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EMPLOYEE BENEFITS LIABILITY INSURANCE COVERAGE FOR AFFORDABLE CARE ACT LIABILITIES

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This article considers the prospects for Employee Benefits Liability coverage for alleged failures to provide promised health insurance and for the "assessable payments" for large employers that fail to offer coverage to full-time employees.

For most large employers, the Patient Protection and Affordable Care Act ("ACA") creates an option: (1) offer health care coverage to your full-time employees or (2) if you do not offer health care coverage to your full-time employees and one or more of those employees obtains subsidized health coverage through a health insurance exchange, make an "assessable payment" to the Internal Revenue Service ("IRS"). This has become known as the "play or pay" option.

As a result of an incorrect understanding of the ACA, or perhaps as a result of longstanding corporate policies concerning the classification of members of its workforce, an employer may erroneously either treat statutory "full-time employees" as parttime employees or classify fulltime employees as independent contractors. A large employer that promises health benefits to full-time employees (either because of a desire to avoid the ACA "assessable payment" or otherwise), and that misclassifies those employees, may find itself named as a defendant in a class action brought on behalf of persons who claim that they are full-time employees and that the employer failed to provide the promised health care coverage. The employer also may be facing civil litigation and "assessable payments" from the federal government.

When faced with these types of substantial liability exposures, corporate policyholders typically turn to their liability insurance policies for defense and indemnity coverage. For claims alleging failure to provide promised employee benefits, coverage may be found in the insured's Employee Benefits Liability ("EBL") coverage, which generally is sold as a stand-alone policy or as an endorsement to Commercial General Liability or Directors and Officers policies. This article considers the prospects for coverage under the EBL coverage for alleged failures to provide promised health insurance and for the "assessable payments" for large employers that fail to offer coverage to full-time employees.

A hypothetical will assist in clarifying the issues. For many years, ABC Corporation ("ABC Corp.") had a large team of safety experts that it used to provide safety seminars to ABC Corp.'s employees throughout the United States. ABC Corp. always classified these workers as independent contractors and paid them wages and benefits accordingly. After the passage of the ACA, in order to avoid the ACA assessable payment, ABC Corp. amended its health care plan to cover all of its "full-time employees". One of ABC Corp.'s safety experts, Joe Contractor, approached the human resources department and requested health insurance coverage. The director of human resources advised Joe that he was an independent contractor and, therefore, ineligible for health insurance coverage under the ABC Corp. health care plan. Joe filed a putative class action on behalf of himself and all of the other safety experts utilized by ABC Corp. The complaint alleged that Joe was wrongfully misclassified as an independent contractor in an effort to deny him employee benefits, including health care insurance, and that he and the other putative class members are entitled to health coverage afforded to ABC Corp.'s full-time employees. Joe's attorney also notifies the IRS of this situation. After investigating, the IRS requires ABC Corp. to make an assessable payment (including late payment penalties and interest) for failing to provide Joe and other members of the putative class with health insurance coverage. Combined, the private class action and the assessable payment, penalties, and interest expose ABC Corp. to hundreds of thousands of dollars of liability, defense costs, and attorneys' fees. ABC Corp. turns to its EBL carrier for coverage for the class action and the governmental penalties.

We will turn to the insurance coverage issues surrounding ABC Corp.'s claim for coverage following a more in-depth discussion regarding the ACA option and possible private and governmental actions against ABC Corp.

The ACA's Incentive for Employers to Provide Health Insurance

The ACA generally provides that an "applicable large employer" may have to make "assessable payments" to the IRS if it does not offer health coverage to its full-time employees. An "applicable large employer" is generally defined as a person who employed an average of at least 50 full-time or full-time equivalent employees on business days during the preceding calendar year.[1] A "full-time employee" is generally any employee who is employed an average of at least 30 hours of service per week.[2] The ACA does not explicitly define the terms "employee" or "independent contractor." Traditionally, in employment disputes, whether a worker is an employee or an independent contractor is a matter determined under state statutory or common law. The tests for resolving this issue tend to be multifactored and generally focus on the degree of control the "employer" actually exercises or has the right to exercise over the worker and the degree of independence of the worker in performing his work-related tasks. For ACA purposes, the term "employee" is defined by reference to the common law standard.[3] While certain seasonal workers and independent contractors are not factored into the number of full-time employees for purposes of the 50-employee threshold, non-seasonal and part-time employees do count towards that total.

Private Rights of Action to Promised Coverage

The ACA itself does not require any employer to offer or provide any health coverage to any employee. Rather, it provides an applicable large employer a choice to either offer coverage to its full-time employees or to make assessable payments to the IRS. If an employer chooses to offer coverage to full-time employees (to avoid ACA assessable payments or for any other reason), private litigants who seek to enforce their right to health coverage under the employer's plan may do so through the Employee Retirement Income Security Act's ("ERISA") express statutory provisions providing for private rights of action.

Three ERISA provisions create private rights of action. First, Section 502(a)(1)(B) of ERISA (29 U.S.C. § 1132(a)(1)(B)) allows participants and beneficiaries to enforce their quasi-contractual rights under ERISA plan documents. This section permits private causes of action to recover benefits due under a plan, to enforce rights under a plan, and to clarify rights to future benefits. To the extent that the ACA's employer "mandate" is incorporated into plan documents (*i.e.*, by the employer extending coverage to full-time employees), this section provides a vehicle for private enforcement of that "mandate." Next, Section 502(a)(3) of ERISA (29 U.S.C. § 1132(a)(3)) broadly permits private actions for any "act or practice" that violates Title I of ERISA. The remedies provided under this section are equitable only – "appropriate equitable relief" – but as other employment-related class action litigation has shown (especially in the wake of the United States Supreme Court's decision in *Comcast Corp. v. Behrend*[4]), a finding of liability in a class action in which only equitable remedies are sought can be a powerful motivator for an employer to conclude a monetary settlement when the alternative for the employer is to face scores or hundreds of individual lawsuits for damages. Even if settlement is not in the cards, the equitable remedies of Section 502(a)(3) may include reformation of the ERISA plan and monetary relief in the form of a surcharge against the plan trustee to pay money owed to beneficiaries.[5] Finally, Section 510 of ERISA (29 U.S.C. § 1140) grants a broad private cause of action for retaliation against a plan participant or beneficiary for attempting to enforce her rights under an ERISA plan.

So, for example, if ABC Corp. seeks to avoid ACA assessable penalties by offering coverage under its health care plan to all full-time employees, a worker who is misclassified by the employer as an independent contractor, such as Joe Contractor, and to whom the employer does not, therefore, offer coverage, may be able to bring a claim under ERISA to enforce that promise of coverage. Whether the worker's claim will be successful will be dependent in part on the terms of the employer's plan documents and the definition of covered employees used by the employer. (Those definitions may or may not match the "employee" and "full-time employee" definitions used under the ACA.) Many employers have attempted to protect themselves against claims for noncoverage of misclassified workers by clarifying in their plans that coverage is not provided to misclassified workers.[6]

Governmental Enforcement of the Employer Option

In addition to possible private actions, two departments of the federal government may have an interest in ABC Corp.'s activities. First, the Department of Labor ("DOL") has the right to initiate a civil action against employers who are alleged to have violated ERISA by failing to provide promised benefits to fulltime employees. The DOL may bring an action to enjoin an ongoing violation of ERISA and may seek "other appropriate equitable relief" to redress violations and enforce the statute.[7]

In addition, the IRS may levy either of two assessable payments against employers who do not offer sufficient coverage to full-time employees. Under Section 4980H(a) of the Internal Revenue Code (the "IRC"), an employer that fails to offer health coverage to at least 95 percent of its full-time employees (70 percent for the 2015 plan year) and that has at least one full-time employee that has purchased health insurance through a state or federal exchange and qualified for either tax credits or a cost-sharing subsidy must make an assessable payment of $2,000 per year (or $166.66 per month adjusted for inflation after 2014) per full-time employee over 30 employees (80 employees for the 2015 plan year for employers with 100 or fewer full-time employees in 2014).[8] For example, if ABC Corp. employed 94 fulltime employees and had misclassified Joe Contractor and five others as independent contractors where they were otherwise substantively "employees" as defined by the ACA, ABC Corp. would be subject to a $140,000 penalty ($2,000 x

(100 full-time employees minus 30)); the penalty applies regardless of the number of misclassified employees and is dependent solely on the number of full-time employees.

Moreover, under Section 4980H(b) of the IRC, an employer that fails to offer "affordable" health coverage that provides "minimum value" to a full-time employee must make an assessable payment to the IRS with respect to that employee if the employee has purchased health insurance through a state or federal exchange and qualified for either tax credits or a cost-sharing subsidy.[9] The assessable payment under Section 4980H(b) is $3,000 (adjusted for inflation after 2014) for each such full-time employee per year ($250 per month) for whom the employer did not make a qualifying offer of coverage. Generally, the aggregate amount of an employer's Section 4980H(b) penalties will not exceed the amount of the 4980H(a) penalty that the employer would have paid if it did not offer any health coverage

EBL Coverage for Violations of the Employer-Option

EBL coverage terms and conditions can vary materially between carriers. For example, while the Insurance Services Office, Inc. ("ISO") issued a standard form EBL endorsement in 2004, not all domestic insurers have adopted it and alternative language may be more coveragepromoting or coverage-restricting. Further, EBL coverage issued by the London market and other non-U.S. carriers reflect the types of variations common in other lines of insurance. We discuss coverage prospects principally under the ISO standard-form language, but as always in the insurance world, the watchword is to read and compare alternative policy forms for both pronounced and nuanced differences in language and to carefully consider the specific facts in issue and potentially applicable law.

In ISO's 2004 standard form endorsement, EBL insurance provides coverage for

> "any act, error, or omission of the insured, or of any person for whose acts the insured is legally liable"
>
> when the act, error, or omission
>
> "is negligently committed in the 'administration' of your 'employee benefit program.'"

"Administration" is defined to include:

> a. Providing information to "employees", including their dependents and beneficiaries, with respect to eligibility for or scope of "employee benefit programs";
>
> b. Handling records in connection with the "employee benefit program"; or
>
> c. Effecting, continuing or terminating any "employee's" participation in any benefit included in the "employee benefit program."

"Employee benefit program" means, in relevant part:

> 4 . . . . a program providing some or all of the following benefits to "employees", whether provided through a "cafeteria plan" or otherwise:
>
> a . . . . group accident or health insurance, dental, vision and hearing plans . . . provided that no one other than an "employee" may subscribe to such benefits and such benefits are made generally available to those "employees" who satisfy the plan's eligibility requirements.

The definition of "employee" is not found in the EBL standard form endorsement. Rather, it is in the main body of the Commercial General Liability policy, where the term is defined as:

> "'Employee' includes a 'leased worker.' 'Employee' does not include a 'temporary worker.'"

Endorsements that amend or supplement this definition of "Employee" are not uncommon. "Employee" might also be defined to include part-time employees, seasonal employees, and independent contractors.

These definitions are broad. Even assuming that they are not ambiguous, they provide coverage for ERISA claims by private plaintiffs who allege that they are "full-time employees" under the terms of an employer's plan and that their employer wrongfully denied them health coverage by failing to treat them as such. Employer-provided health coverage under ERISA is so obviously an "employee

benefit program," as defined, that there should be little in dispute on that issue, and so we do not discuss it further here.[10] Whether Joe Contractor or other workers who allege that they are "full-time employees" under the terms of an employer's plan also fall under the EBL definition of "Employee" in a given policy depends on the specific language of that policy. For present purposes, because there has been relatively little litigation on the point in EBL coverage disputes, we can assume that Joe Contractor and other plaintiffs fall within the policy's definition of "Employee."

Accordingly, the two key issues for class actions, such as Joe Contractor's, are (a) whether the alleged misclassification of workers is "negligently committed" and (b) whether the alleged misclassification is part of the "administration" of the plan.

The Negligence Defense

Insurers can be expected to contend that the classification of a worker as an employee or independent contractor is an "intentional act" and not a "negligent act" and, therefore, EBL claims arising out of classification decisions are not within the EBL coverage. For example, insurers have attempted to defeat EBL coverage, with some limited success, on the grounds that the underlying claim did not allege the requisite negligence when: (a) an inadvertent error failed to notify a beneficiary that his employer-sponsored life insurance policy was cancelled and the president of the company refused to reinstate the policy,[11] (b) tour guides alleged that they had been "willfully" excluded as participants in their employer's retirement plans and did not expressly allege any negligent acts, errors, or omissions,[12] and (c) the employer changed the scope of benefits available to an entire class of retired employees.[13]

It is an understatement to say that the state of insurance law on coverage for so-called "intentional acts" verses "negligent acts" is, in many jurisdictions, extremely uncertain and fluid. There is a thicket of conflicting concepts and rules across jurisdictions and, sometimes, within a given jurisdiction.[14] On this point, it is useful to recall that the fundamental purpose of insurance is to transfer risk, and thus, at a minimum, there should be coverage for a so-called intentional act when the insured does not subjectively intend the injury or damage within the risk covered by the policy and complained of by the plaintiff. As stated by Justice Cardozo so eloquently more than 90 years ago in *Messersmith v. American Fidelity Co.*,[15] a rule which would "restrict insurance to cases where liability is incurred without fault of the insured would reduce indemnity to a shadow."[16] Justice Cardozo explains:

> Injuries are accidental or the opposite for the purpose of indemnity according to the quality of the results rather than the quality of the causes . . . Every act, if we exclude, as we must, gestures or movements that are automatic or instinctive, is willful when viewed in isolation and irrespective of its consequences.[17]

The approach of the United States Court of Appeals for the Second Circuit in the recent opinion of *Euchner-USA, Inc. v. Hartford Casualty Insurance Company*,[18] is particularly instructive in rejecting the insurer's negligence defense. In *Euchner-USA*, the plaintiff in the underlying claim alleged that she was sexually harassed by a senior executive at Euchner-USA, and that, after she confronted him about his conduct, she was wrongfully terminated as an employee and coerced into accepting a new position as an independent contractor. She further alleged that her misclassification as an independent contractor disqualified her from receiving the benefits she formerly received, including pension benefits under the company's 401(k) plan.[19]

In finding that the underlying plaintiff's claim of misclassification "raised a reasonable possibility of negligence" by the insured, and thus activated the insurer's duty to defend, the Second Circuit focused on the lack of any allegations (a) as to whether the misclassification was intentional or negligent, (b) that the plaintiff was misclassified with the purpose of interfering with her retirement benefits, or (c) that she was subject to unlawful retaliation under Section 510 of ERISA.[20] The court further noted that the ERISA claims did not require a showing of intent, with the implication that Hartford, therefore, could not look to the statute to infer coverage-defeating intent.[21] The court might also have noted that because intent is not an element of an ERISA violation, even allegations of intent should have not defeated coverage, since it would still have been "reasonably possible" that liability might be found on non-intentional grounds.[22]

In short, it is a virtual certainty that the negligence defense will continue to be raised by insurers. That said, policyholders have many paths around this obstacle to coverage.

"Administration"

Coverage disputes under the insuring agreement language can be expected to focus on the term "administration." Insurers are likely to argue that the term "administration" in the EBL coverage is intended to reflect that EBL covers only "ministerial" and nondiscretionary acts relating to the day-to-day management of benefit programs, not corporate policies that affect who is within or outside of the scope of those benefit programs in the first instance. There is some support in the case law for this view. In an insurer-versusinsurer EBL coverage dispute arising out of claims that the employer failed to adequately fund its 401(k) plan, the United States Court of Appeals for the Ninth Circuit ruled that "administration" referred only to "administrative and ministerial actions" and that it "does not include discretionary, decision-making activities."[23] In *Maryland Cas. Co. v. Economy Bookbinding Corp. Pension Plan and Trust*,[24] the court similarly held that "administration" referred to "routine, unministerial acts" and not "the

decision-making and monitoring involved in managing the Plan's investments."[25] On this basis the court granted summary judgment to the insurer for certain activities complained of (*e.g.*, improper investment in the employer's own securities), while denying summary judgment to the insurer on other claims (*e.g.*, failure to examine the trust checking account), and while denying summary judgment to both parties on yet other claims (*e.g.*, improper calculation of benefits, with resultant underfunding of the Plan).

This case law does not address squarely the issue of EBL coverage for the sort of ERISA claims considered here, and moreover, it is at odds with the broad language of the EBL insuring language. "Administration" is not defined in terms of "ministerial," or "routine," or "day-to-day" actions. In the context of the EBL insuring agreement, it broadly refers, in part, to "any act, error, or omission" of the insured in (a) "providing information to employees" regarding their eligibility, or not, to participate in a benefit program and (b) "effecting, continuing or terminating" any employee's participation in such a program. In rejecting the insurer's "ministerial actions" argument with respect to a similar definition of "administration," the Second Circuit in *Euchner-USA* properly stated that "no construction can modify the definition of the term in the contract wording."[26] The court further stated that "classification of someone either as an independent contractor or as an employee for purposes of program eligibility is not a matter of discretion."[27] In other words, whether someone is an independent contractor or an employee is determined by the facts of the working relationship and operative law, not by the choice or discretionary act of an employer. It is for that reason that an employer's classification of an employee as an independent contractor can be wrong legally. In any event, the court found that the allegations of the complaint were within the duty to defend because "determining [the plaintiff's] eligibility may reasonably be considered part of the program's recordkeeping function."[28]

It is significant perhaps that the Second Circuit did not employ the rule of *contra proferentem*, whereby ambiguous policy language is construed against the insurer, as the drafter of the policy language, and in favor of the policyholder, in interpreting "administration." Future courts addressing this issue might well find that rule applicable or may appeal to the reasonable expectations doctrine. The reasonable expectations doctrine, when it is not merely a restatement of the rule of *contra proferentem*, provides that a policy is to be interpreted in accordance with the reasonable expectations of the policyholder and, further, in some jurisdictions, that coverage should be found when an insured would expect coverage even if such coverage is not to be found in the express language of the policy.[29] For example, the United States Court of Appeals for the Third Circuit has stated that "even the most clearly written exclusion will not bind the insured where the insurer or its agent has created in the insured a reasonable expectation of coverage."[30] Here, a policyholder reading a definition of "administration" that includes broad language with strong connotations of choice and discretion (*e.g.*, "providing information to employees . . ." and "[e]ffecting, continuing, or terminating any 'employee's' participation . . .") would have little or no reason to expect that the term "administration" refers only to "ministerial" or "clerical" tasks, especially when those terms are nowhere to be found in the definition.

Even without appeal to the reasonable expectations doctrine, in *Wyman-Gordon Co. v. Liberty Mutual Fire Insurance Co.*, the court rejected the insurer's "clerical or ministerial mistakes" gloss on "administration" because it was inconsistent with the policy's express definition of "administration," which included "'the determination of the eligibility of employees to participate in the employee benefits programs.'"[31] The court effectively held that eligibility determinations are not merely "clerical" or "ministerial" activities and that the express wording of the definition of "administration" defeated the insurer's attempt to deny coverage.

Moreover, insurers have had years to add a "ministerial" or "clerical" limitation to the definition of "administration" in EBL coverage. Their failure to do so should be an additional reason for the courts not to rewrite the policy language and import such limitations.

EBL Exclusions

Insurance coverage disputes regarding ACA class actions will not end with the insuring language. Insurers also are likely to rely on one or more exclusions in attempting to defeat coverage. We consider here five principal exclusions that insurers are likely to raise as defenses to coverage.

First, EBL policies typically exclude coverage for "damages" arising out of intentional acts, errors, or omissions including "the willful or reckless violation of any statue." At a minimum, state of mind issues – intent, willfulness, and recklessness – present questions of fact for the trier of fact at trial. Absent such a final, nonappealable finding, this state of mind exclusion should not bar coverage for the insured's damages. This is especially true where neither intent, willfulness, nor recklessness are elements of an ERISA violation. Note, further, that the exclusion, by its own terms, only applies to "damages" and hence does not relieve the insurer of its duty to defend.

Second, EBL policies often include an exclusion that purports to bar coverage for "[a]dvice given to any person with respect to that person's decision to participate or not participate in any plan included in the 'employee benefit program.'" This exclusion, by its express terms, bears on particular advice given to a particular person by a benefit manager or administrator. Further, it only excludes claims relating to advice given with respect to that *employee's* decision to participate or not. It does not relate to advice given about the *employer's* decision as to who can participate or not in a benefit program. Accordingly, when a corporation is facing ERISArelated claims such as Joe Contractor may assert, this exclusion should not bar coverage.

Third, EBL policies typically include an exclusion for "damages" for which the insured is liable because of liability "imposed on a fiduciary" by ERISA.[32] The apparent intent of this exclusion is to prevent overlapping coverage with Fiduciary Liability Insurance ("FLI") coverage, which, as the name implies, provides coverage for those persons who are deemed to be the fiduciary of an employee benefit plan and who have responsibility for the administration of and investments for the plan. If a fiduciary is found liable for damages with respect to her duties as an administrator of an ERISA benefit program, this exclusion points the policyholder to its FLI coverage. The exclusion does not bar coverage for the claimant's alleged employer or other sponsor of an employee benefit plan.

Fourth, insurers may rely on the common exclusion for "taxes, fines or penalties, including those imposed under the" IRC.[33] This exclusion is untested in the courts in the context of the ACA's employer pay-or-play election and the IRS's assessable payments; it may be an impediment to recovery for the IRS-imposed assessable payments discussed above. Note, again, however, that the exclusion does not expressly bar coverage for defense costs for a governmental civil action such as may be brought by the DOL should the other elements of coverage be satisfied.

Finally, the employment-related practices exclusion bars coverage for "wrongful termination of employment, discrimination, or other employment-related practices." This exclusion apparently is intended to prevent overlapping coverage with Employment Practices Liability ("EPL") policies. Those policies typically exclude coverage for ERISA-related claims, with the exception of retaliation claims under Section 510 of ERISA (as discussed below). Assuming *arguendo* that an EPL policy would exclude Joe Contractor's class action, the employment-related practices exclusion in question here, by its own terms, is focused on what the insurance industry views as traditional employment-related claims under EPL policies, such as wrongful termination and discrimination claims. It is not intended to exclude coverage for claims relating to an employee benefits program, where the claims are otherwise within the scope of the EBL coverage.

As noted above, although most EPL policies exclude coverage for benefits due under ERISA, those exclusions typically carve out an exception with respect to retaliation claims asserted under Section 510 of ERISA. If Joe Contractor amends his complaint to allege that his alleged employer retaliated against him or other members of the class for attempting to secure their rights under ERISA, that claim usually is covered, for both defense and indemnity, under the policyholder's EPL coverage.

In brief, policyholders have strong arguments for coverage under their EBL coverage for alleged violations of ERISA and for retaliation claims under their EPL policies. Because some EBL coverage is written on a claims made basis, and because the courts have tended to strictly enforce the notice provisions under certain types of claims made policies, it is prudent for policyholders to promptly review their EBL coverage if an ACA-related claim has been asserted or if one may be asserted against them, and to provide timely notice to the carrier of the claim or potential claim if appropriate.

Conclusion

The ACA will have far-reaching effects in the delivery of health care in the United States over the next decade and beyond. It is virtually a truism that any new and important social legislation will spawn a new wave of litigation. Corporate policyholders faced with claims asserted by part-time employees or independent contractors alleging that they have been denied rights to employer-sponsored health insurance, or similar suits brought by the DOL, would do well to turn to their corporate liability policies, especially their EBL coverage, to protect valuable corporate assets.

Endnotes

1. I.R.C. § 4980H(c)(2)(A).
2. *Id.*
3. Treas. Reg. § 4980H-1(a)(15); Rev. Rul. 87-41.
4. 133 S.Ct. 1426 (2013).
5. *CIGNA Corp. v. Amara*, 131 S.Ct. 1866, 1880 (2011).
6. The genesis of this effort was *Vizcaino v. Microsoft Corp.*, 97 F.3d 1187 (9th Cir. 1996). In that case, Microsoft's plan provided benefits to certain employees and the court determined that certain workers who had been excluded from the plan because Microsoft had determined that they were independent contractors were in fact "employees." Microsoft thus was required to provide retroactive benefits to the misclassified workers.
7. 29 U.S.C. § 1132(a)(5).
8. I.R.C. § 4980H(a); the 70 percent transition rule is in the preamble to the final 4980H regulations. *See* 79 FR 8543 (Feb. 12, 2014).
9. I.R.C. § 4980H(b). Generally, coverage is "affordable" if the employee's required contribution for self-only coverage does not exceed 9.5 percent of the employee's household income for the year. Generally, coverage provides for "minimum value" if the plan's share of the total allowed costs of benefits provided under the plan is at least 60 percent of those costs.
10. *See, e.g., Euchner-USA v. Hartford Cas. Ins. Co.*, 2014 WL 2576348, at *3 (2d Cir. June 10, 2014) (explaining that the parties did not dispute that 401(k) plan is an "employee benefit program").
11. *Katz Drug Co. v. Commercial Standard Ins. Co.*, 647 S.W.2d 831, 837 (Mo. Ct. App 1983) (holding that the failure to notify was negligent and that the refusal to reinstate was intentional and not negligent).

12. *Group Voyagers, Inc. v. Emp'rs Ins. of Wausau*, 2002 WL 356653, at *3 (N.D. Cal. Mar. 4, 2002) (denying defense coverage when complaint did not expressly allege negligence).
13. *Wyman-Gordon Co. v. Liberty Mut. Fire Ins. Co.*, 2000 WL 34024139, at *41 (Mass. Super. Ct. July 14, 2000) (rejecting insurer's argument because there was no evidence that the corporate decision "was intentional in the sense that [the employer] knew for a certainty either that it was definitively breaching an existing contract or that it would be sued [by the retirees]"). *See also, National Union Fire Ins. Co. of Pittsburgh, PA v. Travelers Prop. Cas. Co.*, 2006 WL 1489243, at *7 (S.D.N.Y. May 26, 2006) (finding that allegations of a "deliberate scheme" to "induce" a class of employees to take actions that would effect significant reductions in their pension plan benefits was not negligent).
14. *See, e.g.*, the discussion of Georgia law in *IFCO Sys. N. Am. v. Am. Home Assur. Co.*, 502 F. App'x. 342 (4th Cir. 2013), and the discussion of California law in J. Fischer, *Accidental or Willful?: The California Insurance Conundrum*, 54 Santa Clara L. Rev. 69 (2014).
15. 232 N.Y. 161 (NY 1921).
16. *Id.* at 163.
17. *Id.* at 165.
18. *Euchner-USA, Inc.*, 2014 WL 2576348.
19. *Id.* at *2.
20. *Id.* at *4.
21. *Id.*
22. *See also Stinker Stores, Inc. v. Nationwide Agribusiness Ins. & Order Co.*, 2010 WL 1338380, at *7 (D. Idaho Mar. 31, 2010) ("After careful consideration of the policy language and the case law urged by both parties, the Court concludes that the reasonable interpretation of the language 'negligent acts, errors or omissions' in the policies at issue in this action is conduct that may include decisions which are discretionary and intentionally made, but may also nonetheless be negligent decisions."); *Medford v. Argonaut Ins. Group*, 2007 WL 4570713, at *4 (D. Or. Dec. 26, 2007) (holding insurers had a duty to defend insured in underlying claim under an EBL endorsement because insured's decision to ignore the advice of counsel in choosing an employee benefits plan that failed to extend benefits to retirees was a negligent act that "effected enrollment, termination or cancellation of employees under the employee benefits program").
23. *Travelers Cas. and Sur. Co. v. Wausau Underwriters Ins. Co.*, 129 F. App'x. 396, 399-400 (9th Cir. 2005); *see also National Union Fire Ins. Co.*, 2006 WL 1489243, at *7 (same).
24. 621 F. Supp. 410, 413 (D.N.J. 1985).
25. *Id.* at 413.
26. *Euchner-USA, Inc.*, 2014 WL 2576348 at *5.
27. *Id.*
28. *Id.*
29. For courts adopting the doctrine, see, e.g., *Bishops, Inc. v. Penn Nat. Ins.*, 984 A.2d 982, 990-991 (Pa. Super. Ct. 2009); *Max True Plastering Co. v. U.S. Fidelity & Ins. Co.*, 912 P.2d 861, 868 (Ok. 1996); *Clark-Peterson Co., Inc. v. Independent Ins. Assocs., Ltd.*, 492 N.W.2d 675, 677 (Iowa 1992); *see also*, R. Keeton, *Insurance Law Rights at Variance With Policy Provisions*, 83 Harv. L. Rev. 961 (1970) (the seminal article); 2 S. Plitt, D. Malonado, J. Rogers, Couch on Insurance § 22:11 (3d ed. 2010) (citing numerous cases); 7 S. Plitt, et al., Couch on Insurance § 102:16 (3d ed. 2013) (citing numerous cases).
For courts declining to adopt the doctrine, *see e.g., QBE Ins. Corp. v. Chalfonte Condominium Apartment Ass'n, Inc.*, 94 So.3d 541, 549 (Fla. 2012); *Ryals v. State Farm Mut. Auto. Ins. Co.*, 1 P.3d 803, 805 (Idaho 2000); *Allstate Ins. Co. v. Magnum*, 383 S.E.2d 464, 467 (S.C. 1989); *Allen v. Prudential Prop. & Cas. Ins. Co.*, 839 P.2d 798, 806 (Utah 1992); *Boeing Co. v. Aetna Cas. & Sur. Co.*, 784 P.2d 507, 520 (Wash. 1990) (en banc); *Wilkie v. Auto-Owners, Ins. Co.*, 664 N.W. 2d 776, 786-87 (Mich. 2003).
30. *West v. Lincoln Benefit Life Co.*, 509 F.3d 160, 169 (3d Cir. 2007) (quoting *Reliance Ins. Co. v. Moessner*, 121 F.3d 895, 903 (3d Cir. 1997)).
31. *Wyman-Gordon Co.*, 2000 WL 34024139, at *2. *Accord, Medford*, 2007 WL 4570713 at *5 (rejecting insurer's ministerial acts argument when the policy defined "administration" to include "[e]ffecting enrollment, termination or cancellation of employees under the employee benefits program.").
32. *See, e.g. Just v. Accu-Turn, Inc.*, 2012 WL 1067106, at *1 (E.D. Wis. March 28, 2012) (granting insurer's motion for summary judgment asking the court to declare nocoverage because the insured's failure to send proper notices regarding COBRA coverage to a terminated employee resulted in a loss "because of liability imposed on a fiduciary" and thus was excluded from EBL coverage); *Enterprising Solutions, Inc. v. Nat. Union Fire Ins. Co. of Pittsburgh*, 2012 WL 3962702 (D.Ariz. Sept. 11, 2012) (excluding coverage for damages arising out of employer's failure to properly calculate contributions necessary to fund group health plans under the EBL exclusion which precluded coverage for sums the employer was legally obligated to pay because of "any breach of fiduciary duty."); *Insurance Co. of PA v. Oce-USA Holdings, Inc.*, 2013 WL 1283819, at *1 (N.D.Ill. March 26, 2013) (explaining the meaning of "liability imposed on a fiduciary" in relation to the duty to defend).
33. *C.f. Benilde-St. Margaret's High School v. St. Paul Mercury Ins. Co.*, 575 N.W.2d 127, 131 (Minn. 1998) (declining to apply the tax exclusion of the EBL policy to damages arising from third-party payroll services' misappropriation of monies due to the IRS because the plain language of the policy covered that portion of monies due as the employer's social security contributions); *Florists' Mut. Ins. Co. v. Ludy Greenhouse Mfg. Corp.*, 521 F.Supp.2d 661, 675 (S.D. Ohio 2007) (same).

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