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Health & Welfare

Does Your Health & Welfare Plan Need a Trust?

Many health and welfare plans, particularly fully insured plans, do not have a separate trust in which plan assets are held. This appears to be due to common practice, and not a result of careful analysis of the trust requirements. While many of these health and welfare plans may be able to avoid the trust requirements, this can only be achieved by a thoughtful and informed understanding of the trust requirements.

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Section 403(a) of the Employee Retirement Income Security Act of 1974 (ERISA) requires that "all assets of an employee benefit plan be held in trust by one or more trustees." Plans not subject to ERISA are not subject to this trust requirement, although governmental Section 457(b) deferred compensation plans are subject to a trust requirement under Section 457(g) of the Internal Revenue Code (the Code). Governmental plans are subject to the exclusive benefit rule under ERISA Section 403(c)(1) which provides that:

> ...the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan.

This is why qualified retirement plans nearly always have an affiliated trust to hold the assets of the retirement plan. What about health and welfare plans?

They are subject to the very same rule, but most employers that sponsor health and welfare plans do not establish a separate trust to hold plan assets. How is this possible without violating the trust requirement? The answer is there are ways for a health and welfare plan to be in compliance with the trust requirement without establishing a trust, but many employers that sponsor health and welfare plans are unaware of the trust requirement and, therefore, are not in compliance.

The threshold issue is whether the health and welfare plan has "plan assets." A health and welfare plan does not need a trust to hold plan assets if the plan does not have assets, or if its assets fall within a non-enforcement policy. Health and welfare plans generally are funded by employer contributions, participant contributions, or a combination of both. A careful structuring of funding methods may allow the plan to operate without a trust and still meet the trust requirements.

Employer Contributions

Many employers contribute at least a portion of the cost for employee health and welfare benefits. In general, until an employer pays the employer contributions to the plan, the contributions are not plan assets. This was recently affirmed in a Ninth Circuit case, *Glazing Health and Welfare Fund v. Lamek*, which held that even where employer contributions are contractually owed (in this case under a collective bargaining agreement) but not yet paid, they are not plan assets. [Glazing Health and Welfare Fund v. Lamek, 885 F.3d 1197 (9th Cir. 2018)] While several district courts had found an exception where either the trust or the plan explicitly provided that contributions due are plan assets, the *Glazing* court declined to find such an exception. This is consistent with the prior Ninth Circuit ruling in *Bos v. Bd. of Trustees (Bos I).* [Bos v. Bd. of Trustees (Bos I), 795 F.3d 1006 (9th Cir. 2015)] Other circuits have concurred with *Bos* and *Glazing*, while others have found exceptions. [*See* IPTE Pension Fund v. Hall, 334 F.3d 1011 (11th Cir. 2003) (finding unpaid employer contributions are not assets of a fund unless the agreement between the fund and the employer specifically and clearly declares otherwise); *In re* Luna, 406 F3d 1192 (10th Cir. 2005) (the contractual right to collect the unpaid contributions is a future interest not a present interest and therefore the unpaid contributions are not plan assets until paid to the plan)]

In a non-union plan context "paying to the plan" basically means that employer contributions are either paid to an insurer or paid to an account for the plan. This means that if employer contributions and/or benefits are paid from the general assets of the employer (*i.e.*, never paid to an insurer or a separate plan account), then they are not plan assets, but remain employer assets. Setting up a separate account in the name of the plan will create plan assets. However, the Department of Labor (DOL) has indicated that a separate employer account set up to pay plan benefits (as opposed to a separate account in the name of the plan) does not create plan assets. [*See*, *e.g.*, DOL Advisory Op. 94-31A (Sept. 9, 1994)]

This may seem simple enough, but it all comes down to how these funds are held and paid, which is not always cut and dried. For example:

- Funds deposited in a separate bank account in the name of the plan (*e.g.*, "The ABC Company Health and Welfare Plan Account") from which premiums and/or benefits are paid are plan assets.
- Funds sent to a third-party administrator (TPA), which pays premiums and/or benefits from the TPA's bank account (general account or set-up for the plan) (*e.g.*, "The XYZ TPA Account" or the "XYZ TPA Account for the ABC Company Health and Welfare Plan Account") are plan assets.
- Funds deposited in a separate bank account in the name of the employer (*e.g.*, "The ABC Company Account"), where the TPA has check-writing authority for that account from which premiums and/or benefits are paid, remain general assets of the employer.
- Funds deposited in a separate bank account in the name of the employer (*e.g.*, "The ABC Company Account B") and/or the employer's main bank account from which the employer pays premiums and/or benefits remain general assets of the employer.

Despite retaining funds in the employer's general assets, under ERISA Section 403(c), the exclusive benefit rule, the employer must keep an accounting of all plan funds so as to be able to establish that all funds were used for the benefit of plan participants. [*See* State of Wisconsin v. Faust, 1997 WL 441358, 570 NW2d 252 (holding that where contributions were deposited in a general revenue account, and it was shown that the amount of the health care claims paid during the existence of the plan substantially exceeded the amount contributed by employees, it sufficiently demonstrated that participant contributions were applied only to the payment of benefits and reasonable

administrative expenses of the plan); Cook v. Jones & Jordan Engineering, 2009 WL 37376, 45 Employee Benefits Cas. 2580, 2009 (plan contributions were held in a general operating account and used in part for general operating expenses (namely payroll), the comingling of funds violated the trust and exclusive benefit requirements of ERISA)]

Participant Contributions

Participant contributions (*e.g.*, participant-paid premiums, health flexible spending account contributions) are *always* plan assets once th3ey can be reasonably segregated. [26 DOL Regs. § CFR 2510.3-102] The only reason the employer has control over participant contributions is to fund the health and welfare plan. However, the DOL has issued a non-enforcement policy for welfare plans (as described in DOL Technical Release 92-01), which provides that where participant contributions such as premiums and salary reductions are made under a cafeteria plan (also known as a flexible benefits plan) pursuant to Code section 125, the DOL will not enforce the trust requirement. In order to satisfy the exemption, participant contributions to welfare plans, like employer contributions, must be paid from the general assets of the employer. This includes after-tax contributions (such as COBRA or retiree contributions) made through a cafeteria plan. If they are not paid through a cafeteria plan, then the participant contributions are not covered by the non-enforcement policy unless they are paid from the general assets of the employer directly to an insurer. Benefits must be paid exclusively through insurance "contracts or policies" issued by "an insurance company or similar organization which is qualified to do business in any State or through a qualified health maintenance organization." Participant contributions under an insured plan must be paid directly to an insurer as soon as they can be reasonably segregated from the assets of the employer, and in no case later than 90 days after they are withheld or contributed. [*See* DOL Reg. §§ 2520.104-20(b)(2)(ii) and (iii), and DOL Reg. §§ 2520.104-44(b)(1)(ii) and (iii).] Failure to transmit participant contributions to a health and welfare plan or insurer within these deadlines will result in a prohibited transaction under ERISA Section 406(a)(1)(D) and require applicable reporting of the prohibited transaction on Form 5500.

As this is not an exemption from the trust requirement, but rather a non-enforcement policy, it protects the employer from action by the DOL when the requirements describe above are met, but it does not protect the employer from a lawsuit on this issue by a participant or beneficiary. Lawsuits of this kind generally arise in the context of a failure to pay claims or where there is embezzlement or other misuse of plan assets.

The MEWA: A Difficult Case

Note that if the health and welfare plan covers employees of two or more unrelated employers, the result is a multiple employer welfare arrangement, also known as a "MEWA." [Defined under ERISA Section 3(40)(A), not to be confused with a multi-employer plan that provides benefits to union members (defined under ERISA Section 3(37)) For MEWAs, the funding arrangement can be particularly complicated among the various employers and may not easily fit into a model that allows the plan to avoid the trust requirements. Frequently in a MEWA, participating employers send contributions (employer and participant) to a single employer in the group (the "Administering Employer"), which then either forwards these funds to an insurer or pays benefits directly. Because the employers are not related, once the contributions leave the general assets of the participating employer and are deposited with the Administering Employer, they are no longer held in the general assets of the participating employer at the time they are paid for premiums or benefits. As a result, employer contributions become plan assets and participant contributions no longer qualify for the non-enforcement policy.

Other Contributions

In some cases, a health and welfare plan may receive refunds from an insurer, and whether they are plan assets will in large part be determined by the original source of the contributions for the premiums being rebated. In turn, this will determine how those rebates can be used. [*See* DOL Advisory Op. 2005-08A (May 11, 2005).] The DOL has established non-enforcement policies for demutualization distributions [*see* DOL Information Letter to Theodore R. Groom (Feb. 15, 2001)], medical loss rebates [*see* ERISA Tech. Rel. 2011-04 (Dec. 2, 2011)], and distributions related to litigation settlements [*see* DOL Advisory Op. 2005-08A (May 11, 2005)], subject to requirements specified in the guidance.

Trusts

If a trust is required, or perhaps determined to be the most beneficial funding method by the sponsoring employer, there are certain requirements that must be met.

In order to establish a trust, a named fiduciary of the plan must appoint one or more trustees for the plan. The trustees may be subject to the direction of the named fiduciary or not, as established in the trust agreement. A trust agreement between the plan and the trustees, setting out the powers and responsibilities of the trustees, should be adopted. While a formal trust agreement is best practice, a trust can be established without a formal trust agreement, where the plan document establishes a trust relationship between the named fiduciary and the trustees. [Barboza v. California Ass'n of Prof'l Firefighters, 594 Fed Appx. 903 (9th Cir. 2014)] All plan assets are then held in an account in the name of the trust. Once a trust is established, fiduciary responsibilities, bonding requirements, and prohibited transaction rules apply to the trust and the trustees of the plan. It also should be noted that welfare plans that have a trust are always considered "funded plans" as opposed to "unfunded plans," which means that two important exceptions to the Form 5500 filing requirements are not available for welfare plans funded by a trust: (1) the exception to the Form 5500 filing requirement under 29 CFR 2530.104-20 for unfunded and/or fully insured plans with less than 100 participants at the beginning of the plan year, and (2) the exception to the requirements under 29 CFR 2520.104-44 to file a Schedule H with the Form 5500 and include an opinion by a qualified independent auditor for an unfunded and/or fully insured plan with more than 100 participants at the beginning of the plan year. Accordingly, welfare plans that are funded by a trust must file a Form 5500 each plan year, regardless of participant count, and file a Schedule H with an opinion by a qualified independent auditor if they have more than 100 participants at the beginning of the plan year.

Non-Compliance

Violations that can occur generally fall into three categories: (1) trust and/or exclusive benefit rules; (2) ERISA's fiduciary responsibility rules; or (3) prohibited transaction rules. Depending on the nature of the violation–from a technical violation with minimal or no harm to the plan to willful misconduct such as embezzlement–the consequences can vary. There are both civil and criminal penalties that may apply, and fiduciaries may be held personally liable for violation of fiduciary responsibility rule violations. However, the most likely and significant liability comes from the potential for lawsuits by plan participants. Under ERISA, participants, beneficiaries, and fiduciaries can bring a suit against a fiduciary for breach of fiduciary duties or to enjoin any act or practice that violates Title I of ERISA or the terms of the plan, obtain other appropriate equitable relief, or enforce any provisions of Title I of ERISA or the terms of the plan. [*See* ERISA §§ 502(a)(2) and 409; ERISA § 502(a)(3).] This can get expensive, particularly where the breach results in unpaid medical claims. In *Cook* (discussed above), employee and employer contributions were not timely forwarded to the insurer (in part in order to make payroll), and coverage was, therefore, canceled. The employer did not notify employees of the cancelation of coverage, and so employees continued to incur and submit medical claims. The employer was not just liable for the unpaid premiums, but for the medical expenses that were incurred after the cancelation of coverage.

Bottom Line

Employers that sponsor health and welfare plans must be aware of how they hold contributions to the plan—employer, participant, and any other–and establish a funding method accordingly. Funding from the general assets of the employer may avoid the trust requirement, if carefully and clearly established, and the plan sponsor has determined that this is an available and preferred option. When in doubt, establishing a trust is a conservative approach. A professional advisor should analyze each situation individually, based on the specific arrangement. In the end, a trust may be the only way, or even the preferred way, to comply with the trust requirement. ■