

ERISA Compliance

for Health & Welfare Plans



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What's New in the 2nd Qtr. 2012 Edition

This What's New section highlights the changes made in the last quarter to *ERISA Compliance for Health & Welfare Plans*—the authoritative ERISA resource for employers, administrators, and advisors.

Also see the 2nd Qtr. 2012 *Current Developments* newsletter, which can be accessed under the Bookmarks tab. The *Current Developments* newsletter summarizes important legal developments that occurred during the quarter.

Below are some highlights of the substantive changes that we made to the Outline and Appendix.

Substantive Changes to the Outline:

- **Section V—What Employers Are Subject to ERISA's Requirements?**
 - V.B—*Exemption for Certain Governmental Entities*. The discussion of ERISA's governmental plans exemption has been updated to reflect a recent DOL Advisory Opinion holding that more than de minimis participation by private nonprofit employers in a governmental plan will cause the plan to fail to meet ERISA's definition of governmental plan.
- **Section VI—What Workplace Fringe Benefits Are Subject to ERISA?**
 - VI.E—*Are Plan Benefits Provided to Participants or Beneficiaries?* In our discussion of one-employee arrangements, we have added a note about a further development in a case discussed in this subsection.
- **Section VII—Voluntary Plans—When Are they Subject to ERISA?**
 - VII.C—*Detailed Review of Voluntary Plan Safe Harbor* and VII.E—*Table of Cases and DOL Opinion Letters Addressing the Voluntary Plan Safe Harbor*. The extent of employer involvement in a voluntary employee-pay-all plan is a key factor in determining whether the arrangement is subject to ERISA, making this issue a frequent subject of litigation. We have updated our detailed review of safe harbor factors to reflect two recent cases addressing whether a plan falls outside the safe harbor if it permits voluntary plan premiums to be paid through the employer's cafeteria plan. These cases have also been added to the Table of Cases.
- **Section XXII—Annual Form 5500 Reporting to the DOL.**
 - XXII.F—*Form 5500 Mechanics: Who, What, When, and How*. We've added a box to this subsection, highlighting recent IRS guidance regarding common errors in filing the Form 5558 extension for the Form 5500.
- **Section XXIV—Summary Plan Descriptions & Summaries of Material Modifications.**
 - XXIV.O—*Four-Page Summary of Benefits and Coverage (SBC) Under Health Care Reform*. The effective date for health care reform's summary of benefits and coverage (SBC) requirement is fast approaching. Group health plans that are subject to the SBC requirement must be prepared to distribute SBCs beginning with the first open enrollment period that starts on or after September 23, 2012 (or, if earlier, the first plan year that begins on or after that date). The agencies responsible for implementing the SBC requirement recently issued FAQs to try to address some of the many outstanding questions about preparing and providing the SBC. These recent FAQs are now reflected in the manual's SBC discussion. We've also updated this discussion to include information about the 2012 list of counties and languages for meeting the "culturally and linguistically appropriate" element of the SBC requirements, which is available on the HHS website.
- **Section XXX—Plan Administration With Third-Party Administrators.** Plan administration is becoming increasingly complex, and many plan sponsors turn to third-party administrators to assist with day-to-day plan operations. Because engaging a third-party administrator has fiduciary implications, employers must exercise prudence in making a selection and entering into an agreement with a third-party administrator. We have revised this Section of the manual throughout, highlighting key issues of concern to employers and service providers alike, and noting many practical pointers and potential pitfalls.

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- **Section XXXIV—*Claims Procedures for Group Health Plans.***
 - XXXIV.E—*Paperwork for Group Health Claims Procedures.* Health care reform requires certain claims and appeals notices to be made available in a “culturally and linguistically appropriate manner.” Specific language requirements apply to a notice sent to an address in a county where 10% or more of the population residing in a county are literate only in the same non-English language (based on U.S. Census data). HHS recently published an updated list, in effect for 2012, of the relevant counties and languages. The discussion of claims procedures for group health plans has been updated to reflect this updated list; we’ve made a few other clarifications to this Section as well.
- **Section XXXVI—*ERISA Litigation.***
 - XXXVI.C—*Standard of Judicial Review Applied to Benefit Decisions Under ERISA Plans*, XXXVI.E—*Time Limits for Filing Benefit Claims: Statute of Limitations*, and XXXVI.J—*Some General Procedural and Remedies Issues in ERISA Litigation.* We have added discussions of recent cases throughout these subsections of the ERISA litigation Section of the manual. These include cases on the application of the standard of review in ERISA cases (de novo or arbitrary and capricious), plan-imposed statutes of limitations for filing lawsuits, and the requirement to exhaust plan claims procedures.

Substantive Changes to the Appendix:

- **Tab 7—DOL Regulations**
 - Updated TOC
- **Tab 11—Miscellaneous**
 - Updated Government Phone Numbers

Lots More to Come! From the feedback we’ve received, we know that our manuals are the premier group health plans resources in the country. But here at EBIA we’re not satisfied. We are constantly striving to make the manual even better. In upcoming editions, look forward to complete coverage of all legal developments affecting ERISA compliance, and to our further analysis of existing law, with more examples and Q/As, etc.

EBIA Weekly. Keep up with new legal developments as they occur: sign up now for the EBIA Weekly, a free email newsletter, at www.ebia.com.

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