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Multiemployer Plan Trustee Loss Prevention

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Foreword

Multiemployer plan sponsors and fiduciaries continue to face increased risks of litigation on a number of fronts. In many of these cases, fiduciaries can face personal liability, meaning their own personal assets can be at risk.

As a leading provider of fiduciary liability insurance, Chubb has been focused on helping fiduciaries of Taft-Hartley trust funds manage risk exposure for almost 50 years. Critical to our risk management partnership with our insureds is providing education in a complex and evolving litigation landscape. That is why Chubb commissioned the Groom Law Group, a leading firm specializing in The Employee Retirement Income Act of 1974 (ERISA) fiduciary litigation, to compile this report. Here, Lars C. Golumbic discusses roles and responsibilities of multiemployer plan fiduciaries, the types of litigation that may be brought against them, and practical suggestions on plan design and administration that may help reduce litigation risk. He shares his insights on the impact of fiduciary liability insurance and other protection in mitigating against financial loss to plan sponsors and fiduciaries when faced with a lawsuit.

Well-educated fiduciaries are, in turn, well-equipped to make sound, prudent decisions, and Chubb is pleased to share this practical resource to support and enhance your overall loss prevention efforts.

As always, we are continually monitoring the fiduciary risk climate for multiemployer plans and Trustees – and committed to partnering with our customers to provide state-of-the-market insights and insurance to manage and mitigate challenging exposures.

I. Introduction

Trustees of multiemployer welfare and retirement benefit plans and employers that contribute to such plans face significant exposure in connection with claims for breach of fiduciary duty, conflicts of interest, and withdrawal liability, among other exposures. Multiemployer plan trustees can be held personally liable for a breach of fiduciary duty, even when the breach is unintentional. Moreover, plan fiduciaries are subject to a 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 doubt under the business judgment rule. Given that a plan fiduciary's personal assets may be at risk, understanding potential fiduciary liabilities, obtaining sound legal guidance, and partnering with a reputable fiduciary liability insurance carrier are crucial.

Multiemployer plan trustees can be held personally liable for a breach of fiduciary duty, even when the breach is unintentional.

Although there is no silver bullet to protect plan fiduciaries from litigation, employee benefits professionals can take steps to help mitigate risk and prevail in 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. This paper endeavors to further this understanding.

In Section II, we provide an overview of the types of multiemployer plans, including pension plans, health and welfare plans, and apprenticeship and training plans. In Sections III and IV, we describe ERISA fiduciary standards of conduct and duties. In Sections V and VI, we give examples of some of the most prevalent and serious types of ERISA claims. Section VII addresses ways in which fiduciaries may delegate responsibility and use advisers to inform their actions. Sections VIII and IX discuss plan asset investment and funding requirements, and Section X is devoted to withdrawal liability, addressing when a "withdrawal" occurs, calculating the related liability for unfunded benefit liabilities, and claims arising out of the same. Section XI details trustee responsibilities, including plan administration and reporting and disclosure requirements. Section XII identifies government agencies with jurisdiction over employee benefit plans, such as the Department of Labor and the Internal Revenue Service and discusses compliance with federal health laws and regulations. Finally, Section XIII considers why fiduciary liability insurance should be an integral part of any employee benefits program, protecting plan sponsors and fiduciaries against personal liability and the potentially significant costs associated with defending employee benefit lawsuits.

II. Overview of Multiemployer Plans

Multiemployer plans, commonly referred to as "Taft-Hartley" plans, generally provide benefits for workers who are members of the same union but employed by different employers. An employer's participation in the plan is collectively bargained and the plan is jointly administered by a Board of Trustees (collectively, known as the "Trustees," and individually as "Trustee"). The union and the employers appoint an equal number of Trustees. A Taft-Hartley multiemployer plan is characterized by provisions that allow participants to continue to earn benefits based on work with multiple employers, as long as each employer participates in the plan.

Congress passed the Taft-Hartley Act in 1947 in response to employer sentiment that the 1935 National Labor Relations Act (NLRA), which gave employees the right to organize and bargain collectively, was unfair to employers. The Taft-Hartley Act imposed on unions the same obligation to bargain in good faith that the NLRA imposed on employers. It also contained an exception to a general rule banning employers from giving money or anything else of value to persons or unions representing employees. This exception allowed employers to contribute to trust funds jointly administered by unions and management, thus enabling the creation of multiemployer benefit plans.

A. Retirement Plans

The most common type of multiemployer pension plan is a defined benefit plan. 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 employer is responsible for ensuring that the plan is adequately funded to provide the promised retirement benefits, and required to insure the risk of underfunding through the federal Pension Benefit Guaranty Corporation (PBGC). Employer contributions to multiemployer plans are determined as part of the collective bargaining process.

Defined contribution multiemployer plans are less traditional but have become more common. These plans typically supplement a defined benefit plan. Defined contribution 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, which is allocated to the participant's account. Because the participant's benefit is not fixed and is instead the balance in their account, it is the participant and not the employer that bears the investment risk. Some defined contribution plans are participant directed, meaning that the participant can choose how his or her account balance is invested from a menu of investment options selected by the employer. Investments in other defined contribution plans are managed by a plan fiduciary. There is no insurance program to protect against investment losses or business failures for this type of plan. As discussed in more detail in Section VIII.F, participants have brought class action complaints against the fiduciaries of some multiemployer defined contribution plans challenging the

fees and/or investment performance associated with these defined contribution plans. Hundreds of these types of complaints have been filed against fiduciaries of single-employer 401(k) plans. This type of litigation, which has increased in recent years and can often be filed just based on publicly available information, poses a significant risk to plan fiduciaries, and the costs of hiring qualified lawyers and expert witnesses to defend against these allegations can reach millions of dollars.

Employer contributions to defined benefit and defined contribution plans are pooled in a trust to provide benefits for participants. Employer contribution obligations are commonly set forth in a collective bargaining agreement. Certain plans also use participation agreements, which may provide for additional employer obligations beyond the collective bargaining agreement, but are typically more limited in scope than the collective bargaining agreement. Benefit levels provided by a multiemployer defined benefit plan are set forth in a plan document maintained by the Trustees.

B. Health and Welfare Plans

Multiemployer health and welfare plans typically provide benefits to cover costs such as doctor's visits, hospital room and board, prescription drugs, surgery, vision care, dental care, life and accidental death insurance, short- or long-term disability, and preventative care. Like multiemployer pension plans, the parties to the applicable collective bargaining agreement negotiate contribution rates for participating employers. Based on those rates, the Trustees design the health and welfare plans, including determining which health and welfare benefits will be offered, who will be eligible for coverage, and what co-insurance or co-payments will be required of employees.

C. Apprenticeship and Training Plans

Apprenticeship and training funds are established or maintained for the purpose of providing apprenticeships or other training programs to prepare for work as an electrician, dental assistant, pipefitter, or other jobs. These funds are considered employee welfare benefit plans under ERISA. Like other ERISA plans, they must be established and maintained pursuant to a plan document, and the assets of the plans must be held in trust. Apprenticeship plans often register with the Department of Labor (DOL) or a state apprenticeship agency authorized by the DOL. Apprenticeship plans are also subject to unique DOL regulations, including antidiscrimination and equal opportunity requirements, and may be subject to employment discrimination laws and other employment-related laws like the Family and Medical Leave Act. As with other ERISA plans, Trustees administering apprenticeship and training plans have a fiduciary duty to act solely in the interest of participants and beneficiaries, and may not cause the plan to incur unreasonable expenses.

Apprenticeship and training programs have been subject to DOL scrutiny due to perceived abuses, including lack of oversight of plan vehicles, equipment, and other inventory, unreasonable instructor salaries and bonuses, excessive employee meal stipends, and payments for staff parties, flowers, or donations. In addition, these plans have been scrutinized for paying excessive marketing and graduation ceremony expenses. The DOL has reiterated that these plans must use their assets to provide training and education benefits or to pay for reasonable plan expenses. While these "other" expenses, like graduation parties or marketing, can be appropriate ways to promote enrollment and encourage completion of the program, the DOL has stated that these expenses should be modest, approved in accordance with internal controls and accounting, and actually used for their intended purpose.

III. "Fiduciary" Defined

A. Strict Standards of Conduct Apply to "Fiduciaries"

ERISA imposes special, heightened duties (called "fiduciary duties") on a variety of individuals and entities that 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, (2) exercises any authority or control over a plan's assets, (3) has any discretionary authority in administering a plan, or (4) provides investment advice to a plan for a fee. See ERISA section 3(21)(A). Anyone who occupies one of these roles is deemed to function as a fiduciary under ERISA, even if they are not named as a fiduciary in the plan's governing documents and even if the person does not acknowledge or is not aware of his or her fiduciary status.

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. ERISA also imposes a duty of prudence on fiduciaries, which requires them to act with the care, skill, and diligence that a prudent person "acting in like capacity and familiar with such matters would use" under the circumstances.

ERISA imposes certain duties on fiduciaries, including a duty to follow plan documents, a duty of loyalty, and a duty of care. To carry out these duties, a fiduciary must act:

- in accordance with the plan terms (insofar as consistent with ERISA);
- solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries and defraying reasonable expenses of the plan; and
- with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise with like character and like aims.

ERISA also requires fiduciaries to diversify plan investments unless it is "clearly prudent not to do so" under the circumstances.

ERISA and Department of Labor (DOL) regulations identify certain roles with respect to plans that are unquestionably fiduciary in nature; for example, the plan Trustee, the plan administrator, and the plan's "named fiduciary." ERISA requires that a plan provide for a "named fiduciary" with "authority to control and manage the operation and administration of the plan."

The fiduciary inquiry is also a functional one that considers not only the person's title, but whether the person in fact exercises any of the functions described in ERISA section 3(21)(A). Courts have emphasized the broad sweep of this functional definition, routinely holding persons who carry out the basic fiduciary functions relating to asset management, plan administration, and provision of investment advice to be fiduciaries. Where,

however, a person performs administerial functions, fiduciary status does not typically arise.

B. Settlor versus Fiduciary Activities

ERISA recognizes that some fiduciaries also serve as "settlors" of their plans. An individual or entity acts in a settlor capacity when it adopts, amends, or terminates a plan. When acting in a "settlor capacity, a fiduciary is not obligated to act for the exclusive purpose of benefiting participants and beneficiaries."

Notably, it is not generally permissible to use plan assets to cover costs associated with settlor activities.

Certain activities can easily be classified as either "settlor" activities or "fiduciary" activities. For example, setting up a new plan or changing the terms of an existing benefit plan are quintessential plan "settlor" activities. On the other hand, administering a plan's terms, such as by determining whether an individual is eligible to participate in the plan, authorizing expenses incurred by the plan, investing and controlling plan assets, communicating with plan participants, and selecting service providers, are core "fiduciary" activities.

In the context of a multiemployer plan, lines between settlor and fiduciary roles may become blurred because the same body — the Board of Trustees — performs both roles. The Supreme Court and other courts have made clear that certain activities, such as amending plans, are settlor functions. On at least one occasion, however, where the relevant plan documents specifically stated that the Trustees were acting as fiduciaries in amending a plan, the DOL took the position that the Trustees' decision to do so was a fiduciary decision. With respect to other activities, such as the implementation of plan amendments, it is less clear whether they are properly classified as settlor or fiduciary in nature.

Notably, it is not generally permissible to use plan assets to cover costs associated with settlor activities. In the context of single-employer plans, this tension is more easily addressed because the corporate plan sponsor can use its own assets — as opposed to plan assets — to pay for settlor activities. In the multiemployer plan context, however, as a practical matter, plan assets are often the only assets available to support activities that may be considered settlor in nature.

IV. ERISA's General Fiduciary Duties

ERISA's fiduciary standards of conduct have been described as "the highest known to the law." "Borrowing from trust law, ERISA imposes high standards of fiduciary duty upon those responsible for administering an ERISA plan and investing and disposing of its assets." When a person is acting as a fiduciary (and not as a settlor), he or she has the following fiduciary duties.

A. Exclusive Purpose/Exclusive Benefit Rule

Under ERISA, a plan fiduciary has a duty of undivided loyalty to the plan and its participants. That is, a Trustee must discharge his or her duties solely in the interest of the plan and its participants and beneficiaries, and for the exclusive purpose of providing plan benefits and defraying reasonable plan expenses. In addition, the Taft-Hartley Act requires the Trustees to manage the assets of multiemployer plans for the exclusive purpose of providing benefits for covered employees and their dependents.

While ERISA's fundamental premise is that plan fiduciaries are required to act "solely in the interest of the participants and beneficiaries," ERISA contemplates that, in some circumstances, fiduciaries may act on behalf of a plan even though they have dual loyalties. Indeed, certain conflicts are inherent in the structure of ERISA, which specifically recognizes that plan sponsors may also serve as plan fiduciaries. Similarly, the fact that the Taft-Hartley Act requires the Trustees of a multiemployer plan to consist of equal numbers of employer- and union-appointed Trustees seems to be a tacit recognition that fiduciaries may, to some extent, approach their duties from their perspectives.

Because ERISA sanctions such dual roles, fiduciaries are often said to be permitted to "wear two hats" — one when acting as a plan fiduciary, in which case the fiduciary must act in the best interest of participants and beneficiaries, and one when acting as a settlor, in which case the fiduciary may act in furtherance of other interests. "ERISA does require, however, that the fiduciary with two hats wear only one at a time and wear the fiduciary hat when making fiduciary decisions." *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000).

Because the Taft-Hartley Act requires that multiemployer plans be jointly administered by an equal number of Trustees appointed by the union and by contributing employers, the Trustees might be viewed as inherently conflicted. Although multiemployer plan Trustees are representatives of the unions or employers that appoint them, they nonetheless must make all fiduciary decisions in the best interest of all plan participants, without regard to the interests of the appointing parties. The Supreme Court has explained that nothing in the language of the Taft-Hartley Act "reveals any congressional intent that a trustee should or may administer a trust fund in the interest of the party that appointed him, or that an employer may direct or supervise the decisions of a trustee he has appointed." *National Labor Relations Board v. Amax Coal Co.*, 453 U.S. 322, 330 (1981). Rather, a "trustee is a fiduciary whose duty to the trust beneficiaries must overcome any loyalty to the interest of the party that appointed him." Id. at 334.

Courts have recognized that where conflicts of interest are present, such as where the fiduciary wears two hats, a greater

degree of caution may be required. Courts have articulated two levels of inquiry into a conflicted fiduciary's actions. First, "[where] the potential for conflicts of interest is substantial, it may be virtually impossible for fiduciaries to discharge their duties with an 'eye single' to the interests of the beneficiaries, and the fiduciaries may need to step aside, at least temporarily[.]" On the other hand, where there is a lesser degree of conflict, i.e., "[w]here it might be possible to question the fiduciaries' loyalty," fiduciaries are "obliged at a minimum to engage in an intensive and scrupulous independent investigation of their options to ensure that they act in the best interest of the plan beneficiaries."

ERISA and its interpretive case law and guidance are not precise regarding when a conflicted fiduciary must step aside and when it may instead undertake an "intensive and scrupulous investigation" of its options to determine the proper course of action. This decision, and the determination regarding what steps would constitute such a sufficient process, is left in the hands of the fiduciary. Nevertheless, the case law suggests that certain factors may support the argument that the conflicted fiduciary has acted prudently. At a minimum, fiduciaries should investigate and carefully evaluate the impact of their decision on plan participants. Fiduciaries should take steps to consider a decision from all sides and investigate other alternatives. Courts have also recognized that soliciting advice from independent counsel may be evidence that a conflicted fiduciary has acted prudently. Similarly, if the decision involves investment or actuarial considerations, consulting with and relying on the opinions of outside advisers in those areas may lend support to the argument that the fiduciaries undertook a prudent process.

A pure heart and an empty head are not an acceptable substitute for proper analysis.

There may, however, be circumstances in which the Trustees operate under a conflict so great that the only prudent path to avoiding a breach of the duty of loyalty is to appoint an independent fiduciary to make the decision.

Courts appear to view the appointment of an independent fiduciary as one of a number of options available to conflicted fiduciaries, even where such an appointment may not be strictly required. As one court explained, "[w]hen a fiduciary finds itself in such a position of divided, or conflicting, loyalties, a proper course of action may be to step aside in favor of a neutral, competent referee." Courts have also recognized that appointment of an independent fiduciary is "some evidence of 'procedural' prudence." Other options include hiring an ERISA expert or having a court appoint an independent Trustee. DOL guidance also provides that individual Trustees who have a personal or business interest in conflict with their fiduciary responsibility with respect to a particular issue or transaction may avoid engaging in a prohibited transaction if they recuse themselves from consideration of and do not "otherwise exercise" fiduciary authority, control, or responsibility with respect to that issue or transaction. Prohibited transactions, discussed in Section V, are ones that ERISA categorically prohibits, subject to certain exemptions.

B. Duty to Act Prudently in Plan Decision-Making

The DOL has described the duty to act prudently as "one of a fiduciary's central responsibilities under ERISA." A fiduciary must act with the care, skill, prudence, and diligence under the circumstances then prevailing that a reasonably prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims. This is a "prudent expert" standard, which means that, when making a particular decision, the fiduciary will be held to the same standard as those with expertise in that area. Addressing this standard, courts have observed that "[a] pure heart and an empty head are not an acceptable substitute for proper analysis." Relatedly, the DOL has advised that a fiduciary lacking that expertise "will want to hire someone with that professional knowledge" to assist or make decisions. Although obtaining an expert's advice is evidence of a prudent investigation, to rely on an expert, a fiduciary must "(1) investigate the expert's qualifications . . . (2) provide the expert with complete and accurate information . . . and (3) make certain that reliance on the expert's advice is reasonably justified under the circumstances."

The duty to act prudently includes employing a prudent process for making fiduciary decisions. The DOL has made clear that fiduciary responsibilities "cover the process used to carry out the plan functions," not just "the end results." For example, the DOL has said, "an investment does not have to be a 'winner' if it was part of a prudent overall diversified investment portfolio for the plan." The DOL has counseled that it is "wise to document decisions and the basis for those decisions." Documenting "the decision-making process to demonstrate the rationale behind the decision at the time it was made" may limit potential liability.

C. Duty to Diversify Investments

ERISA requires that a fiduciary diversify the plan's investments to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so. In a defined benefit plan, the Trustees will typically be responsible for setting the plan's overall asset allocation, which describes how the plan's investments will be diversified among asset classes and investment styles. When the Board delegates investment responsibility for a specific asset class to an investment manager, that manager will be required to diversify the assets it manages.

D. Compliance with Plan Documents

Plan fiduciaries are required to administer the plan and invest plan assets "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions" of ERISA. For these purposes, governing plan documents include the formal plan document, the Trust Agreement, and the collective bargaining agreement (if it contains plan terms), as well as the plan's investment policy.

V. Prohibited Transactions

Trustees of a multiemployer plan have a range of responsibilities, from running a fund office to oversight of the investment of the plan's assets. In addition, ERISA categorically prohibits Trustees from causing the plan to enter into certain transactions that could pose a risk to the plan's participants and beneficiaries, so-called "prohibited transactions." There are two types of prohibited transactions: transactions between the plan and "parties in interest" (individuals or entities related to the plan), and transactions involving conflicts of interest on the part of the plan's fiduciaries.

If a prohibited transaction occurs, there is a 15% excise tax on the "amount involved" in the transaction. Generally, the "amount involved" is the fair market value of the property and cash involved in the transaction, but the tax laws have many special exceptions for applying this tax. The 15% tax applies each year until the prohibited transaction is corrected, and if the Internal Revenue Service ("IRS") finds that the prohibited transaction is not corrected in the taxable period, there is an additional excise tax equal to 100% of the amount involved. The 100% excise tax imposed is on the disqualified person who participated in the prohibited transaction (other than a fiduciary acting only as such).

A. Party in Interest Transactions

Generally, ERISA prohibits all transactions between a plan and a "party in interest" unless the conditions of an exemption are fully met. A plan's parties in interest include not only a plan's fiduciaries and their family members, but also any person providing services to a plan, each employer whose employees are covered by the plan, each union whose members are covered by the plan, and various other individuals and entities that have specific relationships to the plan, its fiduciaries, its employers, its unions, and its service providers. Although only fiduciaries are subject to liability for violating ERISA's general fiduciary duties, both fiduciaries and parties in interest are potentially liable for damages, and, in the case of pension plans, excise taxes, when ERISA's prohibited transaction provisions are violated.

Under ERISA's party in interest provisions, any direct or indirect transaction between a party in interest and a plan is prohibited, including sales, exchanges, or leasing of property; lending of money or other extensions of credit (by a plan or to a plan); furnishing of goods or services; transfers of assets; and using assets for the benefit of a party in interest.

Notwithstanding this prohibition, ERISA recognizes that plans may need to engage in certain, otherwise prohibited transactions, and so it incorporates various statutory exemptions and provides that the DOL also may promulgate administrative exemptions (i.e., class exemptions that provide relief for any plan meeting their conditions). Some of the exemptions commonly used by multiemployer plans include:

1. Exemption: Reasonable Services

One of the most commonly invoked prohibited transaction exemptions, the ERISA section 408(b)(2) exemption allows a party in interest to contract with a plan for services "necessary" for the establishment or operation of the plan. Under applicable regulations, a service is necessary if it is "appropriate" and

"helpful to the plan in carrying out its functions." Reasonable services include custodial, administrative, and investment services. Section 408(b)(2) also covers the leasing of office space to a plan by a party in interest.

The exemption only applies if the arrangement under which services will be provided, and compensation paid to the service provider are "reasonable." For example, a plan could engage a bank already serving as its custodian (a party in interest) to provide additional investment management services to the plan, so long as the arrangement with the bank and the price to be paid to the bank were reasonable.

ERISA prohibits a fiduciary from even considering a transaction for the plan where the fiduciary has an interest.

Even if the section 408(b)(2) exemption can be met, however, the Trustees still must fulfill their duties of prudence and loyalty. Along those lines, the section 408(b)(2) exemption has not been interpreted as providing a safe haven for fiduciary conflicts of interest. Thus, for example, the Trustees could not select a Trustee's relative as a plan service provider, even if the relative was to perform a necessary service for a reasonable price.

In 2012, the DOL issued new regulations under ERISA section 408(b)(2) that, in general, require certain plan service providers to ERISA-covered retirement plans to provide comprehensive compensation and other disclosures to plan fiduciaries at the "point of sale;" *i.e.*, before the fiduciaries engage them to provide plan services. These disclosures must also be updated over time if the compensation and other information changes due to contractual amendments or for other reasons. Trustees should ensure that they receive and document their review of these disclosures before making final service provider selections or before existing contract renewals and amendments are approved.

2. Exemption: Transactions with Service Providers

Section 408(b)(17) permits a plan to engage in other types of transactions (purchases and sales of securities or real estate, loans, leases, etc.) with parties in interest that are service providers (or affiliates of service providers). The service provider on the other side of the plan transaction must not have fiduciary authority (or provide investment advice) with respect to the assets in question, and the plan must pay no more than, or receive no less than, "adequate consideration" in the transaction. This exemption is not available for transactions between the plan and the plan's participating employers or unions (or their affiliates), or for transactions between the plan and individual fiduciaries of the plan.

3. Exemption: Leasing and Service Arrangements for Multiemployer Plans

A DOL class exemption allows a multiemployer plan to lease office space, provide administrative services, or sell or lease goods to (but not *from*) a participating employee organization (*e.g.*, a union), a participating employer, a participating employer association, or another multiemployer plan which is a party in interest with respect to the plan.

B. Fiduciary Conflicts

The second type of "prohibited transaction" is the set of rules prohibiting a fiduciary from making a plan decision in a situation in which that fiduciary has a conflict of interest. ERISA specifically prohibits a fiduciary from (1) dealing with the assets of a plan for the fiduciary's own interest or own account ("self-dealing"), (2) representing both the plan and an adverse party in a transaction between them, and (3) receiving any consideration from a third party in connection with a transaction between the plan and that third party ("kickback"). Examples of these types of prohibited transactions include:

- **Self-dealing:** the Trustees hire as the plan's auditor a firm owned by a Trustee's child, even if the services are necessary and reasonably priced.
- **Both Sides:** the provision of services by one plan to another plan, where the same individuals serve as the Trustees of both plans, although the terms are fair to both plans.
- **Kickbacks:** an individual Trustee receives free rent, discounted services or lavish entertainment from an investment manager who does, or wants to do, business with the plan, even if providing these things is not a quid pro quo for getting the plan's business.

ERISA prohibits a fiduciary from even considering a transaction for the plan where the fiduciary has an interest — financial or otherwise — in the transaction or in a person or entity that could benefit from the transaction. Moreover, it does not matter that the transaction is beneficial to the plan and that the terms are fair from the plan's perspective. In addition to his or her personal interests, a Trustee is considered to have an "interest" in any relative, in any business that he or she owns, and in the employer or union that appointed him or her. For example, a union Trustee will violate ERISA if he or she causes the plan to purchase property from the union sponsoring the plan. If the fiduciary has an interest in the transaction that is separate and distinct from that of the plan, that transaction is prohibited unless a specific exemption can be identified, and requirements fully met. In addition, a Trustee violates ERISA's anti-kickback rule if he or she personally receives a finder's fee, a gift, or discounted services from a service provider to the plan.

Courts have found that Trustees engaged in a prohibited transaction not subject to any of the above-referenced exemptions where, for example, they leased office space owned by the fund to the union at a rate that was less than reasonable rental value, where they pushed a plan to choose particular dental coverage in exchange for personal financial gain, and where they accepted free use of a boat from an insurance company selling insurance to the plan.

Even when he or she has no personal interest in an arrangement, a multiemployer plan Trustee can violate the conflict-of-interest rules if he or she represents both sides in a transaction involving the plan and another party.

VI. Trustee Compensation and Expenses

Plan assets may only be used to pay benefits to participants and beneficiaries, and to defray the reasonable expenses of administering the plan. Trustees cannot use plan assets for personal expenses or gifts for themselves, plan employees, or service providers. ERISA does, however, permit Trustees to be compensated under certain limited circumstances, and to be reimbursed for reasonable expenses that they incur in the course of carrying out their duties to the plan.

A. Trustee Compensation

A fiduciary cannot decide the amount, if any, of the compensation that he or she will receive from a plan. Any fiduciary compensation must be determined by an independent party representing the plan. In addition, even if approved by an independent party, a plan may not compensate a Trustee for the performance of his or her plan duties if the Trustee is already receiving full-time pay from a union, employer, or employer association whose employees or members participate in the plan.

B. Reimbursement of Expenses

While there are limitations on a plan's payment of salary or wages to a Trustee, it is permissible to reimburse a Trustee for the expenses that he or she incurs in performing plan duties. Like all plan expenses, Trustee expenses must be both (1) necessary or appropriate for administration of the plan and approved by the Board of Trustees as such, and (2) reasonable in amount.

Trustees may generally be reimbursed for reasonable expenses associated with traveling to and attending a Trustee meeting, traveling on other plan business, such as investment due diligence trips, or attending an educational conference covering topics relevant to their plan duties. Trustees may be reimbursed only for "direct" expenses, that is, those expenses that would not have been incurred had the Trustee not been performing his or her plan duties. A Trustee may receive an advance for expenses that he or she expects to incur in performing plan duties if the amount of the advance is "reasonable with respect to the amount of the direct expense which is likely to be properly and actually incurred in the immediate future (such as during the next month)," and if the Trustee accounts to the plan at the end of the period covered by the advance for the expenses actually incurred.

The DOL has brought suit against Trustees who allegedly used plan funds for excessive expenses, including first-class travel, meals, alcohol, and auto expenses, and/or did not properly account for the expenses incurred. The DOL has stated that it will generally treat non-cash gifts, gratuities, meals, entertainment, or other consideration paid from any one individual or entity to a fiduciary or a fiduciary's family member as insubstantial, and not an apparent violation of ERISA section 406(b)(3), if the annual aggregate value of the consideration is less than $250 and the receipt does not violate any plan policy or provision. Beyond that, while there are no bright-line rules for what expenses the DOL will consider "reasonable," the DOL has tightened up and challenged the use of plan assets for expensive dinners, alcohol, and parties. Likewise, the DOL has challenged the scheduling of Trustee meetings at resort locations and expensive hotels during peak season.

VII. Formal Fiduciary Roles and Delegation

A. Responsibilities of "Named Fiduciaries" and "Trustees"

Every plan, including a multiemployer plan, must have at least one "named fiduciary" who has the authority "to control and manage the operation and administration of the plan." As the term suggests, a "named fiduciary" will either be identified as a fiduciary in the plan document or be identified by the employer or union under a procedure described in the plan document for appointing named fiduciaries.

With few exceptions, all assets of the plan must be "held in trust." But not all plan trustees exercise full discretion over the plan's assets. Instead, there are two types of trustees: (1) "directed trustees," who make no decisions for the plan but simply hold the plan's assets in trust and follow "proper directions" of a named fiduciary, and (2) "discretionary trustees," who are either named in the plan document or appointed by the settlors of the plan, and who have "exclusive authority and discretion to manage and control the assets of the plan."

Single employer plans typically appoint institutions — *e.g.*, banks — to serve as custodians and directed trustees. In a typical multiemployer plan, a board of individuals — *i.e.*, the Trustees — serves as the plan's trustee as well as its named fiduciary and those Trustees serve as discretionary, and not directed, trustees.

B. Managing Fiduciary Responsibilities in Practice

The tasks and responsibilities involved in administering a plan and managing its assets are extensive. Some typical defined benefit plan duties are listed in Appendix A. Congress and the DOL have recognized this and provided mechanisms that allow fiduciaries to divide responsibilities among themselves, to delegate their fiduciary responsibilities to others, and to rely on advisers and staff for assistance in making decisions.

1. Allocation of Duties Among Trustees

If the plan document describes an *allocation* procedure, named fiduciaries may divide their fiduciary duties among themselves; however, the DOL or a court may take the position that they cannot completely divest themselves of their fiduciary duty to monitor. For example, Trustees may establish a sub-committee of Trustees to handle benefit claims or to monitor or oversee certain service providers. Any allocation among a plan's Trustees must be reflected in a formal resolution of the Trustees.

2. Delegation of Duties to Others

A more commonly used strategy for managing the extensive duties of a named fiduciary and Trustee is to delegate duties to staff or external service providers. ERISA permits a fiduciary to delegate certain duties to others with greater expertise as long as there is an unambiguous provision in the plan document permitting delegation and the fiduciary's decision to do so was prudently made.

Trustees do not, however, absolve themselves of fiduciary responsibility completely when they delegate their duties to others. Trustees retain responsibility (and potential liability) for the selection and monitoring of service providers and investment professionals to whom they delegate duties and should undertake a periodic review of their decisions.

> As the Supreme Court has recognized, once the Trustees have selected a service provider, they have an ongoing duty to monitor the performance and fees of that provider.

It may be prudent for Trustees to document their delegations in a formal resolution consistent with the procedure set out in the plan document and to require that the persons to whom duties have been delegated accept the delegated responsibilities in writing.

3. Reliance on Advice of Staff and Other Advisers

Even though delegation of responsibilities is common, the Trustees may choose to retain complete responsibility for significant decisions, such as the selection of major service providers. When making these decisions, the Trustees are permitted to seek, and rely on advice from staff or other experts. However, when the Trustees receive advice from an expert or adviser, they must exercise their own independent judgment and discretion to make the final decision. Therefore, before relying on the advice of others, the Trustees should investigate the adviser's qualifications, provide the adviser with complete and accurate information, and ensure that reliance on the recommendations is reasonably justified under the circumstances.

C. Selection and Monitoring of Plan Advisers and Other Service Providers

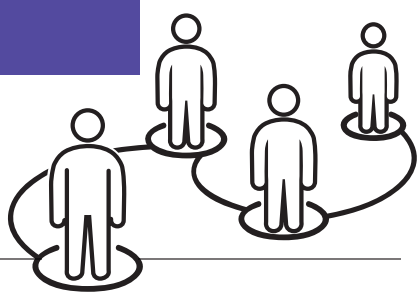
Service providers may include legal counsel, recordkeepers, accountants, actuaries, investment consultants, investment managers, COBRA administrators, flexible spending account administrators, wellness plan vendors, employee assistance program vendors, enrollment administrators, and third-party administrators. The advisers and other service providers engaged by the Trustees to assist them in administering the plan may or may not be fiduciaries, depending on the functions that they perform.

Selecting a service provider for the plan is a fiduciary decision and the Trustees will be bound by the fiduciary duties of loyalty and prudence as well as ERISA's prohibited transaction rules in making that selection. In fact, careful selection and monitoring of plan providers is one of the most important responsibilities of the Trustees. Whether the Trustees' selection of a provider will be considered prudent depends not only on their ultimate decision but also on the process they employ in making that selection. The type of process required will depend on the scope and significance of the service arrangement at issue. A modest contract may not require a full request for proposal (RFP) process or formal bids, while the engagement of a new recordkeeper with significant responsibilities and commensurate compensation may justify a more extensive process. While the RFP process is not specifically required by ERISA, the DOL has stated that "[s]oliciting bids among service providers is a means by which a fiduciary can obtain the necessary information relevant to" a prudent decision-making process.

At a minimum, when selecting a plan service provider, the Trustees should identify the plan's specific needs (*i.e.*, the specific type of services it requires) and develop the information needed to reasonably assess the experience and quality of the

Plan Advisers and Other Service Providers

Legal counsel	Recordkeepers	Accountants	Actuaries	Investment Consultants	Investment Managers
COBRA Administrators	Flexible Spending Account Administrators	Wellness Plan Vendors	Employee Assistance Program Vendors	Enrollment Administrators	Third-party Administrators



prospective providers. The selection process should consider the proposed fees as well as the quality of the services of the prospective providers, but the Trustees are not required to choose the least costly provider. Cost is just one factor to be considered in selecting a service provider. At a minimum, however, a plan fiduciary should inquire about and understand all of the compensation that a provider expects to receive, whether directly or indirectly, in connection with its services to the plan. For example, some recordkeepers or advisers may receive commissions or revenue sharing or other payments from parties *other than the plan* in connection with plan services. The DOL also suggests that when fiduciaries are considering service providers who provide multiple (or "bundled") services, the fiduciaries should ask for specific information about which services will be covered by the provider's fee.

As with all service providers, the Trustees have a fiduciary obligation to prudently select and monitor legal counsel, including an obligation to ensure that fees paid are reasonable in light of the services performed.

As the Supreme Court has recognized, once the Trustees have selected a service provider, they have an ongoing duty to monitor the performance and fees of that provider. The DOL has stated that a provider's performance should be monitored "[a]t reasonable intervals" and "in such manner as may be reasonably expected to ensure that their performance has been in compliance with the terms of the plan and statutory standards and satisfies the needs of the plan." There is no "single procedure" for monitoring that is appropriate in all cases; the monitoring process will necessarily vary depending upon the type of plan, the services at issue, and the magnitude of the arrangement.

In particular, Trustees should regularly monitor a provider's compensation to ensure that it remains reasonable in light of the services provided. Compensation that is based on assets under management or the number of participants can fluctuate significantly over the course of an ongoing arrangement. The DOL has advised that fiduciaries should evaluate any changes in the service provider's compensation or in other information provided by the provider at the time it was engaged. In particular, fiduciaries should review the service provider's performance, confirm that the fees actually charged by the provider are consistent with the provider's contract with the plan, and follow up on any participant complaints. Plaintiffs in recent lawsuits filed against plan fiduciaries have asserted that appointing Trustees should have put service provider contracts up for competitive bidding on a periodic basis.

D. Use of Legal Counsel

Multiemployer plans generally retain legal counsel. Some plans have a single attorney or firm serve as counsel for the Trustees, while others employ one attorney or firm selected by union Trustees, and one selected by management Trustees. A plan may also choose to hire different attorneys or firms to perform different tasks. For example, a plan might engage one firm as general counsel (or primary adviser to the plan's in-house general counsel) and another to handle collection of delinquent employer contributions. Attorneys play an important role in informing the Trustees of relevant legal and regulatory changes, preparing and reviewing plan documents, representing the plan in government inquiries, such as DOL investigations, reviewing and negotiating contracts, handling litigation by or against the plan, and collecting employer contributions and assessing withdrawal liability.

The Trustees' reliance on the advice of counsel is not necessarily a defense to a breach of fiduciary duty. But receiving and following the advice of counsel can demonstrate that the Trustees engaged in a prudent decision-making process. As with all service providers, the Trustees have a fiduciary obligation to prudently select and monitor legal counsel, including an obligation to ensure that fees paid are reasonable in light of the services performed. To that end, if the Trustees hire more than one attorney, they should ensure that the attorneys do not duplicate work.

VIII. Investment of the Plan's Assets

Trustees of a multiemployer plan oversee the trust fund into which all employer and participant contributions are deposited. A defined benefit plan or welfare plan's ability to meet its benefit obligations depends to a large degree on the successful investment of those contributions. In the case of a participant-directed defined contribution plan, the success of the plan depends on the quality and cost of the investment options the Trustees make available to plan participants.

An investment fiduciary is not a "guarantor" of a successful investment outcome.

The Trustees are not required to be investment experts, but no matter the type of plan, they are required to educate themselves about investment concepts and engage investment professionals so that they may prudently implement and oversee the plan's investment program.

A. Fiduciary Standards Applied to Investments

ERISA's general fiduciary duties of prudence and loyalty apply to the investment of the plan's assets whether performed by the Trustees or other investment professionals they engage. In addition, a fiduciary generally has a duty to diversify the plan's investments, unless under the circumstances it is "clearly prudent" not to diversify. Fiduciaries' investment decisions must also be consistent with plan documents, so long as those documents comply with ERISA, and must avoid prohibited transactions.

An investment fiduciary is not a "guarantor" of a successful investment outcome. The DOL has stated that prudence depends on the process a fiduciary uses, rather than the outcome of the fiduciary's decision. Accordingly, a fiduciary will not be liable for losses resulting from the investments it chooses, as long as it engages in a prudent decision-making process.

A prudent process employs appropriate methods to investigate the merits of an investment and structure the investment. Prudence also requires fiduciaries to give "appropriate consideration" to the role a proposed investment plays in the portfolio as a whole (or, if the fiduciary is only responsible for part of a portfolio, for the portion of the portfolio in which the fiduciary's duties apply). "Appropriate consideration" for an individual investment, as for an overall investment plan, includes a determination that the particular investment is reasonably designed to further the purposes of the plan, taking into consideration the composition of the portfolio with respect to diversification, the portfolio's liquidity and return relative to the plan's cash flow requirements, and the projected return of the portfolio relative to the funding objectives of the plan. No particular investment or course of investment is imprudent *per se* under ERISA, even if it entails a high or low degree of risk; instead, prudence is evaluated based on an analysis of all the facts and circumstances at the time of the decision and periodic review, including the role that the chosen investment plays in the overall portfolio. When evaluating allegations of imprudent investment, courts look to whether the fiduciary's decisions were consistent with what a prudent investor with relevant expertise would decide.

B. Adopting an Investment Policy

Although ERISA does not expressly require that fiduciaries adopt a written investment policy, the DOL encourages it, explaining that adopting and maintaining a statement of investment policy is consistent with the investment fiduciary's obligations under ERISA. Investment policies often include a summary of the plan's overall investment objectives, objectives for diversification, upper and lower ranges for the percentage of assets held in different types of investments, benchmarks for assessing performance of investments, the expected rate of return on investments, and the criteria the Trustees will use in evaluating investment managers and collective investment vehicles.

When developing an investment policy, the Trustees should consider the characteristics of the plan, its purposes, and the potential for loss and gain resulting from the chosen investment strategies. The Trustees should also take into account the composition of the plan (or portfolio) with respect to diversification, the liquidity and current return of the plan (or portfolio) relative to the cash flow requirements of the plan to make disbursements, and the projected return of the plan (or portfolio) relative to the plan's funding objectives. Once an investment policy has been adopted, the Trustees have a duty to follow the investment policy to the extent that it is not imprudent to do so. Because a failure to comply with the investment policy can be considered a breach of fiduciary duty (*i.e.*, failure to administer the plan in accordance with its governing documents), the Trustees should ensure that the investment policy is up to date, reflecting their current approach and intent, and that it is not overly prescriptive. On the other hand, compliance with the investment policy does not shield fiduciaries from liability for imprudent actions under ERISA — if a particular investment is imprudent, the fact that it is authorized or required by the investment policy is irrelevant.

C. Investment Professionals

Typically, multiemployer plan Trustees do not directly invest the assets of their plans. Instead, in the case of a defined benefit plan or funded welfare plan, the Trustees establish the plan's overall investment policy and asset allocation, often with the assistance of an investment consultant, and then select investment managers or investment funds which directly select the stocks, bonds, and other assets in which the plan's assets will be invested. In the case of a participant-directed defined contribution plan, the Trustees typically will, again with the assistance of an investment consultant, select and monitor the investment options offered to participants.

ERISA permits and actually encourages Trustees to retain professionals with expertise in plan investments. However, it is important to understand the different roles of investment advisers and investment managers, and the protection provided to Trustees engaging these investment professionals. *Investment advisers* or consultants generally provide *advice* to Trustees. While these advisers may provide expert assistance, the Trustees remain responsible for making final investment decisions. On the other hand, *investment managers* appointed by the Trustees assume full responsibility for investment of a portion of the plan's assets. In ERISA parlance, these investment managers "exercise discretionary authority and control" over the plan's assets and are directly liable for their actions and inactions with respect to those assets.

The question of who will be a "fiduciary" to the plan will be because they provide investment advice has been a controversial subject in recent years. Currently, a long-standing DOL regulation mandates that a provider of investment advice to the plan's fiduciaries for compensation will become a fiduciary only if they meet a five-factor test, including that they provide advice to the plan on a regular basis, subject to a mutual understanding that the advice will be a primary basis for decision making and individualized to the unique circumstances of the plan. In 2016, the DOL finalized a new "definition of fiduciary" regulation that would have greatly expanded the range of providers who would have qualified as a "fiduciary" based on providing investment advice to an ERISA-covered plan. However, that rule was struck down by the U.S. Court of Appeals for the Fifth Circuit. The DOL has recently announced that it is reviewing its regulatory and other guidance related to identifying investment advice fiduciaries and intends to issue further regulatory guidance in this area.

1. Investment Managers

ERISA provides that a named fiduciary and trustee will not be responsible or liable for the investment of plan assets allocated to an "investment manager." As defined in ERISA, an investment manager is a registered investment adviser, insurance company, or bank that (i) has been given the authority to acquire, manage, or dispose of plan assets and (ii) has acknowledged its fiduciary status in writing.

A plan may have a number of investment managers, each responsible for investing a portion of the plan's assets in a particular asset class or strategy. Once selected, an investment manager becomes the sole decision-maker for the assets within its purview, and also assumes the day-to-day monitoring of the investments it makes.

While the fiduciary Trustees are not responsible for the investment of assets allocated to an investment manager, they retain complete responsibility for prudently selecting the manager and for establishing the investment guidelines for the manager and portfolio they have been given. These guidelines help to ensure that the manager's strategy plays the intended role in the plan's overall investment policy. The Trustees are also responsible for ensuring that fees paid to the investment manager are reasonable. A trend in "excessive fee" litigation illustrates this point. In class action suits, participants have alleged that plan fiduciaries, such as the Trustees, violated ERISA by permitting the plan to pay allegedly excessive investment management fees, arguing that less expensive options with comparable performance were available in the market. A number of excessive fee cases have resulted in significant recoveries for participants.

2. Investment Advisers or Consultants

An investment consultant or other investment adviser can provide guidance and counsel to the Trustees in drafting investment policies, recommending and monitoring investment managers and funds, recommending and reviewing the plan's asset allocation, ensuring compliance with a prudent investment process, and selecting and monitoring investment managers. Although investment advisers will generally be held responsible under ERISA for any imprudent advice they provide to the Trustees, because the Trustees retain the final decision-making responsibility for each matter on which the consultant advises, they will still be fully liable for the prudence (or imprudence) of those final decisions. As mentioned earlier, however, having the assistance of the investment consultant does obviate the requirement for the prudence of the Trustees' process.

Perhaps the most important information the Trustees should consider in evaluating an existing investment manager are periodic investment return and risk reports comparing the manager's performance with its peer group, or with a benchmark chosen by the Trustees.

To satisfy their fiduciary obligations when working with advisers and consultants, the Trustees must independently investigate and evaluate an adviser's recommendation before deciding to follow it. In other words, the Trustees must undertake an independent investigation of the merits of a particular investment or investment manager before selecting an investment fund or manager based on an adviser's recommendation.

D. Monitoring Investment Professionals

Fiduciaries are expected to monitor investments with reasonable diligence and to dispose of improper investments as needed. The Supreme Court reaffirmed the ongoing duty to monitor the plan's investments in 2015 and, according to DOL regulations, the scope of a fiduciary's monitoring duty will vary based on the circumstances. This duty to monitor also extends to the monitoring of plan service providers, particularly investment professionals.

Perhaps the most important information the Trustees should consider in evaluating an existing investment manager is periodic investment return and risk reports comparing the manager's performance with its peer group, or with a benchmark chosen by the Trustees. The Trustees should additionally consider any potential conflicts of interest between the investment manager and the investment consultant, or any other plan service providers, paying particular attention to any changes in the investment manager's ownership, organization structure, or staffing that could give rise to potential conflicts. Potentially helpful, too, are the investment manager's regulatory filings, and audits and control testing performed by the plan's auditor. The Trustees may also meet with investment managers on a periodic basis to discuss the performance of investments and the manager's view of the overall market. If the Trustees lack the knowledge or expertise to adequately monitor investment managers' performance, their fiduciary duties may require them to seek additional assistance (such as from an investment consultant) in performing that task. Trustees who fail to monitor the plan's investment managers or funds could be personally liable for any losses to the plan for failure to replace that manager or fund on a timely basis.

E. Investment Funds

When the Trustees decide to invest in a collective investment vehicle, such as a bank collective trust, an insurance company-pooled separate account, a mutual fund or a private limited partnership ("Fund"), the Trustees are effectively selecting an investment manager for the assets they commit to the Fund. However, all Funds are not treated the same under ERISA.

The investment manager of a bank collective trust or insurance company-pooled separate account is always a fiduciary fully subject to ERISA's fiduciary standards when managing assets of the Fund. However, when the plan invests in other types of Funds, the underlying assets of those vehicles may not be considered assets of the investor plans, and therefore the manager of the Fund may not be subject to ERISA's standards. For example, the managers of mutual funds, real estate operating companies (REOCs), venture capital operating companies (VCOCs) and partnerships in which the investment by benefit plan investors is "not significant" are not considered ERISA fiduciaries when managing the underlying assets of those Funds. This does not mean that investment by plans in those Funds is impermissible. The Trustees may purchase an interest in a Fund that does not hold plan assets following a prudent review process. And, once the investment is made, the Trustees will not be responsible for the investment of the assets transferred to the Fund. As with any investment manager selection, however, the Trustees remain responsible for the original decision to select the Fund and any decision to remain in it.

F. Fee and Performance Litigation

As mentioned earlier, participants have brought class action complaints against the fiduciaries of multiemployer defined contribution plans challenging the fees and/or investment performance associated with these defined contribution plans, and there have been hundreds of these types of complaints filed against fiduciaries of single employer 401(k) plans. In these complaints, plaintiffs have asserted claims for breach of fiduciary duty arising out of the:

- selection of investment options that purportedly carry high fees and underperform vis-à-vis other alternative options. These alternative options may include lower-cost share classes, collective investment trusts, or separate accounts instead of mutual funds, or index funds.
- inclusion of too few or too many investment options.
- inclusion of investment options that are too risky or too conservative, too difficult for the average participant to understand, or are affiliated with the plan's recordkeeper or investment consultant.
- payment of recordkeeping fees as a percentage of assets under management or using revenue-sharing payments from the plan's investment options.
- failure of plan fiduciaries to conduct a competitive bidding process to select the plan's recordkeeper.

There has also been fee and performance litigation brought against fiduciaries of multiemployer defined benefit plans. Further, the DOL has also shown increased interest in recent years in investigating and seeking multi-million dollar recoveries against multiemployer plan fiduciaries over these types of issues.

IX. Pension Plan Funding Requirements

Multiemployer defined benefit pension plans are generally funded by employer contributions and the plan's investment returns. The employers that contribute to these plans are required by law to fund the promised benefits over time. The plan's assets need not be sufficient at any given time to pay all promised benefits, current and future, but the plan's assets, together with expected employer contributions and investment returns, must generally be sufficient to pay participants' benefits as they retire.

Timely collection and deposit of employer contributions is essential to ensuring adequate plan funding, and multiemployer plan Trustees usually establish and follow formal collection policies.

A. Employer Contributions

Employer contributions are an important part of a plan's funding. Employers contribute to multiemployer pension plans pursuant to an obligation typically set out in their collective bargaining agreement with the union. The employers and the union typically will bargain over the precise contribution formula. It is common for the formula to be based on hours worked by covered employees (*e.g.*, $1 for every hour worked), but other formulas are permitted.

Timely collection and deposit of employer contributions is essential to ensuring adequate plan funding, and multiemployer plan Trustees usually establish and follow formal collection policies. The collection policy may outline the due date for contributions, any applicable interest charged to delinquent employers, and specific penalties for delinquent payments. In addition, many multiemployer plans perform periodic audits and form delinquency committees to ensure that each employer has satisfied all of its contribution obligations. A DOL class exemption permits the Trustees to settle delinquent contribution claims for less than the full amount owed if certain conditions are met.

B. Underfunded Plans

The Pension Protection Act established additional requirements for multiemployer plans that become substantially underfunded. Generally, the plan's actuary must perform an annual certification of the plan's funded status. If the plan fails certain financial tests, it is required by law to (1) mandate higher levels of employer contributions, (2) decrease certain benefits, or (3) a combination of both. These strategies are implemented through a "funding improvement plan" or a "rehabilitation plan," which is designed to improve the plan's funded status over time. If the Trustees decide to increase contributions, that requirement generally does not apply to a particular employer until that employer negotiates a new collective bargaining agreement, but the Trustees may not accept a new collective bargaining agreement that does not include the increased contributions. An employer need not agree to the higher contribution rate,

but if it fails to do so, it may be deemed to have withdrawn from the plan, triggering withdrawal liability (see Section X below).

In some cases, the measures needed to return an underfunded plan to financial health may be so onerous that implementing them would cause the contributing employers to withdraw from the plan or go bankrupt, resulting in more harm than good. Accordingly, the law allows the Trustees to conclude that "all reasonable measures" have been exhausted and directs the Trustees instead to adopt reasonable measures to either improve funding levels or forestall insolvency to the greatest extent possible.

The American Rescue Plan Act, enacted in 2021, allows highly underfunded multiemployer pension plans to apply for special financial assistance from the federal government. Eligible plans will receive lump sum payments intended to keep the plans solvent until 2051 under assumptions mandated by law. Plans may apply for this assistance until the end of 2025, and the applicable regulations categorize plans into various priority groups depending on their funding levels, with higher priority plans allowed to apply immediately and lower priority plans required to wait before applying. Plans are not required to repay special financial assistance, and it is estimated that nearly $100 billion of relief will be distributed to eligible plans through this program.

X. Withdrawal Liability

When a participating employer "withdraws" from a multiemployer plan, it must pay the plan a portion of the unfunded benefit liabilities, if any. An employer withdraws if it either (1) ceases to have an obligation to contribute to the plan (e.g., it does not renew a collective bargaining agreement that requires contributions to the plan), or (2) permanently ceases to perform covered work (*e.g.*, it shuts down its only plant employing plan participants). An employer can partially withdraw if it significantly reduces its covered work levels over time (but does not stop all work completely), or if part of its ongoing operations ceases to be covered by a collective bargaining agreement that requires contributions to the plan. Many multiemployer plan Trustees periodically distribute questionnaires to employers to ensure a timely determination of whether employers have withdrawn and to confirm additional withdrawal-related information.

Many multiemployer plan Trustees periodically distribute questionnaires to employers to ensure a timely determination of whether employers have withdrawn and to confirm additional withdrawal-related information.

After determining that an employer has withdrawn, the Trustees calculate the amount of "withdrawal liability" the employer owes. Federal law requires that the Trustees use a specific formula to calculate how much the withdrawing employer must pay annually, which depends on the employer's employment and contribution history. The Trustees then send a demand for withdrawal liability to the withdrawn employer.

An employer wishing to challenge the withdrawal liability assessment (either the fact of withdrawal or the amount of the assessment) must follow a specific dispute resolution process set out in ERISA. First, the employer must request the plan review the withdrawal liability determination. In its request, the employer must explain why it has not, in fact, withdrawn, or why the calculation of its withdrawal liability amount is incorrect. The Trustees then review the request and provide a written decision.

If the dispute continues after the Trustees' ruling, the employer must file for arbitration to continue its challenge. If the arbitrator decides in favor of the plan, the employer may file a lawsuit against the plan challenging the assessment. However, ERISA requires that these disputes be arbitrated in a timely manner before proceeding to court. If an employer does not file for arbitration within the deadlines under federal law, the employer effectively has waived its right to bring the issue to court.

The dollar amounts at issue in withdrawal liability disputes can be substantial and the calculations required are complex. It is therefore not uncommon for employers to challenge assessments. Although the matter may be disputed, ERISA generally requires that withdrawn employers make payments to the plan in accordance with the assessment while the dispute is pending. If the employer ultimately prevails, the plan would be required to refund past payments as appropriate. One aspect of assessments that employers frequently challenge is the actuarial assumptions, particularly the interest rate used to measure the liabilities. Historically these challenges have rarely succeeded, though more recently employers have achieved some notable victories. In October 2022, the PBGC issued proposed regulations that, if finalized, would provide plans with explicit authority to use any interest rate that falls within a wide range, potentially making it very difficult for employers to succeed in these challenges in the future.

The Trustees of a multiemployer plan can choose to settle the plan's claim for withdrawal liability with the withdrawing employer. The settlement typically would involve the employer making a single-sum payment in exchange for being released from the withdrawal liability. If this situation arises, the Trustees should carefully consider the advantages and disadvantages of the proposed settlement in order to satisfy their fiduciary duties.

Due to the complex nature of withdrawal liability calculations and the mandatory dispute resolution procedure, it is helpful for multiemployer plan Trustees to adopt policies regarding the calculation and collection of withdrawal liability assessments, as well as the management of withdrawal liability disputes.

XI. Actions by Trustees

A. Plan Administration

The Trustees are obligated by federal law to administer the plan in accordance with "the documents and instruments governing the plan." Each Trustee should be familiar with the terms of key documents related to the plan, which may include:

- **Plan Document:** Many multiemployer plans have a standalone plan document, while some include both the plan document and the trust agreement in a single document. The plan document includes the benefit formula, the form and timing of benefit payments, the eligibility requirements, and how a participant can apply to receive benefits under the plan. It must also describe the plan's fiduciary structure, *i.e.*, its named fiduciary and that fiduciary's authority and responsibility.

The Trustees are obligated by federal law to administer the plan in accordance with "the documents and instruments governing the plan."

- **Trust Agreement:** The trust agreement is the instrument under which the Trustees are appointed, and it describes their responsibility to hold the assets of the plan "in trust." The trust agreement will typically also include (1) a description of the purpose of the trust, (2) a procedure to establish and implement the funding policy, (3) a provision for holding and investing trust assets, (4) administrative procedures, including delegating responsibilities, (5) a procedure to amend the trust agreement, (6) procedures describing how amounts are paid from the trust, (7) the identity of the Trustees and the Trustees' term of office, (8) a description of how the Trustees should conduct the trust's business, (9) a procedure to terminate the trust, (10) a procedure for resolving deadlock, and (11) a procedure for appointing Trustees.
- **Collective Bargaining Agreement:** The collective bargaining agreement is negotiated between the employer(s) and the union. Normally, the collective bargaining agreement requires that employers contribute to the multiemployer plan and includes the formula to determine the amount of those contributions. In some cases, the parties may also bargain over and include in their collective bargaining agreement the benefits that will be provided to the employees who are eligible to participate in the plan. However, in most cases, they leave this to the Trustees.
- **Investment Policy:** As mentioned earlier, ERISA does not explicitly require an investment policy, but the DOL encourages adopting and maintaining an investment policy for a plan to meet its fiduciary obligations. Investment policies often include a summary of the plan's overall investment objectives, objectives for diversification, upper and lower ranges for the percentages of assets held in different types of investments, benchmarks for assessing performance of investments, the expected rate of return on investments, and the criteria the Trustees will use in evaluating investment managers and collective investment vehicles.

Actions by Trustees

Other important documents include:

- **Trustee Meeting Minutes:** The Trustee meeting minutes are the official record of the actions the Trustees take at each meeting. The meeting minutes document that the Trustees followed appropriate procedures in making plan decisions. The minutes should reflect that the Trustees acted prudently and considered all available advice and information and made a decision consistent with the information they reviewed. In the event that an action by the Trustees is challenged, the meeting minutes can help demonstrate that the Trustees satisfied the applicable fiduciary standard. In addition, in the event of a disagreement, the minutes can document each Trustee's position and show that the Trustees followed the proper procedure for reaching a resolution.

Every multiemployer plan trust agreement should contain provisions on dealing with deadlocks in trustee decision-making.

- **IRS Determination Letter:** As a tax-qualified benefit plan, a multiemployer plan must comply with a long list of complex rules. Although the IRS has discontinued its routine determination letter program as of January 31, 2017, a plan's favorable determination letter represents that the IRS has reviewed the plan and concluded that, in form, it satisfies the applicable IRS requirements as of a specified date. After January 31, 2017, a preexisting plan can only request a determination letter if (1) it has never received a determination letter before, (2) the plan is terminating, or (3) the IRS makes a special exception.
- **Expense Reimbursement Policy:** The written policy outlines which expenses can be reimbursed from the plan's assets. The policy details the rationale for the plan's payment of certain categories of expenses (*e.g.*, travel, education, administrative). The policy also includes what is required to substantiate each expense.
- **Annual Audit:** Each year, a multiemployer plan must be audited by an independent auditor. The auditor's report on the plan's financial statements provides a summary of the plan's financial position, including its assets and liabilities and income and expenses. In addition to the financial statements, the auditor will review certain aspects of plan operations. As a result, the auditor's report contains useful information regarding plan management.
- **LM-10 and LM-30 Reporting:** Any payment, loan (direct or indirect), or other thing of value that is received by a union-appointed Trustee (or the Trustee's spouse or minor child), and that was provided by any employer or business related to the union, must be reported unless specifically exempted. The Trustee files the Form LM-30 with the DOL, and the employer files the Form LM-10. A few notable exemptions are employee wages, bona fide investment income, and amounts under $250. Union-appointed Trustees should carefully review any items they (or their spouse or minor children) receive from a union-affiliated employer or business to ensure any amounts are properly reported.

B. Resolving Trustee Deadlocks

Most multiemployer plans have an equal number of Trustees appointed by the participating employers and union. Every multiemployer plan trust agreement should contain provisions on dealing with deadlocks in Trustee decision-making. If the Trustees are deadlock, federal law requires them to agree on an impartial umpire to arbitrate the dispute. If they cannot agree on an umpire within a reasonable amount of time, a Trustee may petition the federal courts to appoint an impartial umpire. In the

event of a deadlock, the Trustees should ensure that any records (such as meeting minutes) are detailed and retained to document each Trustee's actions.

In addition to an equal number of Trustees appointed by labor and management, some multiemployer plans also include a neutral Trustee, which makes a deadlock impossible. Another variation is for the Trustees to adopt "block voting" procedures, under which the labor and management Trustees each possess a single vote on plan decisions and a majority of the Trustees from each respective side determines how the votes are cast. Trustees may also adopt quorum requirements, which may affect the likelihood of a deadlock.

C. Participant Communications

1. General

When a fiduciary communicates with plan participants, he or she must adhere to ERISA's fiduciary standards. Under those standards, the plan has a fiduciary obligation not to intentionally make statements that are materially misleading. If a participant relies on a fraudulent statement by a plan fiduciary, a court may require that the plan provide some kind of "remedy" to the participant, such as a monetary payment, to compensate for any harm the misrepresentation caused. In general, a plan administrator is not obligated to supply participants or beneficiaries with individualized account information. However, when a plan administrator or other fiduciary does provide information to a participant while acting in a fiduciary capacity, the information must be accurate. Along those lines, fiduciaries must answer participant questions forthrightly, and may be found liable for material misrepresentations. As some courts have held, "[l]ying is inconsistent with the duty of loyalty owed by all fiduciaries."

When a fiduciary communicates with plan participants, he or she must adhere to ERISA's fiduciary standards.

2. Promises of Benefits of Life

Pension benefits in defined benefit pension plans are generally intended to be guaranteed for the life of the participant. ERISA requires that retirement benefits in these plans become vested — unable to be modified or terminated — after participants satisfy a minimum service requirement, typically 5 years.

Unlike pension benefits, retiree health benefits and other welfare benefits are not required to become vested after certain conditions are met, or even after the participant's benefits have commenced. As a result, health and welfare plans generally can modify, terminate, or change the eligibility requirements for benefits, at any time. Although ERISA does not require that these benefits become vested, it does not prohibit plan sponsors from agreeing to vest them. These health and welfare benefits can become vested if there has been a promise that the benefits will not be changed or reduced. There is no particular language that transforms a promised benefit into a vested benefit. To analyze whether a particular benefit has become vested, courts review current and prior plan documents, summary plan descriptions, and collective bargaining agreements for provisions indicating intent to guarantee the ongoing health and welfare benefits. The Supreme Court has recently held that documents that are ambiguous or silent on the issue should not be construed as vesting these benefits unless ordinary contract principles reveal an intent to vest benefits. A plan that provides health and welfare benefits should, however, review its documents and communications for any language that could be considered a promise for lifetime benefits or vested benefits, or any unqualified promises to continue to provide these benefits.

D. Reporting and Disclosure

1. Reporting

ERISA imposes various participant disclosure and government reporting obligations, and failure to comply in a timely manner can result in penalties. Common filings and notices include:

- **Form 5500:** Each year, the plan is required to prepare a Form 5500 Annual Report and file it with the DOL. This informational report summarizes many aspects of the plan, including the number of participants, the investment of the plan's assets, the plan's funded level, and the identity of service providers. For funded plans, including funded welfare plans, the audited financial statements are also included. The Form 5500 is technically due within seven months after a plan year ends, but it is common for plans to file a Form 5558 to extend the deadline for another two and a half months (generally until October 15th for calendar year plans).
- **Form 8955-SSA:** Each year, the plan also must file the Form 8955-SSA with the IRS. This form provides information on recently terminated participants whose benefits have vested under the plan.
- **Annual Funding Notice:** For defined benefit plans, this notice must be sent to the PBGC within 120 days after the end of the plan year. This notice generally describes the plan's funding level. The notice must also be disclosed to participants and employers, as described in the section below.
- **Funding Status Certification:** Within 90 days after the start of a plan year, a defined benefit plan's actuary is required to certify the plan's funded status with the IRS.
- **Notice of Endangered or Critical Status:** If the plan is a defined benefit plan and the actuary certifies it as being in "endangered" or "critical" funding status, the plan must send this notice to the PBGC and the DOL within 30 days of the actuary's certification. The notice must also be disclosed to participants and employers, as described in the section below.
- **PBGC Premium Filing:** Defined benefit plans must file with the PBGC to pay applicable PBGC premiums. Generally, this filing is due on the 15th day of the 10th calendar month of the plan year.

- **Self-Insured Group Health Plans:** If the plan is a self-insured group health plan, there are many reporting and disclosure requirements under the Affordable Care Act ("ACA"). Such a plan should consult with counsel to ensure that these requirements are satisfied.

2. Disclosure to Participants and Participating Employers

A multiemployer plan is required to disclose certain information to participants, beneficiaries, and participating employers. Failure to comply with these requirements can misinform participants and put plan fiduciaries at risk for breach of fiduciary duties and trigger monetary penalties. A plan should develop a reporting and disclosure schedule, which should be updated periodically to reflect new developments in legal requirements.

The plan is required to disclose the following documents:

- **Summary Plan Description:** This is a summary of the plan written in plain language that describes the provisions and features of the plan. Generally, it must be provided within 90 days after a participant is covered by the plan, and then every 10 years thereafter (unless the plan has been amended in the interim).
- **Summary of Material Modifications:** If the plan is changed, a description of the changes within 210 days after the end of the year when the change was implemented.
- **Summary Annual Report:** For participants in plans other than defined benefit plans, this report summarizes the most recent Form 5500 (Annual Report). It is provided within nine months after the end of the plan year.
- **Benefit Statements:** If the plan is a defined benefit plan, participants must receive a benefit statement at least once every three years. If the plan is a defined contribution plan, participants must receive a benefit statement at least once each year. However, if participants can direct their investments, this statement must be provided at least once each quarter. A benefit statement should also be provided upon an employee's termination of service from an employer.
- **Annual Funding Notice:** For defined benefit plans, this notice must provide participants, beneficiaries, and participating employers and unions (in addition to the PBGC as mentioned above) a notice describing the plan's funding level. It is due within 120 days after the end of the plan year.
- **Endangered or Critical Status Notice:** If the plan is a defined benefit plan and the actuary certifies it as being in "endangered" or "critical" funding status, the plan must notify participants, beneficiaries, participating employers, and unions (in addition to the PBGC and the DOL, as mentioned above). The notice is due 30 days after the actuary certifies the status.
- **Notice of Reduction in Benefit Accruals:** If a defined benefit plan is amended to significantly reduce future benefit accruals, a notice of the reduction must be provided to participants, alternate payees, employers, and each union at least 15 days in advance of the effective date of the amendment.
- **Contribution Reports:** A defined benefit plan must provide each union and each employer a contribution report within 30 days after the plan completes its annual Form 5500 report.
- **Notice of Blackout Period:** If a defined contribution plan allows participants and beneficiaries to direct their investments, the plan must notify them if the process to direct investments will be restricted for more than three consecutive business days. The notice must be provided at least 30 days before the blackout, but not more than 60 days before.
- **Disclosure of Plan Fees and Expenses:** If a defined contribution plan allows participant-directed investments, the plan must disclose information annually regarding the fees charged to plan accounts.

3. Additional Documents on Request

The plan must also provide the following documents on request. Generally, this means they must be provided within 30 days after receipt of a written request:

- **Plan Documents:** The plan must provide, upon the request of a participant, beneficiary, employee representative, or employer, the summary plan description, the latest plan annual report, current plan documents (including any amendments), actuarial report, Form 5500 Annual Report, any funding improvement plan or rehabilitation plan, any collective bargaining agreement, and any other instrument under which the plan is established or operated.
- **Benefit Statements:** A defined benefit plan must provide benefit statements on request of the participant, but no more than once within any 12-month period.
- **Withdrawal Liability Estimate:** A multiemployer defined benefit plan must provide an estimate of an employer's withdrawal liability within 180 days after it receives a written request from the employer.

E. Maintaining Qualified Plan Status

A tax-qualified pension plan has tax advantages for both participants and employers. Contributions are tax-deductible to the participating employers. Earnings on the plan's assets are not treated as current income to the plan's trust, and are not treated as current income to the participant until the amount is paid. To maintain its tax-qualified status, a multiemployer plan must continue to satisfy the Internal Revenue Code's ("Code") qualification requirements. The plan document itself must incorporate the current qualification rules, and must include certain minimum eligibility, benefit accrual, contribution and distribution provisions. The specific requirements are generally very complex and depend on the type of plan (*i.e.*, defined benefit or defined contribution).

Failing to include the required plan provisions can endanger a plan's qualified status, and therefore the tax benefits provided to participants and employers through the plan. Periodically, new laws or regulations are adopted that modify or expand the requirements for qualified plans. Working with counsel, the

Trustees should regularly review their plan documents to ensure satisfaction of all of the applicable qualification requirements.

Until January 31, 2017, the IRS allowed qualified pension plans to submit their plan documents for periodic review. The IRS would review the plan document against the qualification requirements and issue a ruling (a determination letter) formally stating that the plan document satisfied the Code's requirements. However, effective January 31, 2017, the IRS no longer issues determination letters (except if the plan has never received a determination letter before, the plan is terminating, or if the IRS grants a special exception). Instead, plan sponsors and Trustees will be required to review any changes in applicable law and draw their own conclusions about whether the plan remains tax qualified. The IRS publishes an annual "required amendment list" of new requirements to make plan sponsors and fiduciaries aware of any new plan document requirements.

In addition to ensuring that the terms of the plan document satisfy the Code's qualification requirements, the Trustees must also ensure that the plan is administered in accordance with those terms. When a plan's practice is inconsistent with the plan's terms, the IRS treats this as an operational failure. These operational failures can result in the loss of the plan's qualified status (and its tax advantages). However, plans that discover operational failures can self-correct for minor errors (in accordance with the IRS's procedures) and use the IRS's voluntary correction program for more substantial errors. Under that correction program, the plan makes a submission to the IRS describing the specific failure at issue, and how it is to be corrected. If the IRS agrees with the correction, it issues a compliance statement, and the error is deemed corrected once the plan follows the proposed correction method. Alternatively, as noted earlier, many minor errors can be self-corrected, which does not require a submission to the IRS.

Working with counsel, the Trustees should regularly review their plan documents to ensure satisfaction of all of the applicable qualification requirements.

Although operational failure rarely results in plan disqualification, correction can be costly and require a time-consuming IRS submission. Therefore, multiemployer plan Trustees should routinely confirm that plan operations are consistent with the provisions of their plan document. Most errors, if discovered early, can be readily corrected.

F. Benefit Determinations

1. General

In many plans, specific calculations of benefit determinations can be complex. A clear, comprehensive benefit policy can help prevent costly legal and administrative errors that can be cumbersome to fix later. A benefit policy formally outlines how benefits are calculated, and who is eligible for benefit payments. The Trustees in a multiemployer plan have discretion to interpret plan terms but using a formal benefit policy ensures that the plan is interpreted consistently. Although the benefit policy helps to avoid errors in calculating benefits, sometimes errors inadvertently occur. If a plan miscalculates a participant's benefit, it must correct any overpayment (by asking the participant to return the overpaid amounts) or underpayment (by paying additional amounts). In addition, the IRS has specific correction methods a plan can follow to correct any miscalculations.

A participant may challenge a benefit calculation or denial. The plan must have a written claims procedure that complies with ERISA. Generally, the plan will review the participant's claim and issue an initial decision. If the participant does not agree with the initial decision, the participant can file an appeal with the plan. If the plan denies the participant's appeal, the participant can pursue the claim in federal court.

2. Avoiding Application of De Novo Standard on Judicial Review

If a participant files a lawsuit seeking plan benefits, the court must determine which standard to apply when it reviews the claim. This is the court's "standard of review." Under a *de novo* standard of review, the plan's decision (including any interpretation of the plan's terms) is not afforded deference and the court takes a fresh look at the facts and plan provisions involved in the case. Under an *abuse of discretion* standard, the court will let the plan's decision stand unless the court finds the plan's actions "arbitrary and capricious." The *abuse of discretion* standard is more favorable for a plan.

The first step towards receiving *abuse of discretion* review is to ensure that the plan document sets forth ERISA-compliant claims procedures. Second, the fiduciary deciding benefits claims (called the "claims fiduciary") should carefully follow the plan's claims procedures in deciding each benefit claim. Third, when reviewing a claim for benefits, the claims fiduciary should consider all relevant facts, interpret the plan consistently, and act in accordance with its duties of prudence and loyalty. Lastly, the claims fiduciary should avoid conflicts of interest in handling benefit claims. For example, if a claims fiduciary is affiliated with an employer and an employee working for that employer submits a claim, an alternate claims fiduciary could resolve the claim, reducing any potential conflict of interest.

XII. Government Agencies

A. Department of Labor

The Employee Benefits Security Administration (EBSA) of the DOL is responsible for administering and enforcing the fiduciary and reporting and disclosure provisions of ERISA. Individuals and organizations may submit requests for interpretations of ERISA to EBSA, which may respond in the form of an advisory opinion, which applies the law to a specific set of facts, or an information letter, which calls attention to well-established principles or interpretations. EBSA also issues Field Assistance Bulletins, FAQs, and individual and "class" exemptions from the prohibited transaction provisions discussed in Section V.

In pursuing its enforcement responsibilities, EBSA has the authority to perform on-site investigations of plans, fiduciaries and service providers, require the submission of records, inspect books and records, question individuals, subpoena records and testimony, enforce subpoenas in court, and obtain documents from any source, including plan service providers.

After EBSA completes an investigation, it usually notifies the subject of its conclusions. If EBSA determines that a fiduciary breach has or may have occurred, it will typically send a voluntary compliance letter or "ten-day letter" summarizing its findings and demanding that the fiduciary remedy the fiduciary breach. Following the issuance of the voluntary compliance letter, EBSA may negotiate a comprehensive resolution with the breaching fiduciary, or, if the parties cannot reach a resolution, EBSA may refer the matter to the Office of the Solicitor ("Solicitor"), the attorneys who represent the DOL in litigation matters. The Solicitor may then file a lawsuit in federal court. If EBSA is successful in obtaining a recovery for a plan as a result of an investigation or a lawsuit that it brings and that ends in a settlement or a favorable judgment, it is required to assess a civil penalty of 20% of the applicable recovery amount against the fiduciary or other party who participated in an ERISA breach. However, the Secretary may waive or reduce the 20% penalty if it determines that the fiduciary acted reasonably and in good faith, or if it is reasonable to expect that the fiduciary would not be able to restore all losses to the plan without severe financial hardship without the waiver or reduction. The Secretary has discretion to decide whether waiver or reduction of the penalty is appropriate, and its decision is not subject to judicial review.

If EBSA does not identify a fiduciary breach in its investigation, it may issue a closing letter to the fiduciary or simply close the investigation without notifying the subject of the investigation.

In fiscal year 2022, EBSA closed 907 civil investigations — 595 of those cases (66%) resulting in monetary recoveries for plans or other corrective action. It referred 55 cases to the Solicitor for litigation. In addition, EBSA closed 166 criminal investigations. EBSA's criminal investigations, as well as its participation in criminal investigations with other law enforcement agencies, led to the indictment of 103 individuals — including plan officials, corporate officers, and service providers — for criminal offenses related to employee benefit plans.

B. Pension Benefit Guaranty Corporation

The Pension Benefit Guaranty Corporation (PBGC) is a federal agency that provides insurance to defined benefit pension plans. In the event that a plan does not have sufficient assets to pay promised benefits, the PBGC will provide financial assistance to pay certain minimum benefits. The PBGC has separate insurance programs for single-employer and multiemployer plans, and the two programs operate differently. All multiemployer defined benefit plans must pay premiums to the PBGC annually. For example, in 2023, the multiemployer plan premium is $35 per participant, which will be increased for cost of living in future years.

The PBGC does not necessarily insure a participant's entire benefit. Instead, for multiemployer plans it guarantees 100% of the first $11 of monthly benefit accrued per year of service, and 75% of the next $33. Under this formula, the maximum guaranteed monthly benefit is $35.75 per year of service. Applying this formula, a participant who has 30 years of service has a maximum guaranteed benefit from the PBGC of $1,072.50 per month. Any portion of a participant's benefit above the PBGC's guaranteed level is forfeited when the PBGC starts to pay benefits. As a result, multiemployer plans with modest benefit levels may be nearly completely insured while participants in plans with higher benefit levels could experience dramatic reductions in their pension benefits if PBGC assistance is required.

If a multiemployer plan cannot pay its promised benefits, the PBGC provides a loan to cover the guaranteed benefits and reasonable administrative expenses. The plan continues to operate, and the Trustees remain in their fiduciary roles. It is common, however, for the PBGC to review all administrative expenses, and the PBGC will only advance funds for the expenses it deems reasonable. Although the PBGC's financial assistance is technically considered a loan, in practice, the loans are usually not repaid.

The PBGC multiemployer insurance program is funded by insurance premiums paid by covered plans and prior to the enactment of the American Rescue Plan Act, it was projected to be insolvent in approximately five years. Considering the relief provided by the American Rescue Plan Act, the PBGC multiemployer insurance program is projected to remain solvent for at least the next 40 years. Under current law, the PBGC is not supported by the full faith and credit of the United States Treasury. If the program becomes insolvent, the guaranteed benefits that the PBGC pays will be reduced to what can be afforded by the premiums PBGC receives each year, likely a small fraction of the current guarantee level. If this were to happen, only Congressional action would preserve the PBGC guarantees.

The PBGC is also responsible for implementing and interpreting many of the multiemployer plan provisions of ERISA. For example, PBGC has issued regulations and opinions on the calculation and collection of withdrawal liability, plan mergers and transfers, partitions, and, of course, the guarantee of benefits for insolvent plans. A multiemployer plan's actuary and attorney can assist the Trustees in staying current on PBGC rules and regulations.

If a multiemployer plan is at risk of insolvency, the Trustees are responsible for identifying and evaluating strategies for avoiding it. While healthy plans generally evaluate decisions by taking a long-term view, a plan at risk of insolvency may take a shorter-term outlook, focusing on actions that could forestall insolvency. In determining whether an aggressive or conservative strategy would be in participants' best interests, a plan may wish to consider how the PBGC's program may affect benefits if the plan becomes insolvent.

C. Internal Revenue Service

As discussed in Section XI.E above, as a tax-qualified pension plan, a multiemployer plan enjoys favorable tax treatment. The IRS periodically audits these tax-qualified plans to confirm that they follow all applicable legal requirements. If audited, the IRS may request all the plan materials, including any administrative procedure manuals, to verify that the plan has complied with applicable law. The IRS periodically publishes a list of the recurring issues it encounters during plan audits. This list can be a useful starting point for a plan to perform a periodic self-audit to ensure that it avoids tax-qualification issues. If any issue is discovered upon review, the IRS provides self-correction tools that resolve the problem without jeopardizing the plan's tax-qualified status.

D. Compliance with Federal Health Laws and Regulations

1. HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, protects the privacy and security of health information and provides individuals with certain rights to their health information. HIPAA is made up of several provisions designed to protect the healthcare consumer in a number of ways. The HIPAA Privacy Rule sets national standards for the protection of individually identifiable health information by three types of "covered entities": health plans, health care clearinghouses, and certain health care providers. The HIPAA Security Rule sets national standards for protecting the confidentiality, integrity, and availability of electronic "protected health information" (PHI). Lastly, the HIPAA portability provisions were designed to make it easier for people changing jobs to qualify for health plan coverage for themselves and their family members by limiting preexisting condition exclusions and imposing health-status nondiscrimination requirements.

a. HIPAA Privacy Rule

The HIPAA Privacy Rule establishes national standards that govern the use or disclosure of PHI, which is defined broadly to include almost any type of health information that identifies the individual to whom it relates and that is maintained or transmitted by a health care provider, health plan, or health care

clearinghouse. HIPAA applies to covered entities. HIPAA allows covered entities to use PHI without written authorization from an individual for treatment, payment, and health care operations and in other limited circumstances.

Under HIPAA, the group health plan is considered to be a separate legal entity from the employer or other parties that sponsor the group health plan. Neither employers nor other group health plan sponsors are defined as covered entities under HIPAA. Thus, the Privacy Rule does not directly regulate employers or other plan sponsors that are not HIPAA-covered entities with respect to employee health information they may hold. However, the Privacy Rule does control the conditions under which the group health plan can share PHI with the employer or plan sponsor, such as when the information is necessary for the plan sponsor to perform certain administrative functions on behalf of the group health plan. The Privacy Rule would not permit the group health plan to disclose PHI to an employer plan sponsor for an employment action.

The HIPAA Privacy Rule imposes a number of administrative requirements on covered entities. For example, covered entities are required to enter written contracts, known as "business associate agreements," with third parties that create, receive, maintain, or transmit PHI for functions on behalf of the plan, such as claims processing, data analysis, processing, or utilization review. These parties are referred to as "business associates." HIPAA also requires covered entities to have written privacy policies and procedures to ensure compliance with the Privacy Rule and to train all members of their "workforce," defined broadly to include employees, volunteers, and other persons under the direct control of a covered entity, on their policies and procedures. Covered entities must designate a privacy official to oversee the development and implementation of these policies. HIPAA additionally outlines a number of individual rights, including: i) the right to an accounting of certain disclosures of his or her own PHI; ii) the right to access PHI maintained in a designated record set; iii) the right to amend or correct PHI maintained in a designated record set that is inaccurate or incomplete; iv) the right to request additional privacy protections for certain uses or disclosures of PHI about the individual; v) the right to request to receive communications of PHI from the plan by alternative means or at alternative locations; vi) the right to receive a notice of the covered entities' privacy practices; and vii) the right to receive a notice about certain reportable security breaches.

b. HIPAA Security Rule

The HIPAA Security Rule establishes national standards to protect individuals' electronic PHI created, received, used, or maintained by a covered entity. The Security Rule only applies to electronic PHI. It does not apply to non-electronic PHI or to electronic information that does not contain PHI. Like the Privacy Rule, the Security Rule applies directly to covered entities and, after February 18, 2010, most of the provisions apply directly to business associates. With limited exceptions, the Security Rule also applies indirectly, by plan amendment, to group health plan sponsors that receive electronic PHI from the plan for "plan administration" functions. The Security Rule also requires covered entities to implement and maintain policies and procedures, and maintain written records of all actions, activities, and assessments that are required to be documented. The Security Rule requires covered entities to meet four general security requirements:

- ensure the confidentiality, integrity, and availability of all electronic PHI that the entity creates, receives, maintains, or transmits;
- identify and protect against reasonably anticipated threats to the security or integrity of the information;
- protect against reasonably anticipated, impermissible uses or disclosures;
- ensure compliance by their workforce.

The Department of Health and Human Services (HHS) recognizes that covered entities range from the smallest provider to the largest, multi-state health plan. Therefore, the Security Rule is flexible and scalable to allow covered entities to analyze their own needs and implement solutions appropriate for their specific environments. What is appropriate for a particular covered entity will depend on the nature of the covered entity's business, as well as the covered entity's size and resources.

c. HIPAA Portability Rule

HIPAA's portability rules require group health plans to provide special enrollment rights to certain employees, dependents, and COBRA qualified beneficiaries in group health coverage in the following situations: i) loss of eligibility for group health coverage or health insurance coverage; ii) becoming eligible for state premium assistance subsidy; and iii) the acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption. While HIPAA previously provided for preexisting condition exclusions, new protections under the ACA now prohibit such exclusions for plan years beginning on or after January 1, 2014.

Additionally, a group health plan, or a health insurance issuer offering health insurance coverage in connection with a group health plan, is not allowed to establish eligibility rules that discriminate on the basis of a health factor. That said, a plan can provide different benefits to different groups of similarly situated employees or dependents, so long as the benefits are uniformly available to all similarly situated individuals. Any limitations or exclusions must apply uniformly to all similarly situated individuals and must not be directed at specific participants.

d. Enforcement

The HHS Office of Civil Rights (OCR) enforces HIPAA's Privacy and Security Rules by investigating complaints filed with it, investigating reports of security breaches, conducting compliance reviews, and providing education and outreach regarding the rules' requirements. OCR also works with the Department of Justice to refer possible criminal violations of HIPAA. In addition, state attorneys general may bring actions on behalf of residents of their states.

HHS may enter into a "resolution agreement" with a covered entity. A resolution agreement is a settlement agreement in which the covered entity agrees to perform certain obligations and provide reports to HHS, generally for a three-year period. During the period, HHS monitors the covered entity's compliance with its obligations. A resolution agreement may include the payment of a resolution amount. If the parties cannot reach a voluntary resolution, civil penalties may be imposed against a covered entity for noncompliance.

An important area of focus for many health plan sponsors is compliance with the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, and, more specifically, the audit and investigation risks arising from these.

HIPAA's non-discrimination rules prohibit discrimination in group health plan eligibility, benefits, and premiums based on specific health factors. Under HIPAA, individuals may not be denied eligibility or continued eligibility to enroll in a group health plan based on their health factors. In addition, an individual may not be charged more for coverage than any similarly situated individual based on any health factor.

2. HITECH Breach Notification

In 2009, HHS issued regulations requiring health care providers, health plans, and other entities covered by HIPAA to notify individuals when their health information is breached. These "breach notification" regulations implement provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act.

The regulations, developed by OCR, require healthcare providers and other HIPAA covered entities to promptly notify affected individuals of a breach, and immediately notify the HHS Secretary and the media in cases where a breach affects more than 500 individuals. Breaches affecting fewer than 500 individuals must be reported to the HHS Secretary on an annual basis. The regulations also require business associates of covered entities to notify the covered entity of breaches at or by the business associate.

3. Affordable Care Act and Mental Health Parity and Addiction Equity Act

An important area of focus for many health plan sponsors is compliance with the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA), and, more specifically, the audit and investigation risks arising from these. ACA and MHPAEA enforcement authority is allocated between the states, the federal government, and three federal agencies — the DOL, HHS, and the IRS.

The ACA requires that sponsors of group health plans modify their coverage to comply with various health insurance market reforms, which require plans to, for example, extend coverage to adult children until the age of 26 and eliminate annual and lifetime dollar limits and pre-existing condition exclusions. The application of these rules may differ, depending on whether the group health plan or insurance coverage is considered a "grandfathered" plan exempt from some — but not all — of the ACA's insurance market reforms. A grandfathered plan is a group health plan that existed on March 23, 2010 — the date the ACA was enacted — and has not had certain prohibited changes made to it.

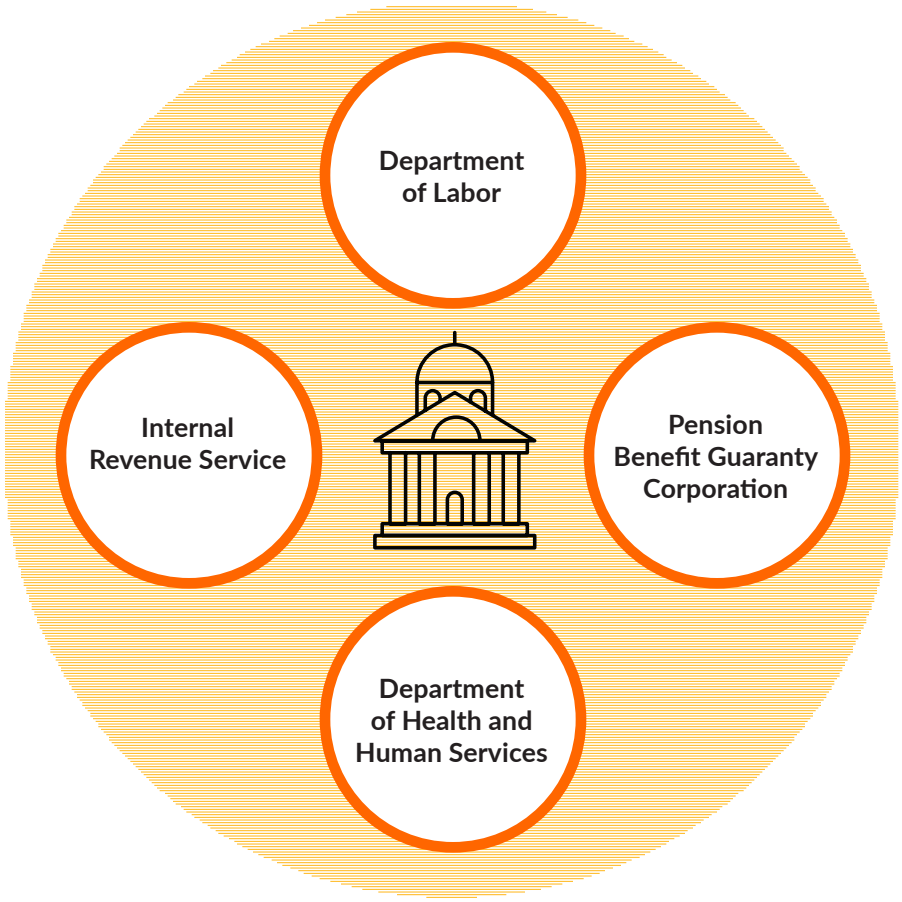
The ACA also imposes reporting requirements for multiemployer plans and employers participating in multiemployer plans. The Trustees of the multiemployer plan must perform "minimum essential coverage" reporting of information regarding each employee's (and spouse/dependent's) months of coverage in a self-insured multiemployer plan. Union employers are responsible for "employer mandate" reporting of offer of coverage information for its full-time employees.

MHPAEA prohibits group health plans that provide mental health/substance use benefits from applying "financial requirements" or "treatment limits" to those benefits that are more restrictive than the "predominant" financial requirements or treatment limits that apply to "substantially all" medical/surgical benefits. MHPAEA defines "financial requirements" to include deductibles, copayments, coinsurance, and out-of-pocket expenses; "treatment limitations" to include limits on the frequency of visits, number of visits, days of coverage, or other similar limits on the scope or duration of treatment; and the term "predominant" to mean the most common or frequent of such type of limit or requirement. MHPAEA also requires group health plans that provide mental health/substance use benefits to ensure that any processes, strategies, evidentiary standards, or other factors used in applying non-quantitative treatment limits (NQTL) to mental health/substance use benefits be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the same "classification." An NQTL is one that affects the scope or duration of benefits under the plan that is not expressed numerically. This requirement extends to medical management standards limiting benefits based on medical necessity or an exclusion for experimental/investigational treatments; prescription drug formulary design; standards for determining provider admission in a network, including reimbursement rates; determinations of usual and customary charges; refusal to pay for higher cost therapies until lower cost therapies are used; and conditioning benefits on completion of a course of treatment.

In addition, the Consolidated Appropriations Act, 2021 (the CAA) that was signed into law on December 27, 2020, amends ERISA, the Public Health Service Act, and the Code to include new provisions which require the DOL to request documents that demonstrate compliance with the MHPAEA NQTL requirements

from a minimum of 20 group health plans per year. The CAA provides that the DOL shall request that a group health plan submit the comparative analysis for plans that involve potential violations of MHPAEA or complaints regarding noncompliance with MHPAEA's NQTL rules and any other instances in which the DOL deem appropriate. Accordingly, plans and issuers must be prepared to submit the NQTL comparative analyses to the DOL upon request. The CAA further requires the DOL to submit to Congress, and make publicly available, a report that identifies each group health plan that is determined not in compliance. The IRS may also enforce violations by imposing an excise tax of $100 per day per individual affected by such noncompliance.

Government Agencies



XIII. Liability of Fiduciaries and Strategies for Avoiding It

A. Liability of Fiduciaries under ERISA

As discussed earlier, ERISA imposes strict standards on plan fiduciaries and these fiduciaries are subject to significant liability for failure to meet those standards. Under section 409 of ERISA, a fiduciary found to have violated ERISA is *personally liable* to the plan for losses resulting from that violation and may be required to "disgorge" (pay to the plan) any personal profit made on the violation. In addition, a breaching fiduciary may be removed and prohibited from serving as a fiduciary in the future. Individuals who serve as fiduciaries are particularly exposed because of ERISA's personal liability — *i.e.*, their personal assets are at risk.

Well-educated fiduciaries are more likely to make sound decisions.

Not only is a Trustee responsible for his or her own fiduciary decisions (and any resulting breaches of duty), he or she might also have liability for the fiduciary violations of others. Plans typically have multiple fiduciaries. One fiduciary may be held liable for the ERISA violation of another fiduciary if the first fiduciary (1) knowingly participates in, or knowingly undertakes to conceal the other fiduciary's act or omission, provided that he or she knows that the other party's act or omission is a fiduciary breach, (2) in committing his or her own fiduciary breach, allows the second fiduciary also to commit a breach — or (3) knows of the second fiduciary's breach, unless he or she makes a reasonable effort, under the circumstances, to remedy it.

Unlike the individual employees who serve as single-employer plan fiduciaries, multiemployer plan Trustees generally cannot look to their employers (or unions) or other entities for indemnification for these liabilities. Therefore, it is important to consider strategies to limit liability and/or to insure against risk.

B. Limiting Liability through Prudent Plan Management

1. Education

Well-educated fiduciaries are more likely to make sound decisions. Although the Trustees can retain experts to advise them on benefit plan issues, the Trustees remain responsible for the final decisions. Therefore, the Trustees should seek to educate themselves on plan management in general and on the significant individual issues that come before them. So long as appropriate and reasonable in amount, a plan may cover the costs of educating fiduciaries and plan staff. A formal policy can provide clear direction about who should get an education, how often education is needed, and what expenses are reasonable and payable from the plan's assets. A written policy provides legal and ethical protection for the Trustees, and the additional education helps the Trustees perform their ongoing plan duties.

2. Thoughtful, Informed Decision Making

Under ERISA's "prudent expert" standard, plan fiduciaries must act with the care, skill, prudence, and diligence that a reasonably prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of

like character and like aims. In practice, this requires that Trustees make thoughtful, informed decisions in their actions as fiduciaries.

A multiemployer plan's Trustees typically have several advisers. Depending on the plan, it may have numerous additional advisers and delegates that assist in carrying out the plan's operations. Due to the complex nature of these benefit plans, often the Trustees will need to use these experts' advice on the best course of action.

3. Documentation and Observance of Formalities

Documentation of the fiduciary decision-making process is essential to defending the Trustees' decisions, and Trustees' actions should be thoroughly documented so the Trustees can demonstrate that they satisfied their obligation to be a "prudent expert. "Trustee meetings, materials and minutes are an important part of the documentation of fiduciary decision-making. Whenever possible, fiduciary decisions should be made at Trustee meetings with the benefit of a written supporting analysis or added to the record at the next possible Trustee meeting. To the extent minutes leave certain issues open and indicate that the Trustees will revisit those issues at a subsequent meeting, failure to do so may invite scrutiny from the DOL or a court."

Because there are varying rules that apply to how long plan records should be retained, a general rule is to keep records for at least six years.

Because Trustee meetings are so important, the Trustees may wish to adopt a formal policy (1) identifying the persons who should attend meetings, (2) indicating whether the Trustees must attend in person, (3) describing the requirements for a quorum to conduct business and whether proxies or alternate Trustees will be recognized, and (4) describing the supporting materials that will be provided to the Trustees in advance of the meeting.

Meeting minutes should be kept for any action by the Trustees. When a question arises as to whether a Trustee decision was legal or appropriate, meeting minutes can be consulted to determine the details of and the rationale for the decision. The minutes should (1) reflect the date, time, and place the meeting was called to order, (2) state who was present for the meeting and whether there was a quorum, (3) reflect each topic covered at the meeting, (4) answer who, what, why, where, when, and how with regard to every topic discussed to establish that a thorough decision-making process was followed consistent with ERISA's fiduciary standard of prudence, (5) precisely reference the written materials supporting the Trustees' decision, and (6) state motions with completeness and clarity. Meeting minutes should not include the details of attorney advice (to preserve the attorney-client privilege) but should include the final decision after consulting with counsel. Prior meeting minutes should be adopted as a fair and accurate recording at the next meeting, after the Trustees have had the chance to review them.

In addition to supporting a prudent decision-making process, certain records are simply required by law to be retained. In general, the records required to be kept by the plan administrator are data that (1) substantiates the plan's organization and operation within applicable law, (2) relates to participants' plan benefits in accordance with the terms of the plan, and (3) is the basis for participating employers' tax deductions, if any, for contributions to the plan. Additionally, maintaining records can be beneficial to demonstrate that the plan and the Trustees have always complied with the applicable legal requirements, including the fiduciary duties under ERISA.

Under the Code and ERISA, plan records must include enough information for the IRS and the DOL to verify the accuracy of reported information. Because there are varying rules that apply to how long plan records should be retained, a general rule is to keep records for at least six years. However, records that relate to participants' benefits should be retained as long as there is any possibility that the records are relevant for determining entitlement to benefits under a plan. These calculations can be challenged long into the future if a plan goes insolvent and the PBGC starts to audit the calculations to determine what level of guaranteed benefits are applicable.

The record retention requirements for an employee benefit plan are extensive and complicated and Trustees should ensure that staff has the requisite education and resources to fully comply.

C. Insurance

A fidelity bond is required by law for every person who "handles" funds or other property of an employee benefit plan (a "plan official"). The bond protects the plan in the event the plan official causes a loss to the plan through fraudulent or dishonest acts. The bond must provide coverage in the amount of at least 10% of the money handled by the plan official in the preceding year, subject to a $1,000 minimum and $500,000 maximum, measured on a per-plan basis. In the case of a plan that holds employer securities (other than through a diversified pooled vehicle) the maximum bond amount is $1,000,000.

1. Personal Liability and Indemnification Issues

While multiemployer plans and their Trustees are exposed to significant liabilities, ERISA Section 409 is particularly concerning to plan fiduciaries, since it imposes *personal* liability on individuals who breach their fiduciary duties, thus putting the individual's personal assets at risk. To ensure this personal liability, ERISA's anti-exculpatory clause prohibits a plan from paying for or indemnifying a fiduciary for a breach of fiduciary duty.[1]

A DOL regulation explains that ERISA permits indemnification of a plan fiduciary by an *employer* whose employees are covered under the plan as long as the fiduciary remains liable for any loss caused by a breach of that fiduciary's duty. For multiemployer plan trustees, however, 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,

[1]ERISA § 410 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"

comprising representatives from both labor and management. As such, fiduciary liability insurance is the only available source of protection for the Trustee fiduciaries.

2. Fiduciary Liability Insurance

ERISA and the types of litigation that can ensue from it is complex. No one wants to be placed in the position of defending against a claim, but by recognizing the fiduciary exposures and purchasing fiduciary liability insurance, insureds may mitigate potential personal loss should they be subjected to such liability. This next section is designed to explain, in simple terms, the purpose and function of fiduciary liability insurance.

No one wants to be placed in the position of defending against a claim, but by recognizing the fiduciary exposures and purchasing fiduciary liability insurance, insureds may mitigate potential personal loss should they be subjected to such liability.

Put simply, a fiduciary liability insurance policy in the multiemployer arena is typically issued on behalf of the plan itself.[2] The policy is designed to protect insureds against claims alleging a breach of their fiduciary duties to the plan or alleging they committed an error in the administration of the plan.

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 and understand how a specific policy will respond to specific claims. Below are some of the more common policy definitions and provisions.

a. Who is an Insured?

A person or entity must be an insured as defined under the policy in order for coverage to apply. In the multiemployer space, the insured will typically be the plan, plan trustees, or plan employees, and a Board of Trustees or committee of such plan.

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 but who are not plan employees, are generally not insureds under the fiduciary liability insurance policy, even if they are considered to be fiduciaries under ERISA.[3]

b. What is a Claim?

Definition of a 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's administration or assets 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 the DOL or the PBGC of an investigation against an insured. Some carriers have expanded claims to include subpoenas or an investigation of Trustees who, when acting in their fiduciary capacity, are targeted by other enforcement units (such as the U.S. Department of Justice, the U.S. Securities and Exchange Commission, the U.S. Department of Health and Human Services, or an attorney general).

Some carriers also offer enhanced coverage that expands the definition of claim to include benefit claim denials as well as fact-finding investigations by the DOL or PBGC where there is no allegation of a wrongful act. Unlike the provisions relative to reporting a claim, the reporting of such denials and investigations is typically optional for the insured.

Finally, some policies provide, under a separate insuring agreement, insurance to cover fees and expenses incurred by insured Trustees or employees in responding to a request for an interview by certain governmental regulatory authorities. This coverage may protect individual fiduciaries from paying out-of-pocket legal fees incurred in responding to interview requests.

A common misconception is that fiduciary liability insurance can be used to restore losses to an employee benefit plan when there is a discovery that an error has been made. 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), 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 required for all individuals handling plan assets. However, some carriers in the multiemployer space have begun to offer "first-party" coverage recognized in the marketplace as "benefit overpayment" insurance. Where an insured has erroneously overpaid benefits and made reasonable efforts to recover the benefit overpayment to no avail, the policy provides coverage if such overpayment is due miscalculation of plan benefits due to the insured's negligence. Such enhanced coverage can be meaningful given that ERISA Section 404(a) requires plan trustees and administrators to fix pension calculation mistakes in order to comply with plan documents and make the plan whole. In a plan where there is no sponsor to make the plan whole for these overpayments, this coverage can be quite valuable. This type of coverage is often subject to a sub-limit — a lower

[2]ERISA § 410 permits plans to purchase fiduciary liability insurance.
[3]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.

limit of liability applicable to this type of coverage as compared to the overall limit of liability for the policy.

Coverage for Voluntary Correction Programs

Many carriers offer coverage for costs associated with an insured's voluntary effort to bring its plan into compliance with certain requirements of ERISA and/or the Code 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 Code 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 IRS. See Rev. Proc. 2021-30. 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. See 67 Fed. Reg. 15052, 15058 (March 28, 2002). 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 sub-limit, 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 sub-limit 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).

c. 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, most fiduciary liability insurance policies cover, at a minimum, breaches of fiduciary duties and errors in the administration of the plan. More recently, some carriers have modified wrongful act to also include acts, errors, or omissions by an insured in their settlor capacity with respect to establishing, amending, terminating, or funding a plan, or merging or consolidating with another trust or plan.

Depending on the nature of the breach and how many beneficiaries are impacted, a claim of breach of fiduciary duty can result in significant exposure to the plan and other insureds, and consequently, significant loss payments under fiduciary liability insurance policies. Examples of such breach of fiduciary duty claims include misinterpreting plan documents, administering 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 plan administration. In this context, administration commonly includes handling plan paperwork, providing interpretations with respect to any plan, or giving advice to participants and beneficiaries regarding the plan. Such claims are common.

d. What is Loss?

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. Loss is often defined to mean amounts that an insured becomes legally obligated to pay as a result of a claim. Such amounts may include compensatory damages, punitive damages (where insurable by law), judgments, settlements, claimant attorney's fees awarded by a court pursuant to ERISA Section 502 (g), as well as defense costs. It is important to note, however, that there are a number of costs that may not generally be considered loss as defined in the policy, such as costs to comply with an order for non-monetary relief. Fiduciary liability insurance policies also typically do not cover benefits due, including settlements or awards in an amount equal to such benefits under a plan. Thus, it is important to understand that such policy provisions may be used to preclude coverage for indemnity payments that constitute benefits that are payable to participants or their beneficiaries under the terms of a plan (or that would have been payable under the terms of the plan had it complied with ERISA).

Equally important to understand is that even when the relief sought is not a loss or benefits due, the insured may still have coverage for defense costs. For example, if a retiree sues a pension plan for erroneously calculating their underpayment of a lump sum distribution, fiduciary liability insurance may 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).

Taxes, fines, and penalties typically do not constitute covered loss in fiduciary liability insurance policies. However, many carriers provide coverage for penalties under ERISA Section 502(c), (i) and (l), as well as certain penalties under HIPAA; the HITECH Act; the ACA; Section 203 of the Bipartisan Budget Act of 2013; and excise taxes imposed under Section 4975 of the Code. Coverage for such penalties and taxes is typically subject to a sub-limit.

e. What are the Reporting and Defense Provisions?

Sometimes insureds are hesitant in reporting claims because they do not believe they have any liability for loss or because they are concerned about rising insurance premiums, or even perhaps because they think that loss can be recovered through other means. However, most fiduciary liability insurance policies require that claims be reported "as soon as practicable" as a

condition to obtaining coverage; failure to do so may result in a denial of coverage. Laws vary widely about when and how late notice applies to coverage. Thus, it is critical that insurance policy provisions be reviewed carefully and that insureds understand not just their reporting obligations but also how to identify a reportable event. Untimely reporting of claims puts the fiduciary in a very precarious position of risking his or her own personal assets.

Most 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.

Some insurance carriers will not unreasonably withhold consent when insureds want to choose their own Fund Counsel as defense counsel for low severity matters. Meanwhile, 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.

While the duty-to-defend provision is sometimes met with resistance, insureds should consider the benefits to be gained by this provision. The right and duty-to-defend provision includes the insurance carrier's right to select defense counsel. Carriers who regularly provide the defense of fiduciary liability claims are familiar with experienced ERISA defense counsel and can play a pivotal role in providing insureds with appropriate counsel to mount the best defense possible. These experienced ERISA defense counsel have familiarity with relevant law, which is constantly evolving, and are often in the best position to obtain favorable results for the insured.

Moreover, due to the volume of the claims they handle, fiduciary liability insurance carriers commonly negotiate lower rates with defense firms. Thus, insureds receive the benefit of being defended by accomplished ERISA defense counsel at reduced rates, preserving available policy limits for any covered loss that may arise either in settlement or judgment. Fiduciary liability carriers also typically have litigation management guidelines in place that help to ensure that the costs of defense are reasonable and necessary. These defense provisions are important because fiduciary liability policies typically pay for defense costs 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.

Another benefit of the duty-to-defend provision is the management of discovery costs, which can be significant. In today's electronic age, a large portion of defense costs may comprise electronic discovery efforts, such as harvesting information from obsolete databases, gathering years' worth of email traffic, and cataloging all discovery information. Fiduciary liability carriers continue to create solutions to deal with this electronic discovery in an efficient, cost-effective manner, such as negotiating vendor agreements with third-party providers to provide these services at reduced rates.

3. Fidelity Bond

Unlike fiduciary liability insurance, a fiduciary dishonesty policy (also referred to as an ERISA bond or fidelity bond) is required by ERISA for all multiemployer benefit plans unless they are "unfunded plans" as defined by the Department of Labor or meet certain exemption requirements. The bond is written in the name of the plan or plans to be bonded against fraudulent or dishonest acts of its plan officials. It is important to note that while many bonds are similar, the DOL does not require a specific bond form, and forms may vary from carrier to carrier. It is the responsibility of the plan's fiduciaries to ensure that their bond meets the requirements under ERISA.

Insureds are wise to consult with their insurance agent or broker for more information about obtaining a policy that is compliant with ERISA. The DOL also has an excellent resource to help fiduciaries understand the bonding requirements imposed by ERISA. Field Assistance Bulletin No. 2008-04 published by the U.S. Department of Labor[4] provides detailed guidance regarding ERISA bonding requirements. Some highlights of the bulletin follow:

a. Who must be bonded?

All plan trustees and employees who "handle" plan funds or other property of an employee benefit plan are considered "plan officials" who must be bonded. This includes employees of the plan, as well as those working for outside service professionals that act as a plan official, such as investment managers, investment advisors, and third-party administrators. Outside professionals can purchase their own bond or be included in the bond procured by the plan. Regardless of who pays for the bond, section 412 of ERISA requires that if a service provider is required to be bonded, the plan fiduciaries 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 the service provider is properly bonded.

b. What does it mean to "handle" funds or other property?

The term "handling" means more than actual *physical* contact with plan assets. A person "handles" funds or other property of a plan whenever his duties or activities create a risk that such funds or other property could be lost in the event of fraud or dishonesty on the part of that person, whether acting alone or in collusion with others. General criteria for determining "handling" include, but are not limited to:

- physical contact (or power to exercise physical contact or control) with cash, checks, or similar property
- power to transfer funds or other property from the plan to oneself or to a third party or to negotiate such property for value (*e.g.*, mortgages, title to land and buildings, or securities)
- disbursement authority or authority to direct disbursement
- authority to sign checks or other negotiable instruments
- supervisory or decision-making responsibility over activities that require bonding

[4] https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2008-04

c. What bond amount is required?

- The value of the bond is fixed at the beginning of the plan's reporting year. It must provide coverage in the amount of at least 10% of the money handled by the plan official in the preceding year, subject to a $1,000 minimum. The maximum bond amount that can be required under ERISA with respect to any one plan official is $500,000.[5]
- In the event that the bond covers more than one plan, the bond must be written in an amount such that each plan can recover loss as if they were bonded separately. This may require a bond in excess of $500,000, depending on the amount handled by each plan official.

d. What losses must be covered?

- The bond must protect the plan in the event the plan official causes a loss to the plan through fraudulent or dishonest acts, such as larceny, theft, embezzlement, forgery, and other acts where losses result from any act or arrangement prohibited by 18 U.S.C. § 1954.
- The bond must allow for recovery even if the person committing the act does not personally gain from his other actions.
- The bond may not contain a deductible or other provision that transfers risk from the plan.

e. Who can provide an ERISA bond?

- Bonds must be underwritten by an admitted U.S. carrier, which has met the Department of the Treasury's requirements for stability and size,[6] or certain underwriters at Lloyds of London, which have otherwise complied with the Department of the Treasury's requirements set forth in 29 C.F.R. § 2580.412–25. Bonds or crime policies which include ERISA language that is written with surplus lines or foreign underwriting companies do not meet these guidelines.

As methods of fraud evolve and expand, plans are increasingly susceptible to loss caused by outsiders who are not plan officials.

As methods of fraud evolve and expand, plans are increasingly susceptible to loss caused by outsiders who are not plan officials. Bonds can be extended, and nothing in the law precludes providing additional coverage for losses outside the scope of ERISA or bonds in amounts in excess of the statutory requirement as long as the bond remains compliant with the provisions otherwise provided under section 412 of ERISA. Consider these additional areas of exposure which are not addressed by the ERISA bonding requirement:

- forgery of a plan's financial instrument (such as a check or draft)
- computer fraud, or the risk associated with the hacking of the plan's computer network which leads to the loss of plan assets
- funds transfer fraud, wherein a fraudster tricks the plan's bank into transferring assets away from the plan without the plan's knowledge or consent
- social engineering fraud, or the risk of imposters pretending to be Trustees, vendors, or plan participants tricking the plan's employees into transferring funds with their knowledge and consent, believing the request was genuine
- expenses to hire accountants to investigate and quantify the plan's loss
- recovery expenses to initiate recovery actions against the wrongdoer in an effort to recuperate the plan's lost funds

While proper compliance with the statutory requirement imposed by ERISA cannot be understated, it is worth mentioning that even the maximum limit required to be purchased can be dwarfed by the size of potentially fraudulent or dishonest acts of plan officials. Fraudulent activity can (and often does) run undetected for years or even decades before being uncovered by Trustees. Often by the time it is discovered, the perpetrator has embezzled millions of dollars and the statutory bond is woefully inadequate to reimburse it and its participants. The ERISA bond, as outlined by the statute, is the minimum needed to be compliant, but as the methods and abilities of fraudsters expand, fiduciaries should evaluate these new perils and the solutions to ensure adequate insurance protection.

4. The Role of Cyber Insurance for Employee Benefit Plans

In today's connected environment, prudent Trustees are taking note of the growing exposure to loss caused by cyber incidents. An evolving consensus among plan Trustees is that the question is not whether a plan will suffer a data breach, but when. Not surprisingly, risk mitigation and protection is becoming a top agenda item at Trustee meetings with a goal of ensuring that an effective cybersecurity program is established to protect Trustees, the plan, and its participants and beneficiaries.

a. Exposure for Pension and Welfare Plans

Participant and beneficiary personal data stored in pension and welfare plans, including birthdates, addresses, social security numbers, and health information, make them a prime target for cyber-attacks as villains place significant value on personally identifiable information. The multitude of parties that readily access data as part of the benefit plan administration process, including third-party service providers, data storage companies, IT providers, as well as participants and beneficiaries, makes the possibility for cyber incidents even greater and containment of the exposure extremely difficult.

Cyber threats add a whole new level of complexity, and Trustees need to be prudent in their planning to respond to potential cyber scenarios. For example:

- What happens when a training director of a joint apprenticeship training committee (JATC) has a briefcase containing student forms stolen and these forms contain social security numbers, names, and birthdates? How should the JATC handle this scenario?

[5]This value is increased to $1 million for those plans which contain employer securities. In the context of multiemployer plans, this requirement is generally not applicable.
[6]For a list of the Department of the Treasury's Listing of Certified companies, go to https://www.fiscal.treasury.gov/fsreports/ref/suretyBnd/c570_a-z.htm

- What if a health and welfare fund's professional administrator's system is hacked and participant and beneficiary personal data is accessed? What if the hacker freezes the fund's computer systems and data can no longer be accessed to produce documents necessary to adhere to reporting requirements? How would Trustees respond?
- If a pension treasurer accidentally opens an email message carrying malicious software that encrypts the funds' computer network, are the Trustees prepared to regain access to critical data? How quickly can this be accomplished? Are they prepared to coordinate and pay for the services of the various vendors that may need to be engaged?
- What if the pension fund director loses a laptop containing participant and beneficiary personal data? What are the prudent next steps?
- What if the plan becomes the victim of a spoofing attack whereby a cyber villain contacts the fund's director impersonating the email address of its TPA and the director transmits personal information to this bad actor? What would the costs be in order to deal with this problem?
- What if, unrelated to the plan's operations, an individual participant's email address or personal information is compromised, and a cyber villain, using that compromised information, seeks a distribution of the participant's benefits? What procedures are in place to verify the identity of the participant? And what efforts did the plan make to educate participants about this risk?

These are just a small sampling of issues that plan Trustees should take seriously. In April 2021, DOL released new guidance for plan sponsors, plan fiduciaries, recordkeepers, and plan participants on best practices for maintaining cybersecurity. Among other topics, this guidance sets forth due diligence practices for hiring and monitoring service providers, advises plan fiduciaries to be on the lookout for contract provisions that would limit a service provider's responsibility for security breaches, and encourages the use of a formal and documented cybersecurity program, annual risk assessments and training, and encryption of data. While some questions remain regarding whether cybersecurity is a fiduciary responsibility and whether state cyber laws are preempted by ERISA, present day benefit plan exposures to cyber incidents are real and have already resulted in several lawsuits against plan fiduciaries and service providers.

Cyber insurance is a very useful tool for protecting benefit plans and rounding out the design of holistic, cost-effective strategies.

b. Insurance Coverage for Benefit Plans

Technical expertise and/or limited resources are often significant challenges for plan fiduciaries as they try to make sense of the complexities around cyber risk. Cyber insurance is a very useful tool for protecting benefit plans and rounding out the design of holistic, cost-effective security strategies.

Cyber insurance coverage can vary dramatically from one policy to another; thus, it is important that Trustees consult with advisors that have expertise in evaluating policy language. Moreover, it is critical that they select reputable and financially strong insurance carriers with significant experience and expertise in cyber claim handling and the ability to facilitate easy access to third-parties that can provide services needed to respond to a cyber incident or a potential incident.

When cyber breaches occur, direct costs (also often referred to as "first-party" costs) to the plan will be incurred, and Trustees will need the services of a variety of vendors, such as a third-party computer forensics firm to determine the cause and scope of the matter, a public relations or crisis communications firm to help mitigate financial and reputational harm to the plan, as well as an attorney to assess contracts that may be in place with other entities who are obligated to provide indemnification. Additionally, the plan will likely incur other expenses, such as legal fees associated with determining the applicability of privacy laws, drafting notification letters, reporting to regulatory authorities, retaining a call center and other related services for notification as required by law, and providing credit monitoring. Other costs that the plan could incur include the actual expenses for notification and credit monitoring for impacted individuals, fraud consultation, and other reasonable service costs.

Generally speaking, cyber insurance, subject to the terms and conditions of the policy, would cover the plan for the aforementioned costs. Notably, these costs are generally not covered in other policies, such as directors and officers liability, fiduciary liability, fidelity bonds, commercial general liability, etc.

A cyber insurance policy can also be further tailored to cover reasonable costs to recover lost digital data, reimburse network extortion expenses, cover business interruption losses, as well as defense expenses resulting from a claim against the plan, or its Trustees caused by a cyber or even media incident depending on the breadth of coverage purchased. It is critical that Trustees review cyber insurance policies in order to understand how exclusionary language may apply and to ensure that the coverage is tailored to meet the plan's unique coverage needs.

Equally important in the cyber space, Trustees should evaluate what an insurer can offer beyond risk transfer. Carriers can offer meaningful loss mitigation services and post-incident services, including access to the tools and resources needed to address and gauge key areas of cyber security risks before an event occurs, as well as incident response services to help limit exposure to a loss when an event occurs. More sophisticated carriers also offer access to online cyber education as well as access to a preferred panel of pre-qualified cyber risk service providers often at preferred rates.

XIV. Conclusion

Multiemployer plan Trustees need to be proactive to insulate themselves from risk in an ever-changing legal environment. Well-designed and well-administered benefit plans are an important foundation for limiting litigation exposure. In addition, proper insurance is vital to comprehensive risk management and to protect plans and Trustees.

XV. About the Author

Lars C. Golumbic

Lars is a Principal at Groom Law Group, Chartered, and Chair of Groom's litigation practice group. Lars is a nationally recognized ERISA litigator, and he is listed by *Chambers USA*, *The Legal 500*, *Best Lawyers*, *and Super Lawyer*s as one of the top ERISA litigators in the country.

Lars's national ERISA litigation practice focuses on fiduciary-based claims, including claims against trustees and other fiduciaries to multiemployer plans. Lars also represents and defends plan trustees, fiduciaries, and service providers in investigations opened by the DOL and in enforcement actions instituted by the federal agency. Lars has appeared in dozens of federal courts across the country as part of his active ERISA litigation practice.

Appendix A

The tasks and responsibilities involved in administering a plan and managing its assets are extensive. Some typical defined benefit plan duties are listed here.

I. Enrollments and Contributions

Duty or Function	Named Fiduciary	Responsible Department/Person	Reports and Other Instructions
Identify eligible employees and distribute enrollment materials.			
Effect enrollments and new voluntary contribution elections, and maintain records.			
Receive participant contributions and transfer to the appropriate trust or insurer (by payroll, check, or retiree deduction).			
Transfer employer payments to the appropriate trust or insurer.			
Return mistaken contributions to employer and employees.			

II. Benefit Claim Processing

Duty or Function	Named Fiduciary	Responsible Department/Person	Reports and Other Instructions
Maintain/monitor benefit claims procedures.			
Review and determine initial benefit claims and pay claims.			
Decide final claims appeals.			
Receive and qualify QDROs.			
Identify and locate “lost participant” and “redeposit” benefit payments.			
Identify and collect overpayments.			
Receive and maintain beneficiary designations.			
Compliance with IRS distribution rules, including minimum distributions and notices, restrictions on involuntary payments.			
Implement tax withholdings.			

III. Plan Administration

Duty or Function	Named Fiduciary	Responsible Department/Person	Reports and Other Instructions
Select administrative service providers and negotiate terms of contracts.			
Monitor fees and performance of service providers. Update contract as required.			
Approve payment of administrative expenses from plan.			
Administer § 420 transfers.			
Maintain fiduciary insurance.			
Maintain fiduciary bond.			
Maintain participant records, including: • employee compensation • benefit accrual and vesting			
Establish plan level record retention policy and implement with providers.			
Establish disaster recovery policy and implement with providers.			
Establish confidentiality policy and implement with providers.			

IV. Tax Qualification and Compliance

Duty or Function	Named Fiduciary	Responsible Department/Person	Reports and Other Instructions
Maintain plan, trust, and insurance documents current and consistent with tax rules, including determination letter requests.			
Operational compliance with IRS and plan requirements, including: • Benefit limitations Code § 415 • Minimum vesting Code §§ 401(a)(7), 411 • Minimum funding Code § 412 • Minimum coverage Code § 410 • Compensation limits Code § 401(a)(17)			

V. Reporting and Disclosure

Duty or Function	Named Fiduciary	Responsible Department/Person	Reports and Other Instructions
Prepare and file annual Form 5500 and audit of financial statements.			
Engage plan auditor.			
Engage plan actuary.			
Coordinate tax reporting, including Forms 1099.			
Prepare and distribute participant disclosure, including: • summary plan description (including SMMs) • summary annual report ("SAR") • enrollment, retirement, termination of employment kits • Section 204(h) notices • VRU/Intranet scripts • other employer-provided disclosure materials, including newsletter articles, employee brochures, and statements			
Respond to participant requests for information.			

VI. Financial Matters: Funding and Investment

Duty or Function	Named Fiduciary	Responsible Department/Person	Reports and Other Instructions
Establish funding policy.			
Select type of funding vehicles for the Plan, e.g., trust and insurance			
Establish investment policy, including asset allocation, proxy voting policy, soft dollars, and directed brokerage.			
Monitor overall Plan compliance with investment policy and periodically review asset allocation.			
Select investment managers, insurers, or investment vehicles (e.g., separate account) and negotiate terms.			
Monitor performance of investment managers and/or insurance contracts used for investment.			
Monitor ERISA compliance of investment managers.			
Approve payment of investment and trust related fees from Plan assets.			
Select and monitor trustee(s).			
Manage plan assets directly.			
Maintain plan-level financial records.			
Monitor/reconcile amounts distributed from plan.			

VII. Mergers, Acquisitions, and Divestitures Affecting the Plan

Duty or Function	Named Fiduciary	Responsible Department/Person	Reports and Other Instructions
Review transaction documents and determine Plan administrative requirements.			
Send notices to affected participants.			
Supervise related financial transactions.			

Notes

www.chubb.com/us/fiduciaryliability

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