a State law enacted pursuant to section 1908 of SSA. Therefore, a plan is not required to provide dependent-only coverage if the plan does not otherwise provide such coverage, or offer enrollment in different plans, unless one plan offers dependent-only coverage. However, the Department believes that it is clear from the passage of ERISA section 609(a) and SSA section 1908 that Congress intended plans to enroll children covered by medical child support orders, if the parent is eligible, whether or not the parent is currently enrolled. Therefore, if a plan does not provide dependent-only coverage, it must enroll, without regard to open season restrictions, the child and the parent covered by the Notice if otherwise qualified.

##### B. Optional Enrollment

Several commenters suggested that the regulation and the Notice should clarify that an employee may be enrolled involuntarily if this is necessary for the enrollment of a named child pursuant to a Notice. In contrast, other commenters objected to the requirement that an employee may be enrolled involuntarily in a plan if this is necessary for enrollment of an alternate recipient. Under such circumstances, one commenter suggested that the employee instead should be given the right to enroll voluntarily, but should not be forced to enroll.

The Department has carefully considered these comments and has decided to publish the final regulation as proposed. The QMCSO provisions clearly were enacted under the assumption that the employee involved might not be enrolled in the applicable coverage. The Department does not believe that Congress intended QMCSOs to be given effect only where the employee consents to enrollment. Rather, it is the Department's interpretation that the underlying order establishing the medical child support obligation requires the plan administrator to provide benefits in accordance with its terms. In addition,

State laws described in section 1908 of the SSA require plans and employers to permit the custodial parent to enroll the child, with the implication that the court ordered group health coverage is not dependent on the acquiescence of the employee, the noncustodial parent.

Another commenter expressed the view that requiring an employee who is presently enrolled in a plan to change options from individual coverage to include dependent coverage might be inconsistent with Treasury regulations regarding permissible election changes in "cafeteria" plans.

In response, the Department understands that final Treasury regulations under section 125 of the Internal Revenue Code (IRC) permit a section 125 "cafeteria" plan to change an employee's election to provide coverage for a child who is a dependent of the employee (including a child of either divorced parent<sup>6</sup> if a medical child support order requires coverage for the child).<sup>7</sup> Likewise, a section 125 "cafeteria" plan may permit a participant to make an election change to cancel coverage for such a child if a medical child support order requires another individual to provide coverage for such child.<sup>8</sup>

##### C. "Unlawful refusal to enroll" Provision

The Department received several comments regarding the "unlawful refusal to enroll" provision in the proposed Notice. One commenter requested that the regulation clarify whether open enrollment restrictions, such as those imposed by HMOs, could be applied to enrollment pursuant to a Notice. Another suggested that the provision should further provide that enrollment cannot be denied on the ground that a child has a preexisting condition that would otherwise make the child ineligible for coverage.

In response, the Department notes that enrollments pursuant to a Notice are to be made without regard to open season restrictions (which generally are limited periodic opportunities to enroll in the plan). This requirement is derived from SSA section 1908(a)(2) and (3).

<sup>6</sup> See section 105(b) of the IRC.

<sup>7</sup> The Department notes that a flexible spending arrangement (as defined in IRS proposed regulation 26 CFR 1.125-2 Q&A 7(c), 54 FR 9460) or medical savings account (as defined in section 220 of the IRC), which may be offered as part of a section 125 "cafeteria" plan, that is subject to Title I of ERISA is a group health plan as defined under ERISA section 607(a), and thus is subject to the requirements of ERISA section 609(a).

<sup>8</sup> See 65 FR 15548, 15552 (March 23, 2000).

However, new enrollees may be subject to pre-existing condition limitations.<sup>9</sup>

#### D. Period of Coverage

A commenter suggested that language should be added to the "period of coverage" provision so that the disenrollment of a child upon provision of evidence that the order is no longer in effect would be permitted only when such evidence is provided by the Issuing Agency. Another commenter requested guidance on the meaning of "comparable coverage" in this provision.

The Department recognizes the concern raised by these comments. The relevant provisions of the Notice require that coverage may only be terminated if the plan administrator is provided "satisfactory" written evidence that the support order is no longer in effect. In response to the second comment on this section, it is the Department's view that "comparable coverage" as used in the "period of coverage" does not mean identical, but generally means coverage that is similar in scope to the current coverage and that would provide approximately the same type and extent of coverage to the child or children. The term "comparable coverage" appears in section 1908 of the SSA, but is not defined. The Health Care Financing Administration (HCFA) is responsible for interpretations of those provisions of the SSA, and it is the understanding of the Department that HCFA intends to promulgate regulations that will include a discussion of the term "comparable coverage."

#### E. Other Termination Matters

The Department received several comments related to the employee contributions necessary for coverage. Commenters requested guidance regarding whether a plan would be required to provide benefits if an employer cannot withhold a sufficient amount because of the application of withholding limits.

It is the Department's view that if the necessary employee contributions cannot be made because of income withholding limitations, the plan is under no obligation to continue coverage.

#### 5. Challenges

A number of comments requested clarification regarding how an employee could contest income withholding or

could challenge certain aspects of the Notice qualification process.

In response to the comment regarding income withholding, the Instructions to the employer on Part A of the Notice explain that the employee may contest the wage withholding based on a mistake of fact (such as the identity of the obligor), and that to contest such enforcement, the employee should contact the Issuing Agency. State law governs the circumstances under which the employee may challenge the underlying State court order that establishes the support obligation. Lastly, in response to the comment regarding the qualification process, it is the Department's view that the plan's QMCSO procedures should explain the employee's ERISA remedies, including the information that the plan administrator's determination whether a notice is a QMCSO is a fiduciary act that is subject to challenge in Federal court under ERISA.

#### 6. Effective Date and Use

##### A. General use of the Notice

Several commenters suggested that the Notice should contain language clarifying that, pursuant to sections 401(e) and (f) of CSPIA, it is intended to effect enrollment in plans established or maintained by state and local governments and churches, which are generally exempt from ERISA, as well as group health plans subject to ERISA. These commenters note that, in accordance with section 466(a)(19) of the Social Security Act, State child support enforcement agencies will be required to send the Notice to an employer regardless of whether the group health plan maintained by that employer is subject to ERISA. These commenters express concern that because the Notice refers specifically to ERISA, it may be misinterpreted as applicable only to ERISA-covered plans.

The Department agrees with this comment. The Notice has been revised to clarify its use with respect to church plans and plans of state and local governments.

A commenter asked whether a Notice would be effective for enrollment purposes if sent directly to a plan administrator by an Issuing Agency.

The Department believes that most, if not all, States will continue the practice of sending medical child support orders, including, when adopted by each State, the Notice, to employers for enforcement, as is required under CSPIA. However, if a plan administrator receives a Notice directly from an Issuing Agency, it should be administered as if it were a medical

child support order under ERISA section 609(a), to the extent possible.

Commenters requested guidance regarding what entity constitutes an "issuing agency" that is permitted to issue a Notice. One suggested that "issuing agency" means the courts and IV-D or child support enforcement agencies; others suggested that it means only IV-D or child support enforcement agencies. Commenters, including the MCSWG in Recommendation #27 of its Report, reasoned that the relevant statutory provisions contemplate an "issuing agency" that is a child support enforcement agency, and that such guidance will clarify that the specific requirements contained in section 609(a)(5)(C) of ERISA will not apply with respect to a Notice that is not issued by IV-D Agency, and that only Notices issued by IV-D Agencies will be deemed QMCSOs.

In response, the Department notes that it is clear that CSPIA contemplates that the Notice is to be issued by State IV-D agencies. It is also clear, however, that Congress did not intend to invalidate existing or alternative child support enforcement efforts outside of the IV-D system. The obligations imposed by section 609(a)(5)(C) of ERISA apply only with respect to those Notices issued by State IV-D agencies. However, a Notice received from a source other than a IV-D Agency may be valid for purposes of enrolling a child. Plan administrators are advised that such orders are "medical child support orders" as defined in ERISA section 609(a)(2)(B), that the procedures mandated by section ERISA 609(a)(5)(A) and (B) remain applicable with respect to such orders, and that if such orders satisfy the ERISA requirements, they are QMCSOs.

##### B. Effective Date

The NPRM proposed an October 1, 2001, effective date for the final regulation, which coincides with the earliest date on which States, under section 401(c)(3) of CSPIA (as amended by section 4(b) of Pub. L. 105-306), will be required to use the Notice to enforce the health care coverage provisions of child support orders.

The Department received a number of comments related to the effective date of the regulation. One commenter requested clarification as to when use of the Notice may begin. This commenter noted that some States may begin to use the Notice prior to the proposed effective date of the Labor regulation. Commenters also requested guidance regarding whether the promulgation of the Notice would invalidate orders being treated as qualified medical child

<sup>9</sup> Under section 702 of ERISA, as added by HIPAA, enrollment cannot be denied because of a preexisting condition, and section 701 of ERISA limits the period for which such conditions can affect eligibility for benefits.

support orders prior to the effective date, and, in any case, whether a Notice would need to be issued with respect to these orders. These commenters also questioned whether a Notice may be used to enforce only those child support orders issued after the effective date of the final Notice regulation.

Section 401(d) of CSPIA, which added section 609(a)(5)(C) to ERISA, did not contain a delayed effective date as section 401(c)(3) does. The Department understands that some States will begin to use the Notice upon its final publication. The Department believes such use is permissible and has therefore amended the effective date provision for the regulation to be effective 30 days after publication. After that date, if a plan administrator receives Part B from the employer, the plan administrator must operate in accordance with section 609(a)(5)(C) of ERISA and 29 CFR 2590.609-2. The Department also believes that Congress did not intend to invalidate previously issued and qualified medical child support orders, and that Congress intended that the Notice could be used to enforce orders issued prior to the passage of CSPIA.

#### **Economic Analysis Under Executive Order 12866**

Under Executive Order 12866 (58 FR 51735, Oct. 4, 1993), the Department must determine whether a regulatory action is "significant" and therefore subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive Order defines a "significant regulatory action" as an action that is likely to result in a rule (1) having an annual effect on the economy of \$100 million or more, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

Pursuant to the terms of the Executive Order, it has been determined that this regulation raises novel legal or policy issues arising out of legal mandates. Therefore, this regulation is "significant" and subject to review

under section 3(f)(4) of the Executive Order. Consistent with the Executive Order, the Department has undertaken an assessment of the costs and benefits of this regulatory action. The analysis is detailed below, following a description of the medical child support process and its relationship to this regulation.

#### *Overview*

The medical child support process requires that a State child support enforcement agency (State agency) issue a notice to the employer of a noncustodial parent, who is subject to a child support order issued by a court or administrative agency, informing the employer of the parent's obligation to provide health care coverage for the child(ren). The employer must then determine whether family health care coverage is available for which the dependent child(ren) may be eligible, and if so, the employer must notify the administrator of each plan covered by the Notice. The plan administrator is then required to determine whether the dependent child(ren) are eligible for coverage under a plan. If eligible, the plan administrator is required to enroll the dependent child(ren) in an appropriate plan.

Even with a medical child support process in place, State agencies and administrators of group health plans have experienced difficulties in obtaining medical coverage for children of noncustodial parents due to problems encountered in establishing what constitutes a qualified medical child support order (QMCSO). In response to these and other problems affecting the child support process, the Child Support Performance Incentive Act of 1998 (CSPIA) was enacted.

As required by CSPIA, the Department and HHS are jointly promulgating a uniform National Medical Support Notice (Notice) to be used throughout the child support process by State agencies, employers, and plan administrators. This Notice is intended to simplify the issuance and processing of medical child support orders, provide standardized communication between State agencies, employers, and plan administrators, and create a uniform process for the enforcement of medical child support.

The Notice has two parts, Part A, the "Notice to Withhold for Health Care Coverage," and Part B, the "Medical Support Notice to Plan Administrator." The HHS regulation establishes procedures that would be followed once the Notice has been transmitted by the State to the employer and by the employer to the plan administrator. Thus, the Department's regulation

provides guidance to plan administrators once Part B has been transmitted to a plan administrator. Part B incorporates the provisions of the CSPIA as it pertains to the Employment Retirement Income Security Act (ERISA). Specifically, Part B would implement section 609(a)(5)(C) of Title I of ERISA, which was added by section 401(d) of CSPIA to provide specific rules for plan administrators to follow upon receipt from an employer of Part B.

For purposes of this economic analysis, the Department estimated the benefits and costs of the regulation relative to the costs of processing child support orders in the current environment. The benefits and costs of the rights conferred by the statute and current practices for processing medical child support orders are included in the baseline and are therefore not considered benefits or costs of the regulation. These include the rights for enrollment in a plan, as well as increased health care coverage and the attendant increases in claims costs faced by employee benefit plans. The Department is not aware of any analysis presently available that seeks to quantify the costs and benefits of the medical support order provisions of CSPIA and, therefore, is not presenting estimates of the costs and benefits of the statute in conjunction with evaluating the incremental cost and benefits of discretion exercised in the regulation.

The Department's analysis indicates that the benefits of the regulation substantially exceed the costs. There are two types of economic effects of the regulation: (1) The more general and primarily indirect societal welfare gains associated with facilitating access to health care for dependent children, and (2) the direct administrative benefits and costs associated with implementing standardized Notices. The new procedures will promote timeliness in processing medical child support orders and accuracy in identifying a medical child support order as a QMCSO, thus, providing dependent children greater access to health care on a regular and timely basis. The new procedures will also increase efficiency and decrease administrative costs per Notice that arise when a non-standardized notice system is replaced by a standardized notice system.

The Department's analysis relies on the basic assumption that plans incur a baseline cost to process notices in the current manner. Each notice is assumed to be unique, requiring individualized effort. The first standardized Notice received by a plan administrator is expected to require the same time as the

unique notices previously received. In addition, however, it is assumed that many plan administrators will invest in establishing new procedures upon receiving the first Notice in anticipation of offsetting this start-up cost in future savings associated with standardization. The processing time for each second and subsequent Notice is assumed to be significantly reduced. Plan administrators who do not have a reasonable expectation of receiving subsequent Notices are assumed to simply continue to process Notices as before and therefore to be unaffected by the regulation.

Based on its analysis, the Department believes that significant net benefits will derive from the direct costs and benefits of the administrative efficiencies which

will result from standardization. The degree of the net benefit is a function of the size of the plan. All large plans (those with at least 100 participants) are expected to benefit almost immediately, as they are expected to receive multiple notices the first year, thereby recovering their costs to implement new procedures through decreases in time spent handling subsequent Notices.

An aggregate net benefit is also expected for smaller plans (those with 10–99 participants) although the initial costs associated with procedural changes will be repaid through savings over a longer period of time. The benefits for this group is shown to grow progressively larger over time. Very small plans (those with fewer than 10 participants) are not expected to be

affected in the aggregate by the regulation due to the relative infrequency of their receiving medical child support notices.

The estimated net benefits and costs of the regulation in the first three years of implementation are summarized in the table which follows. As shown, the regulation is estimated to result in savings of \$26.6 million in the first year, reducing total processing costs by nearly one-half. The savings which accrue to plans will increase over the years as a progressively greater proportion of the Notices yield savings. The analysis indicates a net savings of \$31.4 million in the second year increasing to \$34.3 million by year three with a total aggregate savings of \$92.3 million over the period.

	Baseline cost (millions)	Cost of investment under regulation (millions)	Cost of processing under regulation (millions)	Net savings under regulation (millions)
Year 1 .....	\$62.3	\$5.7	\$30.0	\$26.6
Year 2 .....	62.3	3.5	27.4	31.4
Year 3 .....	62.3	3.1	24.9	34.3
Years 1–3 .....	186.9	12.3	82.3	92.3

The more general societal welfare gains that are expected to arise from improvements in the economic security and health of children are not taken into account in the summary of net benefits because they cannot be specifically quantified. A detailed discussion of the development of estimated costs and benefits follows.

*Discussion of the Comments*

As mentioned above, the Department made changes to the Notice to incorporate the public’s comments. These changes to the Notice, however, did not significantly decrease or increase the costs or benefits under the regulation.

The Department did receive one comment about the assumptions used in calculating the economic analysis. The commenter believed that, unlike other health plans, multiemployer health plans would have outside counsel review the notices. Multiemployer health plans are maintained pursuant to *bona fide* collective bargaining agreements and for the benefit of employees represented by a union in the collective bargaining process. Based on the current practice of having outside counsel reviewing qualified domestic relations orders (QDROs), the commenter believed that plan administrators for multiemployer plans would have outside counsel review the notices for multiemployer plans. In

response to this comment, it is the Department’s view that plan fiduciaries must take appropriate steps to ensure that plan procedures are designed to be cost effective and to minimize expenses associated with the administration of medical child support orders.<sup>10</sup> The Department believes the cost of contracting out legal services, when it is cost effective and reasonable to do so, to be a baseline cost. If multiemployer plans contract out legal services, they are currently incurring the cost when processing medical child support orders. As such, any legal costs associated with the processing of such an order that are reasonably and prudently incurred should be included in the baseline cost. Assuming that multiemployer health plans continue the current practice of contracting out legal services to review the Notice when it is cost effective and reasonable, this also will be a cost under the regulation. Thus, increasing the cost under the regulation will offset any net savings that would result from increasing the baseline cost. The result would be a net change of zero. Therefore, for the economic analysis, the Department has decided not to calculate multiemployer health plan costs separately at higher hourly rates.

<sup>10</sup> See Advisory Opinion 94–32, August 4, 1994, footnote 4.

*Costs of the Regulation*

The only cost of this regulation is the start-up cost incurred by ERISA-covered plans to set up procedures to conform with the format of the Notice.<sup>11</sup> This start-up process is assumed to require one hour of a professional’s time at an hourly rate of \$45. It is assumed that plan administrators will complete this work themselves, rather than purchase services. The cost is incurred the first time a plan receives a medical child support order under the standardized Notice format. For plans with 100 or more participants, this start-up cost is incurred entirely in the first year, since every one of these plans receives its first standardized Notice in year one. The start-up cost for these plans is \$1.7 million. Among plans with 10 to 99 participants, each year a fraction receives a medical child support order and incurs a start-up cost in response. As a result, their aggregate start-up cost, estimated at \$4.0 million in year one, falls over time. Plans with fewer than 10 participants receive these Notices too infrequently to make the investment in establishing cost effective procedures

<sup>11</sup> Plans sponsored or maintained by State and local governments and by churches are not subject to Title I of ERISA pursuant to section 4(b)(1) and (2) of ERISA. However, such plans may be required to comply with the Notice under section 401(e) or (f) of CSPIA.

and will be unaffected by the standardized Notice.

### Benefits of the Regulation

The introduction of a uniform notice with clear instructions may improve health care quality for children by preventing delays and denials of enrollment in group health care plans, thereby encouraging early intervention in the treatment of disease and illness. The social welfare loss resulting from uninsured children is well documented in economic literature. Based on analysis of the March 1999 Current Population Survey conducted by the Bureau of the Census, 15 percent of all children (or 11.1 million) are currently uninsured. The lack of private insurance generally increases the likelihood that needed medical treatment will be delayed or forgone, and that the ultimate costs of medical treatment will be shifted to public funding sources.

The link between uninsured children and the deficiencies of the existing child support process is demonstrated in the legislative history of CSPIA.<sup>12</sup> The legislative history indicates that there is a lack of effective communication of medical child support information between the State agencies and plan administrators. State agencies typically send employers an administrative notice (that varies from State to State, and sometimes among different counties or courts within a State) of an employee's medical child support obligations, which many plan administrators contend do not comply with current ERISA requirements. Although all child support orders are required to have a medical support component, only a reported 60 percent of all child support orders actually have this medical support component.

In addition, the legislative history cites a 1996 GAO review of State child support enforcement programs which determined that at least 13 States were not petitioning to include a medical support component in their child support orders, and 20 States were not enforcing existing medical child support orders. The number of children who are uninsured as a direct result of failures of this medical child support process is unknown. However, any reduction in the number of uninsured children that can be accomplished by the regulation will produce substantial benefits for the health of those children, and preserve public resources for those without access to private coverage.

Direct benefits of the Notice will accrue to plans, State agencies, employers, parents, and children. Part B will reduce the inefficiencies inherent in current practice, which often require plan administrators to work with medical child support notices that differ from State to State and from individual to individual. Consequently, confusion arises as to what constitutes a QMCSO, and often as a result, the medical support is not provided. Specifically, benefits will accrue to plan administrators because they will all receive a standardized Notice which is easy to comprehend and to administer. This will limit the plans' risk of exposure to errors in determining which orders are QMCSOs and lead to the accurate identification of the dependent children eligible for enrollment in a group health plan. Finally, Part B will promote one of the objectives of the child support process, which is to ensure access to medical care coverage for children.

In the first year of a standardized Notice system, the total cost to private employer group health plans of processing medical child support orders is expected to drop from the current level of \$62.3 million to \$35.7 million. This estimate is derived as follows.

HHS projects that there will be 1.2 million new child support orders with collections each year. Adjusting this figure to exclude orders received by employers with no ERISA-covered plans or not offering family health coverage, and to add orders that are not new orders but that arise from job changes, the Department of Labor estimates that plan administrators of ERISA-covered group health plans will receive a total of 770,000 Notices annually. The baseline cost (absent this regulation) to handle these notices is estimated to be \$62.3 million annually. This assumes 1 hour and 45 minutes processing time at a \$45 hourly professional's rate, plus 2 minutes in photocopying time at a \$15 clerical rate, and \$0.37 for materials and postage per required response.

The Department assumed that plans that invest in new procedures to process standardized Notices will cut their processing time to 35 minutes. Whether or how quickly ongoing savings from faster processing will offset the one-time cost of establishing new procedures will depend on how many Notices a plan receives. The probability of a plan receiving a Notice in a given year is a function of the number of participants in the plan. The probability is low for very small plans, but high for large plans.

Following this reasoning, the Department concluded that plans with

fewer than 10 participants will not anticipate near-term savings and therefore will not invest in new procedures but will continue to incur baseline costs, estimated at \$2.3 million annually on aggregate.

Plans with 10 to 99 participants will invest in procedures when they receive their first Notice, and will recover their cost and realize net savings within a few years or less on average. On aggregate as a group, these plans will realize net savings beginning in year three. Their aggregate baseline processing costs are estimated at \$7.6 million annually. Under the regulation, their aggregate combined costs of processing and establishing new procedures will decline from \$11.4 million in year one to \$7.4 million in year three, with savings increasing in subsequent years.

Plans with 100 or more participants will invest in new procedures in the first year and will typically recover their cost and realize net savings in that same year. Their aggregate cost will fall from \$52.4 million annually under the baseline to \$22.8 million under the regulation in year one and to \$18.3 million in year two.

Except where noted to the contrary, the assumptions and methods underlying these estimates are the same as those underlying the Department's estimates of the effects of its proposed Notice regulation. These assumptions and methods are detailed in the Notice of Proposed Rulemaking (64 FR 62054, November 15, 1999).

### Alternative Approaches Considered

A number of alternative approaches to this regulation were considered. The first drafts of the Notice presented to the MCSWG consisted of two parts and provided a number of defaults which decreased the discretion required in responding to the Notice and was particularly streamlined. This version was rejected after members of the MCSWG noted that feedback to the Issuing Agency regarding the nature of coverage available and its effective date was essential to the effective enforcement of medical child support obligations. A second version of the Notice was developed which included four parts and provided for more responses to the Issuing Agency. Again the MCSWG provided commentary, responding that this version was too complicated and cumbersome. A third version of the Notice was developed. This version provided feedback to the Issuing Agency, yet it was more streamlined and comprehensible. It enabled the Issuing Agency to select the coverage that would ultimately be provided to the child(ren) from the

<sup>12</sup> 144 Cong. Reg. S7318 (daily ed. June 26, 1998) (Legislative History of Senate and House Amendments to the Child Support Performance and Incentive Act of 1998, ub. L. No. 105-200).

options available to the participant/noncustodial parent. Enabling Issuing Agencies to make this selection, rather than having the child automatically placed in a default coverage option, ensured that the child would receive meaningful and accessible coverage from among the particular options available under the plan. The final version, as published here, reflects more streamlining. Also, some public comments to the proposed regulation and Notice have been incorporated. For example, the Department simplified the Notice by removing guidance available to the parties elsewhere. For a complete discussion of comments, see above.

#### **Paperwork Reduction Act**

In accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3520)(PRA 95), the Department submitted the information collection request (ICR) included in Part B, Medical Support Notice to Plan Administrator of the National Medical Support Notice (Notice) to the Office of Management and Budget (OMB) for review and clearance at the time the Notice of Proposed Rulemaking (NPRM) was published in the **Federal Register** (November 15, 1999, 64 FR 62054). OMB approved the Notice under OMB control number 1210–0113. The approval will expire on January 31, 2003.

The Department solicited comments concerning the ICR in connection with the NPRM. The Department received only one comment addressing its burden estimates. Although the original burden estimates relied on the assumption that all Notices would be processed in-house by plan administrative staff, the commenter expressed the differing view that multiemployer health plans will use the services of outside counsel to process Notices, and incur greater costs as a result. The Department recognizes that in limited circumstances it may be cost-effective, and therefore reasonable, for multiemployer health plans to employ outside counsel to process medical child support orders. However, to the extent that the use of outside counsel may have been cost effective for a plan due to the fact that the plan received differing medical child support orders from different States, or from different counties or courts within a State, the uniformity introduced by use of the Notice should reduce the need to use outside counsel to determine whether any particular Notice is qualified. Because the number of multiemployer health plans is small relative to the total number of plans (approximately 2,000 of a total of 2.5 million), and because

the number of instances among those plans in which it is reasonable for plans to use outside counsel to process the Notices is expected to be limited, the Department continues to consider its original hour and cost burden estimates to be appropriate.

#### **Regulatory Flexibility Act**

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA), imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and which are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a rule will not have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires the agency to present a final regulatory flexibility analysis at the time of the publication of the notice of final rulemaking describing the impact of the rule on small entities. Small entities include small businesses, organizations, and governmental jurisdictions.

For purposes of analysis under the RFA, the Pension and Welfare Benefits Administration (PWBA) considers a small entity to be an employee benefit plan with fewer than 100 participants. The basis for this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans which cover fewer than 100 participants. Under section 104(a)(3), the Secretary may also provide for simplified annual reporting and disclosure if the statutory requirements of part 1 of Title I of ERISA would otherwise be inappropriate for welfare benefit plans. Pursuant to the authority of section 104(a)(3), the Department has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46 and 2520.104b-10 certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans covering fewer than 100 participants and which satisfy certain other requirements.

Further, while some large employers may have small plans, in general most small plans are maintained by small employers. Both small and large plans may enlist small third party service providers to perform administrative functions, but it is generally understood that third party service providers transfer their costs to their plan clients in the form of fees. Thus, PWBA

believes that assessing the impact of this rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity considered appropriate for this purpose differs, however, from a definition of small business based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (5 U.S.C. 631 *et seq.*). PWBA solicited comments on the use of this standard for evaluating the effects of the proposal on small entities. No comments were received with respect to the standard. Therefore, a summary of the final regulatory flexibility analysis based on the 100 participant size standard is presented below.

PWBA is promulgating this regulation because it is required to do so under section 401(b) of the Child Support Performance and Incentive Act of 1998 (CSPIA) (Pub. L. 105–200). CSPIA requires the Department of Labor and the Department of Health and Human Services (HHS) to jointly develop and promulgate by regulation a National Medical Support Notice (Notice). The content of the Notice is prescribed by the statute. Thus, as outlined in the economic analysis section of this preamble, the benefits and costs attributable to the regulation are those associated with the discretion exercised by the Department only in the format of the Notice. The statute affords no regulatory discretion with respect to application of the statutory requirements to entities of differing sizes. Nevertheless, analysis of the impact of the regulation indicates that in the aggregate, small plans with between 10 and 99 participants will benefit from standardization of medical support Notices, and that net benefits to these plans will grow progressively larger over time. Very small plans, those with fewer than 10 participants, are not expected to be affected by this rulemaking because it is assumed that due to the infrequency of their receipt of Notices, these plans will continue to handle medical child support notices as they do in the existing environment.

The objective of the regulation is to introduce Part B—Medical Support Notice to Plan Administrator (Part B), which implements section 609(a)(5)(C) of Title I of ERISA, which was added by section 401(d) of CSPIA. Section 609(a)(5)(C) of ERISA provides that a Notice is deemed to be a Qualified Medical Child Support Order (QMCSO) if the plan administrator of a group health plan which is maintained by the employer of a noncustodial parent or to which the employer contributes, receives an appropriately completed

Notice which meets the requirements for a qualified medical child support order under section 609(a)(3) and (4) of ERISA (which provides the informational requirements for a qualified order and restrictions on new types of benefits). New ERISA section 609(a)(5)(C) also establishes new requirements for plan administrators to enroll alternate recipient(s) in a group health plan and to notify the appropriate state agency, noncustodial parent, custodial parent and alternate recipient(s). Thus, the legal basis for the regulation is found in ERISA section 609(a)(5); an extensive list of authorities may be found in the Statutory Authority section, below.

The direct impact of compliance with Part B of the Notice will fall upon ERISA-covered group health plans. Plans with 10 to 99 participants will benefit from a net aggregate reduction in costs under the standardized Notice system. Their baseline cost to process Notices is estimated at \$7.6 million, or \$85 per plan, annually. Under the regulation, the combined cost to process Notices and establish new procedures to process standardized Notices will decline from \$11.4 million, or \$127 per plan, in year one to \$7.4 million, or \$83 per plan, in year three. The savings will increase in subsequent years as the start-up investment is recouped by more plans.

Plans with fewer than 10 participants receive Notices infrequently and therefore would be unlikely to recoup start-up costs from future savings from processing subsequent Notices. These plans therefore are not expected to establish new procedures for processing standardized notices but will continue to incur baseline costs of \$2.3 million, or \$81 per plan, annually.

The basis for these estimates is summarized in the discussion of Executive order 12866, presented above.

No federal rules have been identified that duplicate, overlap, or conflict with this regulation. As discussed previously in the economic analysis under the Executive Order, a number of alternatives to this regulation were considered. At least three distinct versions of the Notice were developed prior to arriving at this final version. Prior drafts were critiqued by the Medical Child Support Working Group, which included representatives from the small business community. Based on commentary received from the Working Group and the general public, the Agencies feel that this version of the Notice provides the minimum information necessary to comply with section 609(a)(5)(C) of ERISA and imposes the least economic impact on

small entities. The establishment of different compliance requirements or an exemption from compliance for small entities was not considered in light of the goal of this rulemaking. Differing compliance schemes for small entities would frustrate the objective of providing a nationally uniform medical child support notice to be used by all State Agencies and to be easily identified by employers, plan administrators and parents.

#### **Federalism Statement Under Executive Order 13132**

When an agency promulgates a regulation that has federalism implications, Executive Order 13132 (64 FR 43255, August 10, 1999) requires the agency to provide a federalism summary impact statement. Pursuant to section 6(c) of the Order, such a statement must include a description of the agency's consultation with State and local officials, a summary of their concerns and the agency's position supporting the need to issue the regulation, and a statement of the extent to which the regulation meets the concerns of State and local officials. This final regulation has been identified as having federalism implications within the meaning of the Order.

This regulation is mandated by provisions of the Child Support Performance and Incentive Act (CSPIA) that were enacted in response to difficulties that State child support enforcement agencies had experienced in enforcing medical child support orders. In particular, many State agencies, as well as the National Child Support Enforcement Association, an organization representing State child support enforcement agencies, participated in the legislative process that resulted in CSPIA's passage. CSPIA provided specific guidance on the content of the National Medical Support Notice (Notice) and provided for the establishment of the Medical Child Support Working Group, which included seven representatives of State child support enforcement directors and State Medicaid/SCHIP directors. This group was tasked by statute to make recommendations based on assessments of the form and content of the Notice, which it provided both prior to its issuance in proposed form as well as during the comment period. In addition, approximately 15 State child support enforcement agencies submitted comments on the proposed regulation independently during the comment period. These recommendations proved very helpful to the Departments in developing the final regulation.

State representatives generally supported the development of the Notice. They viewed the Notice as necessary to overcome difficulties that State agencies had previously experienced in securing medical child support from group health plans available to noncustodial parents. The Department agreed that the Notice was needed not only to comply with CSPIA's mandate to issue regulations, but also to maximize access to private group health insurance for children. The following discussion summarizes the major concerns of State agencies and the responses offered by the Department in the final regulation.

Early in the development of the Notice, State representatives on the Working Group made recommendations which guided the Departments in developing the format of the Notice. State representatives expressed a strong preference that the Notice resemble to the extent possible the uniform Order/Notice to Withhold Income for Child Support currently used by State agencies to enforce child support orders. They noted that this standardized withholding form has facilitated child support income withholding and is already familiar to employers. Also, State representatives requested that the Notice include a feedback loop to the Issuing Agency in the event that coverage was not available to the noncustodial parent through the employer's group health plan. The Departments agreed that incorporating both features would ease the enforcement of medical child support obligations.

In comments received following the publication of the proposal, State agencies generally objected to the requirement to choose from among the options available under the noncustodial parent's group health plan. They also objected to the possibility that selecting the most appropriate option for the child could entail changing the noncustodial parent's existing coverage. State representatives stated that they lacked the resources and expertise necessary to make such decisions and requested that the choice be either automatic or made by another party. In response, the Department included several default options intended to automate the selection as much as possible, minimizing the instances in which the Issuing Agency must choose. These default options have eliminated the possibility that a noncustodial parent's existing coverage would change based on a selection by the Issuing Agency. However, in cases where the group health plan offers multiple coverage options and the noncustodial

parent has not elected coverage, the Department determined that it was most appropriate for the Issuing Agency to make the selection. The Department concluded that, in this narrow range of cases, the Issuing Agency is in the best position to make the selection consistent with the best interests of the child.

In addition, in cases where the Issuing Agency must choose a coverage option from several available under a group health plan, State agencies requested that the Plan Administrator Response of Part B of the Notice indicate whether the various options serve geographically limited areas, and the additional cost to the participant to enroll the child(ren) in each option. State agencies stated that this information would assist them in making coverage selections. After much deliberation, the Department decided not to require this information directly on the Plan Administrator Response. Instead the Department has included a requirement that the plan administrator provide descriptions of each option to the Issuing Agency which include this information, such as summary plan descriptions. In the interest of expediting the processing of Notices, reducing the length of the Notice, and easing the burden on plan administrators, the Department has not required plan administrators to duplicate this information on the Plan Administrator Response.

State agencies requested that the Notice clarify that it applies both to ERISA-covered and non-ERISA plans as intended by CSPIA. They commented that non-ERISA plans may not honor the Notice because much of the language in the proposed Notice referred to ERISA. In response, the Department included language in the Notice clarifying its application to State and local government plans, as well as church plans, and eliminated some of the ERISA legal terminology.

States requested that they be informed when a noncustodial parent is not eligible for coverage under the employer's group health plan due to a waiting period and that the Notice clarify the obligations of the parties when a waiting period applies. State agencies noted that in the case of a long waiting period, it may be in the best interest of the child to attempt to secure alternative coverage during such a waiting period. The Department responded by including in the Plan Administrator Response a mechanism for the plan administrator to notify the Issuing Agency that a long or indeterminate waiting period applies. In addition, the preamble and the instructions on Part B of the Notice

clarify that, in any case in which such a waiting period applies, enrollment will be processed upon the satisfaction of the waiting period. When a shorter waiting period applies (less than 90 days) the Plan Administrator Response includes a space for the plan administrator to indicate when coverage will become effective, accounting for any remaining days in such a waiting period.

Regarding the type of health care coverage selection on Parts A and B, several State agencies commented that many child support orders are general in nature and do not order specific types of coverage. They requested that this portion of the Notice include a general selection such as "any health coverage available" rather than requiring the Issuing Agency to select from a specific type of coverage. The Department included such a selection in the final Notice as well as guidance in the regulation directing plan administrators to provide all available coverage where the Issuing Agency has failed to indicate any type of coverage.

#### **Small Business Regulatory Enforcement Fairness Act**

The rule in this action is subject to the provisions of the Small Business Regulatory Enforcement Act of 1996 (5 U.S.C. 801 *et seq.*) (SBREFA), and has been transmitted to Congress and the Comptroller General for review.

#### **Unfunded Mandates Reform Act**

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), as well as Executive Order 12875, this rule does not include any Federal mandate that may result in the expenditure by state, local and tribal governments in the aggregate, or by the private sector, of \$100,000,000 or more in any one year.

#### **Statutory Authority**

Sections 505 and 609(e) of ERISA (Pub. L. 93-406, 88 Stat. 894, 29 U.S.C. 1135 & 1169(e)). Section 401(b) of CSPIA (Pub. L. 105-200, 112 Stat. 645).

#### **List of Subjects in 29 CFR Part 2590**

Employee benefit plans, Health care, Medical child support, Pensions, Reporting and recordkeeping requirements.

For the reasons set forth above, Part 2590 of Title 29 of the Code of Federal Regulations is amended as follows:

#### **PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLAN REQUIREMENTS**

1. The part heading is revised to read as shown above.

2. The authority citation for part 2590 is revised to read as follows:

**Authority:** 29 U.S.C. 1027, 1059, 1135, 1171, 1194; Sec. 4301, Pub. L. 103-66, 107 Stat. 372 (29 U.S.C. 1169); Sec. 101, Pub. Law 104-191, 101 Stat. 1936 (29 U.S.C. 1181); Secretary of Labor's Order No. 1-87, 52 FR 13139, April 21, 1987.

3. Part 2590 is amended by redesignating Subparts A, B, and C as Subparts B, C, and D, respectively and a new Subpart A is added to read as follows:

#### **Subpart A—Continuation Coverage, Qualified Medical Child Support Orders, Coverage for Adopted Children**

##### **§ 2590.609-1 [Reserved]**

##### **§ 2590.609-2 National Medical Support Notice.**

(a) This section promulgates the National Medical Support Notice (the Notice), as mandated by section 401(b) of the Child Support Performance and Incentive Act of 1998 (Pub. L. 105-200). If the Notice is appropriately completed and satisfies paragraphs (3) and (4) of section 609(a) of the Employee Retirement Income Security Act (ERISA), the Notice is deemed to be a qualified medical child support order (QMCSO) pursuant to ERISA section 609(a)(5)(C). Section 609(a) of ERISA delineates the rights and obligations of the alternate recipient (child), the participant, and the group health plan under a QMCSO. A copy of the Notice is available on the Internet at <http://www.dol.gov/dol/pwba>.

(b) For purposes of this section, a plan administrator shall find that a Notice is appropriately completed if it contains the name of an Issuing Agency, the name and mailing address (if any) of an employee who is a participant under the plan, the name and mailing address of one or more alternate recipient(s) (child(ren) of the participant) (or the name and address of a substituted official or agency which has been substituted for the mailing address of the alternate recipient(s)), and identifies an underlying child support order.

(c)(1) Under section 609(a)(3)(A) of ERISA, in order to be qualified, a medical child support order must clearly specify the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient. Section 609(a)(3)(B) of ERISA requires a

reasonable description of the type of coverage to be provided to each such alternate recipient, or the manner in which such type of coverage is to be determined. Section 609(a)(3)(C) of ERISA requires that the order specify the period to which such order applies.

(2) The Notice satisfies ERISA section 609(a)(3)(A) by including the necessary identifying information described in § 2590.609-2(b).

(3) The Notice satisfies ERISA section 609(a)(3)(B) by having the Issuing Agency identify either the specific type of coverage or all available group health coverage. If an employer receives a Notice that does not designate either specific type(s) of coverage or all available coverage, the employer and plan administrator should assume that all are designated. The Notice further satisfies ERISA section 609(a)(3)(B) by instructing the plan administrator that if a group health plan has multiple options and the participant is not

enrolled, the Issuing Agency will make a selection after the Notice is qualified, and, if the Issuing Agency does not respond within 20 days, the child will be enrolled under the plan's default option (if any).

(4) Section 609(a)(3)(C) of ERISA is satisfied because the Notice specifies that the period of coverage may only end for the alternate recipient(s) when similarly situated dependents are no longer eligible for coverage under the terms of the plan, or upon the occurrence of certain specified events.

(d)(1) Under ERISA section 609(a)(4), a qualified medical child support 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 a law relating to medical child support described in section 1908 of the Social Security Act, 42 U.S.C. 1396g-1.

(2) The Notice satisfies the conditions of ERISA section 609(a)(4) because it requires the plan to provide to an alternate recipient only those benefits that the plan provides to any dependent of a participant who is enrolled in the plan, and any other benefits that are necessary to meet the requirements of a State law described in such section 1908.

(e) For the purposes of this section, an "Issuing Agency" is a State agency that administers the child support enforcement program under Part D of Title IV of the Social Security Act.

Signed at Washington, DC this December 15, 2000.

**Leslie Kramerich,**

*Acting Assistant Secretary, Pension and Welfare Benefits Administration, Department of Labor.*

**Note:** The following appendix will not appear in the Code of Federal Regulations.

**BILLING CODE 4510-29-P**

APPENDIX  
**NATIONAL MEDICAL SUPPORT NOTICE**  
**PART A**

**NOTICE TO WITHHOLD FOR HEALTH CARE COVERAGE**

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998.

Issuing Agency: _____ Issuing Agency Address: _____ _____ Date of Notice: _____ Case Number: _____ Telephone Number: _____ FAX Number: _____	Court or Administrative Authority: _____ Date of Support Order: _____ Support Order Number: _____
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_____ ) Employer/Withholder's Federal EIN Number	RE* _____ ) Employee's Name (Last, First, MI)
_____ ) Employer/Withholder's Name	_____ ) Employee's Social Security Number
_____ ) Employer/Withholder's Address	_____ ) Employee's Mailing Address
_____ ) Custodial Parent's Name (Last, First, MI)	_____ ) Substituted Official/Agency Name and Address
_____ ) Custodial Parent's Mailing Address	_____ ) Child(ren)'s Mailing Address (if different from Custodial Parent's)
_____ ) _____ ) Name, Mailing Address, and Telephone Number of a Representative of the Child(ren)	_____ ) _____ ) _____ ) Name, Mailing Address, and Telephone Number of a Representative of the Child(ren)

Child(ren)'s Name(s)	DOB	SSN	Child(ren)'s Name(s)	DOB	SSN
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

The order requires the child(ren) to be enrolled in [ ] any health coverages available; or [ ] only the following coverage(s):  Medical;  Dental;  Vision;  Prescription drug;  Mental health;  Other (specify): \_\_\_\_\_

THE PAPERWORK REDUCTION ACT OF 1995 (P.L. 104-13) Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. OMB control number: 0970-0222 Expiration Date: 12/31/2003.

**EMPLOYER RESPONSE**

If either 1, 2, or 3 below applies, check the appropriate box and return this Part A to the Issuing Agency within 20 business days after the date of the Notice, or sooner if reasonable. NO OTHER ACTION IS NECESSARY. If neither 1, 2, nor 3 applies, forward Part B to the appropriate plan administrator(s) within 20 business days after the date of the Notice, or sooner if reasonable. Check number 4 and return this Part A to the Issuing Agency if the Plan Administrator informs you that the child(ren) is/are enrolled in an option under the plan for which you have determined that the employee contribution exceeds the amount that may be withheld from the employee's income due to State or Federal withholding limitations and/or prioritization.

- 1. Employer does not maintain or contribute to plans providing dependent or family health care coverage.
- 2. The employee is among a class of employees (for example, part-time or non-union) that are not eligible for family health coverage under any group health plan maintained by the employer or to which the employer contributes.
- 3. Health care coverage is not available because employee is no longer employed by the employer:

Date of termination: \_\_\_\_\_

Last known address: \_\_\_\_\_

Last known telephone number: \_\_\_\_\_

New employer (if known): \_\_\_\_\_

New employer address: \_\_\_\_\_

New employer telephone number: \_\_\_\_\_

- 4. State or Federal withholding limitations and/or prioritization prevent the withholding from the employee's income of the amount required to obtain coverage under the terms of the plan.

Employer Representative:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

EIN (if not provided by Issuing Agency on Notice to Withhold for Health Care Coverage): \_\_\_\_\_

## INSTRUCTIONS TO EMPLOYER

This document serves as notice that the employee identified on this National Medical Support Notice is obligated by a court or administrative child support order to provide health care coverage for the child(ren) identified on this Notice. This National Medical Support Notice replaces any Medical Support Notice that the Issuing Agency has previously served on you with respect to the employee and the children listed on this Notice.

The document consists of **Part A - Notice to Withhold for Health Care Coverage** for the employer to withhold any employee contributions required by the group health plan(s) in which the child(ren) is/are enrolled; and **Part B - Medical Support Notice to the Plan Administrator**, which must be forwarded to the administrator of each group health plan identified by the employer to enroll the eligible child(ren).

### EMPLOYER RESPONSIBILITIES

1. If the individual named above is not your employee, or if family health care coverage is not available, please complete item 1, 2, or 3 of the Employer Response as appropriate, and return it to the Issuing Agency. **NO FURTHER ACTION IS NECESSARY.**
2. If family health care coverage is available for which the child(ren) identified above may be eligible, you are required to:
  - a. Transfer, not later than 20 business days after the date of this Notice, a copy of **Part B - Medical Support Notice to the Plan Administrator** to the administrator of each appropriate group health plan for which the child(ren) may be eligible, and
  - b. Upon notification from the plan administrator(s) that the child(ren) is/are enrolled, either
    - 1) withhold from the employee's income any employee contributions required under each group health plan, in accordance with the applicable law of the employee's principal place of employment and transfer employee contributions to the appropriate plan(s), or
    - 2) complete item 4 of the Employer Response to notify the Issuing Agency that enrollment cannot be completed because of prioritization or limitations on withholding.
  - c. If the plan administrator notifies you that the employee is subject to a waiting period that expires more than 90 days from the date of its receipt of **Part B** of this Notice, or whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), notify

the plan administrator when the employee is eligible to enroll in the plan and that this Notice requires the enrollment of the child(ren) named in the Notice in the plan.

#### **LIMITATIONS ON WITHHOLDING**

The total amount withheld for both cash and medical support cannot exceed \_\_\_% of the employee's aggregate disposable weekly earnings. The employer may not withhold more under this National Medical Support Notice than the lesser of:

1. The amounts allowed by the Federal Consumer Credit Protection Act (15 U.S.C., section 1673(b));
2. The amounts allowed by the State of the employee's principal place of employment; or
3. The amounts allowed for health insurance premiums by the child support order, as indicated here: \_\_\_\_\_.

The Federal limit applies to the aggregate disposable weekly earnings (ADWE). ADWE is the net income left after making mandatory deductions such as State, Federal, local taxes; Social Security taxes; and Medicare taxes.

#### **PRIORITY OF WITHHOLDING**

If withholding is required for employee contributions to one or more plans under this notice and for a support obligation under a separate notice and available funds are insufficient for withholding for both cash and medical support contributions, the employer must withhold amounts for purposes of cash support and medical support contributions in accordance with the law, if any, of the State of the employee's principal place of employment requiring prioritization between cash and medical support, as described here: \_\_\_\_\_.

#### **DURATION OF WITHHOLDING**

The child(ren) shall be treated as dependents under the terms of the plan. Coverage of a child as a dependent will end when similarly situated dependents are no longer eligible for coverage under the terms of the plan. However, the continuation coverage provisions of ERISA may entitle the child to continuation coverage under the plan. The employer must continue to withhold employee contributions and may not disenroll (or eliminate coverage for) the child(ren) unless:

1. The employer is provided satisfactory written evidence that:

- a. The court or administrative child support order referred to above is no longer in effect; or
  - b. The child(ren) is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan; or
2. The employer eliminates family health coverage for all of its employees.

#### **POSSIBLE SANCTIONS**

An employer may be subject to sanctions or penalties imposed under State law and/or ERISA for discharging an employee from employment, refusing to employ, or taking disciplinary action against any employee because of medical child support withholding, or for failing to withhold income, or transmit such withheld amounts to the applicable plan(s) as the Notice directs.

#### **NOTICE OF TERMINATION OF EMPLOYMENT**

In any case in which the above employee's employment terminates, the employer must promptly notify the Issuing Agency listed above of such termination. This requirement may be satisfied by sending to the Issuing Agency a copy of any notice the employer is required to provide under the continuation coverage provisions of ERISA or the Health Insurance Portability and Accountability Act.

#### **EMPLOYEE LIABILITY FOR CONTRIBUTION TO PLAN**

The employee is liable for any employee contributions that are required under the plan(s) for enrollment of the child(ren) and is subject to appropriate enforcement. The employee may contest the withholding under this Notice based on a mistake of fact (such as the identity of the obligor). Should an employee contest the withholding under this Notice, the employer must proceed to comply with the employer responsibilities in this Notice until notified by the Issuing Agency to discontinue withholding. To contest the withholding under this Notice, the employee should contact the Issuing Agency at the address and telephone number listed on the Notice. With respect to plans subject to ERISA, it is the view of the Department of Labor that Federal Courts have jurisdiction if the employee challenges a determination that the Notice constitutes a Qualified Medical Child Support Order.

#### **CONTACT FOR QUESTIONS**

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed above.

NATIONAL MEDICAL SUPPORT NOTICE OMB NO. 1210-0113

PART B

MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR

This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974, and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998. Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the plan administrator under this Notice are in addition to the existing rights and duties established under such law.

Issuing Agency: _____ Issuing Agency Address: _____ Date of Notice: _____ Case Number: _____ Telephone Number: _____ FAX Number: _____	Court or Administrative Authority: _____ Date of Support Order: _____ Support Order Number: _____
-------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------

\_\_\_\_\_) RE\* \_\_\_\_\_  
Employer/Withholder's Federal EIN Number Employee's Name (Last, First, MI)

\_\_\_\_\_) \_\_\_\_\_  
Employer/Withholder's Name Employee's Social Security Number

\_\_\_\_\_) \_\_\_\_\_  
Employer/Withholder's Address Employee's Address

\_\_\_\_\_) \_\_\_\_\_  
Custodial Parent's Name (Last, First, MI)

\_\_\_\_\_) \_\_\_\_\_  
Custodial Parent's Mailing Address Substituted Official/Agency Name and Address

\_\_\_\_\_) \_\_\_\_\_  
Child(ren)'s Mailing Address (if Different from Custodial Parent's)

\_\_\_\_\_) \_\_\_\_\_  
Name(s), Mailing Address, and Telephone Number of a Representative of the Child(ren)

\_\_\_\_\_) \_\_\_\_\_

Child(ren)'s Name(s)	DOB	SSN	Child(ren)'s Name(s)	DOB	SSN
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

The order requires the child(ren) to be enrolled in  any health coverages available; or  only the following coverage(s):  medical;  dental;  vision;  prescription drug;  mental health;  other (specify): \_\_\_\_\_

**PLAN ADMINISTRATOR RESPONSE**

(To be completed and returned to the Issuing Agency within 40 business days after the date of the Notice, or sooner if reasonable)

This Notice was received by the plan administrator on \_\_\_\_\_.

1. This Notice was determined to be a "qualified medical child support order," on \_\_\_\_\_. Complete **Response 2 or 3, and 4**, if applicable.

2. The participant (employee) and alternate recipient(s) (child(ren)) are to be enrolled in the following family coverage.

- a. The child(ren) is/are currently enrolled in the plan as a dependent of the participant.
- b. There is only one type of coverage provided under the plan. The child(ren) is/are included as dependents of the participant under the plan.
- c. The participant is enrolled in an option that is providing dependent coverage and the child(ren) will be enrolled in the same option.
- d. The participant is enrolled in an option that permits dependent coverage that has not been elected; dependent coverage will be provided.

Coverage is effective as of \_\_\_/\_\_\_/\_\_\_ (includes waiting period of less than 90 days from date of receipt of this Notice). The child(ren) has/have been enrolled in the following option: \_\_\_\_\_ Any necessary withholding should commence if the employer determines that it is permitted under State and Federal withholding and/or prioritization limitations.

3. There is more than one option available under the plan and the participant is not enrolled. The Issuing Agency must select from the available options. Each child is to be included as a dependent under one of the available options that provide family coverage. If the Issuing Agency does not reply within 20 business days of the date this Response is returned, the child(ren), and the participant if necessary, will be enrolled in the plan's default option, if any: \_\_\_\_\_

4. The participant is subject to a waiting period that expires \_\_\_/\_\_\_/\_\_\_ (more than 90 days from the date of receipt of this Notice), or has not completed a waiting period which is determined by some measure other than the passage of time, such as the completion of a certain number of hours worked (describe here: \_\_\_\_\_). At the completion of the waiting period, the plan administrator will process the enrollment.

5. This Notice does not constitute a "qualified medical child support order" because:  
 The name of the  child(ren) or  participant is unavailable.  
 The mailing address of the  child(ren) (or a substituted official) or  participant is unavailable.  
 The following child(ren) is/are at or above the age at which dependents are no longer eligible for coverage under the plan \_\_\_\_\_ (insert name(s) of child(ren)).

Plan Administrator or Representative:

Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

## INSTRUCTIONS TO PLAN ADMINISTRATOR

This Notice has been forwarded from the employer identified above to you as the plan administrator of a group health plan maintained by the employer (or a group health plan to which the employer contributes) and in which the noncustodial parent/participant identified above is enrolled or is eligible for enrollment.

This Notice serves to inform you that the noncustodial parent/participant is obligated by an order issued by the court or agency identified above to provide health care coverage for the child(ren) under the group health plan(s) as described on **Part B**.

(A) If the participant and child(ren) and their mailing addresses (or that of a Substituted Official or Agency) are identified above, and if coverage for the child(ren) is or will become available, this Notice constitutes a "qualified medical child support order" (QMCSO) under ERISA or CSPIA, as applicable. (If any mailing address is not present, but it is reasonably accessible, this Notice will not fail to be a QMCSO on that basis.) You must, within 40 business days of the date of this Notice, or sooner if reasonable:

(1) Complete Part B - Plan Administrator Response - and send it to the Issuing Agency:

(a) if you checked Response 2:

(i) notify the noncustodial parent/participant named above, each named child, and the custodial parent that coverage of the child(ren) is or will become available (notification of the custodial parent will be deemed notification of the child(ren) if they reside at the same address);

(ii) furnish the custodial parent a description of the coverage available and the effective date of the coverage, including, if not already provided, a summary plan description and any forms, documents, or information necessary to effectuate such coverage, as well as information necessary to submit claims for benefits;

(b) if you checked Response 3:

(i) if you have not already done so, provide to the Issuing Agency copies of applicable summary plan descriptions or other documents that describe available coverage including the additional participant contribution necessary to obtain coverage for the child(ren) under each option and whether there is a limited service area for any option;

(ii) if the plan has a default option, you are to enroll the child(ren) in the default option if you have not received an election from the Issuing Agency within 20 business days of the date you returned the Response. If the plan does not have a default option, you are to enroll the child(ren) in the option selected by the Issuing Agency.

(c) if the participant is subject to a waiting period that expires more than 90 days from the date of receipt of this Notice, or has not completed a waiting period whose duration is determined by a measure other than the passage of time (for example, the completion of a certain number of hours worked), complete Response 4 on the Plan Administrator Response and return to the employer and the Issuing Agency, and notify the participant and the custodial parent; and upon satisfaction of the period or requirement, complete enrollment under Response 2 or 3, and

(d) upon completion of the enrollment, transfer the applicable information on Part B - Plan Administrator Response to the employer for a determination that the necessary employee contributions are available. Inform the employer that the enrollment is pursuant to a National Medical Support Notice.

(B) If within 40 business days of the date of this Notice, or sooner if reasonable, you determine that this Notice does not constitute a QMCSO, you must complete Response 5 of Part B - Plan Administrator Response and send it to the Issuing Agency, and inform the noncustodial parent/participant, custodial parent, and child(ren) of the specific reasons for your determination.

(C) Any required notification of the custodial parent, child(ren) and/or participant that is required may be satisfied by sending the party a copy of the Plan Administrator Response, if appropriate.

#### **UNLAWFUL REFUSAL TO ENROLL**

Enrollment of a child may not be denied on the ground that: (1) the child was born out of wedlock; (2) the child is not claimed as a dependent on the participant's Federal income tax return; (3) the child does not reside with the participant or in the plan's service area; or (4) because the child is receiving benefits or is eligible to receive benefits under the State Medicaid plan. If the plan requires that the participant be enrolled in order for the child(ren) to be enrolled, and the participant is not currently enrolled, you must enroll both the participant and the child(ren). All enrollments are to be made without regard to open season restrictions.

#### **PAYMENT OF CLAIMS**

A child covered by a QMCSO, or the child's custodial parent, legal guardian, or the provider of services to the child, or a State agency to the extent assigned the child's rights, may file claims and the plan shall make payment for covered benefits or reimbursement directly to such party.

#### **PERIOD OF COVERAGE**

The alternate recipient(s) shall be treated as dependents under the terms of the plan. Coverage of an alternate recipient as a dependent will end when similarly situated dependents are no longer eligible for coverage under the terms of the plan. However, the continuation coverage provisions of ERISA or other applicable law may entitle the alternate recipient to continue coverage under

the plan. Once a child is enrolled in the plan as directed above, the alternate recipient may not be disenrolled unless:

- (1) The plan administrator is provided satisfactory written evidence that either:
  - (a) the court or administrative child support order referred to above is no longer in effect, or
  - (b) the alternate recipient is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment from the plan;
- (2) The employer eliminates family health coverage for all of its employees; or
- (3) Any available continuation coverage is not elected, or the period of such coverage expires.

**CONTACT FOR QUESTIONS**

If you have any questions regarding this Notice, you may contact the Issuing Agency at the address and telephone number listed above.

**Paperwork Reduction Act Notice**

The Issuing Agency asks for the information on this form to carry out the law as specified in the Employee Retirement Income Security Act or the Child Support Performance and Incentive Act, as applicable. You are required to give the Issuing Agency the information. You are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Issuing Agency needs the information to determine whether health care coverage is provided in accordance with the underlying child support order. The Average time needed to complete and file the form is estimated below. These times will vary depending on the individual circumstances.

	<u>Learning about the law or the form</u>	. . . .	<u>Preparing the form</u>
First Notice	1 hr. ___		1 hr., 45 min.
Subsequent Notices	-----		35 min.