

Health and Welfare Employee Benefit Plans

The AICPA Employee Benefit Plan Audit Quality Center (EBPAQC) has developed this primer to provide members with a basic understanding of health and welfare employee benefit plans. This primer provides a general overview of health and welfare plans; discusses defining the plan, unique aspects of health and welfare plan contributions, funding of benefits, key roles and responsibilities, the annual health care process, unique aspects of health and welfare plan benefit obligations, benefits administration, when an independent audit is required, and applicable laws and regulations; and provides references to additional resources.

Introduction

Welfare benefit plans—commonly referred to as health and welfare plans—are described in Title I of the Employee Retirement Income Security Act of 1974 (ERISA) and include any plan, fund, or program that provides:

- Medical, dental, prescription drugs, vision, psychiatric, long term health-care, life insurance, or accidental death or dismemberment benefits
- Benefits for postemployment (benefits for former or inactive employees after employment has ended but before retirement), such as Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits, severance, or long-term or short-term disability
- Other benefits such as sick leave, vacation, holiday, apprenticeship, tuition assistance, day care, dependent care, housing subsidies, or legal services
- Postretirement benefits, such as medical, dental, prescription drugs, vision and life insurance
- Supplemental unemployment benefits

Plans may cover active employees, terminated employees, dependents, retirees, or beneficiaries.

A defined benefit health and welfare plan specifies a determinable benefit, such as medical coverage, to participants. The level of benefits may be defined or limited based on factors such as age, years of service, and salary. The benefits may be in the form of reimbursements to participants or a direct payment to the providers or third-party insurers for the cost of specified services. Contributions may be determined by an actuary or calculated based upon premiums, actual claims paid, hours worked or other factors.

A defined contribution health and welfare plan provides an individual account for each plan participant (for example, a medical plan where a specified dollar amount is contributed by the employer on behalf of the participant and made available for use in paying that participant's eligible medical expenses). The plan's terms specify the means for determining contributions rather than the amount of benefits that will be covered by the plan. Benefits are limited to amounts contributed and any forfeitures allocated to the participant's account, plus or minus investment experience, minus expenses incurred. When the participant's account is depleted, no additional benefits are available to that participant.

Some plans may include a combination of both a defined benefit and a defined contribution component (for example, a group medical plan (defined benefit) with a flexible spending account feature (defined contribution)).

Health and welfare benefit plans may be single employer, multiemployer, or multiple employer plans. See the EBPAQC Primer, *Multiemployer Employee Benefit Plans* (Multiemployer Plans Primer), for more information about multiemployer health and welfare plans.

Laws and Regulations

Health and welfare plans are subject to the provisions of ERISA, which generally requires plans to file an annual Form 5500, *Annual Return/Report of Employee Benefit Plan* (Form 5500), with the U.S. Department of Labor (DOL). Fully insured and unfunded health and welfare plans with fewer than 100 participants as of the beginning of the plan year (as defined by ERISA) do not have to file a Form 5500. Multiple employer welfare arrangements (MEWAs) have additional unique filing requirements.

ERISA also establishes standards for participation and vesting and benefit accruals, rules that all fiduciaries of the plan must follow, and which plans require an independent audit. Not all health and welfare plans require an independent audit under ERISA. Generally, plans that are unfunded, fully insured, or a combination of unfunded and insured do not require an audit. If the plan is funded (which may be indicated by the establishment of a trust to hold assets to pay all or part of covered benefits, or the existence of a separate fund or account for the plan from which benefits are paid) *and* there are more than 100 participants as of the beginning of the plan year, an audit generally would be required. Generally, no regulatory funding requirements exist for health and welfare plans.

Health and welfare plans receive and maintain large amounts of personal information (for example, name, address, date of birth, Social Security number, financial account number, and health information). The confidentiality of such information is protected by both federal (the Health Insurance Portability and Accountability Act [HIPAA] and Technology for Economic and Clinical Health [HITECH] Act) and state laws and regulations. For example, HIPAA establishes standards for the privacy and protection of individually identifiable health information. HIPAA rules (applicable to health plans, health care clearinghouses, and certain health care providers, known collectively as "covered entities") present standards with respect to the rights of individuals who are the subjects of this information, procedures for the exercise of those rights, and the authorized and required uses and disclosures of this information. HIPAA requires that plan sponsors enter into a business associates' agreement with any of their service providers (including plan auditors) that have access to any protected health information (PHI). The HITECH Act expanded several HIPAA security and privacy requirements (including business associates being subject to civil and criminal penalties and enforcement proceedings for violations of HIPAA) and added an affirmative notice requirement for health plan sponsors and business associates that discover a breach of an individual's "unsecured" PHI if the breach constitutes significant risk of financial, reputational, or other harm to an individual.

The *Patient Protection and Affordable Care Act*, signed into law in 2010, contains many changes for plan sponsors that may affect plans and plan participants, including but not limited to fees, coverage mandates, taxes, and benefits.

Defining the “Plan” and Determining Its Reporting Requirements

For various reasons, unlike a defined benefit or defined contribution retirement plan, defining a health and welfare “plan” for financial and regulatory reporting purposes is not always clear. Whereas a single document describes the retirement plan’s terms and conditions related to the operation and administration of the plan, multiple documents may exist for a company’s health and welfare plan (for example, a plan agreement, summary plan description, insurance carrier certificates of coverage, and employee handbooks).

Employers may sponsor an individual health and welfare benefit plan that provides only one type of benefit (for example, one that provides only medical benefits), or a plan that includes various “programs” (which may or may not have their own documents that specify their terms) combined into a single plan using a wrapper plan document. For example, a wrapper plan may provide medical benefits, dental benefits, and vision benefits. The wrapper plan document generally does not define plan terms or describe plan benefits; rather, they are defined in the documents described above. However, the wrapper plan document provides the

important documentation backbone shared by the plans wrapped therein. Wrapper plans are also known as "omnibus" or "umbrella" plans.

The nature and design of the plan (the covered participants, benefits covered under the plan, who contributes to the plan, and how benefits are funded) directly affects its accounting and reporting. Determining what actually constitutes the "plan" likely will require a review of all the relevant documentation noted above as well as previously filed *Annual Return/Report of Employee Benefit Plan* (Form 5500s) and any wrapper documents. Consultation with ERISA counsel may also be needed in situations where the available documentation is unclear. Sponsors of health and welfare plans typically go through an annual comprehensive process to evaluate the benefits they provide, which frequently results in changes made to the benefits offered, vendors utilized, and cost sharing amounts. This further complicates the process of identifying the plan.

A plan that meets the criteria described in the "Laws and Regulations" section above must file an annual Form 5500 with the DOL. In situations where employers sponsor multiple individual plans, an evaluation must be made for each separate plan as to whether a Form 5500 must be filed. However, a wrapped plan will file a single Form 5500 that includes all wrapped programs.

Following are two scenarios for XYZ Company that result in different Form 5500 filing requirements for its health and welfare benefit offerings, which include: self-funded medical benefits with stop-loss insurance (200 participants); self-funded prescription drug benefits (200 participants); fully insured vision benefits (180 participants); self-funded dental benefits (80 participants), and fully insured life insurance benefits (150 participants).

Scenario 1: XYZ Company has combined the five benefit programs into a single plan using a wrapper plan document. As such, all benefits are considered a part of one single welfare plan, and a single Form 5500 will be filed for that "plan".

Scenario 2: XYZ Company sponsors a separate plan for each benefit provided and, as such, each plan must be evaluated separately to determine whether it requires a Form 5500 filing. In this scenario, separate Form 5500 filings would be made for the medical plan, the prescription drug plan, the vision plan, and the life insurance plan because they each have more than 100 participants. The dental plan, though self-funded, would not require a Form 5500 filing as it only covers 80 participants.

An unintended consequence of sponsoring a single wrapper plan for all of an employer's benefit programs, as discussed above, is the need to subject certain components of the wrapped plan to the DOL's audit requirement that may not have otherwise required an audit (for example, in scenario 1 above, if contributions to the wrapped plan are made into a trust for the payment of benefits, the dental plan would be subject to audit even though it only has 80 participants). As such, some employers may choose to have more than one wrapper plan document for different plans.

Once the reporting entity has been established, all plan transactions, whether paid through a trust or otherwise (for example, some plans may pay only a portion of the plan's benefit payments and expenses through a trust), should be recorded in the plan's Form 5500 and financial statements, if required.

The Internal Revenue Code (IRC) provides for certain types of tax-advantaged financial arrangements such as flexible spending accounts (FSAs), health savings accounts (HSAs), and health reimbursement accounts (HRAs). FSA and HRA activity would be included in the plan's Form 5500 and financial statements (if required), whether in a wrapped or standalone plan. Alternatively, when an HSA (an individual account similar to an individual retirement account (IRA) that reimburses individuals for out-of-pocket medical expenses and health insurance premiums) is wrapped into a health and welfare plan, the activity would not be included in the plan's Form 5500 or financial statements (if required), but certain financial statement disclosures may be appropriate.

Unique Aspects of Health and Welfare Plan Contributions

Contributions to a health and welfare plan can come from the employer, participants (active or inactive employees, retirees, or COBRA participants), or a combination of both. Employer contributions may be voluntary or required under the terms of the plan (or a multiemployer plan's collective bargaining agreement). Contributory plans require contributions from participants and/or employers, while noncontributory plans do not require contributions from participants.

Contributions by active participants typically are made through payroll withholdings. When contributions are withheld from payroll, they either are remitted to the related plan trust account or sent directly to the applicable service provider.

Contributions by participants covered under COBRA and retirees are paid directly to the plan sponsor or to a third-party administrator. For retirees, the contribution amounts also may be withheld from pension retirement checks. More commonly, COBRA and retiree contributions are made to the plan sponsor or trustee by way of a lock box, and then deposited from the lock box into the plan's trust. Payments made directly to the plan sponsor are either deposited into the trust or used directly to pay benefits. In many cases, the collection of COBRA and retiree contributions is performed by outside administrators. However, there are times when enrollment records for COBRA and retirees are maintained by the plan sponsor who, in turn, collects the contributions.

By law, participant contributions deposited into a trust of a health and welfare plan must be used to pay benefits or be deposited on the earliest date they can reasonably be segregated from the employer's general assets, but in no event later than 90 days from the date on which such amounts are withheld or received by the employer.

Funding of Benefits

Many health and welfare plans are self-funded, meaning that the employer bears the risk of paying plan benefits. A plan sponsor may choose to pay health benefits on a pay-as-you-go basis directly from the general assets of the corporation (which may include participant contributions collected by the plan sponsor), in which case the plan is considered to be unfunded. Alternatively, a trust may be established to hold assets from employer and/or employee contributions to pay all or a part of the covered benefits, in which case the plan is considered funded. There are various trust arrangements under which assets may be segregated and legally restricted for the purpose of paying benefits, including:

- A voluntary employee benefit association, or VEBA – A VEBA is an IRC Section 501(c)(9) trust that generally is tax exempt, defined as a mutual association of employees providing certain specified benefits to its members or their designated beneficiaries which may be funded by the employees or their employer.
- A supplemental unemployment trust – A supplemental unemployment trust is an IRC Section 501(c)(17) trust that is tax exempt if it meets certain requirements. It provides for the payment of supplemental unemployment compensation in situations of involuntary separation from employment; sick and accident benefits may be included in the plan if these are subordinate to the unemployment compensation benefits.
- A taxable trust – Benefits may be funded through a taxable trust, such as a grantor trust, which is a flowthrough entity for tax purposes that files an informational return and all income and assets are reported on the "grantor's" income tax return.
- A 401(h) account – Some defined benefit pension plans provide a postretirement medical benefit component in addition to the normal retirement benefits of the plan pursuant to Internal IRC Section 401(h). The 401(h) assets may be used only to pay current retiree health benefits, which generally are obligations of a separate health and welfare plan or health benefit arrangement.

- Other funding vehicles – In certain instances, when a separate fund or account is in the name of the plan to hold contributions and make distributions, the plan may be deemed funded under ERISA even if that was not the intent.

Plans also may be fully insured, whereby a premium is paid by the plan sponsor to an insurance company and the insurance company assumes the risk for the payment of benefits. The plan may be insured under a pooled arrangement (insurance premiums are based on the experience of a pool of other similar plans) or an experience-rated arrangement (insurance premiums are based on the experience of the specific plan).

Sometimes the insurance company and the plan sponsor share the risk of paying benefits. A plan sponsor may enter into a minimum premium arrangement whereby the employer pays a reduced monthly premium to an insurance company and agrees to assume the cost of the expected, or predictable, claim payments. The insurance company funds the cost of any excess, or catastrophic, unpredictable, claims. Or the plan may enter into a stop-loss arrangement that limits claim coverage by the plan to a specific amount, which ensures that catastrophic or higher-than-expected claims do not deplete the financial reserves of a self-funded plan or endanger the financial stability of the employer if the plan is unfunded. For example, if total claims exceed the stop-loss limit, the insurance company reimburses the plan.

Key Roles and Responsibilities

Following is a list of the key parties involved in the operation and administration of a health and welfare plan. An understanding of the roles and responsibilities of these parties can be obtained from the plan document, collective bargaining agreement, trust document, service agreements, insurance contracts, and internal policies and procedures manuals.

- *Plan sponsor.* Typically, the employer or an employee organization, such as a union, trade association, or professional association.
- *Plan administrator.* An individual who is identified in the plan document as having responsibility for managing the day-to-day administration and strategic decisions for the plan. The plan administrator can be the employer, a committee of employees, a company executive, or someone hired for this purpose.
- *ERISA counsel.* Legal counsel that has a specialization in the IRC, ERISA, and legal matters surrounding plan operations.
- *Trustee.* The party who has the exclusive authority or discretion to manage the plan's assets. The trustee can be subject to the direction of a named fiduciary (person or entity specified in the written plan).
- *Custodian.* The custody of the plan's investments is entrusted to a bank, an insurance entity, or a member of a national securities exchange that is responsible for their receipt, delivery, and safekeeping under a contract. A custodian may also serve as the trustee.
- *Insurance company.* As discussed above, the insurance company may provide fully-insured benefits or stop-loss coverage, and may hold plan assets, process claims, or serve as an outside administrator for plans.
- *Claims processor (also referred to as a claims adjudicator).* The party that processes participant claims for self-funded benefit plans.
- *Outside administrators.* A third-party provider commonly used for outsourced enrollment, eligibility, and contributions for COBRA and postretirement participants.
- *Plan actuary.* Specialist used by management who is engaged to determine the present value of the plan's benefit obligations, such as claims incurred but not reported [IBNR], postemployment, and postretirement obligations.
- *Pharmacy benefits manager.* A third party organization used by employers providing prescription drug benefits to help control drug costs.
- *Other service providers.* Third-party organizations that provide services such as payroll processing and human resources management (open enrollment, eligibility, claims administration oversight).

Annual Health Care Process

As noted above, sponsors of health and welfare plans typically go through an annual comprehensive process to evaluate the benefits they provide, which frequently results in changes made to the benefits offered,

vendors utilized, and cost sharing amounts. Following are activities in which plan sponsors engage during this process.

Annual Contract Negotiation With Service Providers. Plan sponsors assess existing contracts and then engage in contract negotiations with their service providers, giving consideration to any new legislation or regulatory changes. Once the contracts are executed, the plan sponsor determines the contribution rates to be paid by participants depending on the level of coverage the participant has selected.

Employee Communication and Open Enrollment. Plan sponsors communicate the annual benefit offerings to eligible participants during the open enrollment process. Changes in benefit vendors benefit costs, options, and eligibility criteria (if any) are communicated at this time. Participants then select their benefits and level of coverage.

Payroll, COBRA, and Retiree Contribution Process. Required contributions from eligible participants are input into applicable systems so the proper contributions can be withheld, collected, and remitted to appropriate vendors.

Benefits Administration. Benefit claims are processed either internally or externally through a third party.

Funding or Payment of Service

Payments of claims or premiums are made based upon pre-established funding criteria as documented in contractual agreements.

Unique Aspects of Health and Welfare Plan Benefit Obligations

Benefit obligations represent the cost of the future benefits "promised" by the plan and earned by the participants up to the measurement date. Benefit obligations are calculated based on claims experience, health trends and demographic information maintained by the plan, its third party administrator, or both. The fact that benefits may be reduced or even eliminated in the future ordinarily would not affect the promise made as of the end of the plan year unless certain criteria are met (for example, an amendment is in place or has been communicated to employees).

In addition to amounts payable for claims that have been submitted and premiums due to insurance companies, health and welfare plans have the following unique benefit obligations:

- *IBNR* are amounts due for services that have been rendered as of the financial statement date, but not yet billed to the plan.
- *Postemployment benefit obligations* are actuarially determined based on amounts expected to be paid in subsequent years to current participants who will receive benefits after employment has ended but before retirement.
- *Accumulated eligibility credits* allow participants who have accumulated a sufficient number of "eligibility credits", or hours, continued coverage in periods when they may not have worked the minimum required hours to maintain coverage. Accumulated eligibility credits are more common in multiemployer plans. The Multiemployer Plans Primer provides more details on accumulated eligibility credits.
- *Postretirement benefit obligations* are actuarially determined and include benefits expected to be paid to or on behalf of retired plan participants, including their beneficiaries and covered dependents, other plan participants fully eligible for benefits, and plan participants not yet fully eligible for benefits.

Benefits Administration

Some plan sponsors use administrative service only agreements (ASO), where the plan contracts for administrative services, such as preparation of an administration manual, communication with employees, preparation of government reports (e.g., Form 5500), preparation of summary plan descriptions, accounting, and adjudication and payment of benefits (claims processing).

The claims administration process is complex. Service centers or clearinghouses may be utilized by claims processors to process submitted claims and queries from participants or health care service providers. As participants receive services from a physician or other providers, participants or their providers generally submit claim forms (electronic or paper) to a clearinghouse that reviews the claim for accuracy and completeness and then submits the claim to the individual claims processor. Paper claims are typically imaged and then manually keyed into an electronic format by the clearinghouse before processing through the claims processor's system. Electronic claims received by claims processors follow one national standard format.

Once a claim is received into the claims processor's system, information on the claim is validated electronically against stored data. For claims not validated, a request for additional information may be sent back to the participant, eligible dependents or beneficiaries, or service provider.

In the claims payment process, electronic edit checks match information submitted via the claim with known information in the claims processor's system. Significant edit checks may include, but are not limited to, the following:

- Member eligibility
- Covered benefit
- Required referral on file
- Excluded coverage or procedure
- Proper coding
- Timely receipt of claim
- Benefit limits
- Authorized provider
- Coordination of benefits
- Duplicate claims
- Others, depending on the claims processor

Passing or failing edit checks determines whether claims are approved, denied, or suspended for manual review. Claims adjustments, such as errors identified in quality reviews, requests for reconsideration, refunds from physicians, recoveries from subrogation (reimbursement from the responsible party for a claim the plan has already paid) and legal settlements, claims audits, and credit balance recoveries, could result in refunds to the plan.

The plan sponsor typically will negotiate with the claims processor when and how the plan will be billed for claims paid. The claims processor may require a cash deposit from the plan to pay benefits. The deposit is reduced as claims are paid and is subsequently replenished. Alternatively, the claims processor may pay the claims and then seek reimbursement from the plan for claims paid. Payments are prepared and sent to providers or plan participants and either an invoice is created for issued payments, or the plan bank account is charged for the payments that have cleared the bank.

An explanation of benefits that includes details about how and why claims were or were not covered, a summary of charges submitted and processed, amount allowed, amount paid, and other relevant information is sent to the participant for each claim. Reports are made available by the claims processor to plan sponsors related to the claims activity of the plan (claim expense reports, claim lag study, detail payment logs, payments by benefit type, payments by month, and large claim reports) usually through an online portal.

Additional Resources

FASB ASC 965, *Plan Accounting—Health and Welfare Benefit Plans*, provides the reporting and disclosure requirements for health and welfare employee benefit plans.

AICPA Audit and Accounting Guide, *Employee Benefit Plans*, provides information about health and welfare plans and guidance on auditing those plans, and provides illustrative financial statements, including notes, for a health and welfare benefit plan.

Annual AICPA Audit Risk Alert, *Employee Benefit Plans Industry Developments*, highlights the hot topics in the employee benefit plans industry, including current issues related to health and welfare plans. **AICPA Technical Practice Aids, *Technical Questions and Answers, TIS Sections 6931-6939***, address frequently asked questions about various employee benefit plan related topics, including health and welfare plans.

AICPA AU-C Sec. 500, *Audit Evidence*, addresses the auditor's responsibilities relating to the work of a management specialist, including actuaries, when that work is used to assist the auditor in obtaining sufficient appropriate audit evidence.

AICPA *Employee Benefit Plans Accounting Trends & Techniques*, provides illustrative disclosures for financial statements of employee benefit plans, including health and welfare plans.

AICPA EBPAQC Primer, *Plan Sponsor Subsidies Under the Medicare Prescription Drug Improvement and Modernization Act of 2003*, provides information the Act and how it might be relevant to plans.

AICPA EBPAQC Primer, *Insurance Company Products Offered to Employee Benefit Plans*, provides readers with a general understanding of products offered by insurance companies as funding options for employee benefit plans.

AICPA EBPAQC Primer, *Multiemployer Employee Benefit Plans*, provides readers with a basic understanding of multiemployer employee benefit plans.

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