A Chubb Special Report

Who May Sue You and Why: How to Reduce Your ERISA Risks, and the Role of Fiduciary Liability Insurance

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Foreword

Lawsuits against any and all parties involved with retirement and welfare plans have continued to escalate over recent years. Indeed, plan sponsors and fiduciaries now face increased risks of litigation on a number of fronts, and the need for comprehensive fiduciary liability insurance is greater than ever. For these reasons, Chubb commissioned the ERISA-experienced law firm of Groom Law Group, Chartered to compile this special report to help our customers and brokers understand the potential liability that fiduciaries face in today's litigious environment.

In this report, Lars C. Golumbic of Groom Law Group discusses the responsibilities of ERISA fiduciaries and the types of litigation that may be brought against them, as well as some practical suggestions on plan design and administration that may help reduce litigation risk. He then shares insights on how the role of fiduciary liability insurance and other forms of protection can mitigate against financial loss to plan sponsors and their fiduciaries when faced with a lawsuit.

Chubb is pleased to share this information and hopes it will help you raise the awareness of your company's fiduciaries about the potential risks they face and serve as a practical resource in your overall loss prevention efforts.

Introduction

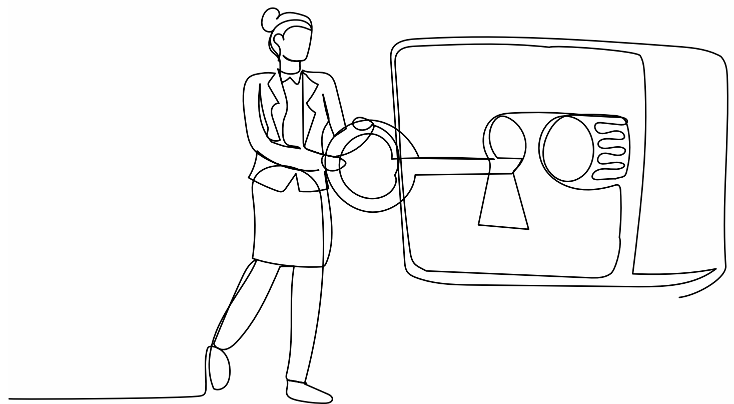
Fiduciary liability in connection with employee welfare benefit plans and retirement plans can be one of the most misunderstood exposures faced by directors, officers, employees, and trustees. Many fiduciaries fail to appreciate that they can be held *personally* liable for a breach of fiduciary duty, even when the breach is unintentional *and even when they aren't expressly named as plan fiduciaries*. Moreover, plan fiduciaries are subject to a very high standard of care ("the highest duty known to the law"), even higher than the duty imposed on corporate directors and officers. Yet, plan fiduciaries' decisions, unlike those of corporate fiduciaries, are not given the benefit of corporate law's business judgment rule. To further complicate matters, traditional Directors and Officers insurance does not cover plan fiduciary liability, and there may be limitations on the ability of a benefit plan or employer to indemnify a fiduciary who has been sued. In short, a plan fiduciary's personal wealth may unwittingly be at risk, so understanding potential fiduciary liabilities, obtaining sound legal guidance, and partnering with a reputable fiduciary liability insurance carrier are crucial.

Employers have long understood that providing a well-structured employee benefits program (e.g., medical, life, disability, and retirement plans) can be an important piece of the package necessary to attract and retain an appropriately skilled workforce. And doing so has always been challenging, but today the stakes are higher than ever, as the area of law has become more regulated, the amounts at issue have soared, and the plaintiffs' class-action bar has become more aggressive. Establishing a balance between corporate benefits and obligations is especially difficult for employers, because the legal rules governing employee benefit plans – established under the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. § 1001, et seq. (ERISA) – are complex. As a result, engaging skilled and experienced ERISA counsel who understand ERISA's complexities and nuances is more critical than ever for purposes of plan management and for defending ERISA claims as doing so provides a strong tactical advantage.

Employers and plans of all types and sizes are vulnerable. And, in a concerning trend, ERISA class actions are being filed against conscientious fiduciaries of plans that are well-managed and that provide valuable benefits to their participants. This is because many of the class actions are attorney-driven, meaning that they are motivated by an aggrieved person who is seeking redress, because they believe their plan was mismanaged or instigated by plaintiffs' firms whose business model is to decide which companies to target and then recruit plan

participants (usually former employees) to become their clients and serve as the class representatives. As such, companies may be even more at risk of a class action in times of economic transition – when layoffs, workforce adjustments, and corporate mergers and acquisitions may create a larger pool of plan participants (ex-employees) who may be willing to step forward and serve as ERISA plaintiffs. On top of that, ERISA contains a provision that almost always allows plaintiffs (but not defendants) to recover attorneys' fees when they prevail. This provision provides additional incentives to plaintiffs' lawyers to bring suit under ERISA.

Although there are no "silver bullets" to protect employers, plans, and fiduciaries from litigation, employee benefits professionals *can* improve the chances that their company's benefits programs will avoid litigation and defeat any legal challenges that may arise. The path to reducing legal exposure begins with a sound understanding of the ERISA-defined roles of plan-related personnel. ERISA does not impose liability at large. Rather, from the board of directors to the benefits manager, an individual's potential exposure, including possible individual liability, depends in significant part on his or her role with respect to the employee benefit plan in question. We address those roles and responsibilities in Section I of this report. In Section II, we provide an overview of the most prevalent (and serious) types of ERISA claims currently being filed. Section III, in turn, discusses a variety of plan-drafting and plan-administration measures that plan sponsors and fiduciaries should consider to mitigate litigation exposure. Section IV considers why fiduciary liability insurance should be deemed an integral part of any employee benefits program, providing protection to plan sponsors and fiduciaries against both personal liability and the sometimes significant costs associated with the defense of employee benefit lawsuits.



Employers have long understood that providing a well-structured employee benefits program (e.g., medical, life, disability, and retirement plans) can be an important piece of the package necessary to attract and retain an appropriately skilled workforce. And doing so has always been challenging, but today the stakes are higher than ever, as the area of law has become more regulated, the amounts at issue have soared, and the plaintiffs' class-action bar has become more aggressive.

I. Identifying Plan Sponsors, Fiduciaries and Parties in Interest and Understanding their Roles and ERISA Responsibilities

A variety of people and entities have roles regarding employee benefit plans. The plan sponsor is the entity that establishes and maintains the plan. This is typically the employer unless the plan is a multi-employer plan or multiple employer plan.

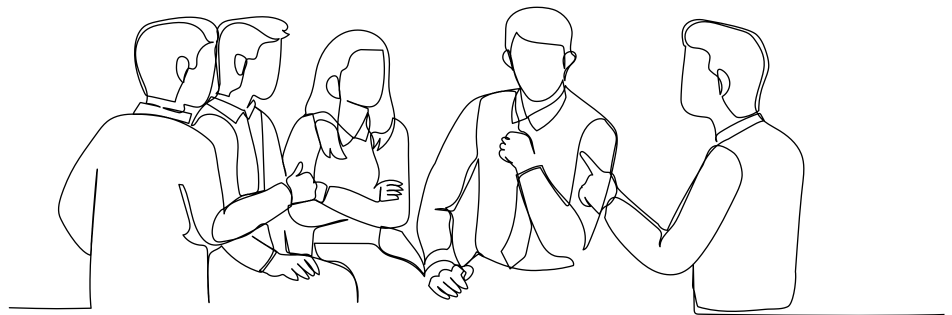
Fiduciaries are individuals or entities upon which ERISA imposes special, heightened duties, called fiduciary duties, when they carry out certain responsibilities with respect to pension and welfare plans. ERISA's fiduciary duties apply to anyone who: (1) exercises any discretionary authority or control over a plan or exercises any authority or control over a plan's assets; (2) has any discretionary authority in administering a plan; or (3) provides investment advice to a plan for a fee. Anyone who occupies such a role is deemed to function as a fiduciary under ERISA, even if not named as a fiduciary in the plan's governing documents.

In particular, ERISA requires fiduciaries to adhere to a strict duty of loyalty, which requires them (when acting with respect to a plan), to act for the exclusive purpose of administering the plan and providing benefits to participants and beneficiaries. Additionally, ERISA imposes a duty of prudence on fiduciaries, which requires them to act with the care, skill, and diligence that a "prudent man acting in like capacity and familiar with such matters would use" under the circumstances. As a related duty, ERISA requires fiduciaries to diversify plan investments unless it is "clearly prudent not to do so" under the circumstances (certain plans, called employee stock ownership plans (ESOPs), are exempt from the duty to diversify). The challenge of navigating these ERISA requirements means that even diligent and well-intentioned professionals can find themselves as defendants in lawsuits alleging a breach of their duties under ERISA.

Not everyone who interacts with an ERISA plan is a fiduciary, however, and even if a person is a fiduciary, he or she is not necessarily a fiduciary at all times and for all purposes. Instead, ERISA permits persons to wear "two hats" at separate times – a fiduciary hat and a "settlor" hat. Settlor activities are generally those that arise out of the establishment and design of the plan. Setting up or changing benefit plans is the quintessential plan "settlor" activity. On the other hand, administering the plan is a core "fiduciary" activity. By definition, settlor activities do not carry fiduciary liability with them. Despite this important distinction between settlor activities and fiduciary activities, the distinction does not always provide protection from class action litigation where, as a general rule, anyone remotely connected to an ERISA plan will be named in the lawsuit. Lawsuit

targets typically include: the plan sponsor; the plan administrator; any named fiduciaries, particularly members of any investment committees; appointing fiduciaries, particularly the CEO and members of the board of directors; the recordkeeper and/or trustee of the plan; investment managers; and other service providers.

ERISA also identifies certain individuals or entities as "parties in interest," which is important because ERISA regulates transactions involving parties in interest. Parties in interest include not only ERISA fiduciaries and their family members but also any person providing services to a benefit plan, the employer whose employees are covered by the plan, unions whose members are covered by the plan, and various other defined parties or entities that have some relation to the plan or its fiduciaries. Although only fiduciaries are subject to ERISA's prudent man standard, both fiduciaries and parties in interest are subject to the statute's prohibited transaction provisions. This complex set of provisions is designed to prevent transactions that might pose a conflict of interest with respect to the plan or its assets. These provisions automatically bar certain enumerated transactions unless the parties involved can demonstrate that a particular statutory exemption applies.



In particular, ERISA requires fiduciaries to adhere to a strict duty of loyalty, which requires them (when acting with respect to a plan), to act for the exclusive purpose of administering the plan and providing benefits to participants and beneficiaries.

II. Legal Actions Brought Against Employee Benefit Plans and Personnel

The types of legal actions asserted against benefits plans and associated personnel vary significantly in their frequency and potential exposure. ERISA defines two broad categories of benefit plans:

Welfare benefit plans, which include medical plans, disability benefit plans, vacation benefit plans, and the like.

Pension benefit plans, which include any plan designed to provide retirement income to employees or that results in a deferral of income by employees to periods extending beyond termination of covered employment. There are two main types of pension benefit plans:

- **Defined benefit plans** are based on the traditional "pension" plan model, in which the employer guarantees to the employee a stream of payments, often based on his or her years of service, payable as an annuity throughout the employee's retirement. In defined benefit plans, the risk of providing retirement income falls on the employer, although the employer is required to insure that risk through the federal Pension Benefit Guaranty Corporation (PBGC).
- **Defined contribution plans**, which are now far more common than defined benefit plans, include the well-known 401(k) plan, as well as any other type of plan in which the employer makes a set contribution to the plan on the participant's behalf and then the participant bears the investment risk. Some defined contribution plans are participant-directed, meaning that the participant can allocate his or her assets among some set of investment options selected by the employer. There is no governmental insurance program to protect against investment losses or business failures for this type of plan.

The most common legal claims asserted under ERISA, by far, involve individual "denial of benefit" claims under medical and disability benefit plans. Typically, after having made an unsuccessful (or only partially successful) claim for coverage of a certain medical procedure under the terms of a medical plan, or for disability income benefits under a disability plan, the plan participant sues in court claiming that he or she was improperly denied coverage or reimbursement. Benefit claims litigation has become more complicated in recent years following the Supreme Court's decision in *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). There the Court held that a plan administrator that is the payer on a benefit claim it evaluates operates under an inherent conflict of interest. Following this decision, courts in denial of benefit cases have permitted discovery on discrete

issues, such as whether a conflict may have impacted the benefits determination.

Other types of individual benefit claims, although somewhat less common, involve retirement plans. Upon retirement, a participant may claim that the employer miscalculated his or her retirement benefits, or that the employer improperly denied a surviving spouse the survivor benefits to which he or she was entitled.

In a defined contribution plan, participants may claim that the plan administrator failed to follow specific investment instructions (e.g., move assets from Fund A to Fund B) or took some other action that adversely affected their retirement accounts.

These types of claims are the grist of employee benefits lawsuits – raising issues that in most circumstances personally affect the participant or claimant. These participant-focused disputes often are resolved short of litigation. Once a claim is filed, it is filtered through the benefits claims procedure that ERISA requires every plan to have. The claim may be allowed, adjusted in part, or denied. Normally, it is only after the claims procedure is fully exhausted and unsuccessful that litigation ensues. As discussed later, all benefit plan personnel should understand their roles, both to ensure that participant claims are handled properly and to increase the chances that decisions made under the plan will be upheld should the dispute make its way to court. Fiduciary liability insurance can play a role in mitigating the cost of defending such claims.

Although less prevalent in terms of the number of lawsuits filed, the frequency of class action claims fueled by the plaintiffs' bar has exploded in recent years. These claims purport to be brought on behalf of part or all of the entire class of plan participants, and the aggregated financial exposure can be significant. For example, plaintiffs may claim that investments affecting all retirement plan participants as a group contained excessive expense charges, or were selected in order to confer some benefit on the employer or another party in interest, or that a medical plan or other agreement barred the plan sponsor from modifying retiree medical benefits. Although not as frequent as individual actions, class actions/plan derivative suits carry greater exposure, often alleging substantial damages. Additionally, these lawsuits sometimes demand significant injunctive relief – to change the plan terms or long-established practices. Some of these class action cases are styled as claims to recover benefits due, but many seek to hold plan sponsors and fiduciaries personally liable for breaches of fiduciary duty.

Some of the most significant and up-and-coming litigation concerning benefits plans includes:

Claims Involving Retirement Plans:

- "401(k)/Defined Contribution Fee" cases alleging that the plan fiduciaries breached their obligations to the plan and its participants by charging or permitting excessive fees and expenses for plan services provided by third parties, such as investment management, recordkeeping, and asset custody. Participants also may allege that they were harmed by the poor performance of one or more investment options offered by the plan.
- "Proprietary (or affiliated) fund" cases, which often fall into the category of 401(k) fee cases, in which participants in a plan sponsored by a financial institution allege that the plan sponsor included mutual funds or other investments offered by the financial institution or its affiliates in the plan's investment lineup in order to benefit the institution, without regard to whether those investments were best for the plan.
- Claims involving employer stock, including employee stock ownership plan (ESOP) stock purchase or sale claims alleging that the employer's stock was improperly valued, or that plan fiduciaries engaged in prohibited transactions or other conflicts of interest, and stock drop cases alleging plan fiduciaries acted imprudently in offering an employer stock fund or misrepresented the risks associated with investments in a plan sponsor's stock.
- "Actuarial equivalence" cases, in which plaintiffs allege that defined benefit plans use unreasonable actuarial equivalence factors, primarily outdated mortality tables, when calculating the benefits.

Claims Involving Health and Welfare Plans:

- COBRA notice class actions in which it is alleged that the employer failed to comply with the Consolidated Omnibus Budget Reconciliation Act when notifying employees of their rights to continue healthcare coverage upon certain qualifying events.
- Litigation regarding the requirements imposed by the Mental Health Parity and Addiction Equity Act.

Claims Involving All Plan Types

- Cybersecurity-related litigation and investigations in response to increases in data breaches impacting plans.
- Investigations into the plan's activities by the Department of Labor, which may or may not result in litigation.
- Litigation concerning the enforceability of provisions requiring individual arbitration of ERISA claims.

On the pages that follow, we discuss recent developments in these and other selected areas to illustrate the potential liability exposure of employee benefit plans and plan fiduciaries, recognizing that there may be additional types of risks that are outside the scope of this discussion.

A. Claims Involving Retirement Plans

1. Defined Contribution Plan "Excessive Fee" Cases

Overview:

Over the last 5 years, the scope of so-called 401(k) "excessive fee" litigation – another staple of the plaintiffs' bar – has expanded to the point where every plan sponsor and plan service provider dealing with a 401(k) plan should be on notice that it may be the next defendant in this type of ERISA class action.

Indeed, numerous plan sponsors and fiduciaries have been named as defendants in cases alleging "excessive fees" with regard to their 401(k) plans in the past few years. Since 2020, well over 250 such lawsuits have been filed, and there is no indication the plaintiffs' bar's interest in bringing these cases has waned. Settlements in excessive fee cases have proven to be very lucrative for plaintiffs and plaintiffs' firms[1].

Historically filed against only the largest organizations, an increasing number of smaller retirement plans have faced excessive fee litigation. For much of the last decade, these claims had targeted very large 401(k) plans with tens of thousands of participants and billions of dollars in plan assets. That has changed in recent years with an increase in lawsuits against all types of plans (e.g., 403(b) plans, multiple employer plans, defined benefit pension plans, and even ERISA-exempt plans) and all types of plan sponsors (e.g., publicly traded companies, privately held companies, universities, not-for-profit organizations, financial institutions, and healthcare systems). Furthermore, there has been an uptick in lawsuits involving smaller plans, with dozens of new cases filed since 2020 related to plans with under $500 million in assets. There have even been lawsuits targeting plans with fewer than 1,000 participants and less than $100 million in assets.

With this surge in litigation, it's important that all fiduciaries, regardless of plan size, understand the history and recent trends relating to excessive fee claims, the plan features that may make it a target of litigation, and steps fiduciaries can take that may reduce exposure to excessive fee claims.

In general, plaintiffs in these cases allege that the plan sponsors and the members of their benefits committees have breached their fiduciary duties under ERISA by requiring participants to pay excessive fees – either in the form of overly high investment management fees for mutual funds offered as plan investment options or overly high fees paid by the plan participants for recordkeeping and other administrative services. The lawsuits often also allege that one or more of the funds offered by the plan have underperformed purportedly comparable funds with better investment returns chosen by plaintiffs' counsel. Additionally, plaintiffs sometimes include claims alleging some or all of the following: inappropriate use of proprietary funds; improper revenue sharing; failure to use the lowest cost share class; failure to make use of Collective Investment Trusts (CITs) or Separately Managed Accounts (SMAs) rather than mutual funds; allowing investment or transaction "drag" to occur with unitized stock funds; and claims that plans engaged in "prohibited transactions" under ERISA. Recordkeepers and other service providers to the plans have also been swept into some of these cases, particularly with respect to revenue sharing.

Categories of 401(k)/Defined Contribution Excessive Fee Cases:

Excessive fee cases can be broken down into three broad categories: general excessive fee cases, proprietary fund cases and revenue sharing cases. And while all three categories involve many of the same claims – including the general claims

[1] For example, Lockheed Martin Corporation agreed to a $62 million settlement of an excessive fee case; the Boeing Corporation agreed to a $57 million settlement; and Ameriprise Financial agreed to a $27.5 million settlement.

of excessive fees in the form of high mutual fund expense ratios and overly costly recordkeeping services, each category raises its own unique issues.

General Excessive Fee Cases

The most straightforward type of excessive fee cases are those that involve claims against companies, their boards, executives, and officers with the general theme that less expensive investment options (with equivalent risk and return) are available in the marketplace, and the failure to provide these less-expensive options constituted a breach of a fiduciary duty under ERISA. The basis for this general claim has most often been supported by allegations that plan fiduciaries: offered funds that had inferior investment returns relative to purportedly comparable funds in the market and/or market indices; offered the more expensive share class of an investment option; offered a more expensive actively-managed fund instead of a comparable, less expensive index fund; failed to take into account, and disclose to participants, revenue sharing arrangements in which the plan investment funds participated; offered the wrong type of investment option (i.e., a bank investment option instead of a stable value fund); or failed to offer CITs or SMAs rather than mutual funds. In recent years, plaintiffs began attacking plans offering investments previously viewed as safe due to their relatively low fees, such as Vanguard funds, alleging that plan fiduciaries could have negotiated for fees that were lower still.

In mid-2016, a number of colleges and universities across the nation became the targets of this type of "excessive fee" litigation by the plaintiffs' bar. These cases against educational institutions were novel in that they expanded the scope of excessive fee litigation to 403(b) retirement plans (as opposed to 401(k) plans) sponsored by not-for-profit institutions, making clear that any sponsor of a large retirement plan is at risk for an excessive fee lawsuit.

Another trend in the last few years has been for plaintiffs to challenge plan fiduciaries' selection and monitoring of target date funds offered in their plans. Target date funds typically are the Qualified Default Investment Alternative ("QDIA") for the challenged plan, so there is often a significant proportion of plan assets invested in these funds. Like other excessive fee lawsuits, plaintiffs in these cases have alleged that the challenged target date fund suite had excessive fees and/or inferior performance compared to other target date fund suites in the market. Plaintiffs also have sometimes alleged that plan fiduciaries should have chosen the version of a target date fund comprised of passively-managed funds, rather than the version comprised of actively managed funds. In that regard, these lawsuits reflect a broader trend in which plaintiffs' counsel often have attacked actively-managed funds as being significantly more expensive and poorer-performing than allegedly similar passively-managed funds.

The proliferation of these excessive fee lawsuits has generated numerous district court decisions on motions to dismiss, and the issues have made their way to the courts of appeals and the U.S. Supreme Court. In January of 2022, in Hughes v. Northwestern University, 142 S. Ct. 737 (2022), a lawsuit challenging investment management fees and recordkeeping fees with respect to a university's 403(b) plan, the Supreme Court held that the fact that a plan offers a diverse array of investment options, including low-cost index fees, is not a sufficient basis on its own for granting a motion to dismiss. In reaching its holding, the Supreme Court commented on the pleading standard for excessive fee lawsuits, directing lower courts considering motions to dismiss to be mindful of the "difficult tradeoffs" fiduciaries face in making investment decisions and "give due regard to the range of reasonable judgments a fiduciary may make based on her experience and expertise." Id. at 742. Since Hughes, several circuit courts have weighed in on excessive fee lawsuits at the pleading stage with mixed results. Some circuit courts have sided largely with the defendants[2], while others have sided largely with plaintiffs.[3] This area of the law promises to continue developing as more cases make their way to the courts of appeals.

Proprietary Fund Cases

Proprietary fund cases are similar to general excessive fee cases in many ways, but they include one very significant difference. Namely, these cases arise out of a

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[2] See *Smith v. CommonSpirit Health*, 37 F.4th 1160 (6th Cir. 2022); *Albert v. Oshkosh Corp.*, 47 F.4th 570 (7th Cir. 2022); *Matousek v. MidAm. Energy Co.*, 51 F.4th 274 (8th Cir. 2022); *Matney v. Barrick Gold of N. Am.*, 80 F.4th 1136 (10th Cir. 2023).

[3] See *Davis v. Salesforce.com Inc.*, No. 21-15867, 2022 WL 1055557 (9th Cir. Apr. 8, 2022); *Kong v. Trader Joe's Co*, No. 20-56415, 2022 WL 1125667 (9th Cir. Apr. 15, 2022); *Hughes v. Northwestern Univ.*, 63 F.4th 615 (7th Cir. 2023).

conflict of interest or self-dealing theory. These claims involve plans sponsored by entities in the financial services industry for the benefit of their own employees. Plaintiffs allege that the fiduciaries of these plans breached their fiduciary duties by selecting investment options for the 401(k) plan that are affiliated with the plan sponsor. Plaintiffs allege that these "proprietary" funds were selected by plan fiduciaries to provide some benefit to the employer or its affiliates. For example, plaintiffs may allege that the plan sponsor included one of its new mutual funds in the plan's investment lineup in order to provide "seed money" for the new fund, or they might allege that the fiduciaries included proprietary funds simply in order to generate fees for the institution. Plaintiffs then allege that the proprietary funds underperformed the market and/or charged excessive fees, causing a loss to plan participants.

Over the last several years, many large financial institutions have been the targets of proprietary fund cases. Essentially, any financial institution operating a 401(k) plan that includes proprietary investment options should consider itself a potential target for this type of suit.

Revenue Sharing Cases

The final general category of excessive fee cases is the "revenue sharing" case. This type of excessive fee claim rests on the assertion that financial service providers and their affiliates engage in a variety of revenue sharing arrangements with plan service providers that result in the providers receiving fees that are excessive in light of the services they provide. Although general excessive fees cases often contain supplemental allegations complaining that revenue sharing is improper or should have been disclosed, these cases focus on the idea that revenue-sharing arrangements are nothing more than "kick-back" payments that improperly encourage a greater investment of plan assets in funds operated by a certain financial service provider.

These cases are sometimes called "gatekeeper" cases because the basis for the financial services provider and its affiliates' fiduciary liability is found in the claim that these providers screen what funds are available as plan investment options, thus acting as a "gatekeeper" to what funds participants are offered access.

Best Practices

While some courts have proven to be less receptive to "excessive fee" cases than others, many 401(k)/ Defined Contribution Fee cases have gone forward and have resulted in substantial settlements for plaintiffs. Accordingly, before becoming the target of a fee case, employers should act affirmatively to review and, potentially, change[4]:

- The process by which their 401(k) or 403(b) plan adds, reviews, and removes plan investment options and monitors plan fees and investment performance – also focusing, if applicable, on review of the inclusion of proprietary funds;
- The procedure in place for review of plan recordkeeping services and any use of revenue sharing;
- The process for documenting decisions concerning plan investment options and recordkeeping services, as well as the rationale for those decisions, such as by keeping meeting minutes and/or other written documentation; and
- Plan-related documents and agreements with outside fiduciaries to ensure that the documents are clear on who is and is not a plan fiduciary, what duties each fiduciary has, and whether any of those fiduciary duties have been delegated.

2. Employer Stock Litigation

The most common type of case relating to employer stock involves ESOPs. ESOPs are a type of defined contribution employee benefit plan created by Congress as a means of fostering employee ownership. By definition, ESOPs are designed to invest primarily in employer stock. ESOPs, particularly those established by privately-held companies, have come under increased scrutiny from the Department of Labor (DOL) in recent years. DOL began an ESOP enforcement project in 2005, and between 2007 and 2017 closed more than 2,000 civil ESOP investigations. Private plaintiffs, too, have initiated ESOP litigation, and DOL has supported such litigants, including by filing amicus briefs at the appellate level.

A large number of ESOP cases center around the ESOP's purchase of employer stock. Typically, these cases present a scenario in which an ESOP,

[4] These "best practices" are in addition to any applicable topics addressed herein in Section III, Practical Suggestions for Plan Design and Administration.

represented by an independent trustee, has engaged in a so-called "prohibited transaction" – a purchase of company stock by the ESOP from company officers, directors, and/or majority shareholders. Such a transaction is exempt from ERISA's prohibited transaction rules if the stock purchase is made for "adequate consideration." Where the stock is not publicly-traded, ERISA defines adequate consideration as "the fair market value of the asset as determined in good faith by the trustee." To make this fair market value determination, the ESOP trustee generally retains a valuation expert to advise it as to the appropriate purchase price. Litigants have often challenged the value of the stock purchased in the subject transaction, claiming that it was overvalued and the purchase price too high.

ESOPs often purchase company stock in a leveraged transaction. The use of leverage may lead to claims that the company was harmed as a result of its inability to service the debt load incurred by the leveraged buyout of the selling shareholders.

DOL has also alleged various conflicts of interest in ESOP transactions, such as: where the company's board of directors appoints the trustee to represent the ESOP in connection with the proposed transaction, and the selling shareholders participate in the appointment in their capacity as directors; or where a valuation firm performs a preliminary valuation for the sellers offering their stock for sale to the ESOP, and the ESOP trustee later engages the same firm to conduct the valuation upon which it will base its fair market value determination.

In addition to probing the technical aspects of company stock valuation, ESOP litigation tends to focus on the ESOP trustee's process in arriving at a determination of fair market value. Notably, DOL entered into a settlement agreement with GreatBanc Trust Company in June 2014.[5] The parties agreed to certain process requirements to which GreatBanc would adhere going forward when serving as ESOP trustee in connection with the purchase or sale of company stock. DOL has publicly endorsed this settlement as a "template" for ESOP transactional trustees.

Other ESOP litigation issues have involved ESOP terminations and repurchase obligations. With respect to ESOP terminations, one court ruled that fiduciary defendants breached their duties by failing to properly liquidate certain ESOP stock as the plan required. ESOP repurchase obligations have given rise to liability where there is insufficient liquidity to purchase allocated and vested shares from terminating participants and/or participants electing diversification.

One type of employer stock case that has become less prevalent in recent years is "stock drop" cases filed against publicly-traded companies that offered their own stock as an investment option in their defined contribution plans. These cases generally alleged that fiduciaries of such plans should not have continued to offer company stock as an investment option after a business or market event caused the company's stock price to drop and/or that fiduciaries misrepresented to the participants the risks associated with investing in employer stock. The Supreme Court's decision in *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409 (2014) – which set out a modified pleading standard in these cases – was a significant factor in the decline of stock drop litigation.

3. Actuarial Equivalence Cases

In recent years, there has been an uptick in litigation concerning the actuarial assumptions–namely mortality assumptions and interest rates – used to calculate certain forms of benefits provided by defined benefit plans. Indeed, since 2019, more than a dozen class action lawsuits have been filed against plan sponsors and fiduciaries.

In the defined benefit plan context, ERISA arguably requires that all forms of benefits be no less than an amount that is "actuarially equivalent" to a single life annuity. Because plans often offer additional forms of benefits such as lump sums, plans must perform calculations to convert a single life annuity into these other benefit forms. To make these calculations, plans rely on actuarial assumptions including an interest rate and mortality assumptions (i.e. the participant's anticipated life expectancy). Although ERISA requires use of specific mortality assumptions when calculating lump sum benefits, it does not prescribe the use of particular assumptions when calculating other optional benefit forms, such as joint and survivor annuities, early retirement annuities or certain and life annuities.

[5] Perez v. GreatBanc Trust Co., 5:12-cv-01648-R-DTB (C.D. Cal. June 2, 2014) (Dkt. 166-1).

In these lawsuits, plaintiffs allege plans are using "unreasonable" actuarial equivalence factors. Plaintiffs typically focus on the use of allegedly "outdated" mortality tables. Plaintiffs contend that using these unreasonable actuarial factors results in optional benefit forms that are not actuarially equivalent to the plan's normal retirement benefits. Plaintiffs generally assert that using an updated mortality table or different interest rate would result in a higher monthly benefit.

4. Forfeiture Claims

These are new claims that target how ERISA forfeitures are used. Forfeitures are monies that are abandoned in the plan, such as when a participant separates from employment before he or she vests in the employer contributions that were made on their behalf during their employment. It is common for plans to contain language allowing these forfeited funds to be used to either offset future employer contributions or to offset plan expenses. Although Internal Revenue rules and regulations have long permitted this practice, plaintiffs have recently taken issue with it, claiming that it's a breach of fiduciary duty not to use those forfeitures to offset plan expenses so as to benefit the participants.

B. Claims Involving Welfare Plans

1. Observations on Welfare Benefits Claims

The types of welfare benefits claims that might be made in litigation are extremely varied. Claims may be made for medical benefits, life insurance benefits, disability benefits, or severance benefits. Most of these cases are highly individualized, turning on the particular circumstances of the claimant and often on difficult-to-apply plan provisions. If the claimant is successful, exposure is generally limited to the benefits provided under the plan, but the claimant can seek a statutory attorney's fee.

ERISA requires that every plan provide a benefits claim procedure to facilitate administrative (non-judicial) consideration of claims by fiduciaries who must consider the claim in light of what the plan requires. In a number of cases, the Supreme Court has made it clear that the plan administrator functions as a fiduciary when resolving a benefits claim. Thus, in making the claim decision, the fiduciary owes a duty of loyalty to the plan participant and a parallel duty to enforce the plan as the settlor intended it to be enforced.[6] If the plan is written to give the plan administrator discretion in construing the terms of the plan and the plan administrator complies with his/her duties in construing and administering the plan, the administrator's decision may be entitled to some measure of deference in the event the claimant is not satisfied and brings a claim to court[7]. These rules also apply to retirement plan claims in most instances.

2. Affordable Care Act Litigation

Over the past several years, health plan participants have filed several lawsuits related to the Affordable Care Act (ACA), and in particular its anti-discrimination rule.

The anti-discrimination rule, found in Section 1557, protects a member of a protected class (race, gender, age, and disability, respectively) from being excluded from participating in, being denied the benefits of, or being subjected to discrimination under a "health program or activity" that is receiving federal financial assistance. In doing so, Section 1557 references four civil rights statutes: (1) Title VI of the Civil Rights Act of 1964, (2) Title IX of the Education Amendments of 1972, (2) the Age Discrimination Act of 1975, and (4) section 504 of the Rehabilitation Act of 1973 and explicitly applies the enforcement mechanisms provided for in those statutes.

The regulations implementing Section 1557 have been in flux over the past several because of changes in presidential administrations:

[6] See, e.g., *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989)

[7] See *Met. Life Ins. Co, supra* (holding that the measure of deference can vary depending on reviewer's financial interest in outcome and possible conflicts).

- In 2016, under the Obama Administration, the Department of Health and Human Services (HHS) finalized its section 1557 regulations creating broad, detailed requirements for health insurers, group health plans, third-party administrators, and providers.
- In 2020, under the Trump Administration, HHS finalized new regulations which reduced the scope of covered entities and eliminated certain nondiscrimination requirements.
- In 2022, under the Biden Administration, HHS issued its proposed Section 1557 rules reflecting a return to a more expansive view of Section 1557.

Litigation risk exists to the extent participants are excluded from participating in health coverage, are denied the benefits thereof, or are otherwise discriminated against with respect to health coverage because of race, gender, age, or disability. HHS' final rules also have significant notice and access (language, physical/sensory, and electronic) requirements. Failure to comply or to provide reasonable modifications where appropriate also poses litigation risk.

Courts have already found a private right of action under Section 1557. For instance, in *Briscoe v. Health Care Service Corp.*, 281 F. Supp. 3d 725 (N.D. Ill. 2017), the district court – pointing to the decisions of several other district courts around the country – concluded Section 1557 provides a private right of action. While these courts have agreed a private right of action exists, the standards for evaluating section 1557 claims has differed. For instance, whereas the court in *Rumble v. Fairview Health Services*, No. 14-2037 (D. Minn. Mar. 16, 2015) (unpublished) reasoned Section 1557 creates a health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status, the district court in *Southeast Pennsylvania Transp. Authority v. Gilead Sciences, Inc.*, 102 F. Supp. 3d 688 (E.D. Pa. 2015), concluded that Congress intended to import into Section 1557 the various standards and burdens of proof from each of the four civil rights statutes, depending upon the protected class at issue.

One can anticipate continued litigation challenging coverage options ranging from gender transition to specialty medications. With respect to transgender individuals, courts have ruled that Section 1557 prohibits categorical exclusions of treatments sought by transgender patients, as well as failing to cover particular treatments for gender dysphoria. For instance, in *C.P. v. Blue Cross Blue Shield*, No. 3:20-cv-06145 (W.D. Wash. Dec. 19, 2022) (unpublished), the district court granted summary judgment in plaintiff's favor on his claims that the plan's provisions excluding gender affirming surgery was discriminatory in violation of Section 1557. With respect to specialty drugs, plaintiffs have challenged what had previously been considered elements of routine plan design, such as formularies and drug cost-sharing tiers, when drugs such as those prescribed to treat HIV are all assigned to a higher cost-sharing tier or are only available through a mail-order pharmacy.

To minimize the risk of Section 1557 claims, it will be incumbent on employers and health care providers to work closely with experienced counsel when crafting policies and coverage options to prevent discriminatory distinctions on the basis of protected classes.

3. Mental Health Parity and Addiction Equity Act Litigation

Litigation involving the Mental Health Parity and Addiction Equity Act ("MHPAEA") has grown substantially in recent years. In 2021 alone, plaintiffs filed over 100 lawsuits. Congress amended MHPAEA at the end of 2020 to, among other things, require the Departments with jurisdiction over MHPAEA to collect at least 20 required MHPAEA analyses from group health plans per year and to report to Congress (and publicly) the names of plans that the Departments determine are not in compliance with MHPAEA. The DOL has likewise increased its focus on MHPAEA enforcement and in 2022 the DOL, along with Health and Human Services and the Treasury, announced MHPAEA enforcement would be a top priority.

MHPAEA sets forth various requirements for providing benefits to treat mental health and substance use disorders. At a high level, MHPAEA requires that benefits for these health issues be provided in parity with the benefits for medical and surgical benefits. To that end, MHPAEA requires that financial requirements and treatment limitations be no more restrictive than those that apply to substantially all medical and surgical benefits. MHPAEA also prohibits plans from imposing separate treatment limitations for mental health and/or

substance use disorders. Examples of a financial requirements might include deductibles, copays, and coinsurance. Treatment limitations might include limits on the number of office visits or limits on the scope or duration of benefits.

Lawsuits asserting MHPAEA violations generally allege a plan's terms improperly limit coverage for treating mental health and substance use disorders. Although these cases can vary, many target limitations on specific mental health benefits. Cases often concern (1) applied behavioral analysis therapy to treat Autism Spectrum Disorder, (2) residential treatment, and (3) wilderness therapy. Plaintiffs typically bring a claim for benefits, which may be joined with a request for injunctive relief and statutory penalties. Some plaintiffs have asserted claims for breach of fiduciary duty as well.

The law in this area continues to shift and the pleading standards are not well-defined. Indeed, when confronted with similar allegations, different courts have reached conflicting conclusions. There is also little guidance from appellate courts.

Congress has been active in this area as well and a number of legislative proposals have been made in recent years that may impact MHPAEA litigation. For instance, in 2022 the House of Representatives passed the Mental Health Matters Act, which expands the DOL's enforcement authority.

4. COBRA Notice Cases

Another category of health plan litigation focuses on the notice requirements under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") – which requires most employers to offer continued health coverage to employees and their families when coverage would otherwise end (e.g., upon termination of employment). Because an individual must affirmatively elect coverage COBRA (that is, coverage is not automatic), plan administrators are required to notify individuals of their rights by providing a COBRA election notice.

The central claims in these lawsuits focus on alleged deficiencies in a COBRA election notice. While the specific alleged deficiencies may vary, plaintiffs commonly allege the notice fails to provide the name, address, and telephone number of the plan's administrator. Other alleged deficiencies include the failure to (i) adequately explain the process for electing coverage, (ii) identify the specific end date of coverage, (iii) provide an address for making payments, (iv) explain the impact election has on the individual's rights under the Health Insurance Portability and Accountability Act, and (v) offer a translated version in the participant's spoken language.

In addition to claims related to alleged deficiencies, plaintiffs have also brought claims alleging a failure to timely provide a COBRA notice. As a general rule, plan administrators are required to provide a COBRA election notice within fourteen days after notice of a qualifying event (or forty-four days if the employer and plan administrator are the same entity).

5. Health/Medical Plan Fee Litigation

Health plan fiduciaries, like retirement plan fiduciaries, have an obligation to assess the reasonableness of fees paid to plan service providers pursuant to ERISA's prohibited transactions rules. ERISA section 408(b)(2), 29 U.S.C. § 1108(b)(2) provides an exemption from the prohibited transactions rules for "reasonable arrangements" with service providers that provide services that are "necessary for the establishment or operation of the plan," as long as no more than "reasonable compensation" is paid for the services arrangement.

The Consolidated Appropriations Act of 2021 ("CAA") amended ERISA section 408(b)(2) to require that "covered service providers" to ERISA-covered group health plans provide "responsible plan fiduciaries" with a disclosure describing their fees and services. "Covered service providers" are the providers of "brokerage services" and "consulting services." The requirement applies to fully insured and self-funded health plans, regardless of the plan's size. If the disclosure requirement is not complied with, the services arrangement is not considered to be "reasonable" and therefore is a prohibited transaction to which ERISA section 408(b)(2)'s exemption does not apply.

This new requirement took effect as of December 27, 2021. The Department of Labor has recognized that "covered services providers" and plan fiduciaries have struggled to understand their obligations under the new requirement. There is uncertainty regarding which service providers are subject to the rule as well as the form and content of the required disclosure.

At or around the time this disclosure requirement took effect, group health plans also became subject to other disclosure requirements. Among other

things, the CAA also prohibited plans from entering into provider contracts that bar the disclosure of provider-specific cost and quality information and prevent plans from accessing de-identified claims and encounter information on a per-claim basis, including financial information. Further, as of July 1, 2022, the Transparency in Coverage Rule requires that group health plans to disclose in-network negotiated rates, out-of-network allowed amounts, and a prescription drug negotiated rate and historical net prices by posting machine-readable files on a publicly available website.

Against this backdrop, in 2023, a well-known plaintiffs' firm began soliciting potential plaintiffs for putative class action lawsuits to be filed against plan sponsors of self-funded health plans. It is anticipated that this plaintiffs' firm, and others, may initiate ERISA litigation against health plan sponsors related to the amounts that are charged to participants for coverage and/or services. It is possible that these suits will borrow from theories developed in the retirement plan litigation space and will leverage the CAA's new "covered service provider" disclosure requirement to assert breach of fiduciary duty and prohibited transactions claims against plan sponsors.

C. Claims and Issues Pertaining to All Plan Types

1. Cybersecurity Considerations

In response to a growing number of cybersecurity breaches in recent years, plaintiffs have filed a number of lawsuits alleging that fiduciaries failed to adequately safeguard plan assets. Although this area of law continues to develop, plaintiffs generally allege that plan fiduciaries violated their ERISA duty of prudence by failing to take steps to protect participant information and/or assets. Additionally, plaintiffs have faulted plan fiduciaries for failing to monitor plan service providers in relation to cybersecurity breaches.

The DOL has also been active in responding to cybersecurity threats. In 2021, the DOL issued its first ever cybersecurity guidance for plans. The DOL's guidance addresses three topics: (1) "Tips for Hiring a Service Provider," (2) "Cybersecurity Program Best Practices," and (3) "Online Security Tips." A detailed description of this guidance is available on the DOL's website, https://www.dol.gov/newsroom/releases/ebsa/ebsa20210414. In addition to issuing guidance, the DOL has been active in issuing document requests targeted at cybersecurity issues.

This is a novel and developing area of litigation that plan sponsors and fiduciaries should monitor closely in the coming months and years.

2. Department of Labor Investigations, Audits, and Settlements

Thousands of times each year, fiduciaries of ERISA-covered plans and service providers receive an unexpected letter or phone call from DOL noticing an investigation "to determine whether any person has violated or is about to violate" any provision of Title I of ERISA. These investigations, sometimes called audits, can drag on for months or years at great expense.

Though it shares enforcement authority with a number of different agencies, DOL has primary responsibility for enforcing violations of Title I of ERISA, such as breaches of fiduciary duty and prohibited transactions. DOL's Employee Benefits Security Administration (EBSA) is charged with investigating ERISA violations, while DOL's Office of the Solicitor of Labor acts as DOL's in-house counsel with respect to litigating any such ERISA violations. EBSA investigates compliance with employee benefits law through ten regional and three district offices throughout the country. Most EBSA investigations are civil, but EBSA also has the authority to conduct criminal investigations.

In recent years, EBSA has focused its enforcement resources in certain areas and has developed a set of National Enforcement Projects – areas on which each EBSA Regional Office focuses investigative resources. These include: ESOPs, Health Enforcement Initiatives, Protecting Benefits Distribution, Plan Investment Conflicts, Contributory Plans Criminal Project, Voluntary Fiduciary Correction Program, and the Abandoned Plan Program. A detailed explanation of these enforcement projects is available on EBSA's website, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/enforcement.

EBSA has broad investigative authority with respect to ERISA violations. An investigation may be initiated for a variety of reasons. For instance, an employee/participant may lodge a complaint with EBSA, EBSA may identify unusual information reported on a Form 5500, an investigation may arise out of a national or

regional office enforcement priority, the matter may be referred to EBSA by another agency, or EBSA may even initiate a random investigation (a theoretical but unlikely possibility).

The subjects of an investigation may include, but are not limited to, various types of employee benefit plans (retirement, health, welfare, apprenticeship), plan sponsors, plan trustees, named fiduciaries, functional fiduciaries, plan administrators, and plan service providers (consultants, custodians, investment advisors, and directed trustees). EBSA investigations typically begin with an initial contact from the Investigator (or Auditor), often by a letter. The letter usually includes a request for documents and information that should be made available to the Investigator. If the subject fails to cooperate with the request for documents, DOL will most likely issue a subpoena. In rare instances, DOL will begin the investigation with a subpoena rather than a document request. There is no requirement that DOL identify the target, scope, origin, or end of an investigation. Typically after reviewing at least some documents, DOL may request to conduct witness interviews. At other times, DOL will issue subpoenas for testimony and conduct formal depositions on the record and under oath.

After receiving the Notice of Investigation, it may be advisable to contact the fiduciary insurance carrier covering the plan or provider (if any) and retain counsel. Experienced ERISA counsel can coordinate with the Investigator at the outset of the investigation to narrow, or at least prioritize, the requested information. ERISA counsel also will assert written objections to subpoenas to protect clients' rights and prepare and represent clients in interviews and depositions.

The closing of an investigation, like the opening of an investigation, takes place with a letter. EBSA regional offices issue a number of types of closing letters. Where the investigation detected no ERISA violations, a letter closing the investigation and indicating that no further action will be taken is usually provided. When any potential violations that are identified are de minimis or have been adequately corrected, the closing letter may note the potential violations but will also state that no further action will be taken. When EBSA concludes an investigation and determines that violations of ERISA may have occurred, the regional office issues a Voluntary Compliance Letter. In general, the letter describes the relevant facts identified during the investigation, states the DOL's position on legal violations that may have occurred, invites discussion regarding correction of the potential violations, and advises that, without correction, the matter may be referred to the Solicitor of Labor for possible litigation. ERISA counsel will assist clients in responding in writing to Voluntary Compliance Letters and in attempting to negotiate a resolution.

The vast majority of EBSA investigations are resolved without litigation. Serious violations of ERISA may require a written settlement agreement with DOL. Before considering this option, it is important to note that, under ERISA Section 502(I), DOL is required to assess a 20 percent penalty on amounts recovered by a settlement agreement or court order.

3. Arbitration of ERISA Claims

Courts have long held that, as a general matter, ERISA claims may be resolved through arbitration. What that means in practice and whether a particular provision is enforceable, however, has been the heavily contested in recent years. Of particular importance to the plaintiffs' bar are arbitration provisions which preclude plan participants from seeking plan-wide relief and require individual arbitration of their claims, rather than class or collective actions.

While a number of legal issues can arise in cases addressing the enforceability of an arbitration provision, one of the central issues concerns the so-called "effective vindication" doctrine – judge-made rule that addresses whether enforcing an arbitration provision prevents a plaintiff from pursuing a substantive statutory right or remedy. In the ERISA context, the effective vindication doctrine often focuses on a participant's ability to

pursue plan-wide relief. ERISA's civil enforcement provision found in ERISA section 502, 29 U.S.C. § 1132, provides, in relevant part, that a civil action may be brought by a participant or beneficiary "for appropriate relief under section 1109." 29 U.S.C. § 1132(a)(2). Section 1109, in turn, allows for plan-wide relief (e.g., monetary relief, removal of fiduciaries) for fiduciary breaches. Plaintiffs typically take the position that arbitration provisions limiting participants to individual arbitration prevents them from "vindicating" these alleged statutory rights. The effective vindication doctrine is not the only issue court have been grappling with in these cases, however. Another issue that frequently arises is whether plan participants must consent to arbitration provisions and class action waivers contained in ERISA plan documents.

Several courts of appeal have issued conflicting decisions on this issue in recent years, including: (1) the Tenth Circuit in *Harrison v. Envision Management*, 59 F.4th 1090 (10th Cir. 2023); (2) the Ninth Circuit in *Munro v. Univ. of S. Cal.*, 896 F.3d 1088 (9th Cir. 2018) and *Dorman v. Charles Schwab Corp.*, 780 Fed. Appx. 510, 514 (9th Cir. 2019); (3) the Seventh Circuit in *Smith v. Board of Directors of Triad Manufacturing, Inc.*, 13 F.4th 613 (7th Cir. 2021); (4) the Sixth Circuit in *Hawkins v. Cintas*, 32 F.4th 625 (6th Cir. 2022); and (5) the Second Circuit in *Cooper v. Ruane Cunnif & Goldfarb Inc.*, 990 F.3d 173, 184 (2d Cir. 2021). Although there has been a flurry of activity and judicial decisions concerning arbitration provisions, the law remains in flux as additional cases make their way to through the courts of appeals.

D. A Special Note About Public Entity (Government Sponsored Plan) Exposure

Public-entity plans are typically created by statute and are subject to the laws of the jurisdiction where the plan was created, meaning that the standard of conduct imposed on these plan fiduciaries is dictated by state law, as are the remedies for any breach. These plans are not subject to ERISA's fiduciary requirements.[8] However, the fact that these plans are not subject to ERISA does not relieve the fiduciaries of liability exposure and may even broaden the scope of potential liability. This is because ERISA sets forth clear, tightly-drafted statutory conduct requirements and limitations on liability, as well as the specific causes of action and remedies that plaintiffs may pursue. For example, plaintiffs cannot recover consequential or punitive damages under ERISA. ERISA also contains an exclusivity provision that dictates that ERISA preempts all other laws regarding fiduciary liability. This means that, with respect to nonexempt, qualified ERISA plans, plaintiffs cannot make any state law claims or unrelated federal law claims against fiduciaries regarding an alleged breach of duty. Because public entity plans are exempt from ERISA, they do not get the benefit of the limitations that ERISA imposes on claims. As a result, fiduciaries of public entity plans could face liability for state law claims, such as common law breach of fiduciary duty, violation of traditional trust law, and negligence.

[8] See ERISA § 401(b)(1), 29 U. S. C. § 1101(b)(1).

The most common legal claims asserted under ERISA, by far, involve individual "denial of benefit" claims under medical and disability benefit plans. Typically, after having made an unsuccessful (or only partially successful) claim for coverage of a certain medical procedure under the terms of a medical plan, or for disability income benefits under a disability plan, the plan participant sues in court claiming that he or she was improperly denied coverage or reimbursement.

III. Practical Suggestions for Plan Design and Administration

There is no one "best" plan design for all plan sponsors and all purposes. At the same time, although standardized plans offered in the marketplace might be useful starting points, it is important to have a plan structure that is (1) thoughtfully and intentionally designed; and (2) well-administered and consistently followed. Although no one plan provision or combination of provisions can eliminate the risk of litigation, employers may want to consider the following suggestions in consultation with their benefits counsel.

A. Overall Administrative Structure and Design

The following overall administrative structure and design features should be considered:

- **Avoid naming the plan sponsor as a fiduciary.** Plan sponsors should not name the sponsoring employer as the fiduciary of an ERISA plan. Instead, consider whether a committee structure is more appropriate, creating an Employee Benefits Committee to be named as the fiduciary. The committee structure may help differentiate the fiduciary functions from the non-fiduciary (i.e., business or settlor) functions and may also help to avoid attribution of knowledge from the sponsoring employer's executives to the fiduciaries.
- **Avoid naming key corporate officers as fiduciaries.** CEOs and CFOs often possess inside information that plaintiffs may claim prevented them from fulfilling their duty of loyalty. The general counsel often possesses privileged information about the sponsor that plaintiffs may claim must be divulged if the general counsel wears "two hats" and the privileged information is arguably relevant to plan administrative matters.
- **Carefully craft delegation authority.** Consider allowing the named fiduciaries to designate a person who is not a named fiduciary to carry out fiduciary responsibilities without being liable for the latter's acts or omissions. However, in order to do so, DOL requires that the plan provide a procedure for such delegation. If procedures are included in the plan, a named fiduciary will not be liable for the acts or omissions of delegated fiduciaries, provided the named fiduciary acts prudently in the delegation of responsibility *and* periodically reviews the performance of the delegated fiduciaries.
- **Define the roles of plan sponsor and fiduciaries.** In order to differentiate fiduciary functions from non-fiduciary functions, the fiduciary structure should clearly define the different roles; that is, it should clearly identify the individuals who act as "appointing fiduciaries," with the duty to appoint, monitor, and remove delegated fiduciaries.

B. Retirement Plan Design

The following retirement plan design features should be considered:

- **Include a Section 404(c) provision in defined contribution plans.** Compliance with ERISA Section 404(c) may relieve the fiduciaries from liability for damages for "any loss or any breach" where a participant exercises control over assets allocated to his or her account in a defined contribution plan. This language should explain that the participants are responsible for managing the decision to invest or not invest in particular funds. That is, assuming the plan allows for investment diversification among various investment funds as provided in Section 404(c) regulations, the plan document and summary plan description should be clear that the participants have the full authority and responsibility to manage their investments from among the options available under the plan, and that the fiduciaries are not liable for resulting losses. The fiduciaries will also need to ensure that they provide all of the information to participants required by Section 404(c).
- **Hire an outside fiduciary.** Consider engaging a third-party, independent fiduciary to be responsible for and exercise authority over any employer stock investment fund. If an independent fiduciary is appointed, the plan sponsor may consider granting the fiduciary the authority to remove the employer stock investment fund as an option if prudence requires. At the very least, should the sponsor opt against a third-party fiduciary, consideration should be given to removing corporate officers (insiders) and directors from membership on the fiduciary committee responsible for overseeing the employer stock investment fund. Be aware, however, that the company will continue to have ongoing fiduciary obligations even after the delegation (e.g., to monitor whether the delegation itself is prudent, to correct/prevent fiduciary breaches, etc.).
- **"Hard-wiring" certain provisions into plans.** Consider designing the plan so that certain conduct is required by the plan instead of selected by the plan's fiduciaries in their discretion. For example, consider designing the plan to "hard-wire" how plan forfeitures will be used (e.g., requiring forfeitures to be used to offset future employer contributions rather than used to pay plan expenses).

Plans that include investment in employer stock should also consider:

- **Converting the employer stock fund into an ESOP.** This may trigger a higher standard for plaintiffs to prove claims related to the prudence of employer stock and will generally require relatively small changes in most plans that already offer employer stock as an option.
- **Encouraging diversification outside of company stock.** Remove restrictions on the sale or diversification of company stock. Offer employer stock through either a match or an employee-directed investment, but not both. Place a cap on the amount of company stock that participants can hold in their accounts.

C. Medical Plan Design

The following medical plan design features should be considered:

- **Include a strong, clear reservation-of-rights clause.** Ensure that all plan documents include an express reservation of rights to terminate or amend the plan at any time and for any reason. Be sure to include a description of the clause in the summary plan description.
- Explain the plan's reimbursement rules. Clearly explain in the summary plan description how the plan reimburses or pays for benefits, especially out-of-network services and services for which the participant fails to get precertification for treatment, and make the plan's payment schedules accessible to participants and providers. In-network providers are typically paid according to a contractual fee schedule, so the participant has limited financial exposure. Most plans encourage participants to get precertification of treatment, which means (among other things) that they will know before the procedure exactly what it will cost. Because out-of-network providers have not agreed to be bound by the plan's provider-reimbursement agreements, however, plans typically pay a much smaller portion of bills for out-of-network services than for in-network services. These limitations are a frequent source of litigation because participants are commonly surprised by the size of their liability for out-of-network service bills. Similarly, it is important to alert participants to the penalties, and unexpected liabilities, they will face if they fail to comply with the plan's precertification requirement.

D. Plan Administration

With respect to plan administration, "procedural prudence" is vital. In fact, even if the outcome of a fiduciary decision turns out, in retrospect, to have been substandard, fiduciary liability should not attach if the fiduciary can demonstrate that they followed a prudent process. Therefore, set up a procedure in consultation with benefits counsel to help meet fiduciary obligations and to ensure that these procedures are followed.

General procedures may include the following:

- **Have regular, structured meetings.** The plan administrative committee should meet regularly, in person, with agendas and binders of relevant materials, and should keep minutes.
- **Read the plan documents.** Every administrator and fiduciary of a plan should be familiar with the documents that govern the plan, such as the plan document itself, its trust instruments, its summary plan description, any underlying collective bargaining agreements and insurance policies, and the like. The first question DOL or a plaintiff's attorney is likely to ask is whether the defendant has read the plan.
- **Document plan processes and fiduciary decisions, including the rationale behind them.** Although a prudent process is paramount, it does little good if there is inadequate documentation to evidence that the process took place. A fair number of claims that lack substantive merit have settled due to poor process documentation. Fiduciaries should implement and consistently follow procedures to appropriately document their decisions and the rationales behind those decisions.
- **Identify point person(s).** Clearly identify the individuals who act as "appointing fiduciaries" with the duty to appoint, monitor, and remove fiduciaries. Appointing fiduciaries should remain at arms' length for fiduciary decisions and not themselves be active plan fiduciaries (i.e., they cannot monitor themselves). Ensure that your ERISA fiduciary liability insurance policy covers those who are responsible for appointing fiduciaries.
- **Appoint with care.** Follow a clearly defined process for appointing fiduciaries, carefully evaluating possible fiduciary candidates and documenting the selection process. When reviewing applicants, ensure that candidates' qualifications are consistent with duties assigned to that individual.
- **Keep fiduciaries informed.** Consider providing training to fiduciaries, not only when they are initially selected but also periodically throughout their tenure, especially as ERISA case law evolves and changes.

With respect to plan service providers:

- **Understand the scope of services provided and ensure that they are adding value:** Look at the services offered and what kind of benefits they confer on participants. Consider whether they add value or are redundant or not used by participants. Conversely, consider whether the participants' usage of the service or product might provide leverage for negotiating rate reductions (e.g., cheaper prescription drug pricing).
- **Understand provider fees, including any indirect compensation and negotiate them.** Demand full disclosure of all fees and know exactly what the providers are being paid – including from other sources such as through revenue sharing or third party commissions – and benchmark those fees against the market in light of the services provided. Consider regularly conducting periodic requests for proposals or requests for indications in order to get a fuller picture of market rates and alternatives. (The DOL has a strong bias against "perma-vendors," although change just for the sake of change may not be prudent).
- **Review performance.** Meet at least annually with appointed fiduciaries to review the scope and quality of services provided, fees and costs, and other significant events. These meetings should be documented. Replace non-performing fiduciaries!
- **Review agreements with outside fiduciaries.** Ensure that the acceptance of fiduciary status is documented, and that the parties' agreements include a clear statement of duties. Also review

indemnities and limitation-of-liability clauses for compliance with ERISA Section 410, and require that corporate fiduciaries and other service providers are adequately capitalized and insured.

With respect to selecting and managing plan investment options:

- **Consider establishing an investment policy.** If one is already established, review it at least every three years.
- **Use an investment manager or consultant.** Introduce an independent expert's analysis and advice or decision-making into the process.
- **Review investment performance.** On a regular basis, periodically review investment performance of all options against relevant benchmarks. Have and follow "watch list" standards for underperforming funds, and consider retaining an independent advisor to provide assistance in monitoring fund performance and in identifying new managers, asset allocation strategies, and new asset classes. Identify and interview potential replacement managers for underperformers. Document all decisions.
- **Remember diversification.** Consider periodically whether the investment menu has the right number of options. Too few may limit ability to diversify appropriately, but too many may lead to "paralysis by analysis." In a defined benefit plan, be open to changing asset-allocation strategies and testing new asset classes.
- **Be cognizant of investment fees.** Know what you are paying and to whom. Investment fees are often layered and may include fees that are not germane to investment management (i.e.,12b-1 marketing fees), which can be negotiated or rebated. Make sure to periodically review and document fund choices that affect fees and why they make sense (e.g., active vs. index funds, optimal share classes, mutual funds vs. managed accounts, etc.). Investigate whether there are less expensive share classes or investment vehicles (e.g., collective investment trusts) and consider using them, including attempting to leverage the plan's bargaining power to ask for waivers of any eligibility requirements that might otherwise prevent their use.
- **Educate participant investors about the risks of company stock.** The employer should make clear that a concentrated holding in one stock (such as employer securities) can be a very aggressive investment. This language should be included on all participant communications, and any language suggesting any prospective degree of return on company stock or encouraging company stock investments should be avoided.
- **Enhance disclosure to participants about fees.** Consider providing an annual "all-in" fee summary to participants to avoid claims that participants were not aware of fees and expenses. Consider providing a link to available DOL disclosure regulations.
- **Considerations for offering participants access to "non-traditional" investments.** The DOL has issued statements describing concerns it has about the ability of the average plan participant to directly evaluate hedge funds, private equity or cryptocurrency and has described factors that a fiduciary would want to consider when evaluating a multi-asset class product (like a target-date fund) that includes an allocation to non-traditional investments. Consider how the allocation to the non-traditional investments will impact diversification, fees, liquidity, and whether the valuation system used is transparent.
- **Proprietary fund issues.** With respect to proprietary funds, consider taking steps to clearly document that their costs and performance compare favorably to funds available from third-party managers and that the proprietary funds pass the plan's selection and monitoring process applied to all funds. In addition, it is necessary to ensure that the conditions of applicable prohibited transaction exemptions are satisfied.
- **Use safe harbors.** Periodically review regulatory requirements for the safe harbor of ERISA Section 404(c) to ensure that issues or concerns are addressed.

With respect to privately held ESOPs:

- **Hire help.** Ensure that the ESOP has an independent valuation advisor (appraiser), who is required by law to be independent. Consider whether the trustees should engage legal counsel; this is especially important if the trustee is not independent or not experienced. Use an independent trustee to represent the ESOP in an initial stock purchase transaction after the ESOP is created or when engaging in a second stage transaction.
- **Monitor the trustee's performance.** Consider whether the trustee has retained independent financial and legal counsel. Consider whether the trustee has conducted a thorough investigation of the transaction. Review how the trustee negotiated

on behalf of the ESOP. Consider the trustee's review and understanding of any valuation report.

- **Understand the importance of a proper valuation.** Ensure that the appraiser is independent and qualified, a full valuation report is prepared and delivered to the trustee each year, the valuation opinions are dated appropriately, and the valuation reports follow the format specified in the DOL's proposed adequate-consideration regulation.
- **Conduct repurchase studies.** Mature ESOPs should consider projecting, monitoring and planning for their future repurchase obligations, including identifying future funding sources.
- **Sell company stock with care.** For related-party transactions, bring in an independent trustee to address any conflicts of interest, and ensure that the trustee receives independent financial and legal advice. For sales to unrelated parties, consider obtaining a fairness opinion for the ESOP. Ensure that all sales are supported by independent valuations.
- **Watch executive compensation.** Consider monitoring executive compensation (including synthetic equity such as stock appreciation rights) to minimize the risk of participant claims alleging improper dilution, and ensure that appropriate safeguards are in place (e.g., a compensation committee comprising outside directors and/or independent compensation consultants).

Consider trustee indemnification. Although ESOPs hire independent trustees for their professional expertise, trustees often seek to reduce their legal exposure for their professional services in the event that the trustee is sued or investigated by the DOL via indemnification provisions in their agreements with ESOP sponsors. Review these indemnification provisions in your trustee agreements.

Although no one plan provision or combination of provisions can eliminate the risk of litigation, employers may want to consider the following suggestions in consultation with their benefits counsel.

IV. The Role of Fiduciary Liability Insurance for Protecting Plan Sponsors, Fiduciaries, and Parties in Interest

A. The Pivotal Role of Insurance in Protecting Insureds Against Fiduciary Liability

1. Personal Liability and Indemnification Issues

It should be apparent by now that plan sponsors and fiduciaries may be exposed to significant liabilities. This should be of particular concern to plan fiduciaries because ERISA Section 409 imposes personal liability on individuals who breach their fiduciary duties, thus putting the personal assets of the fiduciary at risk.

To make matters worse, ERISA's anti-exculpatory clause prohibits a plan from paying for or indemnifying a fiduciary for a breach of fiduciary duty.[9] Specifically, ERISA § 410, 29 U.S.C. § 1110 provides that "any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy."

A DOL regulation explains, however, that ERISA permits indemnification of a plan fiduciary by an *employer* whose employees are covered under the plan, rather than by the plan itself, so long as the fiduciary remains liable for any loss caused by a breach of that fiduciary's duty. Thus, as between the plan sponsor and the plan fiduciaries, the plan document, trust agreement, and/or an operative engagement agreement may provide for indemnification of the fiduciary by the corporate plan sponsor.

Such indemnity may have limits, however. Even assuming an employer/plan sponsor is willing to indemnify a fiduciary for such a claim, there is a risk that the employer/plan sponsor may not have sufficient funds or liquidity to do so or that it may be prohibited from doing so by law. This concern is especially present during any economic downturn, when insureds are often faced with insolvency and bankruptcy.

Even when an employer/plan sponsor is willing and financially able to indemnify plan fiduciaries, it may be prohibited from doing so by applicable law. For example, plaintiffs may make the argument to a court to hold that the employer/plan sponsor is

[9] Contribution and indemnification issues may arise in ERISA litigation, either between the plan sponsor and plan fiduciaries or among co-defendants. As between co-defendants, ERISA does not include a statutory right to contribution or indemnification. Courts that have decided the issue are split on whether there is a federal common law right of indemnification and contribution under ERISA.

prohibited from honoring its agreement to indemnify the plan fiduciaries, when such agreement to indemnify is conditioned on the plan fiduciaries following instructions provided them without exercising independent judgment. Plaintiffs will contend that courts should prohibit indemnification in such situations to dissuade fiduciaries from not questioning whether the instructions that they were given were in the best interests of the plan and plan participants because of their fear of losing their rights to indemnification. Courts have also suggested that public policy underlying ERISA's anti-exculpatory provision may prohibit indemnity that absolves fiduciaries of responsibility for their breaches of duty.

A special note of concern surrounds multiemployer plans because there is no sponsor present to indemnify fiduciaries as there is with a traditional single employer plan. Instead, the plan is established under a collective bargaining agreement and then a board of trustees is assembled, comprising representatives from both labor and management. As such, the Labor Management Trust policy, which is described later in this report, is usually the only available source of protection for the trustee fiduciaries.

2. Special Considerations for Indemnification of ESOP Fiduciaries

Likewise, courts may preclude indemnification by ESOP sponsors. ESOPs are designed to invest in the stock of the participants' employer (i.e., the plan sponsor). Some courts have determined that ERISA's anti-exculpatory provisions prevent ESOP-owned companies from indemnifying the ESOP's fiduciaries for a breach of fiduciary duty, because doing so would harm the ESOP participants. Ultimately, the value of the participants' benefits (i.e., the value of the company stock held by the ESOP) may be adversely impacted by liabilities incurred by the plan sponsor, including indemnification liabilities. Accordingly, some courts have found that allowing the company to indemnify the fiduciaries (and thus reduce ESOP share value) is akin to the plan indemnifying (i.e. exculpating) the fiduciaries in violation of ERISA. And in the settlement and award context, the theory goes, the ESOP would receive nothing of value because any monies paid would simply be "changing pockets" – from that of the sponsor to that of the ESOP, with no real change in the ESOP's share value. The DOL and some courts have supported this prohibition on indemnification.[10] At least one court has rejected it, however, citing regulations providing that, absent certain circumstances, assets of the corporate plan sponsor are not treated as assets of the ESOP.[11] In addition, in ESOP stock purchase transaction litigation where the selling shareholder defendants, but not the trustee defendants, have reached settlements with DOL, several courts have recently entered settlement bars preventing the non-settling defendant trustee from seeking indemnification or contribution from the selling shareholder.

3. State Restrictions on Indemnification

State corporate indemnification laws may also prevent or limit a plan sponsor's ability to indemnify plan fiduciaries. Some state statutes permit indemnification only when the fiduciary serves at the employer's request (e.g. not de facto fiduciaries). Also, state corporate law may preclude indemnification unless the fiduciary was acting in good faith and in the best interests of the *employer* (not necessarily the best interest of the *plan*). This corporate law standard of conduct could be at odds with ERISA's requirements that all acts be undertaken in the exclusive interests of the plan participants. Thus, there is a potential disconnect between a fiduciary's standard of conduct for purposes of indemnification and ERISA's standard of conduct for fiduciaries. One obvious area where this disconnect could become acute is when the fiduciary is required to pursue his or her employer (the plan sponsor) to contribute funds to the plan.

4. Other Constraints on Indemnification

Also, fiduciaries should keep in mind that even if an employer/plan sponsor is legally capable of indemnifying fiduciaries, it must be sufficiently capitalized and liquid to do so. Even if the sponsor has the financial wherewithal to indemnify fiduciaries, it may not be required to indemnify fiduciaries, absent some undertaking in the corporate documents.

[10] See *Johnson v. Couturier*, 572 F. 3d 1067 (9th Cir. 2009), and *Fernandez et al v. K-M Industries Holding Co.*, 646 F. Supp. 2d 1150 (N. D. Cal. 2009).

[11] See *Harris v. GreatBanc Trust Co.*, No. EDCV12-1648-R (DTBx), 2013 WL 1136558 (C.D. Cal. March 15, 2013).

Fiduciary liability insurance should not be subject to the same legal and financial restrictions that limit corporate employer indemnification of fiduciaries. Fiduciary liability insurance from a reputable, highly rated insurer provides fiduciaries with the added comfort that adequate funds will be available for their defense even when their employers are illiquid or financially troubled. In many instances, a fiduciary liability insurance carrier's decision to defend and/or indemnify a fiduciary may be independent of a plan sponsor's decision to defend and/or indemnify a fiduciary.

B. Types and Terms of Fiduciary Liability Insurance

This report has demonstrated the complexity of ERISA and the types of litigation that can ensue. No one wants to be placed in the position of defending against an ERISA claim, but by recognizing the potential fiduciary exposures and purchasing fiduciary liability insurance, insureds may mitigate against unnecessary inconvenience and personal loss should they be subjected to such a claim.

This section is designed to explain, in simple terms, the purpose and function of fiduciary liability insurance in protecting fiduciaries against ERISA claims.

A good starting point is an explanation of what a fiduciary liability insurance policy does. Put simply, a fiduciary liability insurance policy can be issued either to the plan itself or to an employer that sponsors an employee benefit plan. It is designed to protect insureds against claims alleging the breach of their fiduciary duties to the plan or alleging they committed an error in the administration of the plan.

It goes without saying that every insurance policy has its own particular terms, conditions, limitations, and definitions. Each claim is unique and policy terms vary, so care should be taken to review the specific policy against the specific claim. However, it is helpful to understand some of the more common policy provisions.

1. What Is A Claim?

Definition of Claim

In order to trigger coverage under a fiduciary liability insurance policy, a claim must be made against an insured for a wrongful act allegedly committed by the insured. In other words, the claimant must accuse the insured of having done something wrong with regard to the plan and demand some form of relief.

Generally, a claim may be a written demand for monetary damages or injunctive relief, a civil complaint, a formal administrative or regulatory proceeding commenced by the filing of a notice of charges or formal investigative order, or a written notice by DOL or the PBGC of an investigation against an insured for a wrongful act.

A common misconception is that fiduciary liability insurance can be used to restore losses to an employee benefit plan when a plan sponsor or employer discovers that it made an error. That is not the case. Fiduciary liability insurance is "third-party" coverage, meaning that someone must make a claim against an insured for a wrongful act. In turn, the fiduciary liability insurance policy will provide a defense against the claim (assuming that the policy includes a duty to defend provision, as discussed further on) and then pay for any covered award entered against the insured up to the policy's limit of liability. Fiduciary liability insurance is not "first-party" coverage, meaning that the insured cannot draw on the policy to restore losses to the plan. Likewise, fiduciary liability insurance should not be confused with the mandatory ERISA bond that is required for all persons handling plan assets.

Optional Coverage for Voluntary Correction Programs in Absence of a Claim

Many carriers offer optional coverage for costs associated with an insured's voluntary effort to bring its plan into compliance with certain requirements of ERISA and/or the Internal Revenue Code (IRC) without requiring that a claim be made against an

insured. Such correction programs typically carry a filing fee and/or fine or penalty, which cannot be paid out of plan assets on behalf of fiduciaries.

An insured can pursue several different compliance actions depending on the circumstances. When an insured has discovered that its retirement plan is out of compliance with IRC requirements, it can correct such inadvertent non-compliance without risking plan disqualification through the Employee Plans Compliance Resolution System(EPCRS), which is administered by the Internal Revenue Service.[12] The EPCRS is made up of several components, including the Self-Correction Program, the Voluntary Correction Program, and the Audit Closing Agreement Program. Similarly, the Employee Benefits Security Administration of the Department of Labor administers the Voluntary Fiduciary Correction Program and the Delinquent Filer Voluntary Compliance Program.[13] These programs are designed to encourage employers to voluntarily comply with ERISA, including ERISA's annual reporting requirements, by self-correcting certain violations of law. And lastly, the PBGC administers the Premium Compliance Evaluation Program.

This type of coverage is often subject to a sublimit, meaning that there is a lower limit of liability applicable to this type of coverage as compared to the overall limit of liability for the policy. The sublimit is usually part of, and not in addition to, the limit of liability. Also, any grant of coverage will usually not cover the actual costs of bringing a plan into compliance (e.g., the policy will not pay for the funding obligations of the |plan sponsor).

Optional Coverage for Department of Labor Investigations, Benefit Denial Appeals, and Interviews

An innovation in the fiduciary liability insurance market is to extend the circumstances in which the policy may respond, going beyond the traditional notion of a Claim, meaning insureds may be able to trigger coverage without having to wait for a formal lawsuit or written demand for monetary damages against an Insured for alleged wrongful acts. In other words, the Insured can trigger coverage in situations where the parties have not yet become truly and fully adverse. These coverage extensions are typically elective, meaning the Insured does not have to avail themselves of it if they prefer to handle the situation on their own, waiting to involve the carrier until if and when the matter ripens into a formal Claim. Electing not to report these elective matters will not form the basis for a late report if a Claim is eventually made and tendered.

Some modern policies now extend coverage to the following situations:

- DOL investigations that do not allege wrongful acts against an Insured (i.e., "Pre-Claim Investigation" coverage).
- Appeals of benefit claim denials. Of course, in the event it is determined that that the Insured owes the disputed, fiduciary liability insurance will not pay out the actual benefits due.
- Interviews concerning the plan requested by governmental regulators,
- Failures to enroll that have been reported to the Insured but for which no Claim has yet been made.

2. Who Is An Insured?

A person or entity must be an insured as defined under the policy in order for coverage to apply. Insureds may include the plan sponsor(s); that is, the entity or group that creates and funds the plan (typically the employer(s) of the plans' participants). Insureds under fiduciary liability policies typically include the sponsoring organization's officers, directors, and employees acting as fiduciaries or as members of any employee benefit committee, investment management committee, or administrative committee for the plan, as well as natural person employee trustees of the plan.

The plan itself, as defined under the policy, is also an insured. "Plan" often includes employee welfare plans and pension plans and can be sponsored by for-profit organizations or not-for-profit organizations.[14] Under many fiduciary liability insurance policies, the term "plan" is not confined to traditional ERISA plans and, as such, may include plans that are not subject to ERISA (e.g., "top hat" plans, excess benefit plans, church plans, government plans, and plans that are created and maintained outside the United States).

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[12] See Rev. Proc. 2003-44, 2003-1 C. B. 1051.

[13] See 67 Fed. Reg. 15052, 15058 (March 28, 2002).

[14] Note that defined contribution plans that are sponsored by not-for-profit organizations or by educational organizations may be known as "403(b) plans," referring to the applicable provision of the IRC addressing these organizations' plans.

Just as important as understanding who is an insured is knowing who is not an insured under the policy. Third- party service providers (such as investment advisors, investment managers, and third-party administrators) who are hired by the plan or plan are typically not insureds under the fiduciary liability insurance policy, even if they are considered to be fiduciaries under ERISA.[15] Fiduciary liability insurance policies typically cover only plan fiduciaries who are employed by the entity that purchases the policy, and not other fiduciaries, particularly those employed by outside providers (such as professional ESOP trustees as discussed above.) This approach is important, because it preserves policy limits for the plan sponsor's employee and director fiduciaries.

3. What Is A Wrongful Act?

Another important policy provision is the definition of the term "wrongful act." The definition varies from carrier to carrier and from policy to policy but, generally speaking, most fiduciary liability insurance policies cover, at a minimum, breaches of fiduciary duties and errors in the administration of the plan.

Alleged breaches of fiduciary duty (with their "prudent expert" standard of care) can drive significant exposure, all of which fiduciaries can be held personally liable for under ERISA. Most, if not all, of the recent class action trends involve breach of fiduciary duty claims (e.g. excessive fee claims, actuarial equivalence claims, COBRA violation claims, etc.). In addition, numerous other breach of fiduciary duty claims may also present significant liability potential, such as allegations involving misinterpretation of a plan document, wrongful administration of a plan in a way that is not in compliance with the plan documents, providing imprudent investment options to participants in a pension plan, failing to accurately communicate relevant information to plan participants, or making misrepresentations about plan investments.

Fiduciary liability insurance coverage may also be triggered by an Insured's error in the administration of the plan. In this context, administration commonly includes handling paperwork for the plan, providing interpretations with respect to the plan, or giving advice to participants regarding the plan. Such claims are common. For example, an employee may miss the window of time in which to add their newborn child to their medical coverage based upon their employer's human resources department's erroneous advice as to the applicable deadline for making the change.

Many carriers offer coverage for "settlor conduct." Settlor conduct includes actions taken by a plan sponsor in the creation, amendment or termination of an employee benefit plan. It does not include fiduciary conduct. Claims of settlor misconduct may accompany breach of fiduciary duty claims, especially where the plan sponsor has amended a plan to change or reduce benefits and the fiduciaries must then carry out those plans. For example, where a sponsor decides to de-risk a defined benefit plan by annuitizing it, the sponsor's decision to de-risk the plan would likely be considered settlor conduct, but any subsequent conduct by the fiduciaries in carrying out the de-risking, such as hiring experts to assist with possible annuitizations, might be considered to be fiduciary conduct.

4. Loss and Benefits Due Provisions

Once a claim has been made against an insured for a wrongful act, the relief sought must constitute loss that is covered by, and not specifically excluded from, the fiduciary liability insurance policy. The definition of "loss" and the "benefits due" exclusion are really two sides of the same coin. Both are approaches that carriers use to address the nature of the requested relief in order to come to a coverage result. These policy provisions may be used to preclude coverage for indemnity payments that constitute benefits that are payable to participants or their beneficiaries

[15] Claims filed against third-party providers are typically covered by that third-party provider's own errors and omissions insurance (not fiduciary liability insurance) policy because their liability arises from professional services rendered for another party's plan.

under the terms of a plan, or that would have been payable under the terms of the plan had it complied with ERISA.

Note that even when the requested relief is not covered loss, such as benefits due, the insureds may still have coverage for defense costs. For example, if a retiree sues a pension plan for erroneously calculating an underpayment of a lump sum distribution, fiduciary liability insurance would likely pay to defend against the retiree's claim, whereas the plan would have to pay any settlement or judgment awarding the retiree the underpaid portion of his/her distribution (i.e. the benefits due under the plan).

5. Defense Provisions

Most fiduciary liability insurance policies include a "duty -to-defend" provision, which means that the insurance carrier has the right and duty to defend the claim against an insured, including the right to select defense counsel. Policies that do not include a duty to defend provision often require insureds to choose from a panel of pre-approved defense counsel for select claims including class action claims.

The duty-to-defend provision is sometimes met with resistance from insureds, and for this reason, many insurers are now giving insureds the option to assume the duty to defend of some claims from the outset. However, before doing so, insureds should consider the benefits to be gained by the exercise of this duty. The right and duty-to-defend provision includes the insurance carrier's right to select defense counsel. Fiduciary liability insurance carriers, who regularly provide the defense of fiduciary liability claims, are familiar with the ERISA defense bench and know their particular expertise, experience and strengths, and are in the most informed and advantageous position to determine the best fit for the case. Accordingly, fiduciary liability insurance carriers play a pivotal role in providing insureds with appropriate defense counsel to mount the best defense possible.

Due to the volume of the claims they handle, fiduciary liability insurance carriers commonly negotiate lower rates and litigation management guidelines with the defense firms so that they become "panel counsel." Thus, insureds receive the benefit of a defense by accomplished ERISA defense counsel at reduced rates and lower expense. This is important because fiduciary liability policies are typically "eroding limits" policies so that defense costs are within the limits of liability, meaning that every dollar spent by the carrier on defense costs erodes the available limit of liability by that same amount. Thus, lower defense costs preserve the available policy limits for any covered loss that may arise either in settlement or judgment.

Also, due to the number of cases that panel firms handle, they not only stay abreast of the rapidly-evolving caselaw, but they are responsible for making much of it. Thus, they are intimately familiar with the caselaw and its underpinnings and have an innate sense as to how to press certain issues in litigation. They are also familiar with opposing counsels' style and proclivities due to their repeated interactions. This background leads to better case results and lower defense costs.

6. Other Forms of Insurance Protection

In addition to the more commonly known fiduciary liability insurance policies that cover traditional, single employer plans, there are other types of fiduciary liability policies designed to cover certain multiemployer plans, commonly referred to as "Taft-Hartley" plans. Established to address collective bargaining agreements in accordance with the Taft-Hartley Act, these plans provide benefits for people who are members of a specific union (e.g., a local chapter of the Teamsters) but are employed by different employers. A Taft-Hartley multiemployer plan is characterized by provisions that allow its participants to continue to earn benefits based on work with multiple employers, as long as each employer contributes to the plan. Policies insuring these plans, sometimes called Labor Management Trust (LMT) policies or Multi-Employer Plan policies, are constructed differently than traditional fiduciary liability insurance policies because LMT policies cannot be issued to a single employer as a plan sponsor. Instead, they are issued to the plan itself.[16] LMT policies typically cover wrongful acts similar to those that are covered by fiduciary liability insurance.

Public entity plans (i.e., governmental plans) are similar to Taft-Hartley/multiemployer plans in that insureds are often public employees who work for a variety of different public agencies or governmental

[16] ERISA Section 410 permits plans to purchase fiduciary liability insurance.

divisions (e.g., a plan may cover all teachers employed by public schools within the state, even though they are employed by several different school districts). Accordingly, these policies, like LMT policies, are usually issued to the plans themselves.

There are also optional Employee Benefit Liability (EBL) endorsements that may be endorsed onto general liability policies.[17] These EBL endorsements should not be confused with the coverage afforded by the fiduciary liability insurance policies; EBL endorsements are usually far more restrictive in scope of coverage. For example, they typically do not cover the all-important breach of fiduciary duty claims that can impose personal liability, and instead cover only claims for errors in the administration of a plan, and even then may often be subject to more restrictive terms and conditions than those of a fiduciary liability insurance policy. One notable exception, however, is that under some EBL endorsements, defense costs might not erode the applicably policy limit, which can be a valuable coverage to have in conjunction with Fiduciary liability insurance.

Fiduciaries should not rely on the fact that they have executive liability insurance, commonly referred to as Directors and Officers (D&O) liability insurance, in the event a fiduciary liability claim is made against them. As discussed previously, the same person may serve as both a plan fiduciary and as a director and/or an officer. A person's status as an insured person depends on their capacity, which depends on the nature of the activity in which he/she is engaged. If he/she conducts business on behalf of the employer, then he/she may be acting as a director and/or officer. If he/she administers the plan or deals with plan assets, then he/she may be acting as a plan fiduciary. Even when a director is also a plan fiduciary and gets sued in both capacities, D&O liability policies typically cover directors and officers only for activities performed in their capacity as directors or officers, not as plan fiduciaries. Furthermore, D&O liability insurance policies typically exclude from coverage any claims based on or arising from an ERISA violation.

Finally, a fiduciary liability policy will not satisfy any bonding requirements under ERISA for theft of plan assets, although the fiduciary liability policy could pay for the defense of a fiduciary who was sued by a plan participant for breach of fiduciary duty for allegedly failing to prevent or detect the theft of funds.

C. Partnering with the Insurance Carrier

Any discussion of fiduciary liability insurance would not be complete without including some best practices for insureds in dealing with fiduciary liability insurance:

Select a carrier with fiduciary expertise, experience and sufficient size. Fiduciary insurers should be more than just a "checkbook" when a claim is made. They should be an integral part of the defense and partnering with the insured and counsel, leveraging their "insiders' knowledge" to the fullest extent appropriate to mount the best defense. Also, policies are simply words on paper conveying a promise. What matters is how the insurance carrier interprets those words and delivers on those promises. Two carriers can apply the same wording in different ways, so make sure you're comfortable that the carrier you're working with has a strong track record of delivering on their promises – not "nickel and diming" claimants nor hiding behind technicalities. And finally, the world of fiduciary litigation has been undergoing a metamorphosis in which this formerly "sleepy" space has awakened – with numerous, severe claims. Carriers that do not

[17] Commercial general liability insurance covers all liability exposures of a business that are not specifically excluded. Coverage typically includes advertising and personal injury liability, product liability, completed operations, premises and operations, and medical payments.

have large presences in the fiduciary space may find themselves facing claims that cause them to rethink their positions in the Fiduciary market, leaving their customers searching for new coverage alternatives. This is why it's important to consider the carrier's tenure and their demonstrated commitment to weathering storms that could pose existential threats to smaller, less stalwart insurers.

Report a claim. A fundamental best practice is to tender any fiduciary claim to the carrier in a timely fashion. Many policies specify the reporting requirements for tendering a claim for coverage. Establishing point persons (e.g., human resources, benefits department, and general counsel's office) who are trained to recognize claims and report them timely through the employer's broker/agent to the carrier will help to ensure that the policy responds as intended. Remember that many policies may define a "claim" as constituting not only civil and criminal complaints, but also verbal or written demands and investigations alleging wrongful acts. Insureds may imperil coverage if they tender a claim belatedly.

Cooperate with your carrier. Once the claim is submitted, insureds should make every effort to cooperate with the carrier to provide all information necessary to evaluate the claim. Also, insureds should not incur any liability, including defense costs, engage in any settlement discussions, or enter into any agreements that could impact the claim without first getting the carrier's consent, because many policies have consent provisions that prohibit this type of activity. Just as an insured needs to cooperate and keep lines of communication open with the carrier, an insured is entitled to expect timely and forthright communication from the carrier, be it on coverage issues or questions about the claim in general. Prominent fiduciary liability insurance carriers employ experienced fiduciary claim examiners, many of whom are attorneys. These examiners can provide meaningful collaboration both with defense counsel and insureds as the claim progresses on such matters as defense arguments, case valuations, and selection of mediators.

Even when an employer/plan sponsor is willing and financially able to indemnify plan fiduciaries, it may be prohibited from doing so by applicable law.

Conclusion

Plan sponsors and fiduciaries need to be proactive to insulate themselves in an ever-changing legal environment. Well-designed, well-executed, and well-administered benefit plans are an important foundation for limiting litigation exposure moving forward. Likewise, fiduciary liability insurance should be considered in any comprehensive corporate risk management program.

About the Author

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Lars Golumbic serves as the co-chair of the firm's Litigation group. His ERISA litigation practice includes the defense of "excessive fee" and ESOP class actions brought against plan sponsors, fiduciaries, and service providers. Lars also represents health plan sponsors and health insurers in actions brought under the Mental Health Parity and Addiction Equity Act. Additionally, Lars defends plan trustees, fiduciaries, companies and their board members, and service providers in Department of Labor investigations and enforcement proceedings instituted by the federal agency. He has appeared in dozens of federal courts across the country as part of his active ERISA litigation practice. While the focus of Lars' national practice is in ERISA litigation, Lars also represents plan fiduciaries and other stakeholders in matters concerning plan funding, restructuring, withdrawal liability, and plan termination.

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