

Trends

Spring 2005

New USERRA Requirements Apply to All Employers

A new law (the Veterans Benefits Improvement Act of 2004) was signed on December 10, 2004. This law updates the Uniformed Services Employment and Reemployment Rights Act (USERRA) in two significant ways:

- Employers must now offer continued health coverage for 24 months, rather than 18 months, to employees who leave to serve in the military. The increased time period applies to all individuals who elect coverage on or after December 10, 2004.
- Employees must be provided with a notice of their USERRA rights, in a posting similar to the postings for the employees' rights with respect to minimum wage, overtime, discrimination, etc. It is available at www.dol.gov/vets/programs/userra/poster.pdf.

In addition, on September 20, 2004 the Department of Labor issued proposed regulations to clarify the employer's obligations under USERRA.

Basically, USERRA is designed to prohibit employers from penalizing employees because of their military service, which includes reemployment rights following discharge from the service and reinstatement and continuation rights with respect to benefits.

Under USERRA, employers (no matter how small they are, and including churches) must offer health care continuation coverage rights to employees (and their dependents) who would otherwise lose their group medical, dental and/or vision coverage as a result of joining the armed services or being called for active duty in the reserves. The USERRA coverage is similar to COBRA, and employees are entitled to elect whichever continuation option would provide better coverage.

Under USERRA, the employer may not charge more than the active employee premium during the first 31 days of military service. If military service lasts more than 31 days, the employer may charge 102% of the full cost of coverage (that is, both the employee and employer portion) during the balance of the period of service. Coverage under the military's insurance is available to the employee and his dependents after 31 days of active duty. Continued health coverage under USERRA must be elected within a "reasonable period of time" following leaving the job – unlike COBRA, there is not a specific time frame set by the law, although an employer could create rules under its internal policies.

The right to continue health coverage only applies if the employee is in the military. If a dependent would lose coverage as a



result of military service, extended coverage does not need to be offered.

When the individual returns to work, USERRA requires that his group health coverage be reinstated without applying any eligibility waiting period or preexisting condition limitation (except with respect to conditions that were a direct result of military service). This is true even if coverage was discontinued while in the service.

In general, time on military leave should be treated as any other absence for purposes of continuing benefits. Consequently, if an individual on a personal leave of absence or layoff continues to have group life coverage, similar coverage must apply to individuals on military leave.

If an individual requests FMLA, time spent in the military or on active duty in the reserves is considered time employed for purposes of meeting

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the 12 month/1250 hour minimum coverage requirement.

Being called for active military duty qualifies as a “change in status” under a cafeteria plan.

With respect to retirement benefits, upon reemployment individuals must be given credit for their military service for purposes of vesting and accruals. Military service may not be treated as a “break in service”. If the retirement plan is a defined benefit plan, the employer must fund the plan for credited service within 30 days after the employee returns to work.

If the plan is a 401(k) plan or any other plan which requires or permits employee contributions, individuals must be allowed to make catch-up contributions to the plan for a period equal to three times the duration of their military service or five years, whichever is less. The allowed amount of contribution is based on what the individual’s compensation would have been if their employment had not been interrupted or, if that amount cannot reasonably be determined, the individual’s average compensation during the year immediately before the year employment was interrupted. Make-up contributions do not count against the elective deferral limit, the annual addition limit, etc. in the year in which the contributions are actually made, but instead count in the year to which the contributions relate.

If employee contributions are required, the employer only needs to match contributions that are made. The employee has the right to make up only a part of the contributions or deferrals that were missed during the period of service. Employees may not be required to pay interest on made-up contributions.

Employers are permitted to be more generous than USERRA requires. However, being more generous than required with respect to one obligation under USERRA does not excuse the employer from meeting any other obligation. •

Timing of Plan Amendments Required to Comply With the New Automatic Rollover Rules

The IRS has released Notice 2005-5 which provides guidance on the implementation of the new automatic rollover rules. The automatic rollover requirement applies to any mandatory distribution greater than \$1,000 where the participant does not make an affirmative election to receive the distribution in cash or roll it over. The new rules require that, in such instance, the amount be distributed directly to an IRA for the benefit of the participant. The Department of Labor (“DOL”) issued regulations on September 28, 2004 establishing a safe harbor under which a plan fiduciary will be deemed to have satisfied his or her fiduciary duty as to the selection of the IRA provider and the initial investment elections. The regulations identify five conditions that a fiduciary must satisfy in order to take advantage of the safe harbor:

- The distribution must be \$5,000 or less, including the value of any rollover contributions.
- The distribution must be rolled over to an IRA for the benefit of the participant.
- The plan fiduciary must enter into a written agreement with the IRA provider, which must be a state or federally regulated bank or savings association, an insurance company or a regulated investment company. The agreement must cover, among other things, how the money will be invested as well as the fees and expenses that will be charged to the account.
- The plan must inform participants of its automatic

rollover procedures prior to making an automatic rollover.

- Plans must comply with the prohibited transaction rules.

Plan sponsors have three alternatives for complying with the new rules. One option is to continue to provide for the automatic distribution where a participant’s vested accrued benefit is \$5,000 or less and implement the new rules. The second option is to lower the automatic distribution threshold to \$1,000 or less. The third option is to eliminate mandatory distributions altogether. Plan sponsors who elect option one should ensure compliance with the DOL fiduciary safe harbor requirements. If the second or third option is selected, the plan can avoid the new rules.

Notice 2005-5 provides that plans (other than governmental and certain non-electing church plans) must be amended by the end of the first plan year that ends on or after March 28, 2005. This means that sponsors whose plan year ends on March 31 must act quickly to amend their plans by March 31, 2005 (calendar year plans have until December 31, 2005). Sponsors must also distribute revised summary plan descriptions or a summary of material modifications. Depending on the option selection and current content, distribution forms and tax notices may also need to be revised.

If you have any questions about the new automatic rollover rules, please contact your Nylhart consultant. •

Final Regulations for HIPAA Portability Have Been Issued and *That's Not All*

On December 30, 2004, the Department of Treasury, Labor, and Health and Human Services issued final HIPAA portability regulations. The final rules apply to health plans and insurers on the first day of the plan year beginning on or after July 1, 2005. Therefore, for example, a health plan with a plan year commencing on January 1 will have to comply with the final regulations as of January 1, 2006.

The Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA, provided for different portability requirements with a focus on: (i) limiting pre-existing condition exclusion periods; and (ii) special enrollment. The final regulations clarify many areas of the 1997 interim rule. In addition, the finalized rules make a few changes to the 1997 interim rule, these include changes to: (i) the varieties of health coverage that are considered creditable coverage under HIPAA; (ii) the model certificate issued when health plan coverage ceases; (iii) special enrollments; and (iv) excepted benefits (i.e., limited scope dental and vision benefits). Furthermore, the three agencies published proposed regulations on a number of issues, including the treatment of gaps in creditable coverage, special enrollment

procedures, and the Family and Medical Leave Act's (FMLA) interaction with HIPAA.

rules require that the notice include the individual (including an address or phone number) to contact in order to obtain more information regarding the preexisting condition exclusions. The final rules provide model language for the general notice.

Furthermore, the finalized regulations require that a health plan that imposes a preexisting condition exclusion must make a



Preexisting Condition Exclusions

The finalized regulations have not significantly modified the preexisting condition exclusion rules, but have added several examples to illustrate provisions that are not in line with the intentions of the HIPAA portability rules. Specifically, a provision that limits or excludes coverage for a prior condition, such as a provision that excludes reconstructive care for an accident that occurred before the person was covered, is considered an impermissible pre-existing condition.

The final regulations retain the requirement that a plan imposing preexisting exclusions must provide a written general notice of preexisting condition exclusions before it can impose them. In addition to clarifying when such notice must be distributed, the final



determination of creditable coverage within a reasonable time after receiving information regarding prior health coverage and cannot impose any time limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

Creditable Coverage

The April 1997 interim rules provided for ten categories of creditable coverage, that is ten categories of health coverage that constitute creditable coverage under HIPAA. The purpose of these delineated categories is to reduce or eliminate any preexisting condition exclusion periods under a new health plan an individual may be considering. The final regulations

added several new types of creditable coverage, including S-CHIP (the State Children's Health Insurance Program) and coverage provided under a plan established or maintained by a foreign country or political subdivision.

Model Certificate

The Certificate of Coverage is intended to enable individuals to establish prior creditable coverage for purposes of reducing or eliminating any preexisting condition exclusion imposed on such individuals by any subsequent health plan coverage. The finalized regulations include updated model certificates. The new model includes an educational statement in order to inform consumers of their HIPAA portability rights. Health plans must have written procedures for individuals to request certificates of creditable coverage.

Special Enrollment

HIPAA special enrollment rights are provided to individuals who are otherwise eligible for coverage under the plan, but declined to enroll (when they enroll they must be treated the same as individuals who enrolled when first eligible) because they had other health coverage and later lost the other coverage. The final rules clarify that special enrollment rights arise when: (i) an individual who initially did not enroll for coverage, without having other health coverage, may later be eligible for special enrollment as a result of subsequent open enrollment periods; (ii) an individual no longer resides, lives, or works in an HMO service area and the HMO does not provide coverage for that reason, as well as

if there is no other coverage under the HMO available to the individual; (iii) a dependent attains an age beyond the maximum age for coverage as a dependent child; (iv) an individual reaches a lifetime benefit limit on all benefits; and (v) an employee is already enrolled in a benefit package, he may enroll in another benefit package if a dependent of that employee has a special enrollment right under the health plan because the dependent lost eligibility for other coverage.

Model language for special enrollment notices is included in the final rules.

Excepted Benefits

Dental-only benefits, vision-only benefits and long-term care benefits are excepted from HIPAA in all circumstances, if they are provided for under a separate policy, certificate, or contract of insurance, or are "not an integral part" of the plan subject to HIPAA. Benefits are not an integral part of a health plan if participants have the right not to elect coverage for the benefits and if elected, must pay an additional premium.

Proposed Regulations

The Department of Treasury, Labor, and Health and Human Services also set forth proposed regulations. The proposed regulations, for which written comments are requested by March 30, 2005, include the following provisions:

- **Limited Tolling Rule** A limited tolling rule for preexisting condition exclusions and special enrollment periods providing that

if a certificate of creditable coverage is not provided on or before the date that coverage ceases, the 63-day coverage gap period (30-day period for requesting special enrollment) be counted from the earlier of the date that a certificate of creditable coverage is provided, or 44 days after the date coverage ceases.

- **Special Enrollment** The Departments proposed that: (i) a request for special enrollment should include any oral or written request made to designated individuals within the 30-day special enrollment period; (ii) health plans may require individuals to complete enrollment materials within a reasonable time after the initial 30-day request period, however individuals may not be required to provide information beyond that required from those enrolling in the plan when first eligible, only information concerning the event giving rise to special enrollment rights may be required, and deadlines must be extended for individuals making reasonable efforts to obtain information (e.g., newborn's social security number); and (iii) coverage in instances of birth, adoption, or placement for adoption must begin on the date of the event once enrollment information is substantially completed. If special enrollment occurs due to loss of other coverage or marriage, coverage must begin no later than the first day of the first calendar month

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beginning after the date the health plan receives the enrollment materials substantially completed.

- **FMLA and HIPAA** Pursuant to FMLA, employees may remain covered under their health plans while on personal approved leave. The proposed regulation provides guidance on HIPAA's interaction with FMLA, for example: (i) if a person on FMLA leave chooses not to continue health coverage for any period of the leave, the leave period is not counted in determining whether the individual incurred a significant break (63-day gap) in coverage; (ii) instances when certificates of creditable coverage must be automatically provided to individuals terminating coverage during or at the end of FMLA leave; (iii) in demonstrating FMLA leave for purposes of reducing or eliminating preexisting condition exclusion periods or obtaining special enrollment rights, a health plan is required to recognize all information about an individual's FMLA leave if s/he attests to that fact and cooperates in the health plan's efforts to verify the FMLA leave, however, a health plan's initial determination may be modified if the health plan subsequently determines that the individual was not on FMLA leave; and (iv) if an individual's coverage is terminated at any time during FMLA leave and the individual does not return to work for the employer at the end of the FMLA leave, the loss of eligibility gives rise to special enrollment rights at the end of the leave. •

Important Medicare Part D Filing Deadline for RX Tax Subsidy

In January 2005, the Centers for Medicare and Medicaid Services issued more guidance on the application process for the retiree prescription drug tax subsidy for qualifying plan sponsors. The highlights of the new guidance were:

- **Plan Sponsors Have Until September 30, 2005** to complete the application in order to receive the 2006 tax subsidy. Sponsors may request an extension of time to complete the application but the



beneficiary with a possible maximum of \$1,300.

Employers who provide health coverage to retirees should be evaluating their options in light of the financial and human relations considerations. The principal options for sponsors that qualify for the subsidy are:

- extension must also be filed by September 30, 2005.
- An actuarial attestation that (i) the employer-provided drug coverage is actuarially equivalent to the Medicare Part D coverage and (ii) the net value, after recognition of retiree contributions, under the employer-plan is greater than the net value under Medicare must accompany the application. (The application form has not been released yet.)

The average tax subsidy is estimated to be \$600 per Medicare

- Make no design changes and take the subsidy,
- Eliminate drug coverage from the plan. Premium reductions or payment of the Part D monthly premium should be considered as a giveback to the takeaway from the lost coverage,
- Reduce drug coverage to the minimum equivalent level and still qualify for the subsidy. Reducing benefit levels will also reduce the amount of the tax subsidy,
- Reduce drug coverage to simply supplement the Medicare Part D design. No subsidy would likely be available under this approach. •

IRS Guidance on Phased Retirement

The IRS in a notice of proposed rulemaking has issued guidance on formal phased retirement programs. Phased retirement would allow employees to cut their work hours and get part of their pension benefit before normal retirement. Under current rules, an employee must sever employment in order to receive an early retirement benefit. The administrative requirements and conditions in the proposed guidance include:

- A written document requirement,
- Employee participation must be voluntary and limited to those at least age 59 1/2,



- Participation must be limited to full-time employees, who partially retire and are expected to reduce their work hours by 20% or more,
- Retirement benefit would be limited to a pro-rata share of the participant's accrued benefit,
- A lump sum distribution or an installment period of less than 10 years is not allowed until the employee elects to take full retirement,
- The benefit must include all applicable early retirement

benefits and retirement-type subsidies,

- Participants would continue to earn additional benefits on a limited basis, and
- No key employees may be allowed to participate.

The employer would also have to make certain comparisons each year to ensure that a participant's work schedule is not materially greater than the work schedule used to

determine the phased retirement benefit. Employers considering implementing or formalizing a phased retirement program should address key issues dealing with:

- What eligibility requirements to use?
- How will incentive programs be affected?
- What is the impact on other benefits such as health care, disability and life insurance?
- What are the short-term and long-term implications?

The comment period on the proposed guidance ended on February 8, 2005. •

Did You Know That Nyhart Offers All of These Services?

COBRA Administration

- Preparation of required notices
- Tracking of election and coverage periods
- Collection and tracking of COBRA premium payment
- Carrier notification
- Compliance assistance

Defined Benefit Plans

- Actuarial plan design consulting
- Annual actuarial valuation
- Retiree medical plan management and consulting
- Non-qualified plan consulting
- Asset-liability modeling
- Plan administration outsourcing
- Plan document and SPD preparation for counsel review
- Web-based calculations

Defined Contribution Plans

- Daily valuation
- Quarterly statements
- Electronic data transmission
- Full compliance testing and consulting
- 24-hour voice response system
- Balance forward recordkeeping
- Plan design consulting
- Plan document and SPD preparation for counsel review
- Web-site retirement planning tool
- ESOP services

Flex Plans and HRA's

- Plan design consulting
- Debit cards
- Preparation of Plan Document and SPD for counsel review
- Custom design of employee communication materials
- Processing of participant enrollment and election information
- Processing, screening and payment of reimbursement requests
- Online account information and employer reports
- Compliance testing and consulting

Human Resource Consulting

Employee Relations

- Communication improvement
- Management training
- Employee relations assessments
- HR Department audits
- HR policy review and drafting
- Employee focus groups
- Leadership coaching

Employee Surveys

- Employee relations climate surveys
- Union organizing risk assessment surveys

Labor Relations

- Preventive labor relations seminars
- Union campaign management
- Strike preparation and management
- Contract strategy management
- Decertification campaign management
- Leadership coaching
- Compensation

Self-Funded Health Plans

- Plan design for medical, prescription drug, vision, dental and disability benefits
- Assistance in determining proper level of and placement of stop loss coverage
- Interface with PPO networks, including repricing services
- Claims screening for coding errors, R & C, unbundling, COB and TPL
- Detailed monthly management reporting
- Plan document and SPD preparation for counsel review
- Actuarial assistance with funding rates, reserve levels and impact of benefit changes
- Calculation of post retirement plan liabilities (FAS 106)
- Predictive modeling

White House Proposal for Pension Reform

The White House recently published its view of what the reform should look like. What follows is a summary of the key concepts and changes proposed by the Bush Administration.

Concept: Base funding rules on meaningful and accurate asset and liability measures

- Funding targets that are based on liabilities that reflect the financial health of the employer. Liability measurements would be based on a plan's projected benefit cashflow and a pension yield curve determined by the IRS based on Moody AA-rated bonds. The projected benefits would only reflect currently accrued benefits. The employer's credit-worthiness could affect this determination by increasing the liability measurement. Credit balances in the funding standard account would no longer be used to offset contribution requirements.
- The use of market values of assets would be required and no smoothing would be allowed.
- A 7-year amortization period for funding shortfalls would be used. Depending on the employer's financial health and funded status, accelerated funding might

be required for benefit improvements.

- Employers would have the opportunity to make additional deductible contributions in good years, even when the plan's assets are above the funding target.

Nyhart comments - The proposed funding rules clearly are changing the focus from long-term funding to short-term funding and restricting the flexibility to select appropriate assumptions and methods that fit a plan sponsor's objectives and financial goals. A long debate will certainly follow that will deal with the transition period to the proposed rules so that employers are not saddled with possible contribution increases.

Concept: Limitations on benefit increases

Employers would be restricted on benefit increases, lump sum payments, benefit accruals, and funding nonqualified executive pension benefits based on the plan sponsor's financial health and the plan's funding level. The funding target would be calculated using the proposed changes described earlier.

Concept: Improve PBGC financial status

- The flat rate premiums will be adjusted (initially to \$30) to reflect the growth in worker wages since 1991, when the current \$19 figure was set. Going forward, the flat rate premium will be indexed for wage growth.
- The risk-based premium will be charged to each plan based on underfunding relative to its funding target. The risk-based premium rate will be adjusted periodically by the PBGC's Board so that premium revenue is sufficient to cover expected losses and improve PBGC's financial condition.
- The PBGC's claims in the event of a bankruptcy would be given a higher priority in bankruptcy court.

Concept: Expand retirement choices for employees

- The administration would push for legislation to support the continuation and creation of hybrid pension plans, such as cash balance plans and pension equity plans that combine the best of defined benefit and defined contribution designs. These types of plans are portable, easier to understand, and guaranteed by the PBGC.
- The administration would also encourage plan sponsors to allow employees to diversify out of company stock after three years. Employees would also have increased access to investment education.

The proposal would be effective for plan years beginning on January 1, 2006 and later.

Please contact a Nyhart consultant or actuary if you are interested in doing an impact analysis of the proposal to your pension plan or would like more information on the proposal. •

Percentage Points Below Required Funding Level (Target)	Bankrupt Sponsor	Junk Grade Sponsor (At-Risk Liability Target)	Investment Grade Sponsor (Ongoing Liability Target)
0 to 19	<ul style="list-style-type: none"> No benefit increases No lump sums No accruals 	<ul style="list-style-type: none"> No new restrictions 	<ul style="list-style-type: none"> No new restrictions
20 to 39	<ul style="list-style-type: none"> No benefit increases No lump sums No accruals 	<ul style="list-style-type: none"> No benefit increases No lump sums 	<ul style="list-style-type: none"> No benefit increases
40 or worse	<ul style="list-style-type: none"> No benefit increases No lump sums No accruals 	<ul style="list-style-type: none"> No benefit increases No lump sums No accruals No preferential funding of executive compensation 	<ul style="list-style-type: none"> No benefit increases No lump sums

Proposed Tax Changes Would Affect Section 125 And 403(b) Plans

On January 27, 2005 the Staff of the Joint Committee on Taxation issued a report outlining 69 suggestions as to how the tax code could be simplified, and additional revenues raised. Several of the proposals would affect Section 125 plans including:

- Dependent care expenses would only be allowable as a tax credit, and dependent care flexible spending accounts would be abolished,
- FICA would be payable (by both the employer and the employee) on Section 125 plans,
- Over-the-counter drugs would no

longer be reimbursable under a health FSA, an HRA or an HSA.

Under the proposal, 403(b) plans would no longer have special rules permitting annual additions after termination of employment or additional elective deferrals if the employee had more than 15 years of service. Additionally, the uniform availability rule would be replaced with the ADP test used under 401(k) plans.

Note that these are simply proposals, but they would significantly impact benefit plans if enacted. If you have concerns, contact your U.S. Senator or Representative. •



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