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Form 5500 – California Wildfires Lead to Deadline Extension

The US Department of Labor (DOL) has extended the deadline for filing Forms 5500 and 5500-EZ for those impacted by the recent California wildfires. Soon after President Bush declared seven Southern California counties a federal disaster area,



the DOL moved Form 5500 due dates falling between October 21, 2007 and January 31, 2008 to January 31, 2008. The extension applies to plan administrators, employers and other entities in areas directly affected by the wildfires, as identified by the Federal Emergency Management Agency (FEMA), as well as to firms located

outside of the wildfire areas that have been unable to obtain information required for their filings from service providers located within the fire zone. The DOL press is available [on line](#).

Filers will need to check Part 1, Box D of the Form 5500 or Part 1 on Form 5500-EZ and attach a statement explaining the reason for the extension.

The following agencies can provide additional information.

- Disaster relief: FEMA at 800 621 3362 or 202 621 FEMA (3362)
- 5500 Extension: EBSA's EFAST Helpline at 866 463 3278

Further Changes Are Coming

Employer-sponsored benefit programs subject to the Employee Retirement Income Security Act (ERISA) are generally required to file an annual report via Form 5500. On November 15, 2007, the DOL and the Internal Revenue Service (IRS) jointly released form revisions largely aimed at implementing changes mandated by the Pension Protection Act of 2006 (PPA). The changes include transitioning to EFAST-2, a mandatory electronic filing system. Many of the changes affect only retirement plans, although some also affect welfare plans.

The major changes include:

- Mandatory electronic filing
- New Short Form 5500-SF providing simplified reporting for plans with fewer than 25 participants
- Expanded reporting requirements for 403(b) plans, which will now be treated like other ERISA-covered retirement plans for annual reporting purposes
- Separate Schedules SB and MB, replacing the current Schedule B (Actuarial Information) with single-employer defined benefit plans filing the SB and multiemployer defined benefit plans and certain money purchase pension plans filing the MB
- Expanded fee reporting on the Schedule C
- Elimination of Schedule E (ESOP Information) and Schedule SSA (which shows separated participants who have deferred vested benefits)



Some of the PPA-mandated changes will apply on a transitional basis for the 2007 and 2008 plan year filings; that is, for Forms 5500 filed for plan years beginning after December 31, 2006.

Other changes not related to the Pension Protection Act will be effective for the Form 5500 filed for plan years beginning on or after January 1, 2009.

The electronic filing requirement, which was to have been effective for 2008 plan years, has been postponed for an additional year. It will apply to Forms 5500 filed for plan years beginning on or after January 1, 2009. As a result, most filers will have until July 2010 to incorporate the non-PPA changes and electronic filing.

The [final rule](#) and [notice of revisions](#) were published in the *Federal Register* on November 16, 2007.

Medicare Eligibility and Benefits: What Should Employers Do?

Plan sponsors are sometimes asked to respond to employee questions about Medicare eligibility and benefits, such as:

- Should an eligible employee elect Medicare coverage and drop employer coverage to avoid double coverage?
- Does it make sense to take Medicare coverage now or wait until later?
- What happens if an employee does not sign up when first eligible – will it cost more to enroll later?

Other questions address details about specific features of Medicare coverage.

Unfortunately, our suggestion to employers is to *desist from responding to those questions* – even in the most general manner. Why do we recommend such an unhelpful response? Offering guidance exposes sponsors to possible legal liability they may not initially perceive. For employers that want to be helpful, a useful and reasonably safe tactic is to direct the worker to a reputable source, such as the CMS (Centers for Medicaid and Medicare Services) web site or the phone number of the local Social Security office. These resources provide guidance every day for people asking just such questions.

Given Medicare's complexity, it is important to recognize that a small, seemingly insignificant change in an employee's situation or in Medicare rules may dramatically alter the answer to an

employee's questions. Many times the retiring employee will communicate his situation in a manner that misstates his real concern. This means that the answer provided, despite care and diligence, may prove to be wrong.

Following are questions that a Medicare professional would likely ask in turn before answering questions put to them.

- Does the employee's spouse have coverage under his or her employer's plan?
- Is disability a factor?
- Is end-stage renal disease a factor?
- Is the prescription drug benefit through the employer's plan creditable or non-creditable?
- What is the employee's financial situation? (Part B premiums are income-related for high-income individuals and special prescription drug benefits are available for low-income individuals.)
- Does the employee have dependents? What Medicare status do the dependent(s) hold?
- What is the employee's underlying health condition?

Our suggestion to employers is to *desist from responding to those questions* – even in the most general manner. Why do we recommend such an unhelpful response? Offering guidance exposes sponsors to possible legal liability they may not initially perceive. Given Medicare's complexity, it is important to recognize that a small, seemingly insignificant change in an employee's situation or in Medicare rules may dramatically alter the answer to an employee's questions.

One especially confusing issue is enrollment periods. While Medicare has special enrollment periods (SEPs) for employees who continue to work beyond age 65 and who have coverage through their employers' plans, the SEPs are for specified (and varying) periods of time. Individuals need to enroll during these periods to avoid late enrollment penalties and gaps in coverage. Furthermore, the SEPs do not apply to COBRA coverage and Medicare-eligible employees must avoid a 63-day gap in creditable prescription drug coverage or pay a

late prescription drug enrollment penalty. Another consideration is that the open enrollment period (during which underwriting considerations are not permitted) in Medigap coverage is tied to the date an individual is first covered by Medicare Part B.

MSP Rules

One of the most serious Medicare-related risks for an employer is being found in violation of the Medicare Secondary Payer (MSP) rules. If an active employee forgoes employer-provided coverage in favor of Medicare, employer assistance in that decision could be seen as unlawful encouragement to drop the employer coverage, in violation of the MSP rules.

MSP rules require employer-sponsored group medical plans to provide primary coverage for active and in some cases disabled employees (and for a period of time individuals with end-stage renal disease) who are eligible for both the employer plan and Medicare. It is unlawful for the employer plan to act as secondary coverage to Medicare for those employees, and it is unlawful for an employer to encourage the employees to drop employer coverage in favor of Medicare. It is perfectly acceptable for an employee to drop employer coverage and only take Medicare (which might be a good financial choice), *but the employer cannot induce the employee to do so.*

Illegal inducements might include offering to pay the employee's costs for Medicare, offering a Medicare supplemental policy to an active employee, or providing a cash incentive to waive employer-provided coverage (unless that same incentive is offered to all employees, not just those that are eligible for Medicare, and is offered in the context of a cafeteria plan). Beyond these clear examples, the rules get a little harder to decipher. Just what constitutes "encouraging" the employee to waive the employer coverage, and what is permissible information that is not misleading? That determination can be difficult to make and even more difficult to justify should the government later question the situation. Given the potential penalties associated with violation of the MSP rules (25 percent excise tax, \$5,000 penalty per violation, and the potential award of double damages for affected participants), we believe that a conservative approach is the most prudent.

States' Rights: More States Enacting Cafeteria Plan Requirements

With the federal government offering little guidance on healthcare benefit policy, states have been moving to fill the void. One of the earliest efforts, the Maryland Fair Share Health Care Fund Act, was knocked down in court on the grounds that the law was preempted by federal ERISA rules (see *Willis EB Alert #74*). A 2007 Massachusetts law requiring employers to establish cafeteria plans has yet to be challenged, however, and other states have taken similar action. Whether or not these efforts will ultimately survive court challenges is an open question, but we note that courts have routinely held that ERISA invalidates state laws requiring self-funded employers to provide health benefits to employees. State legislatures remain undeterred, and several are actively pushing to mandate the establishment of Section 125 programs (also known as cafeteria plans), which allow employees to pay for health insurance premiums on a pre-tax basis.

Connecticut's Cafeteria Plan Requirement. Public Act No. 07-185, effective October 1, 2007, requires that any



employer providing health insurance benefits, where at least some of the premium is paid by employees through payroll deductions, must give employees the opportunity to make their contributions on a pre-tax basis. The law's definition of employer does not provide an exception for small

employers. The law will apply regardless of the number of employees an employer has in Connecticut. Limiting the law to employers that subsidize at least part of the cost of coverage effectively exempts employers that require their employees to pay the full premium. Whether that result was intended is unclear.

Missouri's Cafeteria Plan Requirement. House Bill Number 818 was signed into law on June 1, 2007, and was set to take effect January 1, 2008. The law requires that employers who provide fully insured health insurance and who pay some



percentage of the premium, must create a Section 125 plan for employees. Limiting the law to fully insured employers that subsidize part of the cost of coverage effectively exempts two groups: self-insured plans and employers that require their employees to pay the full premium.

Rhode Island's Cafeteria Plan Requirement. Public Law No. 2007-125, enacted on June 27, 2007, sets a date of July 1, 2009 by which employers must establish a cafeteria plan. The law requires employers to enable pre-tax payment of healthcare premiums – whether or not the employer offers group health plan coverage to its employees. Although employers are obligated to create a pre-tax vehicle for employee contributions, employers are not required to contribute to the cost of health insurance. The law applies to employers with an annual average employment of more than 25 employees for six consecutive months of the year in Rhode Island. State, county and municipal governments are included in the definition of employer. It also appears that employers contributing to a multiemployer fund would be subject to this law as long as they are large enough to meet the above employee requirement.



Compliance Concerns

Most employers already use cafeteria programs and so compliance with the types of state laws described above is not expected to present special challenges. Nevertheless, employers should be aware of the cafeteria plans' inherent difficulties and potential complications. Employers could find themselves unexpectedly subject to ERISA, COBRA and HIPAA requirements. For example, because offering a tax incentive to employees may encourage them to elect coverage, this enticement could be deemed employer endorsement and raise ERISA concerns. A state's requirement to adopt a cafeteria plan may amount to a requirement that employers adopt the underlying health benefits offered through the cafeteria plan as an employer-sponsored plan.

If a court agrees that adopting a cafeteria plan is a de facto mandate that an employer (self-funded or fully-insured) offer health benefits to its employees, the recent decision overturning Maryland's Fair Share law will cast a much bigger shadow over the state laws. Given the similarity between the Maryland and Massachusetts laws, there is a good chance that the Massachusetts law would be found to be preempted by ERISA (along with similar laws from other jurisdictions). However, because the cost of complying with the emerging state laws is relatively small, most employers will likely choose to comply and proceed with adopting cafeteria plans rather than risk a dispute and face corresponding legal expenses.

Opt-Out Reminder to Eligible Government Entities

Sometimes you have to opt-in to opt-out. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains an important opt-out provision for certain self-funded, non-federal government entities. To *maintain* their opt-out status, these entities must re-apply for it annually with the Department of Health and Human Services (HHS) before the start of each plan year. Moreover, each year, eligible entities must remind plan participants, in writing, of their opt-out status. The opt-out provision allows eligible entities to escape many HIPAA requirements (with the exception of HIPAA privacy obligations and certifications of coverage as required by law).

When plan sponsors notify participants of the opt-out, they must specify the federal requirements for the opt-out and state which federal requirements will not apply as a result. Failing to provide such notice negates the opt-out election. If an eligible entity loses its opt-out status, it may be subject to HIPAA compliance obligations that it may not be prepared to meet. Additional details and forms can be found [on line](#).

TRICARE: New Requirements Go into Effect January 1, 2008

The military is moving to safeguard the healthcare funds it provides military personnel and their dependents. When military personnel return to civilian life, they are eligible to receive ongoing health benefits through TRICARE (formerly known as CHAMPUS), the US military's healthcare plan. They may also be eligible for benefits under their employer's plan. In those cases, the military wants the employer to take over, and beginning January 1, 2008, group health plan sponsors are prohibited from offering TRICARE-eligible employees any incentive to choose not to enroll in a group health plan that would provide primary coverage.



The concept behind the new rules closely parallels the Medicare Secondary Payer regulations that generally preclude employers from structuring their health plans around Medicare coverage. The TRICARE ban on incentives is aimed at preventing employers from shifting health costs to the Department of Defense (DoD). In an official report to Congress, the DoD provided important guidance on how it

would interpret this new prohibition. Although the report stated that the DoD planned to publish final rules implementing the law, no regulations or guidance have been published yet.

Action Item

Employee benefit plan sponsors should review their medical plans to determine if TRICARE-eligible employees and dependents are being offered any incentives that may be different from those offered other participants and whether plan changes will be required in light of these new restrictions. (Note: Special MSP rules generally permit incentive arrangements that are uniformly made available to the workforce in the context of a bona fide cafeteria plan arrangement, but further guidance about how the DoD intends to interpret this rule for TRICARE purposes would be welcome.) If calendar-year group health plans have not already done so, they should immediately make necessary changes to satisfy this important requirement. TRICARE incentive prohibitions apply to state and local governments as well as private employers. Religious organizations are apparently not exempt. The rules do allow an exclusion for employers with fewer than 20 employees. As noted above, official regulations to help clarify some of these areas of uncertainty will be welcome.

FMLA Enforcement

The federal Family and Medical Leave Act of 1993 (FMLA), requiring employers of 50 or more employees to give up to 12 weeks of unpaid, job-protected leave to employees for a serious illness or to care for a child, spouse or parent, has generated a healthy share of controversy, confusion and court activity. We offer some pointers on FMLA enforcement.



- A worker who feels his or her FMLA rights have been violated may either file a private lawsuit against his or her employer or file a complaint with the Department of Labor (DOL), but an employee is not required to file an FMLA complaint with the DOL before pursuing private civil action.

This procedural point has been confirmed in a number of court cases.

- FMLA lawsuits are subject to a two-year statute of limitations or a three-year limit if the violation was willful. In other words, an FMLA suit must be brought no later than two years after the date of the last event constituting an alleged violation or within three years of the last event if the violation is thought to be intentional.
- Employers who violate FMLA can be required to pay any or all of the following.
 - **Actual Damages.** Depending on the circumstances, employees can receive lost wages, employment benefits and other compensation. In situations involving an unlawful denial of leave time, the employee can recover any actual monetary losses, such as the cost of providing care. Although actual damages can be readily calculated in many cases, courts will typically limit the actual damage amount to a sum equal to 12 weeks of the employee's wages. Interest may be added to such an award.
 - **Attorneys' Fees.** A court may award reasonable attorneys' fees, reasonable expert witness fees and other costs.
 - **Interest.** The employee may also receive interest on the amount of the actual damages.
 - **Liquidated Damages.** Unless the employer can show that it had reasonable grounds for believing that its actions did not violate FMLA, the employee may also be entitled to liquidated damages equal to the amount of actual damages plus interest. (Note that this is in addition to the actual damages and interest.) The courts have discretion to award or reduce these double damages.
 - **Equitable Relief.** The employee may also receive such equitable (usually non-monetary) relief as may be appropriate, including reinstatement or promotion.
- If an employer has a leave policy that is more generous than that required by the FMLA, an employee cannot use FMLA rules and the DOL to enforce the terms that exceed the protections of the FMLA.
- As under the Fair Labor Standards Act, individuals "acting in the interest of an employer," such as corporate officers, can be individually liable for FMLA violations under compelling circumstances.

Many states – both before and since the federal act – have passed laws similar to the FMLA. They often apply to more workers than does the federal law, and may also differ in the terms and types of unpaid leave involved.

Medical leave typically is defined as unpaid time off due to serious illness. Family leave, however, can be defined in a variety of ways and can include leave to care for an ill child, spouse or parent. It may also encompass forms of parental leave to care for a child following a birth or adoption, attend school-related events or extracurricular activities, or respond to interruptions in day care. Benefits professionals may find it helpful to visit the FMLA page of the [National Conference of State Legislatures website](#). The page summarizes the varying requirements for leave under state laws across the country.

Spotlight On . . .

The Plan Amendment Process

Our readers often express concern about the proper way to amend an employer's benefit plan document and whether they have effectively enacted an amendment. The right method can be clearly stated: the language should be carefully drafted so that it achieves exactly what the plan sponsor envisions, and the plan's amendment process must be scrupulously honored. Achieving that standard, however, is not always easy.

If the plan has a formal plan document, it probably states that it cannot be amended without formal action by the plan sponsor. Such plan documents usually specify procedures for plan amendments and, to ensure that an amendment becomes implemented effectively, those procedures must be followed. In addition, the formalities of corporate and other business laws should be observed. One of the main sources of trouble is determining who has authority to amend a plan. The board of directors of a corporation will have authority in virtually all cases to amend the corporation's benefit plans, even if not otherwise stated in the plan. Unless


the board has clearly delegated that authority, it is always wise to ask if the person signing the plan amendment has the authority to amend this plan. The vice president of Human Resources may be empowered to sign a plan amendment, but the office manager at a remote work site probably is not.

Even seemingly inconsequential plan changes probably will not be considered legal if they do not comply with the formal amendment procedure specified in the plan. In one relevant case, a plan sponsor announced at an employee meeting and also posted a notice on an employee bulletin board that its plan would not cover motorcycle accidents. When a participant was later injured riding a motorcycle, the plan was held liable for the accident expenses after a court held that the oral announcement and informal bulletin board notice did not properly amend the written plan.

On the other hand (as reported in Willis' *Employee Benefits Alert #93*), plans can be amended inadvertently as well. In the case of one merger, transaction documents effectively amended a plan's terms, the courts ruled, because the documents did conform to the plan's stated amendment procedures.

To avoid unnecessary delays and lag time when minor plan corrections are needed, the board of directors (or other governing body) can simply delegate to a corporate officer the authority to make plan changes. Care should be taken to ensure the delegation is consistent with governing business law and company documents and that the delegation is properly evidenced in writing. The person operating under this delegated power must also be careful to act within the scope of the delegation and to document all actions.

It is also important to recognize ERISA reporting and disclosure obligations by asking whether the proposed amendment would change any of the elements of the plan that must be disclosed in the summary plan description. If so, the plan amendment will trigger a requirement that a summary of material modification



(SMM) be provided employees. SMMs must generally be distributed within 210 days of the close of the plan year in which the amendment is adopted. However, if the proposed amendment represents a cutback in health plan benefits, then not only is an SMM triggered, but a special ERISA rule requires that the SMM be distributed within 60 days of the date that the plan modification is adopted.

All of the above is predicated on the assumption that plan sponsors have retained the right to terminate or amend their plan. Language to that effect should always be included in all plan documents or an employer could face the uncomfortable possibility that the plan cannot be amended, at least with respect to current participants. In addition, given the case of the inadvertent amendment mentioned above, plan sponsors should consider whether another boilerplate provision should be included stating that no amendment will be effective if contained in documents that are not specifically intended to amend the plan.

Key Contacts

US Benefits Office Locations

Atlanta, GA
404 224 5000

Florham Park, NJ
973 410 1022

Naples, FL
239 659 4500

San Jose, CA
408 436 7000

Austin, TX
800 861 9851

Ft. Worth, TX
817 335 2115

Nashville, TN
615 872 3700

San Juan, PR
787 725 5880

Baltimore, MD
410 527 1200

Grand Rapids, MI
616 954 7829

New Orleans, LA
504 581 6151

Seattle, WA
206 386 7400

Birmingham, AL
205 871 3871

Greenville, SC
864 232 9999

New York, NY
212 915 5422

Tampa, FL
813 281 2095

Boston, MA
617 437 6900

Houston, TX
713 961 3800

Omaha, NE
402 391 1044

Washington, DC
301 530 5050

Cary, NC
919 459 3000

Jacksonville, FL
904 355 4600

Orange County, CA
949 885 1200

Wilmington, DE
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