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Working with Plan Vendors: Designing and Understanding a Plan's Service Agreement

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Recently, the stakeholders in the US benefit plan industry (Congress, the regulating agencies, employers, participants, consultants, attorneys, and other professionals) have focused a great deal of attention on whether participants in participant-directed 401(k) plans have been charged excessive fees. In December 2007, the Department of Labor (DOL) issued proposed regulations that (if finalized) will impose new levels of detail and documentation on existing disclosure obligations for certain types of plan service providers, and place both fiduciaries and service providers at increased risk of liability if they fail to meet the new standards. In the controversy over the amount and nature of plan fees, it is easy to lose sight of the fact that plan expenses, while an important consideration, are only one aspect of a benefit plan's relationship with plan vendors.

Plan sponsors and fiduciaries (each, a "plan representative") selecting new vendors or reviewing the performance of existing vendors need to look at the entire package of services the vendor offers (and what services the vendor does not offer), the quality of those services, the advantages and disadvantages of having those services available at the proposed cost, and the vendor's role in the overall

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administration of the plan, as well as at the specifics of the vendor's compensation arrangements. Nonetheless, despite the importance of this type of review, plan representatives, especially those overseeing small plans, may simply sign a vendor's standard service agreement without ever reviewing it carefully or seeking expert advice. The proposed regulations provide an incentive to change this practice with respect to covered vendors, and the DOL hopes the new rules will make it easier for plan representatives to obtain accurate and understandable disclosures about plan fees and services. However, regulatory compliance is only one reason to prepare plan service contracts with care.

Plan contracts can involve hundreds of thousands, millions, or even billions in assets, and a vendor's performance can have a huge impact on employee satisfaction with an employer's benefit programs. Thus, plan contracts deserve the same care and attention as the sponsoring employer's business relationships with important vendors and customers. Furthermore, a well-drafted and well-understood plan contract is not just an important tool in preventing errors and breaches of fiduciary duty from occurring; it is often the plan representative's first (or even only) line of defense against liability for vendor errors or malfeasance.

THE VENDOR RELATIONSHIP

The Employee Retirement Income Security Act of 1974 (ERISA), as amended, is concerned with regulating the relationship between plan participants and beneficiaries, on the one hand, and plan sponsors and fiduciaries, on the other. It says very little about relationships between fiduciaries, aside from ERISA Section 405's provisions protecting an innocent fiduciary against liability for the breaches of another fiduciary, and nothing at all about the relationship between fiduciaries and non-fiduciary vendors aside from the prohibited transaction rules.[1] Participants and courts are focusing ever-sharper eyes on employers' and individual fiduciaries' performance of their duties and oversight of those to whom they delegate those duties, and courts have disagreed about the scope of plan fiduciaries' remedies against each other[2] and against non-fiduciaries.[3] Thus, as noted above, a well-drafted service agreement is an essential protection.

Furthermore, a well-drafted, detailed service agreement is important to *both* sides of the relationship, and it is in the vendor's interest from a customer-relations point of view to insist that the client review the agreement in detail, with the assistance of appropriate experts. A vendor with well-defined responsibilities may have a greater risk of liability in the event of a breach, but business realities encourage most reputation-conscious vendors to protect their

customer relationships by taking responsibility for clear errors in any event. While responsible plan representatives do not contract with vendors who do poor work as a general rule, plan representatives understand that some mistakes and misunderstandings are inevitable and value vendors who provide quality service overall and stand behind their work when accidents happen. A vendor with vaguely defined responsibilities or without a clear indemnity clause in its contract may be able to fend off legal liability for its mistakes but is likely to lose the immediate client and endanger the reputation on which it relies to keep other existing clients and win new business. Accordingly, the vendor has much to gain and little to lose by cooperating with the plan representative to prepare a mutually satisfactory service agreement.

DESIGNING A SERVICE AGREEMENT

Most vendors, understandably, prefer to use their standard service agreements. Depending on the size of the plan and the importance of the client relationship to the vendor, the plan representative may have the leverage to insist on clarifying revisions, special terms, or even the use of the plan's standard agreement or standard language for certain concepts. However, even plan representatives who consider it unlikely that they will be able to make significant changes to the standard agreement should invest the time and money to have the agreement carefully reviewed by counsel and by an employee who has experience in contracting and is familiar with the plan's needs and obligations. Most vendors contemplating a long-term relationship with a plan are willing to address reasonable concerns in one fashion or another. If a vendor is not, the plan representative should consider re-opening the search process, since a vendor who is inflexible at the start of the relationship probably will not be a desirable partner in ongoing plan administration.

Setting the Stage

If the plan representative is conducting a formal Request for Proposal (RFP) process, the RFP should require that vendors' bids include a copy of the vendor's standard service agreement and detail the extent to which the vendor is willing to make revisions to that agreement. As part of the RFP process, the plan representative should review the standard agreements it receives and identify changes that the plan will request if it selects that vendor. The plan representative can then make specific inquiries of the vendors involved, and find out whether the vendor would be willing to accede to the plan's requests. That way, the plan representative can identify deal-breaker issues while all the vendors are still at the table.

What to Look For

A well-drafted service agreement is a valuable tool to prevent liability from arising in the first place, as well as a shield to deflect liability from the plan representative to the vendor if the vendor's conduct caused the problem (and vice versa). Setting forth which party has which responsibilities with the requisite level of detail helps ensure those responsibilities are met, preventing errors which might give rise to claims. The DOL's proposed regulations will require documentation of the agreed services in a number of circumstances, and it is in any event prudent to insist on this documentation. For example, if a plan representative believes that a vendor is monitoring whether a participant is entitled to a distribution and simply sends in distribution forms without reviewing to be sure the request is permissible, but the vendor believes that it can pay at the plan representative's direction without conducting its own review, the parties are likely to learn about their misunderstanding the hard way and may find the error expensive to fix. Service agreements also should set forth the rights and responsibilities of the parties if a claim does arise.

A service agreement, therefore, should meet the following standards:

- The vendor should represent and warrant that it is competent to render the services required under the agreement. The agreement should contain any representations and covenants necessary to document the vendor's competence and ensure that any prerequisites continue to be met. For example, an investment management agreement should require the investment manager to represent that it meets ERISA's standards for an investment manager and will continue to do so on each day that the agreement is in effect. The plan or plan representative should represent and warrant that any requirements imposed by the vendor have been satisfied. Each party should represent and warrant that the agreement has been duly authorized under that party's internal governance process.

- The service agreement should include or refer to a detailed, written list of the responsibilities assumed by the vendor and the obligations imposed upon the plan and the employer. For example, if the vendor is required to prepare a signature-ready Form 5500 but needs information from the employer to do so, the agreement should document both the requirement that the vendor prepare the Form 5500 and the type and timing of the information the employer must provide.

- The agreement should delineate the standard of care applicable to the vendor. If the vendor is assuming a fiduciary role, the agreement should so state and should require the vendor to perform its duties in accordance with ERISA, the Tax Code, and other applicable law and "with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims."[4] In the case of a non-fiduciary, the agreement should state that the vendor is not assuming a fiduciary role and should specify an appropriate standard of care.

- The service agreement most likely will contain an indemnity clause from the plan, plan sponsor, and/or plan fiduciaries in favor of the vendor. This indemnity clause should be reviewed carefully to ensure that it does not relieve the vendor of responsibility for the vendor's obligations under the agreement, and to ascertain that it is consistent with the vendor's standard of care and any fiduciary obligations the vendor has assumed. If the plan is responsible for providing any indemnity, the indemnity clause needs to be reviewed under the standards of Department of Labor Advisory Opinion 2002-08A (August 20, 2002)[5] and ERISA Section 410.[6]

- The plan representative should insist that the agreement contain an indemnity clause for the protection of the plan and the plan representative. If appropriate to the services to be performed, the agreement should also include a specification as to whether the vendor needs to obtain or maintain its own fidelity bond coverage, fiduciary liability insurance, and/or non-fiduciary errors and omissions insurance,[7] and in what amounts. The agreement should specify who will pay for this coverage. In this regard, it is important for the parties to bear in mind that under ERISA Section 410, the plan cannot pay for fiduciary liability insurance unless the insurance provides for recourse against the breaching fiduciary.

- The service agreement should allow for termination of the vendor without cause within a reasonable period of time, taking into account the services to be provided and any reasonable additional protections in the event of negligence, misconduct, or breach of the agreement by the vendor, the plan, or the plan representative. The DOL regulations require that any charges specified for early termination be reasonable under the circumstances and be designed to

reimburse the vendor for legitimate costs connected to the early termination. Early termination penalties and reimbursement clauses that do not require mitigation of damages are not permissible.[8]

— The termination clause should provide appropriate protections for the plan representative and the plan in the event of termination by either party, such as an agreement for reasonable transition assistance and the cost for such assistance (which may vary depending on whether termination was for cause), return of records, appropriate advance notice taking into account the services performed, adjustment of fees, and so forth.

- The agreement should include any additional disclosures or provisions required under ERISA or other applicable law, or under the terms of the plan. For example, an agreement with an investment manager must acknowledge the investment manager's fiduciary status in writing, and a business associate agreement for a plan subject to the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) must satisfy the requirements for business associate agreements.

- The agreement should contain appropriate protections for confidential records, addressing both access to the records (during the life of the agreement and upon termination) and proper data security.

- The agreement should include a complete and accurate description of the fees to be paid and designation of the person(s) responsible for paying the fees. With fees receiving so much media and regulatory attention, this aspect of the service agreement is more important than ever. Once the DOL finalizes its proposed regulations, disclosures connected to covered contracts will need to meet the regulatory standards. In the meantime, the DOL's Web site (*http://www.dol.gov/ebsa/*) offers disclosure forms that can serve as a helpful guideline.

How to Review

There are three main questions in the review of service agreements. The first question asks whether the agreement sets forth a legally permissible relationship and service structure. For example, under ERISA Section 405, a vendor that is not an investment manager, trustee, or named fiduciary cannot be given responsibility for plan investment

decisions, although it can be engaged to provide advice to an investment manager, trustee, or named fiduciary that understands that it is retaining the ultimate responsibility. The second question asks whether the terms set forth in the agreement are the terms that the plan representative expects, based on the vendor proposal and negotiations prior to the production of the proposed service agreement. The third question asks whether the agreement sets everything forth with the requisite clarity, so that both parties are comfortable that they understand their respective responsibilities and have recourse in the event of liability caused by the other party's conduct.

The second question must be answered by the plan representative who negotiated the terms of the vendor-client relationship that the service agreement seeks to reflect. However, that plan representative may need the assistance of counsel, the employer's purchasing department, or others with respect to the first and third questions. Large employers may have an in-house benefits staff devoted to overseeing benefit plan contracting and operations, which can fulfill these functions with minimal outside assistance. A small employer may address its benefit plan contracting needs infrequently and need assistance not just with memorializing the terms of the agreement, but with assessing vendors' proposals and identifying market-comparable terms in the first place.

Regardless of the extent to which outside assistance is necessary or helpful, the plan representative entering into the agreement must be sure it understands the agreement, that the agreement is accurate, and that it obtains approval for the agreement using the employer's and/or plan's proper governance process. For example, if the employer's Retirement Committee is the named fiduciary and administrator of the company's 401(k) plan, and the 401(k) plan is hiring a new recordkeeper to administer daily plan operations, the Retirement Committee should meet and review the service agreement in detail, and document its approval of the final version.

Plan fiduciaries must be able to demonstrate that they acted prudently when they assented to the service agreement, in keeping with the course of action that would have been taken by a prudent person familiar with such matters, and that their decision to approve the agreement was in the best interests of plan participants and beneficiaries, as required by ERISA Section 404. Without contemporary documentation to present to the plan's auditor, a government auditor, or a complaining participant, such proof will be difficult. Proper documentation of the review and approval process is especially important if the plan will be a party to and/or paying for the service agreement.

CLAIMS TO CONSIDER

When hiring a vendor, the plan representative should consider the types of issues that are likely to arise in the context of the particular

service relationship. That way, the plan representative knows the potential liabilities against which the service agreement should provide protection, or with respect to which the service agreement should allocate responsibility. The agreement's list of services to be provided, fee structure, and indemnity clauses then can be drafted accordingly.

Generally, it is appropriate for the parties to agree to a reciprocal indemnity arrangement, without dollar limits or other caps, under which both parties take responsibility for their own mistakes and the costs associated with defending related claims, but residual liability for claims not arising from vendor errors or misconduct remains with the employer, the plan, and/or the plan fiduciaries. The indemnity clause may also require the losing party to bear the winner's costs if one party brings an action against the other. A plan representative should consider the impact of an agreement's indemnity clause on its ability to seek recourse before entering into a contract and also should take this type of liability into account when deciding whether to bring suit. Ultimately, the nature of a particular agreement's indemnity clause will depend on the services to be provided, the relative responsibilities and expertise of the parties, the bargaining power of the parties, and other factors.

The discussion below assumes that the plan in question has been designed in compliance with applicable laws and is in general administered in good faith and with reasonable care. Accordingly, the discussion does not focus on claims relating to design decisions (such as cash balance plan age discrimination or anti-backloading claims) or on criminal liability. However, even plans that have been competently administered by qualified staff and vendors face the risk of liability arising from circumstances such as errors in plan administration or document preparation; poor investment performance; miscommunication between employer representatives and plan participant(s), between the plan's agents or fiduciaries and plan participant(s), or among the plan fiduciaries and agents themselves; participant misunderstandings; or honest disagreement as to the proper interpretation of the plan or applicable law. In these circumstances, the service agreement assumes particular importance.

Statutory Penalties and Excise Taxes

ERISA and the Internal Revenue Code impose civil penalties or excise taxes on plan administrators or other persons who fail to perform certain functions or respond to certain requests, generally enforced through ERISA Sections 502(a)(1)(A) and 502(c) (in the case of penalties) or through the Internal Revenue Service (in the case of excise taxes). Some of the civil penalties are payable to plan participants, such as the penalty for failure to respond to document requests or to provide Consolidated Omnibus Budget Reconciliation

Act (COBRA) notices, while others are payable to the government, such as the penalty for failure to file an annual report. Excise taxes are paid to the government.

With respect to the most common penalties, most provisions of ERISA Section 502(c) provide for the assessment of penalties against the named plan administrator (the employer, if there is no other person serving as plan administrator). For example, only the plan administrator is liable for a failure to respond to a participant request for documents. These penalties cannot be recovered from third parties even if those third parties were responsible under contract for performing the duties in question.[9] Since it is unusual for a vendor to agree to serve as the "plan administrator," these penalties most often will generate liability for the employer or the person(s) serving as plan administrator. Likewise, excise taxes for various violations of the Tax Code generally apply only to the entity serving in the role designated by the Tax Code as responsible for the obligation in question, regardless of whether that entity actually committed the violation itself.[10] If a vendor committed the actual error, the indemnity clause of the service agreement may be the only sure recourse for the person penalized by statute for the fault.

In theory, many of the civil penalties and excise taxes can reach astronomical amounts if the failure is not promptly discovered and rectified, but the federal courts or government agencies generally have and exercise the authority to waive or reduce penalties (and in some cases, excise taxes) in the event of inadvertent error or to prevent disproportionate awards. Availability of automatic waivers often depends on whether corrective action was taken before the government discovered the problem, and discretionary waivers typically will rest on factors such as the reasons for the error, the speed of correction, evidence (or lack thereof) of the fiduciary's bad faith, the degree of prejudice to the participant at issue, and the adequacy of the plan's procedures to address such situations as a general matter.[11] A service agreement that clearly details the manner in which the vendor is to respond to situations that generate the potential for penalties or excise taxes, specifies the employer's and plan's responsibilities in such situations, and requires a vendor to maintain adequate internal controls and provide assistance with corrections when needed is a valuable tool for avoiding or minimizing this type of liability.

For example, if a recordkeeper is obligated to respond to requests for the summary plan description, the service agreement should require the recordkeeper to do so within 30 days. The summary plan description and other participant communications should give the proper contact information for such requests while still identifying the actual plan administrator by name in the summary plan description as required, and the employer and its employees serving as plan fiduciaries must be sure to supply the recordkeeper with sufficient

up-to-date documents to meet requests. In the event of misdirected requests (for example, requests directed to a recordkeeper that should be directed to the plan administrator, and vice versa), the parties need to have a reliable procedure for identifying and forwarding the requests in a timely fashion.[12] Errors associated with disclosure obligations are avoidable, and a demonstration of a well-publicized and reliable procedure for responding to requests will assist the plan administrator in seeking a waiver or reduction of penalties if an error does occur. Likewise, vendors providing COBRA administration and the plan sponsor's employees need to be sure to understand their respective roles in assuring timely COBRA notices and processing of COBRA elections. In all cases, adequate records demonstrating compliance are essential, and the parties need to know which of them is obligated to maintain those records.

Claims for Plan Benefits

ERISA Section 502(a)(1)(B) permits a participant or beneficiary to bring a claim for benefits due under the terms of a plan, to enforce the terms of a plan, or to clarify rights to future benefits. Liabilities arising from a claim for plan benefits generally fall into three different categories:

- Benefit amounts claimed and paid through routine plan procedures (*e.g.,* undisputed claims for covered medical care under a health insurance plan);
- Benefit amounts claimed and paid following a benefit dispute (*e.g.,* a participant claims disability benefits, which are originally denied but subsequently granted as a result of the administrative appeals process or litigation); and
- Costs associated with the claims process, routine or otherwise, successful or otherwise.

The payment of benefits determined to be properly payable by the plan (whether so determined by the plan administrator or by a court following litigation) obviously is the responsibility of the plan, and benefits should be paid from the plan's insurance policy or trust fund or from the employer's general assets, depending on how the plan is funded. Extra costs, such as claims processing expenses, pre- and post-judgment interest, and attorney's fees, may in some cases be assessed against or payable by the employer or a third party rather than the plan.

The service agreement should address the allocation of routine duties and associated costs, the nature of which will vary depending on the type of plan. For example, claims processing is likely to

be a much larger aspect of administration for a health plan than for a retirement plan. With respect to a need for special services arising from a dispute or a problem, the service agreement should address the vendor's support obligations, and may provide for a specified extra fee if a claim is disputed past the level covered by the service agreement's set fees, or if it presents unusually complicated circumstances requiring more extensive services not covered by the service agreement's regular fee structure. For example, if a claim requires reconstruction of a participant's benefit records to confirm a benefit calculation, the recordkeeper may charge an hourly rate for reviewing the records and performing the necessary calculation.

The courts vary somewhat as to the list of entities that are proper defendants in a suit claiming plan benefits, but nonfiduciary third-party service-providers are not included in any court's list. In many cases, fiduciaries as such are not permissible defendants either. The plan is a permissible defendant, and some courts also permit suit against the employer (if the plan is funded or administered by the employer), the plan administrator, or the insurer (again, if the plan is funded or administered by the insurer).[13] In short, claims for benefits are much more likely to be brought against and involve the plan directly than to be brought against third-party vendors. However, in some cases involving insurance companies and/or vendors serving as fiduciaries involved in the claims process, or mistakenly filed lawsuits that generate costs for the vendor, indemnity claims against the plan, or plan representative may arise.

Established jurisprudence provides that ERISA does not permit the award of punitive or extracontractual damages.[14] However, if the claim goes to litigation, the associated expenses, such as attorney's fees and court costs, can be significant in themselves, even without the addition of extracontractual damages. In this regard, it is important to bear in mind that ERISA Section 502(g)(1) allows a court to require one party to pay some or all of the other party's attorney's fees.[15] If the vendor was acting as the claims fiduciary and conducted the claims process improperly, or was otherwise responsible for an unnecessary delay in processing or approving a claim or acted wrongly in denying a claim, the plan or plan sponsor should have the protection of a contract that clearly places the responsibility on the vendor, and of an indemnity clause that requires the vendor to bear the expense of interest, litigation costs, or other extra expenses under the agreement's indemnity clause. In contrast, in the event of an honest difference of opinion regarding the merits of a claim, liability normally should remain with the plan and the employer.

By way of avoiding liability in the first place, the plan representative also should consider an audit procedure or other oversight process to ensure that the claims review process is administered in a fair and efficient manner, allowing valid claims to be approved promptly

while also providing for proper controls to prevent payment of invalid claims. Whether or not the plan representative has the ability to insist on such a structure as part of the service agreement, the plan representative should review plan participant satisfaction with the vendor's performance as well as the overall plan claims data periodically, and search for a new vendor if the existing vendor is not performing at an acceptable standard.

Claims for Additional Amounts Not Owed Under the Plan

In some circumstances, the participant and the plan may be in agreement that the plan does not provide the benefit (or the amount of the benefit) sought by the participant, but the participant may assert a claim to receive the benefit (or the additional benefit) anyway. These claims frequently arise when a participant has been given erroneous information by someone associated with the plan, such as a promise that certain benefits will be available when in fact they are not. In such a circumstance, the participant may assert a claim of promissory estoppel, equitable estoppel, or both. Courts differ in the extent to which they will recognize estoppel claims,[16] but even those courts that do allow them limit them to "extraordinary circumstances."[17] Accordingly, plaintiffs seeking benefits to which they are not entitled under the terms of the plan must satisfy a high standard of proof and situational equity.

Despite this high threshold, such claims are far from uncommon, and even unsuccessful claims require expenditures of time and money for the fiduciaries and vendors involved. Such claims may be brought against a plan fiduciary or sponsoring employer, even if the misrepresentation was made by a third-party vendor, or may be brought against a vendor innocently passing along incorrect information received from the employer.[18] Prudent selection and monitoring of the service provider helps prevent this type of vicarious liability for fiduciaries, and a plan representative should document its expectations regarding vendor staff training and be sure the vendor is familiar with its plan. Both the plan representative and the vendor should establish protocols to ensure that plan questions are routed to appropriate personnel. If errors do occur, a clear indemnity clause protects the fiduciary if it is required to pay for the vendor's error. Likewise, a clear indemnity clause protects a vendor that ends up caught in the cross-fire.

Other ERISA Violations

ERISA Section 502(a)(2) states that a participant, beneficiary, fiduciary, or the Secretary of Labor can bring an action to obtain relief under ERISA Section 409, which provides that a fiduciary who has

committed a breach of fiduciary duty is personally liable to make good the plan's losses and to disgorge any profits resulting from the breach, and shall be subject to such other equitable or remedial relief as a court deems appropriate. ERISA Section 502(a)(3) permits a participant, beneficiary, or fiduciary to sue to enjoin actions in violation of Title I of ERISA or the terms of the plan, or to obtain "other appropriate equitable relief" to redress violations of or enforce Title I of ERISA and the terms of the plan, and ERISA Section 502(a)(5) extends similar rights to the Secretary of Labor. Statutory penalties may also apply in the event of a DOL recovery against a plan fiduciary, under ERISA Section 502(l).

Generally, claims for violation of ERISA involve claims against fiduciaries, or occasionally claims against plan sponsors with respect to plan design, but it is possible for nonfiduciaries to be subject to suit in some circumstances, or to be sued by a fiduciary under state law if the fiduciary is held liable under ERISA. Given the uncertainty of a fiduciary's right to contribution or indemnification from a co-fiduciary and the lack of remedies against nonfiduciaries under ERISA, a contract-based indemnification claim against a vendor that has breached its service obligations is an essential protection for plan representatives. State common law contract or malpractice claims may be available to a plan representative in the absence of an express indemnification clause, as discussed below, but the presence of an express clause has the great advantage of giving both parties certainty. Correspondingly, a vendor held liable under ERISA may have little or no recourse without contractual protections, especially in circuits that do not recognize contribution and indemnity claims under ERISA.

In addition, clear delineation of service responsibilities is essential for a plan representative who must assert a basis for a claim asserting breach of a vendor's fiduciary duty or a breach of contract or malpractice claim in the first place. Detailed contractual provisions are also essential to a vendor seeking to protect itself against a lawsuit attempting to hold it responsible for matters outside its purview, or for plan failures arising from the plan representative's breach of its own responsibilities. In this regard as well, therefore, a well-drafted service agreement will prove its worth if a problem arises.

COBRA

Part 6 of Title I of ERISA and IRC Section 4980B incorporate the group health coverage continuation requirements created by COBRA. Liability issues associated with COBRA deserve special consideration in connection with health plan service agreements. Courts have held that a failure to provide timely notice of COBRA rights can result not only in statutory penalties, as discussed above, but in an obligation to provide coverage.[19] Noncompliance with the COBRA process can

make coverage more expensive than it otherwise might be, and may jeopardize insurance coverage (including stop-loss coverage), leaving the plan and the plan sponsor to self-insure. Accordingly, if a vendor assumes responsibility for COBRA compliance and the retention of records documenting COBRA compliance, special care should be taken to document its responsibilities and liabilities, and the agreement should meet legal requirements for shifting responsibility for the excise tax imposed on COBRA noncompliance.[20] If a health plan vendor is not assuming such responsibilities, the plan representative needs to know this, so it can make other arrangements to comply with COBRA's requirements.

Non-ERISA Claims

While the courts are not unanimous, a number of cases have held that a vendor can be sued under state contract or malpractice law in connection with the services it performs.[21] Generally, claims for breach of contract or malpractice are brought by a plan representative, especially if the contract provides that there are no third-party beneficiaries under the contract. However, if the service contract is directly with the plan, participants may be able to sue on behalf of the plan, as the ultimate beneficiaries of the services purchased by the plan. In either case, depending on the terms of the contract, the plan or plan representative may be responsible for indemnifying the vendor for its defense costs if the vendor prevails. Regardless of who sues whom, the clarity of the contract's terms regarding respective responsibilities and liabilities will help determine which party prevails if a lawsuit is brought.

A vendor may also be subject to suit by third parties not connected to the plan. In most cases, these types of claims should be a matter to be resolved between the vendor and the third party, and will not involve claims arising out of the service agreement with a particular plan so as to give rise to indemnity rights under the service agreement. However, if a third-party claim does involve a specific plan or otherwise is covered in whole or part by a service agreement indemnity clause, indemnity claims may result.

For example, some courts have allowed a provider who was informed erroneously that plan coverage for a patient was available to sue the plan agent who provided that information under state law.[22] If the misrepresentation was made because of inaccurate information received from the plan or the employer, the vendor is likely to seek indemnity. On the other hand, if the vendor itself made the error, the vendor should bear any resulting costs. The plan representative should be sure that the agreement's indemnity clause has an appropriate scope. In addition, clear contractual expectations regarding the flow of information and the content of communications with third parties, as well as prudent selection and monitoring of vendors who

will represent the plan in its dealings with third parties, can help avoid involving the plan in situations giving rise to these types of claims.

CONCLUSION

The vast number of employers offering pension benefit plans, welfare benefit plans, or both demonstrates that employers find it worthwhile to do so despite the potential for liability in the event of plan design flaws, administrative errors, investment losses, and other events. In light of the potential for liability and the employee dissatisfaction that tends to accompany benefit plan problems, however, it is important for an employer to be sure that the employees overseeing its benefit programs have the requisite time, experience, information, and expert assistance to understand their own duties, as well as to select qualified plan vendors and oversee those vendors' performance of their duties. Careful negotiation and periodic reevaluation of vendor service agreements, coupled with regular review of plan operations to ensure the plan is being administered as agreed, are essential to the successful operation of benefit plans and the protection of plan sponsors and fiduciaries on the one hand, and plan vendors on the other.

NOTES

1. ERISA §§ 406 and 408, and the accompanying DOL regulations.

2. *See, e.g.,* Chemung Canal Trust Co. v. Sovran Bank/Maryland, 939 F.2d 12 (2d Cir. 1991), *cert. denied,* 505 U.S. 1212 (1992); *c.f., e.g.,* Call v. Sumitomo Bank of Cal., 881 F.2d 626 (9th Cir. 1989).

3. *See, e.g.,* Gerosa v. Savasta & Company, Inc., 329 F.3d 317 (2d Cir. 2003), *cert. denied,* 540 U.S. 967 (2003) and 540 U.S. 1074 (2003) (state-law malpractice claims against an actuarial firm were not pre-empted by ERISA); Penny/Ohlmann/Nieman, Inc. v. Miami Valley Pension Corp., 399 F.3d 692 (6th Cir. 2005) (holding claims against fiduciary based on benefit plan pre-empted; holding claims against nonfiduciary not pre-empted despite lack of written agreement; collecting cases regarding state law claims against vendors).

4. ERISA § 404(a). This obligation is statutory, but including it in the contract supports a contractual claim in addition to any statutory claims the plan or a plan representative may have. It is, however, relevant to note that the determination of whether a person is a "fiduciary" or not is based on the functions performed by that person, not on the contractual designation, something the parties should bear in mind when designing their contract.

5. The DOL explained that a plan fiduciary deciding whether to agree to an indemnification and limitation of liability clause should bear in mind the following factors:

- The vendor should be competent to perform the services at issue, and the overall service and compensation arrangement should be reasonable; and
- The indemnification clause should not protect the vendor against the consequences of fraud or willful misconduct. A clause extending such

protections would be void as against public policy, and agreeing to such a clause would be facially imprudent. If the indemnification and limitation of liability clause provides protection against negligence or unintentional malpractice, it may be appropriate. The fiduciary should consider the reasonableness of the arrangement as a whole and the potential risks to participants and beneficiaries. As part of this process, the fiduciary should assess the plan's ability to obtain comparable services from a vendor willing to forego an indemnification and limitation of liability clause, or to agree to a clause more protective of the plan.

6. ERISA § 410 prohibits a plan from paying for fiduciary liability insurance unless the insurance provides for recourse against the breaching fiduciary. confirms that an employer can indemnify a fiduciary from its own assets as well as through insurance. Accordingly, insurance and indemnity clauses are both permissible so long as they accommodate the restrictions of ERISA § 410.

7. Plan sponsors and administrators often fail to distinguish between the ERISA-mandated fidelity bond, which protects the plan against theft of plan assets, and fiduciary liability or errors and omissions insurance, which protects the individuals and companies who act as plan fiduciaries or otherwise provide services to the plan against claims relating to the manner in which they fulfill those functions. While fidelity bond coverage and insurance coverage can be provided under the same policy, fidelity bond coverage does *not* automatically include liability insurance coverage.

8. Labor Regulations § 2550.408b-2(c).

9. *See, e.g.,* Caffey v. Unum Life Ins. Co., 302 F.3d 576 (6th Cir. 2002) (insurance company not plan administrator; not liable for penalties); McKinsey v. Sentry Ins., 986 F.2d 401 (10th Cir. 1993) (claim could not be asserted against entity that was not "plan administrator"); Lee v. Burkhart, 991 F.2d 1004 (2d Cir. 1993) (insurer administering self-funded plan could not be "plan administrator" for ERISA purposes when did not meet statutory definition); Moran v. Aetna Life Ins. Co., 872 F.2d 296 (9th Cir. 1989) (insurer that was not plan administrator not liable for penalties; previous statement by insurer that it was "administrator" did not estop insurer from subsequently denying its status as administrator); Schultz v. Progressive Health, Life & Disability Benefits, 380 F. Supp. 2d 780 (S.D. Miss. 2005) (claims administrator is not "plan administrator" and hence is not subject to penalties under ERISA § 502(c)(1)(B)); *but see* Younkin v. Prudential Ins. Co. of Am., CV-05-48-M-DWM, 2006 U.S. Dist. LEXIS 65345 (D. Mont. Aug. 28, 2006) (including "claims administrator" as an "administrator" under ERISA § 502(c); distinguishing *Moran*).

10. For example, under Section 4975 of the Tax Code, a "disqualified person" who engages in a "prohibited transaction" is subject to an excise tax of 15 percent of the amount involved in the transaction per year until the transaction is corrected. Under Section 4980F of the Tax Code, an employer that fails to provide the requisite advance notice of an amendment reducing benefit accruals under a plan subject to Section 412 of the Tax Code is subject to an excise tax of $100 per participant per day until notice is given.

11. *See, e.g.,* Gorini v. AMP Inc., 94 Fed. Appx. 913, 919–920 (3d Cir. 2004) (failure to respond to document request; "court can consider (1) bad faith or intentional conduct of the plan administrator, (2) length of delay, (3) number of requests made, (4) documents withheld, and (5) prejudice to the participant"; noting that employer/plan administrator appeared to have acted in bad faith and that the imposition of penalties was appropriate); McDonald v. Pension Plan of the NYSA-ILA Pension Trust Fund, 320 F.3d 151, 163 (2d Cir. 2003) (same); Starr v. Metro Sys., Inc., 461 F.3d 1036, 1040 (8th Cir. 2006) (failure to provide COBRA notice; "In exercising its discretion

to impose statutory damages, a court primarily should consider the prejudice to the plaintiff and the nature of the plan administrator's conduct. Although relevant, a defendant's good faith and the absence of harm do not preclude the imposition of the § 1132(c)(1)(A) [502(c)(1)(A)] penalty.") (internal citation omitted); Ziaee v. Vest, 916 F.2d 1204, 1211 (7th Cir. 1990) ("The statute commits the size of the penalty to the district judge's discretion; the judge may, but need not, consider the provable injury when exercising that discretion."); Kerr v. Charles F. Vatterott & Co., 184 F.3d 938, 948 (8th Cir. 1999) (failure to produce requested documents; district court on remand directed to consider prejudice to plaintiff and nature of administrator's conduct; prejudice, however, not a prerequisite to an award of penalties); Shapiro v. Continental Casualty Co., 415 F. Supp. 2d 1060 (C.D. Cal. 2006) (failure to provide COBRA notice; reducing statutory penalty of $80,000 to $10,000 in light of defendants' corrective actions mitigating the prejudice that plaintiff suffered through nondisclosure).

12. Romero v. SmithKline Beecham, 309 F.3d 113 (3d Cir. 2002) (document request that was not made to the administrator but which reached the administrator triggered obligation to respond and liability for penalties; counting 30-day response period from date request received by administrator or those under its supervision).

13. *See, e.g.,* Layes v. Mead Corp., 132 F.3d 1246 (8th Cir. 1998) (party controlling administration of the plan is proper defendant); Ford v. MCI Communications Corp. Health & Welfare Plan, 399 F.3d 1076 (9th Cir 2005) (holding that only plan and plan administrator are proper parties; dismissing the claims administrator), Crocco v. Xerox Corp., 137 F.3d 105, 107 (2d Cir. 1998) (plan and not plan sponsor was proper defendant; noting such suits could also be brought against "the administrators and trustees of the plan in their capacity as such"); Blickenstaff v. R.R. Donnelley & Sons Co. Short Term Disability Plan, 378 F.3d 669 (7th Cir. 2004) (ERISA permits benefit claims only against plan); Musmeci v. Schwegmann Giant Super Markets, Inc., 332 F.3d 339 (5th Cir. 2003), *cert. denied,* 540 U.S. 1110 (2004) (employer that paid benefits from general assets was proper defendant).

14. *See* Mertens v. Hewitt Assocs., 508 U.S. 248 (1993) (no compensatory or punitive damages under ERISA § 502(a)(3) of); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) (noting that ERISA provides exclusive remedial scheme and noting *Russell's* finding that ERISA did not provide for punitive damages; dismissing state causes of action alleging bad faith and seeking punitive damages); Massachusetts Mutual Life Ins. Co. v. Russell, 473 U.S. 134 (1985) (no extracontractual damages under ERISA § 502(a)(2) for plan beneficiaries).

15. A fee-shifting award under ERISA § 502(g)(1) is in the discretion of the court. The court generally will take into account (1) the degree of the offending party's culpability or bad faith; (2) the ability of the opposing party to satisfy an award of attorney's fees; (3) whether an award of fees would deter other persons from acting similarly under like circumstances; (4) the relative merits of the parties' positions; and (5) whether the action conferred a benefit on a group of plan participants or sought to resolve a significant legal issue under ERISA. *See, e.g.,* Lauder v. First Unum Life Ins. Co., 284 F.3d 375 (2d Cir. 2002), *quoting* Chambless v. Masters, Mates & Pilots Pension Plan, 815 F.2d 869 (2d Cir. 1987), *cert. denied,* 496 U.S. 905 (1990); Hummell v. S.E. Rykoff & Co., 634 F.2d 446 (9th Cir., 1980). Naturally, these factors make it easier for a court to award fees to a prevailing participant than to a prevailing employer or plan, unless the participant's claim was frivolous.

16. *See, e.g.,* Devlin v. Empire Blue Cross & Blue Shield, 274 F.3d 76, 85–86 (2d Cir. 2001) (authorizing estoppel claim); Vallone v. CNA Fin. Corp., 375 F.3d 623 (7th Cir. 2004), *cert. denied,* 543 U.S. 1021 (2004) (estoppel claim denied on facts but

acknowledged as permissible claim under ERISA; stating that estoppel requires a knowing misrepresentation, usually in writing); Coker v. TWA, 165 F.3d 579 (7th Cir. 1999) (noting narrow scope of estoppel claim but affirming its availability in at least some circumstances; collecting cases regarding scope of claim in other circuits); Hein v. Federal Deposit Ins. Corp., 88 F.3d 210 (1996), *cert. denied,* 519 U.S. 1056 (1996) (denying estoppel claim on merits but acknowledging such claims as permissible); Jones v. Amer. Gen. Life & Accident Ins. Co., 370 F.3d 1065 (11th Cir. 2004) (estoppel available in narrow circumstances when plan is ambiguous and representations made as to proper interpretation); Gaskell v. Harvard Coop. Soc'y, 3 F.3d 495 (1st Cir. 1993) (estoppel may not be invoked to enlarge or extend contract benefits); Watkins v. Westinghouse Hanford Co., 12 F.3d 1517 (9th Cir. 1993), *quoting* Greany v. Western Farm Bureau Life Ins. Co., 973 F.2d 812 (9th Cir. 1992) (estoppel available only when plan documents ambiguous and employee was given representations regarding the interpretation of the plan; cannot result in payment of benefits contrary to the terms of the written plan); Coleman v. Nationwide Life Ins. Co., 969 F.2d 54 (4th Cir. 1992), *cert. denied,* 506 U.S. 1081 (1993) (estoppel cannot be used to vary the terms of a written ERISA plan).

17. *See, e.g.,* Devlin v. Empire Blue Cross & Blue Shield, 274 F.3d 76, 85–86 (2d Cir. 2001) (plaintiffs must show extraordinary circumstances); Vallone v. CNA Fin. Corp., 375 F.3d 623, 639 (7th Cir. 2004), *cert. denied,* 543 U.S. 1021 (2004) (estoppel available only in extreme circumstances); Hein v. Federal Deposit Ins. Corp., 88 F.3d 210 (1996), *cert. denied,* 519 U.S. 1056 (1996) (plaintiff must show extraordinary circumstances).

18. *See, e.g.,* Christensen v. Qwest Pension Plan, 376 F. Supp. 2d 934 (D. Neb. 2005), *aff'd,* 462 F.3d 913 (8th Cir. 2006) (fiduciaries found not liable for administrator's error in absence of evidence of negligence in retaining vendor or knowledge of error); Schmidt v. Sheet Metal Workers' Nat'l Pension Fund, 128 F.3d 541 (7th Cir. 1997), *cert. denied,* 523 U.S. 1073 (1998) (plan fiduciaries not liable for misstatement of nonfiduciary representative absent evidence of lack of due care in hiring or training representative; noting that trustees had provided accurate summary plan description and would have been liable for nonfiduciary agent's misstatement if they had not provided adequate disclosure); Hein v. Federal Deposit Ins. Corp., 88 F.3d 210 (1996), *cert. denied,* 519 U.S. 1056 (1996) (plaintiff sued plan, plan fiduciary, and receiver for plan sponsor alleging claims based on estimate provided by actuary; defendants held not liable); Fitch v. Chase Manhattan Bank, N.A,. 64 F. Supp. 2d 212 (W.D.N.Y. 1999).

19. *See, e.g.,* Smith v. Rogers Galvanizing Co., 128 F.3d 1380 (10th Cir. 1997), *aff'd on rehearing* at 148 F.3d 1196 (10th Cir. 1998) (plaintiffs not given COBRA notice entitled to collect medical bills from plan administrator, reduced by premiums, co-payments, and deductibles they would have paid); McDowell v. Krawchison, 125 F.3d 954 (6th Cir. 1997) (requiring plan administrator to provide coverage); Lincoln General Hosp. v. Blue Cross/Blue Shield, 963 F.2d 1136 (8th Cir. 1992), *rehearing en banc denied,* 1992 U.S. App. LEXIS 14569 (8th Cir. June 24, 1992) ("If the administrator fails to provide [the COBRA election rights] notice to the qualified beneficiary, it may be bound to provide coverage to her;" finding compliance had occurred in this case); *but see* Calhoon v. TWA, 400 F.3d 593 (8th Cir. 2005) (employer that allegedly mishandled COBRA premiums not liable to pay medical bills when COBRA coverage lapsed; such relief would constitute monetary damages; reinstatement not available when plan no longer existed).

20. IRC § 4980B(e)(2).

21. *See* n.3, above.

22. *See, e.g.,* Cypress Fairbanks Medical Center, Inc. v. Pan-American Life Ins. Co., 110 F.3d 280 (5th Cir. 1997), *cert. denied,* 522 U.S. 862 (1997) (holding claim based on Texas Insurance Code's prohibition of negligent misrepresentation of coverage not pre-empted); N. Utah Healthcare Corp. v. BC Life & Health Ins. Co., 448 F. Supp. 2d 1288 (D. Utah 2006) (holding state law breach of contract, negligent misrepresentation, and promissory estoppel claims not preempted when hospital sued claims administrator that inaccurately verified full coverage for expenses at issue; collecting cases on this issue); *cf.* Regency Hospital Co. of S. Atlanta v. United Healthcare of Georgia, Inc., 403 F. Supp. 2d 1221 (N.D. Ga. 2005) (holding that claim for negligent misrepresentation based on claims administrator's precertification of coverage prior to patient's termination of insurance was a claim for benefits under the plan and pre-empted by ERISA).

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