FIDUCIARY LIABILITY EXPOSURES AND INSURANCE COVERAGE

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IRMI on Fiduciary Liability Exposures and Insurance Coverage
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Chapter 1
Introduction and Course Overview

IRMI has teamed up with WebCE to bring you this quality continuing education course.

This Web CE course is designed to give a moderately experienced insurance person a detailed look at (1) the fiduciary liability exposures that were created by the Employee Retirement Income Security Act (ERISA) of 1974 and (2) at the insurance policies that have been developed to cover these liability exposures.

The first part of the course describes the basic fiduciary duties set forth in ERISA, examines the specific types of pension and benefit plans governed by ERISA, and analyzes the particular claims exposures created by these duties. Next, the course discusses the way in which fiduciary liability insurance is underwritten, provides methods of controlling exposures to fiduciary liability claims, and explains how fiduciary liability coverage is coordinated with other types of management liability insurance policies. The second part of the course takes a detailed look at the specific provisions within fiduciary liability insurance policy forms, including insuring agreements, covered persons/organizations, provisions pertaining to status changes, key definitions, limits/deductibles, conditions, exclusions, and coverage triggers.

- Chapter 2 explains the specific fiduciary duties enumerated within ERISA. These include how the law defines a "fiduciary," the standards of care required by fiduciaries, responsibility for outside service providers, prohibited transactions, and bonding requirements.
- Chapter 3 enumerates the types of benefit plans to which ERISA applies. It also describes the plans that are exempt from ERISA regulations.
- Chapter 4 discusses the liability exposures that result from the three major types of employee pension plans: (1) defined benefit, (2) defined contribution, and (3) cash balance plans. Particular focus is directed to exposures from 401(k) plans and the problems resulting from the holding of company stock in these accounts.
- Chapter 5 explores the key factors that insurers use to price and underwrite fiduciary liability coverage. Among the factors discussed include funding adequacy, nature of the plans covered, single versus multi-employer plans, and the profiles of covered fiduciaries.
- Chapter 6 describes how to reduce the exposures to liability claims that are made against fiduciaries. Specific techniques, such as periodic audits and the use of experts to design plans, are discussed in detail.
- Chapter 7 explains how to coordinate fiduciary liability policies with other related coverages, including employee benefits liability endorsements to CGL. It also discusses the advantages

and disadvantages of including fiduciary liability coverage within so-called management liability "package" policy forms.

- Chapter 8, which begins the detailed discussion of fiduciary liability policy forms, addresses the two major insuring agreements within the policies: (1) coverage for fiduciary liability and (2) coverage for claims adjudicated under what are known as "voluntary settlement programs."
- Chapter 9 examines the covered persons and covered organizations provisions of the policy. Special attention is given to the four types of assets covered by the policies, as well as to key coverage extensions, including coverage for spouses and personal representatives of insureds.
- Chapter 10 reviews the manner in which coverage applies for "status changes," such as the addition of employee benefit plans (e.g., when an insured corporation acquires another corporation) and the termination of such plans.
- Chapter 11 explains how fiduciary liability policies define and apply several key terms, including: covered losses, claim, policy territory, defense costs, and claim settlement procedures.
- Chapter 12 describes the functioning of a fiduciary liability policy's limits and retentions/deductibles provisions. Particular attention is paid to how they apply in claim situations involving multiple claimants, a common characteristic of fiduciary liability claims.
- Chapter 13 describes the important policy conditions found within fiduciary liability forms, including subrogation/recourse, severability, and managed care exception wording.
- Chapter 14 looks at the key exclusions found within fiduciary liability policies and discusses the rationale for each, and also addresses the subtle but critical variations within the same exclusion contained in the different insurers' policies.
- Chapter 15 analyzes the manner in which a fiduciary liability policy's coverage triggers apply. Within this context, concepts such as claims first-made, post-policy reporting windows, retroactive dates, discovery provisions, extended reporting and runoff periods are treated at length.

Upon successful completion of this course, you will be able to:

1. Identify the specific fiduciary duties enumerated within ERISA, state how the law defines "fiduciary," and describe the standards of care required by fiduciaries.
2. Explain the significance of "prohibited transactions," and how fiduciaries can avoid them.
3. List the types of plans that are both included within and exempted from ERISA regulations.
4. State the most common fiduciary liability exposures resulting from the three major types of employee benefit plans.
5. Explain the key factors insurers use to underwrite and price fiduciary liability coverage.
6. Analyze the various methods of preventing claims against fiduciaries.
7. Describe the ways in which fiduciary liability policies can be (1) coordinated with employee benefits liability policies and (2) incorporated within executive liability package policies.
8. List and describe the two major insuring agreements found within fiduciary liability policy forms.

9. Give details concerning the covered persons and covered organizations provisions.
10. Analyze the way in which coverage under the policies applies to various types of organizational "status changes."
11. Identify and explain how various coverage terms are defined within the policies, including covered losses, claim, policy territory, defense costs, and claims settlement procedures.
12. Describe the operation of the policy's limits and deductibles/retentions provisions, especially within the context of legal actions involving multiple claimants.
13. Explain the functioning of the following key fiduciary liability policy conditions: subrogation/recourse, severability, and managed care exception wording.
14. Enumerate the exclusions found within the policies, explain the variations within these exclusions as offered by various insurers, and explain the rationale underlying these exclusions.
15. Analyze the components of a fiduciary liability's claims-made provision and explain how these components apply in claim situations.

Chapter 2
Fiduciary Duties under ERISA

Chapter Two examines the specific duties enumerated by the Employee Retirement Income Security Act (ERISA), to which fiduciaries must adhere.

ERISA: The Basics

The U.S. Congress passed the Employee Retirement Income Security Act (ERISA) in 1974 to assure that employees participating in pension and benefit plans would indeed receive the benefits promised by such programs. As a result, the law created numerous fiduciary liability exposures for employers that offered these plans, and, in response, fiduciary liability insurance coverage became available on a widespread basis during the mid-1970s.

According to ERISA's provisions, persons working within business organizations that design, administer, and manage pension and employee benefit plans are fiduciaries. Additionally, there are financial institutions (e.g., banks, insurance companies) and individuals (e.g., attorneys, actuaries, consultants, investment advisers) who also perform fiduciary duties in conjunction with the pension and employee benefit plans sponsored by client companies. (There are other types of fiduciaries, such as those who manage the assets of children or mentally incapacitated adults. However, this course will address the liability exposures and insurance coverage written for corporate fiduciaries.)

Responsibility for the interpretation and enforcement of ERISA is divided among the Department of Labor, the Department of the Treasury (especially the Internal Revenue Service), and the Pension Benefit Guaranty Corporation.

The Purpose of ERISA

ERISA does not require employers to establish or create benefit or pension plans for its workers. Nor does it decree minimum benefit levels if such plans have been established. Rather, the essence of ERISA is that it regulates the manner in which pension and benefit programs must operate once they have been put into place. For example, under ERISA, pension plans are required to provide vested benefits for employees after a certain number of years. (Benefits are "vested" when they become the legal property of the designated beneficiary. For example, under most corporate 401(k) savings plans, the portion contributed by the employer normally requires a 3 to 5 year period before such contributions become vested; that is, when the contributions become the legal property of the employee on whose behalf the contributions were made.) ERISA also mandates that such plans meet certain minimum funding requirements.

ERISA set forth a broad scope of fiduciary obligations. Accordingly, the Act created numerous liability exposures for individuals and companies that create and manage pension and employee benefit plans. The purpose of ERISA was to develop guidelines for administering such plans so that

the interests of employee beneficiaries would be safeguarded. In effect, ERISA is designed to assure that those entitled to pensions and benefits are able to collect them.

Fiduciaries as Defined by ERISA

According to ERISA, an individual or corporation is considered a fiduciary if that person or corporation does any of the following.

1. Exercises any discretionary authority or discretionary control in managing the pension or benefit plan or exercises any authority or control in managing or disposing of its assets.
2. Renders investment advice for a fee or other compensation, with respect to any monies or other property belonging to the plan.
3. Has any discretionary authority or responsibility in administering the plan.

Personal Liability of Fiduciaries under ERISA

One key aspect of ERISA is that it makes fiduciaries personally liable for breaches of duty. Prior to ERISA, there was no personal liability associated with management of employee pension and benefit plans. Although the fiduciary liability exposure actually existed prior to the passage of ERISA, ERISA not only formalized the law associated with the administration of employee pension and benefit plans. It also broadened the scope of such liability so that it became a "personal" rather than simply a "corporate" liability, meaning that the personal assets of a fiduciary can be confiscated to restore any losses suffered by a covered plan if the losses were caused by the fiduciary's negligence. For example, if Joe Smith, the comptroller at Corporation X, who is also a trustee of the corporation's pension plan, is held liable for an error that causes a loss to that plan, Joe's personal assets could be seized to cover the loss. In other words, in addition to Corporation X's assets, Joe's assets, since he is a fiduciary, are also exposed to liability claims. This is illustrated in Exhibit 2.1.

EXHIBIT 2.1
PERSONAL LIABILITY OF FIDUCIARIES UNDER ERISA

Sec. 1109. Liability for breach of fiduciary duty

> Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations or duties imposed upon fiduciaries by this subchapter shall be personally liable [emphasis added] to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan [emphasis added] any profits which have been made through use of assets of the plan by the fiduciary…,

Source: Employee Retirement Income Security Act of 1974, Title 29, Chapter 18, Subchapter I, Subtitle B, Part 4, Sec. 1109.

Expanding Definitions of Fiduciaries To Include Corporate Directors

With the incidence of what is known as ERISA "stock drop" claims (discussed later in this course), a number of courts have broadened the definition of "fiduciary" to include the sponsor corporation's board of directors or its compensation committee—if the directors have the authority to appoint persons who serve as fiduciaries of the plan. Given their power to appoint fiduciaries, some courts have reasoned that corporate directors have a continuing duty to oversee the performance of those they have appointed to these positions. (In most corporations, executive officers, such as the CEO, COO, and CFO, as well as high-level managers such as the human resources manager or director of employee benefits, are appointed as the trustees of corporate benefit plans.)

Standards of Care Required of ERISA Fiduciaries

The ERISA law represents an attempt by the United States Congress to codify the common law standard for fiduciary conduct that evolved from the law of trusts. Although ERISA speaks in terms of the "prudent man standard of care," it compels a broader and more stringent standard of conduct than mere "prudence." Rather, the standard to be met is one of a prudent fiduciary—not a prudent man. More specifically, ERISA imposes certain standards of care on fiduciaries. These are noted in Exhibit 2.2.

EXHIBIT 2.2
STANDARDS OF CARE ERISA IMPOSES ON FIDUCIARIES

- **Exclusive Purpose**. Fiduciaries must discharge their duties with respect to a plan, solely in the interest of the plan's participants and beneficiaries.
- **Prudence**. Fiduciaries must discharge their duties "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims."
- **Diversification**. Fiduciaries must diversify the investments of the plan so as to minimize the risk of large losses, unless, under the circumstances, it is clearly prudent not to do so.
- **Plan Documents**. Fiduciaries are required to discharge their duties in accordance with the documents and instruments governing the plan.

Responsibility for Outside Service Providers

It is important to note that under ERISA, a fiduciary can also be held liable for the acts, errors, and omissions of a co-fiduciary (also known as an outside service provider). Thus, organizations sponsoring employee pension and benefit programs are exposed to claims caused by the actions of outside entities and organizations that provide administrative services for the plans they sponsor. Given the complexity of many pension and benefit programs, several different kinds of specialized expertise are typically required to operate such programs and a number of different firms may be involved in servicing a firm's pension and benefits programs. The different entities commonly providing such expertise are enumerated in Exhibit 2.3.

EXHIBIT 2.3
OUTSIDE ENTITIES SERVICING PENSION AND BENEFIT PLANS

Consulting Firms that possess specialized expertise regarding ERISA are called on to design and implement pension and benefit plans.

Professional Administration Firms are in the business of performing the day-to-day paperwork functions required by benefit plans (e.g., enrollment, claims processing and payments, record keeping, filing reports with government agencies).

Actuarial Consulting Firms must periodically review current pension fund reserve levels and certify that such reserves, coupled with predicted future contributions and expected investment returns, will be adequate to meet anticipated payments to plan beneficiaries when they retire.

CPA Firms perform annual audits of the plans to ascertain that financial statements accurately present the true condition of the plans and that the statements have been prepared in accordance with generally accepted accounting principles (GAAP).

Law Firms must review and analyze all important documents associated with the plans and ultimately render an opinion regarding the extent to which they comply with ERISA.

Investment Advisers assist fiduciaries in establishing investment guidelines and in retaining and reviewing the performance of investment managers.

Investment Management Companies are charged with the duty of investing the assets of plans. In accordance with investment objectives of the plan as specified in the plan documents, the managers must achieve optimal levels of diversification, capital preservation, and rates of return.

Bank Trust Departments are typically in actual possession of invested funds (or evidence of those funds in the form of stock certificates and bonds, for instance) and may also participate in the investment decision-making process. Sometimes they work in conjunction with an independent investment management firm. In other instances, they are also responsible for actually making investment decisions.

Protection from Liability: The Investment Company Act of 1940

Despite a fiduciary's responsibility for the actions of outside service providers, it should be understood that ERISA does provide fiduciaries with a layer of insulation from liability. Specifically, if it can be shown that the fiduciary selected an investment adviser who is registered under the Investment Company Act of 1940, the fiduciary cannot be held liable for the investment adviser's imprudent investment decisions. In effect, liability can only attach when it can be shown that the fiduciary negligently selected the adviser, because it failed to select an adviser who is registered under the 1940 Act.

"Function" versus "Category" Determines Liability

It is important to recognize, however, that depending on the specific nature of their duties, not all of the persons and entities listed in Exhibit 2.3, above, will be considered fiduciaries under ERISA in every instance. This is because "function" rather than "category" is what ultimately controls the question of "who is a fiduciary?" For example, a bank that merely holds securities for safekeeping, but plays no role in the actual investment decision-making process, would probably not be considered a fiduciary. In contrast, a bank performing both of these roles would almost certainly be considered a fiduciary to the extent of its involvement in the decision-making process.

Prohibited Transactions

ERISA specifies two kinds of transactions that are prohibited.

- **Self-Dealing**. Fiduciaries are prohibited from using plan assets to profit personally (e.g., investing pension plan monies in a company in which a fiduciary holds a majority interest).
- **Party-in-Interest Transactions**. These are otherwise legitimate transactions that are prohibited if the transaction is conducted with a "party in interest." A "party-in-interest" includes any fiduciary, legal counsel, employee of the plan, service provider to the plan, employer or employee whose employees or members are covered by the plan, and any other person who has a stated interest in, or a relationship with, a party in interest. For example, pension plan funds cannot be used to buy or sell property to or from or invest any assets with any family member of any trustee, or anyone else who is a party-in-interest.

Penalties for Engaging in Prohibited Transactions

In the event that a plan engages in a prohibited transaction, it will not be disqualified, although an Internal Revenue Service (IRS) 50 percent excise tax will automatically be levied. This tax rises to 100 percent if the situation is not corrected within a certain period of time (usually within 90 days). In addition, the Department of Labor imposes a 20 percent penalty based on the amount of the fiduciary's breach.

Exceptions to Prohibited Transactions

To carve out those prohibited transactions that come within the literal language of ERISA but are not intended to be prohibited, Congress created certain statutory exceptions to what would otherwise be considered prohibited transactions. Some of these include (1) exemptions that permit the rendering of reasonable and necessary services; (2) the collection and compromise of disputes concerning delinquent contributions from participating employers; (3) the sale of securities of parties in interest; and (4) the receipt of reasonable compensation by certain parties in interest.

Bonding Requirements under ERISA

Under ERISA, and effective December 31, 2007, all fiduciaries and persons who handle plan funds or other plan assets must be bonded for 10 percent of the aggregate amount handled, with a minimum bond of $1,000 and a maximum bond of $1,000,000.

It is the insured organization's responsibility to make certain that all employees with access to plan funds are appropriately bonded. However, fidelity bonding is not required of corporate trustees or insurance companies with combined capital and surplus of at least $1 million, if the only assets from which benefits are paid are the general assets of the insured organization or a union. Nor is fidelity bonding required if the Secretary of Labor finds that other bonding arrangements or the overall condition of the plan are adequate to protect participants.

Compliance by Endorsement to Corporate Crime Policy

Compliance with these bonding rules can be attained by attaching an ERISA Compliance Bond to a company's existing crime policy, assuming the policy covers employee dishonesty. In effect, compliance does not require the purchase of a separate insurance policy or bond.

Interestingly, financial institutions are granted a "regulatory exemption" from these mandatory bonding requirements, most likely because financial institutions almost universally maintain ample employee dishonesty coverage. ERISA compliance bonds, which, as mentioned above, are merely endorsements to existing crime policies, cover losses caused by dishonest acts committed by trustees, officers, employees, administrators, or managers of insured plans.

Fiduciary Liability, Employee Benefits Liability, and ERISA Bonding Requirements Compared

There is often confusion regarding the difference between fiduciary liability insurance, employee benefits liability insurance, and the bonding requirements under ERISA.

Fiduciary liability insurance covers claims alleging breach of discretionary duties specified by the 1974 ERISA law (e.g., failure to invest plan assets prudently, failure to select a qualified service provider to a covered plan). Insureds under fiduciary liability policies include both the corporate entity that sponsors the covered plans, as well as the individuals who serve as fiduciaries of such plans.

Employee benefits liability policies cover claims involving nondiscretionary, administrative errors pertaining to pension and benefit plans (e.g., failing to name an intended beneficiary on a life insurance policy, failure to enroll an employee in a company 401(k) plan).

ERISA bonding requirements apply to fidelity/dishonesty situations to protect against a fiduciary's illegal appropriation of funds from an employee benefit plan. These requirements necessitate purchasing an ERISA Compliance Bond, which, as explained above, can be secured by endorsement to a corporate crime policy.

Exhibit 2.4 illustrates the three types of claim situations that would be covered under these different policies.

EXHIBIT 2.4
FIDUCIARY LIABILITY, EMPLOYEE LIABILITY, ERISA BONDING REQUIREMENTS—EXPOSURES AND COVERAGES

Claim Situation	Applicable Coverage
A fiduciary's imprudent investment decision causes a pension fund to become insolvent.	Fiduciary liability policy
A fiduciary fails to enroll an employee in a pension plan.	Employee benefits liability policy or fiduciary liability policy that also covers employee benefits liability
A fiduciary intentionally absconds with pension funds.	ERISA Compliance Bond or endorsement to a corporate crime policy form

Other Important Sections of ERISA

Two additional, key sections of the ERISA law require mention: Section 404(c) and Section 510.

ERISA Section 404(c)

Section 404(c) of ERISA protects a fiduciary against liability for investment losses arising from allocation choices in employee-directed retirement plans (e.g., 401(k) plans) if the following requirements are met.

- Plan participants can allocate funds among a minimum of three investment choices with substantially different risk and return characteristics.
- Each core investment alternative is sufficiently diversified.
- Plan participants can transfer from or among the investment alternatives at least once every 3 months.
- Participants can transfer from or among the investment alternatives with a frequency that is appropriate to each fund's risk level.
- Participants receive sufficient information to make informed decisions about the plan's investment options.

Limitations of 404(c) Protections for Fiduciaries

However, simply providing employees with options that satisfy 404(c) requirements does not safeguard a fiduciary against lawsuits for selecting funds imprudently, failing to monitor them for continuing appropriateness, or engaging in a prohibited transaction.

Moreover, when losses are attributable to the poor selection of the investment, 404(c) offers no protection because the trustee and other fiduciaries are required to make prudent decisions regarding their selection of investment options. That selection is generally linked to the selection of the mutual fund or group annuity provider.

Finally, fiduciaries are not relieved of other fiduciary obligations even if they comply with all of ERISA 404(c). For example, fiduciaries must continue to: (1) prudently select the investment alternatives that are available to participants, (2) monitor the investment performance of these selections, and (3) prudently carry out the participant's investment instructions.

ERISA Section 510

The purpose of Section 510 is to prevent employers from (1) taking actions that might abridge or impair an employee from collecting benefits or (2) taking punitive action against an employee-participant for exercising his or her rights under an employee benefit plan. Accordingly, employees may pursue claims under Section 510 suits for discharges and other similar employment decisions that threaten the accrual of additional benefits through continuous years of employment (e.g., terminating an employee, without cause, immediately prior to the date on which the employee would have become vested in the company's pension plan).

More specifically, Section 510 of ERISA prohibits employers from (1) discriminating or taking adverse action against plan participants or beneficiaries for exercising their rights under ERISA plans, (2) interfering with participants' or beneficiaries' attainment of rights under ERISA, and (3) retaliating against individuals for giving information or testifying in any inquiry or proceeding under ERISA.

However, it should be recognized that while ERISA prohibits employers from taking adverse actions against employees to avoid paying them benefits, employers have the unrestricted right to reduce or eliminate non-vested benefits by changing the terms of a plan in a way that does not discriminate against any sub-group. In enacting ERISA, it was Congress's intent to prohibit discrimination in administering a welfare benefit plan, but still allowing employers to change the terms of those plans as it saw fit.

Chapter 2 Review Questions

1. If she is unclear as to how ERISA applies to her situation, Erica might seek clarity from any of the following federal organizations responsible for the interpretation and enforcement of ERISA, *except:*
   a. Department of Labor (DOL)
   b. Government Accountability Office (GAO)
   c. Internal Revenue Service (IRS)
   d. Pension Benefit Guaranty Corporation (PBGC)
2. As Tractor Corporation treasurer, Alice Chalmers is responsible for managing Tractor's pension plan. Alice was supposed to take any dividend income and plow it back into the plan's investments. Instead, she allowed dividends to accumulate for years in the plan's non-interest-bearing checking account. Under ERISA, losses caused by Alice's negligence can be recuperated:
   a. by confiscating Alice's personal assets as well as Tractor Company's corporate assets.
   b. from the Pension Benefit Guaranty Corporation.
   c. only by confiscating Tractor Company's corporate assets.
   d. only by confiscating Alice's personal assets.
3. As a fiduciary of her employer's pension and benefit programs, Mollie Coddle might be personally exposed to claims caused by actions of any of the following, *except*:
   a. By-Lo Investment Advisors, which assists Mollie and other fiduciaries in establishing investment guidelines.
   b. Dr. Stork, an obstetrician belonging to the HMO used by several pregnant employees.
   c. River Bank, whose trust department holds invested funds and provides some investment advice.
   d. Soo and Wynne, the law firm that reviews plan documents.

4. Fallen Arches Burger Company has combined capital and surplus of approximately $500,000. Under ERISA, a bond covering all fiduciaries who handle Fallen Arches' plan assets must meet all of the following requirements, *except*:

   a. 10 percent of aggregate amount handled.

   b. $1,000 minimum.

   c. $10,000 deductible.

   d. $1,000,000 maximum.

5. Samson Company's Pension Plan assets were all invested in the stocks of a small group of financial services and auto companies that went bankrupt. This, in turn, caused the pension fund to collapse. Which of Samson's policies or bonds applies to claims based on the imprudent investment decisions of its fiduciary?

   a. Employee benefits liability policy.

   b. ERISA Compliance Bond.

   c. Fiduciary liability insurance.

   d. Workers compensation and employers liability policy.

6. Marlene's employer gives her a bad performance review and a demotion because she exercised her ERISA rights. The employer's actions are prohibited under ERISA Section(s):

   a. 2(b) and 2(c).

   b. 401(k).

   c. 404(c).

   d. 510.

Answers to Chapter 2 Review Questions

1. b. Responsibility for interpretation and enforcement of ERISA is divided among the Department of Labor, the Department of the Treasury (especially the Internal Revenue Service), and the Pension Benefit Guaranty Corporation.
2. a. Since Alice is a fiduciary, her personal assets, in addition to Tractor Corporation's assets, could be seized to cover the loss.
3. b. Dr. Stork's services are not of a fiduciary nature, so he is not considered a co-fiduciary.
4. c. ERISA has no deductible requirement.
5. c. A fiduciary liability policy applies to claims resulting from a fiduciary's imprudent investment decisions that cause a pension fund to become insolvent.
6. d. Section 510 of ERISA prohibits employers from discriminating or taking adverse action against plan participants or beneficiaries for exercising their rights under ERISA plans.

Chapter 3
Types of Plans Covered and Exempted by ERISA

Chapter 3 analyzes the two major types of plans to which the ERISA law applies: employee pension benefit plans and employee welfare benefit plans. In addition, this chapter notes the basic requirements included within the ERISA law to which these plans must adhere.

The Two Types of Covered Benefit Plans

ERISA covers two types of employee benefit plans: (1) employee pension benefit plans and (2) employee welfare benefit plans.

Employee Pension Benefit Plans

These are plans created by an employer, a union, or both and which provide for retirement income or the deferral of income (e.g., 401(k) plans, "traditional" defined benefit pension plans, both of which will be discussed later in this course).

Under ERISA, pension plans must provide for vesting of employees' pension benefits after a specified minimum number of years. ERISA also requires that the employers who sponsor plans satisfy certain minimum funding requirements.

In addition, ERISA regulates the manner in which a pension plan may pay benefits. For example, a defined benefit plan must pay a married participant's pension as a "joint-and-survivor annuity" that provides continuing benefits to the surviving spouse unless both the participant and the spouse waive the survivor coverage.

The Pension Benefit Guaranty Corporation (PBGC) was established by ERISA to provide coverage in the event that a terminated defined benefit pension plan does not have sufficient assets to provide the benefits earned by participants. The PBGC will be discussed in more detail later in this section.

Employee Welfare Benefit Plans

These are plans, funds, or programs created by an employer or union for the purpose of providing medical, sickness, accident, disability, death, unemployment, and vacation benefits, apprenticeships, training programs, day care centers, scholarship funds, prepaid legal services, or any benefit allowed by the Taft-Hartley Act.

Again, it is important to stress that ERISA does not require that an employer provide health insurance coverage (or any of the aforementioned types of benefit programs) to its employees or retirees, but it regulates the operation of a health benefit plan if an employer chooses to establish one.

In contrast to employee pension benefit plans and employee welfare benefit plans, other types of programs are exempt from the law. Exhibit 3.1 enumerates both types

EXHIBIT 3.1
ERISA AND NON-ERISA PLANS

Plans Subject to ERISA

- Pension plans
- Profit-sharing plans
- Thrift and savings (401(k))
- Employee Stock Ownership Plan (ESOP)
- Tax Reform Act Stock Ownership Plan (TRASOP)
- Welfare plans
- Life insurance
- Hospital/surgical/medical insurance
- Dental and vision care insurance
- Accident insurance
- Disability income
- Scholarship plans (which are funded)
- Supplemental unemployment
- Prepaid legal services
- Some severance pay plans

Plans Not Subject to ERISA

- Plans falling under other, more specific laws (e.g., workers compensation, unemployment compensation, disability insurance)
- Plans maintained outside the United States, primarily for nonresident aliens
- Unfunded plans maintained solely to provide benefits for certain employees in excess of the limitations imposed on benefits and contributions for tax purposes (Section 415, Internal Revenue Code)
- Plans of federal and state governments and political subdivisions, agencies, and instrumentalities
- Church plans

Basic Requirements of ERISA Plans

In addition to the types of plans that are both subject to and exempt from the law, ERISA has established the basic requirements to which subject plans must comply. These are enumerated in Exhibit 3.2.

EXHIBIT 3.2
REQUIREMENTS FOR PLANS SUBJECT TO ERISA

Plans subject to ERISA must:

- Be maintained pursuant to a written instrument
- Provide for named fiduciaries
- Provide a procedure for establishing and fulfilling a funding policy
- Describe responsible parties for:
  - Operation
  - Administration
  - Fiduciary duties
- Provide a procedure for and identify the parties who can amend the plan
- Describe the basis for payments made to and from the plan

Source: "Fiduciary Liability Comes of Age: Major Litigation Trends at the Beginning of the 21st Century." Presentation at the Professional Liability Underwriting Society (PLUS) Conference, Chicago, IL, 2001.

Two Key Amendments to ERISA

ERISA was later expanded to include two major health laws. Specifically, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended ERISA to make health care coverage more portable and secure for employees.

Continuation of Health Coverage (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits. Such coverage is continued for limited periods of time, under certain circumstances, such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage, up to 102 percent of the cost to the plan.

COBRA requires that group health plans sponsored by employers with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

COBRA outlines how employees and family members may elect continuation coverage. It also requires employers and plans to provide notice of the option for continuation of coverage.

Portability of Health Coverage (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) affords rights and protections for participants and beneficiaries in group health plans. HIPAA includes: (1) protections for coverage under group health plans that would otherwise limit or exclude coverage for preexisting conditions, (2) prohibitions of discrimination against employees and dependents based on their health status, and (3) allowance for a special opportunity to enroll in a new plan, to individuals, under certain circumstances.

Retiree Health Care Benefits: Not Subject to ERISA Protections

During the 1990s and 2000s, a number of employers who promised lifetime healthcare coverage to their retired workers discontinued such programs or substantially reduced the scope of benefits paid under them. However, ERISA does not mandate the vesting of retiree healthcare benefits in the manner that it requires employees to become vested in pension plans. Nevertheless, employees and retirees who had been promised lifetime health coverage by their employers may still be able to enforce these promises by suing on a breach of contract theory or by challenging the right of the health benefit plan to change its plan documents in order to eliminate promised benefits.

The ERISA Preemption for Health Care Plans

As noted above, plans providing health care benefits are governed by ERISA. However, in claims involving administration of an ERISA-qualified health care benefit plan, the Act bars jury trials, punitive damage awards, and limits damages to actual medical expenses incurred. Additionally, claims associated with employer-provided medical plans are not generally covered by fiduciary liability policies, because fiduciary liability policy forms routinely contain exclusions for bodily injury.

The Managed Care Exception Endorsement

Nevertheless, in recent years, insurers have begun to attach, via endorsement, an important exception to this exclusion for coverage of bodily injury claims associated with employer-provided health insurance coverage. Specifically, by means of so-called managed care exception endorsements, fiduciary liability insurers "except"—and therefore cover—bodily injury, sickness, mental or emotional distress, disease, or death, when such events result from the administration of managed health care plans. The two most common claim scenarios associated with the managed care exposures involve an injured employee-claimant suing an employer sponsor of a managed health care plan, alleging:

1. that the employer-sponsor of a managed health care plan negligently selected the managed health care plan provider; and/or
2. that the employer-sponsor of a managed health care plan wrongly denied or delayed medical benefits provided by the plan.

Absent a managed care endorsement that "excepts" (and therefore covers) bodily injury when it arises from managed care plan administration, coverage would otherwise be excluded for these scenarios. However, this coverage is an important aspect of fiduciary liability policy forms since such plans are subject to ERISA and fiduciaries are exposed to personal liability as a result. This aspect of coverage is discussed in more detail in Chapter 13 of this course.

Chapter 3 Review Questions

1. Among other employee benefits, Smart Company makes available to employees a tuition reimbursement plan, also known as a scholarship fund. Under ERISA, this benefit is considered an*:*

   a. Employee pension benefit plan.

   b. Employee welfare benefit plan.

   c. Exempt benefit.

   d. Expendable benefit.

2. Because the Partridge-Pear Tree Corporation's profit-sharing plan is subject to ERISA, the company must do all of the following, *except*:

   a. describe the party responsible for plan administration.

   b. hoard plan assets for the benefit of Partridge-Pear Tree Corporation.

   c. maintain the plan in accordance with a written document.

   d. provide a procedure for establishing a funding policy.

3. Eric's former employer promised lifetime healthcare insurance to workers who retire. Having recently retired, he is concerned that the employer might try to renege on its promise. If that should happen, Eric can:

   a. invoke ERISA's vesting requirements.

   b. invoke HIPAA's vesting requirements.

   c. sue the employer based on a breach of contract theory.

   d. sue the employer to gain access to plan documents.

Answers to Chapter 3 Review Questions

1. b. Employee welfare benefit plans are created by an employer or union to provide a variety of benefits, including scholarship funds.
2. b. The purpose of a profit-sharing plan is to share profits, not to hoard them.
3. c. Retirees who had been promised lifetime health coverage by their employers may still be able to enforce these promises by suing on a breach of contract theory.

Chapter 4
Liability Exposures Associated with Employee Pension Benefit Plans

As already noted, ERISA governs two types of employee benefit plans: employee pension benefit plans and employee welfare benefit plans. By far, the larger of the two exposures to which ERISA fiduciaries are subject is in conjunction with employee pension benefit plans.

Chapter 4 discusses the liability claim exposures resulting from the three major types of employee pension benefit plans: (1) defined benefit plans, (2) defined contribution plans, and (3) cash balance plans.

Types of Employee Pension Benefit Plans

There are three types of employee pension benefit plans.

- **Defined benefit pension plans.** These are retirement plans in which an employer promises to pay a specific monthly benefit amount (or a lump sum) at retirement, based on a predetermined formula. For example, based upon an employee's years of service, age, and salary during the final 10 years, he/she will receive a specific monthly pension payment for life. Such plans are often referred to as "traditional" pension plans.
- **Defined contribution pension plans.** These plans provide no guarantee of a specific benefit amount. However, unlike defined benefit pension plans, under defined contribution plans, the employee has a separate retirement account in which he or she has an ownership interest. 401(k) plans are the most common type of defined contribution plan. Under such plans, employees contribute anywhere from 1 to 15 percent of their annual salary each year to a savings plan. The employer will usually match one-half of the employee's contribution, most often up to 6 percent of the employee's contribution. For example, if an employee contributes 6 percent of her salary to the 401(k) plan, the employer will contribute an additional 3 percent, so that the employee will have saved a total of 9 percent of her annual salary (i.e., 6 percent contribution, plus 3 percent employer match.) According to the Department of Labor, there are an estimated 437,000 defined contribution plans in operation, covering 65 million participants.
- **Cash-balance pension plans.** These plans are a "hybrid" of defined benefit and defined contribution plans. Under such plans, the employer makes contributions to the pension plan, but the accrued benefits are defined in terms of an individual account balance. Legally, however, the plans are defined benefit plans, because the employees do not actually own the individual accounts. Cash balance plans offer a guaranteed benefit like a traditional pension,

but generally provide longtime workers with lower accrued benefits, compared to defined benefit pension plans.

Defined Benefit Pension Plans

As has been the dominant trend since the early 1980s, the nation's employers have been moving away from offering defined benefit pension plans. This is especially true among the country's 100 largest companies. According to a study by Watson Wyatt Worldwide, in 2006, more than four in ten within this group offered new workers only defined contribution plans, such as 401(k) plans. In contrast, just 31 offered defined benefit pension plans. The study also noted that in 1985, 89 of the 100 largest companies offered defined benefit pension plans.

Assuring Pension Plan Solvency: The Pension Benefit Guaranty Corporation (PBGC)

To assure that pension plans set up by corporations will be able to honor their payment obligations to employees, the PBGC was established as a part of ERISA. The mission of the PBGC, which is an independent agency of the federal government, is to: (1) encourage the continuation and maintenance of voluntary private defined benefit pension plans and (2) to provide timely and uninterrupted payment of pension benefits when the plans themselves are financially unable to do so.

The PBGC is comprised of two programs, one for single-employer pension plans and another for multi-employer pension plans. Multi-employer plans are set up by collectively-bargained agreements involving more than one unrelated employer, generally in one industry. As of 2008, the single-employer program protected 34.0 million workers and retirees in 28,800 pension plans. The multi-employer program protected 9.9 million workers and retirees in 1,540 pension plans.

As of 2008, the PBGC paid monthly retirement benefits to approximately 631,000 retirees of 3,800 terminated defined benefit pension plans and was responsible for the current and future pensions of about 1.3 million people. Payments are based upon a retirement age of 65. When a beneficiary retires at an earlier age or elects a survivor benefit, benefit levels are adjusted downward. When a beneficiary retires after age 65, the benefit amount is adjusted upward. Additionally, the PBGC will not fully guarantee benefit improvements that were adopted within the 5-year period immediately prior to a plan's termination nor does it guarantee benefits that are not payable over a retiree's lifetime.

For single-employer plans, in 2008, workers who retire at age 65 can receive up to $4,312.50 a month (or $51,750 a year) under PBGC's insurance program for single-employer plans. For multi-employer plans, the amount guaranteed is based on a formula dependent upon the employee's years of service. For plans that terminate after December 21, 2000, the PBGC insures 100 percent of the first $11 monthly payment per year of service and 75 percent of the next $33 monthly payment per year of service. For example, if a participant works 20 years in a plan that promises $19 per month per year of service, the PBGC guarantee would be $340 per month. Multi-employer plans that terminated after 1980 but before December 21, 2000, had a maximum guarantee limit of 100 percent of the first $5 of the monthly benefit accrual rate and 75 percent of the next $15.

Funding for the PBGC comes from the following sources:

- Insurance premiums paid by employers who sponsor defined benefit pension plans
- Assets held by the pension plans that the PBGC takes over
- Recoveries of unfunded pension liabilities from plan sponsors' bankruptcy estates, and investment income

The Pension Protection Act of 2006

The Pension Protection Act, passed in 2006, is one of the most important pieces of pension-related legislation passed since the enactment of ERISA in 1974. The key provisions of the Act affected two major areas: (1) the PBGC and (2) defined contribution (i.e., 401 (k)) plans.

The following changes to the PBGC were made:

- A requirement that a company must have in its defined benefit pension fund 92 percent of the money needed to meet its pension obligations in 2008, 94 percent in 2009, 96 percent in 2010, and 100 percent by 2011.
- A change in the methodology for calculating the PBGC premium.
- A limitation of the PBGC's guarantee of pension benefits that become payable when a manufacturing plant is shut down.
- A freezing of employees' pension benefits if the PBGC takes over a terminated plan, as of the date of the plan sponsor's bankruptcy filing (which may be months or even years before the plan terminates).
- Simplification of the complicated rules governing the PBGC's pension guarantee for business owners.
- Addition of a requirement that if the PBGC takes over a terminated plan, the plan sponsor is required to pay a "termination premium" of $1,250 per participant per year for 3 years.

Changes to defined contribution plans were:

- Higher dollar contribution amounts were allowed for 401(k) savings plans, including "catch-up" contributions for older workers.
- Addition of several provisions regarding automatic enrollment in 401(k) plans, whereby every new employee is automatically enrolled in the company's plan, unless the employee specifically opts out of enrollment.
- A rule stating that matching contributions must be 100 percent vested after 3 years or must be vested at the rate of 20 percent per year beginning with the second year.
- Added diversification rights allowing participants to diversify out of an employer's stock into a different form of investment.
- A provision allowing an employer to provide investment advice through what is known as an "eligible investment advice arrangement." Such investment advice is generated by an unbiased computer model. (Employers have been traditionally reluctant to provide investment advice, for fear of liability arising from unfavorable investment outcomes based on such advice.)
- Added portability rights so that non-spouse beneficiaries can roll over assets inherited from a 401(k) plan into an individual retirement account (IRA) and avoid tax on the rollover until the assets are actually withdrawn.

Exposures from Defined Benefit Pension Plans

There are several fiduciary liability exposures generated by defined benefit pension plans. These include (1) exposures related to actuarial solvency, (2) conversion of a defined benefit pension plan to cash balance defined benefit pension plans, (3) mergers/terminations of plans, (4) plan disclosures,

(5) imprudent investment of assets, (6) failure to pursue delinquent contributions, (7) negligence not involving discretionary activities, and (8) claims involving securities backed by subprime loans.

Actuarial Solvency

The major exposure to which defined benefit pension plans are susceptible is a lack of actuarial solvency. (Actuarial solvency is a situation in which, based upon certain key assumptions, such as the expected rate of return on pension plan assets and the mortality experience of the pension plan's beneficiaries, that a pension plan will have sufficient funds with which to pay all benefits that are promised by the plan.) As noted, such plans promise to pay employee-beneficiaries a specific amount of money from the time they retire until the end of their lives (or, in the case of employees who elect a joint survivor annuity, to a beneficiary). This amount is usually based on a formula that factors in: (1) years of service, (2) age at retirement, and (3) earnings during the last 5–10 years of employment.

The ability to pay such benefits is based on a number of actuarial assumptions, the most important of which are employee mortality and expected rate of return on employer contributions to the pension fund. If, however, such assumptions prove to be incorrect, a defined benefit pension fund may be unable to pay promised benefits to its beneficiaries. Therefore, the solvency risk is the single largest exposure faced by defined benefit pension plans.

The wrongful acts producing such claims are usually committed by those responsible for administering an insured firm's benefit plan. For example, a common claim scenario is one in which a defined benefit pension fund is unable to pay promised benefits because it had been seriously underfunded for a long period of time and/or because its actual rate of return on funds is much lower than the rate that was anticipated when the original plan was devised. Beneficiaries then sue the company's employee benefits manager and/or those responsible for administering the pension plan, alleging that the administrators were negligent in funding the plan.

Conversions from Defined Benefit Pension Plans to Cash Balance Pension Plans

In the past decade, a number of large employers have restructured their defined benefit pension plans to cash balance plans, in the process producing a number of claims. Before analyzing the nature of such claims, the essential features of cash balance and defined benefit plans will be discussed and compared.

Cash Balance Pension Plans versus Defined Benefit Pension Plans

A cash balance plan makes two promises to employees. First, that an employer will contribute an amount equal to a percentage of each year of the employee's earnings. Second, it promises a specific rate of return on that contribution. Under a cash balance plan, the benefit is always expressed as a total account balance held by an individual employee

This is in contrast to a defined benefit pension plan, which promises an employee a flat dollar pay-out (either on a periodic, usually monthly, or on a lump-sum basis), based on: (1) years of service, (2) age at retirement, and (3) an employee's earnings in the years closest to retirement. On the other hand, distributions from cash balance plans are usually offered in the form of a lump sum payment, although these plans are legally required to offer an annuity option.

Cash balance plans build value steadily and often at the same pace for all employees, regardless of their length of service. The focus of these plans is on wealth building and portability. Conversely, defined benefit plans are aimed at encouraging career employment with a single employer. Instead of

focusing on wealth, their aim is to provide retirement security. The design of these plans does not reward employees who change jobs.

Why Employers Like Cash Balance Plans

Cash balance plans appeal to employers because they (1) allow them to more easily determine their liability for future payments to employees, (2) help to attract and retain workers in a more mobile employment environment in which people frequently change jobs, and (3) avoid the difficulties involved in explaining defined benefit plans and their often-complex formulas.

Why Claims Arise in Conjunction with Cash Balance Conversions

The key "driver" of claims from cash balance conversions is the assertion that younger employees typically fare better than they would under the original defined benefit plan that is being phased out. This is because the accrual pattern under a cash balance plan provides them with a larger benefit if they leave their current employer. On the other hand, older workers with more years of service may not do as well. In response to these conversions, in which older employees would experience significant reductions in their benefit levels, lawsuits have been filed against employers with the Equal Employment Opportunity Commission (EEOC) alleging illegal reduction of benefits.

Restrictions on Plan Changes

ERISA places restrictions on pension plan changes, including amendments that convert a defined benefit pension plan formula to a cash balance plan. Such restrictions require that:

- Advance notification is required if, as a result of the amendment, the rate at which plan participants may earn benefits in the future is significantly reduced.
- Other legal requirements must be satisfied, including prohibitions against age discrimination. In addition, there are prohibitions of discrimination against lower income and non-managerial workers.
- Employers who amend their plans to reduce the rate at which future benefits are earned are prohibited from reducing the benefits that participants have already earned. In other words, an employee may not receive less than his or her accrued benefit under the plan formula at the effective date of the amendment.

Mergers/Termination of Plans

Claims are frequently made when companies merge and pension or benefit plans are terminated in the process. For example, Firm A is acquired by Firm B. Firm A's pension plan is then merged into Firm B's, with a subsequent reduction in expected pension benefits for the employees of Firm A, the acquired company. At the time of the acquisition, however, the managers of the plan fail to communicate these benefit reductions to the affected workers. Ten years later, when the workers are eligible to receive their pension benefits and they are not as high as expected, the workers sue the fiduciaries for failing to communicate these changes.

Plan Disclosures

Claims often result because of the way in which benefit plan changes are communicated to workers. Here is a typical claim scenario. Company A asserts that it has no plans to improve the benefits available under its current defined benefit pension plan. Then, the company provides an early retirement offer to its workers and some, but not all of these workers accept the offer. Shortly

thereafter, Company A is acquired by Company B, which provides enhanced retirement benefits compared to the workers of Company A. Those who accepted the early retirement offer sue Company A, alleging that Company A knew it would soon be acquired by Company B and therefore sought to reduce its pension liabilities by making early retirement offers to its workers.

Imprudent Investment of Assets

Claims alleging imprudent investment of assets frequently involve situations where a high percentage (e.g., 20 percent or more) of a defined benefit pension fund's assets are invested in a single company's common stock. For example, assume that the company in whose stock the pension plan is invested then begins to experience financial difficulties and eventually files for bankruptcy protection. The pension plan suffers a severe loss when the stock is rendered nearly worthless and a claim for imprudent investment of assets is made against the pension fiduciaries by its beneficiaries.

Failure To Pursue Delinquent Contributions

Such claims most often arise when a multi-employer pension fund (typically found in unionized, manufacturing industries) becomes insolvent because the pension trustee had been lax in obtaining periodic employer contributions from one of the major participants in the fund.

Negligence Not Involving Discretionary Activities

Claims within this category typically involve losses arising from administrative errors. For example, a company's employee benefits administrator inadvertently forgets to enroll a new employee in the company’s health insurance program. When the employee is admitted to the hospital following a severe auto accident, the employee learns that he has no health insurance.

Claims Associated with Securities Backed by Subprime Loans

Recently, a growing number of plaintiffs are asserting that pension plan fiduciaries were negligent in making investments in securities backed by subprime loans (i.e., mortgage-backed securities). Claims are being brought against: (1) fiduciaries of the plans, (2) outside investment managers, and (3) directors who have the power to appoint fiduciaries and monitor the plans.

When plans sustain losses because the values of these mortgage-backed securities fall, claimants allege that the defendants breached their fiduciary duties to invest prudently, diversify appropriately, and failed to provide investors with complete and accurate information about the nature of the plan’s investments.

Claims Associated with Pension Monies Invested in Fraudulent Schemes

In December of 2008, it was revealed that Bernard Madoff had been operating an investment company for more than a decade that, in reality, was nothing more than a massive Ponzi Scheme. Specifically, early investors in the company were “paid back” with monies provided by recent investors as a means of hiding the company’s losses. Officials have indicated that investors appear to have been severely defrauded by Madoff, perhaps to the extent of $50 billion. It has also been revealed that monies from a number of prominent, union-sponsored pension funds were “invested” in the scheme. Although no claims have yet been made, they are almost certain to follow in succeeding months. Most likely, the claims will allege that pension fund managers were negligent in failing to discern the fraudulent nature of the Madoff operation and that, had they done so, the managers would not have entrusted such monies to Madoff.

Exposures from Defined Contribution Plans

There are a number of liability exposures faced by fiduciaries from the administration of defined contribution plans. These exposures include: (1) concentration of assets in company stock (i.e., stock in the company sponsoring the plan), (2) blackout periods, (3) lack of guidance regarding investment strategies, (4) failure to follow the investment request of a plan participant, (5) allegations of excessive defined benefit plan fees and (6) losses sustained from the 2008 stock market crash. Each of these exposures will be discussed below. The losses sustained from such exposures are often collectively referred to as "ERISA stock drop" claims.

The Enron Corporation situation provides a case study of how each of these three exposures contributed to liability claims made against the fiduciaries responsible for administering Enron's 401(k) plan. In December 2001, when Enron filed for bankruptcy protection, its stock price plummeted to less than $1 per share. Since its employee 401(k) plan holders maintained approximately 60 percent of their total 401(k) funds in Enron Corporation stock, the employees suffered severe losses.

Clearly, fiduciaries at firms with high concentrations of 401(k) assets invested in their organization's common stock face a significant exposure to liability claims. When the value of stock experiences a precipitous decrease in value, fiduciaries are at risk. Under such circumstances, 401(k) plan participants are likely to allege that intentional, improper internal accounting practices artificially inflated the company's earnings, which in turn had the same effect on the stock price. Plaintiffs allege that plan fiduciaries were aware of such accounting practices, that they misrepresented to plan participants the value and safety of the company's stock, and that the fiduciaries encouraged investment in the stock to support an artificially high price for the stock. Ultimately, the fiduciaries of a defined contribution plan have a duty to tell the truth about the company's stock, encourage diversification of investments within the 401(k) plan, and make participants aware of the need to invest in other vehicles. In the absence of such actions, they face considerable liability. (Note: currently, there are no laws that restrict employees from investing more than a certain percentage of their 401(k) contributions in company stock.)

Concentration of Employer Stock in 401(k) Plans

Studies have indicated that, 6 years after the Enron collapse, company stock is still the largest employee holding in 401(k) plans. More specifically, a 2006 study by Hewitt Associates, a human resources consulting firm, found that over 20 percent of all 401(k) monies are invested in company stock. Moreover, one in five plan participants have at least half their retirement money invested in company shares, the study revealed.

The 10 Percent Rule

Financial advisers usually recommend that employees invest no more than 10 percent of their retirement money in their company's stock. Although investment in company stock remains high, the proportion of money in company stock within such plans has declined since the Enron bankruptcy. Specifically, in 2004, about one-fourth of total 401(k) money was invested in employer stock, but only about one-fifth in 2006. In addition, in 2006, only about 40 percent of employees in their 20s had any company stock in their 401(k) account, compared with around 60 percent in 1998, according to a report by the Employee Benefit Research Institute.

Why Concentration of Employer Stock in 401(k) Plans Remains High

Companies that promote the ownership of company stock in 401(k) plans believe that encouraging employees to own stock creates an "ownership culture" in which employees will be even more committed to the firm's success. Such companies often match employee contributions on a dollar-for-dollar basis when these monies are used to buy company stock. This compares to the typical 401(k) plan that matches only 50 percent of an employee's contributions and only up to 6 percent of the amount contributed.

For example, assume an employee's salary is $50,000, that she contributes 6 percent of her salary, and that the employer will match 50 percent of the employee's 6 percent contribution. In this instance, the employee contributes $3,000 (i.e., 6 percent of $50,000) and the employer adds $1,500 (i.e., 3 percent of $50,000) for a total of $4,500. If the employee were to contribute a higher percentage of her salary, say 10 percent, the employer would not make any additional contribution. So in this case, if the employee put in 10 percent, or $5,000, and the employer contributed $1,500, this would total $6,500.

In contrast, under some 401(k) programs in which employees use their contributions to buy company stock (and using the numbers in the previous paragraph), employers will match the employee's contribution on a dollar-for-dollar basis, up to as much as 10 percent. Thus, if the employee were to contribute 10 percent of her salary for company stock (i.e., $5,000), the employer would match this amount with an additional $5,000, for a total contribution of $10,000, compared to just $6,500 in the example above. Obviously, programs of this nature encourage heavy investment in company stock by 401(k) plan participants.

Vivien versus WorldCom

This case established a legal theory that permitted workers to recover losses in their 401(k) retirement plans that contain investments in their employers' stock.

The basis of the suit was that WorldCom Retirement Plan administrators were "company insiders." As such, they were well aware that the company's share price was highly inflated. This was because these insiders knew about the material misstatements contained within its periodic financial filings to the Securities and Exchange Commission (SEC). When the public eventually learned the true nature of the company's financial condition, WorldCom's stock price collapsed and 401(k) plan holders saw the value of their accounts plummet.

Plaintiff-employees alleged that under ERISA, WorldCom had a fiduciary duty to participants, and that this duty mandated the trustees of the 401(k) plan to invest plan assets in a prudent manner. The lawsuit stated that this duty was breached when the trustees, who, as noted above were "company insiders," continued to invest plan assets in WorldCom stock. They maintained such investments despite the fact that the trustees knew the company's share price in no way reflected WorldCom's actual value. As a result, the court ruled in favor of the plaintiffs, holding that the trustees had, in fact breached their fiduciary duty.

The *Vivien* decision provided the legal framework for many similar suits filed by employees of companies such as AOL Time Warner, Reliant Energy, Tyco International, and others. As a result of these claims, many major companies restructured their 401(k) plans, by eliminating previous requirements that plan participants own certain amounts of company stock.

The Blackout Exposure

Another exposure created by 401(k) plans is one that exists when plan participants are not permitted to change their investments during a specific period of time. This most often occurs when a 401(k) plan changes administrators, for a period of time typically lasting from 4 to 6 weeks.

In the Enron situation, a blackout exposure resulted when the company changed 401(k) plan administrators. Lawyers for Enron's employee-plaintiffs claimed that Enron breached its fiduciary duty to workers when it mandated a “freeze” or “blackout” that prevented employees from selling their shares of Enron stock during this period. Specifically, workers alleged that they were unable to access their accounts from October 21 to November 19, a period in which Enron’s stock price fell from $26.05 to $9.25.

Regardless of the length of the blackout period in the Enron situation, the fiduciaries of any firm sponsoring a 401(k) plan face an exposure to claims under these conditions. Not only does this situation create an exposure when the overall stock market is declining rapidly, but such an exposure is exacerbated when a high concentration of 401(k) plan assets are invested in a single stock—namely, the company's. This is because a single company’s stock is much more prone to drop significantly during the time in which there is a change on administrators, compared to the likely drop in the overall stock market (as represented by Standard & Poor’s index of 500 stocks), during a comparable period of time.

Restrictions on Selling Matching Company Stock Contributions

As already noted, depending on the individual plan, an employee's contributions are typically matched to some extent by the employer. Most often, a company will match 50 percent of each dollar contributed by the employee, up to 6 percent of the employee's salary. However, under some 401(k) plans, the company will match the employee's contribution on a dollar-for-dollar basis, and up to 10 percent of the employee's salary.

Dollar-for-Dollar Matches Only Available on Company Stock

Usually, 10 percent matches are only available in the form of company stock. Moreover, in most such companies, and as was the case with Enron, matching company stock cannot be sold by a worker until a certain age, typically 50 (in Enron's case), or even 55. This contrasts with a mere 4 percent of employers, according to Fidelity Investments, that allow a participant to immediately sell matching contributions of company stock.

Again, when employees are locked into the matching contributions of company stock until age 50 or 55, the fiduciaries of such companies are exposed to additional liability. This is because the company’s employees may be unable to sell their company stock in a weak, overall stock market or when financial reversals within the organization itself contribute to a declining price for the company’s stock.

Lack of Guidance Regarding Investment Strategies

Under ERISA, fiduciaries can face liability for an employee participant's losses within a 401(k) plan when fiduciaries provide advice regarding investment strategies and personal financial planning.

Hiring Outside Advisors

A number of organizations attempt to mitigate this exposure by hiring outside financial experts and counselors to personally assist employees with their investment choices. However, even this approach does not completely absolve employer-fiduciaries from liability, because fiduciaries can still be held responsible if they negligently selected such advisers. Given this situation, a number of firms simply do not provide employees with any investment assistance, which often leads to allegations that they failed to exercise their fiduciary duties.

Failure to Follow the Request of a Plan Participant (*LaRue v. DeWolff, Boberg & Assocs., Inc*)

In *LaRue v. DeWolff, Boberg & Assocs., Inc.,* (2008), the U.S. Supreme Court issued its most important ruling in a fiduciary liability case in more than 20 years. The Court's finding is significant because it is likely to result in an increase in the number of claims alleging that corporate fiduciaries committed errors in managing individual 401(k) accounts.

The general rule that emerged from this case is that employees can now sue fiduciaries not only for acts that cause harm to an overall 401(k) plan, but also for damage to individual 401(k) accounts.

James LaRue sued his former employer for failure to transfer assets in his 401(k) account to less risky investments, as Mr. LaRue had instructed. He asserted that such failure caused him to lose $150,000. The key point of contention in this case was the question of whether Section 502(a)(2) of the ERISA law permitted claims to be brought for losses incurred by individual benefit plan participants like Mr. LaRue, or whether such claims were limited only to losses sustained by the entire plan.

In a unanimous 9–0 ruling, the Court reversed its earlier holding in the 1985 case of *Massachusetts Life Ins. Co. v. Russell*. In that case, the Court barred suits by individuals, instead only allowing claims when a fiduciary's error caused an entire plan to sustain losses. But in LaRue, the Court overturned its earlier finding, this time concluding that Mr. LaRue could sue for damages suffered to his individual account.

It is important to recognize, however, that with its decision, the U.S. Supreme Court did not find the fiduciary liable to the plaintiff, LaRue. Rather, the Court's ruling only means that the plaintiff has the right to prove that the fiduciary's negligence caused his loss, an issue that must be relitigated in a trial court. Prior to the U.S. Supreme Court's ruling, the plaintiff would have been barred from even attempting to prove the fiduciary's negligence, since fiduciaries could only have been held liable for losses incurred by an entire plan, rather than those incurred by an individual (which was what happened here).

The Court's conclusion reflects the changing reality of pension plans since the days of the *Massachusetts Life* decision. At that time, defined benefit pension plans were still the norm, whereas today, defined contribution pension plans (i.e., 401(k)s) are by far the predominant retirement vehicle offered to employees. Since defined benefit pension plans are quickly disappearing, while defined contribution/401(k) plans are now the norm, the Court's ruling recognizes the reality that a fiduciary's error can indeed cause damage to an individual's 401(k) account, without doing likewise to the assets of an entire 401(k) plan. In other words, what was a significant loss for LaRue, may have only represented a relatively small percentage of the entire plan's assets. Regardless of what one thinks of the Court's conclusion in *LaRue*, it does seem to open the door to an increase in claims against fiduciaries because now, individual 401(k) plan holders will have the right to sue fiduciaries for errors and omissions that affect their individual accounts.

Following the U.S. Supreme Court's February 2008 decision in the *LaRue* case, a number of commentators expected there would be a flood of litigation. While it is still too early to tell if this will happen, in October 2008, Mr. LaRue voluntarily dismissed his case in the district court, where it was sent back after the U.S. Supreme Court's decision. Essentially, he concluded that it was not financially feasible to continue his claim, given the magnitude of legal costs, relative to what he would probably be able to recover in actual damages. Accordingly, the true extent of the exposure, created by the holding of this case, remains to be seen.

Claims Alleging Excessive Fees

A number of lawsuits have charged that the sponsors of defined contribution plans have allowed plan administrators and other plan service providers to charge excessive fees, which constitutes a breach of duty under ERISA.

In addition to these allegations, lawsuits have also charged that service providers levy excessive fees on defined contribution plans so that the sponsoring corporation can obtain other services more cheaply. For example, an investment management firm may charge an unusually high fee to manage 401(k) plan assets in return for charging a lower-than-average fee for a line of credit to the sponsoring company. This too constitutes a breach of fiduciary duty under ERISA, because the sponsor is profiting at the expense of the beneficiaries of its defined contribution plan.

Over a long period of time, a difference of 1 to 2 percent in fees can make a substantial difference in a plan holder's balance. For instance, assume a person contributes $2,500 to a 401(k) plan for 40 years, receives a $1,000 annual company match, and the portfolio grows at a rate of 7.5 percent, the person would have approximately $1.2 million at the end of that time. However, if the person was charged an extra 1.5 percent in fees, they will have paid out an additional $500,000 in fees!

The Stock Market "Crash" of 2008

During the Summer and Fall of 2008, the United States and world stock markets dropped substantially, due in part to the sub-prime mortgage crisis in the United States. In the U.S. market, the S&P 500, at one point, dropped by approximately 40 percent from its previous high reached during the Fall of 2007. It is estimated that approximately $2 trillion in 401(k) plan assets were lost during this period, as a result. Given the coming wave of Baby Boomer generation retirements, this is also expected to produce considerable ERISA-related litigation. Again, such exposure will be exacerbated by 401(k) plans holding substantial amounts of company stock.

Chapter 4 Review Questions

1. Delta Pie Company promises to pay retired employees a monthly retirement benefit in an amount based on a predetermined formula. Delta Pie's retirement plan is a:
   a. Cash-balance pension plan.
   b. Defined benefit pension plan.
   c. Defined contribution pension plan.
   d. Retirement annuity pension plan.

2. Among the provisions included within the Pension Protection Act of 2006 was one allowing employers to provide unbiased investment advice based on a computer model. This is advantageous for all of the following reasons, *except*:
   a. It decreases an employer's fiduciary liability exposure.
   b. It will likely improve employees' rate of returns under covered plans.
   c. It will make it easier for employees to arrive at allocation decisions for their savings.
   d. Employers will be able to charge employees for this service and generate revenue as a result.
3. Questions have been raised concerning the actuarial solvency of Green Hornet Company's defined benefit pension plan. Assessing the plan's ability to pay benefits is based on actuarial assumptions that include:
   a. Employee morbidity.
   b. Employee mortality.
   c. Exchange rates.
   d. Rate at which former employees return.
4. As a participant in his employer's defined benefit pension plan, Denny Fu has a right to expect the employer will:
   a. Contribute a specified percentage of Denny's earnings every year.
   b. Express Denny's benefit as a total account balance held by him.
   c. Guarantee a specific rate of return on the employer's contribution.
   d. Promise a flat dollar payout upon his retirement.
5. After Grapefruit Company acquired Lemon Company, pension benefits were reduced for the employees who formerly worked for Lemon. When these employees retire, they will receive lower benefits than they might have expected. To prevent suits from these affected employees, Grapefruit should:
   a. Communicate the benefit reduction to all affected workers.
   b. Avoid disclosing this change.
   c. Level the playing field by decreasing benefits for all employees.
   d. Make a lump sum distribution of plan assets and start fresh with a new plan.
6. The liability exposures faced by a defined contribution plan's fiduciaries include all the following, *except*:
   a. Concentration of assets in company stock.
   b. ERISA stock drop claims.
   c. The sponsoring company decides to increase the percentage of the employer match to its 401(k) plan from 3 percent to 5 percent.
   d. Excessive fees.

7. To broaden the market for Dotcom Company stock and serve other corporate goals, Dotcom management might consider all of the following aspects of its 401(k) plan, *except:*
   a. Dotcom's matching contributions, currently $0.50 per dollar, might be increased when used to buy company stock.
   b. Dotcom might match a higher percentage of employee contributions when company stock is purchased.
   c. Employees whose retirement portfolio includes Dotcom stock are probably more committed to the firm's success.
   d. Employees whose retirement portfolio is heavily weighted with Dotcom stock receive the benefits of diversification.
8. The fiduciaries of Cow Bell Company's 401(k) plan are concerned about the decisions many Cow Bell employees have made in deciding whether to participate or how to allocate their contributions. Which of the following possible responses is *least* likely to lead to liability claims against the fiduciaries?
   a. All employees are given a subscription to Money Magazine.
   b. Benefits administrators and fiduciaries may not give employees investment advice in any form.
   c. Employee meetings are held at which the fiduciaries describe investment strategies.
   d. Fiduciaries select and pay financial consultants to give personal advice to employees.

Answers to Chapter 4 Review Questions

1. b. Defined benefit pension plans are retirement plans in which an employer promises to pay a specific monthly benefit amount (or a lump sum) at retirement, based on a predetermined formula.
2. d. The law does not permit employers to charge for this service. Employers will therefore not be able to generate revenue by offering such a model.
3. b. The ability to pay such benefits is based on a number of actuarial assumptions, the most important of which are employee mortality and expected rate of return on employer contributions to the pension fund.
4. d. A defined benefit pension plan promises a flat dollar pay-out either on a periodic (usually monthly) or lump-sum basis based on years of service, age at retirement, and employee earnings in the years immediately preceding retirement.
5. a. The best way to prevent such suits is to communicate the benefit reductions.
6. c. Increasing the amount of the employer's contribution is an added benefit to employees and would therefore decrease the extent of fiduciary liability exposure.
7. d. Concentration in one stock represents a lack of diversification and violates fiduciaries' duty to encourage diversification and make participants aware of the need to invest in other vehicles.
8. a. The magazine provides a neutral source of general advice, addressed to a broad audience, that probably cannot be construed as improper guidance by the plan's fiduciaries.

Chapter 5
Underwriting Fiduciary Liability Insurance

Chapter 5 describes the major factors that are involved in the process of underwriting fiduciary liability insurance policies.

Factors in Pricing

As is characteristic of most types of professional liability insurance, there is no rating bureau or pooling of loss experience among insurers writing fiduciary liability coverage. Thus, each company must develop its own rating approach based on actuarial analysis of its individual loss experience. Pricing is therefore subjective and depends on an underwriter's individual judgment concerning any particular fiduciary liability risk.

Premiums for fiduciary liability insurance are most heavily influenced by (1) the total assets of the insured plans and (2) the number of participants in the plan. In addition, the nature of such plans (e.g., a 401(k) program with a heavy concentration of employer stock) plays a role in determining premium. Accordingly, premiums are also affected by the underwriter's subjective assessment of a given risk, rather than by applying a strict rating formula.

Underwriting Factors

In deciding whether to insure a given organization, underwriters consider a number of key factors in underwriting fiduciary liability coverage. Such factors are listed in Exhibit 5.1 and discussed in the pages that follow.

EXHIBIT 5.1
FIDUCIARY LIABILITY UNDERWRITING FACTORS

- Funding adequacy
- Nature of plan investments
- Single-employer versus multi-employer plans
- Types of covered plans
- Legal counsel's opinion
- Profile of covered fiduciaries and directors and officers of the organization
- Formal loss control program

Funding Adequacy

A paramount consideration in assessing the insurability of a fiduciary liability risk is the adequacy with which defined benefit plans are funded. To make the assessment as to whether contributions to the plan will be large enough to pay promised future benefits, underwriters must rely on the opinions of an actuary. Therefore, any qualifications or caveats that appear in their actuarial reports should be carefully scrutinized and immediate changes made where shortfalls appear likely.

Nature of Plan Investments

The nature of the investments for both a defined benefit pension plan and a defined contribution plan is another important factor that underwriters assess.

Regarding a defined benefit pension plan, underwriters evaluate the investments: diversification, assumed rate of return, overall level of risk, and maturity structure. Since the duty to diversify assets is continually stressed throughout ERISA, underwriters carefully review situations where a large percentage of a plan's funds are invested in a single investment vehicle. The extent to which a plan's portfolio is invested in "speculative" investments is also critical. Finally, the maturity structure of the assets should mesh properly with payout patterns anticipated under the covered plans.

As respects defined contribution plans, underwriters are most concerned about a heavy concentration of assets invested in company stock, discussed earlier in this course.

Single-Employer versus Multi-Employer Plans

Additional risks are posed by multi-employer benefit plans compared with those generated by single-employer programs. (Multi-employer plans are most often set up by manufacturing firms or governmental employers that employ unionized workers within the same industry.) Since multi-employer plans are usually larger and more complex than single-employer plans, claim frequency and claim severity tend to be higher than for single-employer plans. Of course, this is reflected in higher premium rates for multi-employer plans.

Types of Covered Plans

The kinds of covered benefit plans have a significant impact on the insurability of a given fiduciary liability risk. More specifically, the size of the benefits promised and the duration over which such benefits must be paid, heavily influence the risk of loss under a fiduciary policy. For instance, there is a risk of insolvency associated with a defined benefit pension plan compared to one that is constituted on a defined contribution basis. This is because the sponsoring company assumes the financial risk under a defined benefit pension plan, while in contrast, this risk is shifted entirely to the plan's participants under a defined contribution program. However, as already discussed, defined contribution plans are not also without significant risks.

Legal Counsel's Opinion

Underwriters must also rely on the opinions of a plan's attorney to evaluate the extent of its compliance with ERISA law. It is not uncommon for a given plan to fail one or more compliance tests, given the number and complexity of ERISA rules and regulations. Thus, a "clean" opinion from the plan's law firm is critical.

CPA Firm's Opinion

Periodic, comprehensive ERISA audits, normally conducted by CPA firms with particular expertise in such matters, can also substantially reduce an insure's exposure to claims. Accordingly, some underwriters will grant premium credits to insureds that will submit to audits.

Profile of Covered Fiduciaries

As is the case with directors and officers liability insurance, underwriters seek to insure only reputable fiduciaries. Accordingly, underwriters evaluate the integrity, experience, and knowledge of both the insured fiduciaries as well as the outside services providers they have hired to administer the applicable benefit programs.

Loss Control Program

The extent to which an organization adopts the kinds of measures described above, will reduce its likely exposure to claims, and is yet another important underwriting factor. Companies that implement such approaches will generally receive favorable underwriter consideration, from both a premium, as well as a coverage standpoint.

Chapter 5 Review Questions

1. Pricing fiduciary liability insurance is*:*
   a. Based on many insurers' pooled loss experience.
   b. Done by a rating bureau.
   c. Entirely objective, based on statistical data.
   d. Inconsistent among insurers, each of whom might use a different approach.
2. It seems to be hard to find an insurer willing to underwrite fiduciary liability insurance that will cover Pyar Square Company's "Circle-of-Life" defined benefit retirement plan, which has built a strong asset base thanks to its investment portfolio that consists primarily of two very different asset types: (1) Pyar Square's own stock, and (2) high-interest ("junk") bonds. Underwriters' reluctance is probably based on all of the following factors, *except:*
   a. Extensive use of "speculative" investments.
   b. Lack of diversification.
   c. Level of risk.
   d. Misleading plan name.

3. The exposures of defined benefit plans and defined contribution plans depend, in part, on the entity that assumes the plan's financial risk, which is the:
   a. Investment management company charged with the duty with investing plan assets.
   b. Participants with a defined benefit pension plan and the sponsor with a defined contribution program.
   c. Sponsor with a defined benefit pension plan and the participants with a defined contribution program.
   d. Sponsor with both defined benefit and defined contribution programs.

Answers to Chapter 5 Review Questions

1. d. Each company must develop its own rating approach.
2. d. The plan's name is normally not an important underwriting criterion. Even though retirement plans essentially apply only to the end of an employee's life cycle, "Circle of Life" does not seem to create unrealistic expectations of a type that would lead to a lawsuit. Other characteristics of this plan are much more problematic.
3. c. The sponsoring company assumes the financial risk under a defined benefit pension plan, while in contrast, this risk is shifted entirely to the plan's participants under a defined contribution program.

Chapter 6
Fiduciary Liability Loss Control

Chapter 6 provides methods of reducing exposures to liability claims against fiduciaries.

Controlling Fiduciary Liability Losses

The following techniques can assist persons who have fiduciary responsibilities in reducing the exposure to claims against them. These techniques are summarized in Exhibit 6.1 and discussed in the pages that follow.

EXHIBIT 6.1
FIDUCIARY LIABILITY LOSS CONTROL MEASURES

- Conduct periodic, independent ERISA compliance audits
- Use "experts" to design benefit plans
- Fund plans adequately
- Invest plan assets prudently
- Avoid conflicts of interest
- Avoid prohibited transactions
- Report and disclose plan information as required
- Select and evaluate fiduciaries carefully

Conduct Periodic Audits

Insureds should have periodic audits conducted by independent organizations, in an effort to assure compliance with ERISA regulations. (These should be in addition to regular audits by certified public accounting (CPA) firms.) Although significant costs are associated with such procedures (e.g., fees and management time to assist auditors), consultation with persons conversant in the complexities of ERISA can lower the incidence of claims against fiduciaries. A routine audit should be done each year and a comprehensive audit performed every 5 years. (Routine audits concentrate on a plan's compliance with ERISA procedures, whereas comprehensive ones do likewise, and, in the case of defined benefit plans, perform a detailed analysis of the plan's assets. For instance, such an audit would do an assessment of the specific investments held by a defined benefit pension plan, such as its individual bonds.)

Use Experts To Design Plans

Designing pension and benefit plans requires considerable, specialized expertise. Fiduciaries should enlist the assistance of CPAs and actuaries who specialize in creating such plans, rather than rely on in-house personnel whose background in this area may be limited. Many of the problems plaguing pension and welfare programs stem from errors or inadequacies in the basic design of the plan.

Fund Plans Adequately

Inadequate funding of defined benefit pension plans—and their subsequent inability to pay promised benefits—are frequent sources of claims against fiduciaries. Having an independent CPA firm audit an insured's plan (which is required by most plans with 100 or more participants) and employing an actuary to certify that the plans are adequately funded will usually prevent the problems associated with underfunded plans. This is especially true if such work is performed in the early stages of a potential funding inadequacy.

Invest Prudently

Many of the difficulties experienced by pension plans are the result of imprudent investments. Often, pension monies are invested in too high a proportion of risky alternatives. In other cases, fiduciaries fail to diversify adequately. Because fiduciaries can be held liable for negligence in selecting and supervising outside service providers, use of an experienced, independent investment adviser with a strong track record is desirable. Additionally, fiduciaries should conduct periodic reviews of a plan's investment objectives, as well as assess the extent to which these objectives are being met by the outside advisory organization.

As already noted, one means of providing a layer of insulation from liability for imprudent investment decisions is for an insured to retain an adviser who is registered under the Investment Company Act of 1940. This will afford an insured organization's fiduciaries a valid defense should allegations be made that fiduciaries were negligent in selecting an investment adviser. This protection arises from the fact that corporate fiduciaries cannot be held liable for an investment manager's imprudent decisions. They can only be found liable for negligently selecting the investment manager.

Avoid Conflicts of Interest

Just as corporate directors and officers must avoid conflicts of interest in managing the affairs of the organization, so too should individuals charged with the responsibility of overseeing pension and benefit programs. A high percentage of claims against fiduciaries allege some form of self-dealing, and affected individuals should take particular care when potential conflicts of interest could be alleged. (This is particularly true as respects party-in-interest transactions, which were discussed earlier in this course.) More specifically, the following practices should be avoided.

- Selecting investments in which a fiduciary has a personal stake
- Use of an outside service provider (e.g., actuary, CPA, legal counsel) who is an associate or a relative of the fiduciary
- Changes in plans that would accrue substantial benefit to, or enrich, an individual fiduciary

The First Union Lawsuits: A Case Study in Conflicts of Interest

One high-profile example of conflicts of interest were the class action lawsuits brought against First Union Corporation in 1997. The lawsuits made two key allegations.

The first allegation was that present and former 401(k) plan participants were given no option but to invest their contributions exclusively in mutual funds managed by First Union. The basis of the plan participants' claims is that the performance of these mutual funds lagged those of comparable mutual funds. The claimants alleged that by increasing the size of these mutual funds, First Union made its mutual funds more attractive to investors, to the detriment of its employees. And even if the funds had performed well, the question arises as to whether First Union's intent was to benefit itself or its employees.

Second, the lawsuits alleged that First Union charged higher investment management fees to manage its own defined contribution plan than it charged to outside clients. Moreover, the First Union defined contribution fund was also First Union's investment management group's largest client. Again, even if the First Union employees' pension fund performed well, there was an apparent conflict of interest inherent in such practices.

Ultimately, First Union agreed to settle the lawsuits for $25 million.

Avoid Prohibited Transactions

Given the intricacy of ERISA, avoiding prohibited transactions is not always a clear-cut process. Although some transactions constitute obvious violations, others do not and could be easily overlooked. Consequently, independent outside legal counsel should be sought when gray area situations arise. (An example of a prohibited transaction would be one where a fiduciary of a pension plan invests plan monies in a company where he holds a majority interest.)

Report and Disclose Plan Information as Required

Passage of ERISA created the need to file myriad reports to federal agencies; in particular, annual reports must be provided to the following.

- The Department of Labor
- The Internal Revenue Service
- The Pension Benefit Guaranty Corporation (for pension plans)

Also, reports may need to be filed with the Social Security Administration and made available for inspection by plan participants. Finally, special procedures may be needed to complete reports when the following happen.

- Plan provisions are materially changed
- A plan is terminated or partially terminated
- A plan is merged with another or its assets are spun off

Severe penalties for noncompliance and failure to file can result in fines of up to $1,000 per day. Consequently, every effort must be made not to run afoul of these regulations, which could increase a fiduciary's exposure to liability.

It should also be mentioned that compliance with the ERISA report filing requirements is not, by itself, a complete defense to a fiduciary liability claim. However, failure to comply with such regulations heavily increases the possibility that liability will ultimately attach.

Select and Evaluate Fiduciaries Carefully

Regardless of any specific loss control actions they may take, the ultimate responsibility for controlling the risks associated with pension and benefit plans rests with the individuals who provide services to the insured organization's covered plans. Thus, such persons and firms must be selected on the basis of their experience, expertise, and integrity, rather than for personal or political reasons.

Chapter 6 Review Questions

1. One good loss control method Will Tell Corporation can use with respect to its defined benefit pension plan is to:
   a. avoid using any investment adviser registered under the Investment Company Act of 1940.
   b. design the plan with assistance from specialized CPAs and actuaries.
   c. have Will Tell's own personnel design the plan, because they are more familiar with the firm than any outsider.
   d. include a high proportion of high-risk investment alternatives, in order to produce the highest potential return.
2. As the head trustee of his organization's pension plan, Hobson must choose the individuals and organizations that will provide services to the plan. Which of the following characteristics should *not* be among the primary criteria Hobson uses to make the choice?
   a. Experience.
   b. Expertise.
   c. Integrity.
   d. Politics.

Answers to Chapter 6 Review Questions

1. b. Pension plan design requires considerable specialized expertise.
2. d. The individuals who provide services to the insured organization's covered plans must be selected on the basis of their experience, expertise, and integrity, rather than for personal or political reasons.

Chapter 7
Coordinating Fiduciary Liability Insurance with Other Coverages

Chapter 7 explains how to coordinate fiduciary liability policies with other, related types of coverage.

The manner in which fiduciary liability coverage must be coordinated with other types of insurance has long been a source of confusion. This discussion examines the potential gaps and overlaps that can occur between fiduciary liability and these related coverages and proposes ways to address these coordination issues.

Fiduciary Liability versus Employee Benefits Liability

Fiduciary liability insurance covers claims alleging breach of the duties enumerated by ERISA and by common or statutory law (i.e., discretionary duties). In contrast, employee benefits liability coverage applies to claims involving administrative errors associated with employee pension and welfare plans. Exhibit 7.1 illustrates several claim scenarios that correspond to the types of claims addressed by a policy covering the employee benefits liability exposure.

EXHIBIT 7.1
EMPLOYEE BENEFIT LIABILITY EXPOSURES AND CLAIM TYPES

Activity	Claim Scenario
Counseling employees regarding employee savings plan	An employer offers a 401(k) savings plan. The company's employee benefits administrator suggests that an employee, who seeks capital preservation, put his contributions into an aggressive growth stock fund. The employer is sued when the fund loses 30 percent of its value after a stock market crash.
Interpreting employee benefit programs	Based on an employee benefit administrator's erroneous calculation of an expected monthly pension benefit, an employee elects early retirement. The employee sues when his initial monthly check is significantly less than the administrator calculated.
Handling employee benefit program records	Following his divorce, an employee elects to change the beneficiary on his life insurance policy from his ex-wife to his son. He advises the company's benefits administrator accordingly, but the change is never made. Six months later the employee dies, at which time, his son sues because he cannot collect under the policy.
Enrolling or canceling enrollment in employee benefit plans	A company's benefits administrator forgets to enroll a new employee in the firm's major medical plan. The employee sues after the plan denies medical benefits after being diagnosed with cancer.

The ISO Employee Benefits Liability Coverage Endorsement

In response to the employee benefits exposure, The Insurance Services Office, Inc. (ISO), has developed an endorsement designed for attachment to commercial general liability (CGL) policies, CG 04 35 (10/01), that covers this exposure, although not the exposure to fiduciary liability.

Employee benefits liability (EBL) coverage is rarely, if ever, written on a stand-alone basis. In addition to the ISO employee benefits liability coverage endorsement, individual insurers offer similar endorsements, also as an option available under CGL policies. However, unlike fiduciary liability policies, these endorsements are available only as an endorsement to a commercial general liability (CGL) policy but never as a separate policy.

Is an Employee Benefits Liability Endorsement Worthwhile?

Despite the coverage it provides, an employee benefits liability endorsement is of little value. There are several reasons for this.

First, any firm having an employee benefits liability exposure also has a fiduciary liability exposure. Therefore, buying only an EBL endorsement under a CGL policy and not purchasing a fiduciary liability policy form leaves the organization uncovered for fiduciary liability claims. This is because employee benefits liability policies do not cover fiduciary liability exposures. Moreover, there is little or no advantage to buying both an EBL endorsement and a fiduciary liability policy (since the latter almost always covers the EBL exposure). In fact, buying both a fiduciary liability policy and an EBL endorsement creates a situation where duplicate coverage exists.

Second, as already explained, virtually all fiduciary liability policies also cover the employee benefits liability exposure.

In reality, the only reason for a company to purchase an employee benefits endorsement to a CGL policy is if it is unable to obtain fiduciary liability coverage that also covers the firm's employee benefits liability exposure. However, given today's market conditions, it will almost always be possible to obtain both coverages under a fiduciary liability form.

Considering this situation, purchasing an EBL endorsement to a CGL policy is rarely necessary.

Stand-Alone versus Packaged Approaches to Fiduciary Liability Coverage

In recent years, a packaged approach to obtaining fiduciary liability insurance has become increasingly popular. Specifically, insurers have begun to offer fiduciary coverage along with directors and officers (D&O) and employment practices liability (EPL) policies. Such policies are known as management or executive liability package policies. (Occasionally, kidnap and ransom insurance, also known as "special risk" coverage, is also made available within a package, along with these other three policies.)

Advantages of the Packaged Approach

A packaged approach features separate insuring agreements and separate policy limits for each of the coverages provided (i.e., D&O, employment practices, fiduciary, kidnap/ransom). Accordingly, package policies provide essentially the same scope of coverage that is afforded by a stand-alone fiduciary liability policy. In addition, pricing is usually somewhat lower than that found in a stand-alone fiduciary liability policy. This is because there are underwriting economies of scale under these circumstances. Specifically, much of the same information used to underwrite D&O and EPL coverage is also required when underwriting a fiduciary liability policy.

Approach to Limits

Most often, but not always, executive/management liability package policies are written with separate limits for each of the individual coverages it provides. In a minority of cases, these policies contain a combined single limit. This can operate as either an advantage or a drawback, depending upon the individual claim situation. It can benefit an insured if, for example, there is an especially large fiduciary liability claim, which could exhaust the policy’s entire limit. On the other hand, if, for example, there were also another, smaller type of claim sustained under one of the policy’s other coverages, this would have the effect of depleting limits otherwise available for the larger fiduciary claim.

Limitations of the Packaged Approach

Despite these advantages, a package policy approach to obtaining fiduciary liability coverage may not always be available. In addition, even if a packaged policy can be purchased, a number of privately-held organizations sometimes elect not to purchase a D&O policy, given their relatively limited exposure to claims against their directors and officers. If this is the case, a packaged approach is not feasible, so that a stand-alone fiduciary liability policy becomes the only available option.

Chapter 7 Review Questions

1. Broad Street Company wishes to purchase an insurance policy that provides employee benefits liability coverage. Which method of providing this coverage is *least* likely to be available and appropriate?

   a. An endorsement to a CGL policy.

   b. A fiduciary liability policy that covers employee benefits liability exposures.

   c. A package policy that includes directors and officers liability coverage.

   d. A stand-alone employee benefits liability policy.

2. An insurance agent has recommended that Einstein Electric Light Company purchase a "management liability" package policy in place of the coverages now provided under separate policies. In comparing these two approaches, Einstein will probably find that:

   a. The package policy costs somewhat more than separate policies.

   b. The package policy provides broader fiduciary liability coverage than a stand-alone policy.

   c. The package policy underwriter will use much of the same information to underwrite all the policy's coverages.

   d. The package policy's limit applicable to D&O claims can be eroded by the payment of employment practices claims.

Answers to Chapter 7 Review Questions

1. c. Employee benefits liability coverage is rarely, if ever, written on a stand-alone basis.
2. c. Much of the information used to underwrite D&O and EPL coverage is also required when underwriting fiduciary liability coverage.

Chapter 8
Fiduciary Liability Insurance Coverage: Insuring Agreements

This chapter describes the major insuring agreements found within fiduciary liability insurance policy forms.

As was pointed out in Chapter 2, the fiduciary liability exposure actually existed prior to the passage of ERISA. ERISA merely formalized the law associated with the administration of employee pension and welfare plans. It also broadened the scope of such liability so that it became a "personal" rather than simply a "corporate" liability. This means that under ERISA, the personal assets of a fiduciary can be confiscated to restore any losses suffered by a covered plan if the losses were caused by the fiduciary's negligence. (In that sense, fiduciary liability coverage functions in a manner similar to that of D&O liability insurance, because fiduciary liability coverage also protects the personal assets of those persons who serve as fiduciaries, just as D&O liability coverage protects the personal assets of those who serve on boards of directors.) Soon after the passage of ERISA, along with the substantial increase in exposure that it fueled, fiduciary liability insurance first appeared and immediately became an essential part of all corporate insurance portfolios.

Insuring Agreements

There are two insuring agreements found within fiduciary liability policy forms. The first covers "fiduciary liability," and the second covers "settlement programs," also sometimes referred to as voluntary compliance programs. In addition, the policies provide vicarious liability coverage for the acts of third-parties for which the covered fiduciaries are legally responsible.

Fiduciary Liability Coverage

The coverage provided under the policies' fiduciary liability insuring agreement applies to liability in conjunction with:

a. fiduciary (i.e., discretionary) duties,

b. administrative (i.e., nondiscretionary) duties, and

c. claims made against the fiduciaries simply as a matter of their legal status as fiduciaries (regardless of whether such liability is the result of their specific acts).

Coverage for Fiduciary Duties

The covered acts/covered services provisions under the policies state that coverage applies to breaches of duties by the insureds with respect to plans that are: (1) subject to ERISA and (2) not

subject to ERISA. Liability under both types of plans results from errors in discretionary functions (e.g., failure to select a competent pension fund manager), as opposed to errors that are considered to be ministerial or administrative duties (e.g., inadvertent failure to enroll a new employee in the company's 401(k) savings program). In effect, not all of the duties performed by fiduciaries fall within the scope of the ERISA law.

Coverage for Administration (Employee Benefits Liability Coverage)

In addition to covering fiduciary liability exposures (above), the policies also apply to liability for acts that involve purely administrative errors and omissions associated with managing pension and benefit plans. Examples of administrative errors were noted in Chapter 2 and include such acts as failure to enroll an employee in a company health plan or stating an incorrect pension amount when questioned by an employee as to what she can expect to receive as a monthly benefit upon retirement.

Coverage for Liability Based on Status as a Fiduciary

The policies also cover fiduciaries based solely on their status as covered fiduciaries under the policy. Such a provision is important because in some claim situations, all "fiduciaries" (including persons who did not actively participate in causing a claim) are named in a lawsuit, despite the fact that the lawsuit does not allege specific acts of negligence or breaches of fiduciary duties by one or more of these fiduciaries.

Consider the following example. In a lawsuit, Fiduciary "A" is alleged to have committed a wrongful act in conjunction with an employee benefit plan. In addition, Fiduciaries "B," "C," and "D" are named in the lawsuit, even though there is no specific wrongful act alleged against "B," "C," or "D." Rather, they are named in the suit simply because they are also fiduciaries under the same benefit plans as Fiduciary "A."

Again, this approach to coverage is similar to what is found within D&O liability insurance policies. That is, in addition to covering specifically alleged wrongful acts, coverage under D&O forms also applies to directors and officers based solely on their status as directors and officers of the corporate organization—even if a lawsuit does not indicate that one or more such individuals committed any wrongful acts or were negligent in performing their required duties.

Settlement Programs

"Settlement Programs" are programs operated by various government organizations for the purpose of resolving disputes regarding pension and benefit plans. For example, rather than litigate a claim against one or more fiduciaries, an employee who brings a claim involving a benefit plan and a defendant corporate organization that offers the benefit plan, can voluntarily agree to a settle the claim alleging a wrongful act by the defendant. (This approach is similar to arbitration or mediation, as set forth in commercial general liability and property insurance policies.)

Settlement programs avoid the time and expense of formal litigation and are administered by federal agencies such as the IRS and the United States Department of Labor. Most often, the policies are written with either (1) a sublimit that applies only to claims involving settlement programs (and actually creates an additional amount of coverage) or (2) a provision stating that a specific amount (generally $100,000) applies to claims concluded under settlement programs and any payments made under this coverage reduce the policy's aggregate limit.

To be eligible to receive coverage under this insuring agreement, the insured must first notify the insurer of the fact that a dispute is being submitted to a voluntary settlement. In other words, the insurer must have prior notice of the settlement.

Liability for Acts of Third Parties

Fiduciary liability policies also typically cover "any person for whose Wrongful Acts the Insureds are legally responsible." Such coverage is critical because under ERISA, a fiduciary can be held liable for the acts, errors, or omissions of those persons or entities that provide services to employee benefit plans, as was discussed in Chapter 2.

As a matter of common practice, fiduciaries frequently delegate a number of duties to organizations and individuals who are outside of their own company. For example, the design and management of a firm's pension and welfare plans often require a corporation to hire a number of outside entities such as actuaries, consultants, and investment managers. Should any of these entities commit errors or omissions that cause a loss to the beneficiaries of the covered plans, or act in contravention of ERISA, the fiduciary sponsoring the plan can be held liable for the acts of such parties. Consequently, fiduciary liability policies also cover the corporation sponsoring the benefit programs and the individual fiduciaries' liability for the acts, errors, and omissions of such third-party/outside service providers.

Coverage Applies for Vicarious Liability Only

It should be emphasized, however, that coverage for such liability is vicarious, not direct. Thus, outside organizations working with the insured organizations are not insureds under the policy. Rather, the policies cover only the sponsor organization's vicarious liability for the acts of these outside entities.

For example, if both the insured organization and an outside organization are sued in conjunction with an alleged wrongful act, coverage under the insured organization's fiduciary liability policy does not apply to the outside organization directly. Rather, the insured organization's fiduciary liability coverage will only respond if the outside organization is unable to assume financial responsibility for its own acts or omissions.

Given this situation, organizations that hire third-party service providers to assist in administering their employee benefit plans should carefully check such entities' professional liability insurance coverage before commencing a business relationship with them.

Coverage for Multi-Employer/Employee Stock Ownership Plans

Most fiduciary liability insurance policies are designed to cover the legal liability exposures generated by so-called "single-employer" employee benefit programs. Accordingly, the wording in such policies indicates that the definition of a "sponsored plan" (automatically covered by the policy) does not include either a multi-employer plan or an employee stock ownership plan, except by endorsement. When coverage for these types of plans is required, additional premium is almost always required. The rationale for such an approach is that both types of plans are more prone to claims, compared to other kinds of employee benefit programs.

Multi-employer plans (typically found within unionized industries) tend to be larger, more complex and, because they involve other corporations, are more difficult for any single-employer corporation to control and manage.

Employee stock ownership plans (ESOPs) are also more loss-susceptible. These plans grant significant amounts of shares of stock in the corporation to its employees. However, since these investments are concentrated within a single company, they tend to be more volatile than equity investments in, for example, a broad range of corporations. Consequently, ESOPs are more subject to claims, compared to employee savings programs (such as 401(k) plans) that invest in the shares of a number of companies (an approach that adds diversification and thus lowers risk).

Chapter 8 Review Questions

1. A fiduciary liability policy provides coverage for liability arising out of:
   a. Administrative duties only.
   b. Administrative duties and discretionary functions.
   c. Discretionary functions only.
   d. Plans subject to ERISA only.
2. Jennifer has a minor dispute with Sheridan Company's pension plan that both parties agree can be settled out of court under a government-operated settlement program. Sheridan's fiduciary liability policy provides coverage for such a settlement, provided that:
   a. The dispute is settled within 30 days.
   b. The insurer has prior notice of the settlement amount.
   c. The insurer has prior notice that the dispute is being submitted to voluntary settlement.
   d. The settlement amount does not exceed $10,000.
3. Geek Insurance Company teaches junior underwriters that an employer benefit program with an ESOP is more susceptible to loss than an otherwise-comparable plan with no ESOP. Geek's premise concerning ESOPs is:
   a. A fable.
   b. Not accurate for multiemployer plans.
   c. Accurate, because it involves a concentration of investments.
   d. Applies only to multiemployer plans.

Answers to Chapter 8 Review Questions

1. d. The coverage provided under the policies' fiduciary liability insuring agreement applies to liability in conjunction with (1) fiduciary (i.e., discretionary) duties and (2) administrative (i.e., nondiscretionary) duties.
2. c. To be eligible to receive coverage under this insuring agreement, the insured must first notify the insurer of the fact that a dispute is being submitted to a voluntary settlement.
3. c. A concentrate of stock within any single company tends to be more volatile than equity investments in a broad range of corporations. Also, if the employer gets into financial difficulty, a plan participant might lose his job and his retirement savings all at the same time.

Chapter 9
Fiduciary Liability Insurance Coverage: Covered Persons/Covered Organizations

This chapter discusses the persons and organizations covered by fiduciary liability insurance policy forms.

The persons and organizations covered by fiduciary liability policies normally fall into four distinct categories. Specifically, the policies cover:

1. The assets of the named insured organization
2. The assets of the benefit plans scheduled in the policy
3. The personal assets of the individuals serving as fiduciaries of the insured's firm
4. The personal assets of any additional persons named on the policy

Again, as noted earlier in this discussion, and for the reasons noted, coverage for multi-employer plans applies only by endorsement.

Omnibus "Insured" Wording

To assure that no plans, persons, or organizations are omitted from coverage, the following broadening endorsement should be added to the "insured" definition in an insured's fiduciary liability policy.

> ... and any employee welfare or pension benefit plans maintained or administered by any insured or sponsor organization and its subsidiaries as now exist or may hereafter be constituted, acquired or formed.

Wording of this type will reduce the potential for overlooking any individuals, plans, or organizations that are intended to be covered under a fiduciary liability policy.

Such wording is rarely found within the language of standard fiduciary liability policy forms. However, insurers will sometimes be willing to add it by means of a manuscript endorsement, although they do not generally charge additional premium to do so.

Important Coverage Extensions

In addition to the entities and persons noted above, most fiduciary liability policies extend coverage to (1) spouses of insureds and (2) personal representatives of insureds, such as trustees.

Spousal Coverage

Spousal coverage is necessary because plaintiffs' attorneys often attempt to assert claims against the assets of the spouse of a covered fiduciary when fiduciaries attempt to transfer their assets to a spouse.

Most, but not all versions of the spousal coverage extension also include "domestic partners" within their definitions of "spouse." This is important, because such living arrangements are becoming increasingly prevalent.

Coverage of Legal Representatives

Claims against fiduciaries are personal in nature. Thus, such claims survive the death, bankruptcy, or incapacity of an insured fiduciary. As a result, coverage is required if, for example, a trustee in bankruptcy, executor, or guardian must "stand in the shoes" of an insured fiduciary in defending a claim against him/her. Accordingly, coverage under the policies applies to such persons, as well.

No Coverage for Direct Acts of Insured Legal Representatives

It should be noted, however, that extensions covering legal representatives and spouses do not apply to alleged wrongdoing by an insured's legal representative or spouse. Rather, coverage applies only in the event that a claim is made against the assets held or controlled by a legal representative or spouse.

Chapter 9 Review Question

1. A fiduciary liability policy should *not* extend coverage to encompass the*:*
   a. Domestic partner of a covered fiduciary.
   b. Executor of a covered fiduciary's estate.
   c. Spouse of a covered fiduciary.
   d. Wrongdoing of a covered fiduciary's legal representative.

Answer to Chapter 9 Review Question

1. d. Coverage applies only in the event a claim is made against the assets held or controlled by a legal representative.

Chapter 10
Fiduciary Liability Insurance Coverage: Coverage for "Status Changes" of Covered Organizations and Plans

This chapter will explain how fiduciary liability insurance applies when covered organizations and covered plans undergo various types of "status changes."

Coverage for Acquisition of New Benefit Plans

The policies provide automatic coverage of additional pension and benefit plans over which insured fiduciaries obtain control, typically, when they acquire other companies. For example, if Company A acquires Company B and, as a result, becomes trustee of Company B's pension and benefit plans, Company A's policy will cover acts associated with the management and administration of B's plans, beginning on the date such plans were acquired.

Automatic coverage means (1) coverage immediately applies to the newly acquired plans, even without notification to the insurer and (2) such coverage applies without payment of additional premium. When automatic coverage does not apply, the insurer requires notification of the acquired plan(s), which are then subject to the standard underwriting process, normally requiring additional premium.

Limitations on Coverage of Newly-Acquired Plans

However, insurers place various limits on the actual extent of the coverage they will provide. Three key points should be kept in mind.

Automatic Coverage Applies Only If Assets of Acquired Firm Are "Limited"

First, the policies state that insurers will automatically extend coverage only in situations where the total assets of the company being acquired do not exceed a specific threshold percentage, relative to those held by the acquiring company. This threshold generally ranges from 10 to 25 percent, depending on the particular insurer's form. For instance, assume a company with assets of $100 million acquires another company whose assets are $25 million. If the asset threshold of the acquiring company's fiduciary liability policy is 25 percent, automatic coverage would apply. However, if this threshold were only 10 percent, automatic coverage would not apply. Thus, as this example illustrates, from the insured's standpoint, the higher the threshold specified in a policy, the better.

The intent behind the granting of automatic coverage is that the addition of such plans, given their relatively small size compared to the parent company (as measured by the asset test), will not substantially increase the underwriter's exposure to loss.

Coverage Is Not Automatic When the Asset Threshold Is Exceeded

Second, when the acquired entity's assets exceed the threshold percentage stated in the policy, automatic coverage does not apply immediately. Rather, coverage for the newly-acquired entity's plans must be underwritten separately, and additional premium will usually be charged.

Coverage Applies Only to Acts Following Acquisition

Third, coverage for claims associated with acquired plans (whether obtained on an automatic basis or on the basis of separate negotiation), applies only to those claims that were caused by acts taking place after the acquisition.

For example, assume Company A acquires Company B on January 1, 2010. There would be no coverage if it were alleged that the fiduciaries of Company B committed a wrongful act before January 1, 2010. This is despite the fact that the claim was made against B after January 1, 2010, the date on which when coverage for acquired plans would have been in place. In effect, when plans are newly-added via acquisition, it is not the underwriter's intent to grant what would constitute prior acts coverage.

However, under certain circumstances, coverage for such prior acts can be obtained, although additional premium will almost always be required by the underwriter. Details on this action will be provided later in this course.

Coverage for Other Types of "Status" Changes

There are four other common types of "status changes" relevant to the coverage provided under fiduciary liability policies. These include the following.

- Takeover of the insured and its plan(s)
- Cessation of a subsidiary
- Termination of a plan operated by the named insured
- Newly created plans

Takeover of Insured and Its Plans

When an insured company is acquired by another company, its benefit plan(s) is/are usually incorporated within the acquiring company's existing plans. Under these circumstances, the acquired company's fiduciary coverage continues until the end of the acquired company's policy term. However, coverage applies only for wrongful acts that took place prior to the acquisition date. No coverage applies to wrongful acts that take place after the acquisition date.

For example, assume Company A has a fiduciary liability policy with a January 1, 2010 to January 1, 2011 term. On July 1, 2010, Company A is acquired by Company B. According to the terms of the acquisition agreement, Company A's benefit plans are incorporated into Company B's plans. Coverage under Company A's policy continues until January 1, 2011. However, Company A has no coverage for wrongful acts under its previous policy that took place after July 1, 2010—the date it was acquired.

If, for example, one of the trustees of A's pension plan was accused of embezzling from the plan prior to July 1, 2010, coverage would apply under A's policy, provided the claim was made *on or before* January 1, 2011, the termination date of A's policy.

Conversely, if the alleged embezzlement took place *after* July 1, 2010, no coverage would apply under A's policy, regardless of the fact that the claim was made against A prior to the expiration of its policy on January 1, 2011.

The rationale behind this provision is that once the entity has been acquired, coverage for wrongful acts that took place after the acquisition date will be covered by the acquiring company's fiduciary liability policy. And since coverage will apply to acts that took place prior to the acquisition under the acquired company's policy, in theory, there should be no coverage gaps.

Cessation of a Subsidiary (and Its Plans)

Often, the subsidiary of a company will be "spun off," meaning that another entity acquires the subsidiary, or, as frequently happens, the subsidiary will be purchased from the parent company by its operating managers. Under these circumstances, the question arises as to how coverage applies to the now former subsidiary's plans. The general rule is that coverage applies under the former parent company's fiduciary liability policy for any acts that (1) took place prior to the spin-off and (2) are made against the insured prior to the expiration of the parent's current fiduciary liability policy. Conversely, coverage will apply under the new owners' policy for any acts that took place after the date the subsidiary was acquired/spun off.

Consider the following illustration. On July 1, 2010, a subsidiary of the XYZ Corporation is spun-off when it is purchased by its operating managers. The XYZ Corporation has a fiduciary liability policy in place with a January 1, 2010–11 term. In this situation, coverage will apply under XYZ's fiduciary liability policy to any acts associated with the subsidiary's benefit plans that took place prior to July 1, 2010, provided the claim associated with those acts is made before the expiration of XYZ policy on January 1, 2011. Coverage for acts that took place after the July 1, 2010 acquisition date will be covered under the fiduciary liability policy purchased by the operating managers that bought the subsidiary, even if the claim is made prior to the expiration of XYZ's policy on January 1, 2011.

Termination of a Plan Operated by an Insured

If, during the term of a fiduciary liability policy, an insured terminates a benefit plan, coverage applies to acts associated with the plan, provided these acts took place prior to policy expiration. For example, assume an insured is covered by a fiduciary liability policy with a January 1, 2010 to January 1, 2011 term. One of the insured's benefit plans is terminated on July 1, 2010. Coverage applies to acts associated with the terminated plan, provided these acts took place prior to January 1, 2011 and the claim associated with such acts is also made against the insured prior to the expiration of the policy on January 1, 2011.

Coverage When a Subsidiary Is "Spun Off" versus Coverage for When a Plan Is Terminated

There is a subtle but important difference in how coverage applies when a subsidiary is "spun off" compared to how coverage applies when a plan is terminated. In the later instance, coverage applies to claims made in conjunction with wrongful acts that take place up until the policy expires, provided the claim is made against the insured prior to policy expiration. In the former case, coverage applies to claims made in conjunction with wrongful acts that take place prior to the date on which the

subsidiary is spun off, provided the claim is made against the insured prior to policy expiration. Following are two examples illustrating this distinction.

- **Subsidiary Spin-Off.** The applicable policy is written with a January 1, 2012–13 term. The subsidiary is spun off on July 1, 2012. Coverage applies if (1) the wrongful act causing the claim took place prior to July 1, 2012 and (2) the claim is made against the insured prior to January 1, 2013.
- **Plan Termination.** The applicable policy is written with a January 1, 2012–13 term. The plan is terminated on July 1, 2012. Coverage applies if (1) the wrongful act causing the claim took place prior to January 1, 2013 and (2) the claim is made against the insured prior to January 1, 2013.

The rationale for this difference is that when a subsidiary is spun off, the former parent company no longer has any control over the organization's operations—including its benefit programs. In contrast, when a plan is terminated, the parent company maintains such control. Accordingly, coverage still applies to acts that take place after a plan is discontinued. In contrast, coverage ceases for any acts that take place after a subsidiary is spun-off.

Chapter 10 Review Questions

1. When McCane and Pailing join forces, McCane will assume responsibility for Pailing's benefit plan. McCane's plan currently has $100 million in assets, while Pailing's has $25 million. Because McCane's fiduciary liability policy has a 10 percent threshold, the Pailing plan:
   a. Will automatically be covered for acts occurring before the date of the acquisition.
   b. Will automatically be covered immediately with no additional premium.
   c. Will automatically be covered immediately subject to an additional premium at audit.
   d. Will be underwritten separately, and an additional premium will probably apply.
2. Spinning Wheel Company and its subsidiary, Bobbin Company, are covered by a 1-year fiduciary liability policy effective January 1 of the current calendar year. On July 1, Bobbin's operating managers purchase Bobbin from the parent company and also purchase separate insurance. On September 5 of this year, a claim is made by Bobbin employees for an act that occurred earlier this year on February 14. Assuming the claim is within the scope of coverage, this claim is:
   a. Covered by Spinning Wheel's policy.
   b. Covered by Bobbin's policy.
   c. Not covered by Spinning Wheel's policy because Bobbin is now a separate entity.
   d. Not covered by Spinning Wheel's policy because the act occurred before the acquisition.

Answers to Chapter 10 Review Questions

1. d. Pailing's assets exceed the 10 percent threshold, automatic coverage does not apply; Pailing's plan will be underwritten separately, and an additional premium is probable.
2. a. Coverage applies under the former parent company's fiduciary liability policy for any acts that took place prior to the spin-off.

Chapter 11
Key Definitions in Fiduciary Liability Policies

This chapter explains how fiduciary liability policy forms define the following key terms: covered losses, claims, territory, defense costs, and claim settlement procedures.

Covered Losses

Fiduciary liability policies cover indemnity payments (i.e., compensatory awards and settlement costs), and defense expenses, that result from claims made against insureds (such as pre- and post-judgment interest.) In addition, the policies cover supplementary expenses associated with litigation, including bonds and appeal costs.

Voluntary Compliance Fees

The policies also cover Voluntary Compliance Fees, which are payments made to correct "deficiencies" in benefit programs operated by the insured organization. (Deficiencies refer to amounts by which defined benefit plans are underfunded.) The Employee Plans Compliance Resolution System (EPCRS), operated under the auspices of the Department of Labor, provides an administrative process for arriving at such settlements. This process is advantageous because it eliminates the high legal costs associated with the formal litigation process. Note, however, that fiduciary liability policies do not cover funding deficiencies. Rather, they cover the administrative fees associated with arriving at voluntary settlements under the EPCRS process.

Certain or Limited Fines, Civil Penalties, Taxes, Uninsurable Matters, Benefits Payable under Plans

On the other hand, fines, civil penalties, taxes, any matter deemed uninsurable by law, and actual benefits payable under the insured plans, are excluded by most policies' definitions of "loss." However, some of the policies do cover (subject to sublimits) fines and penalties levied in conjunction with the Health Insurance Portability and Accountability Act (HIPAA). The rationale for affording such coverage is that the HIPAA law falls within the scope of ERISA.

Punitive Damages

Nearly all fiduciary insurers cover punitive damages, that is, damages that intend to punish the wrongdoer, rather than compensate the person or organization suffering the loss. (Note, however, not all states permit insurance coverage of punitive damage awards.)

Definition of "Claim"

The manner in which the policies define the term "claim" is an important coverage issue. The broadest possible definition is ideal because it tends to accelerate the trigger of coverage under a fiduciary liability policy form, which is usually advantageous from the insured's standpoint. Although the exact definition of "claim" varies from policy to policy, the following are events that trigger a claim under the typical fiduciary liability form.

Written Demand for Monetary or Nonmonetary Relief

Under nearly all fiduciary liability policies, a written, rather than an oral, demand is required to trigger coverage. Such demands can seek either money damages or nonmonetary relief (e.g., a cease and desist order).

Civil Proceeding Commenced by the Service of a Complaint

A civil proceeding commenced by the service of a complaint is actually a type of written demand for monetary or nonmonetary relief.

Criminal Proceeding Commenced by Filing of Charges

Coverage is also triggered under a fiduciary liability policy by a criminal indictment. This is important because at times, corporate fiduciaries are indicted for criminal offenses, prior to the time in which civil complaints are filed against them. For example, the trustee of a pension plan could be indicted for embezzlement before being sued in civil court.

The policies exclude coverage for damages alleged in conjunction with criminal acts. However, the policies state that defense coverage is provided when an insured is criminally charged, and that defense coverage continues until "final adjudication," meaning the point at which the insured fiduciary is acquitted, convicted, or the claim is settled.

Formal Administrative or Regulatory Proceeding

Administrative or regulatory agencies frequently file complaints against corporate fiduciaries. In addition, the Department of Labor and the PBGC sometimes request investigations into various benefit programs, such as when a pension plan appears to be seriously underfunded. Thus, it is important for coverage to be triggered by such actions.

Arbitration, Mediation, or Alternative Dispute Resolution Proceeding

Under the terms of most fiduciary liability policies, when an insured is requested to appear at an arbitration hearing, coverage is automatically triggered. This is beneficial because pension and benefit plan-related disputes are increasingly being addressed by the arbitration process, rather than through the traditional court system.

Written Request To Toll/Waive a Statute of Limitations Relating to a Potential Civil or Administrative Proceeding

A written request to waive or toll (i.e., suspend) a statute of limitations generally involves a situation when a government agency or a claimant suspects wrongdoing on the part of a fiduciary but requires additional investigatory time to determine the exact nature of such potential wrongdoing—prior to filing a claim. Often, the agency or claimant eventually does file a formal claim against the insured

fiduciary(ies). Thus, when an insured is notified of such requests, coverage is triggered under most policy forms.

Covered Territory

Nearly all fiduciary liability policies provide coverage on a worldwide basis. That is, coverage applies regardless of where the wrongful act that gave rise to a claim took place or where the claim is brought. Such a provision is important, especially for a company that has even the smallest degree of international operations.

Covered Defense Costs

In addition to covering indemnity payments (i.e., settlements and judgments associated with claims), fiduciary liability policies also cover the costs required to investigate, defend, and settle claims. These items typically encompass attorneys' fees, adjusters' services, court costs, bonds, and related expenses required by the claim settlement process.

Defense within Policy Limits

Under virtually all the insurers' forms, payment of defense costs reduces the policy's limit of liability. However, a handful of insurers, especially those insuring smaller organizations, will sometimes offer the option to cover defense in addition to policy limits, in return for additional premium.

Duty To Defend Provisions

The phrase "duty to defend" in a fiduciary liability policy states that the insurer has the duty to defend any claim alleging a covered act under the policy. In contrast, the phrase "duty to pay" or "non-duty to defend" in a policy states that the insurer does not have the duty to defend claims; rather, it is the duty of the insured to defend claims. Such forms only compel the insurer to pay the defense costs in connection with the insured's executing the defense of the claims.

Virtually all fiduciary liability forms contain wording to the effect that the insurer has a duty to defend. For all but the largest, most legally experienced and sophisticated corporations that have large internal legal staffs, duty to defend provisions eliminate the burden of having to secure appropriate legal counsel and to manage the claim defense process. Since most firms lack both the knowledge and legal talent available to deal with such claims, requiring the insurer to select counsel and control the defense process actually confers a benefit and also protects the insured organization.

"All" Allegations Defense: A Key Benefit of Duty To Defend Forms

Another significant benefit for insureds of duty to defend policies is that under these forms, the insurer is obligated to defend all the allegations in a lawsuit, as long as at least one such allegation is covered by the policy.

The following scenario illustrates this point. A newly-hired employee properly filled out the enrollment form for coverage under the company's medical insurance plan, but the human resources assistant misplaced the application and never mailed it to the insurance company. As a result, the employee had no insurance coverage when he was diagnosed with cancer 1 month later. The employee complained so bitterly and so frequently upon learning he had no coverage, that the company terminated him. The now ex-employee then filed suit for damages relating to the error in administering the company's health care plan and for lost wages resulting from wrongful termination.

Although damages arising from the first allegation—the error in administering employee benefits—is clearly covered by standard fiduciary liability policy forms, the wrongful termination claim is not. However, since coverage exists for the first allegation, an insurer, under a "duty to defend" policy, must also defend the wrongful termination claim (although it would not be liable for any potential damages). In contrast, under a fiduciary liability policy written on a "non-duty to defend" basis, the insurer would only be obligated to defend (and pay) the claim associated with the first allegation, but would have no obligation to defend the wrongful termination claim.

Drawbacks of Duty To Defend Provisions

The major drawback of duty to defend provisions is that they could cause the insured to lose control in defending a claim. This is because duty to defend provisions could give an insurer the right to settle a claim in a situation where the insured was determined to contest it. However, there are instances where, as a matter of principle, an organization would prefer to block a settlement, and yet, duty to defend provisions could be used to deny the organization this opportunity.

Often, the preference for duty to defend provisions is a function of an organization's economic position; insureds with substantial resources sometimes prefer to control their own defense and are fully capable of managing major litigation. In contrast, smaller organizations are usually less capable of managing the defense of a claim and, therefore, generally prefer duty to defend provisions.

Claim Settlement Procedures

At times, there are disagreements between the insurer and the insured as to an appropriate settlement amount in a claim situation. As a result, the policies are written with what are known as co-insurance "hammer clauses" to assist in resolving such disagreements. Such clauses clearly benefit insureds. These provisions provide for a sharing of any settlement or judgment that is larger than the settlement amount the insurer wanted the insured to accept, plus a sharing of additional defense costs incurred in continuing to contest the claim, following the insured's refusal to settle the claim on the basis recommended by the insurer.

Coinsurance Hammer Clause: An Illustration

Assume an insurer wanted to settle a claim for $100,000 but the insured refused to consent. Also assume that the fiduciary liability policy contains a 50 percent coinsurance hammer clause. The claim is eventually settled for $200,000 and $50,000 in additional defense costs are also incurred following the insured's refusal to consent. Under these conditions, the insurer would pay a total of $175,000, broken down as follows.

- **$100,000**, the originally recommended settlement amount, *plus*
- **$50,000**, which is 50 percent of the amount by which the $200,000 final settlement figure exceeded the insurer's original $100,000 settlement recommendation (i.e., 50 percent of $200,000 – $100,000), *plus*
- **$25,000**, the amount of additional defense costs expended following the insured's refusal to settle on the basis initially recommended by the insurer (i.e., 50 percent of $50,000).

Adding these figures yields a $175,000 total insurer payment.

In contrast, under a typical "hammer clause" without a coinsurance provision, the insurer would not have paid any of the $100,000 additional settlement or $50,000 in additional defense costs, following the insured's refusal to settle the claim on the basis suggested by the insurer.

The most common coinsurance sharing percentage contained in fiduciary liability policies is 50/50, but it can go higher (e.g., 70 percent insurer/30 percent insured).

Chapter 11 Review Questions

1. The definition of "loss" in fiduciary liability policies usually includes:
   a. Civil penalties.
   b. Fines.
   c. Indemnity amounts.
   d. Taxes.
2. Vinny has been indicted on charges that he embezzled funds from the plan he serves as a fiduciary. The date of his trial has not yet been scheduled. If Vinny loses the criminal case, plan beneficiaries will most likely bring a civil case against him and other plan fiduciaries and attempt to recover their financial loss. The plan's fiduciary liability policy will cover the cost of Vinny's:
   a. Criminal defense costs, fines awarded in criminal court, civil defense costs, and damages awarded by the civil court.
   b. Criminal defense costs, civil defense costs, and damages awarded by the civil court only.
   c. Civil defense costs and damages awarded by the civil court only.
   d. Damages awarded by the civil court only.
3. The policy limits in most insurers' fiduciary liability policy forms apply to any combination of:
   a. Attorneys' fees, adjusters' services, court costs, bonds, and related settlement expenses, less the amount of any settlement.
   b. Defense costs but not indemnity payments.
   c. Indemnity payments but not defense costs.
   d. Settlements, judgments, and defense costs.
4. The insurer wants to settle a claim against Armand Soda Company for $50,000 (including covered defense costs), but Armand fiduciaries want their day in court, because they believe no wrong has been done. However, the plaintiff prevails and a final judgment against Armand is rendered in the amount of $90,000. Additional defense costs of $20,000 are also incurred. Armand's policy has a 50 percent coinsurance hammer clause and a $1 million limit. The insurer will pay a total of:
   a. $50,000.
   b. $80,000.
   c. $90,000.
   d. $110,000.

Answers to Chapter 11 Review Questions

1. c. Fines, civil penalties, taxes, any matter deemed uninsurable by law, and actual benefits payable under the insured plans, are excluded by most policies' definitions of "loss." The policy is designed primarily to cover indemnity payments and defense costs.
2. b. Fiduciary liability policies provide defense coverage when an insured is criminally charged.
3. d. In addition to covering indemnity payments (i.e., settlements and judgments associated with claims), fiduciary liability policies cover the costs required to investigate, defend, and settle claims.
4. b. With a settlement above the original figure, the insurer pays the originally recommended settlement amount plus 50 percent of the excess judgment plus 50 percent of the excess defense costs.

Chapter 12
Fiduciary Liability Coverage: Limits and Deductibles/Retentions Provisions

This chapter examines the limits and deductibles/retentions provisions found within fiduciary liability policies.

Policy Limits

The interrelated claims provision is central to the application of policy limits under fiduciary liability policies.

Interrelated Claims Provisions

Interrelated claims provisions state that if a series of claims results from a single wrongful act or a series of related wrongful acts, errors, or omissions and these claims are made during more than one policy period, the applicable limit of coverage is the one that was in effect at the time the first claim was made.

Application of the Interrelated Claims Provision

Assume that in 2010, Company A's pension plan is merged with Company B's plan, after Company A is acquired by Company B. The trustees of A's plan are later sued because the benefits under B's plan are lower than under Company A's plan. Also assume that three different fiduciary liability policies were in force during these years, each with a $5 million limit. Three different beneficiaries make claims in 2011, 2012, and 2013, respectively.

Under an interrelated claims provision, the $5 million policy limit applying in 2011 represents the total limit available to pay and defend all three claims—regardless of the fact that claims were also made against the fiduciaries during the 2012 and 2013 policy years.

Purpose of the Interrelated Claims Provision

The purpose of interrelated claims provisions is to prevent a "pyramiding" or "stacking" of limits in which policy limits from more than 1 year are applied to a single wrongful act or series of related wrongful acts.

In the absence of such a provision:

- the insurer's $5 million policy limit applicable during 2011 would have applied to the first claim;

- the insurer's $5 million policy limits applicable during 2012 would have applied to the second claim; and
- the insurer's $5 million limit applicable during 2013 would have applied to the third claim.

Thus, despite the fact that all three claims arose from a single act—the merger of the two companies' pension plans—in the absence of the interrelated claims provision, the insurer would have been responsible for paying as much as $5 million under each of three policies, or a total of $15 million. Interrelated claims provisions are especially important in fiduciary liability policies because claims involving essentially the same wrongful act are often filed by multiple claimants during different policy terms.

Deductibles/Retentions

Most fiduciary liability policies include clauses in their deductible/retention provisions stating that the policy deductible/retention applies per wrongful act rather than to each separate claim. For example, in the scenario noted previously, illustrating application of interrelated claims provisions, only one deductible/retention would apply because all three of the claims arose from a single wrongful act.

The "batch clause" (another term for a per wrongful act deductible/retention) is especially important in fiduciary liability insurance because, if there were no such provision, the application of a separate deductible/retention to each claimant would dramatically reduce the extent of coverage provided by the policy, given the fact that many claims against fiduciaries are filed as class actions, which always involve multiple plaintiffs.

Application of Deductibles/Retentions to Defense Coverage

Fiduciary liability deductible/retention clauses normally state that the deductible/retention applies to both indemnity payments and defense costs, regardless of whether an indemnity payment is made. In effect, the forms do not provide "first-dollar" defense coverage.

To illustrate, assume that an insurer expends $50,000 to defend a fiduciary but is not ultimately required to pay a judgment or settlement on the fiduciary's behalf because the claim is dismissed on a summary judgment basis. If the policy contains a $50,000 deductible/retention, the insurer would seek reimbursement from the insured in the amount of $50,000 to satisfy the policy's deductible/retention provision, regardless of the fact that no indemnity payments were made on the insured's behalf. Alternatively, if, in this scenario, in addition to expending $50,000 in defense costs, the insured settled the claim for $200,000, the $50,000 deductible would still apply and the insurer would pay $200,000 (with the insured absorbing the $50,000 deductible).

First-Dollar Defense Coverage

However, some fiduciary liability policies contain provisions that affirmatively cover defense costs on a first-dollar basis if they are incurred (1) by an individual fiduciary who is not reimbursed for such costs by the corporation sponsoring the employee benefit plan in question or (2) when defense costs are incurred in conjunction with voluntary compliance settlement programs.

Chapter 12 Review Questions

1. For 4 consecutive years, the trustees of Rusty Company's pension plan repeat the same error and fail to fully fund the 401(k) plans of participants who intend to make the maximum permitted contribution. The error is discovered during Year 4, but retroactive plan contributions are not permitted, so affected participants must pay back taxes. Participants make claims against the plan during Years 4 and 5, alleging wrongful acts occurred during Years 1 through 4. Different insurance limits applied to Rusty Trustees' insurance policies each year, but the limit that applies to this claim is the limit for:

   a. Year 1 since that was when the first wrongful act occurred.

   b. Year 4 since that was when the first claim was made.

   c. The sum of all limits in force from Year 1 through Year 4.

   d. The sum of all limits in force from Year 1 through Year 5.

2. JCF Bachelor has a fiduciary liability policy with a $1 million limit and a $50,000 deductible clause that takes the most common approach to defense costs. A claim seeking $100,000 in damages is made against PDQ. The insurer spends $25,000 in defending the claim and reaches a settlement for $150,000 in damages. After all accounts between JCF Bachelor and its insurer with respect to this claim have been settled, the insurer will have paid:

   a. $0.

   b. $50,000.

   c. $75,000.

   d. $125,000.

Answers to Chapter 12 Review Questions

1. b. The applicable limit is the one that was in effect at the time the first claim is made.

2. d. In this claim, the indemnity payment is $150,000 plus $25,000 was expended in defense, for a total of $175,000. The insured must then reimburse the insurer for the $50,000 deductible. This results in a net payment of $125,000 by the insurer ($175,000 - $50,000= $125,000).

Chapter 13
Fiduciary Liability Policy Conditions

This chapter discusses several policy conditions that are especially important in fiduciary liability policies.

The conditions sections of fiduciary liability insurance policies significantly affect the insureds' rights under the policies. Conditions that are particularly important (and are discussed below) in fiduciary liability policies include the following.

- Subrogation/recourse
- Severability of interests provisions
- Managed care exception wording

Subrogation/Recourse

One unusual aspect of the subrogation provisions within fiduciary liability policies is that, unless specified, underwriters ordinarily have what is known as the right of recourse, i.e., the right to subrogate against an insured. (Subrogation is the assignment, to an insurer, by terms of the policy or by law, after payment of a loss, of the rights of the insured to recover the amount of the loss from one legally liable for it. Thus, under a subrogation provision, an insurer could have the right to collect the amount of its payment to a beneficiary under a pension plan, from the fiduciary whose negligence caused the beneficiary to suffer a loss.) Such a procedure represents a distinct departure from the approach used in most other types of professional liability insurance, wherein subrogation against insureds is typically barred by policy language.

When Is Subrogation Permitted Against Fiduciaries?

Section 410(b)(1) of ERISA allows an insurer to pursue subrogation against a covered fiduciary, if the premium for a fiduciary policy is paid out of plan assets. The logic underlying this provision is that fiduciaries should not be financially absolved from the consequences of their wrongful acts when premiums for liability coverage are being paid from the assets of the benefit plans they are administering—to the detriment of the beneficiaries of those plans.

Subrogation/Recourse: An Example

A group of corporate fiduciaries is sued because they hired an incompetent actuary whose recommendations produced a woefully underfunded pension plan. Premiums for the corporation's fiduciary liability policy were paid out of the pension plan's assets. In this instance, the insurer has the right to subrogate (known as the right of recourse) against the insured corporate fiduciaries.

The rationale for allowing subrogation (which, as noted above, is unusual under professional liability policy forms) is that since coverage for the fiduciary liability policy is being paid for from the beneficiaries' assets (i.e., the pension fund), the fiduciaries should not have the benefit of insurance coverage under these circumstances and that, as a result, the insurer has a right to be reimbursed for paying the loss, from the fiduciaries who caused the loss.

Not allowing the insurer to subrogate against the fiduciaries in this example would be like barring a medical insurer from subrogating against a negligent driver who injures a pedestrian covered by the insurer's major medical policy. In this example, it would be unfair for the negligent driver to escape financial responsibility to the pedestrian, because the pedestrian had purchased medical coverage and, as a result, received compensation for the medical expenses incurred in the accident.

Why Subrogation/Recourse Is Rarely Pursued Against Fiduciaries

It should be recognized, however, that in actual practice, subrogation/recourse is rarely pursued against fiduciaries. This is because nearly all corporate organizations pay fiduciary liability premiums as a corporate expense (rather than from benefit plan assets). As a result, the fiduciaries are not, in effect, using the benefit plan beneficiaries' assets to provide liability coverage for themselves. Rather, they are using their own assets (or, in this instance, the corporation's assets, on whose behalf they are administering the benefit plans), to protect themselves from liability claims made against them.

"Waiver of Recourse" Provisions

Given the foregoing, nearly all fiduciary liability policies' recourse/subrogation provisions state that the insurer will "waive its right of recourse" against insured fiduciaries in the event that policy premiums are paid from corporate proceeds—rather than from benefit plan assets—which is almost always the case.

Severability

Provisions that enforce the concept of severability of coverage are included in virtually all fiduciary liability policies. These clauses state that coverage applies separately to each insured under the policy. There are three significant implications of such clauses:

- Actions of one insured do not void coverage as to other insureds.
- False application statements by one insured do not bar coverage as to other insureds.
- Policy limits do not increase based on the number of insured fiduciaries.

These three concepts are discussed below.

Actions of One Insured Do Not Void Coverage as to Other Insureds

First, severability provisions indicate that if the actions of one (or more) insured(s) voids coverage under the policy, such coverage is not invalidated as respects other individuals insured by the policy. This type of severability provision is also contained within certain exclusions found in fiduciary liability policies, typically in the dishonesty and personal profit exclusions, which are discussed later in this chapter, while in other policies, nonimputation provisions are found in sections apart from the exclusions.

For example, assume that one fiduciary commits an act that would be subject to the policy's dishonesty exclusion (e.g., a plan trustee profits when, in return for a kickback, he allows his brother-in-law to manage the assets of a covered plan). Further, assume that as a result of this action, all

fiduciaries insured by the policy are named in a lawsuit. In this situation, the severability provision of the policy will provide defense coverage for the other "innocent" fiduciaries—despite the fact that no coverage would be available to the culpable individual.

Severability provisions are also sometimes referred to as nonimputation clauses, meaning that the wrongful act of one insured (which bars coverage for that person) will not be "imputed" to another person, so as to bar coverage for the innocent insured(s).

False Application Statements Do Not Void Coverage as to Other Insureds

The second common situation in which severability provisions apply is when one (or more) individual(s) intentionally provides false information on an application for fiduciary coverage. In a claim situation involving the false statement, the severability provision voids coverage only for the specific insured person(s) who provided such false information. Consequently, the policy would cover those insureds who were not aware of and were not a party to the false statement made on the application.

Consider the following example. The president of an insured corporation, who also served as a trustee of the firm's benefit programs, signed an application for fiduciary coverage which he knew vastly overstated the assets of the company's defined benefit pension plans, while understating its future liabilities. If all the company's fiduciaries are later sued in connection with that plan, coverage would only be voided as to the president who signed the application, but coverage would be available as to the other fiduciaries who were not aware of the false data to which the president had attested.

Policy Limits Do Not Increase Based on the Number of Insured Fiduciaries

The third effect of severability provisions is to clarify the fact that although coverage can apply separately to individual fiduciaries, severability does not increase the policy's basic limit of liability.

Under a fiduciary liability policy containing a $10 million annual aggregate limit, a maximum of $10 million would be available to defend and pay on behalf of all insured fiduciaries during the policy term. This $10 million limit would apply and not increase—regardless of how many individual fiduciaries were actually named in a single lawsuit.

The first two types of severability provisions discussed above are beneficial to insureds while the third protects the insurer.

Managed Care Coverage Exception Wording

Although fiduciary liability policies exclude coverage for bodily injury, property damage, and personal injury, in recent years insurers have begun to attach, via endorsement, an important exception to this exclusion. By means of so-called "managed care coverage exception endorsements," fiduciary liability insurers except—and therefore cover—bodily injury, sickness, mental or emotional distress, disease, or death when such events result from the administration of managed care health plans. In view of the fact that such plans are subject to ERISA, this is appropriate and, of course, represents a substantial exposure to employers sponsoring such plans.

When the Managed Care Exception Endorsement Applies

The two most common claim scenarios associated with the managed care exposures involve an injured employee-claimant suing an employer sponsor of a managed health care plan, alleging:

1. That the employer-sponsor of a managed health care plan negligently selected the managed health care plan provider; or
2. that the employer-sponsor of a managed health care plan wrongly denied or delayed medical benefits provided by the plan.

In the first scenario, an employee could allege that a physician's malpractice in treating a medical condition caused bodily injury and that the employer was negligent in selecting a managed care plan that included an incompetent physician within its roster of health care providers.

An example of the second scenario might involve an employee who is denied an organ transplant and dies as a result of the denial. The employee's estate could allege that either the employer and/or the managed care organization wrongly denied medical treatment that was covered by the terms of the managed care plan.

Why the Managed Care Exception Endorsement Is Necessary

Absent a managed care endorsement that "excepts" bodily injury when it arises from managed care plan administration, coverage would be excluded for the scenarios noted above, because as already mentioned, fiduciary liability policies exclude coverage for bodily injury. However, this exception wording is both appropriate and necessary since such plans are indeed subject to ERISA and therefore significantly expose the fiduciaries to personal liability, when they are responsible for administering such plans.

Coverage Subject to a Sublimit

One important aspect of managed care coverage endorsements is that they are normally subject to a sublimit, most often $1 million. Insurers usually impose a sublimit, because the exposure to large losses is substantial. Absent a sublimit, insurers would, in some instances, be required to charge a premium approaching that of the fiduciary liability policy limit itself.

Chapter 13 Review Questions

1. Judas, one of the twelve Trustees of Benefit Plan, also serves as its treasurer. In exchange for thirty shares of stock in a silver mine, Judas leaks confidential insider information concerning the fund's investment strategy that operates to the detriment of plan participants. Other fiduciaries are not involved in Judas's actions and learn of them only later. Subsequently, all twelve trustees and the plan itself are named as defendants in a lawsuit resulting from this incident. The severability provisions of Benefit Plan's fiduciary liability policy indicate that:
   a. Judas's betrayal does not preclude coverage for other fiduciaries.
   b. Judas's betrayal voids coverage for all fiduciaries.
   c. only Benefit Plan, not individual fiduciaries, is covered for this claim.
   d. only Judas is covered for this claim.

2. Many fiduciary liability policies are modified by a "managed care coverage exception endorsement" that provides coverage for some events that result from the administration of managed care health plans. Covered events include all of the following, *except*:

   a. Bodily injury.

   b. Death.

   c. Emotional distress.

   d. Libel and slander.

Answers to Chapter 13 Review Questions

1. a. If the actions of one insured void coverage, such coverage is not invalidated as respects other individuals insured by the policy.

2. d. Coverage for personal injury offenses such as libel and slander is not "bought back" by this endorsement.

Chapter 14
Fiduciary Liability Policy Exclusions

Exclusions contained in a fiduciary liability policy can have a significant effect on the scope of coverage it provides and are the subject of this chapter.

Policy exclusions provide a meaningful basis for comparing two fiduciary liability policies. In situations where a decision is to be made regarding which one of two or more policies should be selected, the presence or absence of certain exclusionary language—or variation in the breadth of that exclusion—between two insurers, may serve as a key to selecting one policy over another.

The following exclusions will be discussed in this chapter:

- Dishonesty
- Personal profit
- Contractual liability
- Failure to collect contributions (owed to an employee benefit plan)
- Claims from a subsidiary prior to acquisition
- Failure to fund in accordance with ERISA
- Failure to purchase or maintain insurance or bonds
- Workers compensation, unemployment insurance, Social Security disability benefits
- Discrimination not related to ERISA law
- Benefits payable to a beneficiary
- Bodily injury and property damage liability
- Exposures excluded by other professional liability policies

Dishonesty

Insuring fiduciaries for the individual liability that arises out of their intentional commission of illegal acts is not permitted as a matter of public policy and therefore excluded. (Public policy refers to attempts by the law, to discourage certain types of conduct. Accordingly, if insurance coverage were available for intentional, wrongful acts, such conduct would actually be encouraged, something that would be undesirable for society as a whole.) However, nearly all fiduciary liability policies qualify the exclusion by stating that the exclusion applies only if a "judgment" or "final adjudication" establishes that the insured committed the intentionally dishonest act.

In addition, since an insurer's duty to defend is generally construed as being broader than its duty to indemnify, insurers typically provide defense coverage to allegations of fraud or criminal acts, until such dishonest acts are actually proven by means of a criminal conviction or an adverse judgment.

The Practical Effect of the Dishonesty Exclusion

In actual practice, a settlement is reached between the claimant and the insurer in the vast majority of cases when claims allege dishonest conduct. Within the settlement agreement, the insured rarely makes an admission of liability and the insurer then simply pays the settlement amount on the insured's behalf. Consequently, the practical effect of the dishonesty exclusion is practically nil, because the exclusion is not usually enforced to deny coverage for either defense costs or indemnity payments.

Personal Profit

Liability of fiduciaries who attain personal profit or financial advantage to which they were not legally entitled is another exposure considered to be uninsurable and therefore excluded (e.g., a trustee of a pension plan receives a portion of a broker's commission in return for investing the plan's funds with the broker's company). However, most fiduciary liability policies do not apply this exclusion unless the claim of personal profit is factually established. Therefore, it is important for an insured to ascertain that the policy purchased does contain such exception language and to negotiate with underwriters for its inclusion in the event that it does not.

Severability Provisions in Fiduciary Liability Policy Exclusions

As already explained, by virtue of what are known as severability provisions, for the purpose of applying fiduciary liability policy exclusions, the actions of one insured fiduciary will not be imputed to any other insured fiduciary. For example, assume that a claim alleges dishonest acts were committed by a group of pension plan trustees. If only one of these individuals was, in fact, proven guilty of the dishonesty, based upon the severability provision applying to the policy's exclusions, the non-culpable plan trustees would still have defense coverage available for them, despite the fact that all fiduciary liability policies contain exclusions for dishonest acts. Such coverage is available because the policy's severability provision states that the dishonest acts of the culpable insured will not be imputed to the innocent insureds, so as to bar coverage for these individuals. Severability provisions are also sometimes referred to as nonimputation clauses, which, as already noted in this discussion, are sometimes found in sections of the policy that are outside of the exclusions section.

Insurers typically include severability provisions with respect to the fraud/dishonesty and personal profit exclusions.

Contractual Liability

Nearly all fiduciary liability policies exclude coverage for situations where an insured has held a third-party service provider harmless in conjunction with the operation of a pension or benefit plan. (There are two exceptions to this and they are discussed later in this chapter.)

The following scenario provides an example of how a fiduciary might be required to hold a third-party service provider harmless, in conjunction with an employee benefit plan. A CPA firm requests that an insured fiduciary hold the accounting firm harmless if the firm is sued in connection with auditing services it performs for the plan. Also assume that the accounting firm certifies the plan's financial statements have been prepared according to generally accepted accounting principles

(GAAP) and fairly represent the plan's true financial condition. Six months later, the plan is declared insolvent by the PBGC. The beneficiaries sue the CPA firm, which, in turn, seeks to be held harmless by the trustee of the plan. Given the contractual liability exclusion, no coverage would apply to hold the accounting firm harmless; that is, cover its defense costs and make indemnity payments on its behalf.

Rationale for the Exclusion

Contractual liability exclusions eliminate coverage for hold harmless agreements in situations such as in the above example, for two reasons. First, outside service providers should rightfully maintain professional liability coverage of their own and therefore not require clients to hold them harmless when they provide professional services. Second, insurers are averse to assuming liability for hold harmless agreements unless they can underwrite them at the inception of a policy—in which case some insurers may agree to modify the policy's contractual liability exclusion for a specific hold harmless agreement.

Avoid Holding Other Parties Harmless

As a general rule, it is a sound practice for a fiduciary to avoid holding outside parties harmless for services that outside parties render in conjunction with the fiduciary's benefit and pension plans. However, if an insured fiduciary must hold another entity harmless, the underwriter should be advised prior to policy inception. This allows the insurer time to evaluate the nature of the exposure and assess an appropriate additional premium if the underwriter is willing to cover such an agreement.

Exception Wording

Within the contractual liability exclusion, there is an exception that does provide coverage for two types of hold harmless agreements: (1) an agreement to assume liability that would have applied even in the absence of a contract and (2) an agreement in a trust agreement or in other documents establishing a corporate benefit plan, to assume liability for another party's negligence.

Liability That Would Have Applied in the Absence of a Contract

It is common for contractual liability exclusions to be worded so they provide an exception (and thereby provide coverage) for liability that would have attached even in the absence of a contract. Assume that a contract with a pension actuary required an insured corporation to indemnify and hold harmless the actuary for claims resulting from the insured's sole negligence. Also assume that the insured corporate trustee provided the actuary with erroneous data regarding its pension plan, and that as a result, the pension actuary committed an error. Under these conditions, even in the absence of an agreement to hold the actuary harmless, the corporation would still be required to indemnify the actuary for any claims made against the actuary. This is because such claims would have been the result of the trustee's negligence (not the actuary's). In this instance, the policy would therefore cover the corporation's assumption of liability, because such liability (i.e., for the corporation's sole negligence) would apply even if the insured corporation never agreed to hold the actuary harmless.

Liability Assumed in Benefit Plan Documents

If, according to the documents governing an insured benefit plan, an insured fiduciary is required to hold a benefit plan service provider, such as an investment manager, accountant, or attorney, harmless (even if a claim results from the service provider's negligence), most fiduciary liability policies contain exception wording stating that coverage applies under these circumstances (i.e., benefit plan

governing documents.). Underwriters are willing to cover hold harmless agreements of this type because such requirements are stated in plan documents, which insurers presumably have had an opportunity to review during the underwriting process, prior to binding coverage.

Failure to Collect Contributions Owed to an Employee Benefit Plan

The majority of, but not all, fiduciary liability policies exclude coverage for claims caused by a fiduciary's failure to collect contributions owed to a pension or benefit plan. This exposure typically arises in multi-employer, union-sponsored plans, but not in single-employer plans.

Rationale for the Exclusion

This exclusion appears in fiduciary liability policies because the collecting of pension and benefit plan contributions from companies participating in a multiemployer plan is an activity that is completely within an insured's control. Accordingly, insurers exclude this exposure because they do not intend to provide what would, in effect, serve as "financial guarantee insurance."

However, many of the forms do provide key exception wording under two circumstances. A handful of forms afford defense coverage to allegations that the insured(s) failed to collect contributions owed to a benefit plan. In addition, a handful of insurers provide coverage if it is alleged that failure to collect contributions was the result of the insured's negligence, rather than the result of an intentional act. The rationale for this exception to the exclusion is that an insurer will cover an insured's unintentional failure to make such collections, but not the deliberate failure to do so. For example, if this exception wording were found in a policy, coverage would apply (to the resulting $250,000 shortfall) if an insured thought it needed to collect $500,000 in annual premiums from its employees to fund its self-insured medical plan, when it actually needed to collect $750,000 in a given year.

Claims from a Subsidiary Prior to Acquisition

The policies routinely exclude coverage for claims associated with a subsidiary that were the result of wrongful acts taking place prior to the date on which the insured corporation acquired the subsidiary. As was noted in Chapter 10 under “Coverage for Other Types of Status Changes,” claims against fiduciaries frequently result from such circumstances.

Rationale for the Exclusion

The rationale for this exclusion is that the underwriter did not insure the subsidiary at the time of the wrongful act and, thus, should not be responsible for covering claims associated with such acts.

This exclusion is necessary because, absent such wording, claims from a subsidiary's pre-acquisition wrongful acts would otherwise be covered. Specifically, if such a claim were made against the insured during the term of the policy and the wrongful act took place on or after the policy's retroactive date, the insurer would not be able to deny liability for it. Although such claims can be precluded by manuscript exclusionary endorsements, these endorsements could become difficult for an underwriter to manage, especially in the case of an insured that frequently acquires other companies. Accordingly, this "blanket" exclusion accomplishes what a number of individual manuscript endorsements would otherwise be required to do.

Failure To Fund in Accordance with ERISA

Exclusions for claims alleging failure to fund in accordance with the ERISA law are contained in most fiduciary policies. The rationale for the exclusion is that covering losses would be contrary to public policy since, under such conditions, the insurer would be providing coverage for intentional violations of federal law (although providing defense coverage to allegations of legal violations would not be contrary to public policy). Accordingly, many of the forms do provide defense coverage to allegations that the insured(s) failed to fund in accordance with ERISA.

Failure To Purchase or Maintain Insurance or Bonds

As noted earlier in this course, ERISA requires that employee dishonesty coverage be arranged to protect the assets of an insured organization's pension and welfare plans. Claims arising from the insured's failure to purchase such coverage are uninsurable because avoidance of claims arising from this failure is within the insured's control.

Workers Compensation, Unemployment Insurance, and Social Security Disability Benefits

Nearly all fiduciary liability forms preclude coverage for claims produced by obligations from workers compensation, unemployment insurance, and disability laws. The rationale for this exclusion is that other, more specific insurance is available to cover such liabilities (i.e., workers compensation coverage).

However, some versions of this exclusion provide an exception and, therefore, cover claims associated with Consolidated Omnibus Budget Reconciliation Act (COBRA) plans and claims made under the Health Insurance Portability and Accountability Act (HIPAA). Such plans allow employees to purchase an extension of their health care insurance coverage for an 18-month period following the end of their employment with an organization. The rationale for this exception is that separate insurance is not available to cover these exposures.

Discrimination Not Related to ERISA Law

A number of the policies contain an exclusion for claims alleging discrimination that is not related to the ERISA law. The rationale for this exclusion is that fiduciary liability policies are not intended to cover the types of discrimination typically addressed by employment practices liability policy forms, including discrimination on the basis of sex, race, age, or national origin under laws such as the Equal Pay Act of 1963, the Age Discrimination in Employment Act (ADEA) of 1967, the Americans With Disabilities Act (ADA) of 1992, and the Family and Medical Leave Act (FMLA) of 1993.

Exception and Coverage for Discrimination under Benefit-Related Laws

On the other hand, this exclusion would not preclude coverage if, for example, a claimant were to allege that he or she was discriminated against as respects the availability of or eligibility to receive benefits under an employee benefit plan covered by a fiduciary liability policy. As explained earlier in this course, section 510 of ERISA prevents employers from taking actions that might abridge or prevent an employee from collecting benefits or taking punitive action against a participant for exercising his or her rights under an employee benefit plan. Accordingly, such claims are "excepted" by this exclusion and therefore covered by fiduciary liability policies.

Benefits Payable to a Beneficiary

Most fiduciary liability policies preclude coverage for payment of benefits owed to a claimant unless such benefits represent a personal obligation of an insured fiduciary and such claim results from a specific wrongful act. For example, assume an employee's beneficiary is unable to collect a death benefit under a company's term life insurance program because the insurer that provided such coverage is insolvent. The fiduciary liability policy will not pay such benefit unless it can be shown that one or more of the individual fiduciaries committed a wrongful act that caused the survivor to be unable to collect the benefit due. If it could be demonstrated that the fiduciary(ies) knowingly purchased the life insurance from a financially unsound insurer, and that soon after the purchase, the insurer was declared insolvent, the fiduciary liability policy would provide coverage for the benefit due.

Rationale for the Exclusion

The purpose of this exclusion is to prevent the fiduciary liability insurer from becoming a financial guarantor of benefits due under an insured corporation's benefit programs. Rather, coverage for benefits due will only apply when a wrongful act is committed by one or more of the insured fiduciaries and this specific wrongful act prevented the employee or dependent from collecting a benefit that was due him or her (such as in the example above).

Bodily Injury and Property Damage

As noted earlier in this section in the discussion of managed care exception wording, fiduciary liability policy forms exclude coverage for bodily injury and property damage. However, as also explained, the forms except, and therefore cover, bodily injury and property damages claims when they result from the management or administration of managed health care plans. The two most common allegations associated with such plans are that (1) the administrators of the plan were negligent in including an incompetent professional within its network of medical providers or that (2) the administrators of the plan wrongfully denied (or delayed) treatment that was covered by the plan and that as a result of delay/denial of treatment, bodily injury or property damage resulted.

Other than in cases such as these, the policies preclude coverage for bodily injury and property damage.

Exposures Excluded by Other Types of Professional Liability Policies

In addition to the exclusions already discussed that are particular to fiduciary liability insurance policies, a number of exclusions pertain to exposures also excluded by other types of professional liability policy forms. These are noted in Exhibit 14.1 and discussed further in other courses within this series.

EXHIBIT 14.1
EXCLUSIONS FOUND IN STANDARD PROFESSIONAL LIABILITY POLICIES

- Claims Reported to Prior Insurers
- Claims Covered by Other Insurance
- Prior and Pending Litigation
- Pollution

Chapter 14 Review Questions

1. As the primary administrator for her firm's pension plan, Bea Sting allegedly committed illegal acts. If a claim based on this allegation should be made against Bea, the strict terms of the policy provide that the sponsor's fiduciary liability insurer would:

   a. Defend Bea until dishonest acts are proven by a criminal conviction or an adverse judgment.

   b. Defend Bea until dishonest acts are proven by a criminal conviction or an adverse judgment and then pay any damages awarded on her behalf.

   c. Deny coverage to Bea because the allegation involves dishonesty, which is not covered.

   d. Deny coverage to Bea despite the lack of an applicable exclusion, because the alleged acts are contrary to public policy.

2. Nearly all fiduciary liability policies _____ coverage for most situations where an insured has held a third-party service provider harmless in connection with the operation of a pension or benefit plan.

   a. endorse

   b. exclude

   c. limit

   d. provide

3. Tonka Motors abruptly discharged a number of office employees in order to shave expenses. Mary, one of the discharged employees, had been responsible for collecting benefit plan contributions from the firm's subsidiaries. It took 6 months before anybody noticed that nobody had taken over Mary's responsibilities. If a claim alleges that Tonka Motors was negligent in failing to collect these contributions:

   a. Coverage will be denied, because all fiduciary liability policies have a failure to collect contributions exclusion.

   b. Coverage will be denied because the act of collecting contributions is clearly within the control of the insured.

   c. Coverage will be denied because the failure resulted from negligence rather than an intentional act.

   d. Some insurers' fiduciary liability policies will provide coverage because the failure resulted from unintentional negligence.

4. Some fiduciary liability claims allege a failure to fund a plan in accordance with ERISA law. Many fiduciary liability policies:
   a. Provide both defense and indemnity coverage for these claims.
   b. Provide defense coverage against unproven allegations but exclude coverage for intentional violations.
   c. Provide neither defense nor indemnity coverage for these claims.
   d. Treat these claims the same as other claims unless a court finds payment to be contrary to public policy.
5. Soon after her late husband's unfortunate fall from a cliff, Miley Coyote files a claim against the fiduciaries of his employee benefit plans. The husband's employee handbook states that the company provides accidental death insurance under which an employee's beneficiary is entitled to receive accidental death insurance benefits equal to three times his annual salary. The employer purchased accidental death coverage, but the insurer is now insolvent. Most fiduciary liability policies *preclude* coverage for Miley's claim against the employer's fiduciaries:
   a. Because the fiduciaries lack any contractual relationship with Miley that would support a claim based on a statement in her late husband's employee handbook.
   b. Because the fiduciary liability policy covers only claims made directly against the insolvent insurer.
   c. Unless the claim results from a specific wrongful act such as knowing the insurer was financially unsound.
   d. Unless the fiduciary liability insurer is also a financial guarantor of the insured employer's benefit programs.

Answers to Chapter 14 Review Questions

1. a. An insurer's duty to defend is generally construed as being broader than its duty to indemnify, insurers typically provide defense coverage to allegations of fraud or criminal acts, until such dishonest acts are actually proven by means of a criminal conviction or an adverse judgment.
2. b. Subject to two exceptions, nearly all fiduciary liability policies exclude coverage for situations where an insured has held a third-party service provider harmless in conjunction with the operation of a pension or benefit plan.
3. d. A handful of insurers provide coverage if it is alleged that failure to collect contributions was the result of the insured's negligence, rather than the result of an intentional act.
4. b. Covering the exposure would be against public policy, but defending allegations of violating federal law is not against public policy.
5. c. Most fiduciary liability policies preclude coverage for an insured fiduciary's payment of benefits owed to a claimant unless the claim results from a wrongful act, such as knowing at the time the policy was purchased that the accidental death insurer was financially unsound.

Chapter 15
Fiduciary Liability Policy Coverage Triggers

This chapter will address the essential features of claims-made coverage triggers as they appear within fiduciary liability policies. Virtually all the major insurers' policy forms are written on a claims-made basis.

Operation of Claims-Made Coverage Triggers

To be covered under a claims-made policy, a claim must be:

1. *first made* against an insured during the policy period,
2. result from a wrongful act that took place on or after the policy's *retroactive date*, and
3. be *reported to the insurer*, prior to the expiration of the policy (or within 30 to 60 days following expiration).

The italicized terms will be explained in the pages that follow.

Operation of a claims-made coverage trigger is illustrated in Exhibit 15.1.

EXHIBIT 15.1
HOW A CLAIMS-MADE POLICY FUNCTIONS

Policy Period: 1/1/11–1/1/12
Retro Date: 1/1/10
Wrongful Act: 7/1/10
Claim Made: 7/1/11
Claim Reported: 9/1/11

Retro Date	Wrongful Act	Policy Inception	Claim Made	Claim Reported	Policy Expiration
1/1/10	7/1/10	1/1/11	7/1/11	9/1/11	1/1/12

------x----------x----------x----------x----------x----------x--------

In this example, coverage applies because: (1) the claim was first made against the insured during the 1/1/11–12 policy period, (2) the wrongful act that caused the claim took place after the policy's 1/1/10 retroactive date, and (3) the claim was reported to the insurer prior to policy expiration. Had the wrongful act taken place prior to the policy's 1/1/10 retroactive date, coverage would not have applied. Similarly, there would have been no coverage, had the claim been made against the insured prior to 1/1/11 or after 1/1/12.

The Significance of "First Made" Language

Use of the term "first made" is significant because it indicates that coverage will apply only when the claim has not already been made in conjunction with: (1) a previous policy written by the current insurer or (2) made under a policy written by a different insurer, covering the insured prior to the current insurer.

Claims-Made and Reported Policies

Under a minority of fiduciary policies, coverage applies only if the claim is both first made against the insured and reported to the insurer during the policy period. This is known as a "claims-made and reported" policy. For example, under such a policy with a January 1, 2010–11 term, no coverage would apply unless a claim was both made against the insured during the policy period and also reported to the insurer prior to January 1, 2011.

Claims-Made Policies and Reported Policies with Post-Policy Reporting "Windows"

In contrast, a majority of forms provide what are known as post-policy claim reporting "windows," under which claims made against the insured during the policy period can be reported to the insurer for either 30 or 60 days (depending upon the insurer) after expiration of the policy.

Fiduciary liability forms containing post-policy reporting "windows" are preferable to claims-made and reported policies not containing post-policy reporting windows. This is because some circumstances could render it impossible for an insured to report a claim made late in a policy period. For example, if a summons is delivered to an insured pension trustee's office late in the day that a policy expires, the insured may be unable to notify the insurer within the policy period. This may be especially true if he or she is not in the office that day or if the summons were served late in the day at the start of a long, holiday weekend, as a result of which the insurer's office had closed earlier than usual. Under such circumstances, a claims-made policy that contains a 30- or, preferably for the insured, a 60-day post-policy reporting window is advantageous for the insured compared to a claims-

made and reported policy, because it allows an insured to report a claim to the insurer after the term of coverage has expired.

Retroactive Dates

Retroactive dates in fiduciary liability policies state that for coverage to apply, the wrongful act giving rise to a claim must have taken place on or after the retroactive date. Thus, retroactive dates preclude coverage for claims stemming from acts that took place prior to a policy's retroactive date.

Purposes of Retroactive Dates

Retroactive dates have the effect of excluding coverage for possible wrongful acts committed in conjunction with some known event (i.e., known to the insured) that took place prior to policy inception. They also preclude coverage for wrongful acts that transpired in the distant past—even if unknown to the insured.

Retroactive dates are generally included in fiduciary liability policies for organizations that are buying coverage for the first time. This is because underwriters are reluctant to offer "full prior acts coverage" (i.e., policies without retroactive dates) under such circumstances. Their concern is that the insured's sudden desire to obtain a policy may have been prompted by the need to obtain coverage for circumstances they suspect could produce a claim in the future. For example, if a company began offering a full program of employee benefits on January 1, 2000, but did not seek to buy fiduciary liability coverage until January 1, 2010, an underwriter could have the impression that the company expects a claim to be made against it shortly, since it operated these plans for 10 years without purchasing fiduciary liability coverage.

"Full Prior Acts": Coverage without a Retroactive Date

However, for a firm that already has a fiduciary liability policy in place with another insurer, inclusion of a retroactive date should be resisted unless there is a specific underwriting reason, such as a complete change in the company's pension and benefit programs. By eliminating a retroactive date, a policy will provide what is known as "full prior acts coverage" for all acts, going back to when the company's benefit programs were initiated.

Retro date should be no later than the insured's first fiduciary liability policy inception date. Ideally, an insured will have a policy written with full prior acts coverage. But at the very least, an insured should always require an insurer to offer a policy with a retroactive date that coincides with the date on which it first began buying fiduciary liability coverage (known as "prior acts" coverage), even if that date precedes the date on which its current insurer first began writing coverage. If an insured's retroactive date does not coincide with the date on which it first began buying coverage, a coverage gap will result since there will be no coverage for wrongful acts that took place between the inception date of the insured's first fiduciary liability policy it purchased and the retroactive date of the new insurer's policy.

Always resist retroactive date advancements when replacing coverage. At times, underwriters seek an "advanced" retroactive date when writing coverage for a new account. This has the effect of limiting the coverage they are willing to provide to the start of the period of time this new insurer will be on the account. This approach is detrimental for an insured because it provides no coverage for acts that took place from the inception date of its first policy to the inception date of the new insurer's policy.

Accordingly, insureds under fiduciary liability policies and their agents/brokers should always resist such advancements, even if additional premium is required to achieve "prior acts" coverage. If this is not possible, insureds can still purchase extended reporting periods (ERPs) from their current insurer. (ERPs are discussed later in this chapter.) However, as will be noted, there are a number of disadvantages inherent in ERPs, including the fact that they are costly and usually apply for only one year.

Discovery Provisions

Circumstances often arise under which it is probable that an act, error, or omission will eventually cause a claim to be made against insureds under fiduciary liability policies—despite the fact that litigation may not be initiated for some time. Accordingly, virtually all fiduciary liability policies provide, by means of what are called "discovery provisions" (also known as "incident reporting provisions" or "notice of potential claim provisions"), that if the insured advises the insurer of "incidents" or "potential claims" during the policy, any actual claims arising out of such "incidents" will be considered to have been "made" during that policy period.

Use of a Discovery Provision: An Example

For example, the trustee of a corporation's defined benefit plan reveals in a report that the plan is seriously underfunded and might not be able to continue paying promised benefits in the future. After an announcement of this nature, and even before actual claims have been filed, there is a strong possibility that beneficiaries of the plan will eventually initiate legal action against the insured fiduciaries.

A discovery provision allows the insured to give notice of a potential claim under these and similar circumstances. When such notice is provided to the insurer, coverage for claims arising out of reported incidents will apply regardless of how far in the future actual claims are made. Exhibit 15.2 illustrates the operation of a discovery provision.

EXHIBIT 15.2
HOW A DISCOVERY PROVISION FUNCTIONS

Policy Term: 1/1/10–11

Retro Date	Incident	Insurer Notified	Policy Inception	Claim Made	Policy Termination
1/1/10	7/1/10	8/1/10	1/1/11	7/1/11	1/1/12

------x----------x----------x----------x----------x----------x--------

In this example, coverage applies under the 1/1/10–11 policy term because the insurer was notified by the insured of an "incident" on 8/1/10. Although the claim associated with the incident was not made against the insured until *after* the 1/1/10–11 policy had expired, coverage applies nonetheless because the insurer was notified of the incident under the policy's discovery provision during the 1/1/10–11 policy period.

Catch-22 Aspects of Discovery Provisions: To “Laundry List” or Not

Despite the benefits they convey, discovery provisions are not without drawbacks. On the surface, it would appear to benefit an insured to notify his or her insurer of all possible, potential claims prior to

policy expiration— a practice known as "laundry listing." There are, however, four problems that may result when an insured engages in this practice.

Higher Premiums in Renewal Policies

Although a claim may not yet have been made, an underwriter will be inclined to provide a somewhat higher premium in renewal policies, given the potential claim(s) that the underwriter could be called on to pay in the future. A safety margin of this kind will increase the cost of an insured's renewal policy(ies).

Possible Cancellation/Nonrenewal

Many underwriters believe that "frequency breeds severity." Therefore, if an insured reports numerous incidents, it could indicate recurring problems associated with the insured's professional practice or corporation which might, at some time, eventually produce a catastrophic loss. Accordingly, if, in the underwriter's perception, an insured begins to over-report incidents, the underwriter may question the wisdom of continuing to insure him or her—at any premium—and may be inclined to cancel or refuse to renew upon expiration.

Problems When Changing Insurers

Reporting numerous incidents under discovery provisions makes it more difficult for the insured to secure replacement coverage should he or she decide to change insurers. This is because when an insured discloses circumstances surrounding possible claims to an incumbent insurer, he or she must also reveal these circumstances (on the application form) to an insurer who is providing a quotation for a replacement policy. This has two important implications. First, the replacement insurer will not cover claims that may eventually be made in conjunction with such incidents. Second, if several such circumstances are revealed on the application, the prospective replacement insurer might become wary of the insured and decline to provide coverage.

Possible Admission of Guilt

If an insured reports an incident to an insurer, and the incident eventually gives rise to a claim, evidence of that report will be discoverable by the claimant's attorney during the litigation process. While a report of this kind is not necessarily an admission of an insured's culpability, it nevertheless provides evidence that the professional/executive was concerned about either the level of competence with which his or her services were performed or about the outcome produced by the performance of those services. Either way, evidence of the report—regardless of whether the insured's conduct was not negligent and/or entirely justified under the circumstances—will make it more difficult to defend the insured against a claim.

It is, however, always a good approach for insureds to report all relevant information concerning an incident, especially any details that would absolve, or at least mitigate the professional's potential liability.

When "Laundry Listing" Is Advantageous for the Insured

A certain degree of selectivity is required when notifying an insurer of potential claims under a policy's discovery provision. There is, however, one situation in which it is clearly advantageous to report every possible incident as a potential claim. This happens when an insurer will no longer be writing a specific line of coverage and therefore nonrenews or cancels all policies (of a certain coverage line, or in a specific territory, for example).

In this case, an insured may consider reporting more possible circumstances under a policy's discovery provision than he or she ordinarily would be inclined if the policy were being renewed. By laundry listing these circumstances, the insured would not be faced with higher renewal premiums or possible cancellation/nonrenewal by the incumbent insurer. Also important is the fact that a replacement insurer would tend to be more understanding of an insured who "laundry lists" under these conditions, recognizing that the measure is more justifiable because there is no guarantee that the insured will be able to secure a replacement policy.

When "Laundry Lists" Are Rejected

On the other hand, "laundry lists" are often rejected by insurers. This is especially true if, as already noted, an insured merely compiles a list of all clients, cases, or projects conducted within the past several years, without providing specific details about the acts that could result in potential liability associated with services rendered. Therefore, under most circumstances, an insured should only supply information about circumstances that he or she believes—on a "good-faith" basis—have the potential for producing a claim.

Extended Reporting Provisions

Extended reporting periods (ERPs), which are also known as extended discovery or "tail" provisions and are included in all fiduciary liability policies, give an insured the right to present claims after a policy has expired or been canceled. Exhibit 15.3 illustrates how an ERP provision functions.

EXHIBIT 15.3
HOW AN EXTENDED REPORTING PERIOD FUNCTIONS

Insurer A's Policy Term: 1/1/11–12

Insured buys an ERP from Insurer A with an ERP term of 1/1/12–13

Wrongful Act: 7/1/11

Claim Made and Reported: 7/1/12

	Wrongful Act		**Claim Made and Reported**	
1/1/11	**7/1/11**	**1/1/12**	**7/1/12**	**1/1/13**

------x----------x----------x----------x----------x----------

Coverage applies under the ERP because the wrongful act took place during Insurer A's 1/1/11–12 policy term and a claim associated with the act was made and reported during the term of Insurer A's 1/1/12–13 ERP. One final, key point regarding ERPs: no coverage would have applied in this example if both the wrongful act took place and the claim were reported during the 1/1/12–13 ERP period. Rather, the wrongful act must take place during the expired/canceled policy period for coverage to apply during the ERP.

ERPs Do Not Reinstate Remaining Policy Limits

ERPs do not, however, increase or reinstate the policy's limit of liability. Thus, coverage during an extended reporting period is always subject to available remaining limits under the original policy. In some instances, especially where one or more significant claims are pending under an expiring policy, insurers will, at times, make additional limits available under an ERP provision. However,

reinstatement of this type will almost always require substantial additional premium, over and above the scale provided for in the policy, and as discussed below.

No Coverage for Wrongful Acts during the ERP

Nor do ERPs cover claims from wrongful acts that took place during the ERP. In effect, they only extend the time period during which wrongful acts that took place during the expired (or in some instances, canceled) policy can be reported to the insurer. Thus, for coverage to apply under an ERP, the alleged wrongful act giving rise to the claim must have taken place on or after the retroactive date, if any, of the policy and before the policy's termination date. ERPs do not afford coverage for an act that took place during the extended reporting period itself, in spite of the fact that such a claim is reported during the ERP.

Discovery Provisions versus ERPs

Although these two provisions are often confused, the difference is actually straightforward. Discovery provisions allow insureds to obtain coverage for incidents or potential claims that are reported during the policy period. In contrast, ERPs provide coverage for claims that are reported after a policy period has expired.

Key Variations between ERP Provisions

There are several important variations between the key provisions associated with ERPs as they are written by the different fiduciary liability insurers. These differences are described in the following paragraphs.

Availability

The vast majority of fiduciary liability forms permit the insured to purchase an ERP if cancellation/nonrenewal is at the insured's or the insurer's election. This is known as a two-way or bilateral tail. A few provide this option only in the event that cancellation/nonrenewal is initiated by the insurer, termed a one-way tail. Clearly, fiduciary liability policy forms that contain bilateral ERPs are preferable to those offering only a one-way tail provision. The latter should be vigorously resisted when negotiating coverage with an insurer.

Coverage for "Notice of Circumstances" or "Incidents" during the ERP

A key variation between the ERPs in fiduciary liability forms is whether a report of circumstances that have the potential—but have not yet resulted in a formal claim against the insured—are covered by an ERP. In effect, under some insurers' ERP wording, the policy's discovery provision (discussed earlier in this chapter) is operative, whereas in others, it is not.

To illustrate: A fiduciary liability policy expires on January 1, 2010, at which time the insured firm buys a 1-year ERP. On August 1, 2010, the insured firm becomes aware of circumstances (from a wrongful act that took place during the expired policy) that could potentially materialize into a formal claim but have not yet. Under some insurers' policies, the report of such circumstances would trigger coverage. However, under other insurers' ERP wording, no coverage would apply until the insured has a formal claim made against it, even if these circumstances are reported to the insurer during the ERP.

Given the above scenario, the insured would be compelled to purchase (if available) another ERP at the expiration of the current ERP, if the potential claim had not yet been made against the firm but was expected at some point. In this situation, the advantage of having a policy's discovery provision that is operative during the ERP provision is apparent.

Duration

In most instances, fiduciary liability insurers offer ERPs of 1 year in duration, although in a few cases, ERPs of longer duration are offered, as well. Multiple duration options (e.g. 1 year, 2 years, and 3 years) are occasionally available under fiduciary liability policies written for privately-held and not-for-profit organizations. However, publicly-traded companies are rarely offered anything other than a 1-year option.

Premium Charge

In nearly all instances, the policies state the premium charge for the ERP option. This is typically done by indicating that the ERP will cost a fixed percentage of the expiring policy's premium; normally 100 to 150 percent, depending upon the individual policy, for a 1-year ERP.

Time in Which To Elect

The policies allow the insured up to 30 days following nonrenewal, expiration, or cancellation to purchase the ERP. A few allow as long as 60 days in which to make this election, which is, of course, preferable since it is beneficial to maximize the time period in which the insured can make this election.

Runoff Policies

As an alternative to an ERP, there are certain circumstances under which insureds should consider purchasing a runoff policy.

Runoff Policies versus ERPs

Like ERPs, runoff policies also permit an insured to report claims (that resulted from wrongful acts taking place during prior policy periods) for a specified period of time in the future. In contrast, the use of runoff policies is typically restricted to situations in which an insured merges with or is acquired by another organization, rather than when the insured replaces coverage with another insurer, as is usually the case when an ERP is purchased. Like ERPs, runoff policies are usually offered on a 1-year basis. However, unlike ERPs, they are generally offered on a renewable basis.

Why Are Claims-Made Coverage Triggers Used for Fiduciary Policies?

The key reason underwriters use claims-made triggers to write fiduciary liability policies (rather than occurrence triggers) is that claims-made policies make it easier to predict their ultimate liability on any given set of fiduciary liability policies they may write, which assists them in setting more accurate rates for succeeding policies.

More Accurate Prediction of Ultimate Claim Liabilities

Normally, there is a fairly long time lag between the commission of a wrongful act by a fiduciary and the making of a claim. As a result, if underwriters wrote an entire book of fiduciary liability business using occurrence triggers, at the expiration of an occurrence policy term, the underwriter could still expect a number of claims to be made. For example, under a book of business written with a January 1, 2010–11 term, on an occurrence basis, any claim that occurred within this time frame could still be made against the insured 5, or even 10 years later, and would thus be covered by the policy. This time lag makes it difficult to set rates for succeeding policies, since the underwriter still doesn't know his/her actual dollar claim exposure on the just-expired policies.

Rate Setting under Occurrence versus Claims-Made Policies

In contrast, under a book of fiduciary liability business written with claims-made coverage triggers, virtually all claims under such policies will have already been made on the date of expiration (or, no later than 60 days after this date, if the policies contained 60-day post-policy reporting windows). Accordingly, the underwriter is better able to assess his/her actual liability for ultimate claims payments under such policies than if they were written on an occurrence basis. This fact makes it much easier to set accurate premium rates for succeeding fiduciary liability policies.

Chapter 15 Review Questions

1. Chuck Little made a fiduciary liability claim against Blue Sky Company's benefit plan administrators last year when Blue Sky was insured by Egg Insurance Company. Upon hearing that Blue Sky never reported the claim to its insurer before it changed insurers and is now insured by Chicken Insurance Company, he files another claim with the same allegations, which Blue Sky promptly reports to Chicken Insurance Company. Because both policies have claims-first-made language in their policy triggers, Chuck's claims trigger coverage under:

   a. Egg Insurance Company's policy.

   b. Chicken Insurance Company's policy.

   c. Both Egg Insurance Company and Chicken Insurance Company policies.

   d. Neither Egg Insurance Company nor Chicken Insurance Company policies.

2. Mirror Company's fiduciary liability policy has a January 1, 2009, retroactive date. Assuming all other conditions are met, coverage applies under the policy for claims resulting from wrongful acts that take place:

   a. After the policy expires on January 1, 2009.

   b. Before January 1, 2009.

   c. Before the policy expires on January 1, 2009.

   d. On or after January 1, 2009.

3. When investigators broke the news that Daniel had made off with millions of dollars invested in his Ponzi scheme, trustees of the Gopher-Broke defined benefit plan revealed that plan funds had been heavily invested in Daniel's worthless scheme and the plan might now be unable to pay promised benefits. Trustees predict that plan beneficiaries will bring actions against them for years to come and regret having made such bad investment decisions. If the trustees utilize their fiduciary liability policy's discovery provision and report this incident to the insurer during the current policy period,
   a. Any resulting claims will be treated as though they were made before the retroactive date expires.
   b. Any resulting claims will be treated as though they are made during the current policy period.
   c. The trustees enable the insurer to allocate policy limits among the resulting claims.
   d. The trustees preserve their rights to renew the policy despite this incident.
4. Wyatt's fiduciary liability policy has a policy term of July 1, 2011 – July 1, 2012 and an ERP term of July 1, 2012 – July 1, 2013. A wrongful act took place on October 1, 2012, and a claim was made and reported to the insurer on February 1, 2013. In this situation:
   a. Coverage applies because the event occurred and the claim was made during Wyatt's ERP.
   b. Coverage applies because the event occurred and the claim was made during Wyatt's policy period.
   c. Coverage does not apply because the event occurred after the policy period.
   d. Coverage does not apply because the claim was made after the policy period.

Answers to Chapter 15 Review Questions

1. d. Coverage applies under neither policy. No coverage applies under the Egg Insurance Company policy, because the claim was never reported to the insurer. No coverage applies under the Chicken Insurance Company policy because the wrongful act giving rise to the claim took place during the Egg Insurance Company's policy term. But despite having knowledge of the claim, the insured never reported it to Egg Insurance Company. Therefore, the Chicken Insurance Company would be able to deny coverage for late reporting of a claim about which the insured had prior knowledge.
2. d. for coverage to apply, the wrongful act giving rise to a claim must have taken place on or after the retroactive date.
3. b. If the insured advises the insurer of "incidents" or "potential claims" during the policy period, any actual claims arising out of such "incidents" will be considered to have been made during that policy period.
4. c. No coverage applies if both the wrongful act takes place and the claim is reported during the ERP period; rather, the wrongful act must take place during the expired/canceled policy period for coverage to apply during the ERP.