

Chapter 5 Benefits

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This material is provided as general information and is not a substitute for legal advice. Consult your attorney for advice concerning specific situations.

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Chapter 5 Benefits

Find key considerations and concepts for options in leave benefits, other employee benefit programs and events such as tuition assistance or recognition programs, and insurance benefits such as health, dental, life, disability and long-term care. Understand benefits eligibility, benefits contribution structures, and requirements for offering continuation of benefits.

RELEVANT LINKS:

HR Reference Manual,
[Chapter 4.](#)

[Employee Benefits Self-Audit
Checklist](#), LMC model form.

I. Benefits and compensation

A total compensation program for employees contains both compensation and benefit components. The benefit package offered by a city is an important part of an employee's overall compensation package and can be a crucial component when trying to recruit, motivate and retain good employees. Some elements of a total compensation program may be difficult to classify strictly as "compensation" or only as a "benefit." Other elements may be considered both. For example, some may consider employee use of city cell phones as a "benefit", but depending on reimbursement strategies, may also consider it taxable "compensation". Similarly, deferred compensation can be considered both compensation and a benefit because the arrangement includes a portion of an employee's income to be paid out at a later date after which the income was actually earned and the benefit is derived from the fact that depending on the arrangement, it allows eligible employees to accumulate additional retirement savings on a tax-favored basis through automatic payroll deductions.

For purposes of this chapter benefits include various insurances, leaves and other time off, and selected other events and programs such as employee recognition, tuition reimbursements, membership, uniforms and childcare and housing assistance. The compensation chapter is devoted to actual salary and wage issues.

II. Applicable state and federal law

A city needs to be aware of the many state and federal laws affecting all aspects of the employment relationship, from application and hire, through compensation, benefits and protections while on the job, and finishing with end-of-employment requirements and sometimes continuing employer obligations in a post-employment relationship.

This material is provided as general information and is not a substitute for legal advice. Consult your attorney for advice concerning specific situations.

RELEVANT LINKS:

HR Reference Manual,
[Chapter 1.](#)

A number of the laws govern how benefits are handled by all employers—both public and private. Laws that may have the most impact for a city when setting up and maintaining employee benefits are discussed throughout this manual with regard to each applicable topic.

Minnesota has additional laws governing benefits in the public sector that do not apply in the private sector – such as special benefit continuation rules for police and fire employees, and pension participation requirements which will be discussed in detail later in this chapter.

Applicable state and federal laws for various points in the employment process are discussed within the City Employment Basics chapter of the HR Reference Manual, including, but not limited to:

- Age Discrimination in Employment Act
- Americans with Disabilities Act
- Benefit continuation laws
- Civil Rights Act of 1964 and 1991; Title VI
- Genetic Information Nondiscrimination Act
- Leave laws
- Minnesota Government Data Practices Act
- Minnesota Human Rights Act
- Minnesota Laws regarding Pregnancy Accommodations, Pregnancy Leave and Nursing Mothers
- Minnesota Open Meeting law
- Minnesota Pay Equity Minnesota Women’s Economic Security Act (WESA)
- Patient Protection and Affordability Care Act (PPACA)
- Pregnancy Discrimination Act of 1978
- Public Employees Retirement Association (PERA)
- Severance pay limitations
- Veterans’ Preference
- Voting and time off work to serve as an election judge
- Whistleblower laws.

III. Leave benefits and time off

Generally speaking, state and federal law do not mandate any paid leave benefits (with a few exceptions such as military leave under Minnesota Statutes which allows up to 15 days of paid leave in any calendar year). However, if a city elects to offer some type of paid leave like vacation or sick leave, there are a number of laws to ensure all employees will receive that benefit, without regard to race, color, national origin, or any other protected status.

HR Reference Manual,
[Chapter 1.](#)

RELEVANT LINKS:

[Minn. Stat. § 471.61.](#)

LMC information memo,
[Public Purpose Expenditures.](#)

[Minn. Stat. § 412.111.](#)

HR Reference Manual,
[Chapter 7.](#)

[29 C.F.R. § 825.215](#),
discussing ‘What is an
equivalent position?’

LMC information memo,
[City Employees and Military Leave.](#)
LMC information memo,
[Family and Medical Leave Act.](#)

For a greater review of common practices for vacation, sick leave, leave donation, and paid time off, as well as other various leaves, please refer to the link on the left.

IV. Other employee benefits, events and programs

In the last decades, the definition of employee benefit has changed substantially. In addition to traditional benefits like health insurance and vacation, many employers have added benefits such as childcare assistance and tuition reimbursement. A city’s legal ability to add benefits not specifically authorized by statute has been called into question by the Office of the State Auditor (OSA). While the observations of the OSA should be carefully considered, they are generally of an advisory, not legally binding, nature. Before adding any new employee benefits expenditures not specifically authorized by statute, the city should review the two-fold test for validity. First there must be a public purpose for the expenditure, and second there must be specific or implied authority for the expenditure found in statute or a city’s charter.

A. Service credit

Some benefit programs are based on an employee’s length of service with the city. Although length of service sounds relatively easy to calculate, it actually can be quite difficult. This is especially true if the city does not have any guidance about what constitutes service credit and what does not. Ideally, the city should define service credit in its personnel policy and use that definition consistently across all programs and policies. Sometimes, however, the city’s union contract or a state or federal law will impact how service credit is to be calculated.

Ideally, the city’s personnel policy should address certain questions with regard to service credit and how it is calculated. The Personnel Policies Chapter of the HR Reference Manual lists some items a city should cover with regard to service credit calculation.

Under certain circumstances, time spent on leave such as leave time covered by the Family and Medical Leave Act, must be counted for purposes of service credit. Qualified military leave for training or active duty also must be counted in many circumstances. These laws are complex and change frequently; the city should consult with an attorney if it is considering denying service credit for time spent on FMLA or military leave.

RELEVANT LINKS:

LMC information memo,
[Public Purpose Expenditures](#).

MN Office of State Auditor:
[Employee Recognition Programs and Events](#).
[Minn. Stat. § 15.46](#).

MN Office of State Auditor:
[Statement of Position, Employee Recognition Programs and Events](#).

[IRS Publication 525](#).

B. Employee recognition awards and employee social events

The League has historically taken the position cities can sponsor and pay for employee recognition programs (including social events such as employee picnics or holiday parties) if they are structured so they constitute part of an overall employee compensation program. The Attorney General has taken a narrow interpretation of the term compensation and suggested the term means only monetary compensation. In 2007, state law permitted cities to establish and operate a program of preventive health and employee recognition services for its employees. However, the Office of the State Auditor issued guidance in 2011 to the City of Dayton that seems to question expenditures for employee picnics or holiday parties. Cities wishing to provide employee recognition programs should consider the following:

- Take formal action to adopt a program, preferably well in advance of any actual expenditures, using language specifying the program is adopted as additional compensation for work performed by the employees.
- Develop a well-thought-out and modestly priced program applicable to all employees who meet certain conditions. For example, “all employees who reach 25 years of service will receive a plaque thanking them for their dedicated years of service to the community.” Or, “all regular full-time and regular part-time employees will be invited to attend the city’s summer employee picnic to thank them for their work throughout the year.”

Each city council should decide whether it believes these types of employee benefits promote a public purpose and serve the best interests of the citizens of their community. A good argument can be made that such expenditures are a natural incident of the employer/employee relationship and the authority for such expenditures is implied as part of the authority to compensate employees.

With respect to taxability for various recognition awards, the IRS has requirements for length of service awards. Among them, the awards cannot be given prior to the employee’s fifth anniversary of employment with the city. Also, the city may not award the employee another length of service award during the year or the previous four years. An employee achievement award must be an item of tangible personal property, and it must be given to an employee for his/her length of service or for some safety achievement. The circumstances surrounding the award must also demonstrate the award is not likely to be disguised pay.

RELEVANT LINKS:

[IRS Publication15B,
Educational Assistance.](#)

[26 U.S.C. § 127.
Minn. Stat. § 290.01 subd.
19.](#)

Specifically, an incentive award cannot be in the form of cash or a gift certificate (other than a non-negotiable certificate conferring only the right to receive personal tangible property). Any certificate that may be converted to cash is not “tangible personal property” and cannot qualify for preferential tax treatment.

C. Childcare or housing assistance

Some cities provide employees with assistance in locating quality childcare or housing in their community. This assistance may take the form of providing information, paying for the cost of a “search service,” or actually helping to pay the cost of childcare or housing. The same arguments with regard to public purpose expenditure and authority apply to these types of programs as discussed in the above section.

D. Credit union

Many Minnesota cities affiliate with a local credit union as a benefit to their employees. The city’s participation generally takes the form of allowing payroll deductions for that credit union and supplying employees with information regarding how to join the credit union.

E. Tuition reimbursement

Tuition reimbursement is another common benefit offered by many Minnesota cities. This benefit usually takes the form of reimbursing an employee for a portion of the costs of college and graduate level courses related to the employee’s job with the city. Sometimes, the program allows for reimbursement of courses relating to a promotional opportunity for the employee. These programs often stipulate an employee must receive a passing grade or tie the percentage of reimbursement to specific grade levels (e.g., a “C” = 50 percent reimbursement; “B” = 75 percent reimbursement, etc.). Some cities require an employee to pay back the reimbursement if they do not remain with the city for a year or longer after completion of the course.

Educational assistance offered to employees may be exempt from federal income tax under Section 127 (the educational assistance exclusion) and Section 132 (the fringe benefit exclusion) of the Internal Revenue Code. Section 127 allows employers to offer up to \$5,250 annually per employee in tax-free education help as long as the benefits are provided under a qualified educational assistance program. Educational assistance may be subject to state tax.

RELEVANT LINKS:

[Minn. Stat. § 136a.1792, subd. 4.](#)
MN Office of Higher Education: [Public Service Loan Forgiveness: For Borrowers and Employers.](#)

LMC information memo, [Management of Personnel Files.](#)

[Minn. Stat. § 471.96.](#)

LMC information memo, [Public Purpose Expenditures.](#)

A.G. Op. (June 27, 1997) (informal letter opinion to Staples).

LMC information memo, [IRS Audits of City Payroll.](#)

A qualified plan includes, among other things, a separate written plan providing graduate and/or undergraduate assistance exclusively to employees (not their spouses or dependents) that is open to everyone and does not favor highly compensated employees. The \$5,250 limit has been in place since 1986.

F. Promotion of student loan forgiveness program

On an annual basis for existing employees, and within two weeks of a newly hired employee's first day of work, public employers are required to provide written or electronic information regarding the federal student loan forgiveness program, including a one-page letter, fact sheet, and frequently asked questions, all of which have been created and made available to employers by the Office of Higher Education. Sample annual and new employee notifications from the State are linked to the left. Additionally, and pursuant to an employee's request, an employer must provide the employee with a copy of the employment certification form. For information on the retention period cities must keep associated completed certification documentation for this program, please see the link to left.

G. Memberships

Cities are authorized to spend funds for membership of the city in county, regional, state, and national associations of a civic, educational, or governmental nature "which have as their purpose the betterment and improvement" of city operations. The same statute also allows cities to pay the expenses associated with having city representatives attend and participate in meetings of these associations.

The Attorney General, in a 1997 informal opinion letter to the City of Staples, indicated that Chambers of Commerce could not be characterized as meeting the above criteria. While the Attorney General's opinion should be given weight, it is largely a city council's discretion as to whether they think the Chamber of Commerce is an organization meeting this definition.

H. Uniforms

Many cities either pay for or provide uniforms to certain positions within the city such as police, fire, and public works personnel.

If the city provides a uniform allowance and does not require employees to provide receipts, the allowance probably constitutes taxable income to the employee.

RELEVANT LINKS:

HR Reference Manual,
[Chapter 4](#), Section III.

LMC information mom:
[Public Purpose Expenditures](#).

[Minn. Stat. § 471.61.](#)
[Minn. Stat. § 179A.03, subd. 14.](#)

PERA. LMC website:
[Federal Health Care Reform](#).
29 U.S.C. § 621 et seq., The
Age Discrimination in
Employment Act of 1967.
PERA: [Employee Eligibility](#),
[Mandatory Membership](#).

Cities may use a payroll deduction to charge employees for city uniforms unless a city policy or union contract specifies the city will pay the entire cost. There are limitations on how a city can handle payroll deductions for an employee's share of uniform costs.

Cities need to be mindful that an expenditure must have a public purpose and the city has direct or implied authority in law to make this type of purchase. Therefore, it is highly recommended a city consults with the city attorney before expending any funds on clothing reimbursements outside of a working condition of employment uniform.

V. Insurance benefits

A. Benefits eligibility and contribution

Cities generally have flexibility in establishing which employees are eligible for benefits and how much the city will contribute towards such benefit options.

1. Eligible participants

Cities have some flexibility in determining which individuals are eligible to participate in the city's benefits program. However, it is important to keep in mind an eligible participant may be defined in federal or state law, in the city's personnel policy, and/or collective bargaining agreements, and also in the city's insurance policy.

Some of the city's benefit programs (e.g., cafeteria plan, health reimbursement arrangement, post-employment health care savings plan, etc.) may also be subject to nondiscrimination rules that prohibit the plan from discriminating in favor of highly compensated employees.

a. Employees

Cities offering health, dental, and life insurance benefits are authorized to do so under state law. In addition, the Minnesota Public Employment Labor Relations Act further defines who is considered an employee. However, cities generally exclude temporary, seasonal, and sometimes those employees working part-time from participating in the benefits program.

Certain benefit programs, such as PERA, base eligibility on minimum salary and position eligibility requirements set by Minnesota statute. Generally, PERA membership is required for public employees filling non-elected positions whose salary from one governmental subdivision exceeding \$5,100 per year.

RELEVANT LINKS:

Minn. Stat. § 471.61.
LMC website: [Federal Health Care Reform](#).

LMC website: [Federal Health Care Reform](#).

LMC website: [Federal Health Care Reform](#).

Cities may choose to offer benefits only to full-time employees or may extend benefits to part-time employees.

(1) Employer mandate under health care reform

The employer mandate is officially part of the Employer Shared Responsibility Provision. Under the Affordable Care Act, the federal government, state governments, insurers, employers, and individuals are given shared responsibility to reform and improve the availability, quality, and affordability of Health Insurance Coverage in the United States.

Although there is no definition in state or federal law requiring cities to offer health insurance coverage to either full- or part-time employees, the responsibility for providing insurance to your employees will depend on the number of full-time equivalent employees (FTE) at your organization. Therefore, the League encourages cities to establish their eligibility requirements in a personnel policy or collective bargaining agreement to avoid discrimination on the basis of any protected status.

In addition, the insurance carrier may have minimum requirements relating to eligible employees.

Although a city is not required to offer coverage or pay any part of the coverage, it is recommended that a city should offer affordable coverage to employees working an average of 30 or more hours a week in order to avoid possible penalties under the Affordable Care Act.

Cities with 50 or more full-time equivalent employees that do not offer insurance, offer insurance that is unaffordable (can't cost more than 9.56% of employee household income), or offer coverage not meeting a minimum value standard (the plan does not pay at least 60 percent of health care expenses for a typical population, as defined by the IRS) will be subject to the fees indicated below:

- If coverage is not provided, the fee is \$2,000 per full-time employee (minus first 30 full-time employees).
- If coverage provided does not meet affordability and minimum-value requirements, the fee is **the lesser of** \$3,000 per full-time employee receiving subsidies, or \$2,000 per full-time employee (minus the first 30).
- In general, the fee is only “triggered” if at least one employee shops on the marketplace **and is eligible for a federal premium subsidy**. Employees eligible for a premium tax credit are those whose household income is less than 400 percent of the federal poverty level.

RELEVANT LINKS:

LMC website: [Federal Health Care Reform](#).

LMC website: [Federal Health Care Reform](#).

LMC website: [Federal Health Care Reform](#).

Due to the complexities with the Affordable Care Act, cities should become familiar with all requirements to determine if the city qualifies for a health care tax credit, whether the city has less than 50 full-time equivalent employees or will have a greater responsibility in the future if the city is determined to be an “applicable large employer” or ALE. For further assistance on Affordable Care Act requirements for cities, click on the link to the left.

(2) Employer

If the city has at least 50 full-time equivalent employees and it offers coverage, but at least one employee receives a premium tax credit for purchasing coverage in the exchange, the city would be assessed the lesser of an annual \$3,000 penalty for each full-time employee who declines the coverage and instead purchases subsidized individual coverage through an exchange, or \$2,000 per full-time employee. An employee who is offered coverage will only be eligible for subsidized coverage if the employee’s contribution exceeds 9.5 percent of the employee’s household income or if the plan’s share of the total allowed cost of benefits is less than 60 percent and the employee’s household income is less than 400 percent of the federal poverty level.

(3) Determining full-time status

The city will need to review the hours worked by its employees to determine if they meet the full-time employee threshold of working an average of 30 or more hours. Under the Affordable Care Act, generally an employee is considered full-time if he or she is reasonably expected to work on average at least 30 hours per week, or 130 hours per month. Variable hour and seasonal employees may also be considered full-time under the ACA rules.

For purposes of the employer mandate penalties, the IRS Guidance permits a city to use a “look-back measurement period/stability period” safe harbor to determine which of its employees are considered full-time employees. A city may use a standard measurement/stability period for ongoing employees, while using a different initial measurement/stability period for new variable and seasonal employees. If it is determined when using the look-back measurement period that an employee meets the full-time employee threshold (averaging 30 or more hours per week), the city (if it has 50 or more full-time equivalent employees) would be required to offer affordable coverage to the employee or be subject to a penalty.

RELEVANT LINKS:

See section V-A-2-c-(1), *Age Discrimination in Employment Act* for more information on its application to employee benefits.

Minn. Stat. § 471.61, subd. 1a.

LMC website: [Federal Health Care Reform](#).
Minn. Stat. § 471.61, subd. 1a.

Minn. Stat. § 62A.042.
Minn. Stat. § 62A.048.
Minn. Stat. § 62A.302.

Additionally, cities must offer benefits to all eligible employees to prevent any discrimination issues. For example, cities will want to stay away from offering benefits only to younger employees and excluding older employees to ensure compliance under the Age Discrimination in Employment Act (ADEA).

Cities are encouraged to establish their eligibility requirements in a personnel policy and/or collective bargaining agreement. However, it is important to realize the insurance carrier may have minimum requirements relating to an eligible employee. Cities should take these minimum requirements into consideration when establishing their eligibility requirements.

b. Dependents

Health care reform defines an eligible dependent differently based on whether the plan is considered a grandfathered plan or a non-grandfathered plan. If the plan is grandfathered, the plan must provide coverage to children to age 26 unless they are eligible to enroll for any other employer-provided coverage that is not a group health plan of a parent. This could include coverage through their own employer's plan or through a spouse's employer's plan. For a non-grandfathered plan and for all plans (including grandfathered plans) starting in 2014 and later, coverage must be available to a child until age 26 regardless of whether the child has any other coverage.

Under health care reform, a child includes the biological children of the employee, stepchildren, adopted children, an individual who is placed with the employee for legal adoption by the employee; or eligible foster child(ren). Coverage can be discontinued for children in any of the above categories prior to age 26 if the applicable relationship no longer exists.

Health care reform does not extend coverage to children where the employee or employee's spouse is appointed the legal guardian of the child. Under these circumstances, Minnesota state law will apply if the child is an eligible child as follows.

Minnesota statute defines an eligible dependent as the following:

Dependent child to the limiting age" or "dependent children to the limiting age" means those individuals who are eligible and covered as a dependent child under the terms of a health plan who have not yet attained 26 years of age. A health plan company must not deny or restrict eligibility for a dependent child to the limiting age based on financial dependency, residency, marital status, or student status.

RELEVANT LINKS:

[Minn. Stat. § 62A.14.](#)
[Minn. Stat. § 62A.141.](#)
[Minn. Stat. ch. 62A.](#)

[Minn. Stat. § 471.61.](#)

[Minn. Stat. § 471.61.](#)
[Lilly v. City of Minneapolis](#),
527 N.W. 2d 107 (Minn. Ct.
App. 1995).

A disabled child may have further eligibility under the plan if they are incapable of sustaining employment by reason of mental retardation, mental illness, mental disorder, or physical handicap and are dependent on the employee for support and maintenance.

c. Domestic partners

The term “domestic partner” describes two adults who share an emotional and financial relationship but choose not to marry. Domestic partners could refer to same-sex couples or to unmarried couple of the opposite-sex. There is no legal definition of domestic partner. Examples of criteria often used to define a domestic partner relationship include:

- Maintaining the same permanent residence.
- Having a close, personal relationship.
- Sharing responsibility for each other’s welfare as evidence by financial interdependence.
- Expressing that the relationship is permanent.

Domestic partner benefits are benefits that an employer chooses to offer to an employee's unmarried partner, whether of the same or opposite sex.

State law which applies to local government entities, allows cities to insure their employee “and their dependents.” The statute further defines dependents to include the employee’s spouse and children under the age of 26 years.

Because Minnesota permits marriage between two people regardless of their sex, domestic partners are not spouses or dependents as defined under this law, therefore cities may not offer health benefits to an employee’s domestic partner akin to that provided to employees’ spouses.

Additionally, courts have ruled that domestic partners are not eligible to be covered as dependents under a city’s benefit plan. Other employment benefits, e.g., bereavement leave, may be offered, if a city chooses.

d. Same sex partners

Same sex partners who are legally married are eligible for coverage under a city’s group insurance plans in the same manner as opposite sex spouses.

2. Contribution structure

City contribution structures can vary widely and may change frequently as health care costs and the costs for other benefits continue to rise.

RELEVANT LINKS:

LMC website: [Federal Health Care Reform](#).

Cities should consider outlining their contribution structure in general terms rather than providing specifics in the personnel policy and/or collective bargaining agreement. This will minimize the number of changes needing to be made to the city's personnel policy.

a. Active employees

City contributions towards employees' coverage can vary widely from city to city. In some cases, the city may contribute towards benefits based on a flat dollar amount and others may contribute a percent of premium. In addition, cities offering benefits to full-time and part-time employees may prorate the amount of the city's contribution towards benefits for part-time employees.

For example, the city pays 100 percent towards the single premium for full-time employees and 50 percent towards the premium for part-time employees.

For cities offering age-rated premiums (most common in cities with fewer than 50 employees), it may be best to contribute on a percent basis. This seems to be the best approach in avoiding potential age discrimination issues. See the discussion below relating to the EEOC and ADEA.

Larger cities may establish a flat dollar contribution or may contribute a percent of premium towards benefits. Contributing a flat dollar amount towards benefits potentially minimizes the impact of future rate increases, since the city's cost will increase only if it changes the amount of its contribution.

The city's insurance carrier will likely set a minimum employer contribution requirement in order for benefits to be available. The most common contribution requirement for health benefits is a minimum of 50 percent of the single premium. Most cities are able to meet this minimum requirement without any problem, but it is something to keep in mind as the city evaluates its benefit options.

The city's collective bargaining agreement may further detail how much the city will contribute towards certain benefits. Cities with collective bargaining agreements should carefully consider any changes to their contribution structure. An argument could be made that changes to the city's contribution structure first need to be negotiated with the unions.

A city will need to consider whether the single-only contribution rate for health care is considered affordable to the employee for purposes of the Affordable Care Act, if the city is covered by the Employer Shared Responsibility provisions of the act and is attempting to avoid penalties.

RELEVANT LINKS:

See section V- *Insurance Benefits*.

[Minn. Stat. § 179A.20, subd. 2a.](#)
[Minn. Stat. § 471.61, subd. 2b.](#)

LMC information memo,
[Continuation of Benefits](#).

See Section VI-D, *Post-employment health care savings plans*.

Summary of GASB Statements No. 43 and No. 45 [Governmental Accounting Standards Board](#).

See Section V-A- 2-e, *Governmental Accounting Standards Board/other post-employment benefits*.

[Norman v. HRA of Chisholm](#), 696 NW 2d 329 (Minn. 2005).

Employees may contribute towards certain benefit options on a pretax basis or an after-tax basis. It is important to note that employee contributions cannot be made on a pretax basis unless the city has a cafeteria plan in place that complies with IRS regulations. Cities informally allowing for pretax deductions without meeting the appropriate requirements may create a tax liability for the city and for the employee. For more information about pretax contributions under a cafeteria plan, refer to the Insurance Benefits section in this chapter.

b. Retired employees

Two Minnesota statutes govern retiree health coverage. One prohibits governmental entities from obligating themselves to pay retiree health benefits beyond the duration of a collective bargaining agreement.

The other addresses the availability of continuation coverage for retirees and recognizes a governmental entity's ability to pay for retiree health coverage. While there is no requirement under these statutes for the city to contribute towards retiree benefits, the city may obligate itself to do so through the city's personnel policy and/or collective bargaining agreement.

In an effort to reduce costs, many cities have considered reducing or eliminating the amount they contribute towards retiree benefits and/or evaluating innovative and creative ways to help employees pay for the cost of benefits once they leave city employment. One of the options many cities consider for funding post-employment benefits is a post-employment health savings plan.

In addition, cities are faced with reporting standards for certain retiree benefits. Even cities not contributing towards retiree coverage may have some liability with their retiree benefits because of state law regarding continuation of coverage for early retirees and can be subject to requirements pertaining to post-employment benefits. For example, if the city pools early retirees with their active employees as required by state law, the city is required to calculate an "implicit subsidy" under GASB rules.

Any changes to the city's contribution structure should be carefully considered, as it could be problematic for cities—especially when the discussion turns to eliminating or reducing benefits for city retirees covered under a collective bargaining agreement.

A 2005 Minnesota Supreme Court case illustrates how making the decision to eliminate employer contributions towards retiree benefits may impact cities.

RELEVANT LINKS:

[Minn. Stat. § 179A.20.](#)

LMC information memo,
[Continuation of Benefits.](#)

[Equal Employment
Opportunity Commission
website.](#)

In Norman the collective bargaining agreement in place at the time of the employee's retirement provided the HRA would continue to pay the retiree's health insurance premiums indefinitely. Subsequently, the collective bargaining agreement expired and the HRA discontinued paying the retiree's insurance premiums relying on Minn. Stat. § 179A.20.

The court held that a public employer may obligate itself in a collective bargaining agreement to pay retiree health care premiums indefinitely. Where the HRA did not limit its obligation to pay benefits and the employee retired under a collective bargaining agreement, the court held the HRA could not discontinue its contribution towards the insurance premium for the employee.

It did not matter the contract later expired or that the union eventually decertified.

A couple of issues cities should take into consideration when evaluating changes to their retiree benefits include the following:

- Will the change impact current retirees? If so, consider union contracts and/or personnel policies in force at the time the employee left the city—was a promise made to contribute indefinitely?
- Consider impact of GASB accounting standards for non-pension retiree benefits, such as health benefits.
- Work with union representatives to begin discussing any potential changes that might need to be made to the city's contribution structure as a result of the new accounting standards—realize changes may not be able to be made for current employees or retirees.
- Carefully evaluate options for implementing a post-employment health savings plan and make sure the plan complies with appropriate IRS regulations.
- If considering a post-employment health savings plan, first negotiate this benefit with the city's unions and/or change your personnel policy to reflect this new benefit prior to the effective date of the program.

c. Equal Employment Opportunity Commission

The U.S. Equal Employment Opportunity Commission (EEOC) is the enforcement agency for a variety of federal laws prohibiting job discrimination. The EEOC also provides oversight and coordination of all equal employment opportunity regulations, practices, and policies.

Virtually all cities with 15 or more employees who worked for the organization for at least twenty calendar weeks (in this year or last) are subject to the laws under the EEOC (some exceptions may apply for cities with fewer than 15 or 20 employees).

RELEVANT LINKS:

[29 U.S.C. § 621 et seq.](#), The Age Discrimination in Employment Act of 1967.

[EEOC Compliance Manual, Directive 915.003, October 3, 2000, Chapter 3: Employee Benefits.](#)

[Federal Register: Disparate Impact and Reasonable Factors Other Than Age Under the Age Discrimination in Employment Act.](#)

[Minn. Stat. § 471.61.](#)

[LMC information memo, Continuation of Benefits.](#)

The Age Discrimination in Employment Act (ADEA) is one of the laws falling under the EEOC's enforcement and has a direct relation to certain employee benefits offered by the city.

d. Age Discrimination in Employment Act

The ADEA offers certain protections to individuals who are 40 years of age or older from employment-based discrimination based on age. Under the ADEA it is unlawful to discriminate against a person because of his/her age with respect to any terms, conditions, or privileges of employment, including benefits (among other things). Cities are subject to the ADEA no matter how many employees it has.

The EEOC issued a compliance manual in 2000 outlining the EEOC's interpretation of how cities must structure their employee benefit plans in order to avoid violating the ADEA. Some of the issues raised under the ADEA for cities in Minnesota include the following:

- The basic ADEA requirement is that the city provides the same benefit to employees of all ages, but there's an exception for benefits costing more to provide to older individuals (health, life, and disability insurance are examples). For these benefits, the city can provide a lesser benefit to older employees as long as certain conditions are met.
- Age-rated premiums are not discriminatory in and of themselves. However, cities offering a flat dollar contribution towards all employees could be subject to charges of age discrimination. The League recommends cities contribute to these types of plans on a percentage basis and consult with their city attorney regarding their specific situation.
- If it is more expensive to provide benefits to older employees, the city can provide reduced benefits to older employees as long as the following are maintained:
 - The cost is the same.
 - The benefit reduction for older workers is no more than what is necessary to keep the cost level.
- The age brackets are no wider than five years (i.e., providing rates for health, life, or disability benefits in five-year-age bands appears to be okay under the ADEA).
- A "Medicare carve-out" provision is permissible and probably a good idea for most cities. That is, the city's health plan for over-65 retirees can exclude coverage for things that Medicare covers.
- The ADEA apparently would allow the city to provide different benefits to a younger retiree (under the age of 65) than to an older retiree (over the age of 65).

RELEVANT LINKS:

[Minn. Stat. § 471.61 subd. 2b.](#)

[GASB: Implementation Guide for Statements 74 and 75 on Other Postemployment Benefits.](#)

[Governmental Accounting Standards Board, Summary of GASB Statements No. 43 and No. 45.](#)

In addition, Minnesota state law requires cities to offer qualified retirees the option to continue medical and dental coverage indefinitely in a city-sponsored health plan. Here are some key points regarding this requirement:

- The statute allows, but does not require, the city to contribute to retiree health coverage. The retiree must pay the full premium to continue coverage unless otherwise provided in either a collective bargaining agreement or the city's personnel policy.
- Retirees under age 65 must be pooled with active employees. Both premiums and benefits must be the same for pre-65 retirees as for active employees.
- Under state law, the premiums and benefits for post-65 retirees can be different from the premiums and benefits for active employees and under age 65 retirees.

There are a number of ways in which cities might run afoul of Minnesota law and/or ADEA requirements with respect to the benefits offered and the contribution structure in place for both active employees and retirees, thus it is vital cities work with a benefits specialist and legal counsel prior to implementing benefit plans.

e. Governmental Accounting Standards Board/other post-employment benefits

The Governmental Accounting Standards Board updated accounting and financial reporting standards (Statements 74 and 75, replaced Statements 43 and 45) relating to other post-employment benefits (OPEB) other than pensions, such as retiree health insurance benefits. Prior to Statements 43 and 45 Historically, public sector employers funded retiree benefits on a pay-as-you-go basis, which created unfunded liabilities that were not reflected in the city's financial reports until after an employee retired and benefits were paid out. Two of the bigger changes in the updated statements was moving information reported in the notes section of the financials to the Statement of Net Position and biennial actuarial valuations are now required (plans with less than 100 members are still allowed to use the alternative measurement method).

GASB sees OPEB like pension benefits in that the cost of the promised benefits should be recognized when the employer receives the services of the employee and not when the benefits are paid after the employee leaves employment. The standards require OPEB costs to be measured on an accrual accounting basis over the careers of employees.

In other words, the standards shift the future cost of retiree benefits after employment to the years of employment.

RELEVANT LINKS:

See generally, the [Governmental Accounting Standards Board \(GASB\) website](#).

[GASB: Implementation Guide for Statements 74 and 75 on Other Postemployment Benefits](#).

[Governmental Accounting Standards Board, Summary of GASB Statements No. 43 and No. 45](#).

LMC website: [Federal Health Care Reform](#).

GASB Statements 74 and 75 do not require cities to pre-fund the promises made to retirees, but they must determine and disclose how they plan to pay for the benefits in the future.

Cities not funding these benefits, however, may experience negative consequences related to their credit ratings, bonding, and ability to borrow money.

It is important to realize virtually all Minnesota cities offering health benefits to retirees will have some OPEB liability regardless of size and/or their contribution towards retiree benefits. This is because Minnesota law requires cities to keep early retirees on the same plan and at the same cost as active employees. The premium cost charged to early retirees is generally less than the retirees expected cost. This creates the issue of implicit subsidy, which is considered an OPEB liability and must be quantified under the GASB standards.

Cities should take into consideration the following when evaluating their OPEB liability:

- Evaluate existing plans that might fall under the GASB standards. Retiree health benefits will be the most common, but other benefit plans may also come into play.
- Retain an actuary to help evaluate and calculate the city's OPEB liability.
- Determine whether and how to fund OPEB liabilities.
- Consider changes to the city's benefit plan. Is changing from a defined benefit plan to a defined contribution plan going to help? Should the city consider implementing a trust to help with employer contributions?
- Work with union representatives to discuss any potential changes that might need to be made to the city's contribution structure as a result of the accounting standards.

Cities can access additional information about the GASB requirements (GASB Statement 74 and GASB Statement 75) by going to the GASB website.

B. Health insurance benefits

Cities are not required to offer health benefits to employees unless provided for under a collective bargaining agreement or personnel policy. However, starting in 2015, the Patient Protection and Affordable Care Act (health care reform) imposes a shared responsibility requirement.

RELEVANT LINKS:

See Section V-A, *Benefits eligibility and contribution*.

Under this requirement, cities with 50 or more full-time equivalent employees may be subject to penalty if they fail to offer minimum affordable coverage.

As health care costs continue to rise, health insurance has become a very valuable benefit for employees. Many cities consider health benefits to be an integral part of the overall compensation package to attract and retain good employees. In addition, many employees view health benefits as a crucial source of protecting their income in the instance that they are faced with a major health crisis, which could easily jeopardize an individual's financial security with unanticipated medical expenses.

1. Factors contributing to rising health care costs

The largest portion of the city's health insurance premium dollar is influenced directly by medical costs and medical providers (doctors, clinics, and hospitals) and not so much by the insurance company itself. Approximately 80 to 85 cents of the city's premium dollar goes directly to pay the cost of the claims incurred, things like doctor visits, prescriptions, hospital stays, and any other medical costs.

Only about 15 percent of the premium dollar goes towards administrative costs associated with running an insurance company (such as claims processing, enrollment functions, and billing activities) and taxes and assessments the insurance companies are required to pay in order to conduct business in the state. There are several factors contributing to the rising cost of health care.

a. Medical technology

While medicine has come a long way in developing technology to better diagnose and treat illnesses and injuries, this new and better technology comes at a price.

b. Shift to less tightly managed care

Managed care was initially able to control costs by limiting access to providers and to services—essentially requiring patients to go through a primary care physician to get a referral to a specialist. The plans were able to control costs by negotiating lower fees with providers and by offering this type of gatekeeper approach. However, there are several factors that have made it difficult for managed care plans to control costs, such as consumer backlash, legislative mandates, provider consolidation (providers were now able to negotiate higher reimbursements because of their size), and consumer sentiments of more choices, greater flexibility, and fewer restrictions.

RELEVANT LINKS:

MN dep't of Health:
[Shortage designations.](#)

What we are faced with now is a loosening of managed care and double-digit rate increases with no end in sight.

c. Increased prescription drug spending

While prescription drugs represent less in total health care spending than other medical costs (such as physician visits and hospital stays), they are increasing at almost twice the rate. Employees are using a greater number of prescriptions than they have in the past—some argue this is due to direct consumer marketing and new and better drugs emerging in the market. This factor along with employees using name brand drugs (rather than generic alternatives) and inflation are the three major contributors to the increased cost of prescription drugs.

d. Aging population

According to State Demographic Center projections, by 2025 there will be almost one million elderly Minnesotans. Generally, the older you are the more health care services you will use, which increases your claims and ultimately impacts your health insurance premium.

In the future, a greater number of your employee population will be over 40 so an aging population will continue to be a factor of increased premiums well into the future.

e. Shortages in health care providers

This last factor contributes to the supply and demand issue. Labor costs are increasing due to shortages in certain medical-related professions, such as pharmacy and nursing. Simple supply and demand mean health care workers can demand higher wages because they are harder to find, so many health care facilities are paying higher wages and signing bonuses to attract and retain certain health care professionals.

2. Controlling health care costs

Minnesota employers are dealing with the rising cost of health care in a variety of ways, including the following.

a. Cost shifting

Many cities have taken the approach of shifting costs to employees through plan design changes (such as increasing deductibles or co-payment amounts) and through the city's contribution structure.

RELEVANT LINKS:

[Minn. Stat. 471.6161 Subd 5.](#)

This means employees end up paying more of the out-of-pocket costs for things like office visits and may also end up contributing more towards their insurance premium (even towards single coverage). There are a couple of things to take into consideration as you evaluate this approach.

Cities interested in potentially adjusting the benefit levels of their health insurance plans should be aware of a state statute that can limit a city's ability to reduce these benefits levels. Minnesota Statutes Section 471.6161, Subdivision 5 provides that "[t]he aggregate value of benefits provided by a group insurance contract for employees covered by a collective bargaining agreement shall not be reduced, unless the public employer and exclusive representative of the employees of an appropriate bargaining unit . . . agree to a reduction in benefits."

In applying this law, it is important for cities to understand what qualifies as a "benefit." The Attorney General's Office has indicated that benefits includes details such as deductibles and co-payments. Benefits do not include premium amounts.

It is also important to understand that this legal requirement to seek union approval only applies where there is a reduction in the "aggregate" value of benefits. This means the entire group of proposed changes must be viewed together to determine if there is a "net loss" in benefits. Sometimes this is not difficult to determine.

For example, if a city simply wants to increase the amount of the deductible or co-payment without a corresponding increase in benefits, there has been a reduction in the aggregate level of benefits. The question becomes more difficult where there is a proposed change in the benefit level that has increased benefits in some areas as well as decreased benefits in other areas. It is likely that such an "aggregate value" determination would become an actuarial calculation.

In negotiating benefits, the first step is to determine whether there would be a reduction in "aggregate benefit levels" under the city's proposal. If the change does not reduce the aggregate benefit level, then the city does not have any obligation under this law to seek the union's approval. A city making this determination must then look at the language of the collective bargaining agreement or determine where there is any binding practice setting the benefit levels at a particular amount. Without a contractual or existing practice limitations, the city has significant flexibility in changing the benefit levels.

Where the city has determined it wants to make a change that will reduce the aggregate benefit level, it is best to already have a provision in the collective bargaining agreement that permits the city to make such a change in "aggregate benefits levels."

RELEVANT LINKS:

Some cities have “me too” provisions in the collective bargaining agreement that permit the city to provide the same level of benefits as that provided to non-union employees. They can then argue that the union has given permission for the city to make the change.

Cities without a “me too” provision may want to seek to include one in order to have this flexibility. In the event that the union does not want to give up its authority in this process and allow a city to unilaterally increase the co-payments and deductibles of bargaining unit members, the city must take a different approach.

One recommended approach is for the city to provide the union with the information about the premiums differences resulting from a change in benefit levels. This information can be used as a starting point for discussion on how the city and employees can benefit from the lesser benefits by focusing on a reduced premium. This approach recognizes that the employer and employees who contribute toward the health insurance premium benefit from lower health insurance premiums.

In summary, the city may be limited in making any changes in benefit levels and/or contributions if they have a bargaining agreement in place. Under Minnesota law, the city cannot reduce the value of group insurance benefits for employees covered by a collective bargaining (union) agreement without the agreement of the union. This may mean, in some cases, the city cannot increase the co-payments of their health insurance plan or increase the deductible without the agreement of the union. Thus, cities with bargaining agreements would first need to negotiate any changes with the unions before adjusting benefit levels (especially if there is a change in the aggregate value of benefits) or having employees pay more for their coverage.

Additionally, there’s not much evidence (if any) showing the impact cost shifting has on changing people’s behavior or reducing spending growth. By shifting the cost from the employer or insurance company to the employee, a city is not addressing the reasons why costs are increasing to begin with—costs will remain the same (regardless of who pays for it) and employees’ behaviors aren’t likely to change under this type of approach.

b. Shopping the market

Shopping the market means essentially looking for the cheapest quote.

If a city chooses to receive bids on their insurance, a couple of cautions need to be addressed. A city should be wary of taking the lowest quote without first comparing the benefits being quoted to make sure you aren’t trading reduced benefits for lower premiums.

RELEVANT LINKS:

LMC website: [Federal Health Care Reform](#).

Some carriers may also “low ball” the quote to get a city’s business and then raise rates significantly the following year or two to recover their costs. If a city decides to go with the lowest quote, the city will want to enter into the arrangement with eyes open—the city may get a cost savings for the first year or two and then get hit with significant premium increases the following year.

c. Dropping coverage

Some cities have considered dropping their group health insurance plan altogether and offering employees extra salary so they can purchase an individual insurance plan on their own.

This approach needs to be taken with caution, especially in light of the Patient Protection and Affordable Care Act (also known as PPACA or health care reform).

If the city employs more than 50 full-time equivalent employees (requiring a calculation of hours counting both full-time and part-time hours), not offering health coverage to full-time employees (averaging more than 30 hours per week) could result in significant penalties to the city as well as having other consequences. Prior to 2014, it is important to realize some employees may not have been able to get insurance coverage on their own due to their health status, so a city could have ended up with a number of employees without any insurance at all, which is not good for employee morale or employee retention, as well as resulting in penalties if the city employs more than 50 full-time equivalent employees.

Also, this does not ultimately address the issue of the rising cost of health care or with employee absenteeism and productivity (both of which can be huge cost factors for cities). Finally, the approach of offering employees more salary instead of coverage can result in the city inadvertently offering a cafeteria/flexible benefit plan, which may lead to troubles with the IRS.

Since January 2014, all individuals are able to purchase coverage on state health care exchanges without evidence of insurability. This will lessen the impact of the problem of having a pre-existing health condition; however, the coverage may still be quite costly unless an employee is entitled to assistance from the government.

d. Health risk management wellness programs

City wellness programs have taken a variety of different forms and evolved over time.

RELEVANT LINKS:

Traditional wellness programs generally provide employees with a variety of wellness information and may include some employer-sponsored wellness activities, such as health fairs or a walking program.

Under traditional wellness programs, the employer essentially “sets the table” with the options available, leaving employees to pick and choose the information that is important to them. However, employer groups are beginning to take more of a proactive approach to wellness with the goal of changing lifestyle behaviors of employees resulting in a healthier, more productive population and lower health care costs.

Health risk management (HRM), also known as population health management, takes a more proactive approach at identifying the risk factors within the city’s population and then directing the appropriate information, tools, and activities to encourage people to change their lifestyle behaviors, lower their risk factors, and keep them from moving into an active disease state.

HRM focuses on controlling or limiting cost not only related to health care expenses, but also to workers’ compensation costs, employee absenteeism, and employee productivity—all of which can be huge cost factors for cities. Some components of health risk management may include the following:

- Information for high-risk or at-risk individuals. Depending on the risk factors identified for an individual, educational material may be provided explaining ways in which health risks might be lowered. For example, an employee at risk for diabetes may receive information about the benefits of exercise and good nutrition. They may also receive information on how to establish a fitness and/or healthy eating program.
- Telephonic counseling/coaching. Health counselors will contact an individual with certain risk factors to encourage lifestyle changes and help counsel and encourage individuals as they make these changes.
- Medical self-care guide. This guide provides a lot of information about general symptoms and at-home care for certain conditions. In addition, it provides guidance on when an individual should seek immediate medical care if they are experiencing certain symptoms.
- General health and wellness information. This can take the form of wellness brochures on a variety of topics most prevalent within the city’s employee population. Examples may include information on the importance of exercise, stress reduction, preventing colds/flu, etc.
- Health fairs. Health fairs can provide a variety of information and services depending on the unique needs of the city. Some cities offer health screenings, blood pressure checks, and massages, as well as general information on a wide range of topics.

RELEVANT LINKS:

- Health risk assessment (HRA). This is a questionnaire which asks employees a series of questions about their health status and lifestyle behaviors (e.g., do they exercise regularly, do they smoke and how often, do they drink and how much, etc.), as well as their willingness to change their lifestyle behaviors. If an employee completes an HRA, they generally receive a confidential assessment/analysis of their risk factors with details and action steps on how they are able to reduce their health risks. In addition to the confidential individual feedback and depending on the number of employees, the employer may also receive an aggregated data assessment report back showing the most prominent risk factors of its employee population. This information allows employers to more effectively target and direct wellness information to its employees.

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Your city may want to inquire with your health insurance carrier, as many of them have developed wellness and health risk management programs available to their clients. Many of these programs are already built into the city's premium costs, so cities are encouraged to contact their carrier to find out what wellness/health risk management programs are available.

Note there are certain limitations on incentives when wellness plans are based on health factors (i.e., tobacco use, maintaining a specific cholesterol range, etc.). A city will want to consult with its benefits advisor to ensure the city's wellness plan is in compliance when establishing incentives.

Many cities are simply trying to do the best they can to deal with the rising cost of health care. They may review their health plans and contribution structure to make sure they are being smart about the benefits they are offering to employees. The next step is to ensure the city's employees understand why health care costs are increasing. As the city evaluates new options, it may be important for employees to understand the relationship between cost and premiums, as well as some of the benefits of Health Risk Management. Also, the city should begin informing employees and unions (if a city has them) about options in the market, such as consumer-driven health plans.

This is important so when the city is ready to make a change, employees will be educated about the options, which may lead to greater buy-in at both the employee and union level.

RELEVANT LINKS:

IRS: [Rev. Proc. 2020-32](#).

Again, the city will need to review the hours worked by its employees to determine if they meet the full-time employee threshold of working an average of 30 or more hours. Under the Affordable Care Act, generally an employee is considered full-time if he or she is reasonably expected to work on average at least 30 hours per week, or 130 hours per month. Variable hour and seasonal employees may also be considered full-time under the ACA rules.

If the city is a large employer (has 50 or more full-time equivalent employees), it would be required to offer affordable coverage to the employee or be subject to a penalty so will need to review its benefits coverage and eligibility rules to assess any risk of penalty.

e. Consumer-driven health plans

A consumer-driven health plan (CDHP) is really an idea rather than a product and many available products apply this concept.

The idea behind consumer-driven health is to promote a more prudent use of health care services by giving employees more responsibility in how they spend the money available to them on health care services. CDHPs attempt to get consumers actively engaged and accountable for their health care decisions by showing them the true costs of care and giving them individual tools to reduce costs.

(1) Components of consumer driven health plans

(a) High deductible health plan

A health plan requiring a high deductible amount. For example, the IRS defines a high deductible health plan as any plan with a deductible of at least \$1,400 for an individual or \$2,800 for a family for 2020 and those amounts is the safety net that protects an employee from large or catastrophic claims—there is also a limit to the out-of-pocket expenses. The health plan typically provides 100 percent coverage for preventive care. Premiums for this type of plan are relatively low compared to other plans in the market. The city and/or the employee may contribute towards the premiums, but employers generally contribute some amount towards the premiums for single and family coverage.

Typically, high deductible health plans are offered with either a health reimbursement arrangement (HRA) or a health savings account (HSA).

These two options have important differences, and only the city can determine which is better for its particular employee group. One of the more important differences is that HRAs are strictly funded by employer dollars; individual employees cannot contribute to them.

RELEVANT LINKS:

HSAs have more restrictions about how the high deductible and other plan features are set up. Call the League for more detailed information about the differences between these two types of accounts.

(b) Personal care account

The personal care account can be either a health reimbursement arrangement (HRA) or a health savings account (HSA) which the employee can use to pay for medical expenses not covered by the high-deductible health plan.

The city may want to consider funding the personal care account at an amount below the deductible, so employees have some out-of-pocket costs, which is intended to provide them some incentive to think about how they are spending their health care dollars. Also, amounts remaining in the personal care account at the end of the year can roll over to the next year, so employees can build up their accounts year after year if they don't use all of those dollars.

(c) Health information

A critical component of a CDHP is health and wellness information. The goal is to educate employees about their health and how to improve it in a way that will reduce their health care costs. Some examples of wellness activities might include a wellness/health risk management program (including a health risk assessment employees complete to help identify if the employee has any risk factors that could be addressed by making certain lifestyle changes), information about doctors and provider networks, and online and phone-in resources (such as a nurse line or customer service center where employees can get information about medical conditions, providers, etc.).

(2) Considerations before implementing

There are a few issues to consider before implementing a consumer-driven health plan:

- Consumer-driven health plans (CDHPs) are now health benefit options available to employees in many large companies.
- Although most CDHPs were initially only offered to larger, self-insured plans, CDHP options are now more widely available to other employer groups.
- Are your employees ready for consumer-driven health? Do they want to be responsible for researching doctors and medical conditions to determine which providers and treatments will be the most beneficial and at the lowest cost?

RELEVANT LINKS:

[Minn. Stat. § 471.61.](#)

[Minn. Stat. ch. 62A.](#)

- Employers offering CDHPs are typically offering them as an additional plan option alongside existing plans. This may result in adverse selection where all the healthy employees enroll in the CDHP leaving the unhealthy employees to drive up costs in the city's other health plan options.
- Employee communication is key—before, during, and after the CDHP is implemented. Employees aren't likely to embrace a new plan option if they don't know anything about it or how to use it effectively. Communicating with employees (and the unions) is key to successfully offering a CDHP.

3. Group health plans

Minnesota law provides the appropriate authorization for cities to offer group health benefits to employees and to pay all or some of the premium for this coverage. There is no specific requirement relating to the number of plans cities must make available or the type of benefit plan and level of coverage (e.g. single, single plus one, family, etc.) offered.

However, cities should be aware of health care reform requirements that may dictate plan design options. Additionally, a collective bargaining agreement and/or personnel policy may dictate what the city offers to its employees.

If the city is going to offer group health benefits to its employees, a variety of state and federal laws and regulations govern these plans, including, but not limited to, state insurance laws and regulations for accident and health insurance, federal and state continuation requirements, Health Insurance Portability and Accountability Act, health care reform, etc. Other state and federal requirements for group health insurance are discussed throughout this chapter.

There are primarily four larger insurance carriers in Minnesota offering group health benefits to cities—Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica, and PreferredOne. Cities also have the option of obtaining their benefits through a number of purchasing groups established for public sector employers in Minnesota, such as the Public Employee Insurance Program (PEIP), LOGIS, or the Service Cooperatives, etc.).

The city may subject itself to additional liability if it assumes the premium payment for a plan it does not own. If the premium payment is late or never made on behalf of the individual and the coverage is terminated for nonpayment of premium, the employee may argue the city has liability for the medical costs incurred after the policy terminated.

RELEVANT LINKS:

[IRS Publication 502.](#)

HR Reference Manual,
[Chapter 1.](#)

a. Cash in lieu of insurance programs

It is no longer acceptable under the Affordable Care Act for cities to offer funding arrangements such as cash to reimburse the employee for the purchase of an individual health insurance policy. Therefore, the League generally recommends cities with employees covered under an individual policy should not provide cash in lieu of health care benefits and instead consider making changes to its employee compensation plan such as appropriately increasing salary which is taxed accordingly to ensure the city is still competitive with other employers. This appears to be the most conservative approach to avoid any tax issues and inadvertently subjecting the city to benefit regulations and IRS tax issues that it otherwise would not be subject to. Given the complexities of the ACA, please contact the League of Minnesota Cities and/or your city attorney for additional guidance.

Cities offering group health insurance to employees often will ask about offering cash payments to employee opting to waive the city's group health plan coverage. There are three primary issues a City will want to consider before implementing a cash in lieu program:

- Impact on enrollment. Offering cash in lieu likely will result in some additional employees waiving coverage. If a City has a large group insurance policy, a decline in enrollment could have an impact on underwriting and the premiums for the policy. Furthermore, the participation level in the plan can impact whether the current carrier offers to renew the policy from year to year (regardless of whether a City is in the small or large group market). Note, however, that due to guaranteed availability requirements, a City is guaranteed a right to purchase insurance coverage regardless of its participation level. If the current carrier refuses to renew the policy due to the participation level, that City would need to move to a different carrier.
- Constructive receipt. Offering employees a choice between medical plan coverage (a nontaxable benefit) and cash compensation causes employees who elect the medical plan coverage to constructively receive the cash compensation offered to them. To avoid that problem, the election between the cash in lieu and the medical plan coverage must be made under the City's Section 125 cafeteria plan. Accordingly, if a City decides to implement such a program it will need to amend its cafeteria plan.

RELEVANT LINKS:

[26 U.S.C. § 4980H.](#)

LMC website: [Federal Health Care Reform.](#)

[Treasury Notice 2011-28, Interim Guidance on Information Reporting to Employees on the Cost of their group Health Insurance. Fees on Health Insurance Policies and Self-Insured Plan for Patient-Centered Outcomes Research Trust Fund](#), Federal Register Dec. 6, 2012.

- **Employer mandate.** If a City is an applicable large employer for purposes of Section 4980H of the Internal Revenue Code (i.e., the ACA employer mandate), offering cash in lieu will adversely impact the affordability of the City's coverage unless the cash in lieu program is structured a certain way. Specifically, the cash in lieu will not have an impact on the affordability of a City's medical coverage so long as the cash in lieu is provided only to employees who attest that they and their "expected tax family" will have health coverage that qualifies as minimum essential coverage (other than individual market coverage) during period covered by the cash in lieu payments.

b. ERISA plans

The Employee Retirement Income Security Act (ERISA) governs many employer health and welfare plans and falls under the regulation of the U.S. Department of Labor.

However, governmental entities are specifically excluded from the requirements under ERISA, so cities do not need to comply with these regulations. Cities should review their plan documents carefully to be sure any ERISA language referenced in these documents is removed.

c. Traditional health care plans

These plans, also known as indemnity or fee-for-service health insurance, existed long before managed care plans were popular.

Traditional health plans work on a system of copays and deductibles, typically offering the most choice of doctors and hospitals, but that choice is often associated with higher co-payments compared to other types of plans.

4. Cafeteria/flexible benefit plans

Flexible benefit plans (also referred to as cafeteria plans) emerged in the 1980s. As cities struggled with significant rate increases to their health plans and sought innovative ways to attract and retain quality employees, flexible benefit plans became a popular way for cities to provide benefits and flexibility to their employees. Cafeteria plans provide a way for cities to offer a variety of benefit options employees can choose from based on individual or family needs.

RELEVANT LINKS:

[26 C.F.R. Part 1 \(summary\).](#)
[IRS: FAQs for Government Entities Regarding Cafeteria Plans.](#)

In addition, employees may be able to enroll in a flexible spending account where the employee is reimbursed for certain medical expenses or dependent childcare expenses.

Cafeteria plans allow employees the option to choose between taxable (such as cash) and nontaxable benefits (such as health, dental or vision benefits) and serve as a way for employees to finance their elections with pretax dollars, thereby reducing the employee's taxable income. This approach reduces the employee's taxable income by the amount contributed towards the flex plan. However, employees contributing pretax dollars towards a flexible spending account may lose that amount if they don't use it towards eligible expenses by the end of the year (use-it-or-lose-it rule). Once an election is made, it cannot be changed during the benefit year unless there is a qualifying event allowing for a change (e.g., marriage, birth or adoption of a child, divorce, spouses change in employment, etc.).

As a city begins to evaluate whether or not to implement a flexible benefit plan, the question will arise about what benefits might be offered within the plan. While each city's situation will vary, there are two perspectives that should be considered when deciding to implement a flexible benefit plan—the city and the employee.

A city might consider a flex plan for the following reasons:

- Help manage benefit costs. Flexible benefit plans allow cities to better control costs by defining the contribution level they will provide each year for employees to apply towards a flex plan. Since the employees generally choose their benefits under a flex plan, employees are more likely to accept changes or cost containment measures.
- Make employees more aware of the cost of medical care. Depending on how the city structures some of these benefits, they may also make employees more aware of the cost of health care and may make them more responsible for how they spend their dollars on medical services.
- Pay less in taxes. Generally, cities will save on Social Security, Medicare, and federal unemployment (FUTA) taxes.
- Offer employees new or expanded benefits. Flexible benefit plans allow cities to offer a variety of benefits while providing a tax advantage to employees at little or no cost to the city.
- Respond to needs of a diverse workforce. Flexible benefit plans allow employees to choose the benefits that best meet their own needs.
- Enhance the perception and awareness of benefits as an integral part of total compensation. With a flexible benefit plan, employees tend to view their benefits as another form of pay.

RELEVANT LINKS:

- Reduce inequities in compensation. There has been ongoing debate about city contributions towards single or family health insurance premiums. By having a flex plan in place where a city contributes a flat amount, it reduces the perception of inequities in compensation.

Employees benefit from a flex plan in the following ways:

- Choice. Employees can choose the benefits that best meet their individual or family needs.
- Flexibility. Employees can adjust their choices annually to accommodate their changing needs.
- Tax Savings. Employees do receive a tax break on income and Social Security tax for certain qualified expenses, because they are reducing their taxable income by the amount, they contribute towards the flex plan.
- Increased awareness of benefits. Since employees are electing their benefits based on their individual or family needs, they are more likely to have a greater appreciation of the value of their benefits.
- Employees may become more aware of the cost of medical care. Depending on how the city structures some of these benefits, employees may also become more aware of the cost of health care, which may make them more responsible for how they spend their dollars on medical services.
- Wider variety of benefits. Flex plans provide employees with additional benefits that can be financed with pretax dollars.

Cities wanting to provide employees with the tax benefits of such a plan must do so within the scope of IRS regulations; Section 125 of the IRS tax code describes the requirements for implementing a cafeteria plan.

If a city is going to offer its employees a flexible benefit plan, the city must comply with the IRS regulations in order for the city and its employees to receive any tax-free benefits. A flexible benefit plan must not discriminate in favor of highly compensated individuals or key employees in terms of eligibility, contribution, and benefits.

In addition, Health FSAs may not discriminate based on the health condition of the employee.

The definition of a highly compensated individual in a flexible benefit plan is NOT the same as the definition used for retirement plan purposes. Under a flexible benefit plan, a person considered highly compensated varies depending on the individual circumstances of each city. Generally, a flexible benefit plan will be considered nondiscriminatory if it meets the following criteria:

RELEVANT LINKS:

U.S. Dep't of Labor:
[Employee Retirement
Income Security Act
\(ERISA\)](#).

U.S. Dep't of Labor:
[Employee Retirement
Income Security Act
\(ERISA\)](#).

IRS: [FAQ's for Government
Entities regarding Cafeteria
Plans](#).
IRS: [Definition of
governmental plan](#).

[29 U.S.C. § 125](#).

- Must have a fair cross-section of employees (for example, not just management or supervisors are eligible to participate).
- A participation requirement of no more than three years of employment in order to participate (with no break in service).
- Once the service requirements are satisfied, employees are allowed to participate no later than the first day of the plan year.

Cities must have a plan document in place prior to the beginning of the plan year. The plan document must include all eligibility requirements, define the plan year, indicate what qualified benefits may be elected, note how the plan is funded, set maximum amounts for employer and employee contributions, and list rules relating to the method, timing, and irrevocability of elections. In addition, a Summary Plan Document must be provided to each plan participant.

If the city does not comply with the various IRS regulations (for example, having a separate plan document for the cafeteria plan and/or not filing any required tax forms each year), then the tax benefit of all participants may be jeopardized, and the city could be subject to additional fines or penalties.

Many employee benefit plans are subject to the Employee Retirement Income Security Act of 1974 (ERISA) and are required to file Form 5500 (a form used for required annual reporting for certain pension and welfare benefit plans) to meet ERISA reporting guidelines. In general, ERISA does not cover group health plans established or maintained by governmental entities. City cafeteria plans are not required to file IRS Form 5500.

While these are the basic requirements, cities can make adjustments within those guidelines. For example, a city may set a policy an employee can participate in the flexible benefit plan immediately upon becoming employed by the city. Regardless of the policy established by the city, it must meet the minimum requirements for nondiscrimination listed above and be clearly outlined in the flexible benefit plan document.

With each requirement listed above, there are additional regulations and guidelines established by the IRS. For instance, the IRS provides additional guidelines for eligibility requirements (who can and cannot participate); qualified benefits (what benefits may and may not be included); and the method, timing, and irrevocability of elections (how and when a participant can make changes to his or her election).

RELEVANT LINKS:

MN Contact: (320) 351-7658

The IRS has reported increased activity in auditing employers for violations of cafeteria requirements. Many IRS agents have undergone training in auditing cafeteria plans, so there is clearly an effort underway to increase audit activity of cafeteria plans.

The IRS has established maximum penalties for a variety of violations that would likely impact both a city and its employees.

The Federal, State, and Local Government Division (FSLG) of the IRS is responsible for ensuring federal tax compliance by governmental entities and providing individualized assistance on a voluntary basis. The FLSG has a Minnesota office in Bloomington (contact number is provided to the left).

If you have further questions about flexible benefit plans and the various requirements under the IRS tax code, you may contact their office. By attempting to resolve the problem early, you may significantly reduce any potential fines that the city and employees may experience as a result of the city not complying with the IRS tax code.

There are a variety of cafeteria plan options the city may offer to employees. The information below briefly describes the types of plans that can be offered under a cafeteria plan.

a. Premium conversion

Premium conversion plans (also known as premium only plans or POPs) are the simplest form of a flex plan and allow employees to pay his or her portion of the qualified group insurance premiums on a pretax basis. Qualified group insurance benefits may include medical, dental, vision, disability, AD&D, and/or group term life insurance benefits. The contribution towards qualified group insurance benefits is taken out of the employee's salary before any federal or state taxes, therefore, providing a tax savings to the employee and the employer.

The city can easily administer a POP itself by deducting (on a pretax basis) the appropriate premium amount(s) each pay period from the employee's paycheck.

However, the city must develop a plan document and authorization form allowing the city to deduct these amounts pretax in order to receive the tax benefits of offering such a plan. The city must also ensure the appropriate salary is represented on the employee's W-2 forms and all necessary forms are filed with the IRS each year.

It is important to note that contributions for a spouse's group plan cannot be paid on a pretax basis.

RELEVANT LINKS:

If the city provides a contribution to help pay or offset the cost for the employee's health coverage outside of what is provided by the city, then the amount of that contribution must be considered part of the employee's wages and taxed accordingly.

One of the most common questions asked by cities is whether individual health insurance policies can be provided on a tax-free basis. While it is possible, this practice is problematic in a number of different ways:

- The city may inadvertently create an employer-sponsored health program that might then subject the city to additional federal benefit regulations that it otherwise would not be subject to (e.g., HIPAA, FMLA, ADEA, possible FLSA impacts, IRS tax code, etc.). The city will in turn have great difficulty in getting the insurance company to help them meet these additional requirements, because they consider the individual plans to be exempt from group health plan requirements.
- The city may be creating an additional liability if it assumes responsibility for paying the premiums on a plan that is not "owned" by the city. If the premium payment is not made on time and coverage is terminated, the employee could argue the city is responsible for the medical costs incurred after the plan terminated.

As mentioned previously, because it is no longer acceptable under the Affordable Care Act for cities to offer funding arrangements such as cash to reimburse the employee for the purchase of an individual health insurance policy, the League generally recommends cities no longer serve as the conduit for handling payments for individual health policies and instead consider making changes to their employee compensation plan such as appropriately increasing salary which is taxed accordingly to ensure the city is still competitive with other employers. Again, this appears to be the most conservative approach to avoid any tax issues and inadvertently subjecting the city to benefit regulations and IRS tax issues that it otherwise would not be subject to. Please contact the League of Minnesota Cities and/or your city attorney for additional guidance.

b. Flexible spending accounts

Flexible spending accounts (FSAs) allow employees to set aside money on a pretax basis to pay for certain eligible expenses, such as certain medical expenses under a health flexible spending account (Health FSA) or childcare services under a Dependent Care Flexible Spending Account (DCFSA). Again, the contribution towards these accounts is taken out of the employee's paycheck before any other taxes.

RELEVANT LINKS:

[IRS Publication 502.](#)

[26 C.F.R. § 601.602](#) see page 17.
[IRS: Rev. Proc. 19-44.](#)

[Guidance on FSA Grace Period and HSA Eligibility,](#)
U.S. Treasury Press Release,
Nov. 22, 2005.

Health FSAs and DCAPs fall under different sections of the IRS tax code (Sections 105 and 123 for Health FSAs and Sections 129 and 21 for DCFSAs) and have separate requirements. The IRS defines what expenses are reimbursable under a health FSA and a DCFSA and how those expenses must be reimbursed to an employee participating in the plans.

If a city is going to include a health FSA or DCFSA in their flexible benefit plan, then each of these requirements will need to be outlined in the plan document and administered accordingly.

(1) Health flexible spending account

Health flexible spending accounts allow employees to set aside pretax dollars to pay for certain eligible medical expenses. Under a health FSA, an employee may elect at the beginning of the plan year how much he/she wishes to have withheld on a pretax basis each pay period. The city's plan administrator places the employee's contribution in an account the employee draws upon during the year for reimbursement of qualified medical expenses. The medical expenses eligible for reimbursement are those under Section 213(d) of the IRS tax code and include such things as deductibles and copays under the health plan, eyeglasses, contact lenses, and over-the-counter medications with a doctor's prescription. It is important to realize individual health insurance premiums or premiums for a spouse's group plan cannot be reimbursed under a health FSA.

Beginning with plan years starting on or after Jan. 1, 2020, a health FSA must limit employee contributions to an annual maximum of \$2,750 (or any lower amount set by the plan). This amount is indexed for inflation and may change from year to year. The full amount of the employee's election must be available to the employee on the first day of the plan year. If the employee requests reimbursement for an eligible medical expense and then subsequently leaves employment, the city is not able to recoup the additional contributions that the former employee would have made had they remained active at work. By attempting to recover these contributions from the employee, the tax benefit of the plan may be jeopardized for all employees.

Flexible spending accounts are generally "use-it-or-lose-it" plans. This means that amounts in the account at the end of the plan year generally cannot be carried over to the next year. However, the plan can provide for either a grace period of up to 2½ months after the end of the plan year or a carryover. If there is a grace period, any qualified medical expenses incurred in that period can be paid from any amounts left in the account at the end of the previous year. Cities are not permitted to refund any part of the balance to employees.

RELEVANT LINKS:

See Section VIII-A, *Federal COBRA*.

[IRS Publication 503.](#)

[26 U.S.C. § 129.](#)

[IRS: FAQs for Government Entities Regarding Cafeteria Plans.](#)

Plans may allow a carryover of up to \$500 of unused amounts remaining at the end of the plan year to be paid or reimbursed for qualified medical expenses incurred in the following plan year. The plan may specify a lower dollar amount as the maximum carryover amount.

If the plan permits a carryover, any unused amounts in excess of the carryover amount are forfeited. The carryover does not affect the maximum amount of salary reduction contributions that employees are permitted to make.

Cities may allow either the grace period or a carryover, but it cannot allow both and are not required to allow either. Especially if the grace period or carryover option is not allowed, employees should carefully consider how much they are going to set aside into their health FSA each year, since the employee may lose any amount remaining in the account at the end of the year (use-it-or-lose-it rule). Cities may use any amounts remaining at the end of the year to offset their risk and any administrative costs associated with offering the plan. It is advisable that the plan document outline how the city will use any FSA monies left at the end of the plan year and, if applicable, amended to allow for either the grace period or carryover.

Health FSAs in some cases may be subject to federal COBRA continuation requirements—usually if the employee has underspent his/her accounts.

(2) Dependent care assistant program (DCAP)

Employees are able to set aside money on a pretax basis to be reimbursed for certain qualified dependent care expenses, such as the cost of childcare services. The maximum amount that can be contributed to a dependent care account is \$5,000 per year per household. Employees cannot be reimbursed through a flex plan and then claim the childcare credit on their tax return. Each individual employee will need to consider their filing status (married or single) and the number of qualified dependents in order to determine which option will provide a better tax savings to the employee.

Cities offering dependent care accounts must comply with Section 129 of the IRS tax code.

c. Full flex

Under a full flex plan, employees can choose from a variety of taxable and nontaxable benefits. Benefits may include health, dental, group life, medical and/or dependent care reimbursement accounts, vacation buy and sell, cash out options, long-term disability, short-term disability, etc.

RELEVANT LINKS:

[26 U.S.C. § 132\(f\).](#)

[IRS: Administrative, Procedural, and Miscellaneous; Tax forms and instructions.](#)

Both the employer and the employee may contribute towards the benefits offered under a full flex plan. Cities may require employees participating in the full flex plan to choose from a core set of benefits (e.g., health, dental, and life insurance) before selecting other benefits offered under the full flex plan.

Cities with flex credits-based full flex Section 125 cafeteria plans need to reevaluate their affordability determination in consideration of the ACA Employer Mandate.

Cities should not assume the entire flex credit amount could be counted as an employer contribution for affordability purposes. Cities may need to designate a portion of the total flex credit amount that may only be spent on benefits providing medical care (such as medical, dental, vision and health FSA) in order to be able to count the flex credit in the affordability calculation. Due to the complexities of Health Care Reform, the League recommends you consult with your city attorney or benefits consultant for updates on this issue.

The following benefit options cannot be offered under a city's cafeteria plan:

- Term life insurance over \$50,000
- Dependent group term life
- Educational assistance program
- Any benefit that defers compensation

d. Qualified transportation fringe benefits

Cities may offer two types of qualified transportation benefits, which provide employees with a nontaxable fringe benefit: transportation expense conversion plan or transportation expense reimbursement account.

Under a transportation expense conversion plan, cities may permit employees to convert their mass transit or company-paid parking from an after-tax contribution to a pretax contribution.

Cities may also allow employees to set aside pretax contributions into a transportation expense reimbursement account (similar to a Health FSA) whereby the employee is reimbursed for parking or other valid transportation expenses, such as transit passes or vanpooling arrangements. The amount reimbursed cannot exceed the amount set aside in the account.

Beginning in 2016, the monthly maximum tax exclusion for transit or parking benefits is \$255, subject to an annual inflation adjustment.

RELEVANT LINKS:

LMC website: [Federal Health Care Reform](#).

LMC website: [Federal Health Care Reform](#).

5. Health care reform

Health care reform is an extremely extensive law with many mandates and employer responsibilities. The following section will briefly describe important health care reform provisions each city should be aware of when offering health benefits.

a. Grandfathered and non-grandfathered plans

Grandfathered plans are those plans that as of March 23, 2010, have not made significant plan changes which would require them to lose their grandfathered status. As long as a plan remains grandfathered, it will not be required to make some of the required changes to the plan pursuant to health care reform. Once a plan loses its grandfathered status, it will be required to make specific changes to the plan, including coverage for preventive services with no cost-sharing, coverage for all eligible dependent children to age 26 regardless of whether they are eligible for other coverage, and new claims and appeals rules.

A plan can lose its grandfathered status if any of the following six plan design changes are made:

- Elimination of all or substantially all benefits for a particular medical condition.
- Any increase in the employee's coinsurance percentage.
- A deductible or out-of-pocket maximum increase that exceeds the medical inflation percentage rate plus 15 percent.
- A copayment increase that exceeds the medical inflation percentage rate plus 15 percent (or, if greater, \$5 plus medical inflation).
- A decrease in the employer contribution towards the cost of coverage by more than 5 percent.
- Imposition of annual limits on the dollar value of all benefits below specified amounts.

b. W-2 reporting

Cities with 50 or more full-time equivalent employees are subject to the ACA employer responsibility provisions and required to report the aggregate cost of the employer sponsored health coverage on the employee's W-2.

The amount to be reported on the W-2 is not included in the employee's gross income. Cities with fewer than 50 full-time equivalent employees are exempt from the ACA employer shared responsibility provisions and therefore from the employer reporting requirements.

RELEVANT LINKS:

IRS: [Patient-Centered Outcomes Research Trust Fund Fee: Questions and Answers](#).

c. Medical loss ratio/rebate

Health care reform requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR).

It also requires them to issue rebates to enrollees if this percentage does not meet minimum standards.

MLR requires insurance companies to spend at least 80 percent or 85 percent of premium dollars on medical care, with the review provisions imposing tighter limits on health insurance rate increases. If they fail to meet these standards, the insurance companies will be required to provide a rebate to their customers.

If the city receives a rebate, there are specific guidelines on how it can spend the money. Nonfederal governmental plans must use the amount of the rebate that is proportionate to the total amount of the premium paid by all participants under the policy to:

- Reduce subscribers' portion of the annual premium for the subsequent policy year for all subscribers covered under any group health policy offered by the plan;
- Reduce subscribers' portion of the annual premium for the subsequent policy year for only those subscribers covered by the group health policy on which the rebate was based; or to
- Provide a cash refund only to subscribers that were covered by the group health policy on which the rebate is based.

d. Comparative clinical effectiveness research fee or Patient-Centered Outcomes Research Institute Fees (PCORI fees)

PPACA established the Patient-Centered Outcomes Research Institute.

Funded by the Patient-Centered Outcomes Research Trust Fund, the institute will assist patients, clinicians, purchasers, and policymakers in making informed health decisions through the dissemination of comparative clinical effectiveness research findings.

The trust fund will be funded in part by fees paid by health insurers and plan sponsors. The fee is imposed for each plan year ending on or after October 1, 2012, and before October 1, 2029.

For plan years ending in 2015 the fee is \$2.17 multiplied by the average number of lives covered under the plan for the plan year.

RELEVANT LINKS:

[IRS Form 720](#), (April 2020).

[IRS: Patient-Centered Outcomes Research Institute Fee.](#)

[IRS: Patient-Centered Outcomes Research Institute Fee \(IRC 4375, 4376, 4377\): Questions and Answers.](#)

For insured plans, the insurer will be responsible for all the Clinical Effectiveness Research fee requirements including reporting on and paying the fee.

For self-funded plans, the plan must pay and report the fee on IRS Form 720, Quarterly Federal Excise Tax Return. The Form 720 can be filed and paid electronically or submitted online using an approved transmitter software. The fee is due once a year (not quarterly), which will be due by July 31 of each year. The payment and return will cover the plan year that ended during the preceding calendar year. For example, for applicable plan years that end in 2019, the first due date for filing Form 720 is July 31, 2020.

C. Dental insurance benefits

Cities are not required to offer dental benefits unless provided for in a collective bargaining agreement or personnel policy. However, as with health insurance benefits, many cities consider dental benefits to be part of the overall compensation package offered to employees.

Many cities view dental benefits to be important in helping to attract and retain good employees.

The benefits offered under a dental plan are typically designed to help pay for dental costs associated with more expensive procedures and to encourage people to receive regular dental care, which can help prevent other serious health problems.

The benefits provided under a dental plan are generally grouped into four different categories of benefits:

- Diagnostic and preventive services (e.g., oral exams, x-rays, fluoride treatment for children, sealants, etc.).
- Basic or minor restorative services (e.g., fillings, crowns, oral surgery, etc.).
- Complex or major restorative services (e.g., bridges, dentures, etc.).
- Orthodontics.
- The least expensive procedures (examinations, x-rays, etc.) are more likely to be covered at a higher level than the more expensive procedures (e.g., fillings, endodontics, periodontics, oral surgery, etc.).

The least expensive procedures (examinations, x-rays, etc.) are more likely to be covered at a higher level than the more expensive procedures (e.g., fillings, endodontics, periodontics, oral surgery, etc.).

RELEVANT LINKS:

However, benefits can vary widely from one dental plan to another with cities electing to offer plans with different coinsurance levels (e.g., 100 percent, 80 percent, or 50 percent).

Most dental plans include an annual benefit maximum (i.e., the maximum amount that the plan will pay for any services incurred during the plan year).

Orthodontic treatment is offered as an option for some employer groups and is subject to a separate lifetime benefit maximum—the most common being a lifetime benefit maximum of \$1,000 or \$1,500 (i.e., the dental plan will pay no more than \$1,500 for orthodontia coverage).

Depending on how the plan is set up, a network may or may not be included. Higher levels of benefits are generally offered for services received from an in-network provider than those received from an out-of-network provider.

Cities are not required to contribute towards dental benefits unless provided for in a collective bargaining agreement or personnel policy. The city may elect to contribute towards some or all of the premium amounts or offer dental benefits strictly on a voluntary basis to employees. Eligibility and participation requirements may vary depending on whether the plan is offered on a voluntary basis or if the city contributes towards the cost of the plan.

D. Life insurance

Many cities provide some basic life insurance benefits to their employees. In some cases, the city may contribute towards a certain amount of life insurance coverage and then offer additional or supplemental life the employee may purchase for themselves and/or for their dependents. However, state statute limits the ability of the city to require an employee to participate in a life insurance plan as a condition of employment unless the city pays for the coverage.

1. Group term life insurance

Many cities offer some type of group term life insurance coverage to their employees, employees' spouses, and dependent children.

Term life insurance coverage is bought for a specific time-period (usually one year), is renewable each year, and remains in effect only as long as the premiums are paid. There is no savings feature or ability to build up the cash value under a term life policy. It is strictly insurance protection, paying benefits only at the time of death.

[Minn. Stat. § 61A.091.](#)

[Minn. Stat. ch. 61A.](#)

RELEVANT LINKS:

[Minn. Stat. § 61A.091.](#)
[IRS Publication 15-B,](#)
Employer's Tax Guide to
Fringe Benefits.

The following life insurance benefits are typically offered under a group plan:

a. Basic

Many cities typically provide some basic life insurance coverage to benefit-eligible employees.

The benefit amount offered to an employee varies from city to city. Some cities determine the basic life insurance amount they provide on a percent-of-salary basis (e.g., the employer will provide basic life insurance in the amount equal to 125 percent of the employee's salary to a maximum of \$50,000) or a flat dollar benefit amount available to eligible employees regardless of salary.

Most cities offer basic life insurance in a flat dollar amount typically something less than \$50,000 (this is the amount at which the benefit is not taxable to the city or to the employee—the premium amount for any benefit above \$50,000 must be taxed accordingly regardless of whether the coverage is provided by the city or paid for by the employee).

b. Supplemental

Employees may be given the option of purchasing additional life insurance on themselves and/or a spouse. Employees generally pay the entire cost of additional life insurance benefits.

Supplemental life insurance amounts may be available in \$5,000 or \$10,000 increments (depending on plan design) with a maximum benefit amount available to the employee or spouse. Individuals may be subject to underwriting before benefits are effective.

c. Dependent child

Employees may also have the option of purchasing life insurance coverage for their children. Benefits are generally offered as a flat dollar amount (e.g., \$1,000, \$5,000, or \$10,000). Coverage is generally extended available to children from six months to 19 years (possibly longer for non-married children that are full-time students).

d. Accidental death and dismemberment

Most life insurance plans include accidental death and dismemberment (A D & D) coverage, which provides additional benefits that pays for a covered accident resulting in a loss of life, speech, hearing or sight, paralysis and other losses.

RELEVANT LINKS:

Gallagher Byerly Inc. -
NCPERS - Minnesota.
National Conference on
Public Employee Retirement
System.

LMC website: [Disability Insurance](#).

Premium amounts for basic life insurance are generally provided in flat dollar amounts based on the amount of life insurance for each employee.

Premium amounts for supplemental life insurance are typically provided in five-year age bands. Dependent child life usually is offered at a flat premium rate.

2. Group decreasing term life insurance

Group decreasing term life insurance is intended to pay a covered individual's beneficiary a higher benefit amount in their younger years and a gradually decreasing benefit amount as the covered individual ages

The rates for this coverage tend to be set at a flat dollar amount regardless of age and typically will cover the employee, the spouse, and dependent children. In addition, the plan may be guaranteed issue (i.e., no health questionnaire is required before coverage is extended).

Through the National Conference on Public Employee Retirement Systems (NCPERS), cities may offer this type of plan option to employees. All active members of PERA who are actively at work are eligible to participate. Employee contributions are handled through payroll deduction. For more information about the coverage available.

E. Disability insurance

An unexpected illness or injury can result in a person's inability to work, causing financial problems for the individual and his or her family.

Disability insurance protects an employee's income when he or she is not able to work due to an illness or injury that is not work-related—work-related disabilities fall under workers' compensation benefits and are excluded under short-term and long-term disability plans.

1. Short-term disability

Short-term disability (STD) protects employees' income during a temporary absence from work due to an illness or injury. STD plans typically define short-term disability as an employee's inability to perform the duties of his or her own occupation.

The amount of time benefits is paid to an employee can vary from plan to plan; although benefits typically range from 13 weeks to 52 weeks (plans with a 13-week or 26-week benefit seem to be the most common options offered by cities). STD plans may be purchased through a private insurance company or the city may choose to self-fund these benefits.

RELEVANT LINKS:

PERA Employer Manual [5-Eligible Earnings](#) see page 11.

LMC website: [Disability Insurance](#).

Generally, STD plans usually provide an average benefit of 40 - 60 percent of the employee's weekly gross income up to a set maximum amount and for a certain benefit period. The STD plan may also have a waiting period before benefits will be payable.

Again, this can vary from plan to plan, but the most common waiting periods seem to be one or two weeks. Cities may want to consider establishing a longer waiting period in order to better control costs under the plan.

Some cities may choose to offer a STD plan as a voluntary option where each employee decides whether or not to participate in the plan.

Those employees enrolling in the voluntary STD plan pay the premiums through payroll deductions. Other cities may provide the short-term disability benefit to employees at the city's cost and/or integrate the short-term disability plan with the city's paid time off policy.

One of the issues to consider in offering a plan where the employee pays for the cost of coverage is whether the employee's contribution towards the premium will be made on an after-tax basis or a pretax basis.

This distinction can be important from the employee's perspective because if premiums are made on a pretax basis, then the employee is taxed on the benefit they receive if they become disabled.

If premiums are paid on an after-tax basis, then the employee is only taxed on the value of the premium amount and not on the benefit itself.

When processing STD employee benefits, it is important to be mindful PERA generally does not consider disability insurance payments as PERA-eligible salary. This includes short term disability payments from self-insured employers unless PERA determines that the payments are more like an extension of a current or previous sick leave program, rather than a disability insurance benefit. Self-insured employers that are not sure if payments to their employees under a short-term disability program are salary for PERA purposes should request a review by PERA staff of the program's provisions.

2. Long-term disability

Long-term disability (LTD) plans also help protect an employee's income when they are unable to work for an extended period of time due to an illness or injury.

Disability under most LTD plans is defined the same way as short-term disability plans for the first two years of disability—the inability to perform the duties of his or her own occupation.

RELEVANT LINKS:

LMC information document:
[Comparing long-term disability quotes.](#)

LMC website: [Disability Insurance.](#)

After two years, disability is typically defined as the inability to perform any occupation that the person is reasonably suited to do by training, education, and experience.

Long-term disability plans generally pay benefits based on a percent of the employee's monthly income—a 60 percent benefit is common but could be higher. Long term disability usually kicks in after a short-term disability policy has run out (if STD is provided).

In addition, most plans will have a provision that the disability benefit plus other sources of income, such as Social Security and PERA, cannot exceed a certain amount (75 percent is common for most city LTD plans). Most LTD plans also provide a minimum and maximum benefit amount that the employee may elect (e.g., minimum of \$500 benefit to a maximum of \$5,000 but not to exceed 60 percent of the employee's monthly income).

Long-term disability benefits may be paid for entirely by the employee, the city, or a combination of employee/city contributions. As with short-term disability, the issue of whether employee premium amounts are paid on a pretax or after-tax basis should be taken into consideration. This distinction can be important from the employee's perspective because if premiums are made on a pretax basis, then the employee is taxed on the benefit they receive if they become disabled.

If employees pay the premiums for LTD coverage on an after-tax basis, then the employee is not taxed on the benefit that is paid out if there is a claim.

F. Long-term care insurance

Long-term care (LTC) insurance provides benefits to help pay for care costs when an individual is no longer able to care for him/herself. If an individual suffers from an illness, injury, or old age, they may become unable to perform day-to-day activities such as getting out of bed, dressing, eating, etc.

Unlike other benefits, including Medicare, long-term care insurance pays for more than just nursing homes. LTC coverage may provide benefits for in-home care, home and hygiene services, cooking and cleaning benefits, and more.

Long-term care insurance can help protect employees' retirement assets by the following:

- Helping keep employees at work when a spouse or parent has a long-term illness.

RELEVANT LINKS:

The Office of MN Attorney
General: [Long-Term Care Insurance](#).

Minnesota Department of
Revenue, [Long-term Care Insurance Credit](#).

The Office of MN Attorney
General: [Long-Term Care Insurance](#).

- Helping pay for care costs when an individual is no longer able to care for him/herself.
- Paying for services that might otherwise drain employees' savings and retirement funds.

Many cities offer long-term care coverage to their employees as a voluntary benefit option and will handle premium payments for employees through payroll deductions. Depending on the plan offered, coverage may be available not only to employees, but also to an employee's spouse, parents, parents-in-law, grandparents, and grandparents-in-law.

The State of Minnesota also provides a tax credit of 25 percent of premiums paid towards long-term care insurance for the employee and spouse (if applicable) to a maximum of \$100 (\$200 if filing jointly). In order to be eligible for this credit, the LTC policy must have a lifetime benefit of \$100,000 or more. The appropriate forms can be found at the Department of Revenue's website.

General information about long-term care insurance can be found by going to the state's website.

G. Employee assistance programs

Employee Assistance Programs (EAP) offer access to professional counselors who provide confidential assessment and short-term counseling to employees and their families in order to assist in dealing with a variety of issues.

Over the years, EAPs have expanded the range of services they offer to go beyond just counseling on mental health issues, including marriage and family issues, stress-related problems, financial and legal difficulties, and psychological and workplace conflict. Some examples of services frequently offered by an EAP include:

- Substance abuse.
- Grief and loss.
- Consumer credit counseling.
- Childcare arrangements.
- Eldercare/aging issues.
- Wellness issues (e.g., smoking cessation).
- Retirement and/or college planning.
- Legal issues (e.g., adoptions, wills, consumer laws, bankruptcy, etc.).
- Marital problems.
- Issues involving blended families.

RELEVANT LINKS:

For more information see Section V-H-1, *Health Insurance Portability and Accountability Act*, and Section VIII, *Continuation of Benefits*.

U.S. Dep't of Labor: [Health Information Privacy](#).

U.S. Dep't of Health: [HIPAA administrative simplification statute and rules](#). U.S. GPO: [Public Law 104 - 191 - Health Insurance Portability and Accountability Act of 1996](#).

LMC website: [HIPAA](#).

Individuals utilizing the EAP typically do not have to pay for services. The EAP may be offered through the city's health insurance carrier or some cities may contract with an EAP vendor to offer the program on a stand-alone basis. It is important to realize if the city offers the EAP on a stand-alone basis or if the EAP offers medical services such as counseling sessions (rather than just referral), the EAP may be considered a health plan for purposes of HIPAA's privacy standards and COBRA continuation requirements.

Cities wishing to offer an EAP on a stand-alone basis may want to consider issuing a request for proposal (RFP) for these services.

H. Insurance administrative requirements

1. Health Insurance Portability and Accountability Act

a. Administrative requirements

Congress passed the Health Insurance Portability and Accountability Act (HIPAA) in 1996 to reform health care.

HIPAA has several major administrative requirements for private and government-sponsored health plans.

The League has helpful information about complying with the privacy and security standards and/or to determine if the city is a covered entity under HIPAA.

(1) Portability

HIPAA initially placed limitations on a group health plan's ability to impose pre-existing condition exclusions and provides for special enrollment rights for certain individuals.

Under the Affordable Care Act (ACA), new protections prohibit group health plans from imposing any preexisting condition exclusion. Under this protection, a plan generally cannot limit or deny benefits relating to a health condition that was present before the employee's enrollment date in the city's plan.

Group health plans are required to issue certificates of creditable coverage that help individuals transfer to a new health plan without pre-existing condition exclusions and limitations.

RELEVANT LINKS:

29 C.F.R. 2590.702.
U.S. Dep't of Labor: [Self-Compliance Tool for Part 7 of ERISA: Health Care-Related Provisions.](#)

U.S. Dep't of Labor: [Health Information Privacy.](#)

U.S. Dep't of Labor,
[Summary of the HIPAA Privacy Rule.](#)

45 C.F.R. §§ 160, 162, 164.
U.S. Dep't of Health and Human Services: [HIPAA Administrative Simplification Statute and Rules.](#) Centers for Medicare and Medicaid Services: [Transaction and Code Sets Standards.](#)

Centers for Medicare and Medicaid Services: [Transaction and Code Sets Standards.](#)

Dep't of Health and Human Services: [HIPAA Security Standards: Technical Safeguards.](#)

Most insurance carriers will issue the certificates of prior creditable coverage for their clients, but the city will want to ensure this is part of the services provided.

If the city's insurance carrier does not issue the certificates on behalf of the city, then the city will need to do so on its own.

(2) Non-discrimination

Prohibits discrimination in benefits eligibility and premiums based on health-related factors.

(3) Fraud and abuse

The law creates a national data bank for fraud and abuse information and strengthens the ability of Medicare and Medicaid programs to fight health care fraud. New civil and criminal penalties for fraud and abuse were established under HIPAA for both public and private sectors.

(4) Administrative simplification

It adopts standards for financial and administrative transactions and data elements exchanged electronically.

These standards are intended to improve the operation of the health care system and to reduce administrative cost.

The Administrative Simplification Standards are the most far-reaching of HIPAA's requirements for cities and potentially the costliest. Cities may be subject to the Administrative Simplification Standards because they sponsor group health insurance plans (e.g., major medical, dental, HRAs, EAP, etc.) or because they are considered a health care provider (e.g., city-owned hospitals, clinics, and ambulance services). There are three sets of standards that may come into play for a city:

(5) National standards for transmitting electronic health information

Eight different transactions fall under these standards including health claims, health care payment, coordination of benefits, health claim status, enrollment and disenrollment, eligibility, health plan premium payments, and referral certification and authorization. Health plans and health care providers must transmit and/or receive health information according to the standards or have a health care clearinghouse process the information for them.

RELEVANT LINKS:

U.S. Dep't of Health and Human Services: [The Privacy Rule](#).

LMC website: [HIPAA](#).

LMC website: [HIPAA](#).

(6) Privacy standards

Intends to protect individual's health information from improper use and disclosure; provides individuals with more control over how and when their health information is used and disclosed. Protected health information (PHI) may only be used in limited cases without individual authorization. If information is disclosed, it is limited to the minimum necessary to accomplish the intended purpose. The privacy standards apply to PHI that is paper-based, oral or in electronic form, and require that a covered entity implement policies and procedures for the use and disclosure of PHI.

Cities with fully insured plans are probably subject to HIPAA privacy regulations. However, if the city takes a hands-off approach to plan administration (i.e., the city basically only conducts billing and enrollment functions), then the city can take advantage of the shortened rules under privacy. But note there are no shortened rules for security if you have protected health information in electronic form.

(7) Security standards

Applies to all protected health information that is transmitted or stored in electronic form.

The security standards require that a covered entity conduct an assessment to determine if e-PHI exists, implement reasonable and prudent protections, implement policies and procedures, and then document the compliance activities.

b. Technology initiatives

The passage of the American Recovery and Reinvestment Act (ARRA) of 2009 included expansive technology initiatives to encourage the use of electronic technologies in health care.

In addition, ARRA expanded several of the existing rules and extended the reach of the HIPAA privacy and security provisions to business associates. Some of the major changes include the following.

(1) New disclosure rules

Creates specific disclosure requirements when PHI is "breached." How a breach is defined and under what circumstances disclosure is required is addressed. Rules outline a risk analysis requirement and notice procedures if unsecured PHI is breached.

RELEVANT LINKS:

[Minn. Stat. § 471.6161.](#)

(2) Business associates

Extends HIPAA's privacy and security requirements directly to business associates and expands the definition of business associates to include a broader list of service providers.

(3) Accountability

Requires more vigilance over business associates' privacy practices. Business associates are now expected to report to covered entities if they know of any violations.

(4) Enforcement escalation

Audits will be dramatically increased. The state attorney generals will be permitted to bring a civil action to enforce HIPAA's privacy and security requirements.

(5) Increased liability

Individuals may be held accountable in addition to organizations.

2. Bid requirements for group insurance plans

Only cities with 25 or more employees offering group insurance coverage are required to go out for bids at least once every 60 months. The request for proposal (RFP) must be in writing and public notice of the RFP must be given in the local newspaper at least 21 days prior to the final date for submitting proposals.

Cities must compare benefits and costs and thoroughly evaluate the proposals using the written criteria outlined in the proposal.

Written rationale must be provided prior to entering into a contract with the selected carrier.

Cities may choose to evaluate their benefit options on their own or work with a broker or consultant to help the city through the bid process. If the city works with a broker and consultant, the commission may be paid directly by the city to the broker/consultant or the commission can be built into the insurance premium and paid by the insurance company.

Regardless of whether the broker/consultant is paid directly by the city or through the insurance carrier, they must disclose the amount they are paid in commission. Generally, commissions for a large group (over 50 employees) are based on a percentage of premiums. A flat dollar amount per enrolled individual seems to be the typical commission structure for smaller groups (less than 50 employees).

RELEVANT LINKS:

[Minn. Stat. § 13.43, subd. 2.](#)

[DPO 17-004.](#)

a. Providing census information to carriers

Many cities find insurance carriers will often want employee census information in order to provide a bid to the city. Much of the requested census information may contain Private Health Information (PHI), protected under HIPAA and the MN Data Practices Act. Typically, there is a fairly short turn-around to obtain the census information for the carrier(s).

Generally, cities may share private employee information in limited cases without individual authorization and if information is disclosed for the necessary purposes of the administration and management of programs such as benefits administration. The information shared must be limited to the minimum necessary to accomplish the intended purpose. However, a 2017 Minnesota DPO Advisory Opinion has provided guidance that a Tennesen warning notice must be issued (prior to obtaining private data from individuals).

What cities need to look at what exactly does the insurance carrier need in order to properly provide a bid for services? Does it need to look at each individual employee? Most likely, no. An aggregation of information without personal identifiable information may suffice to provide enough of a picture for a good and responsible bid to be made. For example, the insurance company may need to know how many employees total, how many are over age 40, how many had some type of serious medical condition last year that required surgery and/or ongoing medical services, etc. In this situation, cities are not giving away specific information on any given employee, and that usually circumvents privacy concerns.

That doesn't ignore the best practice, however, of providing employees with a generic statement informing employees their information will be aggregated without personal identifiable information and provided to carriers for bid purposes.

If the carrier does need specific information, a more direct notice should be provided to employees letting them know their individual information may be shared with a carrier for bid purposes and only "minimally necessary" information will be shared. Further, there should be a contract between the city and the carrier that stipulates how this information will be handled – i.e., maintained while determining status and destroyed if the carrier is not chosen.

Even though permitted use is allowed as noted above, cities should still consult with their city attorney because of the potential ramifications for the failure to properly safeguard employee information.

RELEVANT LINKS:

[Minn. Stat. § 471.6161.](#)

LMC website: [Federal Health Care Reform.](#)

[Minn. Stat. § 471.6161, subd. 5.](#)

[A.G. Op. 59a-25 \(Dec. 15, 1987\).](#)

[Norman v. HRA of Chisholm, 696 NW 2d 329 \(Minn. 2005\).](#)

[West St. Paul Federation of Teachers v. ISD No. 197, 713 N.W.2d 366 \(2006\).](#)

3. Benefits and union contracts

Cities with union contracts may be limited in changing benefit levels or contribution structure under the city's health plan. This is because the aggregate value of benefits provided under a group health contract generally cannot be reduced unless the city and the union agree to a reduction in benefits and complying with any other existing contract language pertinent to the situation. Likewise, the city cannot change the contribution structure, if it is specified in the union contract, without negotiating with the union. State law provides, "the aggregate value of benefits provided by a group insurance contract for employees covered by a collective bargaining agreement shall not be reduced, unless the public employer and exclusive representative of the employees of an appropriate bargaining unit...agree to a reduction in benefits."

In applying this law, it is important for cities to understand what qualifies as a benefit. The Attorney General's Office has indicated benefits include details such as deductibles and copayments. Benefits do not include premium amounts.

Two court cases highlight the difficulty of changing health insurance benefits. In the Chisolm case, the collective bargaining agreement in place at the time of the employee's retirement provided that the HRA would continue to pay the retiree's health insurance premiums indefinitely. Subsequently, the collective bargaining agreement expired and the HRA discontinued paying the retiree's insurance premiums, relying on Minn. Stat. § 179A.20. The Minnesota Supreme Court held that a public employer may obligate itself in a collective bargaining agreement to pay retiree health care premiums indefinitely.

Where the HRA did not limit its obligation to pay benefits and the employee retired under a collective bargaining agreement, the Supreme Court held the HRA could not discontinue its contribution toward the insurance premium for the employee. In this case, it did not matter that the contract later expired or that the union eventually decertified.

In the West St. Paul case, the teachers' union and the school district were negotiating a new 2003-05 collective bargaining agreement. The West St. Paul school district (ISD 197) at that time offered two benefit plan options to employees. Although the benefits were the same under both plan options, the provider networks were different—one plan incorporated a primary care network with limited clinics and providers, and the other plan offered a more open access network with an almost unlimited provider network.

RELEVANT LINKS:

[Minn. Stat. § 471.6161.](#)

Under the benefits committee's recommendation, the Primary Care plan remained unchanged while the Open Access plan changed considerably, including increased out-of-pocket maximums, increased office visit and emergency room copays, and decreased coverage for inpatient hospital. Employees who did not want to pay the additional out-of-pocket costs could enroll in the Primary Care plan with the higher benefits but more limited network. After a public hearing, the school board approved changes to the Open Access plan.

The teachers' union brought suit against the school district for violating Minn. Stat. § 471.6161, subd. 5, relating to changes in the aggregative value of benefits and argued the unilateral change to the Open Access option constituted unfair labor practices under Public Employees Labor Relations Act (PELRA). The Minnesota Court of Appeals held that the school district unilaterally reduced the aggregate value of benefits in violation of the Minn. Stat. § 471.6161, subd. 5.

In addition, changing the coverage under the Open Access plan, which resulted in greater out-of-pocket costs for the employee to retain choice in health care providers, constituted an unfair labor practice under PELRA.

4. Implications and key considerations

In the West. St. Paul case, the court noted a few points cities should weigh carefully when evaluating benefits changes under a union contract:

- When evaluating whether there has been a change in the aggregate value of benefits, the proper method for determining this would be to compare the value of coverage under all plan options before the change against the value of coverage under all plan options after the change.
- The term benefit is not limited to tangible, monetary benefits (e.g., deductibles, out-of-pocket maximums, copays, etc.), but also includes nonmonetary benefits that promote or enhance well-being, or constitute an advantage, such as retaining the choice of health care providers without incurring additional out-of-pocket costs. The term benefit, however, does not include premium amounts.
- A public employer commits an unfair labor practice when the employer refuses to meet and negotiate in good faith over the terms and conditions of employment. Health insurance coverage is a fringe benefit included under terms and conditions of employment and therefore cannot be changed unilaterally. A city commits an unfair labor practice when it unilaterally reduces the existing choice of health care providers.

As the city evaluates benefit options and possible changes, consider the following:

RELEVANT LINKS:

[Minn. Stat. § 471.6161.](#)

- Determine whether the benefits changes being proposed would result in a change in the aggregate value of benefits. If the change does not reduce the aggregate benefit level, then the city does not have any obligation to seek the union's approval.
- Review union contracts to determine if there is anything that would bind the city to offering specific benefit amounts and/or the network of providers available under the collective bargaining agreement.
- Review union contracts for provisions permitting the city to make a change in the aggregate value of benefits. Some cities have "me too" provisions in the collective bargaining agreement that permit the city to provide the same level of benefits as that provided to nonunion employees. They then can argue the union has given prior permission for the city to make the change.
- Provide union representatives with the premium differential of the proposed changes. This information can be a good starting point for discussions on how benefit changes can help the city and employees reduce premiums. This approach recognizes that the employer and employees who contribute toward the health insurance premiums benefit from lower health insurance premiums. The following example demonstrates how such a change would benefit both the city and the employees in such a situation:
 - A city can reduce insurance premiums by \$20 per month if it increases its copayment for office visits by the same \$20. Thus, if an individual does not average one visit per month, the premiums savings would more than offset the change in benefit level.
 - If the city contribution to the health insurance premium stayed at the same dollar amount, the employee would achieve this entire savings. If the city and the employee equally shared the \$20 savings, the employee would save the \$120 in premium contribution and would benefit unless he or she had six office visits in the same year.

For retiree benefits also consider the following:

- Will the change impact current retirees? If so, consider union contract and/or personnel policies in force at the time the employee left the city—was a promise made to contribute indefinitely?
- The impact of GASB accounting standards for non-pension retiree benefits, such as health benefits.
- Working with union representatives to discuss any potential changes that might be needed to the city's contribution structure as a result of the new accounting standards—realize that changes may not be able to be made for current employees or retirees, only future employees and retirees.

RELEVANT LINKS:

Minn. Stat. § 176.021.
MN Dep't of Labor and
Industry: [Work Comp: For
Employers](#).

Minn. Stat. ch. 79A.

LMC website: [LMCIT
Workers' Compensation
Coverage](#).

Minn. Stat. § 471.61, subd.
2b.

LMC information memo,
[Continuation of Benefits](#).

- Carefully evaluating options for implementing a post-employment health savings plan and ensuring the plan complies with appropriate IRS regulations. Note: If considering a post-employment health savings plan, this benefit must first be negotiated with the union(s) and/or changes in the city's personnel policy prior to the effective date of the program.

As a general rule, cities wishing to change the benefit levels or contribution structure under the group health insurance plan for union employees should begin negotiations with the union as soon as possible—it could easily take a year or longer simply to make a few minor changes in the benefit levels offered under the plan.

I. Workers' compensation coverage

Minnesota law states every employer is liable to pay compensation in every case of personal injury or death of an employee arising out of and in the course of employment. The burden of proof of these facts is placed upon the employee. However, if the injury was intentionally self-inflicted or the intoxication of the employee is the cause of the injury, then the employer is not liable for compensation. In this case, the burden of proof of these facts is upon the employer.

The workers' compensation system provides employees with benefits if they become injured or ill from their job. It covers injuries or illnesses caused or made worse by work or the workplace. Workers' compensation benefits are paid regardless of fault of either the employer or employee. The Minnesota Department of Labor and Industry (DOLI) provides general information about the requirements under workers' compensation laws and regulations.

Cities may obtain workers' compensation coverage through the League of Minnesota Cities Insurance Trust (LMCIT), a private insurance carrier, or larger cities may choose to self-insure their workers' compensation benefits. Minnesota statutes address self-insuring workers' compensation benefits.

VI. Pension and retirement plans

A. Medical and dental

Minnesota statutes allow some former city employees and their dependents to continue their health and dental insurance coverage indefinitely.

RELEVANT LINKS:

See Section VIII,
Continuation of Benefits.

See Section VIII,
Continuation of Benefits.

[Medicare Frequently Asked Questions](#), courtesy of
Gallagher consultants.

[Centers for Medicare and Medicaid Services. 42 U.S.C. § 1320a-71. Medicare Frequently Asked Questions](#), courtesy of
Gallagher consultants

City employees who are receiving a disability or retirement annuity from a Minnesota public pension plan (other than volunteer fire fighters) or have met the age and service requirement necessary to receive an annuity from a public pension plan, are eligible to continue group health and dental benefits they participated in before retirement.

Early retirees (those employees retiring before the age of 65) must be offered the same plan option at the same rate as active employees until they reach the age of 65.

Once the retiree reaches age 65, or for employees retiring at 65 or older, the city must continue to offer coverage to the retiree; however, it does not have to be the same plan structure or at the same rate as active employees.

If an employee does not meet the requirements under Minnesota law for indefinite continuation of coverage, then the city must still offer continuation of coverage options under COBRA and state continuation requirements.

B. Medicare

Many employees have heard that the timing of enrollment for Medicare benefits is important, and there can indeed be a few tricky issues in play. Like all employers, cities should avoid giving direct advice about benefit decisions; however, providing some guidance on post-retirement benefits is something employees have come to expect from their employers. For a great list of frequently asked questions on Medicare Parts A through D as well as some general information on tricky timing enrollment issues to be aware of, please click on the link to the left.

C. Medicare Part D

Medicare Part D is a voluntary prescription drug benefit program created by the Medicare Modernization Act (MMA) of 2004 to help cover outpatient prescription costs. Its intent is to provide increased resources to make prescription drug coverage more affordable for those individuals on Medicare—mainly retirees.

Medicare Part D imposes a disclosure notice obligation to certain participants and beneficiaries (Part D eligible individuals) under the employer-sponsored group health plan. The intent of the notice is to provide eligible individuals with the information necessary to determine whether to enroll in Part D. Employers are required to provide a disclosure notice of “creditable coverage” to those individuals eligible for Medicare Part D.

RELEVANT LINKS:

The disclosure notice must identify whether the prescription drug coverage provided under the group health plan is “creditable coverage” (the prescription drug coverage available through the group health plan must be at least the actuarial equivalent to the prescription drug coverage available through Part D).

Where the coverage is not creditable, the notice must also describe Part D enrollment limitations, including late enrollment penalties (i.e., the possibility of paying higher premiums).

Part D individuals include individuals who are both entitled to Medicare (actually covered by Medicare) and covered by an employer-sponsored group health plan. If the city sponsors a plan that covers anyone who is actually covered by Medicare, the obligations apply. No distinction is made between employees, former employees (COBRA participants, retirees) and dependents (spouses, dependent children).

If the city sponsors a plan that covers anyone who is actually covered by Medicare, the obligations apply.

“Group health plan” means each program that offers prescription drug coverage, including: private sector, public sector, and church programs; collectively bargained programs; stand-alone prescription drug programs; Health Reimbursement Arrangements, to the extent the HRA is offered in conjunction with another group health plan (a high deductible health plan) the plans may be combined for purposes of determining “creditable coverage.” Guidance from the Centers for Medicare and Medicaid Services (CMS) clarified that Part D notification obligations do not apply to medical reimbursement accounts through a cafeteria plan, medical savings accounts and health savings accounts.

Employers sponsoring health plans must determine whether the prescription drug coverage under the city-sponsored medical plan provides creditable coverage. Medicare Part D imposes disclosure notice obligations to certain participants and beneficiaries (Part D eligible individuals) under the employer-sponsored group health plan. In addition, there is an annual disclosure notice to the Centers for Medicare and Medicaid Services (CMS) required from employer groups sponsoring a health program. The intent of the notice is to provide eligible individuals with the information necessary to determine whether to enroll in Part D. The disclosure notice must identify whether the prescription drug coverage provided under the group health plan is “creditable coverage” (the prescription drug coverage available through the group health plan must be at least the actuarial equivalent to the prescription drug coverage available through Part D).

RELEVANT LINKS:

Centers for Medicare and
Medicaid Services –
[Disclosure to CMS Guidance
and Instructions.](#)

Centers for Medicare and
Medicaid Service, [Medicare
Part D Model Notice Letters.](#)

Centers for Medicare and
Medicaid Services –
[“Creditable Coverage
Disclosure to CMS.”](#)

Where the coverage is not creditable (meaning pays on average less than the standard Medicare prescription coverage), the notice must also describe Part D enrollment limitations, including late enrollment penalties (i.e., the possibility of paying higher premiums).

The disclosure notice is intended to provide information to CMS about the prescription drug coverage under the city-sponsored health plans. Information about providing this notice can be found by clicking on the link to the left.

Cities should consult with their insurance carrier to determine what if anything the insurance company will do with respect to providing these notices both to employees and to CMS. If the insurance company won't provide the notice on behalf of the city, then the city will be required to provide the notices at the appropriate times.

Cities with insured plans should contact their carriers to confirm that the carrier is determining whether the health plan provides creditable coverage.

If the city also sponsors an HRA, the city should confirm that the carrier is treating the major medical coverage and the HRA as a combined plan for purposes of determining creditable coverage

Cities with self-funded plans and stand-alone HRAs will need to determine creditable coverage on their own with the assistance of service providers, such as TPAs, actuaries, and/or accountants. If the city sponsors an HRA in addition to a self-funded major medical plan, the plans should be combined in order to determine creditable coverage.

Notice must be provided to individuals covered under the employer-sponsored health plan at the following times

- Prior to the eligible individual's initial enrollment period for Part D.
- Prior to the eligible individual's effective date of enrollment for Part D.
- Prior to commencement of annual coordinated election periods—begins each October 15th.
- Upon request by an individual

For general information about prescription drug benefits under Medicare, go to the Centers for Medicare and Medicaid Services and click on any of the topics under Prescription Drug Coverage.

RELEVANT LINKS:

[PERA.](#)

[PERA.](#)
60 Empire Drive
Saint Paul, MN 55103.
800. 652.9026 or
651. 296.7460.

[Minn. Stat. § 353.01.](#)

D. Public Employees Retirement Association

The Minnesota Legislature created the Minnesota Public Employees Retirement Association (PERA) in 1931. PERA administers four different retirement plans that provide retirement, survivor, and disability benefits for city and county employees and nonteaching employees of the schools.

PERA serves over 250,000 current and former public employees from over 2,000 local units of government throughout the state of Minnesota. PERA also provides monthly benefits to over 80,000 retirees and other benefit recipients.

Cities and city employees with questions about PERA are encouraged to access one of the many information resources available through PERA. The PERA website allows employees to track their benefit estimates online using their “My PERA” feature.

Information in this section provides a broad overview of the plans available through PERA and the circumstances under which a city employee would be required to participate. The PERA plans available include the following:

- **Basic Plan.** This plan includes members who are not subject to Social Security. It is no longer open to new membership. Some cities, however, may have employees who participate in this plan.
- **Coordinated Plan.** This plan includes members who are subject to Social Security rules. The majority of city employees participate in this plan.
- **Police and Fire Plan.** This plan is not subject to Social Security rules. It is made up of police officers and firefighters.
- **Correctional Plan.** Effective July 1, 1999, correctional officers new to PERA coverage and those formerly members of the PERA Coordinated or Police and Fire Plan, became members of the PERA Correctional Plan.
- **Defined Contribution Plan.** Qualified elected officials, volunteer ambulance personnel, and governmental physicians may participate in this plan. (More information about this plan is available from PERA).

Membership in PERA is automatic for nonelected public employees who meet the eligibility requirements established by state statute.

In other words, employees and employers are required to participate. Both the employee and the city contribute to PERA. The plans listed above differ from one another, so it is important cities and employees consult the various PERA resources when questions arise.

RELEVANT LINKS:

[PERA.](#)

PERA has a comprehensive and useful handbook for each of the four plans. Representatives from PERA are available to answer employer and employee questions. In addition, a great deal of information about PERA benefits is available on the PERA website.

1. Eligibility

a. Employers

To join PERA and enroll employees in a PERA-administered plan, employers must meet the definition of a governmental subdivision as defined in Minnesota statute. Governmental employers subject to coverage under PERA are the counties, cities, towns, and school districts within Minnesota; a department or unit of state government; or any other governmental body whose revenue is derived from taxation, fees, assessments, or other sources.

In addition to the employers meeting this definition, there are certain employers specifically included for PERA participation, as well as others specifically excluded from PERA participation by Minnesota law.

b. Employees

Public employees whose annual salary from one governmental subdivision exceeds \$5,100 are required to participate as members of PERA. If an employee's annual compensation from one governmental subdivision exceeds an annual salary of \$5,100, contributions must be made on behalf of the employee from the first month in which the employee received salary exceeding \$425 in a month.

Certain city positions do not qualify to participate in PERA for various reasons—generally, any city employee whose annual earnings are less than \$5,100 from one city. Before deciding that a position does not qualify for PERA, cities should consult state law or the appropriate PERA handbook or representative. The following are examples of the kinds of positions not eligible to participate in PERA:

- Elected officials. Public officers (other than county sheriffs) elected to a governing body or people appointed to fill a vacancy in an elective office of a governing body whose term of office first commences on or after July 1, 2002, for the service to be rendered in that elective position (such employees are eligible for the defined contribution plan, however) have the option to participate in PERA. Participation in a PERA plan is not mandatory for local elected officials.

[Minn. Stat. § 353.01.](#)

RELEVANT LINKS:

[Minn. Stat. § 353.01](#)

[PERA: Employers Manual Chapter 3 Defined Benefits Plan.](#)

[Minn. Stat. § 353.028, subd. 2.](#)

[Minn. Stat. § 43A.17.](#)

[IRS Publication 15, \(Circular E\), Employers Tax Guide for use in 2020.](#)

[PERA.](#)

- Election officers/election judges.
- Seasonal personnel. Persons hired to fill positions related to a specific season or seasons whose employment is limited in duration to 185 consecutive calendar days in each year of employment.
- Temporary personnel. Persons hired to fill a position for a predetermined period of six months or less.
- Full-time students. Any city employee who has not reached the age of 23 and is enrolled full time to attend or is attending classes on a full-time basis at an accredited school, college, or university in an undergraduate, graduate, or professional-technical program or a public or charter high school.
- For more information on those positions exempt from PERA participation, follow the link in the left column.

2. City managers and administrators

City managers or administrators may elect to be excluded from membership in PERA. They must choose exclusion within six months of the day they begin employment. The law also provides for refunds of contributions made before the election.

If they elect exclusion, they and their city may agree the city will defer and contribute additional compensation on behalf of the employees to a deferred compensation program or to PERA's defined contribution plan. The deferred compensation program must meet federal income tax laws. This amount is not subject to the salary limitation (governor's salary cap) established under state law as long as it does not exceed the amount the city would have made as a PERA contribution.

3. Contributions

The PERA fund receives matching contributions from the employee and the employer, plus an additional contribution from the employer to amortize actuarial deficits in the fund. Social Security (FICA) also receives matching contributions from both employer and employee. The contributions, in both cases, are expressed in percentages of covered payroll. PERA percentages are based on total salary. FICA percentages are capped at a certain amount with annual changes.

The city collects employees' contributions through payroll deductions and should remit them to PERA within 15 days from each paycheck. The city should remit employer contributions along with employee contributions. Both employer and employee contributions to Social Security go directly to the IRS, which acts as an agent for the Social Security Administration.

RELEVANT LINKS:

[Social Security Administration. 800.772.1213.](#)

[PERA: Repaying a Refund.](#)

[PERA: Repaying a Refund.](#)

[PERA: Repaying a Refund.](#)

[PERA.](#)

Current contribution rates are available on the PERA website or by contacting PERA directly.

4. Taxes

Federal and state income taxes on PERA contributions are deferred; thus, most PERA benefits are taxable when they are received.

5. Social Security

PERA members may be eligible for benefits through Social Security. PERA benefits are in addition to any payment an employee may receive from Social Security. Cities should advise any employee preparing to retire to contact the Social Security Administration directly.

6. Refund of payments

An employee ending public service and remaining out of public employment for more than 30 days may elect to receive a refund of contributions instead of leaving them with PERA and drawing a deferred pension later.

7. Repayment of a refund

If an employee returns to Minnesota public service after receiving a refund, the employee may repay all or a portion of the refund, plus 8.5 percent interest compounded annually, to restore prior service credit with PERA. Partial repayments are allowed under certain conditions. The employee should contact PERA for time frames for doing so and the associated cost.

8. Options for payment

There are a number of payment options available from PERA. Each plan offers a full retirement, early retirement, and/or combined service pension. In addition, each plan has a disability benefit and a survivor benefit. Employees preparing to retire or interested in learning more about another payment option should contact a PERA representative.

9. Calculating payment

Most PERA pension plans are paid as equal monthly payments for the employee's lifetime with annual adjustments. The benefit is a product of the employee's age, average salary, and a percentage for each year of credited service. These factors vary from member to member and from plan to plan.

RELEVANT LINKS:

[Minn. Stat. § 352.965.](#)

[IRS: IRC 457\(b\) Deferred Compensation Plans.](#)

[26 U.S.C. § 457.](#)
[Minn. Stat. § 352.965.](#)

[IRS: Eligible Deferred Compensation Plans under Section 457.](#)

[Minn. Stat. § 356.24.](#)

The amount of pension also depends upon whether the employee elects to provide income protection to a survivor in the event of the employee's death.

City employees approaching retirement may refer to their "high five salary" to be used for retirement. The "high five" is the gross salary an employee earns during the 60 consecutive months in which her salary was greatest, not calendar or fiscal years.

If the employee worked less than five years in public service and qualifies for a benefit, the salary for all years of service will be averaged. Benefit formulas are available on the PERA website or by contacting a PERA representative.

E. Deferred compensation plans

Deferred compensation plans are voluntary retirement savings plans offered by a public employer.

Deferred compensation plans are authorized by the Internal Revenue Code and Minnesota statutes. Cities most commonly adopt plans authorized under Internal Revenue Code Section 457(b). These are pretax, payroll deduction plans which helps employees save for retirement by using pretax contributions and tax deferred growth. In other words, employees are able to defer paying taxes on the contributions, as well as the earnings on those contributions, until they decide to withdraw funds for retirement.

City employees are also eligible to participate in 401(a) plans under federal law. However, state law does not currently authorize city contributions for such plans and if funded solely by employee contributions, a 401(a) becomes a post-tax plan.

To participate in a deferred compensation plan, the employee and city must have a written agreement authorizing deductions for deferred compensation, and each employee must request the deduction in writing.

Contributions to a deferred compensation plan are subject to Social Security (FICA), Medicare, and Federal Unemployment Insurance (FUTA) taxes if they are immediately vested.

Providing a deferred compensation plan for employees requires the city to comply with a number of very involved state and federal regulations. Many of these regulations have changed over time. In particular, one of the applicable state laws was amended effective July 1, 2020. See Minn. Stat. §356.24.

RELEVANT LINKS:

[MN State Retirement System. Nationwide: 457 Retirement Plans.](#)

[ICMA RC: 457 Deferred Compensation Plans.](#)

[IRS: COLA Increases for Dollar Limitations on Benefits and Contributions.](#)

[Retirement Topics 457b Contribution Limits | Internal Revenue Service.](#)

[IRS: 457\(b\) Contribution Limits.](#)

The League encourages any city interested in beginning a deferred compensation program, as well as those already offering one, to work closely with the plan provider and a tax advisor.

Three commonly used plan providers are the Minnesota State Deferred Compensation Plan, Nationwide and the ICMA Retirement Corporation.

It is important to note the city must comply with an employee's request to defer his/her compensation to the Minnesota State Deferred Compensation Plan. The city cannot require an employee to make contributions to any other deferred compensation plan instead of the Minnesota State Deferred Compensation Plan if the employee wishes his/her deferrals to go to Minnesota State Deferred Compensation Plan.

1. Employee contributions

a. Regular contributions

Employee contributions to a 457 deferred compensation plan are made on a pretax basis through payroll deduction.

Contribution limits are as follows through the year 2020:

- Year 2015 = \$18,000
- Year 2016 = \$18,000
- Year 2017 = \$18,000
- Year 2018 = \$18,500
- Year 2019 = \$19,000
- Year 2020 = \$19,500

b. Age 50 and over additional contribution

If a participating employee is age 50 or over, the employee can set aside a higher amount through deferred compensation. Contribution limits in this category are as follows:

- Year 2015 = \$24,000
- Year 2016 = \$24,000
- Year 2017 = \$24,000
- Year 2018 = \$24,500
- Year 2019 = \$25,000
- Year 2020 = \$26,000

2. Catch-up contributions

Under Section 457 of the Internal Revenue Code, deferred compensation plans are authorized to allow participants approaching retirement to defer more than the normal annual limit under certain circumstances. The catch-up provision cannot be used at the same time as the age 50 and over additional contribution.

This catch-up limit allows participants who are within three years of attaining the normal retirement age of 65 to contribute up to twice the annual contribution limit. For these participants, the maximum amount allowed is actually the lesser of either of the following:

- Twice the annual limit.
- The annual limit, plus the total amount of underutilized contributions from prior years.

Under this provision, additional amounts may be deferred if a participating employee is within three years of the age at which the employee becomes eligible for normal retirement age or unreduced retirement benefits, and the employee has not deferred the maximum amount allowed for all applicable years after Jan. 1, 1979.

In this case, during the three calendar years prior to the year of the employee's retirement, the employee may catch up on the deferrals that are eligible to be set aside.

The pre-retirement, catch-up limit will vary by participant depending on a number of factors, including the amount the participant has previously contributed to the plan.

3. Deferring paid leave (sick, vacation, etc.)

It is generally not advisable for a city to defer payment of paid leave for an employee who is retiring in order to set up an account to pay health insurance premiums without using a plan that has been legally reviewed to meet IRS requirements and other legal standards. For more information, see the Post-Employment Health Care Savings Plans section below.

4. Employer contributions

Cities wishing to make contributions to participating employees' deferred compensation accounts should work directly with their tax advisor and the plan provider. Employer contributions are allowed under certain circumstances but may not exceed one-half of the federal maximum allowed for that employee and must be matched by the employee him or herself.

RELEVANT LINKS:

HR Reference Manual,
[Chapter 1](#) see page 49 on
Constructive Receipt.

F. Post-employment health care savings plans

In many cases, employees pay the full premium price for their insurance after leaving the city's employment unless otherwise provided by state law, a collective bargaining agreement, personnel policy, or individual employment contracts. The city can help employees fund their health insurance costs after employment by implementing a post-employment health care savings plan.

Post-employment health care savings plans are funded by employer contributions, which may include conversion of unused sick or vacation leave, severance pay, mandatory salary reductions, or a combination of any of these. Contributions made into these accounts are nontaxable and are used to pay for eligible medical expenses and certain insurance premiums once the employee leaves employment.

The city may be able to offer a post-employment health care savings plan to certain groups of employees; however, it cannot be offered only to individual employees and not others. Post-employment health care savings plans must be established carefully in order to comply with IRS requirements.

If employees are given the choice of what they are contributing (severance pay vs. salary reduction) and how much, the employee will be deemed to be in "constructive receipt" and will be taxed as though he or she took 100 percent of the severance pay as cash, for example— regardless of how much the employee actually directed to the post-employment health care savings plan.

The League recommends cities work closely with an attorney to ensure the plans are set up correctly.

These plans must meet certain IRS and other legal requirements in order to maintain the nontaxable status of the contributions. For this reason, it is generally not advisable for a city to set aside these dollars and pay the employee's premiums on behalf of the employee without using a plan that has been legally reviewed to meet IRS requirements and other legal standards.

Many vendors in Minnesota offer post-employment health care savings plans. The League does not endorse any particular post-employment health care vendor and suggests cities consult with an attorney specializing in benefits issues before selecting a vendor for post-employment health care benefits. Also, as with any written contract, the city will want to ensure it is reviewed by the city attorney prior to entering into any agreement.

VII. Other insurance benefits

There are a variety of other insurance benefits cities may consider offering to employees. In many cases, the additional benefits offered through the city provide discounted rates on certain plans and provide ease of payment for the employee, as the employer will remit premium payments directly to the vendor through payroll deductions. These benefit options are typically offered on a voluntary basis and tend to be entirely portable so the employee may continue the policies on a direct basis with the insurance company if they leave city employment.

A. Supplemental/specialty benefits

Supplemental/specialty benefits may include benefits such as the following:

- Cancer/specified disease
- Accident/sickness
- Vision
- Hospital confinement
- Hospital intensive care

In most cases, these policies provide cash directly to the individual for eligible benefits. For instance, if an employee is diagnosed with cancer, the insurance policy might pay a flat dollar amount to the individual for the diagnosis. The individual might also receive a benefit for treatment provided due to the condition.

Cities that consider offering these voluntary benefit options may want to check with the Minnesota Commerce Department to make sure the insurance company is licensed to conduct business in the state.

B. Auto/homeowner's insurance

Auto and homeowner's policies available through the employer typically provide employees access to coverage at discounted rates.

The city may pay the premium for this coverage directly to the vendor/insurance company on behalf of the employee through payroll deductions, although it is not required for the city to do so.

C. Prepaid legal services

Through a prepaid legal service program, employees have access to participating attorneys and/or a law firm for a monthly fee.

RELEVANT LINKS:

[Minn. Stat. § 471.61.](#)

LMC information memo:
[Continuation of Benefits.](#)

[Minn. Stat. § 61A.092.](#)

Employees contact the providing attorney or law firm when they have a legal question or problem. Additional services, such as identity theft assistance and access to an attorney if detained or arrested, may be available to employees for an additional fee.

Before offering prepaid legal services to employees, the city should take into consideration the following:

- Are the attorneys qualified and in good standing with the State Bar Association?
- Is there overlap between the services being provided through the prepaid legal plan and the city's Employee Assistance Program (EAP)? Some EAPs provide some basic legal consultation services, so there may be some duplication of benefits being offered to employees.
- Conduct an employee survey to determine if there is enough interest in offering this plan. Some vendors may have participation requirements for offering the plan through the employer.
- Consider any processes available to assess user satisfaction with the plans and how to address any service complaints that may arise. Consider excluding assistance and advice relating to employment-related issues. It is a good idea to determine with the vendor how these situations will be handled prior to the program being implemented, so everyone knows how to treat the matter if a question were to arise.

VIII.Continuation of insurance benefits

Minnesota cities are required under federal and state law to offer employees continuation of some benefits for a period of time when certain qualifying events have occurred, such as termination of employment, retirement, disability, divorce, dependent child no longer eligible under the plan, death of an employee, and Medicare eligibility. Generally, a city will need to offer continuation of health, dental, vision, health flexible spending accounts (under the city's cafeteria plan), certain employee assistance programs, health reimbursement arrangements (HRAs), and life insurance. However, the city should examine its obligations first under federal laws and then state laws.

In many cases, Minnesota law provides a better option for continuation of coverage to the individual than does federal continuation. If the city would like to administer its continuation of benefits in the most conservative manner, it would be best to coordinate all the continuation requirements to ensure a city is meeting the requirements under each body of law at any given time (i.e., the city is essentially giving the employee the "best deal" under each law).

RELEVANT LINKS:

U.S. Dep't of Labor, Fact Sheet [COBRA Continuation Coverage](#). U.S. Dep't of Labor "Continuation of Health Coverage – COBRA."

If one set of regulations doesn't address a specific issue (such as the time frame for sending out notices or whether a written notice is required) or if the length of time available to continue the benefits expires, then check the other applicable regulations to see if the city has any additional obligations that must be met.

There are some downsides to taking the most conservative approach. Most notably is the possibility any individual opting back into a plan he or she had previously waived may impact the city's claims experience. In other words, the city's claims may increase as a result of allowing the individual (and his or her dependents) to re-enroll in the plan during open enrollment. However, the former employee in this situation would only have continuation in that plan for the remaining months of an initial 18-month continuation period, so there is a limit as to how much "risk" the city might take in allowing this approach.

Thus, the League generally recommends cities determine their obligation under COBRA first and then apply state continuation requirements (if any) so a city is meeting the greatest number of requirements at any given time.

When one ends, check the other to determine if an ongoing obligation to provide continuation of coverage exists. In some cases, COBRA will end first leaving only state continuation and vice versa.

Before making any determination on how to handle a continuation situation, it is important for the city to first review their collective bargaining agreements and/or personnel policies to see if a policy has already been established on how the issue will be handled.

Also, it will be important for the city to review their COBRA procedures to determine if there any changes needed in order for the city to take one approach over another.

Finally, the city should check with the insurance carrier and the plan contract to make sure both allow for the coverage continuation. The information below describes the various requirements and what cities should be considering as they apply these various requirements to specific situations.

A. Federal COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 was signed into law on April 7, 1986. COBRA applies to state and local governmental entities through the Public Health Services Act (PHSA).

RELEVANT LINKS:

Centers for Medicare and Medicaid Services:
[“Ensuring the Affordable Care Act Serves the American People.”](#)

LMC information memo,
[Continuation of Benefits.](#)

See Section VIII-9, *Special issues to consider.*

[Minn. Stat. § 61A.092.](#)

The U.S. Department of Health and Human Services has regulatory oversight with respect to public sector COBRA (the U.S. Department of Labor has oversight of private sector COBRA).

COBRA requires public sector employers sponsoring group health plans to offer employees and covered family members the opportunity to continue the group health coverage in certain instances when coverage would otherwise terminate. Typical group health plans covered under COBRA are included below:

- Medical
- Dental
- Vision care
- Health reimbursement arrangements (HRAs)
- Health Flexible Spending Accounts (Health FSAs) under the city’s cafeteria plan.
- Certain employee assistance programs (EAPs).
- Certain wellness programs.

There are special issues to consider, discussed below, for continuation requirements of Health Flexible Spending Accounts under the city’s cafeteria plan and Health Reimbursement Arrangements.

COBRA does not cover plans providing only life insurance or disability benefits. However, Minnesota insurance continuation law provides continuation of group health benefits (medical, dental, vision, and prescription drug plans), for periods equal to and often longer than COBRA periods, and group term life benefits, generally for up to 18 months, for all public-sector employers providing group health coverage or life insurance coverage to Minnesota resident employees. Regardless of whether federal COBRA applies, all group health plans sponsored by cities in Minnesota are subject to at least some Minnesota insurance continuation laws. COBRA also does not apply to group health plans sponsored by organization that employed fewer than 20 employees during the preceding calendar year.

The COBRA provisions of the Public Health Service Act (PHSA) covering state and local government plans are administered by the Department of Health and Human Services. References in this memorandum to “COBRA” refer only to the federal law known by that name.

RELEVANT LINKS:

U.S. Department of Labor:
“An Employer’s Guide to
Group Health Continuation
Coverage Under COBRA,
the Consolidated Omnibus
Budget Reconciliation Act.”

U.S. Department of Labor:
“An Employer’s Guide to
Group Health Continuation
Coverage Under COBRA,
the Consolidated Omnibus
Budget Reconciliation Act.”

Rev. Ruling 2002-88.

Rev. Ruling 2002-88.

See Section VIII-C, *State
continuation requirements*,
for more information on
continuation requirements
when there has been a break
in the marital relationship.

*Boudreaux v. Rice Palace,
Inc.*, 491 F. Supp. 2nd 625
(2007).

1. Qualifying event

A qualifying event is something that results in a loss of coverage for the employee, his or her spouse, and/or the employee’s covered dependent child(ren) which allows him or her to continue certain benefits through the city. Under COBRA, an employee and covered dependents may continue coverage on the city’s benefit plan if current coverage ends due to any of the qualifying events listed below:

- Voluntary or involuntary termination of the covered employee (other than by the employee’s gross misconduct).
- Reduction in a covered employee’s hours, including retirement, strike, or layoff.
- Death of the covered employee.
- Divorce or legal separation of the covered employee from his or her spouse.
- Child ceases to be an eligible dependent under the terms of the plan.
- For a spouse or dependent, when the covered employee becomes entitled to Medicare.
- For a dependent, a loss of dependent status.

2. Qualified beneficiary

The city must offer coverage continuation to all qualified beneficiaries. Qualified beneficiaries include the covered employee, spouse, and dependent children (including newborn or children placed in the qualified beneficiary’s home for adoption) of the covered employee who were covered on the day before the qualifying event. Qualified beneficiaries also include individuals for whom a covered employee is required to provide coverage under the group health plan pursuant to a medical child support order. Qualified beneficiaries generally do not include domestic partners, illegal aliens, or incarcerated employees.

If coverage is lost in anticipation of a qualifying event (e.g., the covered employee drops spouse coverage in anticipation of divorce), the loss is disregarded when determining a qualified beneficiary. The former spouse would be considered a qualified beneficiary even though not covered on the day before the qualifying event if his/her coverage was dropped in anticipation of the divorce.

a. General length of coverage

Under COBRA, an employee and his or her covered dependents are allowed to continue coverage for a period of 18 months when one of the following qualifying events occur.

RELEVANT LINKS:

[COBRA fact sheet.](#)

See Section VIII-C, State continuation requirements.

U.S. Dep't of Labor: [Disability.](#)

See Section VIII-C, State continuation requirements.

LMC information memo, [Continuation of Benefits.](#)

See Section VIII-C, State continuation requirements, for information on continuation requirements for employees that retire from the city.

- A reduction in the employee's work hours (including strike or layoff).
- Voluntary or involuntary termination of the employee for reasons other than gross misconduct. The COBRA regulations do not define gross misconduct, but it generally requires a higher standard than termination for cause. Cities should seek legal advice before denying COBRA coverage for gross misconduct.

In the instance of divorce, legal separation, or death of the employee, COBRA provides a maximum of 36 months of coverage. However, the length of continuation of coverage under Minnesota continuation law may differ significantly from COBRA in several circumstances.

b. Disability

Disability alone is not a COBRA qualifying event. However, if an employee terminates employment due to a disability or becomes disabled after terminating employment, COBRA rights may apply. Minnesota continuation requirements differ regarding coverage continuation for a disabled employee.

See the section on State Continuation Requirements for more information about continuation options for disabled employees who terminate city employment, as well as requirements for continuing coverage for police officers and firefighters injured in the line of duty.

COBRA allows for up to 29 months of coverage (standard 18 months plus an additional 11 months) when an employee receives a Social Security disability determination and leaves employment. COBRA also allows for special coverage should a covered employee, spouse, or dependent become disabled within 60 days following an employee's termination of employment or reduction in hours. Coverage for all covered individuals may then be continued for up to 29 months. This extension of COBRA continuation is designed to provide coverage until the disabled employee, spouse, or dependent becomes entitled to Medicare.

c. Retirement

Under COBRA, an employee who retires, along with their covered spouse or dependents, will have the option to continue coverage for up to 18 months.

However, Minnesota state law allows retirees to continue on the city-sponsored health and/or dental plan indefinitely if certain requirements are met.

RELEVANT LINKS:

LMC information memo:
[City Employees and Military Leave.](#)

U.S. Dep't of Labor:
[USERRA advisor.](#)

LMC information memo,
[City Employees and Military Leave.](#)

LMC information memo,
[City Employees and Military Leave.](#)

d. Military service

The city must offer continuation coverage to employees who leave for military service; however, many employees do not elect the coverage because the military provides its own coverage.

If an employee leaves city employment for military service, benefits are generally provided in accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994. For periods of military service of less than 31 days, an employer can only require the employee to pay the employee's share for health insurance premiums.

When on active military duty for over 31 days, employees and their dependents typically receive health insurance through the military. In the event a city has employees eligible for Family and Medical Leave Act protection, be aware that if an employer continues to provide the employer contribution toward medical insurance benefits for the 12-weeks of Family and Medical Leave, the city will also need to provide that same 12-week employer insurance contribution for an employee on military leave.

For those on extended military leave, continuation of benefits may be an issue. Some employees may elect to remain on their employers' health care plan. Under USERRA, an employee must be offered continuation options in accordance with state and federal laws. An employee may elect to continue coverage at his or her own expense for up to 24 months but may be required to pay no more than 102 percent of the full premium under the plan. While it is rare that an employee on military leave would choose to pay for such coverage, the city must still provide the required notices of an employee's continuation rights under COBRA, Minnesota law, and USERRA.

When the employee returns to work, the employee, spouse, and covered dependents may re-enroll in the city's insurance plan without any pre-existing condition limitations or waiting periods that might otherwise apply to a new employee, whether or not the employee and dependents chose to continue coverage during military leave. In other words, the employee and dependents simply re-enter the city's policy as though the leave had not occurred.

Under USERRA, the city in most cases must offer re-employment to an employee returning from military service, but there are some limited exceptions.

RELEVANT LINKS:

[Minn. Stat. § 471.61.](#)

See Section VII-B, *State continuation requirements*, for more information.

US. Dep't of Labor: [Compliance Assistance](#).

LMC information memo, [Continuation of Benefits](#).

U.S. Dep't of Labor: [Model General Notice](#).

COBRA notice and election procedures in U.S. Department of Labor: "[An Employer's Guide to Group Health Continuation Coverage Under COBRA, the Consolidated Omnibus Budget Reconciliation Act](#)."

Since there are such limited exceptions, before a city denies re-employment to an employee returning from military service, it is crucial the city works with legal counsel before proceeding. Note that public sector continuation requirements for individuals who retire due to a disability may have additional continuation options under Minn. Stat. § 471.61.

3. Notification requirements

COBRA requires employers to comply with a number of notification and administrative guidelines. While the requirements for these notifications are placed on the employer, some cities choose to outsource COBRA administration. If your city contracts for these sorts of services, be sure to check that both federal and Minnesota laws are being met.

a. Initial notice

At the time an employee enrolls in a group health plan, written notice must be provided to covered employees and their covered spouses (if any) with general information about their COBRA rights and responsibilities. COBRA provides that the group health plan is responsible for providing the initial notice of COBRA rights.

However, the statute does not elaborate on who is responsible for a failure to provide this notice. This notice must include the following:

- Name of the plan.
- Name, address, and telephone number or the party where additional information on COBRA rights can be obtained.
- General description of the plan's COBRA rules (e.g., who might be a qualified beneficiary, qualifying events that might lead to the right to continue coverage, employer's obligation to notify the plan administrator of certain qualifying events, the maximum COBRA period available, and how and when COBRA may be extended).
- Information about how the individual should report any personal events (e.g., divorce/legal separation, loss of dependent child status, disability determination from Social Security, etc.) that could trigger, extend, or terminate COBRA coverage.
- Explanation that the plan administrator must be kept informed of updated addresses of all plan participants.

The initial notice of continuation rights generally must be given to the employee within 90 days of the date that the employee or spouse becomes covered by the plan. This notice may be sent via first-class mail to the employee's last known address.

RELEVANT LINKS:

U.S. Dep't of Labor: [Model Election Notice](#).

[29 C.F.R. § 2520.104\(b\)\(1\)](#).

One notice to the employee at the home address satisfies this requirement if all individuals covered under the plan reside at the same address. A separate notice must be provided to the spouse and/or covered dependents if they reside at a separate address.

Documentation of notice being given or mailed is recommended via log or certificate of mailing. However, sending the notice by certified mail is not necessary—the city must demonstrate the notice was sent, not that it was received.

Initial notification triggering events include the following:

- New hires.
- Newly covered spouse of an existing employee.
- Any one newly covered at open enrollment.
- Newly covered spouse or dependent due to HIPAA special enrollment.

b. Election notification

When a qualifying event occurs, it is the city's responsibility to notify the employee, their spouse, and/or covered dependents of their opportunity to continue their group coverage. This notification must be sent within 14 days of the city or plan administrator being notified of a qualifying event.

The Department of Labor takes the position that the plan administrator (employer) is responsible for providing this notice and is liable for failure to do so, even in the event the plan administrator delegates the responsibility to another person or entity. The election notification must include the following:

- Clarification that each qualified beneficiary has the right to elect COBRA continuation coverage independently of all other qualified beneficiaries.
- The manner in which the plan will handle coverage during the election period—either continuous coverage (i.e., if coverage is not elected, then the plan will cancel retroactively) or canceled coverage (i.e., if coverage is elected and paid for, the plan will reinstate coverage retroactively).
- Type of coverage provided.
- Amount of monthly premium for each option.
- Date premiums are due, including the specified grace period for payment (at a minimum 30-day grace period).
- Applicable HIPAA amendments to COBRA, such as portability and creditable coverage.
- Maximum COBRA period for which coverage may be continued and the date coverage will end.

RELEVANT LINKS:

[“Interim Policy on Electronic Disclosure Under 29 CFR 2550.404a-5,” Technical Release No. 2011-03, U.S. Department of Labor \(Sept. 13, 2011\).](#)

[Centers for Medicare and Medicaid Services: “Ensuring the Affordable Care Act Serves the American People.](#)

- Reasons for which coverage will terminate prior to the expiration of the COBRA period.
- Contact information for the plan administrator, should the qualified beneficiary require more information or has questions.
- A statement that the notice only provides summary information and that more detailed information can be found from the plan administrator and in the summary plan description.

The election notice must be provided in a good faith manner that is reasonably calculated to ensure actual receipt of the material. No specific method of delivery is required, but the DOL suggests that using first-class mail is sufficient, provided it is sent to the employee and spouse (if covered) via first-class mail to their last known address. One notice to the home satisfies the requirement if the spouse and/or all covered dependents reside at the same address. A separate notice must be sent to the spouse and/or covered dependents if they reside at a known separate address.

Documentation of notice being given or mailed is recommended through a tracking log showing the date the notice was sent via first-class mail. However, certified mail is not necessary—again, the city must demonstrate the notice was sent, not received.

There is guidance regarding notification through electronic media, but keep in mind that upon request by a participant, beneficiary, or other individual a paper version of the electronically furnished documents will need to be provided by the city. In addition, this guidance is provided to plans covered by the Employee Retirement Income Security Act of 1974, which most city plans are not. However, the guidance is still helpful in understanding what is likely to be acceptable for non-ERISA plans as well.

c. Individual notice to the plan administrator

Employers subject to COBRA must establish policies and procedures for how and when notice must be provided to the plan administrator when an individual has a personal event that could trigger, extend, or terminate COBRA coverage. The policies and procedures should be reflected in the summary plan description and plan document of the group health plan.

If a certain qualifying event occurs, such as termination of employment or reduction in hours, the city must notify the plan administrator (if different than the city) within 30 days that the event occurred. If the qualifying event is a divorce or legal separation or a dependent no longer being eligible under the plan, the covered employee or qualified beneficiary must notify the plan administrator of the qualifying event within 60 days of the event.

RELEVANT LINKS:

U.S. Department of Labor:
“An Employer’s Guide to
Group Health Continuation
Coverage Under COBRA,
the Consolidated Omnibus
Budget Reconciliation Act.”

LMC information memo,
Continuation of Benefits.

U.S. Department of Labor:
“An Employer’s Guide to
Group Health Continuation
Coverage Under COBRA,
the Consolidated Omnibus
Budget Reconciliation Act.”

LMC information memo,
Continuation of Benefits.

U.S. Dep’t of Labor: [FAQs
about COBRA Continuation
Health Coverage](#).

LMC information memo,
Continuation of Benefits.

d. Notice of unavailability of COBRA

This notice must be provided anytime that COBRA coverage is requested but is not available or is denied. The notice explains to the individual the reason(s) why they are not entitled to COBRA or why continuation of coverage is being denied. The notice must be provided within 14 days after the request is received, and the notice must explain the reason for denying the request.

e. Termination notice

Plan sponsors must provide a notice to qualified beneficiaries if their COBRA coverage will terminate prior to the end of the applicable COBRA period (e.g., failure to pay premiums, individual becomes covered under another group health plan, etc.). The notice must be given as soon as practicable after the decision is made, and it must describe the date coverage will terminate, the reason for termination, and any rights the qualified beneficiary may have under the plan or applicable law to elect alternative group or individual coverage, such as a right to convert to an individual policy.

No notice is required to be sent to a qualified beneficiary upon expiration of COBRA coverage; however, it is recommended that the city consider doing so.

4. Coverage election

A qualified beneficiary has 60 days from the date coverage ends or the date of the COBRA election notice, whichever occurs later, to elect COBRA continuation.

The election notice must be provided in person or by first-class mail within 14 days after the plan administrator receives notice that a qualifying event has occurred. Claims incurred by a qualified beneficiary during the election period do not have to be paid before coverage is elected and the premium payment is made. Also, the city may terminate the employee’s coverage during the election period. Reinstatement of the coverage is not necessary until the election is made and the premium payment is received.

Under COBRA, if the employee declines to continue coverage, each dependent has the option of continuing individual coverage. However, an election by the employee to continue coverage may be deemed to be an election for all dependents residing with the employee.

RELEVANT LINKS:

LMC information memo,
[Continuation of Benefits](#).

LMC information memo,
[Continuation of Benefits](#).

[Minn. Stat. § 471.61](#).

U.S. Dep't of Labor: [FAQs COBRA Continuation Health Coverage](#).

U.S. Dep't of Labor: [FAQs COBRA Continuation Health Coverage](#).

[Minn. Stat. § 471.61, subd. 2b](#).

5. Employee responsibilities

Each city employee is responsible for notifying the city within 60 days of a divorce, legal separation, or a covered dependent becoming ineligible for coverage under the plan. Once a qualifying event has occurred, the qualified beneficiary plays an important part in the continuation of his or her coverage. These responsibilities include the following:

- Making a continuation election within the election period.
- Making timely payments to the city to ensure continued COBRA coverage.
- Notifying the city of any status changes during the continuation period.

6. Termination of COBRA coverage

COBRA coverage may only be terminated for the following reasons:

- The maximum available period of continuation coverage has been reached.
- The qualified beneficiary fails to make a timely payment.
- The qualified beneficiary becomes covered by another group health plan after the date of the COBRA election period.
- The qualified beneficiary becomes entitled to Medicare (Part A or Part B) after the date of the COBRA election.
- The city ceases to provide any group health plan to any of its employees.
- The qualified beneficiary ceases to be disabled according to the Social Security Administration after the 11-month disability extension has begun.

7. Billing and payment of COBRA premiums

When an employee or dependent elects and becomes effective on COBRA continuation coverage, she/he becomes personally responsible for the full cost of the applicable monthly premium (the total premium charged for active employees). This premium will be paid directly to the city, or to the city's designated third-party administrator, who will then pay the carrier.

The city may charge the qualified beneficiary an additional 2 percent administrative fee, except in the case of disability or retirement when Minnesota continuation laws only allow for 100 percent of the premium to be charged to the individual on COBRA. Premiums may not be raised more than once in a predetermined 12-month period of time (e.g., at renewal).

RELEVANT LINKS:

U.S. Dep't of Labor: [FAQs COBRA Continuation Health Coverage](#).

U.S. Dep't of Labor: [FAQs COBRA Continuation Health Coverage](#).

26 C.F.R. § 54.4980(b)(10).
29 U.S.C. ch. 28.

U.S. Dep't of Labor:
[Maintenance of Health Benefits](#).

The initial COBRA premium payment cannot be required earlier than 45 days after the date of the COBRA election. However, the city does not need to reinstate the qualified beneficiary's coverage until payment has been received.

Qualified beneficiaries must be allowed to make monthly premium payments, and the city must allow at least a 30-day grace period every month from the first day of the coverage period for premium payments to be made. Payment is considered made on the date on which it is sent (not the date on which it is received). The city is not required to send out monthly bills, however, the due date and grace period must be made clear to the qualified beneficiary, in writing, prior to the start of the COBRA continuation period. The city should mention in the COBRA election notice that monthly billing statements will not be sent out and that it is the individual's responsibility to remit premium in the appropriate time frame.

If a monthly premium payment is short by an amount that is "not significantly less than the amount due," the city must either accept payment as payment in full or notify the qualified beneficiary of the deficiency and allow 30 days from the date of notification to correct the deficiency.

8. Special issues to consider

a. Coordination with the Family and Medical Leave Act

FMLA generally requires that certain employers (e.g., those with 50 or more employees) maintain group health coverage in the same way as before the FMLA leave began, including the employer's contribution towards benefits. Upon return from FMLA leave, the employee is required to be treated as if the leave had not occurred.

In the case where an employee returns at the end of FMLA, there has been no loss of coverage. Therefore, there is no qualifying event that triggers COBRA.

However, COBRA may come into play at the end of the FMLA leave if the employee is not able to return to work and health coverage is lost. COBRA would also begin when the employee gives unequivocal notice of intent not to return to work. COBRA coverage is then provided for 18 months from the date the health coverage is terminated. Cities should review their city policy to determine how benefits are handled for leaves that extend beyond FMLA.

RELEVANT LINKS:

[Minn. Stat. § 13.43.](#)

[Minn. Stat. 13.43, subd. 2 \(6\).](#)

[LMC information memo, *Continuation of Benefits*.](#)

[U.S. Department of Labor: "An Employer's Guide to Group Health Continuation Coverage Under COBRA, the Consolidated Omnibus Budget Reconciliation Act."](#)

b. Severance packages

If the city offers an employee a severance package including continued payment of insurance premiums, the city is still obligated by COBRA and Minnesota continuation law. The city may run continuation benefits concurrently with severance benefits only if the employee is properly notified of his or her continuation rights at the time of severance. Otherwise, the city will need to offer the terminated employee COBRA continuation coverage after the paid coverage offered as part of the severance runs out.

Cities will want to be mindful of 2012 law changes impacting separation agreements. Including that the "complete" terms of an agreement settling any dispute arising out of an employment relationship, including buyouts, are public data, if it involves payment of more than \$10,000 of public money.

c. Benefits renewal and open enrollment

Continuation coverage is deemed to be equivalent to the benefit coverage provided by the city to active employees. If the city modifies a benefit plan, the same modifications will apply to continuation participants. During the city's annual renewal period, all COBRA participants must be notified of any plan design and premium rate changes.

Employees and dependents electing COBRA continuation coverage also must be allowed to make the same elections available to active employees during open enrollment (e.g., change plans or add/drop dependents). If a qualified beneficiary adds a spouse or dependent to their health plan during open enrollment, the newly covered individual does not become a qualified beneficiary (unless addition is for birth or adoption during the COBRA continuation period) and, therefore, would not have the same rights as the individual who elected to continue coverage.

d. Multiple qualifying events

Continuation of coverage may extend if another qualifying event occurs during the initial 18-month continuation period. COBRA specifically provides for additional continuation of benefits if one of the following multiple qualifying events occur:

- Divorce or legal separation.
- Death of the COBRA-covered employee.
- Employee entitled to Medicare.
- Loss of dependent child status.

RELEVANT LINKS:

Individuals must notify the plan administrator that a second qualifying event has occurred. However, they must also be notified of this responsibility ahead of time so the initial notice sent out to new hires and the election notice should contain information about how and when the individual should notify the plan administrator of a second qualifying event.

State continuation laws do not recognize second qualifying events. Nevertheless, a spouse and/or dependent child covered under the group health plan will have additional continuation rights under state law for divorce/legal separation, death of the employee, and loss of dependent child status regardless of whether the individual is on the plan as an active employee, retiree, or COBRA participant.

e. Health Flexible Spending Accounts under cafeteria plans

COBRA only applies to a Health Flexible Spending Account (Health FSA) when an employee has underspent his or her account. Under COBRA, an employee has the right to continue coverage under a Health FSA as long as the remaining annual limit exceeds the maximum COBRA premium that can be charged for the remainder of the plan year.

The city may charge employees an additional 2 percent fee towards the remaining contribution amounts.

For example, an employee elects to contribute \$100 per month, or \$1,200 annually, to a Health FSA. This same employee then terminates employment with the city nine months into the plan year, having been reimbursed \$500 for eligible expenses.

The city must offer the employee COBRA under the Health FSA, because the remaining annual limit ($\$1,200 - \$500 = \$700$) exceeds the maximum COBRA premium that can be charged for the remainder of the plan year ($\$102 \times 3 \text{ months} = \306).

If the employee elects continuation coverage, she/he must make the remaining contributions on a monthly after-tax basis and then would be able to submit eligible expenses for reimbursement under the same time limits defined in the plan for active employees.

It is important to realize that the full amount of the former employee's election for the year is available during the month in which they paid the COBRA premium.

It is possible that the COBRA participant may receive reimbursement for their full annual contribution amount without fully contributing the COBRA premium.

RELEVANT LINKS:

[DOL Opinion 91-26A.](#)

[Rev. Ruling 2002-45.](#)

In cases where the employee has underspent his/her Health FSA, coverage is only continued until the end of the cafeteria plan year. This is because reimbursements can only be made for expenses incurred during the plan year and contributions cannot be rolled over to the following year. Cities electing to implement the FSA 2 ½-month grace period will need to extend the same coverage to COBRA participants.

f. Employee assistance programs

Cities that offer an Employee Assistance Program (EAP) separate from a health insurance plan may be required to offer continuation of benefits under COBRA if the EAP provides employees with a direct benefit, such as access to trained counselors that provide ongoing mental health services. If the EAP is a referral-only service, it likely is not subject to COBRA. For a related DOL Opinion Letter 91-26A, please contact HR Benefits staff. Cities are encouraged to carefully evaluate their EAPs to see if COBRA continuation is an issue. Minnesota continuation law does not address EAP coverage.

g. Health reimbursement arrangements

Health Reimbursement Arrangements are strictly employer-funded plans that reimburse employees for certain medical expenses incurred by the employee and the employee's spouse and/or dependent children. The employer will fund reimbursements up to a maximum amount during a certain period—either a calendar year or the plan year for the health coverage (if different than a calendar year). Contributions made by the employer and reimbursements paid to the employee are generally excludable from the employee's gross income under Sections 106 and 105 of the Internal Revenue Code. Health Reimbursement Arrangements for large employers are not typically offered on a stand-alone basis, but rather are offered under a consumer-driven health plan or a post-employment/retirement health care savings plan.

The biggest difference between an HRA and a Health FSA is that an HRA is funded solely by the employer and not through salary reductions (as is the case with a Health FSA). In addition, any unused funds remaining in the HRA at the end of the plan year are able to roll over to following years, so the use-it-or-lose-it provision applicable to Health FSAs does not apply to HRAs.

However, an employer may elect that contributions to a HRA be forfeited at the end of the year should they so choose.

RELEVANT LINKS:

IRS; Health Reimbursement Arrangements: [Notice 2002-45](#).

Under the new Patient Protection and Affordable Care Act (PPACA), a new HRA may not be established for active employees unless it is integrated with a health plan (for example, it is used to offset the deductibles and coinsurance of the employer-sponsored health plan the participant has enrolled in). No further contributions may be made to an existing stand-alone HRA for active employees as of January 1, 2014, however, employees may be permitted to spend down any balances in an existing stand-alone HRA.

However, HRAs are still subject to the complex rules surrounding nondiscrimination requirements and COBRA, which cities must comply with if they decide to implement this plan option. The nondiscrimination requirements may be reviewed and tested within each of the separate collective bargaining units within the city (versus the entire employee population).

In June 2002, the IRS issued guidance confirming COBRA coverage applies to Health Reimbursement Arrangements (HRAs).

HRAs are authorized under IRC Section 105 and are considered group health plans for purposes of complying with a variety of federal benefit laws and regulations including COBRA.

Cities offering HRAs with a high-deductible health plan will need to carefully evaluate how the HRA is offered to employees and should consult with their benefit consultant on the applicable COBRA premiums to be charged. The basic issues to consider when evaluating COBRA coverage for the HRA include the following:

- Whether COBRA coverage for the HRA is separate from COBRA coverage for the high-deductible health plan. The answer depends on plan design and whether the city has bundled the HRA and deductible plan or whether they have taken the unbundled approach.
- The length of COBRA coverage. The COBRA period is the same for any other group health plan.
- Defining the COBRA coverage available for the HRA. The HRA must provide for the continuation of the maximum reimbursement amount available at the time of the qualifying event, which must be charged at the same time and by the same increment as for similarly situated, non-COBRA beneficiaries (and decreasing it for claims reimbursed).
- Who is a qualified beneficiary? The qualified beneficiary is the same under COBRA for the HRA as for other group health plans.
- What qualifying events trigger COBRA coverage? This is the same as other group health plans.

RELEVANT LINKS:

- Does the plan offer alternative coverage in lieu of COBRA? For example, does the plan provide spend-down access in lieu of COBRA? Note: There is no alternative in lieu of COBRA for former spouse or former dependent (they must elect COBRA and pay the appropriate premium amounts to continue to have access to the HRA).
- Determining the applicable premium for HRA COBRA coverage. COBRA regulations state that a group health plan may charge up to 102 percent of the premium (employer and employee cost) for similarly situated, non-COBRA participants. However, no guidance exists regarding how exactly to calculate the cost of COBRA.

Given the complexities in determining the COBRA coverage available for the HRA and the cost for continuing this coverage (especially relating to situations of divorce and loss of dependent child status events), cities are encouraged to seek assistance from their benefit consultants.

(1) Qualified Small Employer Health Reimbursement Arrangements

Effective January 1, 2017, if a city is a small employer (less than 50 employees and not subject to ACA coverage requirements) and does not offer a group health plan to any employees, then it can offer a pre-tax contribution for insurance premiums and health expenses to all eligible employees under a “Qualified Small Employer Health Reimbursement Arrangement” (QSEHRA). A QSEHRA is not a group health plan, nor subject to ACA coverage requirements, but is solely funded by the City as a method to reimburse employees for qualified medical expenses, including health insurance premiums, on a pre-tax basis. In addition to these eligibility requirements:

- Not be an Applicable Large Employer (“ALE”) under PPACA. This means that the employer must have fewer than 50 full-time and full-time equivalent employees in the preceding calendar year.
- Not offer group health coverage to any employee.

The small employer HRA must also meet the following criteria:

- Be funded solely by an eligible employer (employees may not be permitted to make salary reduction contributions, either directly or indirectly);
- Upon an eligible employee producing proof of coverage, the HRA must provide payment or reimbursement for the medical expenses (as defined in section 213(d) of the Internal Revenue Code) incurred by the eligible employee or the eligible employee’s family members (as determined under the terms of the arrangement);

RELEVANT LINKS:

LMC information memo,
[Continuation of Benefits](#).

LMC information memo,
[Continuation of Benefits](#).
Minn. Stat. § 62A.17.

- For 2018, the amount of payments and reimbursements for any year cannot exceed \$5,050 for self-only coverage (previously at \$4,950 for 2017) (\$10,250 (previously at \$10,000 for 2017) in the case of an arrangement that also provides for payments or reimbursements for family members of the employee); and
- The HRA must be provided on the same terms to all eligible employees of the employer.

B. State continuation requirements

In addition to COBRA, cities are subject to state continuation laws, as well as state laws regarding public sector retiree coverage, and police officers' and firefighters' health coverage. The application of state continuation to the city's benefit plan may differ in the following ways from COBRA:

- State continuation requirements only apply to group health plans, such as major medical and dental. State continuation requirements do not apply to other types of plans covered under COBRA (e.g., EAPs, Health FSAs, and HRAs).
- State continuation does not have a small employer exception. Cities with fewer than 20 employees will need to comply with state continuation even though they may be exempt from COBRA.

In addition, cities that are self-insured will also need to comply with state continuation requirements, as well as COBRA.

This is because cities are authorized under state laws to self-insure and are required to comply with state laws and regulations (private sector entities that self-insure do so under ERISA, which exempts these private sector entities from state regulations).

The League generally recommends cities first determine what obligations they might have under COBRA for offering continued coverage to an employee or covered dependent and then applying the appropriate state requirements (if any). Below is a summary of some of the additional differences between state continuation and COBRA.

1. Termination of employment or layoff

State continuation provides for 18 months continued coverage in the case of termination of employment or layoff. However, state continuation differs from COBRA in the following ways:

- Election by the employee (no independent election for the spouse or dependent children). COBRA allows each qualified beneficiary to independently elect continued coverage.

RELEVANT LINKS:

LMC information memo,
[Continuation of Benefits](#).

[Minn. Stat. § 62A.147.](#)
[Minn. Stat. § 62A.148.](#)

See Section VIII-C, *State retiree continuation*, for more information.

- Under state continuation, notification of continuation must occur within 10 days of termination of coverage. COBRA requires notification within 44 days from the loss of coverage if the employer and plan administrator are the same. If the employer and the plan administrator are different, then notice must be given within 14 days.
- Election must be made in 60 days from the later of 1) the date coverage would otherwise terminate, or 2) the date notice is received. COBRA requires an election period of at least 60 days from the later of 1) the date coverage would otherwise terminate, or 2) the date the notice is provided.
- State continuation requires monthly premium payments. COBRA allows for premiums to be made more or less frequently.
- State continuation does not provide a time frame for which the initial premium payment must be made. COBRA states that the qualified beneficiary pay the initial premium payment within 45 days from the date he/she elected COBRA.

2. Disability extension

Both COBRA and state requirements provide continuation of coverage for total disability. For purposes of state continuation, total disability means: 1) the inability of an injured or ill employee to engage in or perform the duties of the employee's regular occupation or employment within the first two years of such disability; and 2) after the first two years of such disability, the inability of the employee to engage in any paid employment or work for which the employee may, by education and training, including rehabilitative training, be or reasonably become qualified. Coverage may continue until the earlier of 1) the individual is no longer disabled or 2) the date coverage would otherwise end (e.g., eligible for Medicare). However, keep in mind that public sector entities are also subject to state retiree continuation, so a city dealing with an employee that is disabled may need to offer continuation of coverage essentially indefinitely—including beyond the age of 65. Due to the complexity of coordinating the various continuation requirements for disability, the League suggests the city contact us or an attorney for more information if faced with this issue.

State continuation for total disability does not require that the employee elect continuation of coverage, so coverage automatically continues. If an employee has a spouse or dependent children covered under the plan, then they essentially tag along on the employee's coverage (there is no independent right to elect continuation for the spouse and dependent children).

RELEVANT LINKS:

LMC information memo,
[Continuation of Benefits](#).

[Minn. Stat. § 62A.21](#).

LMC information memo,
[Continuation of Benefits](#).

While COBRA allows for employers to charge 150 percent of the premium for qualified beneficiaries that are disabled, state requirements do not allow for the city to charge more than 100 percent of the total premium.

If the disabled individual is no longer employed by the city, then the city may begin charging 102 percent of the premium once the individual is no longer disabled. Keep in mind that the city may have an obligation to continue paying its share of the premiums if the disabled individual is a police officer or firefighter injured in the line of duty.

3. Divorce or legal separation

State continuation law prohibits the involuntary termination of group health coverage of a former spouse and dependents merely because of a break in marital relationship. Minnesota law allows a spouse and/or dependent child to continue coverage indefinitely until either of the following:

- The date the former spouse becomes covered under another group health plan.
- The date coverage would otherwise end under the plan.

The Department of Health and the Department of Commerce have stated that the total premium charged for continuation of coverage couldn't be more than the premium charged for coverage prior to the divorce. This may result in no additional cost to the former spouse.

In other words, the total received by the carrier for the family unit does not change if there is a divorce. For instance:

- Example 1. Assume the city only offers single or family coverage. An employee elects family coverage and enrolls his/her spouse and dependent children. The employee and spouse divorce, and the employee continues to provide coverage for themselves and their dependent children. The former spouse would continue coverage at no additional cost because the employee-maintained family coverage.
- Example 2. Assume the city offers single, single plus children, and family coverage. Same scenario as above—employee elects family coverage, the employee and spouse divorce, and the employee drops down to single plus children. The former spouse would be charged no more than 102 percent of the difference between the family premium amount and the premium amount for single plus children.

RELEVANT LINKS:

[Minn. Stat. § 62A.146.](#)

LMC information memo,
[Continuation of Benefits.](#)

[Minn. Stat. § 62A.20.](#)

LMC information memo,
[Continuation of Benefits.](#)

U.S. Dep't of Labor: [FAQ's about COBRA Continuation Health Coverage.](#)

4. Death of an employee

If coverage for a covered employee's spouse and/or dependent child ends due to the employee's death, coverage must be continued until the earlier of either of the following:

- The date the spouse is covered under another group health plan.
- The date the coverage would have ended under the plan had the employee lived (e.g., dependent child no longer meets the definition of an eligible dependent under the plan—note that an additional COBRA continuation period could come into play as a result of the loss of dependent child status).

There is no requirement under state continuation for the individual to elect continuation of coverage; therefore, it is probably a good idea for the city to get written notice from the spouse that they do not wish to continue before terminating coverage. For those individuals that do elect to continue coverage, the city cannot charge more than 102 percent of the premium. Premium must be made within 90 days from written verification of the cost to continue coverage. However, written notice of cancellation of coverage must be mailed to the survivor's last known address at least 30 days prior to cancellation of coverage.

Minnesota law also includes special continuation rights for the surviving spouse and children of a police officer or firefighter killed in the line of duty.

5. Loss of dependent child status/employee entitled to Medicare

Continuation coverage must be offered to a dependent child if they lose coverage because they are no longer an eligible dependent under the plan.

In addition, a spouse and dependent child have continuation rights if they were to lose coverage due to the employee becoming entitled to Medicare. Coverage in both cases must continue until the earliest of any of the following:

- 36 months.
- The date the individual becomes covered under another group health plan.
- The date coverage would otherwise end under the plan.

Those that elect to continue coverage cannot be charged more than 102 percent of the premium.

RELEVANT LINKS:

[Minn. Stat. § 62A.20.](#)

LMC information memo,
[Continuation of Benefits.](#)

[Minn. Stat. § 471.61, subd. 2b.](#)

LMC information memo,
[Continuation of Benefits.](#)

[Minn. Stat. § 471.61.](#)

LMC information memo,
[Continuation of Benefits.](#)

[Minn. Stat. § 299A.465.](#)

6. Life insurance coverage

Minnesota continuation law allows employees terminating employment for any reason, and their covered dependents, to continue life insurance coverage for a period of up to 18 months from their termination date. The city must offer a conversion option at the end of the continuation period.

C. State retiree continuation

An employee retiring from the city, along with covered spouses and/or dependent children, may continue coverage under COBRA for up to 18 months. However, state law allows retirees to continue coverage on a city's group health and/or dental plan indefinitely as long as they are either of the following:

- Receiving disability benefits or a retirement annuity from a Minnesota public pension plan (such as PERA) other than a volunteer firefighter plan.
- Have met the age and service requirement necessary to receive an annuity from a public pension plan but have opted not to draw upon the funds at the time they retire.

Employees who retire before age 65 must be allowed to stay in the group benefit plan at the same rate as active employees until age 65. At age 65, retirees may be offered a different plan sponsored by the city and at a different premium rate. Retirees 65 and older must still be offered an option to continue on some city-sponsored benefit plan, but they do not have to be offered the same benefit plan as active employees and early retirees. Because state law is silent regarding whether an administrative fee may be charged in addition to the premium to the early retiree, some cities have interpreted this to mean that, in general, a city has no authority to charge such a fee.

Thus, many cities choose not to charge a 2 percent administrative fee for pre-65 retiree health and/or dental insurance premiums. This requirement, however, only applies until the early retiree reaches age 65.

D. Police officers and firefighters

Minnesota law provides continued health insurance coverage for peace officers and firefighters disabled or killed in the line of duty and for dependents meeting the eligibility criteria.

The city is responsible for continued payment of the city's contribution for coverage (and, if applicable, covered dependents) when the peace officer or firefighter suffers a disabling injury that:

RELEVANT LINKS:

MN Dep't of Public Safety:
[Public Safety Officer Benefit Programs](#).

MN Dep't of Public Safety:
[Public Safety Officer Benefit Programs](#). See Forms links on right side of page.

- Results in the officer's or firefighter's retirement or separation from service.
- Occurs while the officer or firefighter is acting in the course and scope of duties as a peace officer or firefighter.
- Results in PERA approval to receive his or her duty-related disability pension.

Coverage must continue for the officer and firefighter (and, if applicable, the officer's or firefighter's dependents) until the officer or firefighter reaches the age of 65. Cities can apply for partial reimbursement of the employer's share of health care costs through the Public Safety Officer Benefits Program. Appropriate forms can be found at the Minnesota Department of Public Safety website.

The League's policy position is that this benefit was intended to be used in a very limited fashion; i.e., for officers and firefighters who are injured while performing hazardous duties—duties which can be more dangerous than the duties performed by most other city employees.

While the state originally provided reimbursement to cities for their portion of the contribution that the city must continue to pay, the number of eligible claims has increased substantially since the law was passed. In many years, the number of claims has exceeded the available funding and thereby has passed a majority of the cost of providing these benefits to cities.

Issues to consider:

- Cities must continue benefits to retirees, including disability retirees, under state law regardless of whether Minn. Stat. ch. 299A is applicable.
- Cities should consult an attorney on any applications they believe are not in line with the intent of the law.
- Assist PERA by providing as much information as appropriate about the employee's disability pension application.
- Ensure the employee has met all of the requirements outlined in the law.

E. Action plan for cities

Following are some guidelines that may help minimize the city's liability when administering continuation coverage:

- Communicate directly with spouses and dependents regarding their
- Continuation rights.

RELEVANT LINKS:

- Communicate to employees what situations require notification to the city, such as marriage, birth or adoption of a child, divorce or legal separation, dependent child no longer eligible under the plan, Medicare entitlement, and disability determination.
- Give proper notice and provide correct payment periods, including allowing the complete grace period in which to pay the premium.
- Document policies and procedures and administrative action—especially mailing of notices.
- Ensure that all notices are up to date with current legislative and regulatory requirements by reviewing them with legal counsel.
- Audit all COBRA procedures and policies on an annual basis.
- Be sure that all COBRA procedures and policies coordinate fully with other Human Resource policies such as FMLA, disability, and retirement.
- When not sure how to handle a particular situation, be sure to contact the League of Minnesota Cities and/or your city attorney.