

## **EMPLOYEE BENEFIT PLANS: ERISA, AND THE INTERNAL REVENUE CODE IMPACT ON THE EMPLOYMENT RELATIONSHIP**

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Each employer that offers any type of employee benefit to its employees should be familiar with its fundamental duties in establishing, administering, amending and terminating those pension and welfare benefit plans that are subject to the requirements of the Internal Revenue Code (“Code”) and the Employee Retirement Income Security Act of 1974 (“ERISA”). Each time an employee is hired, takes a leave of absence, changes positions within the company, dies or becomes disabled, or terminates employment, the employee’s rights under the employer’s benefit plans are usually affected, and require certain actions by the employer and/or the benefit plan administrator that must comply with the Code and ERISA.

There are two basic types of benefit plans governed by the Code and ERISA: (1) pension plans, which cover any retirement benefit or income deferral that is paid following termination of employment;<sup>145</sup> and (2) welfare benefit plans consisting of medical, dental, vision, life insurance, short term and long term disability insurance, severance, and medical reimbursements under cafeteria plans.<sup>146</sup> The Code contains requirements for favorable tax treatment of pension<sup>147</sup> and welfare<sup>148</sup> benefit plans and also establishes excise taxes for violations.<sup>149</sup> ERISA, on the other hand, establishes rules governing the administration<sup>150</sup> and fiduciary responsibility of plan sponsors, administrators and trustees<sup>151</sup> and provides procedures for participants who challenge the actions of the sponsor or administrator.<sup>152</sup> The Code and ERISA requirements are more complex and detailed for pension plans than for welfare plans, but there are increasing requirements for welfare plans, especially those providing health benefits. There are similar, but not always identical, requirements in the Code and ERISA governing the same conduct or minimum standards. A full discussion of these requirements, however, is beyond the scope of this Guide.

As the sponsor of an employee benefit plan, the employer often will wear two hats: as the employer, it may act to amend a plan, terminate a plan, set contribution limits, and appoint and oversee third parties, such as the record keeper and trustees, who manage the plan and plan assets. Oftentimes, however, the employer also assumes, by law or the terms of the plan, certain fiduciary duties in the administration of the plan and, if applicable, investment of plan assets. When the employer is acting in its role as employer, its acts are subject to the general business judgment rule that governs all other corporate actions. When the employer acts as a fiduciary, it must meet a higher standard: a fiduciary must act for the exclusive benefit of plan participants and beneficiaries, in compliance with employee benefit laws and the terms of the plan document, and must exercise the same degree of care and diligence that a person would use

who is familiar with such matters.<sup>153</sup> Persons who act in a fiduciary capacity may be personally liable for their errors and omissions, although an employer may indemnify employees and directors acting within the scope of their employment as a fiduciary for an employee benefit plan.<sup>154</sup> Persons handling plan assets must also be bonded against theft or embezzlement.<sup>155</sup>

As mentioned above, each time there is a significant change in the relationship between an employer and an employee, there usually is a related effect on the company's employee benefit plans. The following is a general, but by no means exhaustive, list of activities related to employee benefit plans that the employer or plan administrator should consider undertaking in those situations:

**Newly Hired Employees (Or Employees Moving From  
Non-Eligible Into Eligible Employment):**

- Provide employee with information regarding eligibility for enrollment including, if applicable, automatic enrollment in pension and welfare benefit plans and any conditions that apply, such as contributions toward premiums for certain coverages;
- Provide enrollment forms (if required) for the employee to complete and any other eligible persons (spouse and dependents), including authorization for payroll deductions, beneficiary designations and investment choices, if permitted;
- Determine if employee had creditable coverage under a prior health plan to avoid the application of any pre-existing conditions, exclusions, or limitations under the health plan;
- Provide, if applicable, initial COBRA notice to employee and to spouse or other dependents, if any, which details qualifying events permitting continuation of group health plan coverage by employee and any qualified beneficiaries;<sup>156</sup>
- Provide summary plan description or certificate of coverage summarizing material terms of each employee benefit plan within 90 days of the employee becoming covered under that plan and for certain plans, additional information must be provided prior to the employee participating in the plan;<sup>157</sup>
- Notify plan record keepers, administrators and payroll in order to initiate and/or complete the enrollment process and payroll withholding.

### **Begin Leave Of Absence (Including Family & Medical Leave (FMLA) and Qualified Military Leave):**

- Determine which benefits will automatically continue, which benefits the employee may elect to continue, and which benefits, if any, terminate during the leave of absence;
- Determine if the leave triggers a change in family status that would permit a change in the employee's cafeteria plan election;<sup>158</sup>
- Determine the effect on any participant loans from a pension plan and the rights the employee may have to a distribution or withdrawal of funds (employer must suspend loan repayment and loan defaults during the qualified military leave);<sup>159</sup>
- Determine whether the leave results in a qualifying event which will trigger COBRA or state law continuation coverage rights;<sup>160</sup>
- Determine whether the continuation of benefits will require contributions from the employee and determine whether such contributions are to be paid through any remaining payroll deductions or directly by the employee;

NOTE: For FMLA leaves of absence, an employer is required to continue the employee's group health coverage during the period of FMLA leave as if the employee had continued to work, although the employee must continue to pay his or her share of the group health plan premiums in order to retain coverage during the leave. An employee on an FMLA leave of absence will not experience a COBRA qualifying event as a result of being on leave until he or she fails to return from FMLA leave or, if expressed earlier, makes it unequivocally clear to the employer that he or she does not intend on returning to employment.<sup>161</sup>

- For highly compensated executives, determine if the leave triggers a "separation from service" that would require distribution under a non-qualified deferred compensation arrangement.<sup>162</sup>
- Determine when benefits end if employee fails to return from leave.

### **Return To Employment After Leave Of Absence:**

- Restart the employee payroll deductions for current contributions toward premiums and salary deferrals;
- For qualified military leave, determine whether employee is entitled to make up missed salary deferrals to pension plans for period of military leave and re-amortize any participant loan; and credit any missed employer-funded pension or profit sharing contributions;<sup>163</sup>

- Determine whether the period of leave affects (counts) toward vesting, if any, or for benefit accruals under pension plans;
- Determine if the employee is permitted to repay any prior pension plan distribution received as a result of the leave.

**Promotion, Increase In Compensation Or Change In Job Location:**

- Determine whether there are any new or different benefits for the employee or if any benefit levels increase;
- Check each plan's definition of "compensation" to determine if new or additional compensation items are included or excluded in determining pension or profit-sharing contributions, life and disability insurance levels, and if the current deferral election covers those new or additional compensation items;
- If group health plan coverage is lost due to job relocation or change to non-covered employment, determine if those constitute "qualifying events" that trigger COBRA or state law continuation coverage rights.

**Termination Of Employment (Including Disability, Retirement and Death While Employed):**

- Provide COBRA or state law continuation notice to employee and qualified beneficiaries and determine whether any employer paid group health plan continuation coverage runs concurrent with, before or in place of, COBRA coverage;
- Determine if the employer owes any severance to the employee (e.g., Severance Pay Plan or terms of employment agreement);
- Notify record keepers, other plan administrators and insurers of change in the employee's employment status;
- Determine whether the employee is eligible to a year-end matching or profit-sharing contribution;
- Determine whether an additional year of vesting should be credited for pension benefit payout;
- Determine the status of any outstanding participant loan balance owed to the pension plan and the right to either continue payment or to accelerate the remaining loan;

- Process distributions from qualified plans, if a distribution is elected by participant;
- Determine the right to continued participation in the cafeteria plan for medical expense reimbursement and/or dependent day care reimbursement.
- When health plan coverage ends, provide a certificate of creditable coverage for the participant, if applicable.<sup>164</sup>

### **Miscellaneous Events:**

The following events may also require action by the employer in connection with one or more employee benefit plans:

- Change in the terms of a benefit plan, which may trigger an obligation of the employer to provide employees a written supplement to the summary plan description, describing the plan changes (certain changes to health benefit plans must be communicated within 60 days of the change);<sup>165</sup>
- Plan year-end, which generally triggers an employer obligation to provide an annual (and for certain plans, more frequent) statement of each participant's account in the qualified plan and provide annual notices as applicable about default deferral levels, default investments and fees associated with pension investment options<sup>166</sup> and to file with the IRS an annual tax return for pension and certain welfare plans;<sup>167</sup>
- A participant appeal of a denied claim for benefits, wherein the employer must comply with strict time periods and notice requirements under ERISA;<sup>168</sup>
- A participant's change in family status, such as divorce, birth or adoption, a child reaching age of 26, which may result in:
  - separate COBRA continuation rights;
  - a court issuing a qualified domestic relations order (QDRO) dividing pension and profit sharing plan assets; or
  - a court issuing a qualified medical child support order (QMCSO) to require an employer's health plan cover an employer's children.
- Acquisition or sale of a business or assets, which may result in:
  - a reduction in force that may trigger an employer's obligation to provide affected employees with severance, a COBRA notice, and pension distribution, including a review of vesting, or the buyer hiring additional employees;

- transition of affected employees from seller's to buyer's benefit plans; or
- the acquiring employer possibly assuming certain assets and liabilities of the seller's benefit plans.

**Finally, a word of caution:** employers who sponsor welfare and pension plans have faced increasing liability for errors in the administration of such plans, breach of fiduciary duty and conflicts of interest. Individual participants may sue pension plans directly for errors and certain losses caused by fiduciaries and service providers.<sup>169</sup> Often, a service provider to whom administration has been outsourced does not assume fiduciary status or requires in its service contract that the employer indemnify the service provider for any damages that result from the service provider's actions. Federal and state regulatory agencies have begun to scrutinize fee arrangements and conflicts of interest among service providers, which may in turn necessitate that the employer review provider service agreements and/or fee arrangements. Employers should carefully review plan documents and service provider contracts to determine the extent of any contractual indemnification, what relationship the service provider has to the plan and what fiduciary duties, if any, the employer and the service provider have undertaken under ERISA as applied to the benefit plan in question.

## **CONTINUATION OF GROUP HEALTH AND LIFE INSURANCE COVERAGE**

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Most group health plans and group life insurance arrangements are subject to laws requiring that continuation of coverage be offered to employees, their spouses, and their dependents if certain events occur that would otherwise cause these persons to lose their coverage under the plan (for example, the termination of a covered employee's employment other than for gross misconduct). These requirements are established by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")<sup>170</sup> and similar state laws.<sup>171</sup> Employers who offer these benefits must be aware of the applicable rules governing continuation of coverage and be prepared to provide the appropriate notices and election forms to covered individuals when these events occur.

The legal requirements in this area can be complex and will depend on the type of plan the employer offers. For this reason and because of the potential for liability in the event that an employer fails to comply with the continuation coverage requirements that apply to its plans, the employer should consult legal counsel regarding these requirements.

However, below is a brief overview of federal COBRA and Minnesota law with respect to an employer's continuation coverage requirements.

## **COBRA REQUIREMENTS**

### **Employers and Plans Subject to COBRA**

Employers (including corporations, partnerships, tax-exempt organizations and state and local governments) who maintain group health plans and regularly employ 20 or more full and part-time employees are required to comply with federal COBRA law.<sup>172</sup> Certain small employer plans, certain church plans, and federal government plans are not subject to COBRA.<sup>173</sup>

Group health plans subject to COBRA may include medical insurance arrangements, HMOs, self-insured medical reimbursement plans, dental plans, vision plans, prescription drug plans, employee assistance plans, health reimbursement arrangements and health flexible spending arrangements, among others.<sup>174</sup>

Generally, life insurance plans and health savings accounts are not subject to federal COBRA.

### **COBRA Triggering Events**

There are seven different “qualifying events” that trigger COBRA, which are:

- (1) termination of a covered employee’s employment (other than for gross misconduct);
- (2) a reduction of a covered employee’s hours of work causing a loss of coverage;
- (3) the covered employee’s death;
- (4) a divorce or legal separation from the covered employee;
- (5) a dependent child of the covered employee ceases to be a dependent under the terms of the plan;<sup>175</sup>
- (6) the covered employee becomes entitled to Medicare; and
- (7) an employer bankruptcy (retiree plans only).<sup>176</sup>

Employers generally only have an obligation to offer COBRA continuation coverage when an individual covered under the plan experiences a qualifying event. In order for a qualifying event to occur, there must be both a triggering qualifying event (listed above) and a resulting loss in plan coverage.<sup>177</sup> For example, an employer’s termination of its health plan will not require the employer to offer COBRA coverage, because, while there is a loss of plan coverage, no triggering event occurred that resulted in the loss of coverage.

### **Special Rules**

Special COBRA rules apply to leaves of absence particularly leaves under the Family and Medical Leave Act (FMLA). Under IRS COBRA regulations, a COBRA qualifying event does not

occur when an employee takes a leave under the FMLA. Rather, a qualifying event occurs when:

- an employee (or dependent child or spouse of the employee) is covered on the day before the first day of FMLA leave under the employer's group health plan;
- the employee does not return to employment with the employer at the end of the FMLA leave; and,
- the employee (or dependent child or spouse of the employee) would, in the absence of COBRA coverage, lose coverage under the group health plan prior to the end of the maximum coverage period.<sup>178</sup>

Essentially, an employee will experience a COBRA qualifying event when he or she fails to return from FMLA leave, or, if earlier, when he or she unequivocally informs the employer that he or she does not intend on returning to employment.<sup>179</sup> The COBRA maximum coverage period is measured without regard to any state-required continuation coverage.<sup>180</sup>

An employer should consult with legal counsel for further advice in this area, as well as in other specialized instances, such as in the context of mergers and acquisitions.

Also, if an employer is offering a departing employee severance pay pursuant to a severance agreement, the severance agreement should specifically address COBRA and how the employer will handle it. Employers may agree to pay a departing employee's COBRA premium for a short period (e.g., 3 months) of the COBRA coverage, so long as the employee elects such coverage. However, this approach may raise discrimination issues under the group health plan.<sup>181</sup>

### **Offering COBRA**

Generally speaking, an employer needs to offer COBRA continuation coverage to every person (known as a "qualified beneficiary") who will lose group health coverage under the plan as a result of a qualifying event.<sup>182</sup> Each qualified beneficiary under the plan has an independent right to elect COBRA.<sup>183</sup> The employer must offer COBRA continuation coverage that is identical to the coverage the plan provided for similarly situated qualified beneficiaries prior to the qualifying event.

### **Basic Maximum COBRA Coverage Period**

The maximum length of COBRA coverage the employer will offer depends upon the qualifying event. For termination of employment or reduction in hours, 18 months is the maximum coverage period (24 months for active military personnel).<sup>184</sup> For death of the employee, divorce or legal separation, a child's loss of dependent status under the plan, or an employee's entitlement to Medicare, the maximum coverage period is 36 months.<sup>185</sup> Typically, COBRA coverage will begin on the date of the triggering event. The 18-month period may be extended

for an additional 11 months for a total of 29 months (the “disability extension”) if a qualified beneficiary is or becomes disabled within 60 days of the qualifying event. The 18-month maximum coverage period can also be extended by multiple qualifying events.<sup>186</sup>

### **Termination of COBRA Coverage Prior to Expiration of Maximum COBRA Coverage Period**

A plan is permitted (but not required) to terminate a qualified beneficiary’s COBRA coverage prior to the end of the maximum coverage period in the following situations:

- the qualified beneficiary does not pay the required premium on time;
- the qualified beneficiary becomes covered under another group health plan after electing COBRA coverage;
- the qualified beneficiary becomes entitled to Medicare after electing COBRA;
- a qualified beneficiary who was disabled is determined by the Social Security Administration to no longer be disabled;
- the employer ceases to provide or maintain any group health plan for any of its employees;<sup>187</sup> or
- for cause (such as for filing a fraudulent benefit claim).<sup>188</sup>

### **COBRA Notice Requirements**

COBRA requires employers and/or Plan Administrators to provide plan participants with various notices and other written communication at certain times.

#### **1. COBRA General Notice**

The Plan Administrator, which is often the employer, has the obligation to send the initial COBRA notice to the covered employee (and his or her spouse, if any) when the employee (and spouse, if any) becomes covered under the group health plan.<sup>189</sup> The initial COBRA notice (sometimes referred to as the “General Notice”) contains general information about participants’ COBRA rights and obligations.<sup>190</sup> The Plan Administrator must deliver a General Notice to the participant within 90 days after coverage begins that contains the following items:

- the plan name and address and the name, address, and telephone number of a party from whom additional information about the plan and COBRA continuation coverage can be obtained;
- a general description of COBRA continuation coverage;

- a description of qualified beneficiaries' obligations to provide a qualifying event notice to the Plan Administrator and related procedures (for example, notification of a divorce or child reaching maximum age for coverage);
- a description of qualified beneficiaries' disability notice requirements and related procedures;
- an explanation of the importance of participants/qualified beneficiaries to keep the Plan Administrator informed of their current address; and
- a statement that more complete information regarding COBRA continuation coverage rights is available from the Plan Administrator and from the plan SPD.<sup>191</sup>

A sample form of the COBRA General Notice is available at: [www.dol.gov/ebsa/modelgeneralnotice.doc](http://www.dol.gov/ebsa/modelgeneralnotice.doc). Employers and Plan Administrators are cautioned that this Notice will require tailoring to the particular group health plan. The employer or Plan Administrator should consult with legal counsel for revisions prior to use.

## 2. COBRA Election Notice

The Plan Administrator also has the obligation to send a COBRA Election Notice to each qualified beneficiary who will lose plan coverage as a result of a qualifying event. The Election Notice contains information about a qualified beneficiary's continuation coverage rights and obligations with respect to a qualifying event, and is typically accompanied by a COBRA Election Form.<sup>192</sup>

The Plan Administrator must send out the Election Notice, which must contain the following 14 required items that must appear in the Election Notice,<sup>193</sup> within 14 days of the time it receives notice that a qualifying event has occurred.<sup>194</sup> They are:

- plan name and address;
- identification of the qualifying event;
- identification of each qualified beneficiary and the date the plan coverage will terminate;
- a statement regarding each qualified beneficiary's independent right to elect COBRA continuation coverage;
- an explanation of how to elect COBRA continuation coverage;
- an explanation of the consequences of failing to elect COBRA continuation coverage;

- a description of the COBRA continuation coverage;
- an explanation of the duration of COBRA continuation coverage;
- a description of the circumstances under which COBRA coverage may be extended;
- a description of the plan's requirements concerning a qualified beneficiary's obligation to provide notice to the plan of a second qualifying event and notice of a Social Security disability determination, and related procedures;
- a description of the COBRA premium amount;
- a description of the plan's COBRA premium payment procedures;
- an explanation of the importance of qualified beneficiaries to keep the plan informed of current address; and
- a statement that more complete information regarding COBRA continuation coverage rights is available from the Plan Administrator and from the plan SPD.

A sample form of the Election Notice is available at [www.dol.gov/ebsa/modelectionnotice.doc](http://www.dol.gov/ebsa/modelectionnotice.doc). Employers and Plan Administrators are cautioned that this Notice will require tailoring to the particular group health plan and that they should consult with legal counsel for revisions prior to use.

### 3. Notice Of Termination Of COBRA Coverage

Before a Plan Administrator may terminate COBRA coverage prior to the end of the maximum continuation coverage period, the Plan Administrator must provide each affected qualified beneficiary with a notice that specifies when his or her COBRA coverage will be terminated.<sup>195</sup> Plan administrators can provide the Notice of Termination of COBRA Coverage along with the required HIPAA certificate, which must also be provided to a qualified beneficiary when COBRA coverage ends.

### 4. Notice Of Unavailability Of COBRA Coverage

A Plan Administrator must provide a qualified beneficiary with a Notice of Unavailability of COBRA Coverage when it determines that such qualified beneficiary is not entitled to COBRA coverage (or to an extension of the maximum COBRA period) after receiving notice from the individual of a qualifying event, a notice of a second qualifying event, or notice of a disability.<sup>196</sup>

### 5. Qualifying Event Notice

In order for a Plan Administrator to issue an Election Notice to a qualified beneficiary, it has to first receive notice of when a qualifying event occurs. In general, employers are obligated to

inform the Plan Administrator of certain qualifying events within 30 days of their occurrence, which include:

- death of a covered employee;
- termination (other than for gross misconduct) or reduction in hours of the covered employee;
- the covered employee becomes entitled to Medicare; or
- employer bankruptcy.<sup>197</sup>

Covered employees and qualified beneficiaries also have a duty to inform the Plan Administrator of certain qualifying events,<sup>198</sup> generally within 60 days of their occurrence.

The notices required from covered employees and qualifying beneficiaries include:

- notice of a divorce or legal separation of a covered employee from his or her spouse, and/or a dependent child's losing dependent status under the plan;
- notice of second qualifying events, including the death of a covered employee, divorce or legal separation from the covered employee, the covered employee becoming entitled to Medicare benefits, and a child ceasing to be a covered beneficiary under the terms of the plan;
- notice of a disability determination from the Social Security Administration; and
- notice of a change in disability status according to the Social Security Administration.

Group Health Plans must establish reasonable procedures for employees and qualified beneficiaries to provide notice of these qualifying events to the Plan Administrator, and describe these procedures in the plan's SPD.<sup>199</sup>

### **COBRA Elections**

COBRA continuation coverage is not automatically extended to a qualified beneficiary; he or she must affirmatively elect such coverage.

A qualified beneficiary has 60 days to elect COBRA coverage after the date that plan coverage terminates, or if later, 60 days after the date of the Election Notice to the qualified beneficiary from the Plan Administrator.<sup>200</sup>

When the date of the Election Notice is given later than the date coverage ends, the general rule is that the 60-day notice period starts to run from the date the Election Notice is "sent," although at least one court case held that the period does not begin to run until the qualified

beneficiary actually receives the Election Notice.<sup>201</sup> Remember that each qualified beneficiary has a separate right to elect COBRA among the different types of coverage he or she had prior to the qualifying event.<sup>202</sup> The covered employee or spouse may elect the COBRA continuation coverage for other qualified beneficiaries, although a spouse may not decline coverage on behalf of the other spouse.<sup>203</sup>

### **COBRA Premiums and Payment**

A plan may charge the qualified beneficiary for the cost of COBRA continuation coverage, but it is not required to do so.<sup>204</sup>

The maximum COBRA premium for one month of continuation coverage is 102% of the applicable premium.<sup>205</sup> The additional 2% represents an administrative fee that the Plan Administrator may charge. Under the 11-month disability extension, the plan may charge the disabled qualified beneficiary up to 150% of the applicable premium during the extension.<sup>206</sup> The federal government had also provided COBRA premium assistance for certain employees (and their families) who were involuntarily terminated between September 1, 2008 and May 31, 2010.<sup>36</sup> Under the premium subsidy, the employee paid 35% of the COBRA premium and the employer paid the remaining 65% of the COBRA premium, and was later reimbursed by the federal government for the other 65% through a credit or refund of payroll taxes. The premium subsidy was available for up to 15 months of the employee's maximum COBRA coverage period.<sup>207</sup> Employers should consult with legal counsel for further advice on the COBRA premium subsidy.

The COBRA premium may be different depending upon the type of coverage the qualified beneficiary elects. A plan may require that the qualified beneficiary pay the initial premium for COBRA continuation coverage as early as 45 days from the date of his or her COBRA election.<sup>208</sup> Thereafter, premiums are generally due on the first day of the month, subject to a 30-day (or longer) grace period.<sup>209</sup>

Plans are not required to send out monthly bills, although some do. A plan may terminate a qualified beneficiary's COBRA coverage for his or her nonpayment of premiums after the expiration of any applicable grace periods. In that case, the Plan Administrator must send the qualified beneficiary the Notice of Termination of Coverage before such coverage is terminated prior to the expiration of the maximum coverage period.

### **Penalties for Failure to Comply with COBRA**

- The IRS may assess excise tax penalties of \$100 per day (up to \$200 per day if more than one qualified beneficiary from the same family is affected) for each day a plan fails to comply with COBRA.<sup>210</sup>
- For single employer plans, the overall limit on the liability for excise tax penalties for failures due to reasonable cause (and not willful neglect) is \$500,000.<sup>211</sup>

- Qualified beneficiaries may sue to recover statutory penalties of \$110 per day for a plan's failure to provide him or her with the General Notice or the COBRA or Election Notice.<sup>212</sup>
- Qualified beneficiaries can sue to recover COBRA coverage allegedly due under the plan. In these cases, the employer, Plan Administrator or the insurance company can become obligated to provide COBRA coverage.
- Other relief may be available to qualified beneficiaries based on a plan's failure to provide him or her with the General Notice or COBRA Election Notice.<sup>213</sup>
- The Court is permitted in a COBRA lawsuit to award attorneys' fees and interest to the prevailing party.<sup>214</sup>

## **MINNESOTA STATE LAW REQUIREMENTS**

### **Group Health Plan Continuation Coverage and Conversion Requirements**

#### Continuation Coverage

Minnesota law requires that insured group health plans and plans established by employers through HMOs governed by Minnesota law allow covered employees who are voluntarily or involuntarily terminated (other than for gross misconduct<sup>45</sup>) from employment to elect to continue coverage for the employee and the employee's dependents.<sup>46</sup> The employee is eligible to continue coverage for 18 months after termination, or until he or she becomes covered under another group health plan, whichever is shorter<sup>215</sup> and runs concurrently with the federal COBRA continuation period. Since COBRA only applies to employers with 20 or more employees, many smaller employers who offer health insurance to their employees will be subject only to the requirements of Minnesota law.

The employer has the duty to inform the employee within 14 days after his or her termination or layoff of:

- the right to elect to continue coverage;
- the amount the employee must pay monthly to the employer to retain coverage;
- the manner in which and where the payment to the employer must be made; and
- the time by which the employee must make payments to the employer in order to retain coverage.<sup>216</sup>

The notice must be in writing and sent by first class mail. The employee has 60 days within which to elect coverage.

### Conversion to Individual Policy

Group health plans required to follow Minnesota law with regard to continuation coverage (above) are also required to allow a covered employee, surviving spouse, or other dependent to obtain from the insurer the option to obtain an individual policy of insurance at the end of the continuation coverage period. The employee, spouse, or dependent does not have to provide further evidence of insurability to obtain the conversion policy and coverage must not be interrupted.<sup>217</sup> Employers that do not offer coverage through an insurance policy subject to state law (i.e., all self-insured) are not required to offer this conversion right.

## **Group Life Insurance Plan Continuation Coverage and Conversion Requirements**

### Continuation Coverage

Minnesota law requires group life insurance plans to permit employees who are voluntarily or involuntarily terminated from employment the option to elect to continue the coverage for the employee and his or her dependents. Termination does not include discharge for gross misconduct.<sup>218</sup>

The employee is eligible to continue coverage for 18 months after termination, or until the employee becomes covered under another group life insurance plan, whichever is shorter.<sup>219</sup>

The employer has the duty to inform the employee within 14 days after his or her termination or layoff of:

- the employee's right to continue the life insurance coverage;
- the amount the employee must pay monthly to the employer to retain the coverage;
- the manner in which and where the employee must send the payment; and
- the time by which the employee must make payments to the employer in order to retain coverage.

The notice must be in writing and sent by first class mail. The employee has 60 days within which to elect coverage.<sup>220</sup>

### Conversion to Individual Policy

Group life insurance plans required to follow Minnesota law with regard to continuation coverage (above) are also required to allow a covered employee, a surviving spouse, or dependent the ability to obtain from the insurer an individual policy of insurance providing the same or substantially the same benefits. The employee, spouse, or dependent does not have to

provide further evidence of insurability to obtain the conversion policy and coverage must not be interrupted.<sup>221</sup>

## **HIPAA PORTABILITY AND PRIVACY**

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Employer group health plans are also subject to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).<sup>222</sup>

### **HIPAA Portability Requirements**

HIPAA’s portability, special enrollment, pre-existing condition exclusions restrictions, and nondiscrimination requirements apply generally to group health plans. HIPAA prohibits group health plans from discriminating against employees based on their health status and grants certain health plan enrollment rights to employees. The main purpose of HIPAA, however, is to ensure that workers who change jobs will not lose health insurance coverage due to exclusions for pre-existing conditions.

Under HIPAA, group health plans may not exclude coverage for pre-existing conditions for longer than 12 months (18 months for late enrollees).<sup>223</sup> In addition, any exclusion period is reduced by an employee’s period of coverage under a prior employer’s group health plan. The pre-existing exclusion period runs from the enrollment date, or if there is a waiting period, from the first day of the waiting period.<sup>224</sup>

Group health plans must provide “certificates of creditable coverage” to employees who lose coverage, and accept such certificates from other plans.<sup>225</sup> Insurance companies will often take responsibility for complying with HIPAA’s notice and administrative requirements, but employers with insured plans should verify that their insurer is complying with HIPAA. Employers that maintain self-funded health plans should seek assistance from legal counsel to develop the appropriate notices and forms or contract with a third party administrator for HIPAA compliance services.

The HIPAA portability regulations contain a model certificate of creditable coverage containing a required educational statement.<sup>226</sup> The regulations apply to plan years beginning on or after July 1, 2005. The model certificate for group health plans can be found at <http://www.dol.gov/ebsa/hipaamodelnotice.doc>. Employers and Plan Administrators are cautioned that this Notice will require tailoring to the particular group health plan, and therefore, they should consult with legal counsel for revisions prior to use.

## **HIPAA Privacy Standards**

When HIPAA was originally enacted, it did not contain detailed privacy standards, but required further regulations to be promulgated. The HIPAA final privacy regulations were published on August 14, 2002, and impose rules surrounding the use and disclosure of individuals' protected health information. The American Recovery and Reinvestment Act of 2009 ("ARRA"), includes provisions that significantly change the HIPAA privacy regulations for both "covered entities" and "business associates" (defined below) in the portion of ARRA known as the HITECH Act. Consult with legal counsel to determine the extent to which the HIPAA privacy regulations apply and the steps required to comply.

### **Covered Entities**

HIPAA privacy standards apply to "covered entities." Group health plans, health care providers, and health care clearinghouses are considered "covered entities" required to comply with the HIPAA privacy rules.<sup>227</sup> While employers are technically not covered under the privacy rules, they must comply if they sponsor a group health plan and perform administrative functions which involve handling protected health information on behalf of the plan.

Group health plans with fewer than 50 participants and that are administered by the employer are specifically excluded from the definition of a group health plan, and are therefore not subject to HIPAA privacy standards.<sup>228</sup>

### **Deadlines to Comply**

Covered entities were required to comply with the privacy rules by April 14, 2003. Small health plans (those with annual gross receipts of less than \$5 million in claims or premiums) had until April 14, 2004 to comply.

### **Protected Health Information**

Protected Health Information, otherwise known as "PHI," is defined under HIPAA's privacy regulations to be individually identifiable information that is created, maintained or transmitted by a covered entity, and is subject to the following specific exclusions:

- individually identifiable health information contained in education records covered by the Family Educational Rights and Privacy Act (FERPA):
- health care records of students in post-secondary degree programs; and
- employment records held by a covered entity in its role as an employer.<sup>229</sup>

## **Use and Disclosure**

Covered entities are only permitted to use or disclose PHI as set forth under the privacy rule. Under the rule, covered entities may use or disclose PHI for treatment, payment or health care operations purposes, which are specifically defined.<sup>230</sup> A signed authorization is usually required for further use or disclosure,<sup>231</sup> although there are exceptions, such as to avoid a serious threat to health or safety, for public policy purposes, for public health activities, or as required by law, among others.<sup>232</sup>

## **Individual Rights**

HIPAA's privacy rules guarantee individuals specific rights with respect to their health information, including the right to:

- receive a copy of the covered entity's Notice of Privacy Practices;
- inspect and copy protected health information contained in their designated record set;
- receive an accounting of disclosures made by the covered entity;
- amend or correct inaccurate or incomplete PHI; and
- request additional restrictions on the use and disclosure of their own PHI.<sup>233</sup>

## **Privacy Notice**

Covered entities are required to develop and provide a copy of their privacy practices to each individual that is the subject of the PHI. The regulations describe specific information that the notice must contain, including the types of uses and disclosures that the covered entity is permitted to make.<sup>234</sup> A fully insured group health plan's insurer will generally have the obligation to provide the notice to the insured. Self-funded plans must provide their own notice.

## **Administrative Safeguards**

HIPAA's privacy standards require covered entities to take specific actions designed to protect the privacy of an individual's PHI, including, but not limited to:

- designating a privacy official who is responsible for developing and implementing privacy policies and procedures;
- designating a contact person responsible for receiving complaints;

- providing training to all members of the covered entity’s workforce on policies and procedures with respect to PHI;
- establishing safeguards to protect the privacy of the PHI (physical and technical);
- developing a complaint procedure;
- developing appropriate sanction/disciplinary procedures for employees who violate the privacy rules; and
- implementing policies and procedures to comply with the privacy rules.<sup>235</sup>

### **Business Associates**

Business associates are outside entities or individuals that assist covered entities in performing their functions. As part of the HITECH Act, some of the HIPAA privacy and security rules now apply directly to business associates. The HIPAA privacy rule requires that a covered entity enter into a written contract or other arrangement with the business associate in order to disclose PHI to the business associate, and in order to allow the business associate to create or receive PHI on behalf of the covered entity.<sup>236</sup> For example, business associates can be providers of legal, actuarial, accounting, consulting, management or financial services.<sup>237</sup>

### **Fully Insured Group Health Plans**

Employers who sponsor fully insured group health plans and do not create, maintain or receive PHI (i.e., are “hands-off”) have vastly reduced obligations under the HIPAA privacy standards. In this situation, the requirements to comply with the use and disclosure rules, provide the HIPAA privacy notice, comply with the various individual rights, and comply with the HIPAA administrative safeguards are imposed upon the insurer.<sup>238</sup>

### **Enforcement**

The HITECH Act created new and stronger HIPAA enforcement capabilities. Criminal penalties apply to individuals who without authorization obtain or disclose individually identifiable health information that is maintained by a covered entity. Criminal conviction can subject an individual to the following:

- (1) a fine of not more than \$50,000, imprisonment of not more than 1 year, or both;
- (2) if the offense is committed under false pretenses, a fine of not more than \$100,000, imprisonment of not more than 5 years, or both; and

(3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, a fine of not more than \$250,000, imprisonment of not more than 10 years, or both.

Civil penalties are tiered based on the severity of the violation as described below:

(1) If the person did not know (and by exercising reasonable diligence would not have known) that such person violated a provision, the civil penalty is between \$100 and \$50,000 for each violation, up to a total of \$25,000 to \$1,500,000 for all violations of an identical requirement;

(2) If the violation was due to reasonable cause and not to willful neglect, the civil penalty is between \$1,000 and \$50,000 for each violation, up to a total of \$100,000 to \$1,500,000 for all violations of an identical requirement;

(3) If the violation was due to willful neglect, the civil penalty is between \$10,000 and \$50,000 for each violation, up to a total of \$250,000 to \$1,500,000 for all violations of an identical requirement.

The federal Department of Justice and the State Attorneys General have enforcement authority. HHS is required to do periodic audits to ensure that covered entities and their business associates are complying with the HIPAA regulations.

### **For More Information**

The U.S. Department of Health and Human Services Office of Civil Rights website is located at [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa) and provides answers to frequently asked questions regarding HIPAA privacy compliance.

However, because the HIPAA privacy and security standards are so complex and detailed, plan sponsors should consult with legal counsel to ensure proper and complete HIPAA compliance.

## **HEALTH CARE REFORM**

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On March 23, 2010, Congress passed and the President signed into law the Patient Protection and Affordable Care Act (Pub. L. No. 118-148 (2010)) (PPACA). That will, over the next 4 years, mandate minimum standards for health care coverage and require individuals to obtain such coverage. Health care reform is a series of laws, regulations and guidelines that also impose new requirements that employers will need to address. The legal requirements under health care reform are complex and subject to change. Therefore, an employer should consult legal counsel regarding these requirements. Below is a summary of some of the important requirements that employers will need to consider between now and 2013.

## Grandfathered Health Plans

Group health plans that had at least one participant on March 23, 2010 are considered to be grandfathered health plans.<sup>239</sup> The significance of being a grandfathered health plan is that the plan will have extended deadlines to make changes and is permanently exempt from certain provisions of health care reform. The requirements of health reform that do not apply to grandfathered plans are listed below under Important Changes to 2010. Grandfathered health plans may enroll new employees and family members of current participants without causing the plan to lose its grandfathered health plan status.<sup>240</sup> However, in order to preserve grandfathered health plan status, a grandfathered health plan cannot make any of the following changes to its terms and policies as in effect on March 23, 2010:<sup>241</sup>

- **Significantly Cut or Reduce Benefits.** For example, if a plan decides to no longer cover care for people with diabetes, cystic fibrosis or HIV/AIDS.
- **Raise Co-Insurance Charges.** Typically, co-insurance requires a patient to pay a fixed percentage of a charge (for example, 20% of a hospital bill). Grandfathered plans cannot increase this percentage.
- **Raise Co-Payment Charges.** Frequently, plans require patients to pay a fixed-dollar amount for doctor's office visits and other services. Compared with the copayments in effect on March 23, 2010, grandfathered plans can only increase those co-pays by no more than the greater of \$5 (adjusted annually for medical inflation) or 115% of the medical inflation rate.
- **Significantly Raise Deductibles.** Many plans require patients to pay the first bills they receive each year (for example, the first \$500, \$1,000, or \$1,500 a year). Compared with the deductible required as of March 23, 2010, grandfathered plans can only increase these deductibles by 115% of the medical inflation rate.
- **Significantly Lower Employer Contributions.** Many employers pay a portion of their employees' premium for insurance and the employees' pay the remainder through payroll deduction. Grandfathered plans cannot decrease the percent of premiums the employer pays by more than 5 percentage points (for example, decrease their own share and increase the workers' share of premium from 15% to 20%).
- **Add or Reduce an Annual Limit on What the Insurer Pays.** Some insurers cap the amount that they will pay for covered services each year. If they want to retain their status as grandfathered plans, plans cannot reduce any annual dollar limit in place as of March 23, 2010. Moreover, plans that do not have an annual dollar limit cannot add a new one unless they are replacing a lifetime dollar limit with an annual dollar limit that is at least as high as the lifetime limit.

- **Force Employees to Switch Plans.** Employers cannot force its employees to switch to another grandfathered plan that, compared to the current plan, has less benefits or higher cost sharing if there is no bona fide employment-based reason for the switch.
- **Merge with Another Plan.** A plan will lose its grandfathered status if the principal purpose of a merger, acquisition, or similar business restructuring is to cover new individuals under a grandfathered plan.
- **Change Current Insurance Company Agreements.** If an employer enters into a new policy, certificate, or contract of insurance with the plan's current insurance issuer and this causes a violation of the previous rules, the plan will not be considered a grandfathered health plan; an employer may change carriers and retain grandfather status if the above requirements are met.

In order to preserve grandfathered health plan status, grandfathered health plans are required to:<sup>242</sup>

- **Disclose Grandfathered Status.** A grandfathered plan must include a statement, in any plan materials provided to a participant or beneficiary describing the plan, that the plan believes it is a grandfathered plan within the meaning of the health care reform laws and must provide contact information for questions and complaints.
- **Keep Records of the Grandfathered Plan.** A grandfathered plan must maintain, and make available upon request, records documenting the terms of the plan in effect on March 23, 2010, and any other documents necessary to verify, explain, or clarify its continued status as a grandfathered plan.

Employers may wish to consult with legal counsel and their insurance provider or actuary to determine if the cost savings of grandfather plan status outweighs the cost savings of other changes that would cause a loss of the grandfather status.

**Important Changes in 2010:<sup>243</sup> (\*indicates grandfather plans exempt from requirements)**

- **Coverage of Adult Children Required.** If the plan provides coverage for dependent children, it must provide coverage for adult children until the child turns 26 years of age. The cost of coverage for an adult child is excluded from an employee's federal gross income. Grandfathered plans do not need to cover adult children who are eligible for other employer-sponsored coverage until 2014.
- **No Pre-Existing Exclusions for Children.** Plans may not impose any pre-existing condition limitations on participants who are under 19 years of age. This is extended to all enrollees in 2014.

- **No Annual or Lifetime Limits.** Generally, plans may not establish lifetime or annual limits on the dollar value of essential health benefits. Existing plans that have lower limits (so-called “mini-med plans”) may apply for an annual waiver prior to 2014.
- **Rescission of Coverage Prohibited.** Plans will not be able to rescind an individual’s coverage, except in the case of fraud and misrepresentation.
- **Preventive Care Coverage.\*** Plans must cover preventative care, such as immunizations, without co-payments or deductible.
- **Emergency Services Coverage.\*** If a plan covers emergency services, it must cover such services without requiring prior authorization and out-of-network expenses.
- **Provider Choice Requirement.\*** Plans must allow designation of any doctor as a primary care physician. For example, an OB/GYN for a female, and a Pediatrician for a child.
- **Small Business Tax Credit.** Employers with no more than 25 employees with average annual wages of less than \$50,000 may be eligible for a tax credit of up to 35% of the premiums paid by the employer.
- **Reimbursement for Early Retiree Health Benefits.** Plans may be reimbursed for 80% of annual claims between \$15,000 and \$90,000 for each retiree between age 55 and 65 who is not Medicare-eligible. The program will not be accepting applications after May 5, 2011.
- **Appeals Process Required.\*** Plans must establish an appeals and external review process for coverage and claims determinations and must provide benefits to the individual during the appeals and external review process. Enforcement of some of the appeals process requirements have been delayed until years beginning on or after January 1, 2012.
- **Adoption Assistance Limit.** Plans may increase limits for adoption assistance programs to \$13,170 (from \$12,170), adjusted annually for inflation.
- **Medicare Part D Deduction Accounting Change.** Although, employers will no longer be allowed to deduct the subsidy that is received for continuing retiree drug programs in 2013, accounting rules require immediate recognition of the changed tax treatment in the employer’s financial statements for 2010.
- **Nondiscrimination Testing.\*** Fully-insured plans are subject to nondiscrimination testing under IRC § 105(h). Prior to this, only self-insured plans were subject to testing. The effective date of this requirement has been delayed until regulations are issued.

- **Auto Enrollment.** Employers with more than 200 employees that offer coverage must automatically enroll new full-time employees in coverage with the opportunity to opt-out. The effective date of this requirement has been delayed until regulations are issued.

#### **Important Changes for Policy Years Beginning in 2011:<sup>244</sup>**

- **Exclusion of Over-the-Counter Medicine.** The definition of qualified medical expenses for HSA, FSA, HRA, and Archer MSA excludes over-the-counter medicine unless obtained with a prescription or the medicine is insulin.
- **Increase in Excise Tax.** The excise tax on distributions from HSA or Archer MSA not used for qualified medical expenses is increased from 15% to 20%.
- **SIMPLE Cafeteria Plan for Small Employers.** Employers with 100 or fewer employees may establish SIMPLE cafeteria plans, which are deemed to comply with all applicable nondiscrimination requirements applicable to cafeteria plans.
- **Small Business Grants for Wellness Programs.** Employers with less than 100 employees that did not provide a workplace wellness program as of March 23, 2010 may be eligible for a federal grant to help provide comprehensive workplace wellness programs.

#### **Important Changes for Policy Years Beginning in 2012:<sup>245</sup>**

- **Summary of Benefits and Coverage.** Beginning March 23, 2012, group health plans and health insurance issuers are responsible for providing all eligible individuals a four-page Summary of Benefits and Coverage (“SBC”) during initial and annual enrollment in a group health plan and at least 60 days prior to the effective date of any mid-year material modification. The SBC is a standalone document in addition to providing a summary plan description.
- **W-2 Reporting.** Most employers must report the aggregate cost of employer-sponsored health coverage on each employee’s W-2 form in January 2013. Eventually this information will be used to determine whether the care is affordable.
- **Quality Care Reporting.\*** Plans must report on plan benefits and reimbursement structures in relationship to the cost and quality of the health care. Technical requirements and regulations are due no later than March 23, 2012.

### **Important Changes for Policy Years Beginning in 2013:<sup>246</sup>**

- **Health FSA Limit.** Annual flexible spending account contributions under a cafeteria plan must be limited to \$2,500.
- **Notice of Exchanges.** Employers must provide all new hires and current employees with a written notice about the health benefit exchange and some of the consequences if an employee decides to purchase a qualified health plan through the exchange in lieu of employer-sponsored coverage.

**Repeal of Deduction for Retiree Prescription Drug Plans.** Employers who provide prescription drug benefits for Medicare Part D eligible retirees will not be able to take a tax deduction for the costs of providing those benefits (see 2010 description regarding the earlier effort on an employer's financial statement).

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- <sup>145</sup> ERISA § 3(2); 29 USC § 1002(2)
- <sup>146</sup> ERISA § 3(1); 29 USC § 1002(1)
- <sup>147</sup> I.R.C. §§ 401 et. seq.; 26 USC §§ 401 et. seq.
- <sup>148</sup> See I.R.C. §§ 104-106, 125; 26 USC §§ 104-106, 125
- <sup>149</sup> For example, I.R.C. §§ 4975, 4980B; 26 U.S.C. §§ 4975, 4980B
- <sup>150</sup> ERISA, Title I, Parts 1-3; 29 USC §§ 1021-1085
- <sup>151</sup> ERISA, Title I, Part 4; 29 USC §§ 1101-1114
- <sup>152</sup> ERISA, Title I, Part 5; 29 USC §§ 1131-1148
- <sup>153</sup> ERISA § 404(a)(1)(A)-(D); 29 USC § 1104(a)(1)(A)-(D)
- <sup>154</sup> ERISA § 410(b); 29 USC § 1110(b); M.S.A. 302A.521
- <sup>155</sup> ERISA § 412; 29 USC § 1112
- <sup>156</sup> ERISA § 606(a)(1); 29 USC § 1166(a)(1)
- <sup>157</sup> ERISA § 104(b)(1)(A); 29 USC § 1024(b)(1)(A)
- <sup>158</sup> Treas. Reg §1.125-4
- <sup>159</sup> Treas. Reg §1.72(p)-1
- <sup>160</sup> Treas. Reg §54.4980B-4 Q/A-1(e)
- <sup>161</sup> Treas.Reg54.4980B-10 Q/A-1(a)
- <sup>162</sup> Treas. Reg §1.409A-1(h)(1)
- <sup>163</sup> 38 U.S.C. §§4316-17
- <sup>164</sup> I.R.C. §9801(e)(1)(A); ERISA §701(e)(1)(A); 42 U.S.C. §300gg(e)(1)(A); Treas. Reg §54.9801-5(a)(2); DOL Reg §2590.701-5(a)(2); HHS Reg §146.115(a)(2). Note: Such certificates may no longer be required beginning in 2014 when pre-existing conditions limitations are prohibited under the current provisions of the Patient Protection and Affordable Care Act (P.L. 111-148).
- <sup>165</sup> ERISA § 104(b)(1); 29 USC § 1024(b)(1)
- <sup>166</sup> ERISA § 105; 29 USC § 1025
- <sup>167</sup> ERISA § 104(a)(1); 29 USC § 1024(a)(1)
- <sup>168</sup> ERISA § 503; 29 USC § 1133; 29 CFR § 2560.503-1
- <sup>169</sup> LaRue v. DeWolff, Boberg & Assocs, Inc. (2008 S.Ct); 552 U.S. 248; 128 S.Ct. 1020; 169 L.Ed.2<sup>nd</sup> 847
- <sup>170</sup> Pub. L. No. 99-272 (Apr. 7, 1986).
- <sup>171</sup> Minn. Stat. § 62A.17, § 61A.092 (2005).
- <sup>172</sup> 29 U.S.C. § 1161(b); 42 U.S.C. §300bb-1(b)(1); See 26 U.S.C. § 4980B(d)(1).
- <sup>173</sup> See 26 U.S.C. § 4980B(d).
- <sup>174</sup> Treas. Reg. § 54.4980B-2, Q/A-1(a), Q/A-8.
- <sup>175</sup> Under the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152 (2010), an employee's child may remain covered under the employee's plan until age 26, subject to certain conditions. See Pub. L. No. 111-152 § 104.
- <sup>176</sup> 29 U.S.C. § 1163; 26 U.S.C. §4980B(f)(3); Treas. Reg. § 54.4980B-4, Q/A-1.
- <sup>177</sup> Treas. Reg. § 54.4980B-4, Q/A-1(c).
- <sup>178</sup> Treas. Reg. § 54.4980B-10, Q/A-1(a).
- <sup>179</sup> Treas. Reg. § 54.4980B-10, Q/A-2, Example 2.
- <sup>180</sup> Treas. Reg. § 54.4980B-10, Q/A-4.
- <sup>181</sup> See Pub. L. No. 111-148 § 1001, amending 42 U.S.C. § 300gg-16.
- <sup>182</sup> 29 U.S.C. § 1161(a); 26 U.S.C. § 4980B(f)(1); 42 U.S.C. § 300bb-1).
- <sup>183</sup> 29 U.S.C. § 1165(a)(2); 26 U.S.C. § 4980B(f)(5)(B); 42 U.S.C. § 300bb-5(a)(2). Note: A parent is responsible for electing COBRA on behalf of dependent children.
- <sup>184</sup> 29 U.S.C. § 1162(2)(A); 26 U.S.C. § 4980B(f)(2)(B)(i); 42 U.S.C. § 300bb-2(2)(A).
- <sup>185</sup> 29 U.S.C. § 1162(2)(A); 26 U.S.C. § 4980B(f)(2)(B)(i); 42 U.S.C. § 300bb-2(2)(A).
- <sup>186</sup> 29 U.S.C. § 1162(2)(A); 26 U.S.C. § 4980B(f)(2)(B)(i); 42 U.S.C. § 300bb-2(2)(A).
- <sup>187</sup> However, in an acquisition of a business or its assets, the buyer may be responsible to provide COBRA coverage to persons losing coverage as a result of the transaction.
- <sup>188</sup> 29 U.S.C. § 1162(2)(B)-(E); 26 U.S.C. § 4980B(f)(2)(B)(ii)-(v); 42 U.S.C. § 300bb-2(2)(B)-(E).

<sup>189</sup> 29 U.S.C. § 1166(a)(1); 26 U.S.C. § 4980B(f)(6)(A); 42 U.S.C. § 300bb-6(1).  
<sup>190</sup> 29 C.F.R. § 2590.606-1.  
<sup>191</sup> 29 C.F.R. § 2590.606-1(c).  
<sup>192</sup> 29 C.F.R. § 2590.606-4.  
<sup>193</sup> 29 C.F.R. § 2590.606-4(b)(4).  
<sup>194</sup> 29 C.F.R. § 2590.606-4(b); Preamble to Final DOL Regulations, 69 Fed Reg. 30083, 30091 (May 26, 2004).  
<sup>195</sup> 29 C.F.R. § 2590.606-4(d).  
<sup>196</sup> 29 C.F.R. § 2590.606-4(c).  
<sup>197</sup> 29 U.S.C. 1166(a)(2); 26 U.S.C. § 4980B(f)(6)(B); 42 U.S.C. § 300bb-6(2); 29 C.F.R. § 2590.606-2(b)(3).  
<sup>198</sup> 29 C.F.R. § 2590.606-3.  
<sup>199</sup> 29 C.F.R. § 2590.606-3(b).  
<sup>200</sup> 29 U.S.C. § 1165(a)(1); 26 U.S.C. § 4980B(f)(5); 42 U.S.C. §300bb-5(a)(1).  
<sup>201</sup> *Kerr v. Chicago Transit Auth.*, 1998 WL 89137 (N.D. Ill. 1998).  
<sup>202</sup> 29 U.S.C. § 1165(a)(2); 26 U.S.C. §4980B(f)(5)(B); 42 U.S.C. §300bb-5(a)(2).  
<sup>203</sup> Treas. Reg. § 54.4980B-6, Q/A-6.  
<sup>204</sup> Treas. Reg. § 54.4980B-8, Q/A-1(a).  
<sup>205</sup> 29 U.S.C. § 1162(3)(A).  
<sup>206</sup> 29 U.S.C. § 1162(3).  
<sup>207</sup> Department of Defense Appropriations Act for Fiscal Year 2010, Pub L. No. 111-118 § 1010(b) (2009).  
<sup>208</sup> 29 U.S.C. § 1162(3); Treas. Reg. §54.4980B-8, Q/A-5(b).  
<sup>209</sup> 29 U.S.C. § 1162(2)(C); Treas. Reg. §54.4980B-8, Q/A-5(a).  
<sup>210</sup> 26 U.S.C. § 4980B(b)(1).  
<sup>211</sup> 26 U.S.C. § 4980B(c)(4).  
<sup>212</sup> 29 U.S.C. §§ 1132(a)(1)(A), 1132(c)(1)(A); 29 C.F.R. § 2575.502c-3.  
<sup>213</sup> 29 U.S.C. § 1132(c).  
<sup>214</sup> Minn. Stat. § 62A.17, subd. 2 (2010).  
<sup>215</sup> 29 U.S.C. § 1132(g).  
<sup>216</sup> Minn. Stat. § 62A.17, subd. 5 (2010).  
<sup>217</sup> Minn. Stat. § 62A.17, subd. 6 (2010).  
<sup>218</sup> Minn. Stat. § 61A.092, subd. 1 (2005).  
<sup>219</sup> Minn. Stat. § 61A.092, subd. 2 (2005).  
<sup>220</sup> Minn. Stat. § 61A.092, subd. 3 (2005).  
<sup>221</sup> Minn. Stat. § 61A.092, subd. 5 (2005).  
<sup>222</sup> Pub. L. No. 104-191 (Aug. 21, 1996).  
<sup>223</sup> I.R.C. § 9801(a); ERISA § 701(a); PHSa § 2701(a); 29 U.S.C. § 1181(a) (2007).  
<sup>224</sup> I.R.C. § 9801(b)(3)(A); ERISA § 701(b)(3)(A); PHSa § 2701(b)(3)(A); 29 U.S.C. § 1181(b)(3)(A) (2007).  
<sup>225</sup> I.R.C. § 9801(e)(1); ERISA § 701(e)(1)(A); PHSa § 2701(e)(1)(A); 29 U.S.C. § 1181(e)(1)(A) (2007).  
<sup>226</sup> Treas. Reg. 54.9801-5(a)(3)(ii).  
<sup>227</sup> 45 C.F.R. § 160.103; 45 C.F.R. §164.104 (2011).  
<sup>228</sup> 45 C.F.R. § 160.103 (2011).  
<sup>229</sup> 45 C.F.R. § 160.103 (2011).  
<sup>230</sup> 45 C.F.R. § 164.502 (2011).  
<sup>231</sup> 45 C.F.R. § 164.508 (2011).  
<sup>232</sup> 45 C.F.R. § 164.512 (2011).  
<sup>233</sup> 45 C.F.R. §§ 164.520-28 (2011).  
<sup>234</sup> 45 C.F.R. § 164.520 (2011).  
<sup>235</sup> 45 C.F.R. § 164.530 (2011).  
<sup>236</sup> 45 C.F.R. § 164.502(e) (2011).  
<sup>237</sup> 45 C.F.R. § 160.103 (2011).  
<sup>238</sup> 45 C.F.R. § 164.530(k) (2011).  
<sup>239</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1251 (2010).  
<sup>240</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1251 (2010).  
<sup>241</sup> Treas. Reg. § 54.9815-1251T; DOL REg. § 2590.715-1251; HHS Reg. § 147.140 (2010).

<sup>242</sup> Treas. Reg. § 54.9815-1251T; DOL Reg. § 2590.715-1251; HHS Reg. § 147.140 (2010).

<sup>243</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010).

<sup>244</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010).

<sup>245</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010).

<sup>246</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010).