

Sharon Hutchinson

From: Sharon Hutchinson <sehutchi.wisc@gmail.com>
Sent: Wednesday, January 6, 2016 10:25 PM
To: DOA Public Records Board Comments
Subject: Public Records for all Employment Trust Fund business must remain open by Federal Statutes
Attachments: ERISAFEDghpfdiciaryresponsibilities.12.20.2015pdf.pdf;
OfficeAttnGeneral1_95.pdf

Re: Public Records of the Employee Trust Funds:

None of the money held in Employee Trust Funds can be classified in Wisconsin State Statutes as "state or local funds." **Whatever laws are passed regarding "state funds" do not apply to the funds held at ETF.** The money held in all ETF's funds--including WRS, Health Insurance Premium Trusts, Deferred Comp and many more were all found under ERISA laws and enjoy their "qualified status" for special federal privileges with the IRS for that reason. This matter was settled back in 1995 (See attached letter of the Attorney General, which can also be accessed by the following direct link: http://docs.legis.wisconsin.gov/misc/oag/archival/_29_)

Because the funds overseen by ETF "belong" to hundreds of thousands of active and retired state employees, all ETF officers and associated Boards must prioritize their fiduciary responsibilities to all vested members of those funds **above everything and everyone else.** **Moreover, Federal law sets the fiduciary standards and requirements that ETF officers and board members must meet.** These fiduciary standards include complete transparency, year to year consistency in how funds are measured and financial accuracy. Consequently, every decision regarding the distribution and/or disbursement of ETF's fund monies must be open-record and preserved as such per Federal Regulations and Statutes.

Consequently, Federal law prohibits ETF officers and Board members from make decisions about fund disbursements and/or expenses relating to those funds **behind closed doors.** **Nor can the contract bidding processes that will ultimately draw down such funds be carried out outside the public domain.**

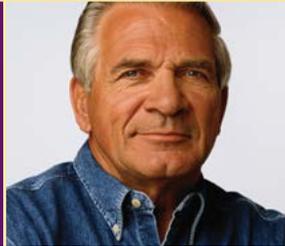
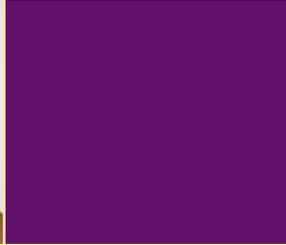
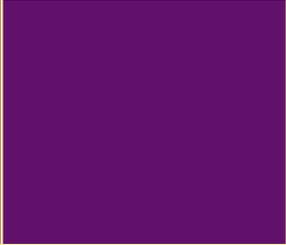
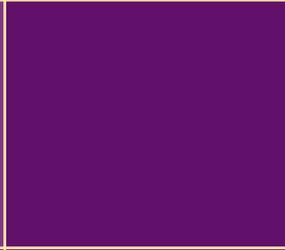
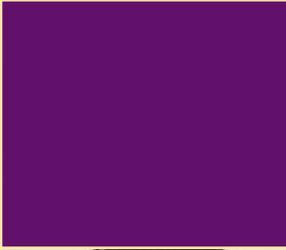
I am attaching a copy of the basic ERISA fiduciary standards which ETF officers must abide by. Although ETF is not a corporate or private trust fund, the U.S. Secretary of Labor and U.S. Secretary of Treasury have the right to enforce fiduciary standards on all state and local government "employee trust funds" as well.

For the reasons noted above, the Public Records Board must take special care to ensure that all meetings, discussions and decisions ETF takes with respect to **those funds remain open to public access and scrutiny.** **Those records must be carefully preserved and the Public Records Board must ensure that this is done.**

Please find attached two documents mentioned above.

Sincerely,
Dr. S. E. Hutchinson

UNDERSTANDING YOUR FIDUCIARY RESPONSIBILITIES UNDER A GROUP HEALTH PLAN



This publication has been developed by the U.S. Department of Labor, Employee Benefits Security Administration (EBSA). To view this and other publications, visit the agency's Web site at www.dol.gov/ebsa.

This material will be made available in alternative format to persons with disabilities upon request.
Voice phone: 202-693-8664
TTY: 202-501-3911

This booklet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

UNDERSTANDING YOUR FIDUCIARY RESPONSIBILITIES UNDER A GROUP HEALTH PLAN

Offering a group health plan can be one of the most challenging, yet rewarding, decisions an employer can make. The employees participating in the plan, their beneficiaries, and the employer benefit when a group health plan is in place. Administering a plan and managing its assets, however, require certain actions and involve specific responsibilities.

To meet their responsibilities as plan sponsors, employers need to understand some basic rules, specifically the Employee Retirement Income Security Act (ERISA). ERISA sets standards of conduct for those who manage an employee benefit plan and its assets (called fiduciaries). An ERISA-covered group health plan is an employment-based plan that provides coverage for medical care, including hospitalization, sickness, prescription drugs, vision, or dental. A group health plan can provide benefits by using funds in a plan trust, the purchase of insurance, or by self-funding benefits from the employer's general assets. *Understanding Your Fiduciary Responsibilities Under A Group Health Plan* provides an overview of the basic fiduciary responsibilities applicable to group health plans under the law.

This booklet addresses the scope of ERISA's protections for private-sector group health plans (public-sector plans and plans sponsored by churches are not covered by ERISA). It provides a simplified explanation of the law and regulations. It is not a legal interpretation of ERISA, nor is it intended to be a substitute for the advice of a health benefits professional. Also, the booklet does not cover those provisions of the Federal tax law or State insurance law that may impact group health plans.

WHAT ARE THE ESSENTIAL ELEMENTS OF A PLAN?

Each plan has certain key elements. These include:

- A written plan that describes the benefit structure and guides day-to-day operations;
- A trust fund to hold the plan's assets¹;
- A recordkeeping system to track contribution and benefit payments, maintain participant and beneficiary information, and to accurately prepare reporting documents; and
- Documents to provide plan information to employees participating in the plan and to the government.

Employers often hire outside professionals (sometimes called third-party service providers) or, if applicable, use an internal administrative committee or human resources department to manage some or all of a plan's day-to-day operations. Indeed, there may be one or a number of officials with discretion over the plan. These are the plan's fiduciaries.

¹If a plan is set up through an insurance contract, then the contract does not need to be held in trust. If a plan is self-funded (paid from the employer's general assets), those funds are not plan assets except for any participant contributions withheld or received.

WHO IS A FIDUCIARY?

Many of the actions involved in operating a plan make the person or entity performing them a fiduciary. Using discretion in administering and managing a plan or controlling the plan's assets makes that person a fiduciary to the extent of that discretion or control. Thus, fiduciary status is based on the functions performed for the plan, not just a person's title.

As noted above, group health plans can be structured in a variety of ways. The structure of the plan will affect who has fiduciary responsibilities. Most employers sponsoring fully or partially self-funded group health plans exercise some discretionary authority and therefore are fiduciaries. If the employer sponsors a fully insured plan, fiduciary status depends on whether the employer exercises discretion over the plan.

A plan must have at least one fiduciary (a person or entity) named in the written plan, or through a process described in the plan, as having control over the plan's operation. The named fiduciary can be identified by office or by name. For some plans, it may be an administrative committee or a company's board of directors.

A plan's fiduciaries will ordinarily include plan administrators, trustees, investment managers, all individuals exercising discretion in the administration of the plan, all members of a plan's administrative committee (if it has such a committee), and those who select committee officials. Attorneys, accountants, and actuaries generally are not fiduciaries when acting solely in their professional capacities. Similarly, a third party administrator, recordkeeper or utilization reviewer who performs solely ministerial tasks is not a fiduciary; however, that may change if he or she exercises discretion in making decisions regarding a participant's eligibility for benefits. The key to determining whether individuals or entities are fiduciaries is whether they are exercising discretion or control over the plan.

A number of decisions are not fiduciary actions but rather are business decisions made by the employer. For example, the decisions to establish a plan, to determine the benefit package, to include certain features in a plan, to amend a plan, and to terminate a plan are employer business decisions not governed by ERISA. When making these decisions, an employer is acting on behalf of its business, not the plan, and, therefore, is not a fiduciary. However, when an employer (or someone hired by the employer) takes steps to implement these decisions, that person is acting on behalf of the plan and, in carrying out these actions, may be a fiduciary.

WHAT IS THE SIGNIFICANCE OF BEING A FIDUCIARY?

Fiduciaries have important responsibilities and are subject to standards of conduct because they act on behalf of participants in a group health plan and their beneficiaries. These responsibilities include:

- Acting solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them;
- Carrying out their duties prudently;
- Following the plan documents (unless inconsistent with ERISA);
- Holding plan assets (if the plan has any) in trust; and
- Paying only reasonable plan expenses.

The duty to act prudently is one of a fiduciary's central responsibilities under ERISA. It requires expertise in a variety of areas. Lacking that expertise, a fiduciary will want to hire someone with that professional knowledge to carry out those functions. Prudence focuses on the process for making fiduciary decisions. Therefore, it is wise to document decisions and the basis for those decisions. For instance, in hiring any plan service provider, a fiduciary may want to survey a number of potential providers, asking for the same information and providing the same requirements. By doing so, a fiduciary can document the process and make a meaningful comparison and selection.

Following the terms of the plan document is also an important responsibility. The plan document serves as the foundation for plan operations. Employers will want to be familiar with their plan document, especially when it is drawn up by a third-party service provider, and periodically review the document to make sure it remains current. For example, if a plan official named in the document changes, the plan document must be updated to reflect that change.

LIMITING LIABILITY

With these fiduciary responsibilities, there is also potential liability. Fiduciaries who do not follow the basic standards of conduct may be personally liable to restore any losses to the plan, or to restore any profits made through improper use of the plan's assets resulting from their actions.

However, fiduciaries can limit their liability in certain situations. One way fiduciaries can demonstrate that they have carried out their responsibilities properly is by documenting the processes used to carry out their fiduciary responsibilities.

A fiduciary also can hire a service provider or providers to handle fiduciary functions, setting up the agreement so that the person or entity then assumes liability for those functions selected. If an employer contracts with a plan administrator to manage the plan, the employer is responsible for the selection of the service provider, but is not liable for the individual decisions of that provider. However, an employer is required to monitor the service provider periodically to assure that it is handling the plan's administration prudently.

OTHER PLAN FIDUCIARIES

A fiduciary should be aware of others who serve as fiduciaries to the same plan, since all fiduciaries have potential liability for the actions of their co-fiduciaries. For example, if a fiduciary knowingly participates in another fiduciary's breach of responsibility, conceals the breach, or does not act to correct it, that fiduciary is liable as well.

BONDING

As an additional protection for plans, every person, including a fiduciary, who handles plan funds or other plan property generally must be covered by a fidelity bond. A fidelity bond is a type of insurance that protects the plan against loss by reason of acts of fraud or dishonesty on the part of persons covered by the bond. Many persons dealing with group health plans

that pay benefits from the general assets of an employer or union (unfunded) or group health plans that are insured (benefits are paid through the purchase of a group health insurance contract from a licensed insurer) may be eligible for exemptions from the fidelity bonding requirements.

HOW DO THESE RESPONSIBILITIES AFFECT THE OPERATION OF THE PLAN?

Even if employers hire third-party service providers or use internal administrative committees to manage the plan, there are still certain functions that can make an employer a fiduciary.

EMPLOYEE CONTRIBUTIONS

If a plan provides for salary reductions from employees' paychecks for contribution to the plan or participants make payments directly, such as the payment of COBRA premiums, then the employer must deposit the contributions in a plan trust in a timely manner. The law requires that participant contributions be deposited in the plan as soon as it is reasonably possible to segregate them from the company's assets, but no later than 90 days from the date on which the participant contributions are withheld or received by the employer. If employers can reasonably make the deposits sooner, they need to do so. For plans with fewer than 100 participants, salary reduction contributions deposited with the plan no later than the 7th business day following withholding by the employer will be considered contributed in compliance with the law.

For participant contributions to cafeteria plans (also referred to as (Internal Revenue Code) Section 125 plans), the Department will not assert a violation solely because of a failure to hold participant contributions in trust. Other contributory health plan arrangements may obtain the same trust relief if the participant contributions are used to pay insurance premiums within 90 days of receipt.

HIRING A SERVICE PROVIDER

Hiring a service provider in and of itself is a fiduciary function. When considering prospective service providers, provide each of them with complete and identical information about the plan and what services you are looking for so that you can make a meaningful comparison.

Some actions fiduciaries need to consider when selecting a service provider include:

- When searching for a firm, get information from more than one provider;
- Compare firms based on same information – services offered, experience, costs, etc.;
- Obtain information about the firm itself: financial condition and experience with group health plans of similar size and complexity;
- Evaluate information about the quality of the firm's services: the identity, experience, and qualifications of professionals who will be handling the plan or providing medical services; any recent litigation or enforcement action that has been taken against the firm; and the firm's experience or performance record; ease of access to medical providers and information about the operations of the health care provider; the

procedures for timely consideration and resolution of patient questions and complaints; the procedures for the confidentiality of patient records; and enrollee satisfaction statistics; and

- Ensure that any required licenses, ratings or accreditations are up to date (insurers, brokers, TPAs, health care service providers).

An employer should document its selection (and monitoring) process, and, when using an internal administrative committee, should educate committee members on their roles and responsibilities. Read, understand, and keep a copy of all contracts.

FEES

Fees are just one of several factors fiduciaries need to consider in deciding on service providers. When the fees for services are paid out of plan assets, fiduciaries will want to understand the fees and expenses charged and the services provided. While the law does not specify a permissible level of fees, it does require that fees charged to a plan be “reasonable.” After careful evaluation during the initial selection, the plan’s fees and expenses should be monitored to determine whether they continue to be reasonable.

In comparing estimates from prospective service providers, ask which services are covered for the estimated fees and which are not. Some providers offer a number of services for one fee, sometimes referred to as a “bundled” services arrangement. Others charge separately for individual services. Compare all services to be provided with the total cost for each provider. Consider whether the estimate includes services you did not specify or want. Remember, all services have costs.

Some service providers may receive additional fees from third parties, such as insurance brokers. Employers should ask prospective providers whether they get any compensation from third parties, such as finder’s fees, commissions or revenue sharing.

Who pays the fees? Plan expenses may be paid by the employer, the plan, or both. In any case, the plan document should specify how fees are paid, and the fiduciary must ensure that those fees and expenses are reasonable, necessary for the operation of the plan, and not excessive for the services provided.

MONITORING A SERVICE PROVIDER

An employer should establish and follow a formal review process at reasonable intervals to decide if it wants to continue using the current service providers or look for replacements. When monitoring service providers, actions to ensure they are performing the agreed-upon services include:

- Reviewing the service providers’ performance;
- Reading any reports they provide;
- Checking actual fees charged;
- Asking about policies and practices (such as a TPA’s claims processing systems);
- Ensuring that plan records are properly maintained; and
- Following up on participant complaints.

MAINTAINING THE PLAN'S BENEFITS CLAIMS PROCEDURE

Group health plans must establish and maintain reasonable claims procedures that allow participants and beneficiaries to apply for and receive the plan's promised benefits. Fiduciaries must maintain the plan's procedures. The Department of Labor issued rules setting minimum standards for benefit claims determinations for ERISA plans (including insured and self-funded plans). While many plans hire benefits professionals or insurance companies to process claims, it is important for an employer to understand the requirements before selecting a service provider who can comply with the standards.

A claim for benefits is a request for a plan benefit made in accordance with the plan's procedures by a claimant (participant or beneficiary) or a claimant's authorized representative. Questions concerning plan benefits, coverage and eligibility questions, and casual inquiries are generally not considered claims for benefits.

The key issues to become familiar with are the timeframes for deciding claims, the contents for the notices of benefit denials, and the standards for appeals of benefit denials.

Once a claim is received by the plan, the timeframe for making and providing notice of the claim determination varies based on the type of claim filed –

- urgent care, as soon as possible but not later than 72 hours after the plan receives the claim;
- pre-service claims, within a reasonable period of time not later than 15 days after the plan receives the claim;
- post-service claims, within a reasonable period of time not later than 30 days after the plan receives the claim; and
- disability claims, within a reasonable period of time not later than 45 days after the plan receives the claim.

In the case of pre- and post-service claims, 15 day extensions may be available.

For claims that are appealed, the timeframe also varies based on the type of claim –

- urgent care claims, as soon as possible but not later than 72 hours after the plan receives the request to review a denied claim;
- pre-service claims, within a reasonable period of time not later than 30 days after the plan receives the request to review a denied claim;
- post-service claims, as soon as possible but not later than 60 days after the plan receives the request to review a denied claim; and
- disability claims, within a reasonable period of time but not later than 45 days after the plan receives the request to review a denied claim.

No extensions are available for making decisions on appeals unless the claimant consents.

The notice of a claim denial, referred to as an adverse benefit determination, must contain the following information:

- Specific reasons for denial (for example, not medically necessary, not covered by the plan, or reached maximum amount of treatment permitted under the plan);
- A reference to the specific plan provision(s) relied upon for the denial;
- If denied for a lack of information, the notice must include a description of any additional material(s) needed to perfect the claim and an explanation of why such additional material is necessary;
- A description of the plan's review procedures (for example, how appeals work);
- If used, either a description of rules, guidelines, or protocols relied upon in denying the claim, or that a copy of such items will be provided free upon request;
- If denial is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the denial, applying the terms of the plan to the claimant's medical circumstances, or a statement that an explanation will be provided free of charge upon request; and
- A description of the claimant's right to go to court to recover benefits due under the plan.

The notice of a claim denial on appeal must include the same information as noted above (except the description of the plan's appeal process) as well as:

- A statement of the claimant's right to receive, free of charge, relevant documents (documents and records upon which the decision is based and other documents prepared or used during the process); and
- A description of any voluntary processes offered by the plan to resolve claims disputes.

The plan's claims procedure must provide for a full and fair review of a benefit claim if a claimant files an appeal of the denial. The minimum standards for appeals are:

- Claimants must be given 180 days to file an appeal;
- A *de novo* review, that is, a review that affords no deference to the initial determination, must be conducted;
- When the denial is based on determinations of whether a particular treatment, drug or other item is experimental, investigational, or not "medically necessary," the reviewer must consult with a qualified health professional (and others as needed);
- No more than 2 appeals levels are allowed; and
- Mandatory binding arbitration of claims is generally prohibited. However, non-binding arbitration would be permissible if done within the required timelines.

For more information, request a copy of *Compliance Assistance - Group Health and Disability Plans Benefit Claims Procedure Regulation* (see **Resources**).

ARE THERE SOME TRANSACTIONS THAT ARE PROHIBITED? IS THERE A WAY TO MAKE THEM PERMISSIBLE IF THE ACTIONS WILL BENEFIT THE PLAN?

Certain transactions are prohibited under the law to prevent dealings with parties who may be in a position to exercise improper influence over the plan. In addition, fiduciaries are prohibited from engaging in self-dealing and must avoid conflicts of interest that could harm the plan.

PROHIBITED TRANSACTIONS

Who is prohibited from doing business with the plan? Prohibited parties (called parties in interest) include the employer, the union, plan fiduciaries, service providers, and statutorily-defined owners, officers, and relatives of parties in interest.

Some of the prohibited transactions are:

- A sale, exchange, or lease between the plan and party in interest;
- Lending money or other extension of credit between the plan and party in interest;
and
- Furnishing goods, services, or facilities between the plan and party in interest.

Other prohibitions relate solely to fiduciaries who use the plan's assets in their own interest or who act on both sides of a transaction involving a plan. Fiduciaries cannot receive money or any other consideration for their personal account from any party doing business with the plan related to that business.

EXEMPTIONS

There are a number of exceptions (exemptions) in the law that provide protections for the plan in conducting necessary transactions that would otherwise be prohibited. The Labor Department may grant additional exemptions.

Exemptions are provided in the law for many dealings that are essential to the ongoing operations of the plan. One exemption in the law allows the plan to hire a service provider as long as the services are necessary to operate the plan and the contract or arrangement under which the services are provided and the compensation paid for those services is reasonable.

The exemptions issued by the Department can involve transactions available to a class of plans or to one specific plan. Both class and individual exemptions are available at www.dol.gov/ebsa under Technical Guidance. For more information on applying for an exemption, see *Exemption Procedures Under Federal Pension Law* (this publication and the procedures also apply to group health plans - see **Resources**).

HOW DO EMPLOYEES GET INFORMATION ABOUT THE PLAN? HOW ARE EMPLOYERS REQUIRED TO REPORT PLAN ACTIVITIES?

ERISA requires plan administrators to furnish plan information to participants and beneficiaries and to submit reports to government agencies.

INFORMING PARTICIPANTS AND BENEFICIARIES

The following documents must be automatically furnished to participants and beneficiaries.

The **Summary Plan Description (SPD)** — the basic descriptive document — is a plain language explanation of the plan and must be comprehensive enough to apprise participants of their rights and responsibilities under the plan. It also informs participants about the plan features and what to expect of the plan. Among other things, the SPD must include basic information such as:

- Plan name, address, and contact information;
- What the plan benefits are;
- How to get the benefits; and
- Duties of the plan and/or employee.

More specific information must also be provided, including:

- The plan's claims procedure (either in the document or as separate attachment);
- A participant's basic rights and responsibilities under ERISA (model language is provided in the SPD rules);
- Information on any applicable premiums, cost-sharing, deductibles, co-payments, etc.;
- Any caps (annual or lifetime) on benefits;
- Procedures for using network providers (if PPO/HMO) and composition of network;
- Conditions regarding pre-certification;
- A description of plan procedures governing Qualified Medical Child Support Orders (see below); and
- Notices and descriptions of certain rights under the Health Insurance Portability and Accountability Act (HIPAA) and other health coverage laws, described below.

This document is given to employees within 90 days after they are covered by the plan. SPDs must also be redistributed every 5th year and provided within 30 days of a request. The SPD must be current within 120 days.

The **Summary of Material Modification (SMM)** appraises participants and beneficiaries of material changes to the plan or to the information required to be in the SPD. The SMM or an updated SPD for a group health plan must be furnished automatically to participants within 210 days after the end of the plan year in which such material change was adopted. However, if the changes to the plan or changes to the required information in the SPD result in a material reduction in covered services or benefits, then the SMM must be distributed no later than 60 days from the date the change was adopted. A material reduction is any plan change that eliminates benefits, reduces benefits payable, increases premiums, deductibles, coinsurance or co-payments, reduces the service area covered by an HMO, or establishes new conditions or requirements (such as pre-authorization) for obtaining services or benefits.

A **Summary Annual Report (SAR)** outlines in narrative form the financial information in the plan's Annual Report, the Form 5500 (see below for those plans required to file this report), and is furnished annually to participants in plans that are required to file the Form 5500.

OTHER GROUP HEALTH PLAN NOTICES

There are notices required under other provisions in ERISA (i.e., the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Newborns' and Mothers' Health Protection Act (Newborns' Act), and the Womens' Health and Cancer Rights Act (WHCRA). Some of these notices may be included in the SPD and others must be provided separately due to the timeframes for when they are required to be provided. For more information on these notices, see the Resources section to obtain a copy of the *Reporting and Disclosure Guide for Employee Benefit Plans*. For more information on COBRA, HIPAA, and the other provisions in ERISA related to group health plans, see **Resources** for publications on these provisions.

DISCLOSURES UPON REQUEST

In addition to the SPD, participants can also request the plan document, insurance contracts, and other documents under which the plan is operated. A reasonable copying fee may be charged.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

Plans may receive either private medical child support orders (MCSO) or an order from a state agency regarding an employee's medical child support obligations. Plans must have procedures to receive, process, and implement qualified medical child support orders. If a plan receives an MCSO, the plan administrator has to provide a notice to the participant and any child named in the MCSO (and the child's representative) of the receipt of the MCSO and the plan administrator's determination whether the MCSO is qualified. The notice must be furnished within a reasonable time period after receipt of the MCSO. For more information on QMCSO's and the standards plans must use to determine whether MCSOs are qualified, request a copy of *Qualified Medical Child Support Orders* (see **Resources**).

REPORTING TO THE GOVERNMENT

Plan administrators generally are required to file a Form 5500 Annual Return/Report with the Federal Government. The Form 5500 reports information about the plan, its finances, and its operation. This information is used by the U.S. Department of Labor, the Internal Revenue Service (IRS), other government agencies, organizations, and the public. Participants and beneficiaries can receive a copy of the Form 5500 upon request from the plan. Depending on the number of participants covered and plan design, there may be exemptions from the full filing requirements. A group health plan with fewer than 100 participants that is either fully insured or self-funded (or a combination of both) does not need to file an annual report. Plans with 100 or more participants that are fully insured or self-funded (or a combination) can file a limited report. Plans that have relief from the trust requirement discussed in **Employee Contributions** above are treated as self-funded.

The form is filed and processed under EFAST2. For more information on the forms, their instructions, and the filing requirements, see www.efast.dol.gov. See the **Resources** section to obtain a copy of the publication *Reporting and Disclosure Guide for Employee Benefit Plans*

Administrators of multiple employer welfare arrangements (MEWAs) generally are required to file a Form M-1 Report with the Federal Government. The Form M-1 reports information about compliance by MEWAs with the requirements of Part 7 of ERISA (which includes HIPAA, the Newborns' Act, WHCRA, and the Mental Health Parity and Addiction Equity Act (MHPAEA)). This one-page form is generally required to be filed once per year. For more information on the Form M-1, see www.dol.gov/ebsa and request the publication *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation*.

There are penalties for failing to file required reports and for failing to provide required information to participants.

HOW DO OTHER LAWS AFFECT FIDUCIARY RESPONSIBILITIES?

As noted above, there are other provisions in ERISA, as well as other Federal and State laws that affect group health plans. A fiduciary's responsibilities include making sure the plan complies with ERISA, which includes the COBRA, HIPAA, and other group health plan provisions in the law.

The COBRA continuation coverage provisions require that participants and their covered dependents have the opportunity to maintain coverage under their group health plan for a limited period of time, which they may be required to pay for, upon the occurrence of certain qualifying events that would otherwise result in a loss of coverage. For a more detailed discussion of COBRA requirements, see *An Employer's Guide to Group Health Continuation Coverage Under COBRA – The Consolidated Omnibus Budget Reconciliation Act* (See **Resources** to obtain a copy).

The HIPAA provisions place limits on preexisting condition exclusions; provide for special enrollment rights for certain events; and prohibit discrimination in eligibility, benefits, or premiums based on a health factor. Other group health plan provisions in ERISA include the Newborns' and Mothers' Health Protection Act, which provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth; the Women's Health and Cancer Rights Act, which provides protections for individuals who elect breast reconstruction or certain other follow-up care after a mastectomy; MHPAEA and the Mental Health Parity Act (the Mental Health Parity provisions), which provide for parity in mental health benefits and medical/surgical benefits; and the Genetic Information Nondiscrimination Act, which prohibits discrimination in group health plan coverage based on genetic information. For more detailed information on these provisions, see the **Resources** section to obtain a copy of *Health Benefits Coverage Under Federal Law*.

The Affordable Care Act (ACA) provides additional protections for benefits under an employment-based group health plan. Some plan sponsors may have chosen to make only routine changes and generally keep the coverage under their plan the same as it was on March 23, 2010. These grandfathered health plans are required to comply with some, but not all of the ACA protections under ERISA.

Many of the protections are in effect now including the extension of dependent coverage until age 26, the prohibition of preexisting condition exclusions for children under 19, a ban on lifetime limits on coverage for most benefits, and the phase out of annual limits on coverage. Plans also must provide plain language summaries about a health plan's benefits and coverage. Additional protections will be effective in 2014.

For more information, regarding whether your plan is a grandfathered health plan and the requirements under ACA visit the Employee Benefits Security Administration's ACA Web page at www.dol.gov/ebsa/healthreform.

With respect to other laws, ERISA generally supersedes State laws as they relate to employee benefit plans. However, State insurance laws applicable to health insurance coverage often continue to apply. Therefore, if health coverage is offered through an HMO or insurance policy, check with your State insurance department for more information on that State's insurance laws.

CAN A FIDUCIARY TERMINATE ITS FIDUCIARY DUTIES?

Yes, but there is one final fiduciary responsibility. Fiduciaries who no longer want to serve in that role cannot simply walk away from their responsibilities, even if the plan has other fiduciaries. They need to follow plan procedures and make sure that another fiduciary is carrying out the responsibilities left behind. It is critical that a plan has fiduciaries in place so that it can continue operations and participants have a way to interact with the plan.

WHAT HELP IS AVAILABLE FOR EMPLOYERS WHO MAKE MISTAKES IN OPERATING A PLAN?

The Department of Labor's Voluntary Fiduciary Correction Program (VFCP) encourages employers to comply with ERISA by voluntarily self-correcting certain violations. The program covers 19 transactions, including failure to timely remit participant contributions and some prohibited transactions with parties in interest. The program includes a description of how to apply, as well as acceptable methods for correcting violations. In addition, the Department gives applicants immediate relief from payment of excise taxes under a class exemption.

In addition, the Department's Delinquent Filer Voluntary Compliance Program (DFVCP) assists late or non-filers of the Form 5500 in coming up to date with corrected filings.

For an overview of both programs, visit Corrections Programs at www.dol.gov/ebsa.

TIPS FOR EMPLOYERS WITH GROUP HEALTH PLANS

Understanding fiduciary responsibilities is important for the security of a group health plan and compliance with the law. The following tips may be a helpful starting point:

- Have you identified your plan fiduciaries, and are they clear about the extent of their fiduciary responsibilities?
- If you are hiring third-party service providers, have you looked at a number of providers, given each potential provider the same information, and considered whether the fees are reasonable for the services provided? Have you documented the hiring process?
- Are you prepared to monitor your plan's service providers?
- Are you aware of the schedule to deposit participant contributions and payments by participants to the plan and forwarding them to the insurance company, and have you made sure it complies with the law?
- Have you reviewed your plan document in light of current plan operations and made necessary updates? After amending the plan, have you provided participants with an updated SPD or SMM?
- Does your plan have a reasonable claims procedure that is being followed by plan fiduciaries?
- Does your plan have a procedure for handling QMCSOs?
- Have you identified parties in interest to the plan and taken steps to monitor transactions with them?
- Are you aware of the major exemptions under ERISA that permit transactions with parties in interest, especially those key for plan operations (such as hiring service providers)?
- Have required reports (i.e. Form 5500) been filed timely with the government?



U.S. Department of Labor
Employee Benefits Security Administration

RESOURCES

The U.S. Department of Labor's Employee Benefits Security Administration offers more information on its Web site and through its publications. To order publications or to request assistance from a benefits advisor, contact EBSA electronically at www.askebsa.dol.gov or call toll free 1-866-444-3272.

For Employers

Compliance Assistance Guide – Health Benefits Coverage Under Federal Law
An Employer's Guide to Group Health Continuation Coverage Under COBRA
– The Consolidated Omnibus Budget Reconciliation Act
Reporting and Disclosure Guide for Employee Benefit Plans
Exemption Procedures under Federal Pension Law (Web only)
Qualified Medical Child Support Orders
Compliance Guide – Group Health and Disability Plans Benefit Claims
Procedure Regulation
VFCP Fact Sheet • FAQs
DFVCP Fact Sheet • FAQs

For Employees

Top 10 Ways To Make Your Health Benefits Work For You
Life Changes Require Health Choices...Know Your Benefit Options
Work Changes Require Health Choices...Protect Your Rights
An Employee's Guide to Health Benefits Under COBRA
Your Health Plan And HIPAA...Making The Law Work For You
Filing A Claim For Your Health Or Disability Benefits



U.S. Department of Labor
Employee Benefits Security Administration

The Honorable Michael G. Ellis

*Chairperson
Senate Organization Committee
210 South, State Capitol
Madison, Wisconsin 53702*

Dear Senator Ellis:

You request my opinion on the applicability of section 20.927, Stats., to health insurance plans provided for state and local government employes by the Group Insurance Board (GIB). Specifically, you question "whether the use of funds by the Group Insurance Board to contract with health maintenance organizations, and to provide a standard plan, that cover abortions is consistent with s. 20.927, Stats." [sic] It is my opinion that monies used to fund state employe insurance plans are not "state or local funds" and that, therefore, the GIB is not subject to the limitation of section 20.927 when establishing and contracting for state and local employe health insurance plans.

Section 20.927 precludes the expenditure of state or local funds for performance of most abortions as follows:

(1) Except as provided under subs. (2) and (3), no funds of this state or of any county, city, village or town or of any subdivision or agency of this state or of any county, city, village or town and no federal funds passing through the state treasury shall be authorized for or paid to a physician or surgeon or a hospital, clinic or other medical facility for the performance of an abortion.

(2)(a) This section does not apply to the performance by a physician of an abortion which is directly and medically necessary to save the life of the woman or in a case of sexual assault or incest, provided that prior thereto the physician signs a certification which so states, and provided that, in the case of sexual assault or incest the crime has been reported to the law enforcement authorities....

(b) This section does not apply to the performance by a physician of an abortion if, due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman....

The same restriction is specifically set forth for counties at section 59.07(136) and for cities, villages and towns at section 66.04(1)(m).

State statutes require the GIB to establish and offer to state employes at least one standard health insurance plan and one health maintenance organization or preferred provider plan. Sec. 40.51(6), Stats. GIB established insurance plans may also be used by local government units. Secs. 40.02(25)(b)9. [active non-state public employes] and 11. [retired non-state public employes].

Current GIB guidelines which form the basis for contracts with health maintenance organizations and preferred providers that in turn insure state and local employes, provide coverage for "therapeutic abortions." "Therapeutic abortions" may be generally defined as, "induced abortions which have been performed to

safeguard the health of the mother, to prevent the birth of a child of a rape victim, or to prevent the birth of a deformed child." 4C Gray, Roscoe N. and Louise J. Gordy, Attorneys' Textbook of Medicine, 311.01 (3rd ed. 1991). Section 20.927 of the statutes is more restrictive on the type of abortions permitted because it does not permit the use of state funds for therapeutic abortions "to prevent the birth of a deformed child." Therefore, if section 20.927 applies to the GIB's establishing government employe health insurance plans, then current GIB provisions for therapeutic abortions would be impermissible.

Monies Paid into Employe Trust Funds are Not State Funds

The operative language of section 20.927 provides that "no funds of this state or of any county, city, village or town... shall be authorized for... the performance of an abortion." Proper statutory interpretation must turn on the meaning of "funds of this state [or local entity]." It has long been an accepted legal principle that "state funds" are not all monies passing through the state Legislature, but are of a more restricted and unique character. Importantly, for this discussion, monies appropriated by the Legislature to the Public Employe Trust Fund are not state funds because those monies have a specialized purpose:

The public employe trust fund is a public trust and shall be managed, administered, invested and otherwise dealt with solely for the purpose of ensuring the fulfillment at the lowest possible cost of the benefit commitments to participants, as set forth in this chapter, *and shall not be used for any other purpose* All statutes relating to the fund shall be construed liberally in furtherance of the purposes set forth in this section.

Sec. 40.01(2), Stats. Sufficient monies to provide benefits under the public employe trust fund are appropriated by section 20.515(1)(r). It is these monies that are used to purchase government employe health insurance plans.

There is a longstanding view in Wisconsin law that trust funds are to be treated differently than general revenue, and that the state has less power to regulate the use of trust funds. In *Attorney General ex rel. Blied v. Levitan*, 195 Wis. 561, 563, 219 N.W. 97 (1928), the court held that state officials could not interfere with the Annuity Board's exercise of its own business judgment in managing retirement funds, and in *State Teachers' Retirement Board v. Giessel*, 12 Wis. 2d 5, 11, 106 N.W.2d 301 (1960), the court refused to let the state charge a portion of its expenses for a study to the retirement fund even though the study's purpose was to improve the retirement system, because the trust money could be used only for the benefit of the retirees. The *Giessel* court rejected the state's argument that retirees had no vested right in the fund until the money was credited to an individual's account.

Past Attorney General opinions have recognized a distinction between trust funds and general revenue. In 1969, the Attorney General opined that the Wisconsin retirement fund was of a different character than the public fisc, and therefore surpluses generated by prudent or lucky investments could be distributed to annuitants without running afoul of the legal principle that public funds may not be used for private purposes. 58 Op. Att'y Gen. 43, 45 (1969). Similarly, a 1985 Opinion found that the State Claims Board lacked the authority to order payments from the public employe trust fund relying on statutory mandate that the fund be managed for the participants, and that participants own those benefits as a "contractual right." 74 Op. Att'y Gen. 193, 198 (1985).

Additionally, the conclusion that there are legal distinctions between moneys passing through the state treasury is also found in *B.F. Sturtevant Co. v. Industrial Comm.*, 186 Wis. 10, 202 N.W. 324 (1925), where the court upheld a worker's compensation statute directing that death benefits owed to employees who lack dependents are

paid into the state treasury earmarked for the benefit of worker's compensation claimants. "We are therefore of the opinion that the words 'public or trust money' as used in sec. 8, art. VIII, of the state constitution refer to public funds in which the general public has a beneficial interest and not to special funds held by the state treasurer as a mere depositor...."

Id.

, 186 Wis. at 21. Funds earmarked for a special purpose are thus not "state funds."

These precedents mandate the conclusion that trust funds are different from general state funds, and that the state is limited in its ability to regulate the use of trust funds. Recently Dane County Circuit Court Judge Angela Bartell specifically found that public employe trust funds are not "state funds" because those funds have been irrevocably placed in trust for the benefit of state employes, and the state itself has given up any right to direct their use.

State Engineering Association v. Employe Trust Funds Board

, Dane County Case Nos. 88-CV-1070 and 88-CV-4062 (On appeal to the Court of Appeals, District IV, Case No. 94-0712). "State funds," according to the Bartell decision, are non-restricted funds that the Legislature may use for any legitimate state purpose, while "trust funds" have a much more restricted purpose.

Thus, a statute that directs that "state or local funds" may not be used to procure abortions, does not prevent the GIB from establishing guidelines for insurance plans that will be purchased with "trust funds." Once appropriated to fulfil the state's obligations under the public employe trust fund, the state monies lose their character as state funds and the Legislature loses its ability to direct their use solely by means of the regulation of general purpose funds.

Trust Funds Pay for Insurance Coverage, and Cannot be

Considered the Direct Funding of Abortions.

Section 20.927, prohibits the actual payment of state funds to a physician for an abortion not covered by one of the exceptions. By adopting guidelines requiring the provision of therapeutic abortions for qualifying health maintenance organizations or preferred providers, the GIB is not authorizing the direct use of state funds to pay for abortions, it is establishing guidelines for insurance coverage. Even if the monies appropriated to the trust fund for insurance purposes were considered to be state funds, they would lose that character once they have been used to purchase health insurance plans.

Had the Legislature specifically intended for the GIB to be prohibited from providing for therapeutic abortions in insurance policies for state and local government employes, it could have done so by restricting the GIB's authority under chapter 40 of the statutes. However, the Legislature has not chosen to do so, and it has not chosen to do so even in light of the well-established rule of law that trust funds are not state funds. By adopting section 20.927, but ignoring the specific health insurance regulations, the Legislature did not indicate an intent to prohibit women who own or are covered under government health insurance plans from securing abortions provided under those plans.

The purpose of the trust fund is to provide benefits to employes at the lowest possible cost, which is achieved through the managing of benefits as a group. If the monies paid into the trust fund were not specifically pooled in order to pay for group health insurance, under the statutory appropriation language, the funds would belong to the public employes. Indeed, the trust fund does not even pay for 100% of a given employe's health insurance costs because section 40.05(4)(a) requires that the employe "contribute" the balance of the required premium amounts after applying the employer's contribution. Employes holding health maintenance organization plans that cost more than the least expensive plan must pay additional sums for insurance coverage, and state employes in their first six months of employment must pay the full premiums if they elect coverage. It is clear that these insurance benefits belong to the government employes, and that, therefore, use of those benefits to procure abortions does not constitute the direct use of state funds for the expenditure.

In 1978, the Governor of Wisconsin vetoed a proposed amendment that would have exempted employe insurance plans from section 20.927. See Senate

Amendment 12 to 1977 Assembly Bill 321; Governor's Veto Messages, Journal of the Assembly, p. 3496 (March 8, 1978). While this history could be used to argue that the Legislature, by failing to override the Governor's veto, actually intended for section 20.927 to prohibit insurance plan coverage for abortions, to do so would give undo effect to legislative history where the plain meaning of the statute is not unclear in the first instance. Resort to legislative history will not be made if the language of the statute is not unclear.

In Interest of Jamie L.

, 172 Wis. 2d 218, 225, 493 N.W.2d 56 (1992). When the Legislature chose the term "state or local funds" for section 20.927, it did so with the knowledge that public employe trust funds were of a different character than state funds, that trust funds were irrevocably placed in trust for the benefit of government employes, and that its ability to regulate trust funds was limited. Moreover, the GIB has never been constrained in negotiating insurance packages, notwithstanding the veto of the proposed amendment, and an administrative agency's interpretation of a statute may be accorded deference.

Richland School Dist. v. DILHR

, 174 Wis. 2d 878, 890-91, 498 N.W.2d 826 (1993).

Summary

Funds appropriated in trust for public employes are not "state funds," and, therefore, the Legislature may not restrict the use of those funds merely by statute governing the use of "state or local funds." Additionally, the use of trust funds to pay for part of the purchase of health insurance does not amount to the direct funding of abortions with state or local funds. For these reasons, the abortion restrictions of section 20.927, do not apply to the GIB's establishment of health insurance plans for covered employes, and the GIB may implement guidelines that provide for therapeutic abortions.

Sincerely,

James E. Doyle
Attorney General

JED:JSL:dah

CAPTION:

Section 20.927, Stats., relating to expenditure of state and local funds for performance of an abortion, does not apply to health insurance plans provided for state and local government employes by the Group Insurance Board.

