FIDUCIARY LIABILITY: WHAT YOU NEED TO KNOW ABOUT EXPOSURES AND INSURANCE

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Fiduciary Liability: What You Need to Know About Exposures and Insurance
Contents

Introduction

This 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) 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 1 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 2 enumerates the types of benefit plans to which ERISA applies. It also describes the plans that are exempt from ERISA regulations.
- Chapter 3 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 4 explores the key factors that insurers use to price and underwrite fiduciary liability coverage. The factors discussed include funding adequacy, nature of the plans covered, single versus multiemployer plans, and the profiles of covered fiduciaries.
- Chapter 5 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 6 explains how to coordinate fiduciary liability policies with other related coverages, including employee benefits liability endorsements to commercial general liability (CGL) policies. It also discusses the advantages and disadvantages of including fiduciary liability coverage within so-called management liability package policy forms.
- Chapter 7, 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," as well as the key coverage extensions available within fiduciary liability policies. This chapter also examines the covered persons and covered organizations provisions of the policy.
- Chapter 8 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 9 explains how fiduciary liability policies define and apply several key terms, including covered losses, claim, policy territory, defense costs, and claim settlement procedures.
- Chapter 10 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 11 describes the important policy conditions found within fiduciary liability forms, in particular, subrogation/recourse and severability.
- Chapter 12 looks at the key exclusions found within fiduciary liability policies, discusses the rationale for each, and addresses the subtle but critical variations within the same exclusion contained in the different insurers' policies.
- Chapter 13 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, and extended reporting and runoff periods are treated at length.

A glossary following Chapter 13 defines the key terms and phrases and the acronyms used in this course. Check the glossary if you are unsure of the meaning of a term or if you have forgotten what an acronym stands for.

Course Objectives

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

- identify the specific fiduciary duties enumerated within ERISA, recognize how the law defines "fiduciary," and identify the standards of care required of fiduciaries;
- recognize the significance of "prohibited transactions" and identify measures fiduciaries can use to avoid them;
- identify the types of plans that are both included within and exempted from ERISA regulations;
- identify the most common fiduciary liability exposures resulting from the three major types of employee benefit plans;
- recognize the key factors insurers use to underwrite and price fiduciary liability coverage;
- identify the various methods of preventing claims against fiduciaries;
- recognize the ways in which fiduciary liability policies can be (1) coordinated with employee benefits liability policies and (2) incorporated within executive liability package policies;
- identify the two major insuring agreements found within fiduciary liability policy forms, and recognize key coverage extensions that are often available;
- recognize the effect of the covered persons and covered organizations provisions;
- recognize how coverage under the policies applies to various types of organizational "status changes";
- recognize how various coverage terms are defined within the policies, including covered losses, claim, policy territory, defense costs, and claims settlement procedures;
- recognize the operation and effect of the policy's limits and deductibles/retentions provisions, especially within the context of legal actions involving multiple claimants;
- identify the purpose and function of the following key fiduciary liability policy conditions: subrogation/recourse, and severability;

- identify the exclusions found within the policies, recognize the variations within these exclusions as offered by various insurers, and identify the rationale underlying these exclusions; and
- identify the components of a fiduciary liability's claims-made provisions and recognize how these components apply in claim situations.

Chapter 1
Fiduciaries and Their Duties under ERISA

Overview

Chapter 1 examines the specific duties enumerated by the Employee Retirement Income Security Act (ERISA) of 1974, to which fiduciaries must adhere.

Chapter Objectives

On completion of this chapter, you should be able to

- recognize the purpose and the basic functions of the Employee Retirement Income Security Act (ERISA),
- recognize parties that qualify as fiduciaries according to the ERISA definition,
- identify the standards of care required of ERISA fiduciaries,
- recognize factors affecting a fiduciary's liability,
- recognize ERISA's specific bonding requirements that apply to fiduciaries, and
- distinguish between fiduciary and settlor functions.

Origins of ERISA

The impetus for passage of ERISA was the closure of Studebaker-Packard Corporation's South Bend, Indiana, manufacturing plant in December 1963, due to financial difficulties. At the time of its closure, the company's pension plan was grossly underfunded, and rather than paying out only partial benefits during an extended period of time, Studebaker's workers were paid lump sum payments representing only a fraction of the pension benefits they had earned during their tenures with the company. Thousands more workers received no lump sum payments at all. Studebaker's misfortunes highlighted the need for legislation aimed at safeguarding and protecting pensions and benefits earned by and owed to workers.

The collapse of the Studebaker pension plan focused legislative attention of the issue of securing pension and benefit programs. In response, a number of bills were introduced in the United States Congress to accomplish this goal. However, opposition to such legislation by both business and labor groups (each of which sought the flexibility in benefit program design and administration afforded during the pre-ERISA era) caused these legislative initiatives to stall for more than a decade. Eventually, the Employee Retirement Income Security Act of 1974 was passed. ERISA established standards for private sector pension, health, and other employee benefit plans and increased protections for plan participants and their families.[1]

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

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. Yet, even before passage of ERISA, employers owed employees a common law duty to avoid clear errors and omissions (the commission of which subjected them to liability for damages resulting from their negligence) in managing employee benefit plans. For example, even without ERISA, employers were required to enroll employees in benefit programs for which they were eligible, make changes in beneficiary designations as requested by beneficiaries of such programs, and issue payments of benefits due to employees as specified by the programs. So even before ERISA's passage, employers could be held liable for errors and omissions they committed in conjunction with employee benefit plan administration. ERISA simply formalized these duties.

In addition, the law heightened the standards of conduct to which persons responsible for managing such programs would be held and made fiduciaries *personally* liable when their failure to comply with the law's requirements harmed the beneficiaries of employee benefit plans.

Purpose of ERISA

ERISA does not require employers to establish or create benefit or pension plans for their 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 (which, for example, include but are not limited to 401(k) plans) must operate once they have been put into place. Thus, 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 ensure that those entitled to pensions and benefits are able to collect them.

Fiduciaries as Defined by ERISA

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. As detailed by 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 fiduciary's negligence caused the losses. 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 1.1.

Exhibit 1.1
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 to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan 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 are 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. (Note: an example of a leading "stock drop" claim involved Enron Corporation, when during the early 2000s the value of Enron stock dropped massively, in response to the disclosure of problems that preceded the company's bankruptcy.) 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, chief operating officer, and chief financial officer, 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 US 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 1.2.

Exhibit 1.2
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 cofiduciary (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, a variety of specialized expertise is 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 assortment of entities commonly providing such expertise is enumerated in Exhibit 1.3.

Exhibit 1.3 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.
Certified Public Accountant (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 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.

Nevertheless, if a fiduciary is sued for the negligent acts of an incompetent outside service provider and raises the Investment Company Act as a defense, the fiduciary will still be required to pay defense costs associated with lawsuits of this kind. Accordingly, fiduciary liability insurance policies (which are addressed beginning in Chapter 7 of this course) explicitly cover such defense costs. Although as will also be explained in Chapter 10, the expenditure of such costs reduces policy limits, a factor that heightens the importance of selecting competent outside service providers.

"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 1.3 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 Involving Benefit Plans

ERISA specifies two kinds of prohibited transactions.

- **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**. Otherwise legitimate transactions 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 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 million.

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. Nor can compliance be achieved by purchasing fiduciary liability insurance, which cannot be used to satisfy these bonding requirements.

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** results from nondiscretionary, administrative errors associated with 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). Importantly, liability for these types of errors and omissions is not based upon, specified within, or created by ERISA. Rather, such liability is a function of common law and existed prior to the passage of ERISA in 1974. As will be discussed shortly, in addition to covering the liabilities set forth within ERISA, fiduciary liability insurance policies also cover employee benefits liability exposures. Furthermore, within commercial general liability (CGL) policy forms, endorsements are available that cover employee benefits liability exposures (although such endorsements *do not* cover fiduciary liability exposures.)
- **ERISA bonding requirements** apply to fidelity/dishonesty in handling pension and benefit plan funds and are designed to protect against a fiduciary's illegal appropriation of those 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 1.4 illustrates the three types of claim situations that would be covered under these different policies.

Exhibit 1.4
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.	Fiduciary liability policy or employee benefits liability endorsement to a CGL policy
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. For instance, a 401(k) plan that offered mutual funds invested in US stocks, international stocks, and bonds would likely satisfy this minimum diversification requirement.
- Each core investment alternative is sufficiently diversified. For example, if a core investment alternative was a mutual fund that invested in bonds, the fund would need to invest in a variety of bonds with various maturities.
- 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, selecting funds with excessive fees, 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 alleging termination and other similar adverse employment decisions that threaten the accrual of additional benefits despite considerable, continuous years of employment (e.g., terminating an employee, without cause, a month 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.

But Employers Can Change the Terms of Benefit Plans to Some Extent

However, it should be recognized that while ERISA prohibits employers from taking adverse actions against employees exclusively to avoid paying them benefits, employers do have the right to reduce or

eliminate nonvested benefits by changing the terms of a plan in a way that does not discriminate against any subgroup. In enacting ERISA, it was Congress's intent to prohibit discrimination in administering a welfare benefit plan but still allow employers to change the terms of those plans as the need to do so arises.

Fiduciaries versus Settlors: A Distinction with a Difference

Fiduciaries and the nature of their responsibilities are one of the key areas addressed by ERISA. In addition, a number of related—but different—functions, which are also associated with employee benefits plans, are carried out by what are known as settlors. Unlike it does with fiduciaries, ERISA imposes no responsibilities, obligations, or duties on settlors. Nevertheless, it is important to examine the nature of the term "settlor," to explain their functions, and to distinguish between settlors and fiduciaries.

Origin of the Term "Settlor"

The term "settlor" was derived from the law of trusts. A settlor is one who operates on a purely discretionary basis. In contrast, a fiduciary functions according to a set of predetermined rules and guidelines.

An Example

A rich uncle who establishes a trust for his niece (which will pay her $1,000 per month for 25 years) is acting in a settlor capacity. Because the uncle does not legally owe his niece anything, the act of setting up the trust is a purely discretionary act.

On the other hand, if the uncle contracts with a banker to carry out the terms of the trust (i.e., send the niece a check for $1,000 a month for 25 years), the banker will be acting in a fiduciary capacity. This is because the banker will not have the discretion to alter the terms of the trust that the uncle has established. Rather, the banker must act strictly within the guidelines of the trust arrangement that were set forth by the uncle and is therefore a fiduciary.

Settlors, Fiduciaries, and Employee Benefit Plans

Using the analogy of a trust, an employer that (1) establishes a benefit plan (governed by ERISA) or (2) changes the amount of the benefits payable by the plan is acting like the uncle (above) who set up a discretionary trust and is therefore considered a settlor when it performs either of these functions. Because the employer is not required to offer a benefits program to his or her employees, whether or not the employer decides to offer such a plan is a business decision that lies within the employer's discretion, just like the benefactor setting up the discretionary trust for his niece. However, once the plan is established, the employer has a fiduciary duty to carry out the benefit plan according to the terms set forth in the documents that govern that plan.

An Example

Assume a company establishes a pension plan that included a specific formula (based on its employees' age, years of service with the organization, and earnings during the employees' last 5 years) for determining the monthly benefit amount payable. According to that formula, the company owed a retired employee $2,000 per month for the rest of his or her life. If the company fails to pay the $2,000 amount to the employee each month, it has breached its duty as a fiduciary.

On the other hand, assume a company establishes a 401(k) savings plan under which the company matches 50 percent of the employees' contributions to the plan, up to 6 percent of their annual salary. If the company suffers financial reversals and as a result decides to discontinue the company's matching contribution, this decision would be the act of a settlor.

Nevertheless, in this situation, a plaintiff could still argue that discontinuing the company match constituted a breach of fiduciary duty rather than the act of a settlor. This is because one could still assert that the fiduciaries should have done a better job of assessing its financial strength, prior to setting up a 401(k) plan that committed the organization to a company match, even if that commitment was legally revocable as the act of a settlor.

Employee Benefits Plan Administration Requires Both Settlor and Fiduciary Acts

The essential, albeit confusing, point is that just because an employer is a fiduciary with respect to an employee benefits plan does not mean that all employer acts in conjunction with that plan are subject to a fiduciary duty. Importantly, when acting as a settlor (i.e., making a decision to offer a pension plan, in the above example), the employer has no fiduciary obligations. Yet, when the employer is making periodic pension plan payments to employee-beneficiaries under the written terms of the pension plan, the employer is acting as a fiduciary. Thus, when an employer acts in conjunction with an employee benefit plan, some of the employer's acts will be those of a fiduciary (i.e., making required, periodic payments), whereas other acts (i.e., making the decision to establish a pension plan) will be those of a settlor.

Every fiduciary liability policy form covers insureds for liability they incur when they act as a fiduciary. However, some, but by no means all, such policies cover insureds for the liability they incur when they act as a settlor. In Chapter 7, coverage for settlor functions is discussed in detail.

Chapter 1 Review Questions

1. If she is unclear as to how the Employee Retirement Income Security Act (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.

    B. Government Accountability Office.

    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 the Employee Retirement Income Security Act, losses caused by Alice's negligence can be recuperated

    A. by confiscating Alice's personal assets as well as Tractor Corporation'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 Advisers, which assists Mollie and other fiduciaries in establishing investment guidelines.

    B. Dr. Stork, an obstetrician belonging to the health maintenance organization 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 the Employee Retirement Income Security Act (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 million maximum.

5. Samsen 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 Samsen's policies or bonds applies to claims based on the imprudent investment decisions of its fiduciary?

    A. Employee benefits liability (EBL) policy

    B. Employee Retirement Income Security Act Compliance Bond

    C. Fiduciary liability insurance

    D. Workers compensation and employers liability policy

Answers to Chapter 1 Review Questions

1.

A. This answer is incorrect. The Department of Labor shares regulatory ERISA interpretation and enforcement responsibility with two other federal organizations.

B. That's correct! 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.

C. This answer is incorrect. The IRS is one of the three federal organizations responsible for the interpretation and enforcement of ERISA.

D. This answer is incorrect. The PBGC shares in the responsibility for interpreting and enforcing ERISA.

2.

A. That's correct! Since Alice is a fiduciary, her personal assets, in addition to Tractor Corporation's assets, could be seized to cover the loss.

B. This answer is incorrect. The PBGC will not assume responsibility for Alice's personal negligence.

C. This answer is incorrect. In this situation, corporate assets are not the only source of recovery.

D. This answer is incorrect. Although Alice's personal assets could be seized, they are not the only source of recovery in this scenario.

3.

A. This answer is incorrect. A fiduciary can be held liable for the acts, errors, and omissions of an outside investment adviser.

B. That's correct! Dr. Stork's services are not of a fiduciary nature, so he is not considered a cofiduciary.

C. This answer is incorrect. A fiduciary can be held liable for the acts, errors, and admissions of a bank trust department.

D. This answer is incorrect. As a fiduciary, Mollie can be held liable for the acts of a law firm that reviews and analyzes plan documents in order to render an opinion on their Employee Retirement Income Security Act compliance.

4.

A. This answer is incorrect. ERISA requires fiduciaries to be bonded for 10 percent of the aggregate amount handled, subject to a minimum and maximum.

B. This answer is incorrect. ERISA requires that fiduciaries be bonded with a minimum bond of $1,000.

C. That's correct! ERISA has no deductible requirement.

D. This answer is incorrect. Even for large plans, ERISA does not require that fiduciaries be bonded for more than $1 million.

5.

A. This answer is incorrect. EBL insurance would respond to claims based on an administrative error such as failing to enroll an employee in a pension plan.

B. This answer is incorrect. The bond would apply if a fiduciary stole pension funds.

C. That's correct! A fiduciary liability policy applies to claims resulting from a fiduciary's imprudent investment decisions that cause a pension fund to become insolvent.

D. This answer is incorrect. Workers compensation applies to work-related injuries, which are not involved in this scenario unless fellow workers attack Samsen when they find out what happened to their pension funds.

Chapter 2
Types of Plans Covered and Exempted by ERISA

Overview

Chapter 2 analyzes the two major types of plans to which the Employee Retirement Income Security Act (ERISA) of 1974 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.

Chapter Objectives

On completion of this chapter, you should be able to

- distinguish between employee benefit pension plans and employee welfare benefit plans,
- identify the basic requirements of ERISA plans, and
- recognize the effects of Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Types of Covered Benefit Plans

ERISA covers two types of employee benefit plans: (1) employee pension benefit plans and (2) employee welfare benefit plans. There are also plans not subject to ERISA.

Employee Pension Benefit Plans

These are plans created by an employer, a union, or both and that provide for retirement income or the deferral of income (e.g., 401(k) plans and "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.

ERISA established the Pension Benefit Guaranty Corporation (PBGC) 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 chapter.

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.

Plans Not Subject to ERISA

In contrast to employee pension benefit plans and employee welfare benefit plans, other types of programs are exempt from the law. Exhibit 2.1 enumerates both types.

Exhibit 2.1
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 2.2.

Exhibit 2.2
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, Illinois, 2001.

Two Key Amendments to ERISA

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

Continuation of Health Coverage (COBRA)

COBRA gives workers and their families who lose their health benefits the right to choose to continue group health benefits. 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 to purchase a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

Such coverage is continued for a limited period of time (i.e., 18 months) under certain "qualifying events" such as voluntary or involuntary job loss, reduction in the number of hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals—rather than the employer—are required to pay the entire premium for coverage, plus up to a 2 percent administrative charge.

On the other hand, COBRA does not apply if employees lose their benefits coverage because the employer has terminated the plan altogether or if the employer has gone out of business.

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

Portability of Health Coverage (HIPAA)

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 Healthcare 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 Healthcare Plans

As noted above, ERISA governs plans providing healthcare benefits. However, in claims involving administration of an ERISA-qualified healthcare benefit plan, ERISA contains a provision that preempts—meaning that it has a higher priority than—similar state laws, even if those state laws took effect after ERISA.

As a result of the ERISA preemption provision, the Act bars jury trials (ERISA cases are tried before judges) and punitive damage awards. Furthermore, damages are limited to actual medical expenses incurred (i.e., damages for pain and suffering are not permitted).

Also important is the fact that fiduciary liability policies do not generally cover claims associated with employer-provided medical plans, because fiduciary liability policy forms routinely contain exclusions for bodily injury.

The Managed Care Exception Coverage

Nevertheless, the vast majority of insurers provide coverage for claims involving ERISA-qualified healthcare plans by adding an exception to this exclusion for coverage of bodily injury claims associated with employer-provided health insurance coverage. Most insurers incorporate this exception by including a coverage extension within their policies that "excepts"—and therefore covers—bodily injury, sickness, mental or emotional distress, disease, or death when such events result from the administration of managed healthcare 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 healthcare plan, alleging

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

Absent managed care coverage wording 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 7 of this course.

Chapter 2 Review Questions

1. Why was the Pension Benefit Guaranty Corporation (PBGC) established?
    A. As an alternative to the Employee Retirement Income Security Act (ERISA) for smaller pension plans
    B. To administer ERISA.
    C. To provide coverage when a defined contribution pension plan does not have enough money to provide the benefits participants have expected
    D. To provide coverage when a terminated defined benefit pension plan does not have enough money to provide the benefits participants have earned
2. Among other employee benefits, Smart Company makes available to employees a tuition reimbursement plan, also known as a scholarship fund. Under the Employee Retirement Income Security Act (ERISA), this benefit is considered an
    A. employee pension benefit plan.
    B. employee welfare benefit plan.
    C. exempt benefit.
    D. expendable benefit.
3. Sheppard Company provides benefits to its employees under all the following plans. Which one is not subject to ERISA?
    A. An employee stock ownership plan
    B. Disability income insurance
    C. Group life insurance
    D. Unemployment compensation
4. Because the Partridge-Pear Tree Corporation's profit-sharing plan is subject to the Employee Retirement Income Security Act (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.
5. 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 the Employee Retirement Income Security Act's (ERISA's) vesting requirements.
    B. invoke the Health Insurance Portability and Accountability Act's (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 2 Review Questions

1.

A. This answer is incorrect. The PBGC was established by ERISA.

B. This answer is incorrect. The PBGC provides coverage in certain situations.

C. This answer is incorrect. The PBGC applies to defined benefit plans.

D. That's correct! ERISA established the PBGC 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.

2.

A. This answer is incorrect. Paying educational expenses for working employees has nothing to do with retirement benefits.

B. That's correct! An employer or union creates an employee welfare benefit plan to provide a variety of benefits, including scholarship funds.

C. This answer is incorrect. "Exempt" refers to the status of an employee, not the status of a benefit.

D. This answer is incorrect. The benefit might be something Smart could do without, but ERISA does not have an "expendable benefits" category.

3.

A. This answer is incorrect. An ESOP plan is subject to ERISA.

B. This answer is incorrect. A disability income insurance plan for employees is subject to ERISA.

C. This answer is incorrect. An employee group life insurance plan is subject to ERISA.

D. That's correct! Unemployment compensation benefits are not subject to ERISA; other, more specific laws govern this benefit.

4.

A. This answer is incorrect. Plans subject to ERISA must describe responsible parties for the plan's operation, administration, and fiduciary duties.

B. That's correct! The purpose of a profit-sharing plan is to share profits, not to hoard them.

C. This answer is incorrect. Plans subject to ERISA must be maintained pursuant to a written instrument.

D. This answer is incorrect. Plans subject to ERISA must provide a procedure for establishing and fulfilling a funding policy.

5.

A. This answer is incorrect. ERISA does not mandate the vesting of retiree healthcare benefits in the manner that it requires employees to become vested in pension plans.

B. This answer is incorrect. HIPAA deals with other matters.

C. That's correct! 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.

D. This answer is incorrect. The plan documents should be readily available to plan participants, but having or obtaining the documents does not ensure that the employer will honor its promises.

Chapter 3
Liability Exposures Associated with Employee Pension Benefit Plans

Overview

As noted in the previous chapters, the Employee Retirement Income Security Act (ERISA) of 1974 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 3 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.

Chapter Objectives

On completion of this chapter, you should be able to

- distinguish among defined benefit, defined contribution, and cash-balance pension plans;
- identify the key provisions of the Pension Protection Act of 2006; and
- recognize pension benefit-related situations that increase the probability of a fiduciary liability claim and select appropriate measures for mitigating the exposure.

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 or 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 individual ownership interest. The most common type of defined contribution plan is a 401(k) plan. Under such plans, employees contribute a percentage of their annual salary each year to a savings plan, up to a specified annual dollar limit (i.e., $18,000 in 2017, with a $24,000 limit for employees 50 years of age or older). The employer will usually match one-half of the employee's contribution, most often up to 6 percent. For example, if an employee contributes 6 percent of his or 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 his or her annual salary (i.e., 6 percent contribution, plus 3 percent employer match). According to a report by the American Benefits Council (*401(k) fast facts*), as of June 2013, there were 638,390 defined contribution plans, with 73,668,000 participants, holding $3.8 trillion in assets.

- **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 employers within the private sector. According to "Worker Participation in Employer-Sponsored Pensions: A Fact Sheet," by John J. Topoleski (March 26, 2014), only 19 percent of the private-sector workforce has access to a defined benefit pension plan, whereas 59 percent of the public-sector workforce has such access. Moreover, 83percent of all state and local government workers have access to a defined benefit pension plan and 32 percent of such workers have a defined contribution plan available.

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

To ensure 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) preserve pension plans and protect pensioners, (2) pay pension benefits on time and accurately, and (3) maintain high standards of stewardship and accountability.

The PBGC guarantees payment of the basic pension benefits earned by more than 40 million American workers and retirees in nearly 24,000 plans. Subject to other statutory limitations, PBGC's insurance program pays pension benefits up to the maximum guaranteed benefit set by law to participants who retire at 65 ($60,136 per year, as of 2016). Since 1974, PBGC has provided for almost 1.5 million people in nearly 4,800 failed single-employer and multiemployer plans. In fiscal year 2015, the PBGC made benefit payments of $5.7 billion to nearly 826,000 retirees from more than 4,700 failed single-employer pension plans. (Source: PBGC, 2015 Annual Report http://pbgc.gov/Documents/2015-annual-report.pdf#page=6.)

Two programs make up the PBGC, one for single-employer pension plans and another for multiemployer pension plans. (Multiemployer plans are set up by collectively bargained agreements involving more than one unrelated employer, generally in one industry.)

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
- Investment income

Exposures from Defined Benefit Pension Plans

Defined benefit pension plans generate several fiduciary liability exposures. These exposures are noted in Exhibit 3.1.

Exhibit 3.1 Liability Exposures from Defined Benefit Pension Plans
(1) Lack of 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
(8) Claims from fraudulent schemes

Lack of 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 on 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 pay 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 to 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

A number of large employers have restructured their defined benefit pension plans to cash balance plans, which has produced 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, it promises that an employer will contribute to the plan 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 payout (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 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 the following.

- 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 nonmanagerial 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.

A Notable Claim Involving Conversion to a Cash Balance Plan

One significant claim involving conversion of a defined benefit pension plan to a cash balance plan was brought against IBM in December 1999 by a group of employee beneficiaries of IBM's pension plans. The employees contended that various changes IBM made to these plans violated ERISA's antidiscrimination provisions, particularly with respect to older workers. This is because cash balance plans build value more quickly in the early years of a worker's tenure with a company than do defined

benefit plans. In contrast, during the latter years of an individual's tenure with an organization, the value of a defined benefit plan grows more rapidly. Thus, older workers with longer tenures can make the argument that conversions from defined benefit plans to cash balance plans discriminate against them. Ultimately, however, US Court of Appeals for the Second Circuit ruled that IBM's conversion of its defined benefit pension plan did not discriminate against such workers.

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 large 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 those 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 total value of the pension plan drops significantly when the stock is rendered nearly worthless. As a result of the plan's imprudent investment of such a high percentage of its assets in a single stock, the beneficiaries of the plan make a claim against the pension fiduciaries.

Failure To Pursue Delinquent Contributions

Such claims most often arise when a multiemployer 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. Frequently, such contributions are delinquent because one or more of the participating firms is experiencing financial difficulties.

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 pension program. When the employee retires and learns that he or she is not covered by the pension plan, he or she sues the administrator.

Claims from Fraudulent Schemes

In December 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. Early investors in the company were "paid back" with monies provided by recent investors as a means of hiding the company's losses. A number of prominent, union-sponsored pension funds were "invested" in the scheme. A pension fund covering about 800 police, firefighters, and other employees in the Connecticut town of Fairfield had about $40 million managed by Mr. Madoff, according to Fairfield's First Selectman Kenneth Flatto. In addition, the $40 billion state pension fund of Massachusetts faced losses of up to $12 million after it invested the money with Austin Capital Management, a Texas-based fund of hedge funds,[2] which placed the money with Mr. Madoff.[3]

Exposures from Defined Contribution Plans

There are a number of liability exposures faced by fiduciaries from the administration of defined contribution plans. Several of these exposures are listed in Exhibit 3.2.

Exhibit 3.2
Liability Exposures from Defined Contribution Plans

(1) Concentration of assets in company stock (i.e., stock in the company sponsoring the plan),
(2) Blackout periods,
(3) Restrictions on selling matching company stock contributions,
(4) Lack of guidance regarding investment strategies,
(5) Failure to follow the investment request of a plan participant, and
(6) Allegations of excessive defined benefit plan fees.

Concentration of Employer Stock in 401(k) Plans

Fiduciaries at firms with high concentrations of 401(k) assets invested in their own organization's common stock face a significant exposure to liability claims. When the value of such stock experiences a precipitous decrease in value, fiduciaries are at risk. Under these circumstances, 401(k) plan participants are likely to allege that intentional, improper internal accounting practices artificially inflated the company's earnings, which drove a temporary rise in, but eventually caused a large drop in, the company's share price. Fiduciary liability in this situation arises from fiduciaries' awareness of these questionable accounting practices and yet allowing such acts to continue but without making any formal objections to senior management.

This was precisely what is claimed to have occurred at Enron Corporation, where employee plaintiffs alleged that plan fiduciaries were aware of such accounting practices, they misrepresented to plan participants the value and safety of Enron's stock, and the fiduciaries encouraged investment in the stock to support an artificially high price for the stock.

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 (as reported in *USA Today*, January 21, 2002, "The Enron Scandal by the Numbers," the employees suffered severe losses.

In contrast to the fiduciary behavior in the Enron situation, 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 potential 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.)

Company Stock in 401(k) Plans: Key Data

Despite Enron's bitter experience, according to a 2013 study by Morningstar Investments, "Employer Stock Ownership in 401(k) Plans and Subsequent Company Stock Performance," the concentration of company stock in 401(k) plans remains high. In fact, the following notable companies had *more than 50 percent* of total plan assets invested in company stock: Exxon, McDonald's, and Lowe's Corp.!

Why and How Companies Encourage Company Stock Ownership in 401(k) Plans

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. These 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 annual salary is $50,000, he or she contributes 6 percent of his or her salary, and 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 his or 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 his or 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.

RadioShack: A Case Study in the Dangers of Offering Company Stock as a 401(k) Plan Option

On February 5, 2015—a date on which the company's stock was selling for roughly 13 cents per share—RadioShack declared bankruptcy. Unfortunately for many of the company's employees, RadioShack offered company stock as one of the investment options in its 401(k) plan.

As reported in the *Dallas Morning News* ("Employees bet their future on RadioShack shares," by Mitchell Schnurman, February 3, 2015), "... six months ago, about 2,600 employees had over 3.5 million shares in the 401(k)." On average, each 401(k) plan participant held 1,346 shares in his or her 401(k) account in 2014, which was 500 more shares than in 2007, the article reported. However, the average value of RadioShack shares in each employee account, worth approximately $27,000 per person in 2007, had plummeted to just $1,300 during the summer of 2014, Mr. Schnurman stated.

The article noted that three class action lawsuits were filed against the fiduciaries of RadioShack's 401(k) plan in November and December 2014. The suits alleged that executives breached their fiduciary duties by failing to take protective actions, such as ending RadioShack stock purchases and selling existing shares in the plans, steps that would have reduced employee losses, the article reported. In December 2014, the Department of Labor began an investigation to determine if the company acted in compliance with laws governing retirement plans, Mr. Schnurman pointed out.

The case underscores the perils confronting both fiduciaries and employees when company stock is a 401(k) plan option. For each group, two distinct sets of risks are created if the company suffers severe financial reversals.

- **Fiduciaries**. First, nonemployee shareholders are likely to bring "traditional" securities class action claims, charging that gross mismanagement of the company caused its stock price to fall. Second, employees who hold company shares in their 401(k) accounts will also bring claims against fiduciaries, asserting that the fiduciaries violated their duties under ERISA to act prudently and for the benefit of their plan beneficiaries. The losses sustained from this exposure are often referred to as "ERISA stock drop" claims.
- **Employees.** Employees who hold shares of their employer's company in their 401(k) account run the risk of losing money in the event the company's earnings fall and its share price follows suit. In addition, when the company declares bankruptcy (as in the case of RadioShack), the employees are also at risk of losing their jobs.

Vivien v. WorldCom: A Legal Theory To Recover Losses in Company Stock

The case of *Vivien v. WorldCom,* No. 02-01329 WHA (N.D. Cal. July. 26, 2002), established a legal theory that permitted workers to recover losses in their 401(k) retirement plans that contained investments in their employers' stock. In this case, the employee plaintiffs alleged that since ERISA imposes a duty on fiduciaries (1) to provide accurate information to employee benefit plan participants and (2) to invest plan monies prudently, a breach of these duties establishes liability for losses sustained.

The basis of the suit by 401(k) employee plan holders was that WorldCom's retirement plan administrators were "company insiders." As such, they were well aware that the company's share price was highly inflated because the administrators knew about the material misstatements contained within its periodic financial filings to the Securities and Exchange Commission. 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. In this regard, the fiduciaries breached their duty to provide accurate information about plan investments.

Plaintiff-employees also alleged that under ERISA, WorldCom had a fiduciary duty to invest plan assets in a prudent manner. The lawsuit charged a breach of this duty because administrators continued to invest plan assets in WorldCom stock despite their awareness of how the company's share price in no way reflected WorldCom's actual value. Thus, given the administrators' failure to provide accurate information about plan investments, coupled with their failure to invest plan funds prudently in light of their knowledge concerning such investments, the court ruled in favor of the plaintiffs. 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 typically lasting from 4 to 6 weeks. This most often occurs when a 401(k) plan changes administrators. In the Enron situation referred to above, 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. 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 a freeze on the selling of company shares 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 of 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, the employer typically matches an employee's contributions to some extent. 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.

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. Yet, 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 rapidly 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 inaccurate advice regarding investment strategies and personal financial planning.

Hiring Outside Advisers

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.*)

The US Supreme Court's ruling in *LaRue v. DeWolff, Boberg & Assocs., Inc.,* 128 S. Ct. 1020 (2008), 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 ERISA 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*, 473 U.S. 134 (1985). 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 US Supreme Court did not find the fiduciary liable to the plaintiff, Mr. LaRue. Rather, the court's ruling only meant that the plaintiff had the right to prove that the fiduciary's negligence caused his loss, an issue that had to be re-litigated in a trial court. Prior to the US 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) plans) 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 Mr. LaRue may have only represented a relatively small percentage of the entire plan's assets.

Claims Alleging Excessive Fees

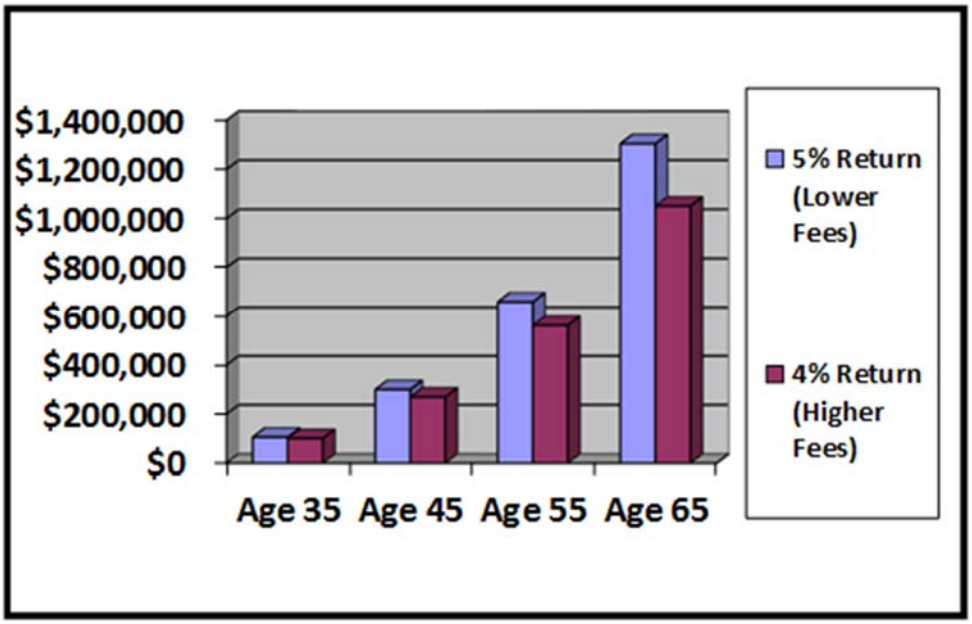
Increasingly, lawsuits are charging that the sponsors of defined contribution plans have allowed plan administrators and other plan service providers to charge excessive fees, which constitutes a breach of duty under ERISA.

In addition to these allegations, lawsuits have also asserted 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 small difference in the fee that is charged by the manager of a mutual fund within a 401(k) plan can make a substantial difference in a plan holder's balance. This effect is illustrated in Exhibit 3.3.

Exhibit 3.3
Small Fee Differences Can Produce Large Differences in 401(k) Balances

An employee making a salary of $70,000 contributes 6 percent of his or her earnings to a 401(k) plan for 40 years and also receives a 50 percent annual company match. Assume that his or her salary increases 3 percent annually. Also assume that his or her portfolio grows at a 5 percent rate, including the charge for annual fees. The employee's balance is $1,304,253 at the end of the 40 years. But, if the annual fees were increased just 1 percent, making the overall growth rate 4 percent, the employee's balance is reduced to $1,051,054—a $253,199 difference. While the discrepancy is not as pronounced in the earlier years of an employee's career, the more than quarter-million-dollar difference at the end of an employee's career is obviously substantial.



401(k) Balance over Time

Differences of this magnitude, while significant for an individual employee, can explode to astronomical proportions when a class action lawsuit by, for example, 5,000 employees asserts that each plan holder's balance was reduced by $253,199 given excessive fees being paid during the life of a 401(k) plan.

Tibble v. Edison International: The Duty To Continuously Review Plan Fees and Investments

On May 18, 2015, by a unanimous 9–0 vote, the US Supreme Court, in *Tibble v. Edison Int'l*, 135 S. Ct. 1823 (U.S. 2015), held that fiduciaries of a 401(k) savings plan have a "… continuing duty to monitor trust investments and to remove imprudent ones." The court held that this duty "… exists separate and apart from the trustee's duty to exercise prudence in selecting investments" and that the fiduciary must "… systematically consider all the investments of the trust at regular intervals to ensure that they are appropriate."

As reported by Robert Powell in *USA Today* on May 19, 2015 ("401(k) lawsuits just got easier"), the case involved an action brought by employees at Edison International. The employee-plaintiffs claimed that the six retail-class mutual funds chosen by fiduciaries charged with managing their 401(k) savings plan were imprudent. The plaintiffs pointed out that the plan was eligible to purchase identical, institutional-class mutual funds that charged lower fees.

Edison International, the defendant-employer, countered this argument by stating that its duties as a fiduciary of the 401(k) plan were governed by provisions of ERISA, which specify a 6-year statute of limitations on the selection of investments. And because the fiduciaries selected the retail-class mutual funds in 1999, Edison contended that the statute of limitations had expired by the time the case was brought in 2007.

In rejecting this argument, the court concluded that the 6-year statute of limitations was inapplicable because fiduciaries have what amounts to an *unceasing duty* to evaluate a 401(k) plan's fees and investments. Accordingly, as a result of the court's holding in this case, fiduciaries must conduct regular, periodic reviews to continuously assess whether and to what extent an investment is appropriate and prudent.

The lesson of *Tibble v. Edison* for 401(k) plan fiduciaries is twofold. First, it established fiduciaries' duty to continuously review plan investments as to whether the fees charged are the lowest for which a plan is eligible. Second, the case also created a duty for fiduciaries to remove underperforming investments.

Chapter 3 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. 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.

3. 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.

4. 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.

5. 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 might increase its matching contributions, currently $0.50 per dollar, when used to buy company stock.

    B. Dotcom might match a higher percentage of employee contributions when employees purchase company stock.

    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.

Answers to Chapter 3 Review Questions

1.

A. This answer is incorrect. In a cash balance plan, benefits are defined in terms of an individual account balance.

B. That's correct! 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.

C. This answer is incorrect. Defined contribution plans provide no guarantee of a specific benefit amount.

D. This answer is incorrect. Individual retirement annuities are retirement plans established by individuals.

2.

A. This answer is incorrect. Sick retirees still collect benefits.

B. That's correct! 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.

C. This answer is incorrect. If the plan has foreign investments, the exchange rate would be considered along with other factors in projecting an expected rate of return on employer contributions to the pension fund.

D. This answer is incorrect. The expected rate of return refers to the financial return on pension plan investments.

3.

A. This answer is incorrect. That's a characteristic of a defined contribution plan.

B. This answer is incorrect. That's a characteristic of a cash balance plan.

C. This answer is incorrect. The rate of return is not "defined."

D. That's correct! A defined benefit pension plan promises a flat dollar payout 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.

4.

A. That's correct! The best way to prevent such suits is to communicate the benefit reductions.

B. This answer is incorrect. Transparency is more likely to accomplish the desired results because it eliminates surprises.

C. This answer is incorrect. If benefits for Grapefruit employees were also decreased, the number of sour employees who might sue would increase.

D. This answer is incorrect. Among other consequences, a lump sum distribution to current employees defeats the purpose of a retirement plan.

5.

A. This answer is incorrect. This change might motivate employees to buy Dotcom stock.

B. This answer is incorrect. This would obviously increase the amount of money being invested by the plan.

C. This answer is incorrect. Employees will recognize that Dotcom's success increases the value of their company stock.

D. That's correct! 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.

Chapter 4
Underwriting Fiduciary Liability Insurance

Overview

Chapter 4 describes the major factors that are involved in the process of underwriting fiduciary liability insurance policies.

Chapter Objectives

On completion of this chapter, you should be able to

- identify factors that insurers typically consider when setting premiums for fiduciary liability insurance, and
- recognize the relevance of various factors that underwriters consider when deciding whether to provide fiduciary liability insurance for a given organization.

Factors in Pricing

As is characteristic of most types of management 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 4.1 and discussed in the pages that follow.

Exhibit 4.1 Fiduciary Liability Underwriting Factors
• Funding adequacy of defined benefit pension plans • Nature of plan investments • Single-employer versus multiemployer plans • Types of covered plans • Legal counsel's opinion • Certified Public Accountant (CPA) firm opinion • Profile of covered fiduciaries and directors and officers of the organization • Formal loss control program

Funding Adequacy of Defined Benefit Pension Plans

A paramount consideration in assessing the insurability of a company that sponsors one or more defined benefit pension plans is the adequacy with which the plan(s) is 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 the Employee Retirement Income Security Act (ERISA) of 1974, 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. For example, if a defined benefit plan holds a substantial percentage of its assets in long-term bonds that do not mature for 20 to 30 years, this could create a problem if a significant proportion of these assets will be needed to pay promised benefits within the next 10 years.

As respects defined contribution plans, underwriters are most concerned about a heavy concentration of assets invested in company stock, discussed earlier in this course. In addition, underwriters must also review the fees being charged for such plans, being mindful as to whether the fees are in line with those of similar plans.

Single-Employer versus Multiemployer Plans

Additional risks are posed by multiemployer benefit plans compared with those generated by single-employer programs. (Multiemployer plans are most often set up by manufacturing firms or governmental employers that employ unionized workers within the same industry.) Since multiemployer plans are usually larger and more complex than single-employer plans are, claim frequency and claim severity tend to be higher than for single-employer plans. Of course, this is reflected in higher premium rates for multiemployer 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, whereas little such risk exists for a defined contribution pension plan. This is because the sponsoring company assumes the financial responsibility for making specified, promised payments under a defined benefit pension plan. In contrast, under a defined contribution plan, the risk associated with future payments is shifted entirely to the plan's participants. However, as already discussed, defined contribution plans are not without other 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 Certified Public Accountant (CPA) firms with particular expertise in such matters, can also substantially reduce an insured's exposure to claims. Accordingly, some underwriters will grant premium credits to insureds that submit to audits.

Profile of Covered Fiduciaries

As is the case with directors and officers (D&O) 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 4 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. Underwriters who underwrite fiduciary liability coverage typically consider all the following underwriting factors, except
    A. funding adequacy of defined contribution pension plans.
    B. the background of covered fiduciaries.
    C. the nature of plan investments.
    D. the types of covered plans.
3. 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.
4. 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 of 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.
5. One of the doctors who runs Hickory Dickory Hospital has raised the concern Hickory Dickory's employee benefits might somehow be out of compliance with the complexities of Employee Retirement Income Security Act (ERISA) law. If that is the case, it might be difficult for the hospital to obtain fiduciary liability insurance. How can Hickory Dickory ascertain whether it meets ERISA requirements?
    A. Have the insurer's loss control department review plan documents.
    B. Have the insurer's underwriter review plan documents.
    C. Obtain a "clean" audit from a Certified Public Accountant.
    D. Obtain a "clean" opinion from the plan's law firm.

Answers to Chapter 4 Review Questions

1.

A. This answer is incorrect. There is no pooling of loss experience among insurers writing fiduciary liability coverage.

B. This answer is incorrect. There is no rating bureau for insurers writing fiduciary liability coverage.

C. This answer is incorrect. Pricing is subjective because each company's rating approach is based on its actuaries' analysis of its own loss experience.

D. That's correct! Each company must develop its own rating approach.

2.

A. That's correct! Funding adequacy is an underwriting factor for defined benefit plans. Employees bear the risks with defined contribution plans.

B. This answer is incorrect. Underwriting factors include the profile of covered fiduciaries and directors and officers of the organization.

C. This answer is incorrect. Underwriting factors include the nature of plan investments.

D. This answer is incorrect. Underwriting factors include the types of covered plans.

3.

A. This answer is incorrect. Junk bonds are high-risk investments.

B. This answer is incorrect. Pyar Square's plan assets are heavily concentrated in two areas.

C. This answer is incorrect. Underwriters evaluate a plan's level of risk, which seems high in this case due to a lack of diversification and heavy investment in the sponsoring organization's own stock.

D. That's correct! 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, the "Circle-of-Life" name 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.

4.

A. This answer is incorrect. The investment management company does not assume the plan's financial risk. However, an investment management company faces its own business risks.

B. This answer is incorrect. The sponsor assumes the risks with a defined benefit pension plan.

C. That's correct! 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.

D. This answer is incorrect. Participants assume the risks with a defined contribution program.

5.

A. This answer is incorrect. Most loss control departments do not deal with legal opinions.

B. This answer is incorrect. The underwriter will be looking for documentation from the Hickory Dickory docs.

C. This answer is incorrect. Accountants are not equipped to provide a legal opinion.

D. That's correct! Underwriters will rely on the opinions of a plan's attorney to evaluate the extent of its compliance with ERISA law; a "clean" opinion from the plan's law firm is critical.

Chapter 5
Fiduciary Liability Loss Control

Overview

Chapter 5 provides methods of reducing exposures to liability claims against fiduciaries.

Chapter Objectives

On completion of this chapter, you should be able to

- identify the types of measures that can reduce the likely frequency or severity of fiduciary liability claims, and
- recognize the applicability of these loss control measures in a given situation.

Various techniques can assist persons who have fiduciary responsibilities, in reducing the exposure to claims against them. These techniques are summarized in Exhibit 5.1 and discussed in the pages that follow.

Exhibit 5.1
Fiduciary Liability Loss Control Measures

- Minimize and, if possible, avoid investments in company stock.
- Select and evaluate fiduciaries carefully.
- Structure benefit plans with "moderate" fees.
- Conduct periodic, independent Employee Retirement Income Security Act (ERISA) of 1974 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.

Minimize and, If Possible, Avoid Investments in Company Stock

The problematic nature of holding company stock within a defined contribution pension plan (i.e., a 401(k) plan), is thoroughly analyzed in Chapter 5 of this course. Admittedly, employee ownership of company stock in a 401(k) plan can serve as a way to align the interests of employees and employers, potentially leading to better future company performance. There are, however, a number of significant risks when 401(k) plans make company stock available as one of the plan's investment options.

- For employees, by making a substantial investment in company stock, the employee is in effect "betting" his or her retirement on the company's fortunes.

- For employers, when the company's financial picture darkens and the shares of its stock plummet, the organization's directors and officers will likely be faced with shareholder class action lawsuits alleging mismanagement of the corporation. In addition, if company stock is made an investment choice within a 401(k) plan, the employees' plan balances will be adversely affected, a situation that will also probably result in lawsuits against the plan's fiduciaries, creating so-called ERISA stock drop claims.

Given the substantial risks to both employees and fiduciaries, company stock should not be available as an investment option within defined contribution benefit plans.

Select and Evaluate Outside Service Providers Carefully

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. Such persons include administrators, investment advisers, actuaries, and accountants. Thus, fiduciaries must select these persons and firms on the basis of their experience, expertise, and integrity, rather than for personal or political reasons.

Structure Benefit Plans with "Moderate" Fees

During the past decade, lawsuits against fiduciaries are increasingly asserting that the sponsors of defined contribution plans (i.e., 401(k) plans) have allowed plan administrators and other plan service providers to charge exorbitant fees. As reported on August 11, 2016, by Tara Siegel Bernard of the *New York Times* ("Employees Sue Four More Universities over Retirement Plan Fees"), there has been a wave of lawsuits filed against an array of prestigious universities acting as retirement plan sponsors, including (but not limited to) Massachusetts Institute of Technology (MIT), Yale, Duke, Johns Hopkins, and Vanderbilt. The root complaint common to each of these lawsuits is that the universities could have, in one way or another, negotiated lower fees for their employees' respective retirement plans.

The failure to negotiate lower fees constitutes a breach of duty under ERISA, a conclusion supported by the United States Supreme Court in *Tibble v. Edison Int'l,* 135 S. Ct. 1823 (U.S. 2015), a case discussed at length in Chapter 3 of this course.

Given the risks associated with a class action lawsuit alleging that 401(k) plan participants were charged excessive fees, employers should obtain multiple quotations when setting up or modifying 401(k) plans and, all other things being equal, select the plan administrator charging the lowest fees. Moreover, administrators must continually monitor the fees being charged by established plans, to be sure that fees are among the lowest available for the type of investment being offered.

Conduct Periodic, Independent ERISA Compliance Audits

Fiduciaries must arrange for periodic audits of their benefit plans, to be conducted by independent organizations, in an effort to assure compliance with ERISA regulations. (These should be in addition to regular, company-wide audits by Certified Public Accountant (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 regulations and procedures, whereas comprehensive ones are more focused on the nature of a plan's assets. For instance, a comprehensive audit would assess the specific investments held by a defined benefit pension plan, such as its individual stocks, bonds, and real estate investments.

Use Experts To Design Plans

Designing pension and benefit plans requires considerable 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 plans.

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 periodic audits conducted by an independent CPA firm and hiring an independent actuary to certify that the plans are adequately funded will usually prevent the problems associated with underfunded plans. This is especially true if an audit and an actuarial analysis are performed in the early stages of a potential funding inadequacy, which allows more time for such inadequacies to be corrected.

Invest Plan Assets Prudently

Many of the difficulties experienced by defined benefit 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 noted in Chapter 1 of this course, 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 are discussed in Chapter 1.) 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 (Defined Contribution Plan)

Conflicts of interest involving fiduciaries were the impetus for class action lawsuits brought against First Union Corporation by its employees in 1997. The lawsuits made two key allegations.

- **Lack of Investment Options**. 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 was that the performance of these mutual funds lagged those of comparable mutual funds. The employee-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 arose as to whether First Union's intent was to benefit itself or its employees.
- **Excessive Management Fees**. Second, the lawsuits alleged that First Union's mutual funds 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 a clear conflict of interest inherent in such practices.

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

Metropolitan Life v. Glenn: A Case Study in Conflicts of Interest (Employee Welfare Benefit Plan)

Wanda Glenn, an employee of Sears, Roebuck & Company, was covered by the Sears long-term disability insurance plan. Metropolitan Life Insurance Company both administered and provided the insurance coverage for the plan. When Ms. Glenn applied for continuing disability benefits, MetLife denied her claim. The US Supreme Court, in ruling in favor of Ms. Glenn, in *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008), found that Metropolitan Life, as plan administrator, was operating under a conflict of interest because any benefits it granted in the role of administrator would *also* be paid as the plan's insurer and ultimately to MetLife's financial detriment. To prevent such conflicts, employers should review all employee welfare benefit plans subject to ERISA and confirm that they have a claims procedure that separates eligibility determination from the insurance payment decision. Accordingly, where appropriate, outsourcing of the claims process should be considered, to avoid the conflict of interest problem in the *Glenn* case.

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 defined benefit pension plan invests plan monies in a company where he or she holds a majority interest. However, such transactions are not always so easily apparent.)

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.

- Department of Labor
- Internal Revenue Service
- Pension Benefit Guaranty Corporation (for defined benefit 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 events occur.

- 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.

Chapter 5 Review Questions

1. Hudson Company executives thought it would be a good idea to encourage Hudson employees to buy Hudson stock through the company's 401(k) plan. However, the Certified Public Accountant (CPA) they consulted strongly advised against providing company stock as a 401(k) investment option. The CPA probably based his opinion on what risk?
    A. The risk of Employee Retirement Income Security Act (ERISA) stock drop claims
    B. The risk of shareholder class action lawsuits
    C. The risk that employees who own a piece of the company will perform poorly
    D. The risk that employees will take an early retirement if the company thrives
2. Which one of the following is not ultimately responsible for controlling the risks associated with pension and benefit plans?
    A. Plan administrators
    B. The employees who participate in the plan
    C. The plan's accountants
    D. The plan's actuaries
3. 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
4. Dropout College must choose one of several potential providers to service its 401(k) plan. All of the following providers have an appropriate level of expertise and integrity. Which of the following choices is least likely to result in a class action lawsuit against Dropout?
    A. Provider A has 30 years of experience and charges a 5 percent management fee.
    B. Provider B has 25 years of experience and charges a 4 percent management fee.
    C. Provider C has 20 years of experience and charges a 3 percent management fee.
    D. Provider D has 15 years of experience and charges a 2 percent management fee.

5. 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 certified public accountants and actuaries.

    C. have Will Tell's own personnel design the plan, because they are more familiar with the firm than any outsider is.

    D. include a high proportion of high-risk investment alternatives in order to produce the highest potential return.

Answers to Chapter 5 Review Questions

1.

A. That's correct! If the value of company stock drops, employees' plan balances will be adversely affected, and this is likely to result in stock drop claims against the plan's fiduciaries.

B. This answer is incorrect. The risk of shareholder class action suits alleging mismanagement of the corporation exists whether or not Hudson's employees are stockholders.

C. This answer is incorrect. Employees whose personal interests are aligned with company interests potentially lead the company to perform better.

D. This answer is incorrect. Thriving is good, not bad.

2.

A. This answer is incorrect. The administrators' fiduciaries select are among those responsible for controlling the risks associated with the plan.

B. That's correct! The only risks employees can control involve deciding whether to participate in the plan and selecting among plan options.

C. This answer is incorrect. The accountants that fiduciaries select are among those responsible for controlling the risks associated with the plan.

D. This answer is incorrect. The actuaries whom the fiduciaries select are among those responsible for controlling the risks associated with the plan.

3.

A. This answer is incorrect. Experience is desirable, especially if accompanied by a favorable track record of good results.

B. This answer is incorrect. The individual organization providing these services should have the necessary expertise.

C. This answer is incorrect. High integrity is of paramount importance.

D. That's correct! 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.

4.

A. This answer is incorrect. Dropout could find a qualified provider with a lower management fee.

B. This answer is incorrect. Dropout could find a qualified provider with a lower management fee.

C. This answer is incorrect. Dropout could find a qualified provider with a lower management fee.

D. That's correct! All potential providers have at least 15 years' experience. All other things being equal, employers should select the plan administrator charging the lowest fees.

5.

A. This answer is incorrect. One means of providing a layer of insulation from liability for imprudent investment decisions is for the insured to retain an adviser who is registered under the Investment Company Act of 1940.

B. That's correct! Pension plan design requires considerable specialized expertise.

C. This answer is incorrect. To avoid being held liable for making unwise investment choices, Will Tell should use outside advisers.

D. This answer is incorrect. Plan participants will not complain about a high return, but a high-risk plan may also generate high losses, and that is likely to generate claims.

Chapter 6
Coordinating Fiduciary Liability Insurance with Other Coverages

Overview

The manner in which fiduciary liability coverage must be coordinated with other types of insurance has long been a source of confusion. Chapter 6 examines the potential gaps and overlaps that can occur between fiduciary liability and these related coverages and proposes ways to address these coordination issues.

Chapter Objectives

On completion of this chapter, you should be able to

- recognize the distinctions between fiduciary liability insurance and other management liability coverages,
- identify the different ways of structuring fiduciary liability insurance, and
- identify advantages and disadvantages of each available approach.

Fiduciary Liability versus Employee Benefits Liability

Fiduciary liability insurance covers claims alleging breach of the duties enumerated by the Employee Retirement Income Security Act (ERISA) of 1974 (i.e., discretionary duties). In contrast, employee benefits liability coverage applies to claims involving administrative errors associated with employee pension and welfare plans. Exhibit 6.1 illustrates several claim scenarios that correspond to the types of claims addressed by a policy covering the employee benefits liability exposures, which are distinct from claims arising from duties enumerated within ERISA.

Exhibit 6.1
Employee Benefit Liability Exposures and Claim Types

Activity	Claim Scenario
Counseling employees regarding 401(k) plans	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 a defined benefit pension plan 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 medical plan. The employee sues after the plan denies her medical benefits following a diagnosis of cancer.

The ISO Employee Benefits Liability Coverage Endorsement

In response to the employee benefits liability exposure, Insurance Services Office, Inc. (ISO), has developed the "Employee Benefits Liability Coverage" (CG 04 35 12 07) endorsement for attachment to commercial general liability (CGL) policies. The endorsement covers this exposure, although not the exposure to fiduciary liability.

Is an Employee Benefits Liability Endorsement Worthwhile?

Despite the coverage it provides, an employee benefits liability endorsement is of little value. Any firm having an employee benefits liability exposure also has a fiduciary liability exposure. Therefore, buying only an employee benefits liability 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 employee benefits liability endorsement and a fiduciary liability policy since virtually every fiduciary liability policy also covers the employee benefits liability exposure. In fact, buying both a fiduciary liability policy and an employee benefits liability endorsement creates a situation where duplicate coverage exists.

Considering this situation, purchasing an employee benefits liability endorsement to a CGL policy is rarely, if ever, 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), employment practices liability (EPL), and sometimes cyber and privacy policies. These coverage formats are known as management liability package policies. (Occasionally, kidnap and ransom insurance, also known as "special crime" coverage, is also made available within a package, along with these other four policies.)

Advantages of the Packaged Approach

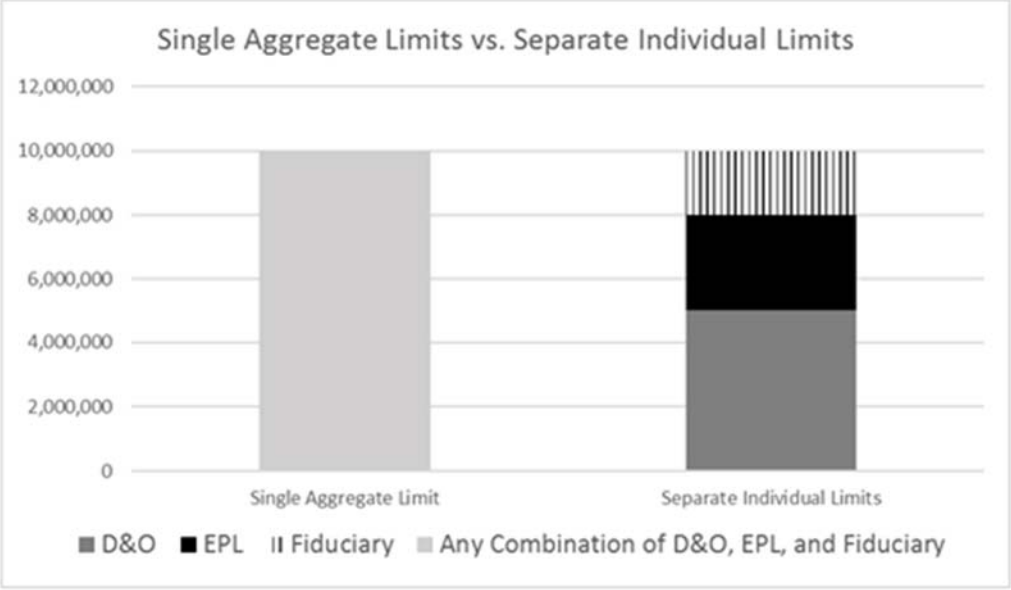
A packaged approach features separate insuring agreements and separate policy limits for each of the coverages provided (i.e., D&O, employment practices, fiduciary, cyber and privacy, kidnap/ransom). Accordingly, package policies provide essentially the same scope of coverage that is afforded by a stand-alone 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. Since much of the same information used to underwrite D&O, EPL, and cyber and privacy coverage is also required when underwriting a fiduciary liability policy, the total cost of a management liability package policy will be roughly 10–20 percent lower than the total cost of buying these "component" policies on an individual basis.

Approach to Limits

Most often, but not always, management liability package policies are written with separate limits for each of the individual coverages they provide. In a minority of cases, these policies are written with a combined single limit that applies to all types of management liability claims during a single policy period.

For example, a management liability policy containing a $10 million combined aggregate limit would cover all D&O, EPL, and fiduciary claims during a policy period up to $10 million, in any proportion.

Contrast this plan of coverage with an insured that buys a management liability package policy containing the following individual limits: D&O ($5 million), EPL ($3 million), and fiduciary ($2 million).



In both cases, available limits total $10 million. However, in the first instance, the insured can apply the $10 million in any proportion, regardless of the type of claim involved. Conversely, in the second instance, specific limits apply to each of the three coverages.

A combined aggregate limit approach is advantageous if, for example, there is an especially large (i.e., $10 million) fiduciary liability claim, which would have exhausted the $2 million of coverage available under the policy written with separate limits. On the other hand, it should be recognized that a policy with a $10 million combined aggregate limit applying to all coverages will cost about 15–25 percent more than a policy with separate limits totaling $10 million of coverage.

Limitations of the Packaged Approach

A package policy approach to obtaining fiduciary liability coverage may not always provide the optimal solution to a company's fiduciary coverage needs. For example, a privately held business may sometimes elect not to purchase a D&O policy despite the fact that the company wants fiduciary liability coverage (and perhaps EPL insurance, as well). Yet, in this situation, many underwriters will not offer a package policy unless an insured buys all three coverage components. In these cases, a stand-alone fiduciary liability policy becomes the company's only available option.

Chapter 6 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 commercial general liability (CGL) policy

    B. A package policy that covers both fiduciary and employee benefits liability exposures

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

    D. A stand-alone employee benefits liability policy

2. Which of the following bases for a claim against Mountain King Hall would be covered by a fiduciary liability policy but not by a policy or endorsement providing only employee benefits liability coverage?

    A. Alberto breaks his leg in a biking accident and submits a health insurance claim, only to discover that Mountain King never enrolled him in the company's medical plan, although he was eligible and had completed an enrollment form.

    B. Kaitlin sues Mountain King when she learns that the company's defined benefit retirement plan had invested in a Ponzi scheme and no longer has the funds needed to deliver the promised benefits.

    C. Mountain King's personnel manager recommended that Mary put her 401(k) contributions into the plan's money market fund. Mary sues Mountain King when she learns she could have earned much more by investing in any other fund that was available.

    D. Upon learning from a Mountain King benefits clerk that Lenore will be eligible to retire at the end of the year, she buys a home in a distant retirement community. Lenore sues Mountain King when she attempts to retire and discovers she must still work another 5 years to qualify.

3. When attached to a commercial general liability (CGL) policy, the "Employee Benefits Liability Coverage" (CG 04 35) endorsement

    A. adds both employee benefits liability coverage and fiduciary liability coverage.

    B. adds employee benefits liability coverage but not fiduciary liability coverage.

    C. adds fiduciary liability coverage rather than employee benefits liability coverage.

    D. excludes coverage for employee benefits liability exposures.

4. 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 payment of employment practices claims can erode the package policy's limit applicable to directors and officers (D&O) claims.

5. Spam Mailorder Company needs to decide whether to purchase a management liability package policy with a $3 million single limit or one with $1 million separate limits for each of its three coverages: directors and officers (D&O), employment practices liability (EPL), and fiduciary liability. An advantage of the $3 million single-limit policy is that

    A. it is more likely to provide adequate protection against a large judgment under any of the coverages.

    B. payment of a major D&O claim would not affect the coverage available for a fiduciary liability claim or vice versa.

    C. the limit would automatically be restored following a covered loss.

    D. the single-limit policy is less likely to be canceled for claims frequency.

Answers to Chapter 6 Review Questions

1.

A. This answer is incorrect. Insurance Services Office, Inc. (ISO), has developed an employee benefits liability endorsement designed for attachment to ISO's CGL policies.

B. This answer is incorrect. It is usually possible to purchase a package policy that also covers a firm's employee benefits liability exposure.

C. This answer is incorrect. These package policies have become increasingly popular in recent years.

D. That's correct! Employee benefits liability coverage is rarely, if ever, written on a stand-alone basis.

2.

A. This answer is incorrect. This should be submitted as an employee benefits liability claim.

B. That's correct! This is the type of claim that fiduciary liability insurance would address.

C. This answer is incorrect. Employee benefits liability insurance applies to counseling claims.

D. This answer is incorrect. Employee benefits liability insurance applies to claims involving interpretation of employee benefit programs.

3.

A. This answer is incorrect. The endorsement does not add fiduciary liability coverage.

B. That's correct! The endorsement adds employee benefits liability coverage but does not address the fiduciary liability exposure that organizations with employee benefits also face.

C. This answer is incorrect. The endorsement adds employee benefits liability coverage.

D. This answer is incorrect. The employee benefits liability endorsement is not an exclusionary endorsement; it does add some coverage.

4.

A. This answer is incorrect. Due to economics of scale, package policy pricing is usually somewhat lower than that found in a stand-alone fiduciary liability policy.

B. This answer is incorrect. Coverage under either approach is comparable.

C. That's correct! Much of the information used to underwrite D&O and employment practices liability coverage is also required when underwriting fiduciary liability coverage.

D. This answer is incorrect. Usually, though not always, package policies have separate limits for each of the individual coverages.

5.

A. That's correct! Assuming no other claims exist, the policy could provide up to $3 million to cover a D&O claim, an EPL claim, or a fiduciary liability claim.

B. This answer is incorrect. Payment of a claim under any of the three coverages will reduce the amount of coverage available for a future claim under any of the three coverages.

C. This answer is incorrect. Limits are eroded; they are not restored.

D. This answer is incorrect. The specter of cancellation for claims frequency exists with either form.

Chapter 7
Fiduciary Liability Insurance Coverage: Insuring Agreements, Covered Persons, and Covered Organizations

Overview

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

Chapter Objectives

On completion of this chapter, you should be able to

- identify the two insuring agreements found within fiduciary liability policy forms,
- recognize the extent to which coverage under each of these insuring agreements applies in a typical fiduciary liability policy, and
- identify the persons and organizations covered by a typical fiduciary liability policy.

As Chapter 1 notes, the fiduciary liability exposure actually existed prior to the passage of the Employee Retirement Income Security Act (ERISA) of 1974 because persons who managed employee benefits programs were already legally liable for any "nondiscretionary" errors or omissions they committed in conjunction with such plans (e.g., failing to change a beneficiary designation on a life insurance policy). ERISA broadened the scope of such liability in two key ways.

First, it transformed liability associated with benefit plan management into a "personal" rather than simply a "corporate" obligation. 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 directors and officers (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.)

Second, ERISA created liability for the discretionary functions handled by persons who manage corporate employee benefit plans. These discretionary functions include (but are not limited to) duties such as selecting a competent investment manager for a defined benefit pension plan, choosing a 401(k) program with a "reasonable" annual fee, and deciding on a medical insurance plan that is appropriate to the needs of a company's employees.

Given the newly created personal liability of fiduciaries along with liability for discretionary acts imposed by ERISA, fiduciary liability insurance first appeared soon after the Act's passage and immediately became an essential part of all corporate insurance portfolios.

Insuring Agreements

There are two major insuring agreements within fiduciary liability policy forms. The first covers "fiduciary liability" (known as Coverage A), and the second covers "settlement programs" (known as Coverage B), also sometimes referred to as voluntary compliance program coverage.

Coverage A: 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,

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), and

d. claims involving the acts of third parties (e.g., third-party administrators of benefit plans) for whom a fiduciary may be vicariously liable.

Coverage for Fiduciary (Discretionary) Duties

Coverage A applies to breaches of duties committed by the insureds in conjunction with benefit plans that are (1) subject to ERISA and (2) not subject to ERISA. (As pointed out in Chapter 2, not all employee benefit plans are 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 ministerial or administrative duties (e.g., inadvertent failure to enroll a new employee in the company's 401(k) savings program).

Coverage for Administrative (Nondiscretionary) Duties: Employee Benefits Liability Coverage

In addition to covering fiduciary liability exposures (above), Coverage A also applies 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 1 and include (but are not limited to) such acts as stating an incorrect pension amount when questioned by an employee as to what he or she can expect to receive as a monthly benefit upon retirement.

Coverage for Liability Based on Status as a Fiduciary

Coverage A also covers 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."

This approach to coverage is similar to what is found within D&O liability insurance policies. That is, 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.

Coverage for Vicarious Liability for Acts of Third Parties

Coverage A also covers "any person for whose Wrongful Acts the Insureds are legally responsible." Vicarious liability 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 1.

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 B: Coverage for Settlement Programs/Voluntary Compliance Programs

"Settlement programs" are programs operated by various government organizations to resolve disputes regarding pension and benefit plans. (Settlement programs are also referred to as "Voluntary Compliance Programs.") This insuring agreement pays the cost of what are known as "voluntary compliance fees." Voluntary compliance fees 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 US 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 actual funding deficiencies. Rather, they only cover the administrative fees associated with arriving at voluntary settlements under the EPCRS process.

Settlement programs avoid the time and expense of formal litigation and are administered by federal agencies such as the Internal Revenue Service (IRS) and the US Department of Labor. 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.

Key Coverage Extensions within Fiduciary Liability Policies

In addition to what is provided within Coverage A (Fiduciary Liability) and Coverage B (Settlement Programs/Voluntary Compliance Programs), there are a number of coverage extensions that some, but not

all, insurers provide. Such coverage is afforded in one of three ways: (a) as a separate insuring agreement, (b) within a policy's definition of "covered loss" or "covered claim," or (c) by means of an endorsement to the policy. These extensions are listed in Exhibit 7.1 and discussed in the following pages.

Exhibit 7.1
Key Extensions within Fiduciary Liability Policies

- Settlor Coverage
- Managed Care Coverage
- Health Insurance Portability and Accountability Act (HIPAA) of 1996 Claim Coverage
- Coverage for 502(c) penalties
- Coverage for Investigations by Various Government Agencies

Settlor Coverage

Every fiduciary liability policy form covers insureds for liability they incur when they act as a fiduciary. However, some, but by no means all, such policies also cover insureds for the liability they incur when they act as a *settlor*. The case of Federal Ins. Co. v. International Bus. Machs. Corp., 18 N.Y.3d 642, 942 N.Y.S.2d 432, 965 N.E.2d 934 (2012), illustrates this important concept.

Federal Insurance Company v. IBM: Coverage for Fiduciary but Not Settlor Acts

A class action lawsuit was brought against IBM by a group of employee beneficiaries of IBM's pension plans. The employees contended that various changes IBM made to these plans violated ERISA's antidiscrimination provisions. IBM settled the claim and then sought reimbursement of the attorney's fees it paid to reach the settlement from Federal Insurance, IBM's excess fiduciary insurer.

The New York Court of Appeals' Ruling

In denying coverage, Federal took the position, which the New York Court of Appeals upheld, that enacting amendments to a benefit plan was not the duty of a fiduciary but rather that of a settlor. Federal pointed out that the plaintiffs' complaint did not assert that IBM had breached its fiduciary duties. Instead, the plaintiffs claimed that in changing from a defined benefit plan to a cash balance plan, IBM had discriminated against certain (older) employees. The New York Court of Appeals agreed with Chubb that no coverage applied to this claim for two reasons. First, changing the nature of a benefit plan is considered the act of a settlor rather than a fiduciary. Second, because ERISA imposes no responsibilities, obligations, or duties on settlors, there was no coverage for the claim under its policy.

Given the fact that fiduciaries routinely perform settlor functions, when arranging fiduciary liability insurance insureds should secure affirmative coverage for both fiduciary *and* settlor acts (which, as explained below, is offered by some, but by no means all, fiduciary liability insurers).

The "Benefits Due" Exclusion

However, it should be noted that even if explicit coverage for settlor acts is provided under fiduciary liability policies, such policies will still be limited to covering only the cost of defense associated with claims alleging that a settlor acted wrongfully.

Thus, in the *Federal Ins. Co. v. IBM* case referred to above, even in the absence of a dispute as to the existence of coverage for settlor functions, there would still have been no reimbursement to IBM for the damages suffered by the plaintiffs and paid in the settlement. Rather, the bone of contention was coverage for the monies that IBM expended in defending the claim.

The lack of coverage for actual benefit payments results because a standard exclusion found within virtually all fiduciary liability policy forms, known as the "benefits due" exclusion, precludes coverage for such payments. (This exclusion is discussed in detail later in this chapter.)

Despite the Benefits Due Exclusion, Defense Coverage Can Be Valuable

One final note on the benefits due exclusion: although defense-only coverage may seem like relatively "thin soup," recognize that in the *IBM* litigation, defense costs amounted to a whopping $88 million! This a considerable sum, even for a business the size of IBM.

Filling the Gap in Coverage for Settlor Acts

A handful of insurers have responded to the gap in coverage for settlor acts. Most do so by means of an endorsement that amends the "wrongful act" definition to include various settlor acts, for which additional premium (typically 5–10 percent) is required. Other insurers afford settlor coverage within their regular policy forms.

Managed Care Coverage

Although fiduciary liability policies exclude coverage for bodily injury, property damage, and personal injury (as will be noted elsewhere in this chapter), most of the policies contain a managed care coverage extension (generally as a separate coverage provision within the policy and less often as a standard endorsement to the policy) that affirmatively covers bodily injury, sickness, mental or emotional distress, disease, or death when such events result from the administration of managed care plans. In view of the fact that managed care plans are subject to ERISA, this is appropriate and, of course, represents a substantial exposure to employers sponsoring such plans.

When Managed Care Coverage Applies

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

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

HIPAA Claim Coverage

This coverage extension applies to claims alleging that the insured violated the Health Insurance Portability and Accountability Act (HIPAA) of 1996, a law that protects employees' health insurance coverage when they lose their jobs or change jobs. The law also promulgates standards for the privacy of electronic healthcare records and transactions.

Coverage under this extension would apply, for example, under the following circumstances. A new employee is permanently denied healthcare coverage under his or her employer's plan, due to a preexisting condition. However, after 12 months, per HIPAA, the employer is no longer permitted to exclude the employee and must begin offering coverage. If the employee brings a lawsuit as a result of the coverage denial, this insuring agreement would defend and indemnify the insured employer.

502(c) Penalties Coverage

Section 502(c) of ERISA states that administrators of employee benefits plans are required to furnish employee participants with information about the plans. According to ERISA:

> The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary, plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.

If, for example, an employee requested such documents, as they pertained to his or her employer's 401(k) plan, and the employer refused to comply with his or her request, the employer would be subject to penalties as specified by Section 502(c) of ERISA. This coverage extension applies to such penalties.

Coverage for Investigations by Various Government Agencies

This coverage extension applies when government agencies that oversee employee benefits programs notify an insured that the agency seeks to undertake an investigation of its benefit programs. (Note: some policies refer to coverage for investigations as coverage for "Interviews.") For example, the Pension Benefit Guaranty Corporation (PBGC) may suspect that a particular corporation's defined benefit pension plan is seriously underfunded. Based on this perception, the PBGC notifies the corporation that it wants to audit the company's pension plan. In this situation, the company will likely hire outside counsel to represent it, along with accountants, actuaries, and consultants to work with PBGC auditors. The costs of hiring these various experts will fall within the scope of this coverage extension.

Covered Persons and Covered Organizations: A Summary

Fiduciary liability policies cover the following.

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

Chapter 7 Review Questions

1. Under the Employee Retirement Income Security Act (ERISA), if a fiduciary's negligence causes the plan to suffer a loss,
    A. the corporation that employed the fiduciary is vicariously responsible for the loss.
    B. the fiduciary is immune from personal liability.
    C. the fiduciary must be defended by the plan sponsor.
    D. the fiduciary's personal assets can be confiscated.
2. 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 the Employee Retirement Income Security Act (ERISA) only.
3. Harrison, in his role as a fiduciary of the Bell Company's pension plan, hired Melva to provide actuarial services and Susie to serve as the plan's investment manager. Susie ignored Melva's actuarial projections and made some very unwise investments that caused huge losses for Bell's plan, leading to claims against all involved individuals and entities. In this situation, Bell's fiduciary liability policy will provide coverage only for claims against
    A. Bell.
    B. Bell and Harrison.
    C. Bell, Harrison, and Susie.
    D. Bell, Harrison, and Melva.
4. 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.
5. Brownfield reluctantly hired Dusty, despite his history of asthma attacks, with the stipulation that Brownfield would not pay any medical claims for Dusty's respiratory problems. Eighteen months after he began working for Brownfield, Dusty was hospitalized with bronchitis, and Brownfield denied coverage. If Dusty sues Brownfield as a result of this coverage denial, Brownfield's fiduciary liability insurer will defend and indemnify Brownfield if Brownfield's policy includes
    A. coverage for 502(c) penalties.
    B. coverage for investigation by various government agencies.
    C. Health Insurance Portability and Accountability Act (HIPAA) claim coverage.
    D. settlor coverage.

Answers to Chapter 7 Review Questions

1.

A. This answer is incorrect. ERISA transformed the liability associated with benefit plan management into a personal rather than a corporate obligation.

B. This answer is incorrect. The fiduciary may be held personally liable.

C. This answer is incorrect. Fiduciary liability insurance will defend the fiduciary; ERISA does not require the plan to do so.

D. That's correct! 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.

2.

A. This answer is incorrect. It covers more than administrative duties.

B. That's correct! 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.

C. This answer is incorrect. The policy covers discretionary functions and more.

D. This answer is incorrect. Covered acts/services apply to breach of duties with respect to plans that are and are not subject to ERISA.

3.

A. This answer is incorrect. Coverage is not limited to the sponsoring organization.

B. That's correct! Fiduciary liability policies cover the corporation sponsoring the benefit programs and the individual fiduciaries' liability for the acts, errors, and omissions of third-party/outside service providers.

C. This answer is incorrect. Susie is not covered.

D. This answer is incorrect. Melva apparently did nothing wrong, but she is not protected by Bell's fiduciary liability insurance.

4.

A. This answer is incorrect. There is no such time limit.

B. This answer is incorrect. The settlement amount will not be known until the litigating parties reach agreement.

C. That's correct! 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.

D. This answer is incorrect. The limit is generally $100,000.

5.

A. This answer is incorrect. Section 502(c) deals with an employer's failure to provide plan information to employee participants.

B. This answer is incorrect. This coverage extension applies when government agencies that oversee employee benefits programs notify an insured that the agency seeks to undertake an investigation of its benefit programs.

C. That's correct! After 12 months, per HIPAA, an employer is no longer permitted to exclude an employee and must begin offering coverage. If the employee brings a lawsuit as a result of the coverage denial, the HIPAA claim coverage insuring agreement would defend and indemnify the insured employer.

D. This answer is incorrect. This coverage applies to acts Brownfield conducts as a settlor rather than as a fiduciary.

Chapter 8
Fiduciary Liability Insurance Coverage: Coverage for "Status Changes" of Covered Organizations and Plans

Overview

This chapter explains how fiduciary liability insurance applies when covered organizations and covered plans undergo various types of "status changes." Such changes are of particular importance within the context of fiduciary liability insurance. This is because claims frequently arise when one company acquires another and, as a result, the acquiring company takes over the administration of the acquired company's pension and benefit programs.

Chapter Objectives

On completion of this chapter, you should be able to

- recognize the types of status change that can affect fiduciary liability coverage, and
- given relevant information, determine how or whether coverage applies to the organizations involved in a status change.

Coverage for an Insured's Acquisition of New Benefit Plans

The policies provide automatic coverage of additional pension and benefit plans over which insured fiduciaries obtain control 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

Despite the use of terminology indicating that coverage is "automatic," insurers place various limits on the actual extent of the coverage they will provide under these circumstances. 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 acquisition threshold generally ranges from 10–25 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 acquisition threshold were only 10 percent, automatic coverage would not apply. Thus, as this example illustrates, from the insured's standpoint, the higher the acquisition 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.

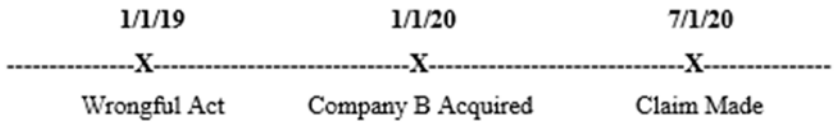
Coverage Is Not Automatic When the Asset Threshold Is Exceeded

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. This is illustrated in Exhibit 8.1.

Exhibit 8.1
Application of Coverage Following an Acquisition



Company A acquires Company B on 1/1/20. On that date, Company B is added as an insured on Company A's fiduciary liability policy. On 7/1/20, a claim is made against Company B in conjunction with a wrongful act that Company B allegedly committed on 1/1/19. In this situation, no coverage for the claim will be available under Company A's policy. This is because the wrongful act that gave rise to the claim took place prior to the 7/1/20 acquisition date. Had the act taken place on or after that date, coverage would have been available.

Under certain circumstances, coverage for prior acts (such as the wrongful act Company B allegedly committed on 1/1/19) can be obtained, although the underwriter will almost always require additional premium. Details on this action are provided later in this course.

Coverage for Other Types of "Status" Changes

Four other common types of "status changes" are 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, 2020, to January 1, 2021, term. On July 1, 2020, Company B acquires Company A. 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, 2021. Thus, Company A will be covered for any claims caused by wrongful acts that took place prior to July 1, 2020 (the date of the acquisition), provided the claim is made against A on or before January 1, 2021. However, Company A has no coverage for wrongful acts under the policy that was in effect on the date it was acquired for any claims resulting from wrongful acts taking place after July 1, 2020—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, 2020, coverage would apply under A's policy, provided the claim was made *on or before* January 1, 2021, the termination date of A's policy.

Conversely, if the alleged embezzlement took place *after* July 1, 2020, 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, 2021.

The rationale behind this provision is that once the entity has been acquired, the acquiring company's fiduciary liability policy will provide coverage for wrongful acts that took place after the acquisition date. And since coverage will apply (under the acquired company's policy) to acts that took place prior to the acquisition, 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 parent company's operating managers will purchase the subsidiary. 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, 2020, a subsidiary of the XYZ Corporation is spun off when its operating managers purchase it. The XYZ Corporation has a fiduciary liability policy in place with a January 1, 2020–21, 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, 2020, provided the claim associated with those acts is made before the expiration of XYZ's policy on January 1, 2021. Coverage for acts that took place after the July 1, 2020, 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, 2021.

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 take place prior to policy expiration. For example, assume an insured is covered by a fiduciary liability policy with a January 1, 2020, to January 1, 2021,

term. One of the insured's benefit plans is terminated on July 1, 2020. Coverage applies to acts associated with the terminated plan, provided these acts took place prior to January 1, 2021, and the claim associated with such acts is also made against the insured prior to the expiration of the policy on January 1, 2021.

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 latter instance, coverage applies to claims made in conjunction with wrongful acts that take place up until the policy expires, if 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, 2022–23, term. The subsidiary is spun off on July 1, 2022. Coverage applies if (1) the wrongful act causing the claim took place prior to July 1, 2022, and (2) the claim is made against the insured prior to January 1, 2023.
- **Plan Termination.** The applicable policy is written with a January 1, 2022–23, term. The plan is terminated on July 1, 2022. Coverage applies if (1) the wrongful act causing the claim took place prior to January 1, 2023, and (2) the claim is made against the insured prior to January 1, 2023.

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 8 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. Whale Company acquired Jonah Company on 6/1/16. On that date, Jonah is added as an insured on Whale's fiduciary liability policy. On 11/15/16, a claim is made against Jonah in connection with a wrongful act that Jonah allegedly committed on 1/15/16. Does Whale have coverage for this claim?

    A. Whale has coverage for this claim because Jonah was automatically added as an insured.

    B. Whale has coverage for this claim because the claim was made after Jonah was acquired.

    C. Whale has coverage for this claim unless the wrongful act occurred before the retroactive date in Whale's policy.

    D. Whale has no coverage for this claim because the act took place before the acquisition date.

3. 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 purchase separate insurance. On September 5 of this year, Bobbin employees make a claim 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.

4. On July 1, 2018, a subsidiary of the NO WAY Corporation is spun off when its operating managers purchase it. The NO WAY Corporation has a fiduciary liability policy in place with a January 1, 2018–19, term. In this situation, coverage will apply under NO WAY's fiduciary liability policy to any acts associated with the subsidiary's benefit plans that took place prior to _____, provided the claim associated with those acts is made before _____.

    A. January 1, 2018/July 1, 2018

    B. July 1, 2018/January 1, 2019

    C. January 1, 2018/January 1, 2019

    D. January 1, 2019/January 1/2019

5. On July 1, 2018, Rump Pump Company terminated one of its benefit plans. Rump has a fiduciary liability policy in place with a January 1, 2018–19, term. In this situation, coverage will apply under Rump's fiduciary liability policy to any acts associated with that plan that took place prior to _____, provided the claim associated with those acts is made before _____.

    A. January 1, 2018/July 1, 2018

    B. July 1, 2018/January 1, 2019

    C. January 1, 2018/January 1, 2019

    D. January 1, 2019/January 1/2019

Answers to Chapter 8 Review Questions

1.

A. This answer is incorrect. Coverage applies only to acts taking place after the acquisition.

B. This answer is incorrect. An additional premium will be charged.

C. This answer is incorrect. When the acquired entity's assets exceed the threshold percentage stated in the policy, automatic coverage does not apply.

D. That's correct! Because 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. This answer is incorrect. It is important to also consider the date of the alleged wrongful act.

B. This answer is incorrect. It is important to also consider the date of the alleged wrongful act.

C. This answer is incorrect. The wrongful act occurred before Whale acquired Jonah.

D. That's correct! No coverage for this claim is available under Whale's policy because the wrongful act that gave rise to the claim occurred before the 6/1/16 acquisition date.

3.

A. That's correct! Coverage applies under the former parent company's fiduciary liability policy for any acts that took place prior to the spin-off.

B. This answer is incorrect. Bobbin's policy will not cover acts that took place before the spin-off.

C. This answer is incorrect. Bobbin was not a separate entity on February 14, when the incident occurred.

D. This answer is incorrect. Generally, coverage applies under the former parent company's policy for acts that took place before the spin-off.

4.

A. This answer is incorrect. Covered claims may still be made after July 1, 2018.

B. That's correct! 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.

C. This answer is incorrect. Acts taking place after January 1, 2018, can also be covered.

D. This answer is incorrect. The subsidiary was acquired before January 1, 2019.

5.

A. This answer is incorrect. Coverage applies to acts taking place after July 1, 2018.

B. This answer is incorrect. Coverage applies to acts taking place during the policy period.

C. This answer is incorrect. Acts taking place after January 1, 2018, can also be covered.

D. That's correct! 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 take place prior to policy expiration.

Chapter 9
Key Definitions in Fiduciary Liability Policies

Overview

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

Chapter Objectives

On completion of this chapter, you should be able to

- identify the correct definition of the following terms:
    - covered losses,
    - claims, and
    - defense costs; and
- apply the foregoing definitions in identifying the insurer's obligations in a given situation.

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. In addition, the policies cover supplementary expenses associated with litigation, including bonds and appeal costs.

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) of 1996. The rationale for affording such coverage is that the HIPAA law falls within the scope of the Employee Retirement Income Security Act (ERISA) of 1974. In addition, some policies include penalties levied under Section 502(c) of ERISA within their definitions of covered loss. (Note that other policies contain specific coverage extensions for HIPAA and Section 502(i) penalties, rather than including such items within their definitions of covered loss.)

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, that not all states permit insurance coverage of punitive damage awards.) Such coverage is achieved by means of most favorable jurisdiction wording.

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

A criminal indictment also triggers coverage under a fiduciary liability policy. This is important because, at times, 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, they 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 or convicted or the claim is settled.

Formal Investigative Proceeding

Regulatory entities, such as the Department of Labor and the Pension Benefit Guaranty Corporation (PBGC), sometimes request investigations into various benefit programs operated by a corporation, such as when a pension plan appears to be seriously underfunded. Thus, it is important for coverage to be triggered by such actions.

Formal Administrative or Regulatory Proceeding

This includes the filing of a notice of charges against an insured, which alleges violation of ERISA.

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 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 attorney 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. In other words, defense costs are paid within policy limits. To illustrate: Assume that a fiduciary liability policy is written with a $2 million limit. Also assume that in defending a claim, the insurer expends $1 million. At this juncture, $1 million of coverage remains to pay any combination of additional defense costs, settlements, or judgments.

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.

Nearly all fiduciary liability forms contain wording to the effect that the insurer has a duty to defend. (A few insurers give insureds the option to buy coverage on a non-duty to defend basis, however.) 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 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 the policy covers at least one such allegation.

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 sued for damages relating to the error in administering the company's healthcare 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.

Chapter 9 Review Questions

1. The definition of "loss" in fiduciary liability policies usually includes
    A. civil penalties.
    B. fines.
    C. indemnity amounts.
    D. taxes.
2. Which of the following incidents involving a Long Company employee is most likely to trigger coverage under Long's fiduciary liability policy?
    A. At an employee meeting, Dora makes a public statement accusing Long's plan administrators of fraud.
    B. Cameron obtains a written cease and desist order against Long.
    C. Gerardo threatens to sue Long unless Long provides more investment options in its 401(k) plan.
    D. Marla tells her friends that Long's benefits program is inferior.
3. Victor 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 Victor 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 Victor'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.
4. The policy limits in most insurers' fiduciary liability policy forms apply to any combination of
    A. attorney 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.

5. A human resources assistant misplaced Miriam's enrollment form for coverage under Carpenter Company's medical insurance plan and never submitted it to the insurance company. As a result, Miriam had no insurance coverage when she was diagnosed with cancer a month later. Miriam complained, and Carpenter responded by firing her. Miriam then sued Carpenter for damages relating to the administrative healthcare plan error and for lost wages resulting from wrongful termination. Because Carpenter's fiduciary liability insurance is written on a duty to defend policy,

    A. the insurer has a duty to defend the administrative error claim but not the wrongful termination claim.

    B. the insurer has a duty to defend the wrongful termination claim but not the administrative error claim.

    C. the insurer is required to defend both the administrative error claim and the wrongful termination claim and to pay damages awarded in response to either or both claims.

    D. the insurer must defend both the administrative error claim and the wrongful termination claim.

Answers to Chapter 9 Review Questions

1.

A. This answer is incorrect. Most policies' "loss" definitions exclude civil penalties.

B. This answer is incorrect. Fines are never treated as losses.

C. That's correct! 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.

D. This answer is incorrect. "Loss" is not defined to include taxes in most policies.

2.

A. This answer is incorrect. To trigger coverage, Dora should put it in writing.

B. That's correct! Nearly all fiduciary liability policies are triggered by a written demand seeking either money damages or nonmonetary relief such as a cease and desist order.

C. This answer is incorrect. Nearly all fiduciary liability policies require a written demand to trigger coverage.

D. This answer is incorrect. Marla has not made a demand for money or other relief.

3.

A. This answer is incorrect. Fines are not covered.

B. That's correct! Fiduciary liability policies provide defense coverage when an insured is criminally charged.

C. This answer is incorrect. Coverage is not limited to these two costs.

D. This answer is incorrect. The insurer will also be involved in the criminal case.

4.

A. This answer is incorrect. Payment of any settlement does not reduce the limits available to cover defense costs.

B. This answer is incorrect. Because defense costs are within limits, nearly all policies' limits apply to both defense costs and indemnity payments.

C. This answer is incorrect. Defense costs are within limits.

D. That's correct! 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.

5.

A. This answer is incorrect. The insurer has a duty to defend the wrongful termination claim.

B. This answer is incorrect. The insurer has a duty to defend the administrative error claim.

C. This answer is incorrect. The fiduciary liability policy does not cover damages for wrongful termination; that's the province of employment practices liability coverage.

D. That's correct! The insurer is obliged to defend all allegations in a lawsuit, as long as the policy covers at least one such allegation. In this case, fiduciary liability insurance covers only the administrative error claim.

Chapter 10
Fiduciary Liability Coverage: Limits and Deductibles/Retentions Provisions

Overview

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

Chapter Objectives

On completion of this chapter, you should be able to

- recognize how the limits and deductibles/retentions provisions in a fiduciary liability policy operate and
- given relevant information concerning a covered fiduciary liability claim, determine the amount payable by the insurer and/or the insured.

Policy Limits

Under most fiduciary liability policies, a maximum aggregate limit applies to all of the insuring agreements contained within the policy. In addition, sublimits are provided for the coverage extensions that are included. These sublimits reduce the amount of coverage available for all other types of claims and do not provide additional amounts of insurance.

The following example illustrates the manner in which limits are afforded under the typical fiduciary liability policy. Assume the policy contains a $5 million aggregate limit. Also assume that the policy contains sublimits ranging from $25,000 to $100,000 for the various coverage extensions the policy provides, such as settlor coverage, managed care coverage, Health Insurance Portability and Accountability Act (HIPAA) of 1996 claim coverage, coverage for 502(c) penalties, and coverage for investigations. Any monies paid out under these coverage extensions will reduce the $5 million aggregate limit. In addition, voluntary compliance settlement coverage is also usually written with a sublimit.

Coverage for fiduciary liability claims is available up to a maximum of $5 million, an amount that could be reduced if monies are paid out under any of the aforementioned coverage extensions the policy also provides.

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 2020, Company A's pension plan is merged with Company B's plan, after Company B acquires Company A. The trustees of A's plan are later sued because the benefits under B's plan are lower than under Company A's plan. Fiduciary liability policies with limits of $5 million were in force during 2021, 2022, and 2023. Three different beneficiaries make claims against the trustees in 2021, 2022, and 2023, respectively.

Under an interrelated claims provision, the $5 million policy limit applying in 2021 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 2022 and 2023 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 2021 would have applied to the first claim;
- the insurer's $5 million policy limits applicable during 2022 would have applied to the second claim; and
- the insurer's $5 million limit applicable during 2023 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).

The policies are written so that a separate retention, usually noted on the policy's declarations page, applies to each insuring agreement and coverage extension.

Chapter 10 Review Questions

1. Root Canal Company has a fiduciary liability policy with a $1 million limit. The policy includes managed care coverage with a $25,000 sublimit. During the current policy term, a managed care claim against Root Canal was made and settled for $25,000 in indemnity and $15,000 in defense costs. A fiduciary liability claim has just been made. How much coverage is available to Root Canal for the fiduciary liability claim?

    A. $960,000 plus defense costs

    B. $975,000 including defense costs

    C. $985,000 including defense costs

    D. $1 million plus defense costs

2. The interrelated claims provision in Pharaoh Company's fiduciary liability policy is most likely to apply

    A. if a series of wrongful acts took place during two or more policy terms.

    B. if the assets of Pharaoh Company's plan were invested in a fraudulent pyramid scheme.

    C. the lowest limit available for any one of the years during which a series of wrongful acts took place.

    D. to permit Pharaoh to apply more than 1 year's policy limits to a claim for wrongful acts that took place over several years.

3. For four consecutive years, the trustees of Rusty Company's pension plan repeat the same error and failed 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.

4. After reading the interrelated claims provisions in his company's fiduciary liability policy, Gerardo is confused. He thinks he understands how the provision works, but he cannot understand what the provision is supposed to accomplish. What is the purpose of the interrelated claims provisions?

    A. to enable policyholders to apply the limits from more than one policy when related acts occur during different policy terms.

    B. to ensure that payouts under one claim do not erode limits and prevent recovery from a subsequent claim involving the same or similar incidents.

    C. to prevent pyramiding limits from more than one year to cover a series of unrelated acts.

    D. to prevent stacking policy limits from more than 1 year to cover a single wrongful act or series of related acts.

5. 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 JCF. 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 10 Review Questions

1.

A. This answer is incorrect. The insurer did not pay $40,000 under a coverage with a $25,000 sublimit. Remember, defense costs are within limits.

B. That's correct! Because of the managed care sublimit, the insurer paid $25,000 on the first claim for both indemnity and defense costs. Therefore, only $975,000 ($1 million – $25,000) remains available for both indemnity and defense costs resulting from the fiduciary liability claim.

C. This answer is incorrect. The insurer has already paid damages under the managed care claim.

D. This answer is incorrect. Payment of the previous managed care claim has eroded the $1 million limit, reducing the remaining limits still available.

2.

A. That's correct! The interrelated claims provisions apply when a series of claims from a single wrongful act or a series of acts, errors, or omissions are made during more than one policy period.

B. This answer is incorrect. The provisions do not specifically apply to pyramid schemes.

C. This answer is incorrect. Although increases are probably more common than decreases, the limits in a series of policies may increase or decrease from one year to the next.

D. This answer is incorrect. The effect of the interrelated claims provision is to eliminate stacking.

3.

A. This answer is incorrect. The interrelated claims provision does not specify that the applicable limit is the one in effect when the error first occurred.

B. That's correct! The applicable limit is the one that was in effect at the time the first claim is made.

C. This answer is incorrect. The interrelated claims provision specifies that one particular policy's limit is the one that applies.

D. This answer is incorrect. No wrongful acts were allegedly committed during Year 5.

4.

A. This answer is incorrect. The provision is intended to prevent applying limits from more than one policy.

B. This answer is incorrect. If this were true, it would defeat the purpose of aggregate limits.

C. This answer is incorrect. The provisions apply to a single act or a series of related wrongful acts.

D. That's correct! The purpose of interrelated claims provisions is to prevent a "pyramiding" or "stacking" of limits in which policy limits from more than one year are applied to a single wrongful act or series of related wrongful acts.

5.

A. This answer is incorrect. The insurer would pay nothing for damages if the claim were settled in the insured's favor, but that's not the case here.

B. This answer is incorrect. The $50,000 deductible will be paid by the insured, not the insurer.

C. This answer is incorrect. This would be the amount payable by the insured if the insured had to pay its own defense costs, but that is not the case.

D. That's correct! 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 11
Fiduciary Liability Policy Conditions

Overview

The conditions sections of fiduciary liability insurance policies significantly affect the insureds' rights under the policies. This chapter discusses three policy conditions that are especially important in fiduciary liability policies.

Chapter Objectives

On completion of this chapter, you should be able to

- recognize the effect of each of the following conditions found in fiduciary liability policies:
    - subrogation/recourse,
    - severability of interests provisions, and
    - managed care exception wording; and
- given relevant claim information, recognize how each of the foregoing conditions would apply.

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—that is, 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 management and professional liability insurance, wherein policy language typically bars subrogation against insureds.

When Is Subrogation Permitted Against Fiduciaries?

Section 410(b)(1) of the Employee Retirement Income Security Act (ERISA) of 1974 allows an insurer to pursue subrogation against a covered fiduciary, if the premium for a fiduciary policy is paid out of a benefit plan's 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

The fiduciaries managing a company's employee benefit plans are sued because they hired an incompetent actuary whose recommendations produced a woefully underfunded defined benefit 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, as described above) against the insured fiduciaries.

The rationale for allowing subrogation (which, as noted above, is unusual under management and 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.

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 (and *not* from benefit plan assets). As a result, the fiduciaries are not 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 statements within the application for coverage made by one insured will not be imputed to other insureds and will therefore 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) void 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 in Chapter 12.

Here is an example in which a severability provision would apply. Assume that one fiduciary commits an act that would be subject to the policy's dishonesty exclusion (e.g., a benefit 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 who committed the dishonest act of receiving a kickback.

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 Statements in Applications 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 to beneficiaries. 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.

For example, 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.

Order of Payments

About half of all fiduciary liability policies contain order of payments provisions, also known as priority of payments provisions.

These provisions state that in the event of a loss for which the insurer is liable for making a payment, such payment will be made in the following order. First, loss will be paid on behalf of the *insured persons* under the policy. Next, loss will be paid on behalf of *insured plans* within the policy. Lastly, loss will be paid on behalf of the *insured company* under the policy.

Directors and officers liability policies contain a similar provision, whereby payment priorities begin with the individual directors and officers (Coverage A), followed by the insured corporation (Coverage B), and lastly coverage for securities liability claims (Coverage C).

Chapter 11 Review Questions

1. The fiduciaries managing Conway Corporation's benefit plans are sued because they hired an incompetent actuary whose recommendations produced a woefully underfunded defined benefit pension plan. Conway has a fiduciary liability policy from Big Rock Insurance Company, and premiums for that policy were paid out of the pension plan's assets. After paying the claim, Big Rock has the right to subrogate against

    A. itself.

    B. the Casualty Actuarial Society (CAS).

    C. the claimant(s).

    D. the fiduciaries.

2. The fiduciaries managing Goaway Corporation's benefit plans are sued because they hired an incompetent actuary whose recommendations produced a woefully underfunded defined benefit pension plan. Goaway has a fiduciary liability policy from Soft Rock Insurance Company, and premiums for that policy were paid by Goaway as a corporate expense. After paying the claim, Soft Rock has the right to subrogate against

    A. itself.

    B. the actuary.

    C. the claimant(s).

    D. the fiduciaries.

3. In practice, insurers rarely subrogate against fiduciaries because

    A. any recovery must be deducted from the indemnity payment, creating a wash transaction.

    B. fiduciary liability premiums are usually paid as a corporate expense.

    C. fiduciary liability premiums are usually paid from plan assets.

    D. the cost of any subrogation recovery usually exceeds the benefit.

4. Judas, one of the 12 trustees of Benefit Plan, also serves as its treasurer. In exchange for 30 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 12 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.

5. Although Parrot Eyes Resort has fiduciary liability insurance, the policy limit is probably not going to provide enough coverage to pay current claims against Parrot Eyes Resort, Inc., the Parrot Eyes Retirement Plan, and the Parrot Eyes Retirement Plan fiduciaries. According to the policy's priority of payments provision, which of these entities is least likely to benefit from the policy's coverage?

    A. Autumn Kirk, the plan's principal fiduciary

    B. Parrot Eyes Resort

    C. Parrot Eyes Retirement Plan

    D. Vernon Best, one of the plan's three fiduciaries

Answers to Chapter 11 Review Questions

1.

A. This answer is incorrect. It would be silly for an insurer to subrogate against itself. At best this would move money from one of the insurer's accounts to another and incur unnecessary expenses in the process.

B. This answer is incorrect. It would be a stretch at best to suggest that the CAS was responsible for the actuary's incompetence which, in turn, led to Conway's plan's loss.

C. This answer is incorrect. The insurer would not pay the claimants and then attempt to recover its payment from them.

D. That's correct! An unusual aspect of the subrogation provisions within fiduciary liability policies is that, unless specified, underwriters ordinarily have the right to subrogate against an insured.

2.

A. This answer is incorrect. It would be silly for an insurer to subrogate against itself. At best this would move money from one of the insurer's accounts to another and incur unnecessary expenses in the process.

B. That's correct! 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.

C. This answer is incorrect. The insurer would not pay the claimants and then attempt to recover its payment from them.

D. This answer is incorrect. Section 410(b)(1) of ERISA allows an insurer to pursue subrogation against a covered fiduciary when the premium for a fiduciary policy is paid out of a benefit plan's assets. In this case, the premium was paid by Goaway.

3.

A. This answer is incorrect. Any recovery would not be deducted from the indemnity payment that claimants receive.

B. That's correct! Insurers can only subrogate against fiduciaries when the premium for the fiduciary policy is paid out of plan assets.

C. This answer is incorrect. Plan assets are not normally used to pay fiduciary liability premiums.

D. This answer is incorrect. Although this might be true, an even stronger reason is that other factors make subrogation out of the question.

4.

A. That's correct! If the actions of one insured void coverage, such coverage is not invalidated as respects other individuals insured by the policy.

B. This answer is incorrect. The severability provision preserves coverage for the innocent fiduciaries.

C. This answer is incorrect. The severability provision applies to all insureds.

D. This answer is incorrect. Coverage for Judas is precluded by the dishonesty and personal profit exclusions.

5.

A. This answer is incorrect. As a fiduciary, Autumn will be first in line.

B. That’s correct! According to the order of payments provision, the insured company has the lowest priority.

C. This answer is incorrect. Another entity has lower priority than the insured plan.

D. This answer is incorrect. As a fiduciary, Vernon will have top priority.

Chapter 12
Fiduciary Liability Policy Exclusions

Overview

Exclusions contained in fiduciary liability policy forms, which can have a significant effect on the scope of coverage they provide, are the subject of this chapter.

Chapter Objectives

On completion of this chapter, you should be able to

- recognize the purpose and the effect of each of the following exclusions contained in a fiduciary liability policy:
    - 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 the Employee Retirement Income Security Act (ERISA) of 1974;
    - failure to purchase or maintain insurance or bonds;
    - workers compensation, unemployment insurance, and Social Security disability benefits;
    - discrimination not related to ERISA law;
    - benefits payable to a beneficiary;
    - bodily injury and property damage; and
    - exposures excluded by other types of management and professional liability policies; and
- given relevant information, recognize how each of these exclusions would apply in a particular situation.

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 is therefore excluded. However, nearly all fiduciary liability policies qualify the dishonesty exclusion by stating that it 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 civil judgment.

Another important aspect of the dishonesty exclusion is that it is usually written with severability language. This has the effect of providing so-called innocent insureds with defense coverage in the event a claim names such individuals as defendants, in addition to one or more culpable insureds.

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 against fiduciaries 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 actual effect of the dishonesty exclusion is practically nil, because the exclusion is not usually enforced in a manner that denies 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 uninsurable and therefore excluded. For example, if a trustee of a defined benefit pension plan receives a portion of a broker's commission in return for investing the plan's funds with the broker's company, a claim arising from such an act would fall within the policy's personal profit exclusion and would thus be excluded.

However, most fiduciary liability policies do not apply this exclusion unless the claim of personal profit is factually established. This approach is similar to what is used within the dishonesty exclusion, whereby application of the exclusion is contingent upon "final adjudication."

Contractual Liability

Fiduciary liability policies typically contain an exclusion that precludes coverage for situations in which a fiduciary is required to hold a third party harmless for the third party's negligent act, error, or omission in conjunction with services that the third party is providing to a benefit plan.

An Example: Holding a Third Party Harmless in Conjunction with a Benefit Plan

A Certified Public Accountant (CPA) firm requests that an insured fiduciary hold the accounting firm harmless if the firm is sued in connection with auditing services the accounting firm performs for the plan. Also assume that the accounting firm certifies that 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 Pension Benefit Guaranty Corporation (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 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 so that it excepts and thus covers 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 a benefit or pension plan. However, if an insured fiduciary must hold another entity harmless (which is sometimes the case when the service provider is a large firm with substantial bargaining power), 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.

Important Exception Wording

Within the contractual liability exclusion, there are usually two key exceptions that provide affirmative 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 that requires the trustee to assume liability for another party's negligence. These two exceptions are discussed below.

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 fiduciary's sole negligence. Also assume that the insured fiduciary provided the actuary with out-of-date data pertaining to its pension plan and that, as a result, the pension actuary's calculations as to the plan's solvency turned out to be erroneous. Under these conditions, even in the absence of an agreement to hold the actuary harmless, the fiduciary would still have been required to indemnify the actuary for any claims made against the actuary. This is because such claims would have been the result of the fiduciary's negligence (not the actuary's). In this instance, the policy would therefore cover the fiduciary's assumption of liability, because such liability (i.e., for the fiduciary's sole negligence) would apply even if the fiduciary had 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. 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 arises more often in multiemployer, union-sponsored plans and less frequently as respects single-employer plans.

Rationale for the Exclusion

The failure to collect contributions exclusion appears in fiduciary liability policies because the collecting of pension and benefit plan contributions from companies participating in a benefit plan is an activity that is 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."

Key Exception Wording

However, many of the forms do provide key exception wording, by providing 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 an insured fiduciary believed it needed to collect $500,000 in annual premiums from each of the 10 participants in a multiemployer pension plan (when it actually needed to collect $750,000), coverage would apply because the failure to collect contributions was the result of the insured's negligence in underestimating the required level of contributions rather than an intentional failure to collect contributions.

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 noted in Chapter 8 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 these types of acts.

This exclusion is necessary because, absent such wording, claims from a subsidiary's preacquisition 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 liability policies. The rationale for the exclusion is that covering losses is 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) of 1985 plans and claims made under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such plans allow employees to purchase an extension of their healthcare 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. Additionally, and as discussed in Chapter 7, insurers frequently provide affirmative coverage grants within their policies that cover these two 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 (EPL) 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 of 1967, the Americans with Disabilities Act of 1990, and the Family and Medical Leave Act 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. In effect, the purpose of the discrimination exclusion is to preclude coverage for traditional employment-related allegations rather than claims alleging that a fiduciary's benefit-related decisions and actions were discriminatory.

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. Accordingly, if it could be demonstrated that the fiduciary(ies) in this example 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 one or more of the insured fiduciaries commits a wrongful act that prevents 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 in Chapter 2, 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 usually contain wording that excepts, and therefore covers, bodily injury and property damage claims when they result from the management or administration of managed healthcare 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 Management and 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 management and professional liability policy forms. These are noted in Exhibit 12.1 and discussed further in other courses within the Management Liability Insurance Specialist (MLIS) program.

Exhibit 12.1
Exclusions Found in Standard Professional Liability Policies

- Claims reported to prior insurers
- Claims covered by other insurance
- Prior and pending litigation
- Pollution

Chapter 12 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 the Employee Retirement Income Security Act. 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, Jean Coffy 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 Jean's claim against the employer's fiduciaries

    A. because the fiduciaries lack any contractual relationship with Jean 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 12 Review Questions

1.

A. That's correct! Because 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.

B. This answer is incorrect. Insurance does not cover the intentional commission of illegal acts.

C. This answer is incorrect. It's only an allegation; Bea might not be guilty of the alleged acts.

D. This answer is incorrect. The policy has a dishonesty exclusion.

2.

A. This answer is incorrect. Coverage for this situation is not usually available.

B. That's correct! 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.

C. This answer is incorrect. There is no sublimit for this coverage.

D. This answer is incorrect. Insurers are not eager to provide this coverage.

3.

A. This answer is incorrect. Not all policies have this exclusion.

B. This answer is incorrect. Although it is within the insured's control, there can be situations like this in which the insured unintentionally fails to make its collections.

C. This answer is incorrect. Some policies cover negligence.

D. That's correct! 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.

A. This answer is incorrect. Only one of the two is covered.

B. That's correct! Covering the exposure would be against public policy, but defending allegations of violating federal law is not against public policy.

C. This answer is incorrect. Some coverage is provided for these claims.

D. This answer is incorrect. Failure to fund a plan is an intentional violation of federal law.

5.

A. This answer is incorrect. The benefit promised in the employee handbook might be considered a contractual obligation.

B. This answer is incorrect. An outside organization (the insurer) providing benefits to the insured's employees is not an insured.

C. That's correct! 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.

D. This answer is incorrect. The exclusion is designed to prevent the fiduciary liability insurer from becoming a financial guarantor of benefits due until an insured corporation's benefit program.

Chapter 13
Fiduciary Liability Policy Coverage Triggers

Overview

This chapter addresses 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.

Chapter Objectives

On completion of this chapter, you should be able to

- identify the differences between occurrence triggers and claims-made triggers,
- identify the distinctive features of a claims-made policy, and
- given relevant information concerning a claim, determine whether claims-made coverage has been triggered.

Operation of Claims-Made Coverage Triggers

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

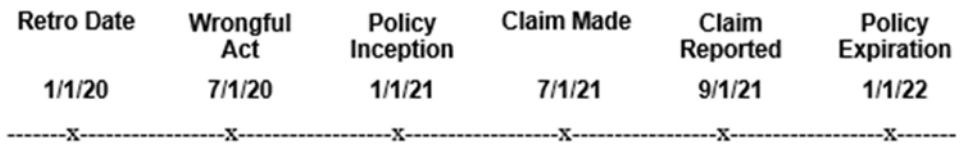
1. *first made* against an insured during the policy period,
2. result from a wrongful act that took place on or after the policy's *retroactive date*, and
3. be *reported to the insurer* prior to the expiration of the policy (or within 30 to 60 days following expiration).

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

Operation of a claims-made coverage trigger is illustrated in Exhibit 13.1.

Exhibit 13.1
How a Claims-Made Policy Functions

Policy Period: 1/1/21–1/1/22
Retro Date: 1/1/20
Wrongful Act: 7/1/20
Claim Made: 7/1/21
Claim Reported: 9/1/21



In this example, coverage applies because: (1) the claim was first made against the insured during the 1/1/21–22 policy period, (2) the wrongful act that caused the claim took place after the policy's 1/1/20 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 1/1/20 retroactive date, coverage would not have applied. Similarly, there would have been no coverage under the 1/1/21–1/1/22 policy had the claim been made against the insured prior to 1/1/21 or after 1/1/22.

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 (1) made in conjunction with 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, 2020–21, term, no coverage would apply unless a claim was both made against the insured during the policy period and reported to the insurer prior to January 1, 2021.

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 on 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, 2010, but did not seek to buy fiduciary liability coverage until January 1, 2020, 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 first fiduciary liability policy the insured purchased and the retroactive date of the new insurer's policy.

Always resist retroactive date advancements when replacing coverage. At times, underwriters may 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 wrongful 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 1 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.

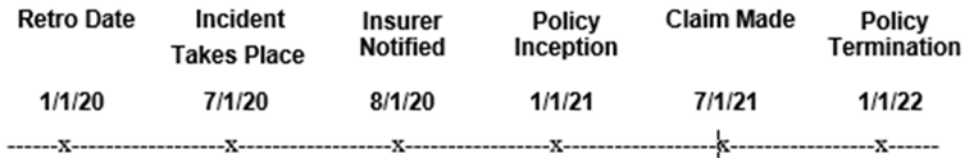
Use of a Discovery Provision: An Example

The trustee of a corporation's defined benefit pension plan reveals in a report to employee beneficiaries 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 13.2 illustrates the operation of a discovery provision.

Exhibit 13.2
How a Discovery Provision Functions

Policy Term: 1/1/21–22



In this example, coverage applies under the 1/1/20–21 policy term because the insurer was notified by the insured of an "incident" on 8/1/20. Although the claim associated with the incident was not made against the insured until *after* the 1/1/20–21 policy had expired, coverage applies nonetheless because the insurer was notified of the incident under the policy's discovery provision during the 1/1/20–21 policy period. Coverage will always be available regardless of how far in the future a claim is made in conjunction with the incident.

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." However, four problems 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 therefore 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 benefit plans that might, at some time, eventually produce a catastrophic loss. Accordingly, if, in the underwriter's perception, an insured begins to overreport incidents, the underwriter may question the wisdom of continuing to insure such plans and their fiduciaries—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 an insured to secure replacement coverage should the insured decide to change insurers. This is because when an insured has already disclosed circumstances surrounding possible claims to an incumbent insurer, the insured must also reveal these circumstances (on the application form) to an insurer that 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 or, at best, offer a much higher quote than it would have had the insured reported a number of incidents.
- **Possible Admission of Culpability.** 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 fiduciary was concerned either about the level of competence with which the insured's benefit programs had been administered or about adverse outcomes associated with the way in which the benefit programs had been managed. Either way, evidence of the report—regardless of whether the insured's conduct was not negligent—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. However, in one situation, 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.

Extended Reporting Provisions

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 to the insurer after a policy has expired or been canceled. Exhibit 13.3 illustrates how an ERP provision functions.

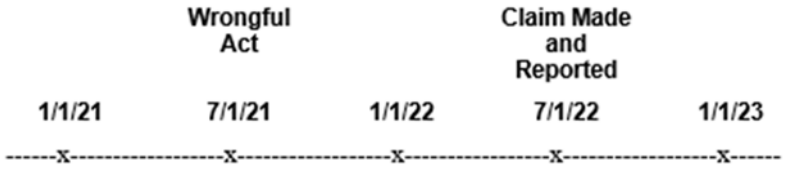
Exhibit 13.3
How an ERP Functions

Insurer A's Policy Term: 1/1/21–22

Insured buys an ERP from Insurer A with an ERP term of 1/1/22–23

Wrongful Act: 7/1/21

Claim Made and Reported: 7/1/22



Coverage applies under the ERP because the wrongful act took place during Insurer A's 1/1/21–22 policy term and a claim associated with the act was made and reported during the term of Insurer A's 1/1/22–23 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 1/1/22–23 ERP. 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 ERP 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 ERP itself, despite 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 the different fiduciary liability insurers write them. These differences are described in the following paragraphs.

Availability

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. (At one time, a minority of insurers provided this option only in the event that the insurer initiated cancellation/nonrenewal, termed a one-way tail. Currently, virtually no insurers write policies containing one-way tails.)

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

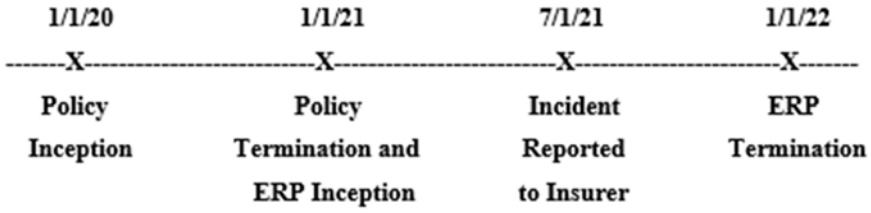
A key variation between the ERPs in fiduciary liability forms is whether a report of circumstances that have the potential to result—but have not yet resulted—in a formal claim against the insured are covered by an ERP. In effect, under some insurers' ERP wording, the policy's discovery provision (discussed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

To illustrate: A fiduciary liability policy expires on January 1, 2020, at which time the insured firm buys a 1-year ERP. On August 1, 2020, 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 has 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. Under these types of policies, 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. This concept is illustrated in Exhibit 13.4.

Exhibit 13.4
Coverage for "Incidents" during an ERP

Policy Period: 1/1/20–1/1/21
ERP: 1/1/21–1/1/22
Incident Date: 7/1/21
Policy states that coverage applies to "incidents" reported to insurer during ERP



In this situation, coverage applies to the incident reported to the insurer on 7/1/21. This is because the policy states that in addition to covering "claims" made against the insured during the term of the ERP, coverage also applies to "incidents" reported during the ERP.

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 –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, under certain circumstances, 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 that took 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 1-year, annually renewable basis.

Chapter 13 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, 2015, 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, 2015.

    B. before January 1, 2015.

    C. before the policy expires on January 1, 2015.

    D. on or after January 1, 2015.

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, 2016–July 1, 2017, and an extended reporting period (ERP) term of July 1, 2017–July 1, 2018. A wrongful act took place on October 1, 2017, and a claim was made and reported to the insurer on February 1, 2018. 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.

5. Irma, the new risk manager for Woods Company, is reviewing Woods's insurance portfolio when she comes across a fiduciary liability policy with an attached Post-It note that reads "CANCELED." She also sees that the cancellation took place two weeks ago. Irma thinks an extended reporting period (ERP) should be added, but first Irma wants to know who initiated the cancelation. Is this information relevant, and if so, why?

    A. If Woods's policy has a one-way tail, the ERP will not be available unless Woods initiated the cancellation.

    B. If Woods's policy has a two-way tail, the ERP will not be available if the insurer initiated the cancellation.

    C. It probably is not relevant.

    D. The premium for the ERP will be much higher if Woods initiated the cancellation.

Answers to Chapter 13 Review Questions

1.

A. This answer is incorrect. Egg's policy is not triggered.

B. This answer is incorrect. Chicken's policy is not triggered.

C. This answer is incorrect. Both policies are not triggered.

D. That's correct! 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, Chicken Insurance Company would be able to deny coverage for late reporting of a claim about which the insured had prior knowledge.

2.

A. This answer is incorrect. The retroactive date would not be the date when the policy expires.

B. This answer is incorrect. The acts must take place after that date.

C. This answer is incorrect. The retroactive date is not the same as the expiration date.

D. That's correct! For coverage to apply, the wrongful act giving rise to a claim must have taken place on or after the retroactive date.

3.

A. This answer is incorrect. A retroactive date does not expire.

B. That's correct! 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.

C. This answer is incorrect. Rather, the trustees want to trigger coverage.

D. This answer is incorrect. The trustees will probably find it difficult to renew their coverage.

4.

A. This answer is incorrect. The event should have occurred during the policy period.

B. This answer is incorrect. The event and the claim happened after the policy period.

C. That's correct! No coverage applies if the wrongful act takes place and the claim is reported during the ERP; rather, the wrongful act must take place during the expired/canceled policy period for coverage to apply during the ERP.

D. This answer is incorrect. The claim was made during the ERP.

5.

A. This answer is incorrect. In the unlikely event that the policy has a one-way tail, the ERP would only be available if the insurer initiated the cancellation.

B. This answer is incorrect. The ERP would be available if the insurer initiated the cancellation.

C. That's correct! Virtually no insurers write one-way tails that permit the ERP option only when the insurer initiates cancellation.

D. This answer is incorrect. The premium charge for the ERP option is typically set at a fixed percentage of the expiring policy's premium and is not dependent on which party initiated the cancellation.

Glossary

401(k) plan—The most common type of defined contribution retirement plan, in which employees choose to defer part of their compensation. Under the typical 401(k), employees contribute anywhere from 1 percent to 15 percent of their pre-tax annual salary each year to the plan. In addition to this amount, many employers will match the employee's contribution, such as 50 percent of up to 6 percent of the employee's contribution. For example, if an employee contributes 6 percent of his or 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 his or her annual salary (i.e., 6 percent contribution, plus 3 percent employer match). There are annual maximum amounts that employees can contribute as well as distribution restrictions prior to age 59.5.

actuarial solvency—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, a pension plan will have sufficient funds with which to pay all benefits that are promised by the plan.

blackout period—A time period during which participants in a 401(k) plan are not permitted to make changes in their investment allocations. The typical blackout period lasts from 4 to 6 weeks and is imposed when an employer-sponsor of a 401(k) plan changes from one plan administrator to another. Claims against fiduciaries charged with overseeing such plans most frequently arise when the stock market falls sharply during blackout periods. Claims are more likely at such times, because employees are unable to transfer monies out of stocks and thus reduce losses. To reduce exposure to such claims, companies offering 401(k) plans should provide notice of blackout periods well in advance of the date on which they are scheduled to begin.

cash balance pension plan—A type of employee pension benefit plan that has two distinct features: (1) the employer contributes to the plan an amount equal to a percentage of an employee's yearly earnings, and (2) the plan promises a specific rate of return on that contribution. Under a cash balance plan, the benefit is always expressed as a total account balance. Cash balance pension plans are distinct from "traditional" defined benefit pension plans, which, in contrast, promise an employee a flat dollar amount (either on a periodic or on a lump-sum basis), based on years of service and an employee's earnings in the years closest to retirement. The focus of cash balance plans is on wealth building and portability. On the other hand, traditional defined benefit plans are aimed at encouraging career employment with a single employer. In recent years, considerable litigation has arisen out of employer conversions from "traditional" defined benefit to cash balance pension plans. Older, long-term employees who typically receive lower benefits under cash balance plans have alleged that such plans are unfairly discriminatory.

claims-made and reported policy—A type of claims-made policy in which a claim must be both made against the insured and reported to the insurer during the policy period for coverage to apply. Claims-made and reported policies are unfavorable from the insured's standpoint because it is sometimes difficult to report a claim to an insurer during a policy period if the claim is made late in that policy period. However, more liberal versions of claims-made and reported policies provide post-policy "windows," which allow insureds to report claims to the insurer within 30 to 60 days following policy expiration.

claims-made policy—A policy providing coverage that is triggered when a claim is made against the insured during the policy period, regardless of when the wrongful act that gave rise to the claim took place. (The one exception is when a retroactive date is applicable to a claims-made policy. In such instances, the wrongful act that gave rise to the claim must have taken place on or after the retroactive

date.) Most professional, errors and omissions (E&O), directors and officers (D&O), and employment practices liability insurance (EPLI) is written as claims-made policies.

COBRA—See Consolidated Omnibus Budget Reconciliation Act.

coinsurance hammer clause—An alternative to the standard hammer clause found within professional, directors and officers (D&O), and errors and omissions (E&O) policy forms. Such a provision provides for a sharing of defense and indemnity costs (between the insured and the insurer) incurred after the insured refuses to consent to a settlement proposed by an insurer. The most common sharing percentage is 50/50, but it can sometimes go higher (e.g., 70 insurer/30 insured). The effect of such clauses is to reduce the amount of indemnity and defense costs that an insured could potentially incur if it refuses to consent to a settlement amount recommended by an insurer.

Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985—A federal law giving workers and their families who lose their health insurance benefits after leaving a job the right to continue receiving those benefits. COBRA requires that group health insurance plans sponsored by employers with 20 or more employees in the prior year offer employees and their families an opportunity for a temporary, 18-month extension of health coverage, when such coverage would normally end. Qualified individuals must pay the entire premium that would otherwise be paid by the employer, plus a 2 percent administrative fee. Generally, only about 10 percent of workers eligible for COBRA benefits elect them, usually because they are unable to afford the cost following the loss of a job.

defense within limits—A liability policy provision according to which amounts paid by the insurer to defend the insured against a claim or suit reduce the policy's applicable limit of insurance. General liability policies are ordinarily not subject to such a provision, although the standard commercial general liability (CGL) policy provides for defense of the named insured's indemnitee "within limits" when the named insured has a contractual obligation to provide such a defense. Defense within limits is more common in professional liability policies.

defined benefit plan—A pension plan providing a specific benefit for each employee. The employer is required to make adequate contributions to the plan to fund the promised benefits. No individual accounts are maintained as is done in defined contribution plans.

defined contribution plan—A pension plan calling for definite annual contributions by the employer but with no specific benefit promised to the employee. The employee's benefits are ultimately determined by the amount contributed plus the investment income.

discovery provisions—Provisions that permit insureds to report incidents or circumstances that may result in claims in the future, found mainly in professional liability insurance policies written with claims-made coverage triggers. Discovery provisions, which are also known as "awareness" or "notice of potential claim" provisions, allow an insured to lock in coverage for such events so that coverage will apply under the current claims-made policy, regardless of how far in the future a claim is eventually made in conjunction with the incident that has been reported.

duty to defend—A term used to describe an insurer's obligation to provide an insured with defense to claims made under a liability insurance policy. As a general rule, an insured need only establish that there is potential for coverage under a policy to give rise to the insurer's duty to defend. Therefore, the duty to defend may exist even where coverage is in doubt and ultimately does not apply. Implicit in this rule is the principle that an insurer's duty to defend an insured is broader than its duty to indemnify. Moreover, an insurer may owe a duty to defend its insured against a claim in which ultimately no damages are awarded, and any doubt as to whether the facts support a duty to defend is usually resolved in the insured's favor.

With respect to directors and officers (D&O) and employment practices liability insurance (EPLI) policies, policies containing explicit "duty to defend" wording obligate an insurer to assume control of the claim defense process, including selecting counsel and paying legal bills. In contrast, non-duty to defend (or duty to pay) policies require only that the insurer reimburse the insured for funds expended by the insured in defending a claim.

employee benefits liability—Liability of an employer for an error or omission in the administration of an employee benefit program, such as failure to advise employees of benefit programs. Coverage of this exposure is usually provided by endorsement to the general liability policy but may also be provided by a fiduciary liability policy.

employee benefits liability insurance—Policies that 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).

employee pension benefit plans—Plans created by an employer, a union, or both that provide for retirement income or the deferral of income (e.g., 401(k) plans, "traditional" defined benefit pension plans). These plans are distinguished from employee welfare benefit plans like employer-provided health, life, and disability insurance plans that address the non-income-related aspects of employee benefits.

Employee Retirement Income Security Act (ERISA)—Federal law that established rules and regulations to govern employer-provided pensions and other employee benefits provided to US employees.

employee welfare benefit plans—Plans, funds, or programs created by an employer or a union to provide medical, sickness, accident, disability, death, unemployment, and vacation benefits; apprenticeship and training programs; day care centers; scholarship funds; prepaid legal services; or any benefit allowed by the Taft-Hartley Act. These plans are distinguished from employee pension benefit plans that provide for retirement income or the deferral of income (e.g., "traditional" defined benefit pension plans, 401(k) plans).

ERISA—See Employee Retirement Income Security Act.

ERISA "stock drop" litigation—Litigation brought against corporate directors and officers and trustees of corporate 401(k) plans. Such litigation, normally filed in the form of a class action lawsuit, arises when the market price of a company's stock drops sharply, and, as a consequence, employee 401(k) plan holders lose substantial sums of money because they hold large amounts of company stock in their individual accounts. In these lawsuits, employee-plaintiffs allege that the directors and officers were fiduciaries of the 401(k) plans and that the conduct governing the administration of such plans is therefore governed by the provisions found within the Employee Retirement Income Security Act (ERISA). Among the most common allegations of negligence asserted in these claims are (1) intentional disclosure of false and misleading information about the company's finances, which induced the employees to buy shares of the company's stock; (2) failure to disclose material information about the company and its financial condition and performance, in statements to the general public, to shareholders, or to employees; (3) failure to disclose such information to other plan fiduciaries (such as investment advisers and brokers) who had responsibility for investing plan assets; and (4) failure to correct misleading statements made by other officers and plan fiduciaries and failure to adequately monitor wrongdoing by other plan fiduciaries.

ERISA—See Employee Retirement Income Security Act.

ERP—See extended reporting period.

extended reporting period (ERP)—A designated time period after a claims-made policy has expired during which a claim may be made and coverage triggered as if the claim had been made during the policy period.

fiduciary—As defined by the Employee Retirement Income Security Act (ERISA), an individual or corporation that (1) exercises any discretionary authority or discretionary control in managing a 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; or (3) has any discretionary authority or responsibility in administering the plan. ERISA, which was passed in 1974, 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. The effect of this change was that soon after ERISA's enactment, insurance companies began offering fiduciary liability insurance policies, which were specifically designed to cover this newly legislated exposure.

fiduciary liability—The responsibility on trustees, employers, fiduciaries, professional administrators, and the plan itself with respect to errors and omissions (E&O) in the administration of employee benefit programs as imposed by the Employee Retirement Income Security Act (ERISA).

fiduciary liability insurance—Insurance that covers claims alleging breach of discretionary duties specified by the Employee Retirement Income Security Act (ERISA) of 1974 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.

full prior acts coverage—A type of claims-made liability policy that does not contain a retroactive date and therefore covers claims arising from acts that took place at any time prior to the inception date of the policy—regardless of how far in the past. For example, assume that an insured has a claims-made policy that includes a January 1, 2000, retroactive date and a January 1, 2016–17, term. If a claim is made against the insured on July 1, 2016, and the claim arose from a wrongful act that took place on January 1, 1998, there would be no coverage under the policy. This is because the wrongful act took place prior to the January 1, 2000, retroactive date. Now assume that another insured has a policy written with the same January 1, 2016–17, policy term, but the policy contains no retroactive date. If a claim were made against the insured on July 1, 2016, from a wrongful act that took place on January 1, 1998, coverage would apply because the absence of a retroactive date means that regardless of how far in the past a wrongful act giving rise to a claim took place, the claim will be covered (as long as it is made against the insured during the policy period). Full prior acts coverage is most likely to be granted when an applicant already has coverage in place at the time it submits an application. On the other hand, underwriters generally do not provide full prior acts coverage to insureds that have not previously purchased liability insurance. This is because underwriters sometimes believe that an applicant's desire to buy coverage at this juncture may be motivated by the applicant's intention to report a claim under the new policy.

hammer clause—A provision (also known as the "consent to settlement clause" and "blackmail settlement clause") found in professional liability insurance policies that requires an insurer to seek an insured's approval prior to settling a claim for a specific amount. However, if the insured does not approve the recommended figure, the consent to settlement clause states that the insurer will not be liable for any additional monies required to settle the claim or for the defense costs that accrue from the point after the insurer makes the settlement recommendation.

Health Insurance Portability and Accountability Act (HIPAA) of 1996—A federal law that 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 of a special opportunity for employees to enroll in a new plan, under certain circumstances, known as "open enrollment."

HIPAA—See Health Insurance Portability and Accountability Act.

interrelated claims provision—Provisions within professional liability insurance policies stating that if more than one claim results from a single wrongful act, and if claims are made during more than one policy period, the insured is entitled to the limit applicable when the first claim was made rather than the sum of the limits that were applicable to the policy periods during which all claims were made. In recent years, this term has replaced the term "noncumulation of limits provision," which has essentially the same meaning in both common usage and within policy forms. The related claims provision is also sometimes referred to as the "interrelated claims provision," although this usage is less common.

Investment Company Act of 1940—A law requiring that mutual funds register with the federal government. The Act's original intent was to protect the public from many of the abuses engaged in by mutual funds during the 1920s, many of which were responsible for the Wall Street Crash of 1929. On a more contemporary basis, the Act has assumed particular importance because it affords individuals who serve as fiduciaries of employee benefits plans a layer of insulation from liability. Specifically, if it can be shown that a 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. Rather, liability can only attach when it can be shown that the fiduciary failed to select an adviser who is registered under the Act.

managed care coverage endorsement—An endorsement to a fiduciary liability policy providing coverage for bodily injury (BI), property damage (PD), and personal injury (PI) when they result from administering managed care health plans. This endorsement is necessary because fiduciary liability policies usually exclude coverage for these perils. However, because managed care plans are subject to the Employee Retirement Income Security Act (ERISA), such coverage is necessary. The two most common claims involving managed care plans allege (1) that the employer-sponsor of a managed healthcare plan negligently selected the managed healthcare plan provider, and (2) that the employer-sponsor of a managed healthcare plan wrongly denied or delayed medical benefits provided by the plan.

occurrence policy—A policy covering claims that arise out of damage or injury that took place during the policy period, regardless of when claims are made. Most commercial general liability (CGL) insurance is written on an occurrence form.

omnibus insured wording—Policy language that reduces the potential for overlooking any individuals, plans, or organizations that are intended to be covered under a fiduciary liability policy.

party-in-interest transactions—Otherwise legitimate transactions that are prohibited under the Employee Retirement Income Security Act (ERISA). The Act defines a party-in-interest as any fiduciary, legal counsel, employee of an employer-sponsored benefit plan, or service provider to the plan. Accordingly, pension plan funds cannot be used to buy or sell property to or from a person who is a party-in-interest. For example, a pension plan could not purchase shares of stock in a company owned by a member of the company's investment committee. ERISA provides for specific monetary fines and penalties for violations of party-in-interest rules. Fiduciary liability insurance policies cover the defense costs incurred in conjunction with allegations of party-in-interest violations; although no coverage is available for damages, fines, and penalties associated with such claims.

Pension Protection Act of 2006—A federal law affecting major aspects of the Pension Benefit Guaranty Corporation (PBGC) and defined contribution (i.e., 401(k)) plans. The intent of the Act was twofold: (1) to ensure the solvency of defined benefit pension plans and (2) to encourage employee participation in defined contribution/401(k) plans by making it easier for employees to increase their retirement plan balances. Among the key provisions are (1) 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; (2) allowance of higher dollar contribution amounts for 401(k) savings plans, including "catch-up" contributions for older (i.e., 50 and up) workers; and (3) provisions allowing automatic enrollment of workers in 401(k) plans, whereby every new employee is automatically enrolled in the company's plan, unless the employee specifically opts out of enrollment. In

December of 2008, however, defined benefit plan funding requirements (item 1, above) were relaxed considerably, given the fact that the stock market had suffered severe losses during the preceding year. This circumstance vastly reduced the assets of nearly every pension fund in the United States, thereby making it nearly impossible for such plans to comply with the more stringent funding requirements originally mandated by the Act.

prohibited transactions—Two types of transactions (involving employee pension and welfare plan funds) that are prohibited under the Employee Retirement Income Security Act (ERISA). These are (1) self-dealing and (2) party-in-interest transactions. Under the first type, fiduciaries are barred from using employee benefit plan assets to profit personally, such as by investing pension plan monies in a company in which a fiduciary holds a majority interest. The second type, party-in-interest transactions, are what would otherwise be legitimate business transactions yet are prohibited if they are conducted with a "party-in-interest." The Act defines a party-in-interest as any fiduciary, legal counsel, employee of an employer-sponsored benefit plan, or service provider to the plan. For example, pension plan funds cannot be used to buy or sell property to or from the family member of any trustee or anyone else who is a party-in-interest. In the event a fiduciary engages in a prohibited transaction, various monetary penalties will be levied against the employer-sponsor of the plan.

punitive damages—Damages in excess of those required to compensate the plaintiff for the wrong done, which are imposed in order to punish the defendant because of the particularly wanton or willful nature of his or her wrongdoing. Also called "exemplary damages." Although the standard commercial general liability (CGL) policy and business auto policy (BAP) contain no punitive damage exclusion, many umbrella and excess liability policies contain such an exclusion.

retroactive date—A provision found in many (although not all) claims-made policies that eliminates coverage for claims produced by wrongful acts that took place prior to a specified date, even if the claim is first made during the policy period.

For example, a January 1, 2010, retroactive date in a policy written with a January 1, 2016–2017, term would bar coverage for claims resulting from wrongful acts that took place prior to January 1, 2016, even if claims (resulting from such acts) are made against the insured during the January 1, 2016–2017, policy period.

There are two purposes of retroactive dates: (1) to eliminate coverage for situations or incidents known to insureds that have the potential to give rise to claims in the future and (2) to preclude coverage for "stale" claims that arise from events far in the past, even if such events are unknown to the insured. In the former case, the retroactive date preserves the principle of "fortuity"—that is, the insurer should not be called upon to cover the so-called burning building. In the latter instance, the retroactive date makes policies more affordable by precluding coverage for events that, while insurable, are remote in time.

settlement programs—Programs operated by various government agencies, such as the US Internal Revenue Service (IRS) and the US Department of Labor (DOL), for the purpose of resolving disputes without resorting to litigation. For example, employees and employers can voluntarily agree to settle claims pertaining to employee benefit programs, using settlement programs. Accordingly, fiduciary liability insurance policies often contain specific policy provisions and separate, additional limits that apply to the resolution of claims using settlement programs. The purpose of this approach is to encourage resolution of claims under such programs because it is likely to reduce total indemnity and defense costs.

severability of interests clause—A policy provision clarifying that, except with respect to the coverage limits, insurance applies to each insured as though a separate policy were issued to each. Thus, a policy containing such a clause will cover a claim made by one insured against another insured.

statute of limitations—A law prescribing the period within which certain types of causes of action must be brought. This period usually begins to run when the injury or damage occurs. Each state has enacted statutes that prescribe the period within which suits must be filed that vary from claim to claim. In most states, the statutory time within which a plaintiff must file suit on a bodily injury (BI) claim based on negligence is 2 years. For malpractice claims, the statute of limitations may be only 1 year. Sometimes, courts may postpone the triggering of a statute of limitation where the plaintiff does not know about the claim. Applying the "discovery rule," some courts hold that statutes of limitations begin running when the plaintiff discovers that he or she has a claim. Actions for declaratory judgment in an insurance coverage matter are generally held to be governed by the statute of limitations for suits on written contracts, which vary in length from state to state. In Texas, for example, suit on a written contract (including an insurance policy) must be filed within 4 years of the date on which one party breaches the agreement, whereas in Ohio, such a suit may be filed at any time up to 15 years after the breach.

subrogation—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.

vicarious liability—The liability of a principal for the acts of its agents. Vicarious liability can result from the acts of independent agents, partners, independent contractors, employees, and children.

voluntary compliance fees—Payments made to correct "deficiencies" in benefit programs operated by the insured organization

End Notes

[1] US Department of Labor; "ERISA at 40: Four Decades of Protecting America's Employee Benefits," **https://www.dol.gov/featured/erisa40/historical**

[2] Funds of hedge funds are an investment vehicle allowing investment in multiple hedge funds. This creates greater diversification, and presumably lower risk, than if an investment were made in only a single hedge fund.

[3] Reuters, Monday, December 15, 2008. "Two U.S. pension funds see $52 mln hit from Madoff."