

- employee assistance plans (EAPs) that provide medical care (e.g., EAPs that are staffed by trained counselors); and
- many other types of plans may be relevant as well.

Note that a benefit could be a group health plan even if it is provided through individual (not group) policies.

Some mandates do not apply to particular types of plans (e.g., dental or vision plans). In addition, some mandates have exceptions for plans with fewer than a specified number of participants.

Distinction Between Group Health Plans and Insurance

Policies. The federal mandates discussed in this booklet apply to group health plans and the employers that maintain such plans. While some mandates have provisions that also apply to insurers, other mandates do not reach insurers (except, of course, to the extent that an insurer provides group health coverage to its own employees). Thus, employers should not assume that an insurance policy (even a group policy) will comply with all of the applicable mandates. It is a good idea to carefully review insurance policies for compliance with federal group health plan mandates, while keeping in mind that if there are areas in which a policy falls short of compliance, the employer may be held liable.

2. What Employers Are Subject to Federal Group Health Plan Mandates?

Many employers will be subject to all of the federal group health plan mandates discussed in this booklet. But some federal mandates have exceptions for certain types of employers. For example, some mandates do not apply to plans of state and local governments or religious organizations. Some mandates also have exceptions for employers with fewer than a specified number of employees. A few mandates allow particular employers to “opt out” if specific requirements are met.

D. Mandated Coverage

Some federal mandates require group health plans to provide coverage to particular individuals. Group health plans generally must provide coverage to a participant’s child pursuant to a qualified medical child support order (QMCSO). Another federal mandate requires coverage for adopted children (including children placed for adoption) under the same terms and conditions that apply to natural children. Group health plans will also be required to continue coverage of dependent students on medically necessary leaves of absence (Michelle’s Law).

1. Qualified Medical Child Support Orders (QMCSOs)

Every group health plan that is subject to ERISA must comply with a QMCSO. QMCSOs are judgments, decrees, or orders (issued by a court or through a state administrative process) that require a group health plan to provide coverage to a participant’s child and meet other specific requirements. QMCSOs typically require the group health plan of a child’s noncustodial parent to provide coverage to the child, even though the child may not be a “dependent” under the plan’s definition. Church group health plans, although not subject to ERISA, are

also required to comply with QMCSOs under a federal law known as the Child Support Performance and Incentive Act of 1998 (CSPIA).

Group health plans may also receive National Medical Support Notices (NMSNs). NMSNs follow a standardized form and are used by state child support enforcement agencies to obtain group health coverage for children. If appropriately completed, an NMSN is deemed to be a QMCSO and an ERISA group health plan must comply with it. Church group health plans and group health plans of state and local governmental employers must also comply with appropriately completed NMSNs.

Most QMCSOs and NMSNs are designed to cover an employee's child under the employer's major medical plan. But these orders may also require coverage under other types of group health plans, such as dental or vision plans, health FSAs, HRAs, or EAPs. Sometimes, the court or enforcement agency wants to take advantage of as many of the employer's group health plans as possible.

a. Who Must Receive Coverage?

Individuals entitled to coverage under a QMCSO are called "alternate recipients." An alternate recipient must be a child of a participant. However, there is no requirement that the child be a tax dependent of the participant (usually, the employee-parent) in order to be eligible for health coverage. The law is unclear as to whether QMCSOs can order coverage for stepchildren, although one district court has held that the answer is yes.

The term "child of a participant" clearly includes a child of an employee who is already enrolled in the employer's group health plan. A court order may also require coverage for the child of an employee who is not enrolled in the plan but is eligible to enroll. (The employee would have to be enrolled along with the child if necessary for the child to have coverage, unless the plan offers dependent-only coverage.) An order may also require coverage for the child of an employee who has not yet satisfied a plan's generally applicable waiting period, although in such cases coverage need not begin until the waiting period is satisfied.

Coverage need not be extended to an alternate recipient where the employee is not eligible for any group health plan option—for example, some plans provide that coverage is not available to certain types of employees.

b. What Requirements Must an Order Meet to Be a QMCSO?

To be a QMCSO, an order must contain the following information:

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

In addition, an order may not require a plan to provide a type of benefit (e.g., orthodontia or mental health treatment), form of benefit (e.g., indemnity coverage if HMO coverage is the only option), or benefit option (e.g., coverage with a lower deductible) not otherwise provided in the plan. However,

some exceptions exist for orders intended to satisfy certain state laws relating to medical child support. For example, if an order has been issued pursuant to such a state law, a group health plan may be required to enroll a child even if the child does not fall within the plan's definition of an "eligible dependent" because the child does not live with the participant, is not claimed as a dependent on the participant's federal income tax return, or was born out of wedlock.

Example: Plan Does Not Provide Any Dependent Coverage at All. If a group health plan does not provide any dependent coverage, can the plan be ordered to provide coverage for a participant's child?

No. An order is not qualified if it requires a plan to provide a type or form of benefit or benefit option that is not otherwise available under the plan. Therefore, an order cannot require a plan to provide dependent coverage when such coverage is not otherwise available under the plan.

c. How Does a Plan Determine Whether an Order Is a QMCSO?

Group health plans are required to establish reasonable procedures for determining whether orders requiring coverage for a participant's child are QMCSOs and for administering the provision of benefits under QMCSOs. QMCSO procedures must—

- be in writing;
- provide that each person specified in an order as eligible to receive benefits under the plan will be notified of such procedures (at the address included in the order) promptly upon the plan's receipt of the order; and
- permit an alternate recipient to designate a representative for receipt of copies of notices regarding an order.

Action Item: QMCSO Procedures. Group health plans that are subject to the QMCSO mandate must establish procedures for determining whether orders are QMCSOs and for administering benefits under QMCSOs. Some plans also develop a qualification checklist to be used in reviewing orders, as well as form notification letters for advising plan participants and alternate recipients as to the order's status.

When a plan receives an order requiring a group health plan to provide coverage for a participant's child, the plan administrator must—

- promptly notify the participant and each alternate recipient of the receipt of the order and of the plan's QMCSO procedures;
- within a reasonable period after receipt of the order, determine whether it is a QMCSO; and
- notify the participant and each alternate recipient of the determination.

d. How Should NMSNs Be Processed?

Employers and plan administrators that receive an NMSN must process it in accordance with the instructions in the NMSN itself. An NMSN consists of two parts:

- Part A, the “Notice to Withhold for Health Care Coverage,” is directed to the employer; and
- Part B, the “Medical Support Notice to Plan Administrator,” directs the plan administrator to enroll the child in the plans covered by the NMSN, if the NMSN has been properly completed.

Each Part includes information about the parties to the order (e.g., the employee, state child support enforcement agency, custodial parent, and child) and the plans in which the child is to be enrolled, as well as a response and a set of instructions.

General QMCSO Requirements Also Apply. When processing and administering benefits under an NMSN, administrators of ERISA group health plans and church group health plans must also comply with the general QMCSO requirements. For example, administrators of these plans should notify the participant and alternate recipient of an NMSN’s receipt and of the plan’s QMCSO procedures, even though this requirement is not included in the instructions to the NMSN.

e. What Happens After an Order Is Determined to Be a QMCSO?

Once an order has been determined to be a QMCSO, the plan administrator must follow the terms of the order as if it were part of the plan. The alternate recipient must be enrolled as soon as possible following the determination (unless the order specifies a later enrollment date).

Any reimbursement from the plan for expenses paid by an alternate recipient (or by an alternate recipient’s custodial parent or legal guardian) must be made to the alternate recipient, custodial parent, or legal guardian, as applicable. In some cases, the plan may be required to pay a state child support enforcement agency or a Medicaid agency. In addition, plans subject to ERISA generally must treat alternate recipients as participants for purposes of ERISA’s reporting and disclosure requirements (e.g., alternate recipients must be furnished with summary plan descriptions (SPDs), summaries of material modifications (SMMs), and summary annual reports (SARs)).

When Does an Alternate Recipient’s Coverage End? Generally, coverage terminates for an alternate recipient under a QMCSO when the period of coverage under the QMCSO ends. But a plan may disenroll an alternate recipient at the same time and under the same conditions as it can disenroll other dependents of participants. If the plan is subject to COBRA, an alternate recipient whose coverage terminates under circumstances creating a COBRA qualifying event has the right to elect COBRA continuation coverage and is entitled to a COBRA election notice.