

CONTINUED HEALTH CARE BENEFITS FOR DEPENDANT CHILDREN AND FORMER SPOUSES

In many cases, one of the spouses carries the family health insurance and the other is dependent on that coverage. Clearly, the loss of this valuable benefit must be considered in negotiations and in presentation of evidence at trial. While COBRA and HIPPA may provide the right to continuing coverage, neither federal law provides the funds needed to pay the premiums for such coverage. Accordingly, the cost of future insurance coverage, the likelihood of post-COBRA ineligibility for coverage, and the cost of future health care of the dependent spouse are important considerations to be dealt with by counsel and the court.

Federal and state laws provide special protection to the continuation of health care coverage for dependent children and require that it be addressed in every court order or judgment of child support. 42 U.S.C. §§ 652(f) and 666(a)(19) and O.R.C. 3119.30. While it is not mandated that all children be covered by health insurance, it is mandated that the courts address the issue of their health insurance coverage and payment of health care costs after divorce.

1. Continued Health Care Benefits for Dependent Children

In any action in which a child support order is issued or modified, the court and child support enforcement agency shall determine the person responsible for the children's health care subject to the child support order. O.R.C. §3119.30 requires that the order include one of the following:

- a) A requirement that the obligor will obtain health insurance for the children if coverage is available through a group plan;
- b) A requirement that the obligee will obtain health insurance for the children if coverage is available through a group plan at a more reasonable cost than is available to the obligor;
- c) If no group plan is available, a requirement that obligor and obligee will share the cost of health care needs of the children under an equitable;

- d) formula established by the court, and that the parties inform the court or
- e) support enforcement agency if coverage later becomes available;
or
- f) A requirement that both the obligor and the obligee obtain health insurance coverage for the children if coverage is available for the children at a reasonable cost to both the obligor and the obligee and dual coverage would provide for coordination of medical benefits without unnecessary duplication of coverage.

Ohio Revised Code § 3119.32 specifies what a child support order must contain:

- a) A requirement that the person responsible for providing health insurance to the children provide to the other party, within 30 days of the issuance of the order, information about the benefits, coverages, copies of insurance forms needed to receive reimbursement, payment or other benefits and a copy of insurance cards;
- b) The identity of the person who is to be reimbursed for out-of-pocket health care expenses;
- c) A requirement that the children be designated as covered dependents under the applicable health insurance policy;
- d) An order allocating the payment or co-payment of deductible costs under the health insurance policy for the children;
- e) A notice that the employer of the person required to obtain health insurance coverage is required to release to the other parent, or the child support enforcement agency on written request any necessary information on the health insurance coverage;
- f) A statement setting forth the full name and date of birth of each child who is the subject of the child support order;
- g) A requirement that the obligor and the obligee comply with any requirement described in section 3119.30 of the Revised Code and divisions (A) and (C) of this section that is contained in an order issued in compliance with this section no later than thirty days after the issuance of the order;

- h) A notice that states the following: "If the person required to obtain health care insurance coverage for the children subject to this child support order obtains new employment, the agency shall comply with the requirements of section 3119.34 of the Revised Code, which may result in the issuance of a notice requiring the new employer to take whatever action is necessary to enroll the children in health care insurance coverage provided by the new employer."

Although the federal ERISA law preempts any state regulation of employer benefits plans, including health insurance plans, 29 U.S.C. 1169 makes an exception for medical child support orders which are issued by state courts. A medical child support order will be deemed to be "qualified", and, therefore, may provide for coverage under an existing health plan to an "alternate recipient" (i.e., the child of the noncustodial parent) who otherwise would not be eligible to be covered by the plan.

A "medical child support order" means any judgment, decree, or order issued pursuant to state domestic relations law which provides for child support for a child of a participant under a group health plan or provides for health benefit coverage to such a child, and relates to benefits under such plan. The order can be issued by a court or by an administrative agency authorized under state law. National Medical Support Notices (NMSNs) issued by child support enforcement agencies are deemed to be qualified medical child support orders. The qualified medical child support order (QMCSO) directs the Plan Administrator to provide health insurance coverage to the named child. *See* 29 U.S.C. 1169.

2. Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), 29 U.S.C. § 1161 et seq.

COBRA is a federal law that provides for continuation of health care benefits by requiring certain employers to allow employees and former spouses and dependents of employees to elect continued coverage upon the occurrence of a “qualifying event,” including divorce or legal separation. *Goode v. Goode*, 89 Ohio App.3d 405, 412, 624 N.E.2d 788, 793 (Ohio App. 10 Dist.,1993). COBRA entitles a former spouse to continue health insurance coverage on the covered spouse’s insurance for up to 36 months after the entering of the decree.

COBRA only applies to employers who have a health care plan and employ 20 or more employees on at least half of its working days in the prior calendar year. The federal government is exempt and churches are exempt.

The insurance carrier is required to provide health insurance coverage to the former spouse at no more than 102% of the cost for single coverage as an employee.

A qualified beneficiary has 60 days to elect coverage from the date coverage ends or the date notice is sent, whichever is later.

Notice must be given to the Plan Administrator within 60 days of a divorce or legal separation or the date a child ceases to be a dependent. The Plan Administrator must then notify qualified beneficiaries with 14 days of receiving notice of a qualifying event (here, divorce, legal separation or loss of dependency status). Notice to the former spouse is deemed notice to all other qualified beneficiaries in the same household.

Divorce decrees and separation agreements should contain provisions directing the employed spouse to provide the mandated notice to the Plan Administrator in the event that the other spouse decided to elect COBRA coverage. If the employed spouse is to pay the premiums, that will need to be addressed as well.

In *Redman v. Francis*, 2006 Ohio 3640, (5th District Ct. App. 2006), the Licking County Court of Appeals upheld a finding of contempt and order to pay wife’s and children’s uninsured medical expenses. The decree provided for husband to make wife’s COBRA premium payments and maintain the children on his policy. He failed to do so

and wife and children were terminated from the plan. During the period of noncoverage, wife amassed over \$29,000 in medical expenses and the children accrued about \$1,000.

3. Health Insurance Portability and Accountability Act of 1996 (HIPAA) 29 U.S.C. §1181

HIPAA not only gave rise to those annoying disclosures we now need to sign every time we have a doctor or dentist appointment, it also provides for the continuation of health care coverage when it is lost due to exhaustion of COBRA coverage. Unlike COBRA, HIPAA applies to all employers who administer group health plans. It limits exclusion of preexisting conditions to twelve months for most participants and reduces the twelve month exclusion for each day that a participant had prior continuous coverage. It does not require employers to offer health insurance, but it makes health insurance portable, limiting the ability of the new insurer or group health plan to deny or restrict coverage for a previously insured individual.

HIPAA is enforced by the Department of Labor and the Department of Health and Human Services.

Fact Sheet

U.S. Department of Labor

Employee Benefits Security Administration

December 2004

The Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) offers protections for millions of American workers that improve portability and continuity of health insurance coverage.

HIPAA Protects Workers and Their Families By

- Limiting exclusions for preexisting medical conditions (known as preexisting conditions)
- Providing credit against maximum preexisting condition exclusion periods for prior health coverage and a process for providing certificates showing periods of prior coverage to a new group health plan or health insurance issuer
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married or add a new dependent
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage for both small and large employers
- Preserving the states' role in regulating health insurance, including the states' authority to provide greater protections than those available under federal law

Preexisting Condition Exclusions

- The law defines a preexisting condition as one for which medical advice, diagnosis, care, or treatment was recommended or received during the 6- month period prior to an individual's enrollment date (which is the earlier of the first day of health coverage or the first day of any waiting period for coverage)
- Group health plans and issuers may not exclude an individual's preexisting medical condition from coverage for more than 12 months (18 months for late enrollees) after an individual's enrollment date
- Under HIPAA, a new employer's plan must give individuals credit for the length of time they had prior continuous health coverage, without a break in coverage of 63 days or more, thereby reducing or eliminating the 12- month exclusion period (18 months for late enrollees)

Creditable Coverage

- Includes prior coverage under a group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corps Act, or a public health plan

Certificates of Creditable Coverage

- Certificates of creditable coverage must be provided automatically and free of charge by the plan or issuer when an individual loses coverage under the plan, becomes entitled to elect COBRA continuation coverage or exhausts COBRA continuation coverage. A certificate must also be provided free of charge upon request while you have health coverage or anytime within 24 months after your coverage ends

-- Certificates of creditable coverage should contain information about the length of time you or your dependents had coverage as well as the length of any waiting period for coverage that applied to you or your dependents

-- For plan years beginning on or after July 1, 2005, certificates of creditable coverage should also include an educational statement that describes individuals' HIPAA portability rights. A new model certificate is available on EBSA's Web site

-- If a certificate is not received, or the information on the certificate is wrong, you should contact your prior plan or issuer. You have a right to show prior creditable coverage with other evidence — like pay stubs, explanation of benefits, letters from a doctor — if you cannot get a certificate

Special Enrollment Rights

-- Are provided for individuals who lose their coverage in certain situations, including on separation, divorce, death, termination of employment and reduction in hours.

Special enrollment rights also are provided if employer contributions toward the other coverage terminates

-- Are provided for employees, their spouses and new dependents upon marriage, birth, adoption or placement for adoption

Discrimination Prohibitions

-- Ensure that individuals are not excluded from coverage, denied benefits, or charged more for coverage offered by a plan or issuer, based on health status-related factors

<http://www.dol.gov/dol/topic/health-plans/portability.htm>

4. Health Insurance for Dependents of Military Service Members

TRICARE is a health benefit program for all members of the seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration. Also eligible for coverage are:

- The spouses and unmarried children of service members, including stepchildren
- Certain family members of active duty service members who were court-martialed and separated for spouse or child abuse
- The victims of the abuse within the family for the period that the abused family receives “transitional compensation” under Section 1059 of Title 10, U.S. Code
- Certain abused spouses, former spouses, and dependent children of service members who were eligible for retirement, but had that eligibility taken away as a result of abuse of the spouse or child. This benefit is effective for medically necessary services and supplies provided under TRICARE Standard (CHAMPUS) on or after October 23, 1992
- 20/20/20 Spouses. Unremarried former spouses under 62 years of age who were married to a service member for twenty years or more, of which at least twenty years overlapped with at least twenty years of creditable service toward retirement. 10 U.S.C. § 1072(2)(F) (2005).

- 20/20/15 Spouses: Unremarried former spouses who were married to the service member for at least twenty years of which at least fifteen, but less than twenty, were during the member's twenty years or more of creditable service, qualify for medical benefits if they are under 65 and not yet eligible for Medicare (Part A). 10 U.S.C. § 1072(2)(G) (2005). These 20/20/15 spouses are entitled to the following:
 - 1) Medical benefits are for the life of the former spouse if the decree of divorce, dissolution or annulment was final before April 1, 1985. 10 U.S.C. § 1072(2)(G) (2005).
 - Medical coverage for two years or until December 31, 1988, *whichever is later*, if divorced on or after April 1, 1985, but before September 30, 1988. 32 C.F.R. § 199.3 (b)(2)(i)(F)(2)(ii) (2005). This entitlement terminates after two years, but can be converted to a private DOD-sponsored health plan.
 - One year of medical benefits for spouses divorced on or after September 30, 1988, after which they may elect to enroll in and pay for coverage under a Department of Defense health benefits program, known as the Continued Health Care Benefit Program (CHCBP).

Continued Health Care Benefit Program (CHCBP) is available to those who lose TRICARE coverage or other coverage under the Military Health System. It is the military analogue to COBRA coverage. Enrollment must be within 60 days of loss of eligibility

for military health care. The premiums for this coverage are \$933 per quarter for individuals and \$1,996 per quarter for families.

5. Temporary Restraining Orders and Temporary Support Orders

It is advisable to file for temporary restraining orders at the outset of a divorce or legal separation to restrain the insured party from terminating, converting or changing the beneficiaries of health and life insurance, although ORC 3105.71 does prohibit such termination and provides remedies to the spouse and dependents whose health insurance was terminated after commencement of a case.

The party who is restrained from terminating the insurance of the other is effectively ordered to pay the premiums, which is a form of temporary spousal support and the party required to pay it can move to modify the temporary order under Civ. Rule 75. An order modifying the obligation to pay the premiums can relate back to the date the motion was filed. *Rush v. Oblinger*, 8th District Case No. 86751 (May, 2006).

§ 3105.71. Party to domestic relations action not to cancel health insurance for spouse and dependents.

(A) If a party to an action for divorce, annulment, dissolution of marriage, or legal separation was the named insured or subscriber under, or the policyholder, certificate holder, or contract holder of, a policy, contract, or plan of health insurance that provided health insurance coverage for that party's spouse and dependents immediately prior to the filing of the action, that party shall not cancel or otherwise terminate or cause the termination of such coverage for which the spouse and dependents would otherwise be eligible until the court determines that the party is no longer responsible for providing such health insurance coverage for that party's spouse and dependents.

(B) If the party responsible for providing health insurance coverage for that party's spouse and dependents under division (A) of this section fails to provide that coverage in accordance with that division, the court shall issue an order that includes all of the following:

(1) A requirement that the party make payment to that party's spouse in the amount of any premium that party failed to pay or contribution that party

failed to make that resulted in that party's failure to provide health insurance coverage in compliance with division (A) of this section;

(2) A requirement that the party make payment to that party's spouse for reimbursement of any hospital, surgical, and medical expenses incurred as a result of that party's failure to comply with division (A) of this section;

(3) A requirement that, if the party fails to comply with divisions (B)(1) and (2) of this section, the employer of the party deduct from the party's earnings an amount necessary to make any payments required under divisions (B)(1) and (2) of this section.

(C) If the party responsible for providing health insurance coverage for that party's spouse and dependents under division (A) of this section cancels or otherwise terminates or causes the termination of such coverage for which the spouse and dependents would otherwise be eligible, the spouse may apply to the insurer, health insuring corporation, or other third-party payer that provided the coverage for a policy or contract of health insurance. The spouse and dependents shall have the same rights and be subject to the same limitations as a person applying for or covered under a converted or separate policy under section 3923.32 of the Revised Code upon the divorce, annulment, dissolution of marriage, or the legal separation of the spouse from the named insured.