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Department of Labor

Pension and Welfare Benefits Administration

Department of Health and Human Services

Office of Child Support Enforcement

29 CFR Part 2590
45 CFR Part 303
National Medical Support Notice; Proposed Rules

DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration

RIN 1210–AA72

29 CFR Part 2590

National Medical Support Notice

AGENCY: Pension and Welfare Benefits Administration, Labor.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document contains a proposed rule that, upon adoption, would implement an amendment to section 609(a) of Title I of the Employee Retirement Income Security Act (ERISA) made by section 401 of the Child Support Performance and Incentive Act of 1998 (CSPIA), Public Law 105–200. CSPIA requires the Secretaries of Labor and Health and Human Services to jointly promulgate 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 ERISA. This proposed rule would affect group health plans, participants in group health plans, noncustodial children of such participants, and State agencies that administer child support enforcement programs.

DATES: Written comments on these proposed rules must be received by the Department of Labor on or before February 14, 2000.

ADDRESSES: Interested persons are invited to submit written comments (preferably three copies) concerning the proposed rules to: Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N–5669, Washington, DC 20210. Attention: National Medical Support Notice. All submissions will be open to public inspection and copying in the Public Disclosure Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N–5638, Washington, DC, from 8 a.m. to 4:30 p.m., E.S.T.

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

Section 609(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), provides that 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 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 received by the plan is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. Section 514(b)(7) 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.[1]

2. The Child Support Performance and Incentive Act

Based on concerns raised both by State agencies that enforce the programs under Title IV–D of the SSA (known as the Child Support Enforcement Program, which is administered by the Federal Office of Child Support Enforcement (OCSE) in the Department of Health and Human Services (HHS)) and by sponsors and administrators of group health plans concerning difficulties in establishing medical child support orders that are qualified, Congress enacted section 401 of the Child Support Performance and Incentive Act of 1998 (CSPIA) to amend both ERISA and the SSA. CSPIA requires State agencies to enforce the medical child support obligations of noncustodial parents by issuing to their employers a National Medical Support Notice (Notice), and requires plan administrators, upon receipt of the Notice from the employer, to accept an appropriately completed Notice that also satisfies the requirements of ERISA section 609(a) as a QMCSO.

In addition to complying with ERISA requirements and the requirements of Title IV–D of the SSA, the Notice must include a separate and easily severable employer withholding notice informing the employer of the noncustodial parent of applicable provisions of State and Federal law relating to any necessary withholding of employee contributions that may be required by the plan to extend coverage to any child named in the Notice. The changes made by section 401 of CSPIA, and that would be implemented by the proposed regulations, will simplify the issuance and processing of medical child support orders, provide standardized communication between State agencies, employers, and plan administrators, and create a uniform and streamlined process for enforcement of medical child support to ensure that all children receive the health care coverage for which they are eligible and to which they are entitled.

Section 401(c) of CSPIA amended section 466(a)(19) of the SSA to require States to enact laws requiring the use of the Notice to enforce medical child support obligations of parents.[2] Pursuant to such laws, State IV–D agencies will be required to use the Notice to notify the employer of the noncustodial parent that a State court or

[1] Section 1908 of the SSA conditions State eligibility for Medicaid matching funds on the enactment of certain specified laws relating to medical child support. Under section 1908 of the SSA, for instance, 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 noncustodial parent or the State agency to apply for available coverage for the child.

[2] 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 calender 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. 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 section ERISA 609(a)(3) and (4), they are QMCSOs.

administrative agency has issued a child support order providing for health care coverage. The employer will then be required to separate and retain the part of the Notice directing the employer to withhold employee contributions and transfer, within 20 business days of the date of the Notice, the remaining part of the Notice to the appropriate group health plan.

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 a 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 section 609(a), the Notice shall be deemed to be a QMCSO in the case of such child. In such a case, the plan administrator, within 40 business days after the date of the Notice, shall notify the State agency issuing the Notice with respect to such child whether coverage is available under the terms of the plan, and, if so, whether the child is covered under the plan and either the effective date of coverage or, if necessary, any steps to be taken by the custodial parent to effectuate such coverage, and provide to the custodial parent a description of the coverage available and any forms or documents necessary to effectuate such coverage.

3. The Medical Child Support Working Group

Section 401(a) of CSPIA mandated that the Secretaries jointly establish a Medical Child Support Working Group (the Working Group) whose purpose is to identify the impediments to the effective enforcement of medical support by State IV–D agencies and to submit a report to the Secretaries containing recommendations for appropriate measures to address such impediments. CSPIA specifically directs the Working Group, among other things, to make recommendations based on assessments of the form and content of the Notice. The Working Group is composed of 30 members, who represent the DOL and 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.

In the interest of developing a proposed Notice that best addresses the needs and concerns of the affected parties, DOL and HHS solicited comments and suggestions regarding the Notice from the Working Group at its public meetings of April 13, and May 12 and 13, 1999. Comments from the Working Group proved very helpful in the development of the Notice that is proposed herein. In an effort to ensure that the statutorily mandated Notice facilitates, rather than complicates, State 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 has determined it appropriate to promulgate the Notice as a proposed rulemaking, rather than as an interim regulation.[3] We believe that this more closely comports with congressional intent to permit the affected parties, including the Working Group, to comment on the Notice before it becomes effective.

4. The Proposed 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 ''Employer Withholding Notice,'' and Part B, the ''Medical Support Notice to Plan Administrator.'' Also being published in the **Federal Register** today is a parallel proposed regulation issued by OCSE, 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 the CSPIA. That proposed regulation, 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 with respect to the Notice.

B. Employer Withholding Notice

As described in the OCSE proposed regulation, a State agency will issue the two part Notice to an employer of an employee who is a noncustodial parent obligated by a child support order to provide medical support for his or her children, which employer may maintain or contribute to a group health plan. Part A, the ''Employer Withholding Notice'' 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 to the administrator of each group health plan providing coverage for which the children may be eligible within 20 business days of the date of the Notice, (ii) to withhold from the earnings of the employee/obligor any participant contributions required under the group health plan for such coverage, and (iii) to transmit those amounts to the plan. Part A also includes an Employer Response, which the Employer would use to notify the State 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 (*e.g.*, part-time or non-union) that is not eligible for family health coverage under any plan maintained by the employer or to which the employer contributes, if the individual is not employed by the employer, or if Federal or State withholding limitations or prioritization rules prevent the withholding from the employee's income of the amount required to obtain coverage for the children under the terms of the plan (participant contribution).

The Instructions in Part A also notifies the employer (i) of Federal and State limitations on withholding, (ii) of the obligation to comply with any applicable withholding prioritization 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.

[3] Section 401(b)(5) of CSPIA provides for the issuance of interim regulations within ten months of enactment of CSPIA, and final regulations within one year of the issuance of the interim regulations. As stated above, under section 401(a)(5) of CSPIA, the Working Group is required to make recommendations, within eighteen months of the enactment of CSPIA, on the form and content of the Notice as issued under interim regulations. CSPIA also provides that State agencies will not be required to use the Notice prior to October of 2001.

The initial meetings of the Working Group have 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 Agencies decided to obtain additional input from the Working Group, which necessitated taking additional time in promulgating these proposed regulations. In addition, it was decided that the final regulations would benefit from public comments, in addition to those from the Working Group. Furthermore, concerns were raised as to the applicability of the Notice if it was promulgated pursuant to interim regulations, subject to alteration in the final regulations. Accordingly, in order to encourage greater public participation in this rulemaking and reduce the possibility for confusion, the Departments decided to issue these regulations in proposed form.

As described below, Part B of the Notice and its Instructions were developed to insure that the Notice would comply with the ERISA QMCSO requirements, and to provide guidance to the administrator of a group health plan that receives Part 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.

C. Notice to Plan Administrator

Part B of the proposed Notice, the ''Medical Support Notice to Plan Administrator,'' includes the same information as is contained in Part A, and a Plan Administrator Response to be returned to the State Agency, along with Instructions to Plan Administrator (Instructions) regarding the administrator's responsibilities in processing Part B.

Part B notifies the administrator of the group health plan in which the named employee is enrolled or eligible for enrollment that the employee is obligated by a court or administrative child support order to provide medical support coverage for the named alternate recipient(s). Part B provides 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 alternate recipient(s) as dependent(s) in the group health plan. Part B also includes a Plan Administrator Response that the plan administrator will use to inform the State IV–D agency whether the Notice constitutes a QMCSO and, if it does, to notify the State agency either that the alternate recipient is enrolled in the coverage offered by the plan, or, if there is more than one option available under the plan, inform the State agency of the options from which to elect coverage.

Receipt by a plan administrator of Part B of a Notice that identifies (i) an issuing State agency (the Issuing Agency), (ii) a participant who is enrolled or eligible to enroll in the plan, and (iii) one or more alternate recipients with respect to the participant is considered receipt of a medical child support order as defined in ERISA section 609(a)(2)(B). Accordingly, the plan administrator would be subject to the statutory requirements of ERISA section 609(a), including section 609(a)(5)(A), which requires the administrator to notify the participant and alternate recipient(s) of the receipt of the Notice and the plan's procedures for determining if a medical child support order is a QMCSO. The Notice is to be treated as an application by the Issuing Agency for health coverage for the alternate recipient(s), to the extent such application is required by the plan and has not been undertaken by the participant.

ERISA section 609(a)(5)(C) provides that if a plan receives an appropriately completed Notice and the Notice satisfies the conditions of paragraphs (3) and (4) of section 609(a), the Notice shall be deemed to be a QMCSO. It is the view of the Department that a Notice is appropriately completed, within the meaning of section 609(a)(5)(C), if Part B of the Notice (i) identifies an employee of an employer, enrolled or eligible for enrollment in a group health plan sponsored by an employer or to which an employer contributes, who is a noncustodial parent obligated by a State court or administrative order to provide medical child support for one or more alternate recipients named in the Notice, and (ii) indicates the type of health care coverage to be provided to the alternate recipient(s). The Notice satisfies ERISA section 609(a)(3) by including the necessary information in Part B, by expressly requiring the plan to treat an alternate recipient as a dependent under the terms of the plan and by specifying that coverage may only end for the alternate recipient when similarly situated dependents are no longer eligible for coverage under the terms of the plan, or upon the occurrence of certain specified events.[4] (Certain other events that may lead to a loss of coverage of the alternate recipient (e.g., the death of the participant) may be ''qualifying events'' as specified in ERISA section 603, thereby triggering the continuation coverage (also known as COBRA) provisions of ERISA.) The Notice satisfies ERISA section 609(a)(4) because it states that the alternate recipient(s) must be provided only the coverage that the plan provides, or be enrolled in an option provided under the plan, except to the extent necessary to meet the requirements of a State law described in SSA section 1908. Accordingly, if Part B is appropriately completed as specified above, and in the Instructions, the Notice is deemed to be a QMCSO.

The Instructions also inform the plan administrator that coverage may not be denied because the alternate recipient was born out of wedlock, is not claimed as a dependent on the participant's Federal income tax return, or does not reside with the participant or in the plan's service area. The Instructions further provide that all enrollments are to be made without regard to open season restrictions.[5] Further, if Part B is appropriately completed, the plan administrator must treat the Notice as QMCSO, even if there is a waiting period to enroll in the plan or there are additional steps to be taken to include the alternate recipient(s) in the group health plan. Even if coverage does not begin immediately, the plan administrator must provide the notifications and information required by section 609(a)(5) and the Notice to the alternate recipient(s), custodial parent, and Issuing Agency.

ERISA section 609(a)(5)(A)(ii) requires that a plan administrator determine whether a medical child support order is qualified within a reasonable period of time after receipt of the order and notify the participant and each alternate recipient named in the order of such determination. Section 609(a)(5)(C)(ii) requires the plan administrator, within 40 days of the date of an Notice, to notify the Issuing Agency whether coverage is available under the terms of the plan, whether the alternate recipient(s) is/are covered under the plan, and either the effective date of coverage or, if necessary, any additional steps to be taken by the custodial parent (or by a State or local official who has been substituted for the address of the alternate recipient) to effectuate the coverage, and provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate the coverage. In order to align these requirements, the Instructions provide that the plan administrator shall, within 40 business days of the date of the Notice, or sooner if reasonable, provide the required notifications and information to the Issuing Agency, the participant/non-custodial parent and the alternate recipient/child. Although what constitutes a reasonable period will depend on the specific circumstances of each medical child support order, it is the view of the Department that, given the uniform nature of Part B of the Notice, a plan administrator should

[4] Section 1908(a)(2)(C) and (3)(C) of the SSA provide that, when a child is provided health care coverage by a parent's insurer pursuant to a court or administrative order, 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.

[5] This requirement is derived from SSA section 1908(a)(2) and (3).

require less time to review Part B than a medical child support order that is not based on such uniform form and content.

The Plan Administrator Response is to be completed by the plan administrator and returned to the Issuing Agency. If the plan administrator determines that a Notice received by the plan is not qualified, he or she completes part 1 of the Response and identifies the specific reason(s) why the Notice is not qualified. If the administrator determines that the Notice is a QMCSO, he or she completes part 2 of the Response, indicating whether there is only one type of coverage provided by the plan (*e.g.*, indemnity coverage) and that the alternate recipient(s) is/are covered, or if there is more than one type of coverage available (*e.g.*, indemnity coverage and a health maintenance organization), the administrator must identify each available option. If there is more than one type of coverage available under the plan, the Issuing Agency will select the option in which to enroll the alternate recipient(s) and return the Response to the plan administrator. Upon completion of the enrollment information, the plan administrator transfers the applicable information on the Plan Administrator Response to the employer for a determination that the necessary participant contributions are available.

The Department is proposing to make the regulation as adopted effective October 1, 2001. This is the earliest date on which States will be required, under section 401(c)(3) of CSPIA, to use the Notice to enforce the health care coverage provisions of a child support order.

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 proposed regulation would raise novel legal or policy issues arising out of legal mandates. Therefore, this proposed 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 proposed 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 non-custodial 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 the plan. 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 non-custodial 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 and Incentive Act of 1998 (CSPIA) was enacted.

As required by CSPIA, the Department and HHS are jointly promulgating a proposed 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 ''Employer Withholding Notice,'' and Part B, the ''Medical Support Notice to Plan Administrator.'' The proposed 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 proposed regulation provides guidance to plan administrators for meeting Part B requirements. Part B incorporates the provisions of the CSPIA as it pertains to 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 proposed 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 proposed 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 is therefore 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 proposed 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 per Notice administrative costs that arise when a fragmented, 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, 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 positive cost/benefit ratio 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 their relatively infrequent receipt of 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 $26.6 million in the first year increasing to $34.3 million by year three with a total aggregate savings of $92.3 million over the period.

[In millions at dollars]

	Baseline cost	Cost of investment under regulation	Cost of processing under regulation	Net savings under regulation
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

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.

Costs of the Proposed Regulation

The cost of this proposed regulation is the start-up cost incurred by ERISA plans to set up procedures to conform with the format of the Notice. This start-up process is assumed to require one hour of a professional's time at an hourly rate of $45, and 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 the 38,500 plans with 100 or more participants, this start-up cost is incurred entirely in year one, since every one of these plans receives its first standardized Notice in year one (because nearly 650,000 Notices are being sent to these plans each year). The start-up cost for these plans is $1.7 million. For plans with 10 to 99 participants, each year only a fraction of the 755,000 plans receive a medical child support order because there are only 95,000 Notices being sent to these plans yearly. However, the benefits of investing in establishing procedures to conform with the format of the Notice outweigh the start-up cost by year three. In year one, the start-up cost to these plans is $4.0 million. In year two the start-up cost falls to $3.5 million, because while some plans are receiving their first standardized Notice, others are receiving their second and subsequent Notices and therefore are benefitting from the initial investment in the process through cost savings. By year three, the start-up cost is $3.1 million, with the cost falling each subsequent year as more plans already have their procedures in place. Plans with fewer than 10 participants receive these Notices too infrequently to make the investment in establishing cost effective procedures (there are 1.7 million of these plans receiving only 28,000 Notices annually). Therefore it is assumed these plans will be unaffected by the standardized Notice.

Benefits of the Proposed 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 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 1998 Current Population Survey conducted by the Bureau of the Census, 15 percent of all children (or 10.7 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 [6]. The legislative history indicates that there is

[6] 144 Cong. Rec. S7318 (daily ed. June 26, 1998) (Legislative History of Senate and House Amendments to the Child Support Performance and Incentive Act of 1998, Pub. L. No. 105–200).

a lack of communication of medical child support information between the State agencies and plan administrators because many State agencies simply notify plan administrators that an order has been issued, and in turn, many plan administrators consider this administrative notice insufficient to comply with current legal 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 proposed 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 Part B will accrue to plan administrators, State agencies, employers, non-custodial parent-participants, custodial parents, and alternate recipient(s). Part B will overcome the inefficiencies inherent in current practice, which often requires 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 (Part B) which is easy to comprehend and to administer, and which limits their risk of exposure to errors in their determinations of which orders are QMCSOs and therefore 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 child medical support orders is expected to drop from the current level of $62.3 million to $35.7 million. This estimate is derived as follows.

The Department estimates that plan administrators of ERISA-covered group health plans will receive a total of 770,000 Notices annually. This estimate is based on the HHS's (Office of Child Support Enforcement (OCSE) of the Administration for Children and Family (ACF)) projection of 1.2 million new child support orders with collections each year using historical data (through 1996) on total child support orders established by State agencies. The Department believes that the HHS data is a reasonable starting point for our analysis because current law requires that each child support order include a provision for medical support. Although the CSPIA provisions apply to church plans and governmental plans, cost estimates for these plans are not included in our analysis because under section 4(b) of ERISA, church plans and governmental plans are generally excluded from the coverage of Title I of ERISA and therefore are outside the Department's regulatory jurisdiction.

Applying the Bureau of Labor Statistics 1998 Current Population Survey (CPS) data on employment distribution between the public and private sectors to the estimated 1.2 million medical support orders projected to be issued annually yields an estimated 1 million new Notices issued to private sector employers. The Department then factored in an estimate of the Notices issued to the private sector that would be required as a result of employees changing jobs. This estimate, which was derived from the 1998 March CPS data is 200,000. Summing these values yields an estimated 1.2 million Notices to private sector employers annually.

For the purpose of distinguishing between those Notices that are QMCSOs and those that are not, either because there is no family group health coverage available through the employer or the parent is no longer employed by the employer receiving the Notice, the Department estimated the percentage of employers that offer a group health plan with family coverage in which a dependent child could be enrolled. This analysis is based on the April 1993 Employee Benefits CPS Supplement, the most recent source of complete data on employer offers of health insurance. These data show that for plans with fewer than 100 participants, 55 percent of plans do not offer family coverage. For plans with 100 or more participants, 15 percent do not offer family coverage. In addition, the Department assumed that approximately 2 percent (regardless of plan size) of the Notices will not be deemed to be qualified because the parent is no longer employed by the employer receiving the Notice. Applying these percentages to the 1.2 million Notices yields an expected number of Notices to be forwarded to plan administrators of 770,000.

The Department then estimated the number of group health plans potentially impacted by the proposed Notice by calculating the probability of a plan receiving a Notice. Given that there are 2.5 million ERISA-covered group health plans and only 770,000 Notices being sent to plans each year, not all health plans will receive a Notice each year. Furthermore, because the likelihood of receiving a Notice is a function of the number of participants, and plans vary widely in this regard, there will be wide variations in the distribution of costs and benefits based on plan size. Consequently, from year to year, not all plans will incur the start-up cost to establish procedures to conform with the Notice, and not all plans will reap the benefits of lower per Notice processing costs.

The probability of a plan receiving a Notice each year depends on the probability of any participant in the plan being subject to a medical child support order. The probability of a participant being the subject of a Notice is assumed to be independent of plan size or other factors. The Department therefore estimated this probability for each participant by dividing the number of participants in private employer group health plans, 65 million, into the number of Notices issued annually, 770,000. To translate the individual probabilities to a plan level required an estimation that would account for the result that some plans, due to the random distribution, would not receive a Notice. The plan level probabilities at different size intervals were therefore estimated as the difference between a 100 percent probability and the probability that a plan of a given size would not receive a Notice. Because outcomes are sensitive to plan size, the Department calculated these probabilities by three plan size groupings—fewer than 10 participants, 10 to 99 participants, and 100 or more participants. Segmentation of small plans by size is useful because due to the distribution of participants in small plans, combining all plans with fewer than 100 participants suggests that no small plans would be affected by the regulation. Further analysis shows that in the aggregate small plans with 10 to 99 participants will realize the net benefits of standardization, while only plans with fewer than 10 participants are expected to be unaffected.

Once the number of Notices by plan size and the probability of a plan receiving a Notice in any year by plan size were estimated, a year-by-year

analysis of the impact of the proposed regulation on group health plans was conducted. In the first year, plans with 100 or more participants would be expected to receive an average of 17 Notices each, because there are only 38,500 of these plans receiving nearly 650,000 Notices annually. Currently, because notices are not standardized, the time required to process each of these Notices per plan does not vary from the first to subsequent Notices. However, with the standardization benefits of the proposed regulation, the processing time for the second and subsequent Notices received by each plan is expected to result in significantly reduced processing time, from 1 hour and 45 minutes to 35 minutes. This reduction in processing time, using a $45 hourly professional's rate, 2 minutes in photocopying time at a $15 clerical rate, and $0.37 for materials and postage per required response, generates a reduction in the cost to plans with 100 or more participants of processing Notices from $52.4 million under the baseline to $22.1 million under the regulation. The savings is larger from the second year on because all of these plans incur the start-up cost in the first year—the cost falls from $52.4 million to $18.3 million.

In the aggregate, plans with 10 to 99 participants also show positive net benefits from a reduction in costs under the standardized Notice system. However, because there are 755,000 of these plans and only 95,000 Notices being sent to them, as a group these plans do not benefit from the reduction in cost until the third year in which the standardized Notice is being used. During the first two years, the aggregate investment to establish a processing system when the first standardized Notice is received outweighs the cost reduction from processing the second and subsequent Notices because more plans receive a first Notice than receive a second Notice. By the third year, enough plans have put their system in place to make the savings outweigh the start-up cost. In year one, the cost of processing medical support orders for plans with 10 to 99 participants is $7.6 million under the baseline and $11.4 million under the regulation (the higher cost is due to the start-up). These estimates assume the same processing hours and fees outlined above for the 100 or more participant plans. Similarly, in year two, the costs are $7.6 million and $10.3 million (slightly lower because of the plans that incurred the start-up cost in year one). By the third year, these plans face lower costs in processing medical child support orders because of the standardized Notice—costs drop from $7.6 million to $7.4 million, with the savings increasing in subsequent years as the start-up investment is recouped.

Standardization of the Notices is not expected to have an economic impact on plans with fewer than 10 participants. These plans receive Notices so infrequently (there are 1.7 million of these plans receiving only 28,000 Notices), that an investment in establishing a processing system for the standardized Notice is not cost effective, and these plans will choose to continue processing notices as they do at the present time. For these plans, the cost of processing Notices is $2.3 million, assuming 1 hour and 45 minutes processing time at a $45 hourly professional's rate, 2 minutes in photocopying time at a $15 clerical rate, and $0.37 for materials and postage per required response.

Alternative Approaches Considered

A number of alternative approaches to this proposed regulation were considered. Initially the Departments prepared a Notice which consisted of two parts. This format provided a number of defaults which decreased the discretion required in responding to the Notice and was particularly streamlined. This Notice was presented to the Medical Child Support Working Group at its first meeting in March of 1999. Members of the Working Group responded unfavorably to this format, noting 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. Based on comments received by the Agencies at this meeting, the Notice was redrafted. A second version of the Notice was developed which included four parts and a number of feedback loops. Again the Working Group provided commentary, responding that this version was too complicated and cumbersome. A third version of the Notice was developed which is being proposed in this rulemaking. This version provides a feedback loop to the Issuing Agency, a feature which the State Agency representatives on the Working Group desired, yet it retains a more streamlined and comprehensible approach than the previous version. Overall it represents a significant improvement over previous drafts. Specifically, it enables the State Agency to select the coverage that will ultimately be provided to the child(ren) from the options that are available to the participant/noncustodial parent. Enabling State Agencies to make this selection, rather than having the child automatically placed in a default coverage option, ensures that the child receives meaningful and accessible coverage from among the particular options available under the plan.

The Department invites comments on its assumptions and estimates of the potential benefits and costs of this proposal for plan administrators.

Paperwork Reduction Act

The Department, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA 95), 44 U.S.C. 3506(c)(2)(A). This helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed.

Currently, the Pension and Welfare Benefits Administration (PWBA) is soliciting comments concerning the proposed information collection request (ICR) included in Part B, Medical Support Notice to Plan Administrator of the National Medical Support Notice (Notice). A copy of the ICR may be obtained by contacting the PWBA official identified below in this Notice of Proposed Rulemaking.

The Department has submitted a copy of the proposed information collection to the Office of Management and Budget (OMB) for its review in accordance with 44 U.S.C. 3507(d) of PRA 95. The Department and OMB are particularly interested in comments that:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology,

e.g., permitting electronic submission of the responses.

Comments on the collection of information should be sent to the Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503; Attention: Desk Officer for the Pension and Welfare Benefit Administration. Although comments may be submitted through January 14, 2000, OMB requests the comments be received within 30 days of the publication of the Notice of Proposed Rulemaking to ensure their consideration.

Requests for copies of the ICR may be addressed to: Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, NW, Room N–5647, Washington, DC 20210. Telephone: (202) 219–4782 (this is not a toll-free number); Fax: (202) 219–4745.

Part B of the Notice would permit plan administrators to comply with the requirements of section 609(a)(5) of ERISA for Qualified Medical Child Support Orders (QMCSOs), as amended by section 401(d) of the Child Support Performance and Incentive Act of 1998 (CSPIA) (Pub. L. 105–200). Part B is comprised of the Medical Support Notice to the Plan Administrator, Plan Administrator Response, and Instructions to the Plan Administrator (hereinafter referred to as Part B). This proposed rule would require the group health plan administrator, upon receipt of Part B from the employer, to examine it and determine whether or not the Notice constitutes a QMCSO. Part B includes a checklist that makes this determination simple for the plan administrator. If any of the identifying information for the alternate recipient/child or non-custodial parent/participant is missing or the alternate recipient is no longer eligible for coverage, the plan administrator determines that the Notice is not a QMCSO. In this case, the plan administrator, having identified that the Notice is not a QMCSO, is required to check off the appropriate reason in Part B and forward it to the Issuing Agency. The plan administrator must also notify the non-custodial parent/participant and the custodial parent and alternate recipient(s) of the specific reasons for this determination. This requirement is met by mailing copies of Part B to these parties.

If the plan administrator determines that Notice is a QMCSO, then he or she must provide information regarding available coverage. Again, this process has been simplified by the provision of checklists for this purpose in Part B. Part B must then be forwarded by the plan administrator to the Issuing Agency. The plan administrator must also inform the non-custodial parent/participant, custodial parent, and alternate recipient(s) of the specific reasons for this determination. Notification of the custodial parent is deemed to be notification to the alternate recipients if they reside at the same address. This requirement may be met by mailing copies of the completed Part B to these parties.

The plan administrator must also provide the custodial parent with any forms, documents, or other information necessary to effectuate coverage. The Department has not assessed the cost to the plan administrator of providing forms, documents or other information because this information would need to be provided regardless of the requirements of the proposed regulation. If no other information or action is necessary, the plan administrator must enroll the alternate recipient in the available coverage, or notify the Issuing Agency and custodial parent of any other action to be taken in order to effectuate coverage.

Once the enrollment information is completed, the plan administrator must forward Part B to the employer for the determination that the necessary employee contributions may be made by the employee. Again, a copy of the completed Part B serves this purpose.

The Department estimates the total annual burden to plan administrators for preparation and distribution of Part B to be 785,000 hours and $1.1 million in the first year, or an average of $7 for each of the 156,000 plans receiving orders each year. The total hours includes 1 hour and 45 minutes of time for each first Notice, and 35 minutes for second and subsequent Notices, to determine whether the Notice is qualified and to prepare a response to the required parties, as well as one hour for start-up procedures for 128,000 plans. In addition, 2 minutes for copying and mailing at a $15 hourly clerical rate and $0.37 for materials and mailing costs for each of the 4 responses required per Notice were assumed for the distribution burden of $1.1 million. Plans with 100 or more participants are expected to bear most of this cost—485,000 hours and $960,000, or an average of $25 per plan—due to their handling of a larger volume of Notices. The annual burden for plans with 10 to 99 participants is estimated to be 250,000 hours and $140,000, or $2 per plan. The annual burden for plans with fewer than 10 participants is 50,000 hours and $42,000, or $1.50 per plan. It is assumed that plan administrators will complete this work themselves, rather than purchase services. Thus, all costs other than distribution costs (materials and mailing) were attributed to burden hours rather than dollars.

In the second and third years, the burden declines for two reasons. First, all plans with 100 or more participants incurred the burden to establish procedures to conform to the standardized Notice in year 1 and do not incur the burden in subsequent years. Second, plans with 10 to 99 participants incur the burden to establish procedures throughout years one, two, and three. However, the burden decreases over time because, of the 90,000 plans with 10 to 99 participants receiving Notices each year, an increasing number of them over time have already established the procedures for complying with the standardized Notice. Specifically, in year two, the Department estimates the total annual burden to plan administrators for preparation and distribution of Part B to be 680,000 hours and $1.1 million (the dollar figures do not change because mailing and distribution costs for the 770,000 Notices do not change over time). In year three, the Department estimates the total annual burden to plan administrators for preparation and distribution of Part B to be 615,000 hours and $1.1 million. The year two and three totals assume the same time, hourly rates, and fees as in year one.

Type of Review: New.

Agency: Pension and Welfare Benefits Administration, Department of Labor.

Title: National Medical Support Notice.

OMB Number: 1210–New.

Affected Public: Individuals or households; Business or other for-profit institutions; Not-for-profit institutions.

Frequency of Response: On occasion.

Total Respondents: 156,000.

Total Responses: 770,000.

Estimated Burden Hours: 785,000 in 2000; 680,000 in 2001; and 615,000 in 2002.

Estimated Annual Costs (Operating and Maintenance): $1.1 million.

Comments submitted in response to this Notice of Proposed Rulemaking will be summarized and/or included in the request for OMB approval of the information collection request; they will also become a matter of public record.

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 proposed rule will not have a significant economic impact on a substantial number of small entities, section 603 of the RFA requires the agency to present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities, and seek public comment on such impact. 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. Thus, PWBA believes that assessing the impact of this proposed 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 therefore requests comments on the appropriateness of the size standard used in evaluating the impact of this proposed rule on small entities.

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 standardized format is expected to reduce costs to process the Notices once an initial Notice is received and a procedure is established to handle subsequent Notices. Because of the infrequency with which very small plans are estimated to receive Notices, and the fact that administrative savings to offset procedural start-up costs can be achieved only on the receipt of second and subsequent Notices, it is assumed that those small plans with fewer than 10 participants will make an economically rational choice not to invest in establishing a new procedure to handle the standardized Notice. As a consequence, each standardized Notice will be handled by very small plans as a unique event, resulting in no cost or benefit over their current handling of these infrequent notices.

The objective of the proposed 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 non-custodial 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 the requirements for plan administrators to enroll alternate recipient(s) in a group health plan and to notify the appropriate state agency, non-custodial 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 cost of compliance with Part B will be borne by 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. However, because there are 755,000 of these plans and only 95,000 Notices being sent to them, these plans will first benefit from the net reduction in cost in the third year in which the standardized Notice is being used. During the first two years, the start-up cost to establish a processing system when the first standardized Notice is received is expected to outweigh the benefit of the cost reduction from processing the second and subsequent Notices. By the third year, enough plans will have put their systems in place to make the savings outweigh the start-up cost.

In year one, the cost of processing medical support order for plans with 10 to 99 participants is estimated at $7.6 million, or $85 per plan, under the baseline and $11.4 million, or $127 per plan, under the regulation (the higher cost is due to the start-up). These estimates assume the same processing hours and fees outlined in the economic analysis section of this preamble for large plans (those with at least 100 participants). Similarly, in year two, the costs are $7.6 million, or $85 per plan, and $10.3 million, or $116 per plan (slightly lower because of the plans that incurred the start-up cost in year one). By the third year, these plans face lower costs in processing medical child support orders because of the standardized Notice—costs drop from $7.6 million, or $85 per plan, to $7.4 million, or $83 per plan. Thus, the savings increases in subsequent years as the start-up investment is recouped by more plans.

Plans with fewer than 10 participants receive Notices so infrequently (there are 1.7 million of these plans receiving only 28,000 Notices), that an investment in establishing a new processing system for the standardized Notice would in most cases not be cost effective—they

would be unlikely to recoup the start-up costs from future savings resulting from processing second and subsequent Notices. For these plans, under the baseline and the regulation, the cost of processing Notices is $2.3 million, or $81 per plan, assuming 1 hour and 45 minutes processing time at a $45 hourly professional's rate, 2 minutes in photocopying time at a $15 clerical rate, and $0.37 for materials and postage per required response.

The data and assumptions underlying these aggregate costs and benefits are presented in detail above in the economic impact discussion. As noted, an estimated 770,000 Notices will be received and processed by plan administrators annually. The Department estimates that 16 percent, or 123,000, will be received by small plans with fewer than 100 participants: 95,000 going to plans with 10 to 99 participants and 28,000 to plans with fewer than 10 participants. This estimate is based on the 1993 Current Population Survey data on distribution of workers by firm size and family health insurance sponsorship by firm size. The Department examined subgroups within the small group health plan (those with fewer than 100 participants) universe. Most of the plans within this universe have fewer than 10 participants, yet most of the participants are found in plans with 10 to 99 participants. Consequently, most of the Notices are sent to plans with 10 to 99 participants.

For plans with 10 to 99 participants, 90,000 plans are projected to receive 95,000 Notices in year one. This means that in the first year, 5,000 of these plans will receive more than one Notice, allowing them to benefit from the cost reduction introduced by the standardized Notice. For each subsequent year, a growing number of these plans will receive two or more Notices, making the benefits of the regulation outweigh the start-up cost for plans with 10 to 99 participants within 3 years.

No federal rules have been identified that duplicate, overlap, or conflict with this proposed regulation. As discussed previously in the economic analysis under the Executive Order, a number of alternatives to this proposed regulation were considered. At least two distinct versions of the Notice were developed prior to arriving at this proposal. Prior drafts were critiqued by the Medical Child Support Working Group, which includes representatives from the small business community. Based on commentary received from the Working Group, 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.

The Department requests comments from small entities regarding what, if any, special problems they might encounter if this regulation were implemented as proposed, and what changes, if any, could be made to minimize these problems.

Small Business Regulatory Enforcement Fairness Act

The rule proposed 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). The rule, if finalized, will be 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 proposed 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, Health insurance, Pensions, Reporting and recordkeeping requirements.

For the reasons set forth above, Part 2590 of Title 29 of the Code of Federal Regulations is proposed to be 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. L. 104–191, 101 Stat. 1936 (29 U.S.C. 1181); Secretary of Labor's Order No. 1–87, 52 FR 13129, 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

Sec.
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 1988 (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 section 609(a)(5)(C). Section 609(a) of ERISA delineates the rights and obligations of the alternate recipient, the participant, and the plan under a QMCSO.

(b) For purposes of this section, 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) (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 if the family group health care coverage required by the child support order is identified and available.

(c) 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 4th day of November, 1999.

Richard M. McGahey,

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

OMB NOS.

PART A

EMPLOYER WITHHOLDING NOTICE

This Notice is issued under Section 466(a)(19) of the Social Security Act and Section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA).

Issuing Agency: _____ Issuing Agency Address: _____ _____ Date of Notice: _____ Case Number: _____ Telephone Number: _____	Court Name: _____ Date of Support Order: _____ Support Order Number: _____

_____)
Employer/Withholder's Federal EIN Number

_____)
Employer/Withholder's Name

_____)
Employer/Withholder's Address

_____)
Custodial Parent's Name (Last, First, MI)

_____)
Custodial Parent's Mailing Address

_____)
Alternate Recipient/Child(ren)'s Mailing Address (if different from Custodial Parent's)

_____)
_____)
_____)
Name, Mailing Address, and Telephone Number of a Representative of the Alternate Recipient(s)/Child(ren)

RE* _____
Employee/Obligor's Name (Last, First, MI)

_____
Employee/Obligor's Social Security Number

_____
Employee/Obligor's Mailing Address

_____
Substituted Official/Agency Name and Address

Alternate Recipient/Child(ren)'s Name(s)	DOB	SSN	Alternate Recipient/Child(ren)'s Name(s)	DOB	SSN

Type of group health care coverage required by the order: ___(Basic); ___(Dental); ___(Vision); ___(Prescription drug); ___(Mental health); ___(Other) - _____

draft

EMPLOYER RESPONSE

(To be completed by Employer, as appropriate)

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

□ 1. Employer does not maintain or contribute to plans providing dependent or family health care coverage or 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.

□ 2. Health care coverage is not available because employee is no longer employed by the employer:

Last known address: _____

Last known telephone number: _____

New employer (if known): _____

New employer address: _____

New employer telephone number: _____

□ 3. 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: _____

draft

INSTRUCTIONS TO EMPLOYER

This document serves as notice that the employee identified above is obligated by a court or administrative child support order to provide health care coverage for the child(ren) also identified above. This 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. Such child(ren) are also referred to as Alternate Recipient(s) in the Notice.

The document consists of **Part A - Employer Withholding Notice** for the employer to withhold any employee contributions required by the group health plan(s) in which the alternate recipient(s) 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 alternate recipient(s)/child(ren).

EMPLOYER RESPONSIBILITIES

As the employer of the employee, you are required to:

1. If the individual named above is not your employee, or if family health care coverage is not available, please complete item 1 or 2 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 alternate recipient(s)/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 alternate recipient(s)/child(ren) may be eligible, and

   b. Upon notification from the plan administrator(s) that the alternate recipient(s)/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 3 of the Employer Response to notify the Issuing Agency and the parties that enrollment cannot be completed because of prioritization or limitations on withholding.

LIMITATIONS ON WITHHOLDING

The amount withheld cannot exceed ___% of the employee's aggregate disposable weekly earnings. The employer may not withhold more than the lessor 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 medical support by the child support order.

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.

DURATION OF WITHHOLDING

The alternate recipient(s)/child(ren) 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 may entitle the alternate recipient to continuation coverage under the plan. The employer must continue to withhold employee contributions and may not disenroll (or eliminate coverage for) the alternate recipient/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 alternate recipient(s)/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.

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NOTICE OF TERMINATION OF EMPLOYMENT

In any case in which the above employee's employment with the above employer 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 named above 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 alternate recipient(s)/child(ren) and is subject to appropriate enforcement. The employee may contest enforcement based on a mistake of fact (such as the identity of the obligor). Should an employee contest, the employer must proceed to comply with the employer responsibilities in this Notice until notified by the Issuing Agency to discontinue withholding.

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.

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NATIONAL MEDICAL SUPPORT NOTICE OMB NOS.

PART B

MEDICAL SUPPORT NOTICE TO PLAN ADMINISTRATOR

This Notice is issued under section 466(a)(19) of the Social Security Act and section 609(a)(5)(C) of the Employee Retirement Income Security Act of 1974 (ERISA). **Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under ERISA section 609(a)(5)(A) and (B).** 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 section.

Issuing Agency: _____ Issuing Agency Address: _____ _____ Date of Notice: _____ Case Number: _____ Telephone Number: _____	Court Name: _____ Date of Support Order: _____ Support Order Number: _____

_____)
Employer/Withholder's Federal EIN Number

RE* _____
Employee/Obligor's Name (Last, First, MI)

_____)
Employer/Withholder's Name

_____
Employee/Obligor's Social Security Number

_____)
Employer/Withholder's Address

_____
Employee/Obligor's Address

_____)
Custodial Parent's Name (Last, First, MI)

_____)
Custodial Parent's Address

_____
Substituted Official/Agency Name and Address

_____)
Alternate Recipient/Child(ren)'s Address (if Different from Custodial Parent's)

_____)
_____)
_____)
Name(s), Mailing Address, and Telephone Number of a Representative of the Alternate Recipient(s)/Child(ren)

Alternate Recipient/Child(ren)'s Name(s)	DOB	SSN	Alternate Recipient/Child(ren)'s Name(s)	DOB	SSN

Type of group health care coverage required by the order: ___(Basic); ___(Dental); ___(Vision); ___(Prescription drug); ___(Mental health); ___(Other) - _____

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PLAN ADMINISTRATOR RESPONSE

(To be completed by the plan administrator and returned to the Issuing Agency)

This Notice was received by the plan administrator on _____.

1. □ This Notice does not constitute a "qualified medical child support order" because:
   □ The name of the □ alternate recipient(s) or □ participant is missing.
   □ The mailing address of the □ alternate recipient(s) or □ participant is missing.
   □ The alternate recipient(s) is/are at or above the age at which dependents are no longer eligible for coverage under the plan.

2. □ This Notice was determined to be a "qualified medical child support order," on _____. If dependent-only coverage is not available under the plan, the employee and alternate recipient(s) are to be enrolled in family coverage as indicated below.

a. □ There is only one type of coverage provided under the plan. The alternate recipient(s) is/are included as dependents of the participant under the plan.

b. □ There is more than one option available under the plan. The Issuing Agency must select from the available options and return this Part B to the Plan Administrator named below for processing. Each alternate recipient is to be included as a dependent under one of the following options that provide family coverage:

□ (1)_____[if enrolled, the participant has elected this option]
□ (2)_____
□ (3)_____

3. The plan administrator received all information necessary for enrollment on _____(date). Coverage is effective as of _____. Any necessary withholding should commence if permitted under State and Federal withholding and/or prioritization limitations. The alternate recipient(s) has/have been enrolled in the following option(s):

Name and address of plan or insurance carrier(s):	PIN or Contract number:	Address to submit claims:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Plan Administrator or Representative:

Name: _____ Telephone Number: _____

Title: _____ Date: _____

Address:_____

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INSTRUCTIONS TO PLAN ADMINISTRATOR

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. 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.

	Learning about the law or the form	Preparing the form
First Notice	1 hr.	1 hr., 45 min.
Subsequent Notices	-----	35 min.

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 alternate recipient(s)/child(ren) if available under the group health plan(s) as described on **Part B**.

(A) If the participant and alternate recipient(s)/child(ren) and their mailing addresses (or that of a Substituted Official or Agency) are identified above, and if coverage for the alternate recipient(s) is or will become available, this Notice constitutes a "qualified medical child support order" under ERISA, and 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, notify the noncustodial parent/participant named above, each named alternate recipient/child, and the custodial parent that coverage of the alternate recipient(s) is or will become available (notification of the custodial parent will be deemed notification of the alternate recipient(s) if they reside at the same address);

(2) furnish the Issuing Agency and custodial parent a description of the coverage available and the effective date of the coverage;

(3) provide to the custodial parent any forms, documents, or information necessary to effectuate such coverage (including the applicability of creditable coverage under HIPAA);

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(4) if the plan has more than one coverage option, notify the noncustodial parent/participant that the option that he or she has elected (if any) may be changed by an election of the Issuing Agency on behalf the alternate recipient(s);

(5)(a) if no other information or action is required, include the alternate recipient(s) in the available coverage, or,

(b) notify the Issuing Agency and the custodial parent of any additional steps to be taken, and

(6) upon completion of the enrollment information, transfer the applicable information on **Part B** to the employer for a determination that the necessary employee contributions are available.

(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 "qualified medical child support order," you must complete **Part B - Plan Administrator Response** and send it to the Issuing Agency, and inform the noncustodial parent/participant, custodial parent, and alternate recipient(s) of the specific reasons for your determination.

UNLAWFUL REFUSAL TO ENROLL

Enrollment of an alternate recipient may not be denied on the ground that: (1) the alternate recipient was born out of wedlock; (2) the alternate recipient is not claimed as a dependent on the participant's Federal income tax return; or (3) the alternate recipient does not reside with the participant or in the plan's service area. All enrollments are to be made without regard to open season restrictions.

PERIOD OF COVERAGE

The alternate recipient(s)/child(ren) 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 may entitle the alternate recipient to continuation coverage under the plan. Once an alternate recipient 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.

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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.

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