Insurance Coverage Law BULLETIN

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ASBESTOS ALERT

Manville Briefing Sets Battle Lines on Unimpaired Claimants

Nearly a year after a hearing dedicated to the problem of depletion of the asset base of the Manville Trust, the Bankruptcy Court for the Southern District of New York has received written submissions from the parties concerning what to do about it. At issue was a set of proposed amended trust distribution procedures (TDPs) that reconfigured the methods by which claims might be paid, but did so without eliminating the allocation of large amounts of trust assets to claimants who show no impairment.

Leading the objectors, as he did before the Senate Judiciary Committee recently, was Steven Kazan, who represents primarily cancer and mesothelioma victims. Mr. Kazan has objected on behalf of an Unofficial Committee of Select Asbestos Claimants (SAC). The SAC takes issue with the allocation of dollars to minimally screened non-symptomatic claimants, as well as with the adoption of certain compensation minimums that are expected to protect unimpaired claimants from dilution even though seriously injured claimants may expect to get only pennies on their claim dollar. In reciting the SAC's objections, Mr. Kazan referred to similar debates going on in connection with a number of other asbestos bankruptcies, including Babcock & Wilcox. There, according to Mr. Kazan, "Since we were outvoted nine to two on any contentious issue and since other members of the committee expressed a felt need to have my concurrence, I

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ERISA LIABILITY COVERAGE

Seventh Circuit Gives Expansive Construction to 'Benefits Due' Exclusion

By Stephen A. Klein

Companies purchase fiduciary-liability policies to protect themselves and their officers and directors against liability for breaches of fiduciary duties, including those in connection with benefits plans established under the Employee Retirement Income Security Act (ERISA). Such policies typically contain an exclusion for claims seeking "benefits due under the terms of the plan," because the policies are not intended to fund a company's contractual obligation to discharge the promises of performance in the plan.

In the first appellate decision by any court to address the scope of the "benefits due" exclusion, the U.S. Court of Appeals for the Seventh Circuit recently adopted an expansive reading of the exclusion that calls into question the practical value of fiduciary-liability coverage for the plan sponsor itself. To the extent that the terms of a policy would purport to cover a plan sponsor's liability, this decision, *May Department Stores v. Federal Insurance Co.*, 305 F.3d 597 (7th Cir., Aug. 19), effectively negates the prospect of realistically obtaining coverage, which should prompt plan sponsors to re-evaluate their coverage purchases, and insurance companies to evaluate the language used to express their intended grant of coverage.

Role of Sponsor vs. Role of Administrator

ERISA establishes a sharp distinction between the function and responsibilities of the sponsor of a benefits plan, i.e., the entity that undertakes to fund the plan's benefits, and the administrator of the plan, i.e., the entity responsible for overseeing the management and investment of plan funds and distributions to participants. The plan sponsor, usually an employer establishing a benefits plan for its employees, may also assume the duties of administrator, or may retain an outside firm to fill that role. Both plan sponsors and plan administrators owe fiduciary and other

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duties, imposed by common or statutory law, to the plan participants, and fiduciary-liability policies purport to cover entities serving both capacities. But under the Seventh Circuit's reasoning in *May Department Stores*, most of a plan *sponsor's* potential liability would be excluded from coverage.

In this case, May Department Stores, the sponsor of an ERISA benefits plan for its employees and their beneficiaries, had purchased an executive protection policy from Federal Insurance Company in order to cover "any breach of the responsibilities, obligations or duties imposed upon fiduciaries of the Sponsored Plan by [ERISA], or by the common or statutory law." May sought coverage under this policy in connection with two separate plan participant class actions it was facing.

One class action challenged the interest rate the company had used when it liquidated annuity benefits to lump-sum payments, which ERISA mandates must be actuarially equivalent; the other complained of the company's alleged failure, in violation of an ERISA regulation, to notify participants that payment of their retirement benefits would be deferred should they elect to continue working. The company paid substantial sums to settle both cases and sought recovery from Federal under the executive protection policy, but Federal denied coverage on the basis of the policy's exclusion for damages that "constitute benefits due or to become due under the terms of a benefit program (i.e., the May ERISA plan)."

May Disputes Application Of 'Benefits Due' Exclusion

May disputed the application of the "benefits due" exclusion and offered three arguments in support of its case. In rejecting each of May's contentions, the Seventh Circuit left little room for coverage of a plan sponsor's liability, and it appears to have done so purposely.

May first contended that the settlement payments could not have constituted benefits "under the terms of the plan" because the class actions alleged statutory and regulatory violations of ERISA and not violations of the plan document, which sets forth the terms of the sponsor's promises to perform. The Seventh Circuit disagreed, finding that an ERISA plan implicitly incorporates the requirements of the statute. Thus, the court held that ERISA's actuarial equivalency requirement was an implicit term of the plan that dictated the method for calculating the interest rate to be used to accomplish the conversion from annuity to lump sum; consequently, May's selection of a different interest rate was not considered by the court to be an exercise of discretion in *administering* the plan.

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Under this reasoning, a plan sponsor's violations of fiduciary duties as well, which represent the core of what fiduciary-liability policies are intended to cover, could almost always be potentially recharacterized as a payment for benefits due under the terms of the plan. Otherwise, what would a payment from the sponsor directly to an individual participant be other than a surrogate for the benefits due him?[1]

May also sought to rely on the difference between ERISA's two private causes of action available to plan participants. Under ERISA § 502(a)(1)(B) (29 U.S.C. § 1132(a)(1)(B)), plan participants may sue to "recover benefits due," while under § 502(a)(3) (29 U.S.C. § 1132(a)(3)), they may sue for equitable relief to redress ERISA violations. May argued that because the class actions alleged the second cause of action and not the first, the plan participants ipso jure were not seeking "benefits due." The court retorted that the plan participants' own characterization did not bind the court, and that, in any event, the plan participants were incorrect to proceed under the second ERISA provision because equitable relief is available only where legal relief, such as a suit for benefits due, is inadequate.[2]

Finally, May argued that if damages paid in response to a claim for a violation of ERISA are excluded, the coverage provided under the Executive Protection Policy would be rendered illusory. The court did not deny that policies must be construed so as to avoid making the coverage illusory, and it even raised sua sponte the proposition that the amount of the premium may be relevant in ascertaining the intended breadth of coverage. But the court nonetheless seemingly acknowledged that the coverage of plan sponsor's liability was illusory—its anodyne was to note that May, which also served as the administrator of the plan, still would have coverage for claims against it in that capacity. The court stated, "May, which, remember, directs the investments of the plan's assets, might during the policy period have violated the prudent-man rule or some other limitation on trust investments, depleting the plan's assets; the violation, unless willful, would be covered by the policy. Such violations are not so uncommon as to render coverage of them a negligible or illusory benefit on the insurance policy." 305 F.3d at 602.

The court did not address any underwriting evidence of what coverage May thought it was purchasing or Federal thought it was selling, but rather found that May's dual capacity meant it enjoyed at least *some* policy benefits in one of its capacities. This sidesteps the question, of course: What is the status of plan sponsors that do not operate in the dual capacity of plan administrator, or of insureds that specifically negotiated and purchased fiduciary-liability coverage in their capacity as plan sponsors? These by no means are exceptional circumstances, and the court provides no answer at all. This may provide a basis for plan sponsors to distinguish the decision.

However, the court did leave open the possibility of one limited area of covered damages: interest on benefits due, which the court found did not itself constitute a "benefit due."[3] By the same token, a plan sponsor's payment of the plan participants' attorneys fees may be found to fall outside the "benefits due" exclusion, though the court did not address that question. But there is no question that *May Department Stores*, if adopted by other courts, will seriously undermine the value of fiduciary-liability policies purchased by plan sponsors.

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(1) The court justified its ruling in part by reference to the "moral hazard problem," *i.e.*, that it would create an undesirable incentive were a plan sponsor to be insured against failing to pay plan benefits pursuant to aggressive interpretations of ERISA. But this assumes the court's conclusion; the question is whether violations of ERISA constitute claims for plan benefits in the first place.

(2) The court did not explain why the plan participants' own sense of what they were seeking was not a relevant consideration, preferring to conclude that the plan participants had mispleaded their claims rather than concede the possibility that they were not seeking "benefits due." Had the carrier's defense obligation been at issue, the court's contortions would have been especially problematic because the defense obligation traditionally requires deference to the underlying pleadings, liberally construed to find the potential for coverage where it reasonably exists.

(3) However, in order to be cognizable under ERISA, interest on benefits due must be characterized as equitable, not legal, interest. Because interest is not a benefit due, it cannot be claimed under a § 502(a)(1)(B) cause of action for the recovery of benefits due. Thus, interest can only be claimed under ERISA pursuant to a § 502(a)(3) cause of action for equitable relief, the only alternative cause of action. Standard pre- and post-judgment interest is legal, the court found, not equitable, so it may not be recovered under the statute. See *Dobson v. Hartford Fin. Serv.*, 196 F. Supp.2d 152 (D. Conn. 2002) (applying to prejudgment interest the rationale of Great-*Western Life & Annuity Co. v. Knudson*, 534 U.S. 204 (2002)). But interest assessed to redress a plan sponsor's unjust enrichment is equitable in nature and may be recovered through the mechanism of a constructive trust. Accordingly, only interest that is measured according to the plan sponsor's unjust enrichment and awarded to the plan participants pursuant to a constructive trust or other equitable remedy may be both cognizable under ERISA and covered under fiduciary-liability policies.

Even this narrow area of potential coverage is called into question by another Seventh Circuit decision, also authored by Judge Posner, which found that the disgorgement of ill-gotten gains does not constitute covered "loss" under a liability policy. *Level 3 Communications Inc. v. Federal Ins. Co.*, 272 F.3d 908 (7th Cir. 2001). It is not clear why Judge Posner seemingly ignores his decision in *Level 3 Communications*, written just nine months earlier, in his discussion in *May Department Stores* of coverage for equitable interest.

Recoupment of Fees

applies only if the paying party has not been asked for payment. However, SST requested payment of the defense costs from United National by tendering the underlying suit for defense. As such, the Sixth Circuit concluded that United National could not be considered a volunteer.

Circuit Judge Eric Clay dissented, concluding that the United National insurance contract did not provide for the recoupment of attorney fees paid subject to a reservation of rights, and United National should not be allowed to foist such a duty on SST. Judge Clay also concluded that no implied-in-fact contract was formed by virtue of United National's unilateral reservation of rights, especially given SST's vigorous pursuit of coverage for the underlying suit. Accordingly, Judge Clay's dissent concluded that United National was not entitled to recoup the defense costs it paid in defending.

As noted above, *SST Fitness* is a significant development with regard to a carrier's right to recoup defense costs paid under a reservation of rights. Carriers should consider this issue when deciding whether to defend under a reservation of rights, and policyholders should not silently acquiesce, as silence may be deemed acceptance of a binding contract.