LITIGATING THE ERISA FIDELITY BOND CLAIM

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I.
INTRODUCTION

The Employee Retirement Income Security Act of 1974[1] requires qualified plans to obtain coverage against loss of plan funds caused by the fraudulent or dishonest acts of persons who "handle" plan funds. Recognizing that ERISA imposes obligations upon the plans, courts and the United States Department of Labor have explained that it is the duty of the plan, not the insurer, to obtain the required coverage.

When faced with a loss not covered under their fidelity policy, insureds have, under the guise of "statutory incorporation," sought to rewrite their policies to expand coverage. In *Rosenbaum v. Hartford Fire Insurance Co.*,[2] the seminal case concerning ERISA bonds, the Ninth Circuit strictly interpreted a policy that complied with "certain" of ERISA's bonding requirements, and held that ERISA does not supplant the plain language of a fidelity bond or impose an affirmative obligations on insurers to provide all of the coverage required thereunder. Arguing several variations on the same theme, several insureds have contended that courts should ignore because *state* law forces wholesale incorporation of ERISA into a fidelity policy—even if the policy does not say so. To date, courts have uniformly rejected such arguments.[3]

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[1] 29 U.S.C. § 1000 – 1461 (2008) [hereinafter ERISA].

[2] 104 F.3d 258 (9th Cir. 1996).

[3] *See, e.g.*, Nevada Urology Assocs. Restated Profit Sharing Plan v. Hartford Fire Ins. Co. of Am., Order granting Hartford's Motion for Summary Judgment, Doc. No. 2730-105, No. CV 06-00236 (2nd Judicial Dist., Washoe County, Nev., Mar. 13, 2008); Employers-Shopmens Local 516 Pension Trust v.

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To successfully defend against claims seeking coverage to the full extent of ERISA's bonding requirements contrary to policy terms, counsel must be well-versed in: (1) ERISA and related regulations pertaining to the bonding requirements for protection of plan assets; (2) the extent to which the policy or bond at issue expresses an objective intent to incorporate ERISA's bonding requirements; and (3) case law addressing attempts by ERISA insureds to override plain policy language via statutory incorporation and related arguments.

The extent to which ERISA bonding requirements are incorporated into a policy or bond is a question that is typically resolved on summary judgment. But counsel should not overlook the need to prepare factual defenses for trial that may apply regardless of ERISA, such as: (1) whether any covered conduct in fact occurred; (2) whether the alleged losses were caused by such conduct; and (3) the extent of any alleged covered losses. These factual questions usually are not resolved on summary judgment, and often require retention of experts and completion of discovery.

Expanding on these themes, this article first provides a detailed overview of ERISA's bonding requirements, as interpreted by the courts and the U.S. Department of Labor. Next, this article analyzes reported claims to date by ERISA plans. Then, the article provides some practical guidance regarding discovery and the use of experts when handling a claim under an ERISA bond.

II.
OVERVIEW OF ERISA'S BONDING REQUIREMENTS

Section 412 of ERISA and its related regulations[4] impose a myriad of bonding requirements on qualified plan. Fidelity bonds are distinct from fiduciary liability insurance, which generally covers losses arising from breaches of fiduciary duties and is not required by ERISA, in that the bonds are designed to cover specific types of conduct perpetrated by an "employee," as defined in the bond.

Travelers Cas. & Surety Co. of Am., No. 0502-01821 (Or. Cir. Ct. Dec. 16, 2006); Local No. 290 v. Federal Ins. Co., No. 07-1521-HA, 2008 WL 3523271 (D. Or. Aug. 11, 2008).

[4] 29 C.F.R. § 2550.412-1 (2008); 29 C.F.R. pt. 2580 (2008).

Other than *Rosenbaum*, there has been little case law interpreting ERISA's bonding requirements. In November 2008, the U.S. Department of Labor issued guidance clarifying ERISA's bonding requirements.[5] The 2008 Bulletin responds to frequently asked questions and provides guidance on the bonding regulations, addressing who must be bonded, who is exempt from bonding, the amount and type of coverage required, and who is responsible for compliance with the bonding requirements.

A. Who Must Be Covered: Fiduciaries and Others Who "Handle" the Plan's Funds

ERISA's regulatory framework divides the universe of those who must be bonded into three broadly defined categories: (1) "administrator";[6] (2) "officer";[7] and (3) "employee."[8] The

[5] Guidance Regarding ERISA Fidelity Bonding Requirements," for Virginia C. Smith, Director of Enforcement, Regional Directors, from Robert J. Doyle, Director of Regulations and Interpretations, Field Assistance Bulletin No. 2008-04, November 25, 2008 [hereinafter 2008 Bulletin], http://www.dol.gov/ebsa/regs/fab2008-4.html (last visited May 18, 2009).

[6] "Administrator" is defined as: "(i) The person or persons designated by the terms of the plan or the collective bargaining agreement with responsibility for the ultimate control, disposition, or management of the money received or contributed; or (ii) In the absence of such designation, the person or persons actually responsible for the control, disposition, or management of the money received or contributed, irrespective of whether such control, disposition, or management is exercised directly or through an agent or trustee designated by such person or persons. 29 C.F.R. § 2580.412-3(a) (2008).

[7] ERISA provides that "[f]or purposes of the bonding provisions, the term 'officer' shall include any person designated by the terms of a plan or collective bargaining agreement as an officer, any person performing or authorized to perform executive functions of the plan or any member of a board of trustees or similar governing body of a plan. The term shall include such persons regardless of whether they are representatives of or selected by an employer, employees or an employee organization. In its most frequent application the term will encompass those natural persons appointed or elected as officers of the plan or as members of boards or committees performing executive or supervisory functions for the plan, but who do not fall within the definition of administrator." 29 C.F.R. § 2580.412-3(b) (2008).

[8] ERISA provides that "[f]or purposes of the bonding provisions the term 'employee' shall, to the extent a person performs functions not falling

regulations also address "other persons" who do and do not fall within the bonding requirements.[9] In effect, ERISA requires every "fiduciary" of an employee benefit plan and every person who "handles" funds or other property of a plan to be bonded, unless included in one of the exemptions in section 412.[10]

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within the definition of officer or administrator, include any employee who performs work for or directly related to a covered plan, regardless of whether technically he is employed, directly or indirectly, by or for a plan, a plan administrator, a trust, or by an employee organization or employer within the meaning of section 3(3) or 3(4) of the Act. 29 C.F.R. § 2580.412-3(c)(2008); *see Rosenbaum*, 104 F.3d at 263 (*citing* 29 C.F.R. § 2580.412-3).

[9] ERISA provides that "[f]or purposes of the bonding provisions, the terms 'administrator, officer, or employee'' shall include any persons performing functions for the plan normally performed by administrators, officers, or employees of a plan. As such, the terms shall include persons indirectly employed, or otherwise delegated, to perform such work for the plan, such as pension consultants and planners, and attorneys who perform 'handling' functions within the meaning of Sec. 2580.412-6. On the other hand, the terms would not include those brokers or independent contractors who have contracted for the performance of functions which are not ordinarily carried out by the administrators, officers, or employees of a plan, such as securities, brokers who purchase and sell securities or armored motor vehicle companies." 29 C.F.R. § 2580.412-3(d) (2008).

[10] Section 412 specifically excludes (1) any fiduciary (or any director, officer, or employee of such fiduciary) that is a bank or insurance company and which, among other criteria, is organized and doing business under state or federal law, is subject to state or federal supervision or examination, and meets certain capitalization requirements; (2) any entity which is registered as a broker or a dealer under section 15(b) of the Securities Exchange Act of 1934 (SEA), 15 U.S.C. § 78o(b); (3) banking institutions and trust companies that are subject to regulation and examination by the Comptroller of the Currency, the Board of Governors of the Federal Reserve System, or the Federal Deposit Insurance Corporation; (4) insurance carriers (or service or similar organization) that provides or underwrites welfare or pension benefits in accordance with state law. This exemption applies only with respect to employee benefit plans that are maintained for the benefit of persons other than the insurance carrier or organization's own employees; and (5) certain savings and loan associations that administer plans for their own employees. 29 C.F.R. § 2580.412-29, § 2580.412-30. 2008 Bulletin, *supra* at Q-15.

Whether a person "handles" plan funds depends on his or her access to, or decision-making authority over, the assets has the potential to make them susceptible to risk of loss from wrongdoing. Those who must be bonded include most plan fiduciaries as well as certain non-fiduciaries if they receive, handle, disburse or otherwise exercise custody or control over plan assets.[11] ERISA refers to those who must be bonded as "plan officials."[12]

Such "plan officials" usually include the plan administrator and those officers and employees of the plan or plan sponsor who handle plan funds by virtue of their duties relating to the receipt, safekeeping and disbursement of funds.[13] "Plan officials" may also include other persons, such as service providers, whose duties and functions involve access to plan funds or investment-decision-making authority that can give rise to a risk of loss through fraud or dishonesty.[14] Where a plan administrator, service provider, or other plan official is an entity, such as a corporation or association, ERISA's bonding requirements apply to the natural persons who perform "handling" functions on behalf of the entity.[15] The term "handling" is broader than actual physical contact with "funds or other property" of the plan.[16] A person is "deemed to be 'handling' funds or other property of a plan so as to require bonding whenever his duties or activities are such that there is a risk of loss in the event of fraud or dishonesty by such person, whether acting alone or in collusion with others."[17] Subject to this basic standard, the general criteria for determining whether a person "handles" ERISA plan funds include:

1. Physical contact (or power to exercise physical contact or control) with cash, checks or similar property;

2. Power to transfer funds or other property from the plan to oneself or to a third party, or to

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[11] 29 C.F.R. § 2580.412-6 (2008).
[12] 2008 Bulletin, *supra* note 5, at Q-3.
[13] *Id.* at Q-5.
[14] *Id.*
[15] *Id.*; *see* also 29 C.F.R. § 2550.412-1(c), § 2580.412 (2008).
[16] *Id.* at Q-18.
[17] *Id.*

> negotiate such property for value (e.g., mortgages, title to land and buildings, or securities);
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> 3. Disbursement authority or authority to direct disbursement;
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> 4. Authority to sign checks or other negotiable instruments; or
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> 5. Supervisory or decision-making responsibility over activities that require bonding.[18]

The 2008 Bulletin explains:

> "Handling" does not occur, on the other hand, and bonding is not required, under circumstances where the risk of loss to the plan through fraud or dishonesty is negligible. This may be the case where the risk of mishandling is precluded by the nature of the "funds or other property" at issue (e.g., checks, securities, or title papers that cannot be negotiated by the persons performing duties with respect to them), or where physical contact is merely clerical in nature and subject to close supervision and control.[19]

General supervision does not by itself mean that supervisors or decision-makers are "handling" funds so as to require bonding. To determine if an individual "handles" funds and is required to be bonded, a plan must consider the system of fiscal controls, the closeness and continuity of supervision, and who is charged with or exercising final responsibility for determining whether specific disbursements, investments, contracts, or benefit claims are bona fide and made in accordance with the applicable trust or other plan documents.[20]

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[18] *Id.* (*citing* 29 C.F.R. § 2580.412-6(b) (2008)).
[19] *Id.*
[20] *Id.*

B. Conduct That Must Be Covered: "Fraud or Dishonesty"

ERISA requires a plan to obtain a bond that protects the plan against loss by reason of acts of "fraud or dishonesty" on the part of persons required to be bonded, whether the person acts directly or through connivance with others.[21] Under ERISA, the term "fraud or dishonesty" includes, but is not limited to, larceny, theft, embezzlement, forgery, misappropriation, wrongful abstraction, wrongful conversion, willful misapplication, and other acts where losses result through any act or arrangement prohibited by 18 U.S.C. § 1954. An ERISA plan is required to obtain a bond that provides recovery for loss occasioned by such acts even if no personal gain accrues to the person committing the act and the act is not subject to punishment as a crime or misdemeanor.[22] Deductibles or other similar features that transfer risk to the plan are prohibited.[23]

C. Amount of Required Coverage

"Generally, each plan official must be bonded in an amount equal to at least 10% of the amount of funds he or she handled in the preceding year. The bond amount cannot, however, be less than $1,000, and need not be more than $500,000 (or $1,000,000 for plans that hold employer securities, unless the Secretary of Labor (after a hearing) requires a larger bond. These amounts apply for each plan named on a bond in which a plan official has handling functions."[24] The regulations require that the bond amount must be reviewed and be fixed annually, at the beginning of the plan's reporting year. The amount of the bond must be based on the highest amount of funds handled by the person in the preceding plan year.[25]

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[21] 2008 Bulletin, *supra* note 5, at Q-1 (*citing* 29 U.S.C. § 1112 (2006) and 29 C.F.R. § 2580.412-1).

[22] *Id.* (*citing* 29 C.F.R. § 2580.412-9).

[23] *Id.* (*citing* 29 C.F.R. § 2580.412-11).

[24] *Id.* (*citing* 29 U.S.C. § 1112 (2006); 29 C.F.R. § 2580.412).

[25] *Id.* at Q-41 (*citing* 29 C.F.R. § 2580.412).

D. Multiple Insureds

ERISA does not prohibit more than one plan from being named as an insured under the same bond. Any such bond must, however, allow for a recovery by each plan in an amount at least equal to that which would have been required for each plan under separate bonds. Thus, if a person covered under a bond has handling functions in more than one plan insured under that bond, the amount of the bond must be sufficient to cover such person for at least ten percent of the total amount that person handles in all the plans insured under the bond, up to the maximum required amount for each plan.[26] The 2008 Bulletin provides two examples to clarify the ERISA regulations:

> Example: X is the administrator of two welfare plans run by the same employer and he "handled" $100,000 in the preceding reporting year for Plan A and $500,000 for Plan B. If both plans are insured under the same bond, the amount of the bond with respect to X must be at least $60,000, or ten percent of the total funds handled by X for both plans insured under the bond ($10,000 for Plan A plus $50,000 for Plan B).
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> Example: Y is covered under a bond that insures two separate plans, Plan A and Plan B. Both plans hold employer securities. Y handles $12,000,000 in funds for Plan A and $400,000 for Plan B. Accordingly, Plan A must be able to recover under the bond up to a maximum of $1,000,000 for losses caused by Y, and Plan B must be able to recover under the bond up to a maximum of $40,000 for losses caused by Y.[27]

The only substantive limitation on this provision relates to the limit of liability. Plans may share a bond, provided that payment of a loss sustained by one plan will not reduce the amount of required coverage available to other plans insured under the bond. The plan may

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[26] *Id.* at Q-23 (*citing* 29 C.F.R. § 2580.412 (2008)).
[27] *Id.*

satisfy this condition either through the terms of the bond or by separate agreement among the parties concerned.[28]

E. Term of the Bond, the Discovery Period, and Other Bond Clauses

An ERISA plan may obtain bonds for periods longer than one year, so long as the bond insures the plan for the statutorily-required amount. At the beginning of each plan year, the plan administrator or other appropriate fiduciary must assure that the bond continues to insure the plan for at least the required amount, that the surety continues to satisfy the requirements for being an approved surety, and that all plan officials are bonded. If necessary, the fiduciary may need to obtain appropriate adjustments or additional protection to assure that the bond will be in compliance for the new plan year.[29]

ERISA requires that the plan to purchase a bond with a one-year post-termination discovery period.[30] How this is accomplished depends upon whether the bond is written on a loss sustained or discovery basis. Bonds written on a "loss sustained" basis typically contain a clause providing for such discovery period. Bonds written on a "discovery basis" typically do not contain such a clause, but such coverage may be available for an additional premium.

Modern fidelity bonds contain numerous other conditions, definitions, and other provisions that are not contained or even-mentioned in ERISA. For example, most bonds do not cover "indirect loss" (including lost potential income), a plan's liability to third party, or the costs of establishing the existence or amount of a covered loss. ERISA does not require or prohibit such conditions and thus, these conditions should be enforceable.

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[28] *Id.* at Q-24 (*citing* 29 C.F.R. § 2580.412 (2008)).
[29] *Id.* at Q-33 (*citing* 29 C.F.R. § 2580.412 (2008)).
[30] *Id.* at Q-26 (*citing* 29 C.F.R. § 2580.412 (2008)).

F. The Plan Is Responsible For Obtaining Requisite Bonding

The responsibility for ensuring that plan officials are bonded may fall upon a number of individuals simultaneously.[31] The plan official is directly responsible for complying with the bonding requirements in section 412(a) of ERISA.[32] Section 412(b) specifically states that it is unlawful for any plan official to permit any other person to receive, handle, disburse, or otherwise exercise custody or control over plan funds or other property without first being properly bonded in accordance with section 412.[33]

The 2008 Bulletin addresses the question: "If a service provider is required to be bonded, must the plan purchase the bond?" Answer:

> No. A service provider can purchase its own separate bond insuring the plan, and nothing in ERISA specifically requires the plan to pay for that bond. If, on the other hand, a plan chooses to add a service provider to the plan's existing bond, that decision is within the discretion of the plan fiduciaries. Regardless of who pays for the bond, section 412 provides that if a service provider to the plan is required to be bonded, the plan fiduciaries who are responsible for retaining and monitoring the service provider, and any plan officials who have authority to permit the service provider to perform handling functions, are responsible for ensuring that such service provider is properly bonded before he or she handles plan funds.[34]

G. Types of Policies or Bonds Providing ERISA Coverage

Other than the requirements listed above, the Department of Labor allows for great flexibility in the arrangements and types of bonds an ERISA plan may purchase to satisfy the bonding requirements. A plan may be covered under a single bond or multiple ones, and one bond

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[31] *Id.* at Q-6.
[32] *Id.*
[33] *Id.*
[34] *Id.* at Q-10.

may cover multiple plans. Examples of permissible bond forms include: individual; name schedule (covering a number of named individuals); position schedule (covering each of the occupants of positions listed in the schedule); and blanket (covering the insured's officers and employees without a specific list or schedule of those being covered).[35] A combination of such forms may also be used.[36]

A plan may be insured on its own bond, or it can be added as a named insured to an existing bond or insurance policy (such as a "commercial crime policy"), so long as the existing bond is adequate to meet the requirements of section 412 and the regulations, or is made adequate through a rider, modification or separate agreement between the parties. For example, an employee benefit plan may be insured under the sponsor's commercial crime policy through the incorporation of an "ERISA rider." Service providers may also obtain their own bonds, on which they name their plan clients as insureds, or they may be added to a plan's bond by way of an "Agents Rider."[37]

Even a blanket bond that provides for an "aggregate penalty" applied "per occurrence" satisfies the requirements of section 412 as long as each plan official is covered up to the applicable amount. For example, if two investment managers handled all the assets of a plan in the preceding year, a blanket bond covering both plan officials could cover ten percent of that amount and still be in compliance even though the plan might lose a greater amount due to the fiduciaries' collaborative wrongful act.[38]

III.
TENSION BETWEEN ERISA'S COVERAGE MANDATE AND POLICY LANGUAGE: DETERMINING THE SCOPE OF COVERAGE FOR ERISA PLANS

The doctrine of statutory incorporation generally provides that statutory provisions may override contrary policy language only where: clear language in the policy itself incorporates the coverage mandate in

[35] *Id.* at Q-22.
[36] *Id.* (*citing* 29 C.F.R. § 2580.412-10 (2008)).
[37] *Id.* at Q-22 (*citing* 29 C.F.R. § 2580.412 (2008)).
[38] *Id.* at Q-40.

the statute at issue; or the statute itself affirmatively requires the insurer to provide the coverage in dispute.[39] Seizing upon this doctrine, plans faced with insufficient coverage have argued, so far without success, that ERISA supplants the plain terms of fidelity bonds because (1) ERISA's bonding requirements (such as who must be covered, and the type of conduct that must be covered), and the ERISA-mandated bond limits operate to replace on a wholesale basis any contrary policy terms; and (2) the terms of the bond should be interpreted in accordance with the definitions incorporated into ERISA.

Rosenbaum v. Hartford Insurance Co.,[40] the seminal decision addressing whether ERISA supplants contrary terms in a policy issued to an ERISA plan, rejected such attempts to use ERISA as a basis to unilaterally expand the scope of coverage afforded by a fidelity bond. *Rosenbaum* held that: (1) ERISA allows its coverage mandate to be fulfilled through one or more policies; and (2) the subject policy promised only partial compliance; therefore, the policy could not be read via a statutory incorporation theory to achieve full compliance with ERISA's bonding mandate.[41]

The insured in *Rosenbaum* was a pension plan for a medical practice. Dr. Rosenbaum and his wife were trustees of the Plan. Over several years, the Plan invested several hundred thousand dollars in shares of second mortgages through Property Mortgage Company, Inc. and its owner, Mr. Glickman. When Property Mortgage Company failed in 1991, the Plan asserted that Property Mortgage Company had engaged in a Ponzi scheme to cover losses and defalcations, in which new investors were being used to pay off old investor funds. The Plan further asserted that the dishonesty of Property Mortgage Company and/or Mr. Glickman was covered under the Plan's employee dishonesty policy issued by Hartford. One of the Plan's theories of coverage was that Hartford sold a bond covering anyone who had to be bonded under ERISA, and Mr. Glickman fell within that class, so the bond covered him.

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[39] Rhone v. Louis, 580 P.2d 549, 550 (Or. 1978); Safeco Ins. Co. of Am. v. Am. Hardware Mut. Ins. Co., 9 P.3d 749, 752 (Or. 2000) (*citing* Or. Rev. Stat. § 742.450 & Or. Rev. Stat. § 806.080))

[40] 104 F.3d 258 (9th Cir. 1996).

[41] *Id.* at 262-63.

Hartford issued an employee dishonesty coverage form containing a definition of "employee" that focused on the payment of wages and the right of direction and control, and excluded "independent contractors." However, the Hartford policy also issued an endorsement labeled "Welfare and Pension Plan ERISA Compliance." This endorsement defined the term "employee" to include:

> In compliance with certain provisions of the Employee Retirement Income Security Act (ERISA):
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> 1. "Employee" also includes any natural person who is:
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> a. A trustee, an officer, employee, administrator or a manager, except an administrator or a manager who is an independent contractor, of any Employee Welfare or Pension Benefit Plan (hereafter called Plan) insured under this insurance, and
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> b. Your director or trustee while that person is handling funds or other property of any Plan insured under this insurance.[42]

Faced with a loss caused by Mr. Glickman, the insured argued that he constituted an employee under this endorsement.

Because it was undisputed that Mr. Glickman was an independent contractor, the plan attempted to circumvent the plain terms of the endorsement by arguing that the endorsement must be construed in accordance with ERISA and since ERISA required that Mr. Glickman be bonded, the endorsement must be construed to provide such coverage.

The Ninth Circuit rejected that notion and held that, even if ERISA required Mr. Glickman to be bonded, the endorsement did not include him among the classes of covered "employees."[43] The bond, according to the court, did not purport to provide "all bonding of any kind required by ERISA," but instead provided coverage "'in compliance

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[42] *Id.* at 261.
[43] *Id.* at 262.

with *certain* provisions' of ERISA. (emphasis added)."[44] The court explained that ERISA "does not require that any bond be construed to cover all persons required to be bonded."[45]

The court acknowledged that the ERISA regulations say that independent contractors such as Mr. Glickman may be bonded by including them in an "agents rider."[46] However, the Plan did not obtain such a rider from the Hartford, and the Policy's expanded definition of "employee" does not provide coverage for independent contractors, such as Mr. Glickman.[47] The court stated that "[i]f Mr. Glickman had to be bonded, then perhaps the Rosenbaums as trustees should not have invested the ERISA plan's money with Property Mortgage Company without ascertaining whether he was. They perhaps could have insured the plan against the risk that he might not be bonded as required by buying an 'agents rider' or coverage including persons in his position."[48]

In 2006, an Oregon trial court, in *Employers-Shopmens Local 516 Pension Trust v. Travelers Casualty & Surety Co. of America*,[49] considered a claim for losses caused by an outside investment manager under a policy with an endorsement identical to the one at issue in *Rosenbaum*. The trial court reached the same conclusion as did the Ninth Circuit in *Rosenbaum*: no coverage.

Local 516 contracted with Capital Consultants, LLC to provide investment management services. Local 516 submitted a claim to Travelers contending that it had sustained covered losses as a result of Capital Consultants' fraudulent and dishonest conduct. Travelers concluded, however, that Local 516's claim was not covered because Capital Consultants and its principals were independent contractors, not "employees" as defined in the Travelers Policy. Local 516 filed a complaint alleging, among other claims, breach of contract against Travelers, as well as alternative claims against Local 516's broker for professional negligence for failing to procure an ERISA-compliant bond.

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[44] *Id.*
[45] *Id.*
[46] *Id.*
[47] *Id.*
[48] *Id.*
[49] No. 0502-01821 (Or. Cir. Ct. Dec. 16, 2006).

Arguing several variations on the same theme, Local 516 contended that Oregon courts should ignore *Rosenbaum* because it was decided under California law, not Oregon law. To that end, Local 516 proffered two routes by which it urged rewriting of the policy language to force coverage for Capital Consultants' acts.

First, Local 516 argued that the Travelers Policy must cover the acts of Capital Consultants under Oregon's version of the doctrine of statutory incorporation. The court applied Oregon law and reached the same result as *Rosenbaum*, reasoning that Oregon law does not incorporate a statute into a policy absent an objective intent to do so on the face of the policy and/or the statute affirmatively imposes an obligation on insurers. Since nothing in the Travelers Policy stated an objective intention to cover the universe of individuals who must be bonded under ERISA (but covers only certain individuals) and controlling federal case law holds that ERISA does not by itself operate to override contrary terms, the Travelers Policy was not construed as a "statutory bond." Second, in a separate but related argument, Local 516 contended that ERISA's expansive definitions of "officer" and "employee" must be inserted into the Endorsement, since the policy Endorsement did not define those terms.

The court granted Travelers' motion for summary judgment, reasoning that the plain language of the policy made clear that independent contractors (such as Capital Consultants and its principals) were not "employees." The court agreed with Travelers that Oregon's doctrine of statutory incorporation did not force wholesale incorporation of ERISA into the Travelers Policy. Like the policy at issue in *Rosenbaum*, the Travelers Policy expressly stated that it was issued in compliance with only *certain* ERISA provisions and the Ninth Circuit held in *Rosenbaum* that ERISA does not impose any affirmative mandate regarding coverage upon insurers.[50] The trial court rejected without discussion the insured's argument that the ERISA definitions of "officer" and "employee," not the plain meaning of those terms should control.[51]

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[50] *Id.*

[51] In insurance coverage disputes the Oregon appellate courts have relied on the statutory incorporation doctrine in two ways: (1) when the language of the policy itself incorporates a statutory mandate or term; and (2) if

Courts have rejected attempts to expand the scope of ERISA bonds in contexts other than the definition of "employee."[52] The district court in *Local 290* addressed this issue in the context of whether an insured can use ERISA to expand the limit of liability. The *Local 290* policy covered several ERISA plans and specified a $1 million limit for all loss or losses in which the same "employee" was concerned or implicated. That policy further provided that Federal's total liability for loss or losses sustained by any or all of the covered plans shall not exceed that limit.[53] Federal investigated Local 290's claim and paid the $1 million stated policy limit, on grounds that the same "employee" was concerned or "implicated" in all the losses alleged by Local 290. The ERISA plan insureds sought to recover multiple limits by, among other things, the incorporation of ERISA's bond limits requirements into the policy.

In addition to arguments unrelated to ERISA that asked the court to accumulate limits from each alleged policy and to impose a separate $1 million limit for each alleged "loss," the insureds asked the court to re-write the Federal policy to incorporate their proffered interpretation of ERISA's bonding requirements to supplant the express policy limit. Local 290 argued that: (1) the policy's stated limits of liability do not satisfy ERISA's mandated minimum, and (2) the liability limit must accumulate annually pursuant to ERISA, rather than for each three-year policy period.

Local 290 contended that the policy was procured for the purpose of complying with ERISA's requirements and that provisions contrary to ERISA's requirements should be displaced. Local 290 relied

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the statute at issue by its terms affirmatively regulates insurance contracts. Am. States Ins. Co. v. Super Spray Ser., Inc., 713 P.2d 682 (Or. App. Ct. 1986) (policy provided that "statements in this policy conflicting with insurance statutes of [Oregon] are hereby amended by us to conform to the statutes"); *Safeco Ins. Co. of Am.*, 9 P.3d at 752 (statute at issue expressly stated that "every motor vehicle liability insurance policy issued for delivery in this state shall provide liability coverage" sought by insured).

[52] Local No. 290 v. Fed. Ins. Co., No. 07-1521-HA, 2008 WL 3523271 (D. Or. Aug. 11, 2008).

[53] *Id.*

first on section 412 of ERISA, which states that "[e]very fiduciary of an employee benefit plan . . . shall be bonded" in a minimum amount:

> The amount of such bond shall be fixed at the beginning of each fiscal year of the plan. Such amount shall be not less than 10 per centum of the amount of funds handled. In no case shall such bond be less than $1,000 nor more than $500,000 . . . . For purposes of fixing the amount of such bond, the amount of funds handled shall be determined by the funds handled by the person, group, or class to be covered by such bond and by their predecessor or predecessors, if any, during the preceding reporting year Such bond shall provide protection to the plan against loss by reason of acts of fraud or dishonesty on the part of the plan official, directly or through connivance with others.[54]

Local 290 also relied on 29 C.F.R. § 2580.412-16(a), which effectively recites the language in section 412 of ERISA and 29 C.F.R. § 2580.412-16(b), which provides:

> When individual or schedule bonds are written, the bond amount of each person must represent not less than 10 percent of the funds "handled" by the named individual or by the person in that position. When a blanket bond is written, the amount of the bond shall be at least 10 percent of the highest amount handled by any administrator, officer or employee to be covered under the bond.

Local 290 also cited 29 C.F.R. § 2580.412-16, which provides that if a plan procures a bond covering more than one plan it must ensure that it allows for a recovery by each plan in an amount at least equal to that which would have been required for each plan under separate bonds.

Local 290 argued that section 412 and related regulations, as applied to the funds managed by Capital Consultants for each of the named insureds, required Federal to write the policy with a $2.15 million

[54] *Id.* at *9 (*quoting* 29 U.S.C. § 1112(a)).

limit to provide the required coverage for each of the named insureds, instead of the $1 million stated policy limit.

Finally, relying on 29 C.F.R. § 2580.412-19(a), Local 290 also contended that the policy's Non-Accumulation of Liability provision is voided by ERISA. That regulation provides:

> The amount of any required bond must in each instance be based on the amount of funds "handled" and must be fixed or estimated at the beginning of the plan's reporting year, that is, as soon after the date when such year begins as the necessary information from the preceding reporting year can practicably be ascertained. This does not mean, however, that a new bond must be obtained each year. There is nothing in the Act that prohibits a bond for a term longer than one year, with whatever advantages such a bond might offer by way of a lower premium. However, at the beginning of each reporting year the bond shall be in at least the requisite amount. If, for any reason, the bond is below the required level at that time, the existing bond shall either be increased to the proper amount, or a supplemental bond shall be obtained.[55]

Local 290 interpreted this regulation to provide that "under no circumstances can a trust receive less coverage under one three-year bond than it would receive under three successive one-year bonds."[56]

The district court rejected Local 290's attempt to supplant express policy terms based upon ERISA's limit provisions. In doing so, the court engaged in a careful analysis of Oregon law and explained that it did not require reformation of the policy absent an objective intent to do so provide all of the coverage required under ERISA.[57] The court found that there is no provision in the Local 290 Policy "indicating that the policy should be amended if it conflicts with ERISA or, indeed, any statute." Instead, the policy's only mentions of ERISA were in the

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[55] 29 C.F.R. § 2580.412 19(a) (2008).
[56] *Local 290*, 2008 WL 3523271 at *10.
[57] *Id.* at *9 (*quoting* Rhone, 580 P.2d at 550-51).

Payover provision and in the Insuring Clause, which defined "employee" as all those natural persons whom ERISA requires to be bonded.[58]

The court made clear that "[e]ven if [Local 290] was correct that the policy 'was clearly drafted exclusively for ERISA plans and trusts,' more is needed under Oregon law."[59] Unlike the insurers in the cases upon which Local 290 relied, Federal denied that its policy was intended to satisfy all of ERISA's bonding requirements. And, unlike the insurance contract in those cases, there was no language in the Local 290 Policy "suggesting it was issued to satisfy ERISA's bonding requirements."[60]

The court also looked to the Ninth Circuit's decision in *Rosenbaum*, which addressed whether ERISA operated to replace a policy's definition of "employee."[61] Although that particular issue was not present in the *Local 290* case, the court agreed with the general holding in *Rosenbaum* and applied it to Local 290's attempt to replace the limit specified by the Local 290 Policy with ERISA's provisions regarding limits of liability.[62]

Nevada Urology Associates Restated Profit Sharing Plan v. Hartford Fire Insurance Co. of America[63] considered this issue in the context of determining coverage for indirect losses. *Nevada Urology Associates* involved a crime shield policy with an ERISA Endorsement

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[58] *Id.*

[59] *Id.* at *10.

[60] *Id.*

[61] *Id.* at *11; *see also Rosenbaum,* 104 F.3d at 262-63.

[62] As *Rosenbaum* and its progeny explained, and confirmed by the Department of Labor in its 2008 Bulletin, the insured's bears the burden to obtain the requisite bonding. This makes sense since only the insured and its broker—not the insurer—have the information necessary to determine the coverage limits that ERISA requires a plan to obtain. If on advice from its broker, Local 290 selected a limit that was less than required by ERISA, then Local 290's recourse lies against the broker. Recognizing this possibility, Local 290 filed a complaint against its broker in the event that the court found in favor of Federal.

[63] Order granting Hartford's Motion for Summary Judgment, Doc. No. 2730-105, No. CV 06-00236 (2nd Judicial Dist., Washoe County, Nev., Mar. 13, 2008).

issued by Hartford Fire Insurance Company of America. In that case, the ERISA plan's investment manager had misrepresented the rates of return he was receiving, the types of investments being made and the general state of those investments. The parties in that case agreed that the investment manager was an "employee" of the ERISA plan insured within the meaning of the policy and that he committed covered "fraudulent or dishonest" acts.

The parties disputed, however, whether: (1) the covered conduct directly resulted in a loss of the Plan's "money," "securities," or "other property"; and (2) the requirement of showing a direct loss and the indirect loss exclusion was supplanted by ERISA. The plaintiffs contended that they sustained a covered loss, because the misrepresentations caused them to keep their retirement funds in the investment account. They argued that, had they known the truth, they would have taken the money out of that account and invested it somewhere else and would have received a better rate of return.

Hartford countered that this alleged loss was speculative, and, at best, resulted *indirectly* from the fraudulent conduct. Hartford maintained that there was no coverage because the policy required a direct loss. Plaintiffs disagreed and argued that the policy did not require them to show a "direct loss" because the ERISA endorsement operated to "read-in" ERISA's regulation to supplant the requirement of a direct loss and the indirect loss exclusion. Put another way, they contended that any limitation for "direct loss" or exclusion for "indirect loss" was void and unenforceable under ERISA.

The court agreed with Hartford and cited *Rosenbaum* for the proposition that ERISA does not operate to supplant policy language and explained that courts "will not increase an obligation to the insured where such was intentionally and unambiguously limited by the parties."[64] The court thus ruled that the policy's plain language—which unambiguously provided that there must be a loss that directly (not indirectly) resulted from the peril—could not properly be written out of the insurance contract. Finding no such loss on the undisputed facts, the court granted Hartford's motion for summary judgment.

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[64] *Id.* at 14; *see also* Wood v. CNA Ins. Co., 837 F.2d 1402 (5th Cir. 1988).

IV.
DISCOVERY

Although many of the issues discussed above implicate legal disputes amenable to resolution on summary judgment, counsel, in the context of prepare for a potential trial, should not overlook the need to conduct discovery and consult with experts.

First, ERISA claims commonly involve factual questions such as whether any fraud occurred, causation and damages. ERISA bond claims often involve losses sustained with respect to investment of plan funds in the market, and it is critical to determine whether losses occurred due to factors other than the alleged fraud, such as market conditions.

Making such a determination, however, is no easy task. It typically requires review and analysis of numerous documents from a variety of sources including but not limited to: (1) the plan's internal records; (2) investment records and other documents maintained by the alleged wrongdoer, which may be maintained by a wholly separate entity from the plan insured; (3) records of any investigation by law enforcement or government officials; (4) records maintained and generated by any appointed receiver or bankruptcy trustee; and (5) independent sources reflecting market conditions at the time the alleged losses occurred. Retention of an expert to assist in this review and analysis is almost always necessary.

The key to managing discovery in any litigation is timing. The earlier discovery can proceed, the better chance there will be that underlying evidence is preserved. To this end, once the threat of litigation appears likely, it is important for counsel to take the necessary steps to preserve any existing information that may be likely to lead to evidence. Unfortunately, most, if not all of such information, will be in the hands of others. It is, therefore, critical to implement a comprehensive discovery plan including the following:

1. Retention of an expert (including e-discovery expert if the document corpus is voluminous) to assist in spotting and analyzing the key issues;

2. Issuance of litigation hold notices to any parties of interest notifying them to preserve ALL information (paper and e-discovery) related to the matter;

3. Witness interviews;

4. Issuance of discovery requests/third-party subpoenas to any appointed receiver or bankruptcy trustee, and FOIA requests to any government agency involved in investigating the alleged wrongdoing; and

5. Examinations under oath and depositions.

Second, experts can assist in litigation over ERISA claims. The selection and use of an expert witness can be one of the most important decisions in litigating an ERISA fidelity bond claim and will be a decision that counsel must live with throughout its case. Due diligence in the selection and clear instructions at the outset can go a long way in ensuring that the use of such experts will be of benefit to a case.

The selection and proper use of experts (both testifying and non-testifying) is a critical step when analyzing an alleged ERISA-related loss, particularly when the loss stems from complicated investments of plan assets. Obviously, how the lawyer will use such experts will often depend on the complexity of the claim. The authors recommend hiring an expert as soon as possible because the expert will be a critical tool in identifying key issues and shaping litigation decisions. As part of this process, an expert should be retained pursuant to an expert retention agreement with strong confidentiality provisions that are designed to protect the attorney-client privilege and work product immunities.

Once the expert is retained, the insurer should decide whether they expect the expert will be used as a testifying or non-testifying witness. This decision may dramatically affect the amount of information shared with the expert. For a non-testifying or coverage investigation witness, it will be necessary for the witness to have unfettered access to underlying documents in order to make the most

informed analysis possible. To this end, the expert also needs to receive clear instructions as to the scope of the assignment. Such instructions will not only result in better work product from the expert but also lead to more efficient use of the expert's time. It is important that the expert understand that their task is to investigate a claim in a straightforward manner consistent with generally accepted principals or industry standards.

Another important role for an expert is to assist the lawyers in identifying key issues related to litigation and assist the attorneys in developing a strategy for the discovery of such information. This may include the development of litigation holds, discovery requests, third party subpoenas and possibly FOIA requests.

V.
CONCLUSION

Case law is fairly uniform that courts may not rewrite an insurance policy based on the insured's subjective, unexpressed coverage wishes. The extent to which an ERISA plan's fidelity bond provides coverage pursuant to ERISA should turn on the policy language. Only where the policy expresses an intent to incorporate ERISA's coverage mandate should a court override contrary policy terms. There is no uniform or standard form for a fidelity bond sold to an ERISA plan. Accordingly, each must be evaluated on a case-by-case basis to evaluate the extent of coverage.

Just because a fidelity bond includes some dishonesty coverage for an ERISA plan, it does not mean that the coverage was intended to satisfy the ERISA bonding requirement in toto. No law requires the insured to obtain only one form of bond to satisfy that requirement, and no law or regulation requires an insurer to issue an all-or-nothing form that either satisfies ERISA entirely or not at all. A policy that by its terms does not purport to satisfy all ERISA bonding requirements should not be reformed to incorporate all of ERISA through wholesale statutory incorporation.