Q&A Session Post NAHU Webinar, "Understanding the Basics of Health and Welfare Form 5500: The Who, What, Why, When, Where and How" held on June 9, 2016.

1. Question:
How do you determine if a self-funded plan is considered "funded." If the plan accumulates a claim reserve or excess funds, is it automatically considered funded. How would a self-funded plan not be considered funded?

Answer:
Before I address your questions I wanted to say that my answers are generally-speaking, applying the basic fundamentals. As I researched I saw some very fine tuned details that are break-aways/outliers. For an example under a self-funded plan, you normally don't hear the term "plan assets." However if under a self-funded Rx plan, the prescription manufacturer's rebates would come back to the Employer as Plan Assets. This is beyond what I am covering, again a very fine detail/outlier.

Metaphorically-speaking, looking at a self-funded plan (also known as unfunded) and funded plan is like comparing apples and oranges. They are two separate types of entities. You cannot have self funded = funded. This may be more understood by looking at the four benefit payment methods.

Benefit Payment	Label	How Claim Reserves Handled?
Payment solely from general assets of the employer;	Unfunded a.k.a Self- Funded	Funds in general assets would be used for claims.*
Insurance purchased from an insurance company or HMO (not counting stop-loss insurance);	Insured-plan a.k.a. Fully-insured	Insurance carrier is responsible to pay claims.
Separate funds maintained exclusively for purposes of the plan	Funded	Funds are allocated within the Plan assets for claims.
Contributions from plan participants or beneficiaries.	Funded	Could be used for claims if need be**

* A Plan Administrator needs to be careful around Self-funded benefits and claim reserves. Per the DOL an employer may, without creating plan assets, "set aside some of its general assets in a segregated employer account for the purposes of providing benefits under the plan." The DOL has also said that "the mere segregation of employer funds to facilitate administration of the plan would not in itself demonstrate an intent to create a beneficial interest in those assets on behalf of the plan." However, if the funding policy is noted in the Plan Document as a separate Plan Account, a trust would be needed. As a result, Wrangle advises for an ERISA attorney to be asked on the do and don'ts self-funded benefits and claim reserves.

**Employee contributions are plan assets. However, the DOL granted them special permission to reside outside of a trust/funded plan and held in general assets no more than 90 days. Within 90 days the contributions are to be segregated from the general assets and paid to the carrier or to pay claims such as those for a FSA Plan. This is known as Technical Release 92-01.

An ERISA Plan can be a combination of each of these payment methods. In other words, you can have running along-side of each other a self-funded benefit, a fully-insured benefit and one that is paid under Plan assets within an ERISA Plan.

As for the question, "If the plan accumulates a claim reserve or excess funds, is it automatically considered funded?"

Answer: Not necessarily. I have seen an insured plan, not under a Trust (funded plan) that is under an experience-rated contract. As a result the Schedule A shows how the carrier calculates the premium and allocates portions for such aspects of claim reserves. Additionally, a self-funded plan can have a portion of its general assets for claims and not have them labeled as "funded." – see **"*"** under the table above.

I hope this helps shed some light to give you a basic understanding. With employee benefits, to learn the basics is certainly just the beginning and often times many need to seek the advice of an ERISA attorney to know how to carry out ERISA provisions with their benefit plans.

2. Question:

Does a small self-insured plan that does accept employee contributions, need to file a 5500?

Answer:

If the self-funded plan is not under a trust and has under 100+ participants* on the first day of the ERISA Plan year, it is not required to file a Form 5500.

*As a reminder the participant is: Active Employees (subscribers) +Active Enrolled COBRA + Active enrolled retiree subscribers; dependents are not included).

3. Question:

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Regarding the Form 5558 and the one-time extension option, is the one-time extension per plan year, or is it that only one extension can be filed over the entire life of a plan?

Answer:
To answer your question, the Form 5558 is to be applied per filing year (and would need to be submitted/mailed by the original DOL deadline). ERISA Plans for instance under a Trust, require the extension to be filed for each filing since Trusts require more time to gather the data from all parties involved.

Your idea to have it be for the life of the Plan is a good one. This certainly would be a help.

4. Question

Is the carrier required to provide Schedule A information (a completed Schedule A) to the plan sponsor or does the plan sponsor need to request the information?

Answer:
Technically speaking, carriers are required under ERISA to send a Schedule A by the 120 days after the end of the Plan Year.* Not all automatically do so. As a result, request(s) need to be submitted. Please note: some carriers such as Aflac will only submit the Schedule A to the Plan Sponsor/Client.

> * The Department's regulation at 29 C.F.R. § 2520.103-5 implements section 103(a)(2) of ERISA with respect to annual reporting requirements under Title I

5. Question

For the Voluntary Delinquent Filer program, if the 5500 has not been filed for a number of years and the plan sponsor reports this through the VDF program with the filings is the penalty limited to $4,000 total, or is it $4,000 per plan year that was not filed in a timely manner?

Answer:

If the Plan Sponsor used the DFVC Program and has multiple years late, the penalty fee is capped at $4,000 per Plan. If there is just one ERISA Plan, i.e. Plan 501 and it is late by six years, the fee is capped at $4,000. If the Plan Sponsor in contrast has Plan 501 and 502 and both are multiple years late, then it is $4,000 per Plan. Two separate checks/online payments of $4,000 would be required.

6. Question

I am still having a hard time determining the Form 5500 filing date of a group with a calendar year ERISA plan year. They have a medical policy year of June 1 – May 31. The first time they reached the 100+ participant threshold for their medical plan was June 1, 2015. Would they need to file by July 31, 2016 or July 1, 2017?

Answer:

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You have asked an excellent question. The provisions and details of 5500s under ERISA are not ones that are easily grasped.
When a Group has an ERISA Plan Year of January 1 – through December 31st but the policies are not of the same timeframe, I still sometimes need to draw out the timeline. Rules to follow:

Schedule A cannot exceed 12 months or exceed the ERISA Plan Year, but can start prior to the ERISA Plan Year. The due date would be July 31, 2017.