



# Understanding Health & Welfare Employee Benefit Plan Compliance

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# Introductions



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# Firm Overview

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# Guest Speaker



**L. Renée Lieux**

**McNees Wallace & Nurick**

Renée is Chair of the Employee Benefits & Executive Compensation Group. Clients seek her assistance with the establishment, compliance, and administration of pension plans, welfare benefit plans, and fringe benefit plans, including defined contribution plans, defined benefit plans, profit sharing plans, 401(k) plans, employee stock purchase plans, ESOPs, governmental plans, Taft-Hartley multiemployer pension and welfare plans, municipal pension plans, 457(b) and (f) plans, 403(b) plans, cafeteria plans, flexible spending accounts, HRAs, VEBA's, and insured and self-insured welfare plans.

Renée has extensive experience counseling clients on ERISA and the complex tax laws which impact benefit plans, including Sections 409A and 280G of the Code. Her experience includes reviewing plan documents for compliance with applicable laws and assisting clients with correction procedures. She regularly advises clients on fiduciary compliance and best practices.

# Understanding Health & Welfare Employee Benefit Plan Compliance

- **Health and Welfare Plan Overview**
  - Understand ERISA audit triggers for health & welfare plans
  - Clarify funded vs. unfunded Plans
  - Understand Form 5500 Requirements
  - Determine which benefits are subject to audit
  - Identify your plan's status and next steps
- **Legal Update**
- **Lessons Learned from Recent ERISA Court Cases**

# When Does a Health & Welfare Plan Need an Audit?

- Audit generally required for “large” ERISA welfare plans that hold plan assets in a trust or separate account (a “funded” plan).
- “Large” usually means 100 or more participants on the first day of the plan year.
- Audit must be performed by an independent qualified public accountant.

# When Is an Audit Not Required?

- “Small” ERISA welfare plans (under 100 participants) do not need an audit.
- Even some large welfare plans (100+ participants) are exempt if they are unfunded or fully insured.

# Funded vs. Unfunded Plans

- **Unfunded:** Benefits paid only from employer's general assets or directly through insurance contracts; typically no audit, even with 100+ participants.
- **Funded:** Contributions held in a trust or separate account as plan assets and used exclusively for paying welfare benefits or plan expenses; if 100+ participants, an annual audit is required.

# Determining Participant Count

- Participant count is taken as of the first day of the plan year.
- Includes employees (and often former employees) who are covered under the plan.
- This count determines “small” vs. “large” status for Form 5500 and audit purposes.

# Participant Count Threshold Rules

- The common 80–120 “small-plan election” does not generally save funded welfare plans from an audit once they reach 100+ participants.
- For unfunded or fully insured welfare plans, the audit exemption can still apply even above 100 participants if other conditions are met.

# Form 5500 Required Without an Audit

- **Unfunded, fully insured, or combination unfunded/fully insured welfare plans with 100+ participants usually must file Form 5500.**
- **These plans are exempt from attaching audited financial statements and completing Schedule H, but may need other schedules (for example, Schedule A).**

# Benefits Subject to Audit

- **Single ERISA “wrap” plan can combine multiple welfare benefits into one plan.**
- **If the wrap plan is large and funded, all ERISA welfare benefits under that plan fall under the same audit (both trust activity and activity running through the plan sponsor).**

# Practical Steps for Employers

- Confirm whether all health & welfare benefits are wrapped into a single ERISA plan.
- Determine whether any plan assets are held in a trust or separate account.
- Count participants on the first day of each plan year and document the methodology.

# Action Items If Audit Is Required

- Engage an independent CPA firm with employee benefit plan experience specific to health & welfare plans.
- Coordinate audit timing with the Form 5500 due date and any extensions.
- Ensure plan documents, trust statements, and participant records are complete and accessible.

# Example Audit Procedures

- **Claims Testing**
  - **Coordination with claims processor**
  - **NDA Process**
- **Participant Data Testing**

# Update HIPAA Notice of Privacy Practices

- Sets forth expanded privacy practices with respect to substance use disorders information (“SUD”).
- SUD information cannot be used or disclosed in a civil, criminal, administrative, or legislative proceeding against the individual without the individual's written consent or a court order.
- **Deadline: February 16, 2026**

# Transparency in Coverage Regulations

- Proposed regulations issued December 23, 2025
- Most of the regulations address the files that are provided
- Clarifies that a self-funded plan may contract with a third-party to provide the information; however, if the third-party fails to provide it, the plan will have violated the regulations.

# OBBB Update

- **Allows telehealth coverage for HSA before the deductible for an HDHP is met**
  - **Retroactive to December 21, 2024**
- **Direct Primary Care Arrangements are not considered a health plan if:**
  - **The services are primary care services performed by a primary care physician**
  - **The only payment is the periodic fixed fee**
  - **Effective after December 31, 2025**

# OBBB Update (cont.)

- **Current litigation trend:**
  - **Voluntary Benefits**
    - **Plaintiffs alleged that the employer breached ERISA in failing to negotiate, monitor, and ensure prudent and reasonable carrier selection, broker commissions, and loss ratios, causing the plaintiffs to pay excessive premiums**
- **DOL 2026 enforcement projects**
  - **Cybersecurity**
  - **Barriers to mental health and substance use disorder benefits**
  - **Protecting benefit distributions**
  - **Retirement asset management**
  - **Surprise billing**
  - **Criminal abuse of contributory benefit plans**

# Lewandowski v Johnson & Johnson

(Prescription drug program)

- Plaintiff claims her employer, Johnson & Johnson (J&J), breached its fiduciary duty under ERISA by overpaying for prescription drugs. Plaintiff alleges failure to demand lower prices from its Pharmacy Benefit Manager (PBM) when establishing the group-medical plan. The higher drug prices have resulted in lower wages and higher health insurance costs for J&J Employees.
- The Complaint alleges in three different places that ERISA's duty of prudence compels fiduciaries "to seek the lowest level of costs for the services to be provided, and to continuously monitor plan expenses to ensure that they remain reasonable under the circumstances."
- J&J sponsors the Salaried Medical Plan and Salaried Retiree Medical Plan. All or most of the Plans' expenses are paid from the Johnson and Johnson Medical VEBA, which is an employer-sponsored trust established under IRC 501(c)(9) for the payment of medical benefits under the Plans.
- Defendants are J&J, the Pension & Benefits Committee of J&J, Peter Fasolo –EVP and Chief Human Resource Officer, Warren Luther – VP of HR, and Lisa Blair Davis, member of the Pension & Benefits Committee and is a fiduciary of the Plans.
- J&J moved to dismiss the lawsuit. According to the motion, the plaintiff received all the benefits she was contractually entitled to receive – prescription drug benefits at the cost established in the Plan documents and J&J claims out-of-pocket expenses would not have changed even if her prescription drugs through the Plan cost nothing.
- 2025 VERDICT: Good news for Employers. The case was dismissed, stating plaintiff's allegations of paying too much in premiums, copays, and coinsurance and that wages were adversely impacted was speculative "at best."
- Takeaway: Plan fiduciaries should have a prudent (and documented) process to select and oversee service providers.

# Bokma v Performance Food Group, Inc.

(Wellness Programs)

- Performance Food Group’s self-insured plan imposed a tobacco-use surcharge deducted from participants’ paychecks unless they certified 12 months of no tobacco use or met conditions under a cessation program (e.g., “Quit for Life”). Plaintiff alleged that:
  - The surcharge violated ERISA’s nondiscrimination rules because the plan did not retroactively refund surcharges when a participant later completed the cessation program.
  - PFG did not provide adequate notice of a “reasonable alternative standard,” and their willingness to consider physician’s recommendations regarding ability to participant in the program.
  - PFG breached fiduciary duties and engaged in a prohibited transaction by using tobacco surcharges to offset its own funding obligations to the plan
- Status: Virginia federal district court DENIED the employer’s motion to dismiss. This is consistent with the April 2025 Mehlberg v Compass group case (Missouri).
- Divide among the courts!! In a similar case later in 2025 (Williams v. Bally’s Management Group), the Rhode Island court dismissed the case on the grounds that Court rejected the argument that ERISA requires retroactive reimbursement as the statute requires the opportunity to earn the full future reward of removing the surcharge upon completion
- Takeaway: The courts are divided and careful consideration to ensure wellness programs are in line with ERISA and HIPAA nondiscrimination rules is needed.

# Kennedy v Braidwood Management Inc.

(Preventative care)

- **2020 Plaintiffs (several Christian-owned employer with a self-insured plan) objected to covering certain preventive services (drugs and screenings) without cost sharing due to economic and religious harm.**
- **Sought to prevent United States Preventive Services Task Force (USPSF) an agency that sits under HHS from enforcing the ACA preventive services requirements for employer health insurance plans.**
- **2022 – Texas district court ruled in favor of Braidwood (Plaintiffs)**
- **2025 – US supreme court heard the case and ruled that the ACA requirement for covering preventive services with no cost-sharing is constitutional.**
- **Takeaway: For now, recommended preventative services established by USPSTF are still generally required to be covered with no cost sharing. HOWEVER, If the membership of the task force changes and/or recommendations regarding services changes, this could have implications.**

# Barbich v Northwestern University

(Plan Design)

- 2025 suit contends that including a high-premium, low-deductible PPO alongside a lower-premium, higher-deductible PPO was imprudent because the richer option allegedly conferred no meaningful financial benefit to participants.
- Claim based on the “financial dominance” concept. A health plan option is considered financially dominated when there is another option that results in lower total out of pocket expense to participants, inclusive of premiums and regardless of the amount of medical care received.
- Allege that the SPD inaccurately suggested participants could financially benefit from choosing the Premier PPO under certain scenarios.
- **SETTLER VS FIDUCIARY** – Courts have historically considered decisions regarding plan design as settlor functions exempt from fiduciary scrutiny. This case attempts to push this into fiduciary decision-making.
- **Status:** In the early stages. If courts are receptive to the allegations, employers could face increasing risk regarding plan design decisions.
- **Takeaway:** Maintain evidence that multiple options meet differing needs of participants (risk profile, cash flow, provider networks)

# Ryan S v UnitedHealth Group

(Parity Act Violation)

- Plan participant was a beneficiary of an ERISA group health plan administered by UnitedHealthcare.
- Participant sought treatment for a substance abuse disorder and alleged that United Health used internal tools to subject mental health / substance use disorder (MH/SUD) treatment services to more stringent review and more frequent denials than comparable medical/surgical care.
- Mental Health Parity and addiction Equity Act requires coverage for MH/SUD to be comparable to coverage for medical/surgical care, including financial implications (copays, deductibles, out of pocket maximums), visit limits, etc to prevent discrimination practices.
- Takeaway: While this case is against the administrator, plan sponsors should consider this in the service provider selection process and also remain in-tune with participant complaints and consider further investigation in order to ensure participants are receiving the benefits of the plan.

# Contact Information



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