This Webinar Will Start Momentarily.

Thank you for joining us.

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May 27, 2021

Basic Benefit Compliance for Public Employers

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Federal Law

ERISA COVERAGE

ERISA does not apply to **governmental plans**.

Under ERISA:

> "The term "governmental plan" means a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing."

Agency or instrumentality portion of definition difficult to apply.

The Internal Revenue Code contains a very similar definition. The IRS is working on regulations that, if finalized, will make it easier to apply the definition. The IRS regulations might be adopted by the DOL for ERISA purposes as well.

ERISA Coverage

Examples:

- Plans maintained by counties, municipalities, and public school districts
- Quasi-governmental entities (e.g., non-profit organizations organized under state law to perform government function)
  - Facts and circumstances test

Note: Nongovernmental employer's participation in governmental plan likely triggers ERISA unless participation is minimal

Tribal plans:

Definition of governmental plan includes a plan which is established and maintained by an Indian tribal government, a subdivision of an Indian tribal government, or an agency or instrumentality of either.

- Applies only if all the participants are employees of the entity and substantially all the employees services are in the performance of essential governmental functions but not in the performance of commercial activities

Church plans are also exempt from ERISA.

Tribal plans and church plans are not the focus of today's presentation.

ERISA Coverage

Examples of rules contained only in ERISA that do not apply to governmental plans:

- No plan document requirement
  - However, Internal Revenue Code may require one
- No SPD requirement
- No Form 5500 requirement
- No Qualified Medical Child Support Orders (QMCSOs)
  - However, must comply with National Medical Support Notices (NMSNs)

Caution:

Similar obligations may apply under other laws

ERISA Coverage

Examples of rules contained only in ERISA that do not apply to governmental plans:

- No claims and appeal requirements
  - However, PHSA includes rules for medical plans
- No general preemption of state law
  - Other federal laws may preempt state law (e.g., HIPAA)
- No ERISA fiduciary duties or prohibited transactions
  - Internal Revenue Code prohibited transaction rules also do not apply
  - However, state or common law duties may apply

Caution:

Similar obligations may apply under other laws

Public Health Services Act

Public Health Services Act

Public Health Services Act (PHSA) provisions generally apply to group health plans that are nonfederal governmental plans

In some cases (noted below), government employer can opt out

- Specific procedures must be followed to opt out
- Submitted electronically to CMS
- If employer sponsors multiple plans, typically separate elections for each plan are required
- Election must be made before start of plan year and is valid only for one year
- Notice that election has been made must be provided to enrollees
- Special rules apply to plans that are collectively bargained

Public Health Services Act

What does the PHSA include?

COBRA

- Federal continuation coverage requirements for group health plans
- No opt out available, but inapplicable to employers who employ less than 20 employees

HIPAA portability

- Special enrollment and nondiscrimination provisions (pre-existing condition rules no longer applicable)
- Opt out no longer available; eliminated by ACA

Mental Health Parity and Addiction Equity Act

- If plan provides benefits for mental health and substance abuse, benefits must essentially be available on an equal basis as medical and surgical benefits
- Opt out available to large employers (with at least 50 employees)
- Inapplicable to employers who employ fewer than 50 employees

Public Health Services Act

What does the PHSA include?

Affordable Care Act

- No opt out available; but grandfathered plans exempt from ***some*** requirements
- Coverage for children under age 26
- Preventive care mandate
- Prohibition of annual and lifetime limits on essential health benefits
- Prohibition of pre-existing condition limitations
- Limit on out-of-pocket maximums
- Prohibition on excessive waiting periods
- SBC requirements
- Section 1557 nondiscrimination requirements, which apply to any "health program or activity," any part of which is receiving federal financial assistance
- Transparency requirements (final regulations issued in Oct. 2020) regarding cost-sharing and pricing

Public Health Services Act

What does the PHSA include?

Affordable Care Act

Claims and Appeals Process – Group Health Plans

- Minimum internal claims and appeals standards
- Full and fair review rules – plan or issuer must:
  - Provide claimant, free of charge, with evidence used to make benefit determinations
  - Give claimant an opportunity to respond and present new evidence
  - Notify claimant of plan's benefit determination in a timely manner
- External Review
  - Non-grandfathered plans must follow PHSA mandates for independent review upon exhaustion of internal review process
  - State standards generally apply to both fully-insured and self-insured plans
  - Except when there is no state external review process by statute, or state standards do not follow PHSA requirements
- Avoid conflicts of interest – ensure impartiality and independence of the person making coverage decision
- Provide notice to claimant of benefit determinations
  - Notice must include:
    - specific information about the claim,
    - the reasons for the benefit determination, and
    - any available internal appeals and external review processes
  - Culturally and linguistically appropriate

Public Health Services Act

What does the PHSA include?

Women's Health and Cancer Rights Act (WHCRA)

- Requires coverage for reconstructive surgery after a mastectomy
- Opt out available

Transparency and surprise billing requirements

- Added by Consolidated Appropriations Act 2021
- No opt out available

Newborns' and Mothers' Health Protection Act (NMHPA)

- Requires coverage for minimum hospital stays following birth
- Opt out available

Genetic Information Nondiscrimination Act (GINA)

- Prohibits group health plans adjusting group premium or contribution amounts based on genetic information; requesting or requiring an individual or an individual's family members to undergo genetic testing; or requesting, requiring, or purchasing genetic information for underwriting purposes
- No opt out available

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Medicare Secondary Payer

Medicare Secondary Payer Rule

Medicare is primary when:

- Employer has < 20 employees and employees are covered by Medicare and group health plan
- Individual is ≥ age 65, covered by Retiree medical plan
- Individual is ≥ age 65, covered by Medicare and COBRA coverage
- Individual on Medicare has End Stage Renal Disease, after 30 months of Medicare entitlement
- Disabled individual has Medicare and employer has <100 employees

Medicare Secondary Payer Rule

- Group health plans are prohibited from “taking into account” Medicare entitlement of an employee “in current employment status” or family member
- Applies to individuals and their dependents “in active employment status” with the employer
- Also applies to individuals not actively at work if they…
  - Are receiving disability benefits from an employer for up to six months, or
  - Retain employment rights in the industry, have not been terminated, are not receiving disability benefits from the employer or social security for more than six months, and have group health coverage (not COBRA)

Coordination with Group Health Plans

- **Age:** 20 or more employees each working day for at least 20 weeks in either the current or prior calendar year

- **Disability:** 100 or more employees on 50% or more business days in previous calendar year
  - Social Security Administration definition of disability
  - Receiving SS benefits for 24 months

- **ESRD:** Group health coverage is primary for first 30 months of entitlement (active or COBRA coverage)

If you	Situation	Pays first	Pays second
Are 65 or older, are covered by a group health plan because you or your spouse is still working, entitled to Medicare	The employer has 20 or more employees (see page 12 for information about multi-employer and multiple employer group health plans) OR	Group health plan	Medicare
	The employer has less than 20 employees	Medicare	Group health plan
Have an employer group health plan through your former employer after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree coverage
Are disabled and covered by a large group health plan from your work, or from a family member (like spouse, domestic partner, son, daughter, or grandchild) who is working, entitled to Medicare	The employer has 100 or more employees	Large group health plan	Medicare
	The employer has less than 100 employees (see page 12 for information about multi-employer and multiple employer group health plans)	Medicare	Group health plan

Medicare Secondary Payer Rule – Prohibited Actions

Primary plans may not:

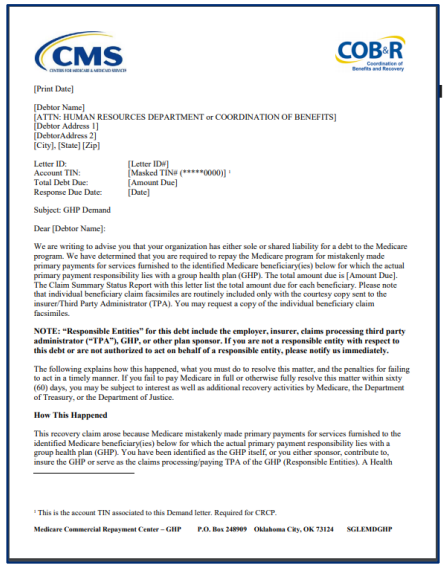
- Fail to pay primary benefits;
- Offer secondary coverage;
- Terminate coverage because the individual has become entitled to Medicare, except as permitted under COBRA;
- Deny or cancel coverage because an individual is entitled to Medicare on the basis of disability without denying or terminating coverage for similarly situated individuals who are not entitled to Medicare on the basis of disability;
- Impose limitations on benefits that don't apply to others enrolled in the plan;
- Charge higher premiums;
- Require a longer eligibility waiting period;
- Pay providers and suppliers less for services plans pay providers for services to an enrollee who is not entitled to Medicare;
- Provide misleading or incomplete information that would have the effect of inducing a Medicare-entitled individual to reject the employer plan, making Medicare the primary payer;
- Induce Medicare-eligible employees or dependents to waive the group health plan in favor of Medicare;
- Include in its health insurance cards, claims forms, or brochures distributed to beneficiaries, providers, and suppliers instructions to bill Medicare first for services furnished to Medicare beneficiaries without stipulating that such an action may be taken only when Medicare is the primary payer; or
- Refuse to enroll an individual, when enrollment is available to similarly situated individuals for whom Medicare would not be the secondary payer.

Medicare Secondary Payer Reporting

- Purposes:
  - Identify Medicare beneficiaries who are covered by a primary group health plan,
  - Determine whether Medicare paid any claims that should have been paid first by the primary group health plan, and
  - Collect any overpayments from health plan

- Overpayments occur when Medicare makes “conditional” primary payments at time of claim

- Reporting Options:
  - “Data Match” response file reporting
  - Proactive Voluntary Data Sharing Agreement (VDSA)



CMS

COB&R Coordination of Benefits and Recovery

[Print Date]

[Debtor Name]
[ATTN: HUMAN RESOURCES DEPARTMENT or COORDINATION OF BENEFITS]
[Debtor Address 1]
[DebtorAddress 2]
[City], [State] [Zip]

Letter ID: [Letter ID#]
Account TIN: [Masked TIN# (*****0000)] [1]
Total Debt Due: [Amount Due]
Response Due Date: [Date]

Subject: GHP Demand

Dear [Debtor Name]:

We are writing to advise you that your organization has either sole or shared liability for a debt to the Medicare program. We have determined that you are required to repay the Medicare program for mistakenly made primary payments for services furnished to the identified Medicare beneficiary(ies) below for which the actual primary payment responsibility lies with a group health plan (GHP). The total amount due is [Amount Due]. The Claim Summary Status Report with this letter list the total amount due for each beneficiary. Please note that individual beneficiary claim facsimiles are routinely included only with the courtesy copy sent to the insurer/Third Party Administrator (TPA). You may request a copy of the individual beneficiary claim facsimiles.

NOTE: “Responsible Entities” for this debt include the employer, insurer, claims processing third party administrator (“TPA”), GHP, or other plan sponsor. If you are not a responsible entity with respect to this debt or are not authorized to act on behalf of a responsible entity, please notify us immediately.

The following explains how this happened, what you must do to resolve this matter, and the penalties for failing to act in a timely manner. If you fail to pay Medicare in full or otherwise fully resolve this matter within sixty (60) days, you may be subject to interest as well as additional recovery activities by Medicare, the Department of Treasury, or the Department of Justice.

How This Happened

This recovery claim arose because Medicare mistakenly made primary payments for services furnished to the identified Medicare beneficiary(ies) below for which the actual primary payment responsibility lies with a group health plan (GHP). You have been identified as the GHP itself, or you either sponsor, contribute to, insure the GHP or serve as the claims processing/paying TPA of the GHP (Responsible Entities). A Health

[1] This is the account TIN associated to this Demand letter. Required for CRCP.

Medicare Commercial Repayment Center – GHP P.O. Box 248909 Oklahoma City, OK 73124 SGLEMDGHP

- Three-Part Process:
  - Quarterly reporting of covered members by GHP (generally completed by insurer/TPA)
  - Response file (letter from CMS)
    - Plan sponsors (employers) must complete questionnaires when letter is received from CMS Benefits Coordination Recovery unit
  - Collection and Recovery of Overpayments (if it is determined health claims were processed incorrectly by primary health plan)

Enforcement
- Must respond within 30 days or penalties may accrue
  - Civil Penalty up to $1,000/day of noncompliance per beneficiary
  - If legal action required, up to 2X the amount of the overpayment

Internal Revenue Code And HIPAA

Internal Revenue Code

Requirements contained in the IRC that apply to governmental plans:

- Cafeteria plan requirements (Section 125)
- Written plan document requirement for self-insured medical reimbursement plan (Section 105)
  - Best practices regarding plan documents in absence of requirement
- Employer mandate (Section 4980H)
- Nondiscrimination requirements
  - Examples: Section 125 (cafeteria plans), Section 105(h) (self-insured health plans); Section 129 (DCAPs)
  - Exceptions: Section 125 key employee concentration test and GTL testing because governmental employers do not have key employees

HIPAA Privacy and Security

HIPAA privacy and security requirements

1

Apply to covered entities, which include group health plans sponsored by governmental entities

2

Require covered entities to protect the privacy and security of protected health information (PHI) created, received, maintained, or transmitted by covered entity

3

For fully insured plans, insurance carrier responsible for most compliance obligations if employer's plan is "hands-off"

Federal Law:
Notice and Reporting

Federal Notice/Disclosure Requirements

- No ERISA SPD requirement
  - Best practices in absence of specific statutory requirement
    - Need to communicate eligibility
      - Eligibility terms also important for stop loss coverage
    - Hard to enforce the terms of the plan if some form of plan document is not distributed
    - Look out for contradictory terms in different employee communications
      - Employment offer letter vs. the employee handbook
  - These issues will generally be litigated in state court

Federal Notice/Disclosure Requirements

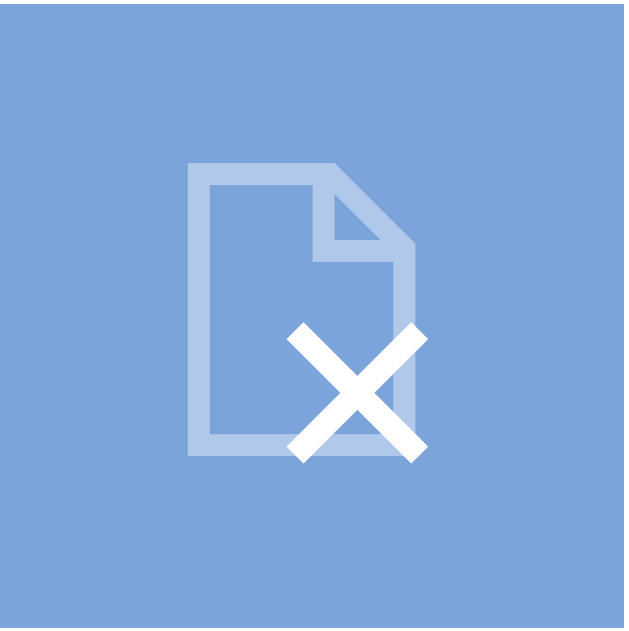
- Notices required by particular laws (e.g., COBRA, HIPAA, etc.)
  - Requirements generally apply to governmental plans
  - Distribution requirements may differ (because ERISA electronic distribution rules do not apply)
    - e.g., HHS regulations have special electronic distribution rules for distribution of SBCs
- No right under Federal law to request and obtain copies of plan documentation
- Internal Revenue Code may impose notice requirements
  - e.g., Section 129 requires employers to provide reasonable notification of the availability and terms of a DCAP to eligible employees

Federal Reporting Requirements

- No Form 5500 filing requirement
- Forms 1094/1095 required
  - Apply to coverage providers (employers that sponsor self-insured plans that constitute minimum essential coverage) and applicable large employers
- W-2 reporting of cost of employer-provided health applies
- General tax reporting of certain applies
  - e.g., W-2 reporting of DCAP benefits and HSA contributions
- PCORI fees apply (Form 720)

Enforcement of PHSA Mandates

Enforcement Under Federal Law



- No ERISA civil penalties for violations
- No excise taxes under Internal Revenue Code (Sections 4980B and 4980D)
- PHSA remedies
  - Daily penalties for certain violations under Section 2723
    - $100 for each day for each individual with respect to which such a failure occurs
    - Subject to certain limitations and exceptions
  - Participant lawsuits
  - No penalties for COBRA violations

State Law Requirements

State Law Requirements

Generally, no preemption of state law by federal law

- Governmental plans typically must comply with applicable federal law and applicable state law

Political subdivisions (counties, municipalities, school districts, etc.) typically need specific statutory authority to act

- State law will govern what benefits a political subdivision can offer, to whom, and what form
- See examples in next slide

Laws governing fully-insured plans

- Generally, apply to insurance policy but in some cases apply to employer's purchasing insurance policies
- e.g., Minnesota insurance continuation laws impose notice requirements on employer

Examples – Authority to Provide Benefits

	Connecticut	Minnesota
Statutory Authority to Provide Benefits	(a) Any town, city or borough may, through its authorized officials, provide such form or forms of group life, health and accident and hospital plan benefits for its employees as it deems advisable. Any town, city or borough that provides health and accident and hospital plan benefits for its employees may arrange and procure the same benefits for each active member of a volunteer fire company or department or volunteer ambulance service or company within such town, city or borough, provided the member (1) elects coverage under such plan or plans, (2) pays one hundred per cent of the premium charged and any additional costs for such coverage, and (3) meets the requirements for active status set forth by said town, city or borough. . . . (c) A self-insured town, city or borough that provides group health benefits for its employees has a lien on that part of a judgment or settlement that represents payment for economic loss for medical, hospital and prescription expenses incurred by its employees and their covered dependents and family members when such expenses result from the negligence or recklessness of a third party. The self-insured town, city or borough may recover such paid health benefits from any tortfeasor recovery but only upon the following terms and conditions . . . *(Conn. Gen. Stat. Sec. 7-464)*	Subdivision 1.Officers, employees. A county, municipal corporation, town, school district, county extension committee, other political subdivision or other body corporate and politic of this state, other than the state or any department of the state, through its governing body, and any two or more subdivisions acting jointly through their governing bodies, may insure or protect its or their officers and employees, and their dependents, or any class or classes of officers, employees, or dependents, under a policy or policies or contract or contracts of group insurance or benefits covering life, health, and accident, in the case of employees, and medical and surgical benefits and hospitalization insurance or benefits for both employees and dependents or dependents of an employee whose death was due to causes arising out of and in the course of employment, or any one or more of those forms of insurance or protection. . . . Subd. 1a.Dependents.Notwithstanding the provisions of Minnesota Statutes 1969, section 471.61, as amended by Laws 1971, chapter 451, section 1, the word "dependents" as used therein shall mean spouse and children under the age of 26 years. *(Minn. Stat. Sec. 471.61)*

State Law Requirements

Laws governing self-insured plans

- May be authorized only in certain cases
- Registration/filing requirements in some states
- Benefit mandates
- Stop loss mandates
- See examples on next slides

Wage deduction laws

- Most states prohibit taking deductions from wages (e.g., for plan contributions) without affirmative consent
- See examples on next slides

State continuation laws

- Insurance continuation requirements might apply to self-insured plans (e.g., Minnesota)
- Special continuation rules (e.g., retiree continuation, etc.)
- See examples on next slides

Examples – Laws Governing Self-Insured Plans

	Minnesota
Authority to Offer; Compliance with Insurance Laws; Stop Loss	*Subdivision 1.If more than 100 employees; conditions. A statutory or home rule charter city, county, school district, or instrumentality thereof which has more than 100 employees, may by ordinance or resolution self-insure for any employee health benefits including long-term disability, but not for employee life benefits. Any self-insurance plan shall provide all benefits which are required by law to be provided by group health insurance policies. Self-insurance plans must be certified as provided by section 62E.05 and must be filed and certified by the Department of Commerce before they are issued or delivered to any person in this state.* *…* *Subd. 3.Stop-loss coverage. Any self-insurance plan covering fewer than 1,000 employees shall include excess or stop-loss coverage provided by a licensed insurance company, an insurance company approved pursuant to sections 60A.195 to 60A.209, or service plan corporation, but excess or stop-loss coverage need not be obtained for long-term disability.* *(Minn. Stat.* § 471.617*)*

Examples – Laws Governing Self-Insured Plans

Benefit Mandate	California	Colorado
Health Coverage for Registered Domestic Partners/Civil Union Partners	Group hospital, medical or surgical plans must "provide equal coverage" for registered domestic partners to coverage provided to spouses. Discrimination against same-sex spouses and domestic partners is prohibited. *(CA Health and Safety Code, § 1374.58)*	Civil union partners have the same rights, responsibilities and protections as legal spouses under the state law *(CO Stat. Ann., § 14-15-107)*

Examples – Laws Governing Self-Insured Plans

Benefit Mandate	Illinois	South Dakota
Dependent Age Definition	Children remain eligible for coverage until their 26th birthday. Former military personnel residing in IL who served as an active or reserve member of the US armed forces may remain on parent's insurance following discharge, until age 30. *(215 ILCS 5/356z.12)*	Dependents are eligible for health coverage to age 26. Coverage may not be terminated if dependent is unable to seek self-support due to disability. Full-time students age 26-29 may continue health coverage at insured's option. *(SD Codified Laws § 58-17-2.3)*

Examples – Wage Deduction Laws

Wage Deduction Laws	Minnesota
	Subd. 2.Payroll deductions. A written contract may be entered into between an employer and an employee wherein the employee authorizes the employer to make payroll deductions for the purpose of paying union dues, premiums of any life insurance, hospitalization and surgical insurance, group accident and health insurance, group term life insurance, ... *(Minn. Stat. § 181.06)*

Examples – State Continuation Laws

State Insurance Continuation Laws	Minnesota
Health coverage continuation – Divorce or Legal Separation	Former spouse remains eligible for coverage on the same basis as current spouse, until the earliest of the date: (a) the insured's former spouse becomes covered under any other group health plan, or (b) coverage would otherwise terminate *(Minn. Stat. § 62A.21)*

Examples – State Continuation Laws

Special Continuation	Florida	Minnesota
Retiree	Any state agency, county, municipality, special district, community college, or district school board that provides life, health, accident, hospitalization, or annuity insurance, or all of any kinds of such insurance, for its officers and employees and their dependents upon a group insurance plan or self-insurance plan shall allow all former personnel who retired before October 1, 1987, as well as those who retire on or after such date, and their eligible dependents, the option of continuing to participate in the group insurance plan or self-insurance plan. Retirees and their eligible dependents shall be offered the same health and hospitalization insurance coverage as is offered to active employees at a premium cost of no more than the premium cost applicable to active employees. For retired employees and their eligible dependents, the cost of continued participation may be paid by the employer or by the retired employees. To determine health and hospitalization plan costs, the employer shall commingle the claims experience of the retiree group with the claims experience of the active employees; and, for other types of coverage, the employer may commingle the claims experience of the retiree group with the claims experience of active employees. Retirees covered under Medicare may be experience-rated separately from the retirees not covered by Medicare and from active employees if the total premium does not exceed that of the active group and coverage is basically the same as for the active group.. *(Flor. Stat. § 112.0801(1))*	Insurance continuation. A unit of local government must allow a former employee and the employee's dependents to continue to participate indefinitely in the employer-sponsored hospital, medical, and dental insurance group that the employee participated in immediately before retirement, under the following conditions: (a) The continuation requirement of this subdivision applies only to a former employee who is receiving a disability benefit or an annuity from a Minnesota public pension plan other than a volunteer firefighter plan, or who has met age and service requirements necessary to receive an annuity from such a plan. (b) Until the former employee reaches age 65, the former employee and dependents must be pooled in the same group as active employees for purposes of establishing premiums and coverage for hospital, medical, and dental insurance. However, a former employee under the age of 65 who is enrolled in Medicare Parts A and B due to the former employee's disability and for whom Medicare's obligation to pay claims is primary, and the former employee's dependents, must be pooled in the same group for purposes of this paragraph as former employees who have reached age 65. . . . *(Minn. Stat. § 471.61, subd. 2b)*

State Law Requirements

Statutory or common law fiduciary duties

- Compliance with ERISA fiduciary duties may be a best practice

Cafeteria plan laws

- State laws requiring employers to establish cafeteria plans
- State laws governing FSAs
  - e.g., California law regarding notices about FSA balances
- See examples on next slides

State notice and reporting requirements

- See examples on next slides

State collective bargaining laws

- Many states have labor relation laws to protect union employees
- May require negotiation of terms and conditions of employment, which generally includes benefits
- See examples on next slides

Examples – State Cafeteria Plan Requirements

State Cafeteria Plan Requirements	Missouri
	An employer that provides health insurance coverage for which any portion of the premium is payable by the employer shall not provide such coverage unless the employer has established a premium-only cafeteria plan as permitted under federal law, 26 U.S.C. Section 125. The provisions of this subsection shall not apply to employers who offer health insurance through any self-insured or self-funded group health benefit plan of any type or description. *(RSMo § 376.453)*

Examples – State Reporting Requirements

State Reporting Requirements	Minnesota
Self-Insured Pools	*Subpart 1. Financial statements. A pool must prepare annual financial statements containing a balance sheet; a statement of revenues, expenses, and surplus; a statement of changes in financial position; and a schedule of investments. The statements must be prepared on forms and according to instructions prescribed by the commissioner. The financial statements must be filed with the commissioner no later than March 1 of each year, or if the pool's fund year is other than the calendar year, no later than 60 days after the end of the pool's fund year. The financial statements must be audited by an independent certified public accountant, and the auditor's report must be submitted no later than 180 days after the end of the pool's fund year. For employee health benefit pools, the first annual financial statement and every second annual financial statement thereafter must be accompanied by a statement from a qualified actuary concerning the balance sheet items that are based on actuarial assumptions and methods. The form of the actuary's statement and the scope of the actuarial review must be according to instructions prescribed by the commissioner.* *(Minn. Rule § 2785.1600)*

Examples – State Collective Bargaining Requirements

State Collective Bargaining Requirements	Minnesota
Fully Insured	*Subd. 5.Collective bargaining. The aggregate value of benefits provided by a group insurance contract for employees covered by a collective agreement shall not be reduced, unless the public employer and exclusive representative of the employees of an appropriate bargaining unit, certified under section 179A.12, agree to a reduction in benefits.* *(Minn. Stat. § 471.6161)*
Self-Insured	*Subd. 4.Exclusive representative. (a) No statutory or home rule charter city or county or school district or instrumentality of any of them shall adopt a self insured health benefit plan for any employees represented by an exclusive representative certified pursuant to section 179A.12 without prior notification and consultation on ten days' written notice to the exclusive representative and agreement by the exclusive representative that represents the largest number of employees to be included in the plan.* *(b) Prior to a decision to dissolve any self-insurance, trust fund, or dedicated insurance fund created by a single statutory or home rule charter city, county, school district, or instrumentality of any of them, either by ordinance or resolution, the employer must provide 30 days' written notice to each exclusive representative of employees and each individual currently receiving health benefits, and also obtain approval for the proposed action by the exclusive representative that represents the largest number of employees included in the plan. All assets from the trust fund must be audited before closure, and remaining assets must be dedicated for use for health insurance benefits for all individuals currently receiving health benefits. This paragraph does not apply to joint self-insurance trusts or pools.* *(Minn. Stat. § 471.617)*

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- This Program, ID No. _____, has been approved for 1.00 HR (General) recertification credit hours toward aPHR™, aPHRi™, PHR®, PHRca®, SPHR®, GPHR®, PHRi™, and SPHRi™ recertification through HR Certification Institute® (HRCI®).

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May 27, 2021

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