

EMPLOYEE BENEFITS

Employers commonly provide some form of health care, life insurance and retirement benefits for their employees. Although employers are not required to provide these plans, if the plans are provided they must comply with federal and state laws.

FEDERAL EMPLOYEE RETIREMENT INCOME SECURITY ACT

At the federal level, the Employee Retirement Income Security Act (ERISA), 29 United States Code §§ 1001-1461, governs pension plans and medical, surgical, sickness, disability and death benefit plans sponsored by employers who are engaged in interstate commerce or in other activities affecting interstate commerce. ERISA establishes standards governing information to be provided participants, eligibility for participation, benefit rights and benefit accrual, vesting, employer and employee contributions, payment of benefits, plan termination and mergers, and survivor benefits. Federal agencies charged with enforcing ERISA include the Department of Labor, the Treasury Department, the Internal Revenue Service, and the Pension Benefit Guaranty Fund. Information on ERISA may be obtained from the Department of Labor's Office of Pension, Welfare, and Benefit Programs at the address and telephone number provided in the Resource Directory section of this Guide.

ERISA is an extremely complex and technical law. Historically it has been amended frequently by Congress, and been the subject of a great deal of litigation. Failure to conform to its requirements can create civil liability for the employer, and can cause the employer to lose a tax deduction for amounts contributed to the benefit plan. For these reasons, employers who are contemplating benefit plans covered by ERISA should obtain the advice of experts in this field before setting up the plan.

MINNESOTA REQUIREMENTS FOR GROUP HEALTH AND LIFE INSURANCE

Minnesota employers who offer group health insurance, health maintenance (HMO) coverage, or group life insurance must comply with Minn. Stat. and regulations of the Minnesota Department of Commerce concerning those products. In addition, HMO coverage is also regulated by Minn. Stat. and regulations of the Minnesota Department of Health. This is the case regardless of whether the employer is also covered by ERISA, although in some situations ERISA may preempt state law.

The state statutes and regulations establish minimum standards and requirements in areas like filing and obtaining approval of policy forms and certificates, minimum coverage requirements, content requirements for insurance certificates, limitations on cancellation and conversion procedures on termination of employment.

As with ERISA, the state requirements governing these plans are technical and complex. Expert advice should be sought before establishing any of these plans.

Insurance is regulated in Minnesota by the Minnesota Department of Commerce and, in the case of HMO coverage, by the Minnesota Department of Health. The departments can be contacted at the address and telephone number provided in the Resource Directory section of the Small Business Assistance Office publication, *A Guide To Starting A Business In Minnesota*.

RECORDKEEPING

Both federal and state laws impose record keeping requirements on documents relating to employee benefit plans. These include plan descriptions, participants' elections, worksheets and other documents. Retention periods range from six years to duration of the plan plus one year. Each year a comprehensive update of federal record retention requirements is published in the *Federal Register*. A business or government reference librarian can direct employers to the latest compilation.

COBRA NOTIFICATION

Health Insurance

The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who sponsor group health plans to offer covered individuals the right to elect continuation of the group coverage under certain circumstances. Minnesota law imposes additional requirements on employers whose health plans are funded through insurance contracts.

Employers who offer these types of benefits must provide employees (and, if covered, their spouses and dependents) with notice of their continuation rights when an event occurs that would otherwise cause a loss of coverage. The covered individual may elect to obtain for a limited period of time continuation of the coverage they had before the event. The individual may be required to pay up to 102 percent of the cost of the premium for their coverage.

COBRA requirements are complex. Firms that offer group health insurance to their employees should consult with legal counsel to assure that their notice procedures conform to federal and state law.

Life Insurance

There is no right under federal law to continue employer-provided life insurance coverage after employment terminates. Under Minnesota law, however, group term life insurance policies issued within the state must permit covered employees who are voluntarily or involuntarily terminated, incur a reduction in hours to the point where they are no longer eligible for coverage, or are laid off, to elect continuation of the coverage for themselves and their dependents. Coverage ends after 18 months or on the date on which coverage is obtained under another group policy, whichever occurs first. As with health insurance continuation coverage, the employee can be required to pay the cost of the life insurance continuation.

HIPAA NOTIFICATION

Employer group health plans are also subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA prohibits certain forms of discrimination based on 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). In addition, any exclusion period is reduced by an employee's period of coverage under a prior employer's group health plan. To implement these requirements, group health plans must provide "certificates of creditable coverage" to employees who lose coverage, and accept such certificates from other plans.

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 are on their own, and should seek assistance from legal counsel to develop the appropriate notices and forms (or contract with a third party administrator for HIPAA compliance services). HIPAA also made changes to COBRA and cafeteria plans, and employers should review related forms and plan documents with the assistance of legal counsel.

HIPAA PRIVACY REGULATIONS

HIPAA identifies three types of "covered entities" that must comply with the privacy requirements: health plans, health care providers that conduct certain transactions electronically, and health care clearinghouses.

For employers, that focus will be mainly on health plans. The regulations define a "health plan" broadly as any individual or group plan, insured or self-insured, that provides or pays for the cost of medical care. This includes group medical plans, dental plans, health care flexible spending accounts, managed care arrangements, and HMOs. If an employer operates an on-site medical clinic (or otherwise directly provides medical services) which conducts transactions electronically, that clinic may be covered under the new HIPAA privacy rules as a health care provider.

The HIPAA privacy regulations do not apply to group health plans with fewer than 50 participants, unless such a plan is administered by a covered entity other than the employer that established it. Plans that provide coverage that is incidental or secondary to medical care also are generally excluded from HIPAA privacy regulations.

Compliance with HIPAA privacy regulations is essential and should be discussed with private counsel.

EMERGING ISSUE: HEALTH CARE REFORM

The Patient Protection and Affordable Care Act, and the Health Care and Reconciliation Act of 2010 (together known as "Health Care Reform") will dramatically affect nearly every aspect of health care. It imposes requirements that employers will need to address over much of the next decade. From 2010 to 2013, changes largely involve new taxes, fees and mandates on individuals and small business. Most healthcare system changes begin in 2014 and later years.

The centerpieces of Health Care Reform are "individual responsibility" provisions, which generally require individuals to maintain health coverage (e.g. coverage purchased through an Exchange or group health coverage) or pay assessments, and the "employer responsibility" provisions, under which certain employers must offer group health coverage to full-time

employees, and contribute to the cost of coverage, or pay a penalty. In addition, there are many other aspects of Health Care Reform that will affect the design, coverage or administration of group health plans.

Given the far-reaching changes to the health care system brought about by the new legislation, and the potential for additional changes by Congress, there are still many unanswered questions regarding its implementation and application to employer-sponsored health laws. Businesses are advised to seek the advice of a professional familiar with this area.