FOCUS
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USERRA Compliance

USERRA stands for the *Uniformed Services Employment and Reemployment Rights Act of 1994*. It provides various protections to individuals who leave their jobs to serve in the military — including those called up from the reserves or National Guard. Virtually all employers, public and private, and regardless of size, are subject to USERRA.

The Department of Labor (DOL) recently published final USERRA regulations which began January 18, 2006. The first compliance step directs employers to post a new notice as described below.

Posting Requirement

On or before January 18, 2006, employers should place the updated USERRA poster where other employee notices are posted. Alternatively, employers may hand-deliver or mail the notices.

The DOL has issued two versions of the poster — one for private and state employees, and one for federal agencies. The new notices are available online through the Department of Labor at:

- http://www.dol.gov/vets/programs/userra/USERRA_Private.pdf (private/state employers), and
- http://www.dol.gov/vets/programs/userra/USERRA_federal.pdf#federal (federal employers).

Employee Benefits Requirements

In the category of continuing benefits, the regulations explain USERRA requires employers to:

- Allow a COBRA-like opportunity to continue health coverage for up to 24

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months during military leave (only 18 months is required for those who elected USERRA continuation before December 10, 2004); and

- Allow those on leave for military service to continue non-seniority benefits other than health plan coverage (e.g., accrual of vacation pay, life insurance, and disability coverage) on the same basis as other employees on comparable leaves with benefits continuation.

The regulations cover a variety of other employee benefits issues. Here are some highlights.

- Cafeteria Plans. The final regulations confirm that health care flexible spending account (FSA) plans provided through cafeteria plans are considered health plans under USERRA. As a result, employees on military leave must be allowed to continue health FSA participation for up to 24 months. The COBRA rule that allows termination of COBRA coverage under certain health FSAs at the end of the plan year in which the qualifying event occurs does not apply to USERRA continuation rights.

- Health Benefits When Reemployed. USERRA requires that employers negotiate with third-party health insurers to provide health coverage. An employer remains liable for violating USERRA even if the violation is caused by an insurer's refusal to reinstate coverage. All employers should take care to have that provision included in their contracts.

- Make-Up Contributions to Pension Plans. An employer generally is required to make contributions to a defined contribution plan for an employee returning from military leave in the same amount and manner as it made contributions on behalf of other employees during the military leave. No make-up contributions are required unless the employee is actually reemployed. In the case of plans that do not require or allow participant contributions, the employer must make required contributions no later than the date they are normally due for the year in which the military service was performed or, if later, 90 days after the date of reemployment. If employer contributions to a plan are contingent on employee contributions and the employee funds the make-up contributions as permitted under USERRA, the employer's matching contributions must be made according to the plan's terms for such contributions.

- Repayment of Plan Distributions. Only defined benefit plans may require an employee to repay amounts distributed from the plan in connection with a period of uniformed service upon reemployment with the same employer.

Other Provisions

The regulations also interpret USERRA's anti-discrimination and anti-retaliation provisions, explain the requirements that an individual must meet in order to have reemployment rights under USERRA, and describe the role of the DOL in enforcing USERRA. The regulations provide a number of helpful details and they are well worth reading.

The regulations are available at http://edocket.access.gpo.gov/2005/pdf/05-23961.pdf.

Reporting Creditable Coverage Status

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* required *all* plan sponsors to distribute creditable coverage notices to Part D eligible individuals by November 15, 2005. The Centers for Medicare and Medicaid Services (CMS) also had to be notified of the creditable coverage status of the plan. Creditable status is important since an individual will be assessed a Part D late en-

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rollment fee if he or she initially waives enrollment in Medicare's prescription drug benefit and later enrolls after incurring a break in creditable coverage of 63 days or longer.

CMS has long said that an entirely separate procedure to report the plan's creditable status to CMS was in development. That procedure is now operational on the Internet at: http://www.cms.hhs.gov/creditablecoverage.

Who Must Report

Entities required to report creditable status include group health plans sponsored by employers, unions, churches, federal, state and local governments, and other group-sponsored plans. Disclosure is required whether the entity's coverage pays primary or secondary to Medicare.

Because plan sponsors often do not know which employees, spouses, or dependents covered under any of their plans are enrolled in Medicare; many plan sponsors distribute notices to all plan participants. These plan sponsors must report creditable status to CMS despite the difficulty in estimating the number of Part D individuals covered by the plan option.

Exceptions

A sponsor claiming the retiree drug subsidy is exempt from reporting the creditable status with respect to those individuals. This exception means that even subsidy-approved sponsors must report the status to CMS for others who are not subsidy-eligible (for example, for individuals who enroll in Medicare Part D but for whom the plan is still providing prescription drug benefits).

If a plan sponsor contracts with a Part D plan, or if the plan becomes a Part D plan through an application and approval process administered by CMS, creditable coverage notices and reporting to CMS are not required. By definition, these plans are Part D plans and individuals enrolled in them are enrolled in a Medicare prescription drug plan.

Reporting Deadlines

The initial reporting to CMS must be completed by March 31, 2006. Future information will be reported to CMS on an annual basis, and after any change that affects whether the prescription drug coverage is creditable.

- For plan years that end on or before December 31, 2006, disclosure of creditable coverage status must be provided no later than March 31, 2006;
- For plan years that end in 2007 and beyond, disclosure must be provided within 60 days after the first day of the plan year for which the entity is providing the disclosure to CMS;
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status of the prescription drug plan.

How to Report

An entity is required to complete the disclosure form on the CMS Creditable Coverage Disclosure Web site at http://www.cms.hhs.gov/creditablecoverage. Completing the form will only take a few minutes, provided the sponsor has the information at hand. Online transmission is the *only* method for compliance.

For entities with subsidiaries (or different divisions, lines of business, operating units, control groups, etc.), one disclosure form can be submitted to CMS for the entire entity if the plan year is the same for all subsidiaries/divisions. Alternatively, an additional form can be submitted for each subsidiary/division, etc. with the subsidiary-specific information.

Types of Coverage

CMS requires a separate disclosure for each type of coverage sponsored by an entity. Types of coverage for group health plans include employer-sponsored plans, union/Taft Hartley plans, church, federal, state, local government, and other entity plans. For example, an employer that sponsors a union plan and a non-union plan would need to report each type separately.

Benefit Options

Creditability or actuarial equivalence is determined separately for each benefit option within a plan. A benefit option is a particular benefit design (for example, HMO, PPO, indemnity), category of benefit, or cost-sharing arrangement offered within a group health plan. Benefit options are referenced on the form as "options," and the entity must report whether all options are creditable, all are non-creditable, or whether there is a mix of creditable and non-creditable options.

Each option will also require more specific information such as the plan year; the number of Part D eligible individuals covered under the option as of the beginning of the plan year; the estimated number, if applicable, of those individuals expected to be covered through an employer or union retiree group health plan; the date the Disclosure Notice was completed; and a section to note if the information reported reflects a change to a previous Disclosure Notice provided to CMS.

Except for those plan sponsors applying for the drug subsidy payment, reporting the plan's creditable status to CMS is the last main step for plan years that end in 2006. The notice distribution to participants and the reporting to CMS will be annual requirements for all group medical plans. Plan sponsors need to remember that any future change in creditable coverage status means that new notices must be distributed to Part D eligible individuals prior to the effective date of the change and that a new online disclosure form must be completed within 30 days of the change in creditable coverage status.

The disclosure guidance is online at http://www.cms.hhs.gov/creditablecoverage. Additionally, CMS may release questions and answers relating to creditable coverage issues from time to time. This information will be posted at http://www.cms.hhs.gov/.

Mental Health Parity Law Extended

In a long-anticipated move, President Bush has signed legislation (H.R. 4579) that extends the *Mental Health Parity Act* (MHPA) provisions of ERISA, the Code, and the Public Health Service Act (PHSA) until December 31, 2006. The MHPA's provisions were first effective for plan years beginning on or after January 1, 1998 and were originally set to expire for qualifying services provided on or after September 30, 2001. However, various laws passed over the years have extended the MHPA to its current expiration date.

Congress is considering legislation that would toughen MHPA provisions and make the law permanent. However, most observers expect annual compromises where the two parties come together and merely approve extension of the current law. The MHPA prohibits a group health plan from applying a lower annual or aggregate lifetime dollar limit to mental health benefits than the plan applies to medical/surgical benefits.

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IRS Announces 2006 Mileage Rates

The Internal Revenue Service has issued the 2006 standard mileage rates used to calculate the deductible costs of operating an automobile for business, charitable, medical or moving purposes. Beginning January 1, 2006, the standard mileage rates for the use of a car (including vans, pickups or panel trucks) will be:

- 44.5 cents per mile for business miles driven;
- 18 cents per mile driven for medical or moving purposes; and
- 14 cents per mile driven in service of charitable organizations, other than activities related to Hurricane Katrina relief.

The new rate for business miles compares to a rate of 40.5 cents per mile for the first eight months of 2005. Last fall, the IRS made a special one-time adjustment for the last quarter in 2005, raising the rate to 48.5 cents per mile. This was a result of the dramatic increase in gas prices which topped $3 a gallon. The 2006 mileage rates reflect that gas prices have dropped. For a copy of the announcement see http://www.irs.gov/pub/irs-drop/rp-05-78.pdf.

HSA Contributions and Grace Period Coordination

Earlier this year the IRS announced that it would allow FSA participants up to two months after the end of the plan year to use any balances remaining in their flexible spending accounts (FSAs). The dilemma is that participating in a traditional FSA generally makes a person ineligible to make tax-deductible contributions to a health savings account (HSA).

Health savings accounts allow participants to pay for certain medical and long-term care expenses with pre-tax dollars. Only eligible individuals may participate in an HSA: those who are covered under a high deductible health plan on the first day of the month and are not in a health plan that covers benefits already covered under the high deductible health plan. Basically, this means that an individual entitled to FSA reimbursement for qualified Code Section 213(d) medical expenses (without any other restrictions) would not be eligible to make HSA contributions until the FSA is no longer available. An individual who participates in a health FSA and who is covered by the cafeteria plan grace period is generally not eligible to contribute to an HSA until the first day of the first month following the end of the grace period; *even if the participant's health FSA has no unused benefits at the end of the prior cafeteria plan year.*

On December 5, 2005 the IRS issued Notice 2005-86 that gives guidance about amending a cafeteria plan document to enable a health FSA participant to simultaneously participate in an HSA.

Background

IRS Notice 2005-42 modified the "use-it-or-lose-it" cafeteria plan rule to allow an employer plan to be amended to provide a grace period immediately following the end of each plan year. A plan providing the grace period must provide the grace period to all participants who are covered on the last day of the plan year (including COBRA participants). Any grace period remains in effect for the entire length specified, even if the participant terminates employment before the end of the grace period. The employer may initiate the grace period for certain benefits and not others.

Health Savings Accounts

HSAs can operate in tandem along with specific types of FSAs. Such FSAs place restrictions on the

types of reimbursement which will be issued from the FSA. These special FSA accounts were described in Revenue Ruling 2004-45 and include the following:

- Limited-purpose FSA: This FSA reimburses expenses only for preventive care and dental and/or vision care.
- Post-deductible FSA: This FSA reimburses expenses for preventive care and other qualified medical expenses only if they were incurred after the minimum annual deductible for the high deductible health plan has been satisfied.

Employer Options

IRS Notice 2005-86 outlines two options that plan sponsors can choose if they offer both an HSA and a health FSA.

Take no action: In this instance, any person who participated in the health FSA in the prior plan year and who is covered by the cafeteria plan grace period will not be eligible to contribute to the HSA until the first of the month following the end of the grace period.

Plan amendment: An employer may amend its cafeteria plan document to provide for a grace period in addition to mandatory conversion of a general purpose health FSA to either a limited purpose or post-deductible plan. This mandatory conversion will apply during the grace period and must apply to *all* participants in the health FSA. If a plan sponsor amends its plan document in keeping with the mandatory conversion option, individuals in a health FSA will also be able to contribute to an HSA.

Retiree Prescription Drug Coverage

When the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* (MMA) was enacted, Congress and others expressed concerns that employers would stop sponsoring retiree prescription drug coverage when the new Medicare prescription drug benefit became effective. About 12 million retirees obtain coverage through employer and union programs. These plans typically provide more comprehensive prescription drug coverage than Medicare's standard benefit. This being the case, the Medicare subsidy payment that reimburses sponsors of qualifying plans with 28 percent of a retiree's prescription drug claims (between $250 — $5,000) was designed to encourage the continuation of employment-related coverage.

Now, as reported in the *Washington Post*, Black & Decker Corporation has announced it is ceasing retiree prescription drug coverage for 3,000 post-65 retirees. Their decision was based on a comparison of retiree costs, including premium payments and out-of-pocket expenses such as deductibles and co-payments, between what the retiree would pay for prescription drug coverage through Medicare versus total retiree costs for the Black & Decker plan. Their conclusion was that 85 percent of retirees would be financially better off with Medicare's coverage. (Black & Decker is continuing a separate prescription drug plan for 750 former employees of an acquisition since the analyses on this plan showed it to be more financially advantageous for retirees than Medicare's plan.)

Reacting to this event, Congressman Ben Cardin (D-Md.) said "We knew that there was a high risk that a large number of companies would terminate their retiree prescription drug coverage, it will mean that many seniors have less coverage than they did before." However, Gary Karr, a representative of the Centers for Medicare and Medicaid Services believes that companies dropping coverage are concluding that their coverage is less valuable than Medicare's and that "The law is working as it's intended to work."

Proposal to Expand FASB Obligations

Pension liability and other post-employment benefits (such as retiree healthcare coverage), have traditionally been included in the footnotes. The *Wall Street Journal* reports that, a new rule would require the over- and under-funding of pension and other benefit plans to be included on company balance sheets. The Financial Accounting Standards Board (FASB) plans to implement this rule by the end of 2006.

In a new report, Standard & Poor's (S&P) suggests that this change could have a significant impact on companies' balance sheets, as well as shareholder equity. S&P analysts tout the move as an important step that "will awaken a lot of investors." They also estimate that liabilities for under-funded plans may total more than $440 billion, which would correlate to a more than ten percent reduction in shareholders' equity among S&P 500 companies. These companies have funded 88 percent of their pension obligations and reserved enough cash to cover less than 22 percent of other bills they expect to receive for retiree benefits.

Inquiry on Pensions

According to the *New York Times*, House Members George Miller (D-Calif.) and Edward Markey (D-Mass.) have asked the Government Accountability Office (GAO) to investigate whether federal agencies have failed to enforce pension laws aimed at consultants and money managers.

Different sections of the pension laws are enforced by a variety of federal agencies, while the U.S. Securities and Exchange Commission (SEC) oversees money managers. As a growing number of companies struggle to maintain their pension programs, related burdens have increased on the Pension Benefit Guaranty Corporation (PBGC) — which was established to take over pension plans from insolvent firms. With the PBGC facing the duty to absorb more and more pension programs, some members of Congress has been clamoring for a solution to the retirement savings problem.

This most recent call for an investigation arrives on the heels of an Aircraft Mechanics Fraternal Association request that federal regulators examine whether United Airlines consultants had been acting in the interests of the pension plan participants or choosing money managers for business reasons. Soon after the union made its request, United Airlines filed for bankruptcy and dumped its pension plan on the PBGC. Several investigators from the SEC have hinted at possible conflicts of interest between the consultants and the money managers working on the United Airlines pension plan. The *Times* articles note that some key officials at the SEC believe that the PBGC has not shown enough interest in fully investigating allegations related to plans that it now controls.

SEC Rules on Executive Pay

As reported in the *Wall Street Journal*, the U.S. Securities and Exchange Commission (SEC) is expected to issue new rules to force firms to disclose additional information about retirement benefits, total compensation, and other items regarding executive compensation.

The new rules would require firms to publish (in a separate column on proxy statements) this disclosed information, which would be for the top five highest paid executives in the firm. Companies would also be required to give a monetary number to stock option grants and place those in the same disclosure space on the proxy statement. The rules would then face a public comment period, but many critics note that businesses are likely to be displeased with further rules and regulations. An SEC spokesman has commented that the new rules are intended to help the market obtain the information necessary to

curb excessive executive pay without necessitating further government regulatory interference.

Avoiding Employee Misclassification

In the late 1990s a high profile series of *Microsoft* cases addressed the proper classification of individuals as employees, independent contractors, benefit-eligible, or benefit-ineligible individuals. This raised the entire employee classification issue to a new level and made many employers painfully aware of the dangers associated with improper employment classifications — particularly with regard to employee benefits.

Microsoft's problems arose in large part because it maintained two classes of workers. Both groups generally performed the same services for Microsoft. However, one group was defined as "employees" and received salary and benefits while the other group was defined as "independent contractors" and did not receive benefits although they did receive a higher level of base pay.

The IRS claimed that the "independent contractor" group consisted of employees for FICA purposes and ultimately the courts agreed. Those same workers then sued demanding benefits that had been denied to them because Microsoft did not characterize them as being in an eligible class. The courts determined that the reclassification by the IRS meant that they were entitled to benefits (at least to stock options which was what they sued for). Ultimately then, Microsoft was required to pay back withholding and employment taxes, and provide historically denied employee benefits.

The Microsoft experience serves as an important reminder that employers should carefully consider the eligibility provisions of their benefit plans along with the factors that the IRS considers when assessing appropriate worker classification.

An IRS decision (though unreleased), may help employers construct plan eligibility language to guard against the problem experienced in *Microsoft*. In the IRS decision, the employer at issue sponsored two benefit plans, one of which included the following plan language:

> "An individual shall only be treated as an employee if he or she is reported on the payroll records of an affiliated company as a common law employee. This term does not include any other common law employees or any leased employees. In particular, it is expressly intended that individuals not treated as common law employees by affiliated companies on their payroll records are to be excluded from plan participation *even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.*" (Emphasis added.)

This language meets the IRS requirement to clearly demonstrate the employer's intention to deny benefits to a certain group of workers, whether or not the employer's classification of that group was appropriate.

The second plan excluded two classes of workers:

- Those hired for "special assignments" and covered by another plan; and
- Terminated union employees hired for limited time periods to perform specific tasks or projects.

The IRS office ruled that the exclusions in both plans were permissible and neither violated any participation rules under the tax code. The IRS went on to state that the employer's classification of eligible workers drew clear lines of distinction between employees and was not subjective but predictable; there

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was no employer discretion after the eligibility distinction was clearly outlined.

Although the IRS decision may prompt employers to rely on a reasoned business purpose in outlining employee classifications and eligibility provisions, we strongly caution employers to note that the legal value of the unreleased IRS decision is extremely limited. Nevertheless, with a carefully-drafted plan provision, an employer might escape the burden of retroactively granting benefits to formerly ineligible individuals.

Health Care: Ballooning Benefit Costs

Historically, retirement costs have accounted for the bulk of employers' total spending on benefits. However, according to a recent study conducted by the *Employee Benefit Research Institute* (EBRI), fast-growing health care costs are on track to become the largest portion of employers' total outlay.

Health care spending has grown from 8.8 percent of benefit expenses in 1950; it rose to 26.7 percent in 1980 and 38.3 percent in 1990. As this percentage has increased, the percentage allotted to other benefits has fallen. Retirement costs in 2004 narrowly exceeded health care as the leading employer benefit spending expense.

Other benefits (such as life insurance) have declined from one-third of employer benefit spending in 1950 to less than ten percent today. These figures include total spending for mandatory programs such as Social Security, Medicare, and workers' compensation in addition to all other benefits such as health care, retirement, and other voluntary offerings.

U.S. Benefit Office Locations

Anchorage, AK (907) 562-2266	Atlanta, GA (404) 224-5000	Austin, TX (800) 861-9851	Baltimore, MD (410) 527-1200
Birmingham, AL (205) 871-3871	Boise, ID (208) 340-0645	Boston, MA (617) 437-6900	Cary, NC (919) 459-3000
Charlotte, NC (704) 376-9161	Chicago, IL (312) 621-4700	Cleveland, OH (216) 861-9100	Columbus, OH (614) 766-8900
Dallas, TX (972) 385-9800	Denver, CO (303) 218-4020	Detroit, MI (248) 735-7580	Eugene, OR (541) 687-2222
Farmington, CT (860) 284-6137	Florham Park, NJ (973) 410-1022	Ft. Worth, TX (817) 335-2115	Grand Rapids, MI (616) 954-7829
Greenville, SC (864) 232-9999	Houston, TX (713) 625-1023	Jacksonville, FL (904) 355-4600	Knoxville, TN (865) 588-8101
Las Vegas, NV (702) 562-4335	Long Island, NY (516) 941-0260	Los Angeles, CA (213) 607-6300	Louisville, KY (502) 499-1891
Memphis, TN (901) 248-3100	Miami, FL (305) 373-8460	Milwaukee, WI (414) 271-9800	Minneapolis, MN (763) 302-7100
Mobile, AL (251) 433-0441	Mountain View, CA (650) 944-7000	Naples, FL (239) 514-2542	Nashville, TN (615) 872-3700
New Orleans, LA (504) 581-6151	New York, NY (212) 344-8888	Omaha, NE (402) 778-4851	Orlando, FL (407) 805-3005
Philadelphia, PA (610) 964-8700	Phoenix, AZ (602) 787-6000	Pittsburgh, PA (412) 586-1400	Portland, OR (503) 224-4155
Roswell, NM (505) 317-3397	St. Louis, MO (314) 721-8400	San Diego, CA (858) 678-2000	San Francisco, CA (415) 981-0600
San Juan, PR (787) 756-5880	Seattle, WA (206) 386-7400	Spokane, WA (206) 386-7400	Tampa, FL (813) 281-2095
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