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Labor & Employment Update

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Annual ERISA Litigation Review and Outlook – 2024

Gibson Dunn's ERISA litigation update summarizes key legal opinions and developments during the past year to assist plan sponsors and administrators navigating the rapidly changing ERISA litigation landscape.

This past year was another busy one for Employee Retirement Income Security Act ("ERISA") litigation, including significant activity at the United States Supreme Court and the federal courts of appeals on issues impacting retirement and healthcare plans, coupled with the promulgation of new regulations affecting ERISA plan sponsors and administrators.

Our Annual ERISA Litigation Review and Outlook summarizes key legal opinions and developments to assist plan sponsors and administrators navigating the rapidly changing ERISA litigation landscape.

Section I highlights two notable cases pending before the United States Supreme Court addressing the scope of the *Chevron* doctrine and the implications for ERISA plans if *Chevron* deference is curtailed or eliminated.

Section II provides an update on two decisions from the Third Circuit, and one from the Second Circuit, concerning the enforceability of arbitration provisions and class action waivers in ERISA plans.

Section III then explores other noteworthy legal developments for ERISA-governed retirement plans, including how federal courts are implementing the Supreme Court's holdings in *Hughes v.*

Northwestern Univ., 595 U.S. 170 (2022), and *TransUnion LLC v. Ramirez*, 594 U.S. 413 (2021); a growing circuit split on the scope of ERISA's prohibited transaction provisions; and, an update on the lawsuits challenging the Department of Labor's environmental, social, and governance ("ESG") investment rulemaking.

Section IV offers an overview of litigation and rulemaking impacting employer-provided health and welfare plans, such as the Tenth Circuit's application of *Rutledge v. Pharmaceutical Care Management Association*, 141 S. Ct. 474 (2020), to hold that ERISA preempts an Oklahoma law regulating pharmacy benefit managers; decisions from the courts of appeal concerning appropriate remedies under ERISA and the scope of the Mental Health Parity and Addiction Equity Act; and, proposed and final regulations implementing the No Surprises Act that are likely to have significant implications for ERISA health plans moving forward.

And finally, **Section V** looks ahead to key ERISA issues and cases that we expect to see litigated this year.

I. Supreme Court Activity Concerning the *Chevron* Doctrine

We have been closely monitoring two related pending Supreme Court cases pertaining to the *Chevron* doctrine—under which courts defer to an agency's reasonable interpretation of its governing statute if the statute is ambiguous—that carry significant implications for ERISA plans. *See Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–44 (1984). In *Loper Bright Enterprises v. Raimondo*, No. 22-451, and a companion case, *Relentless, Inc. v. Department of Commerce*, No. 22-1219, the Supreme Court is deciding whether to overturn or narrow the scope of this long-standing administrative law principle.

The *Chevron* doctrine has made it easier for agencies to withstand challenges to their legal interpretations, with one study finding that agencies prevail 25% more often when *Chevron* deference is applied than when it is not, and another concluding that courts that find the statute ambiguous uphold the agency view 89% of the time. Cong. Research Serv., R44954, *Chevron* Deference: A Primer 15 & n.143 (2023) (collecting sources). By contrast, under a related doctrine called *Skidmore* deference, courts will accord weight to the agency's view, but only to the extent the agency's interpretation is persuasive. Justice Kagan questioned whether *Skidmore* would have any impact on how cases are actually decided, as it leaves courts free to disregard agency interpretations they find unpersuasive. *E.g.*, Transcript of Oral Argument at 32:17–23, *Loper Bright Enters. v. Raimondo*, No. 22-451 (U.S. Jan. 17, 2024) ("Tr.") (Kagan, J.) ("*Skidmore*, I mean, what does *Skidmore* mean? *Skidmore* means, if we think you're right, we'll tell you you're right. So the idea that *Skidmore* is going to be a backup once you get rid of *Chevron*, that *Skidmore* means anything other than nothing, *Skidmore* has always meant nothing.").

At argument, the Court also raised questions about how overruling *Chevron* would affect regulations previously deemed valid. *See* Tr. at 20–22. One possible outcome is that these regulations will be subject to renewed challenges, which could launch a wave of litigation challenging these regulations under the new framework.

Chevron deference comes into play for ERISA plans because ERISA grants the Secretary of Labor the authority to issue regulations to implement and enforce its provisions. *See* 29 U.S.C.

§ 1135. Over the years, the Department of Labor has issued and revised a number of regulations covering a wide range of ERISA issues, including, *inter alia*, fiduciary responsibilities owed by plan administrators and the minimum requirements for ERISA plans, and the Department's 2022 rule concerning environmental, social, and governance (ESG) investing that we discussed in our March 2023 review. Moreover, the Pension Benefit Guaranty Corporation "generally receives Chevron deference for its authoritative interpretation of ambiguous provisions of ERISA." *Vanderkam v. Pension Ben. Guar. Corp.*, 943 F. Supp. 2d 130, 145 (D.D.C. 2013), *aff'd sub nom. VanderKam v. VanderKam*, 776 F.3d 883 (D.C. Cir. 2015).

For example, in *Vanderam*, neither side argued that ERISA unambiguously supported a PRBC determination that a different survivor annuity beneficiary could not be substituted pursuant to a domestic relations order, but the court found the determination to be "a reasonable and permissible interpretation of ERISA" and upheld the decision. *Id.* at 145–46. And in *National Association for Fixed Annuities v. Perez*, the court upheld new regulations relating to conflicts of interest in retirement investing, finding there was no "affirmative indication" Congress intended to prohibit the interpretation and that the Department of Labor's interpretation of ERISA provision was reasonable. 217 F. Supp. 3d 1, 27–30 (D.D.C. 2016).

The *Loper Bright* case is of particular interest in the ERISA context because, in the decision under review, the D.C. Circuit relied in part on the Secretary of Commerce's general rulemaking authority to promulgate regulations "necessary and appropriate" to further the legislation's aims relating to Atlantic fishing monitorships to uphold the regulation. *See Loper Bright Enterprises, Inc. v. Raimondo*, 45 F.4th 359, 363–69 (D.C. Cir. 2022). Because ERISA uses similar language to authorize the Secretary of Labor to implement regulations "necessary or appropriate" to carry out ERISA, *see* 29 U.S.C. § 1135, a ruling affirming the D.C. Circuit's reasoning could potentially be used by the Department of Labor in defense of future regulations that impose substantial economic costs on plans and plan sponsors, even if ERISA by its terms does not clearly authorize the agency to impose those costs.

The Supreme Court typically issues opinions for a given term by the end of June, and we are closely monitoring and will report the Court's opinions on this important issue.

II. An Update on Arbitrability of ERISA Benefits Claims

The arbitrability of ERISA Section 502(a)(2) fiduciary-breach claims continues to be a frequently litigated issue. As we detailed in our 2020 and 2021 year-end updates, the Ninth Circuit's decision in *Dorman v. Charles Schwab Corp.*, 934 F.3d 1107 (9th Cir. 2019), overturned decades of case law that had held that ERISA fiduciary-breach suits could not be arbitrated. *Id.* at 1111–12. In response to *Dorman*, companies have increasingly incorporated arbitration provisions into their ERISA plans. And as we reported in our 2022 update, courts across the country have since faced complicated arbitration issues. This year, two Third Circuit decisions and one Second Circuit decision on ERISA arbitrability are of particular interest.

First, in *Henry ex rel. BSC Ventures Holdings, Inc. Employee Stock Ownership Plan v. Wilmington Trust*, 72 F.4th 499 (3d Cir. 2023), the Third Circuit found a class action waiver in a

plan arbitration clause to be unenforceable because it "purport[ed] to waive plan participants' rights to seek remedies expressly authorized by" ERISA § 409(a). *Id.* at 507. The class waiver in *Henry* "prohibited a claimant from 'seek[ing] or receiv[ing] any remedy which has the purpose or effect of providing additional benefits or monetary or other relief' to anyone other than the claimant." *Id.* at 503. The court held that this language effectively barred plan participants from pursuing "benefits or monetary relief" on behalf of the plan as a whole, removal of plan fiduciaries, and "such other equitable or remedial relief as the court may deem appropriate," which are all forms of relief statutorily available under ERISA. *Id.* at 507 (citing 29 U.S.C. § 1109(a)). Although the Third Circuit recognized that federal law generally favors arbitration, it noted that agreements to arbitrate are not enforceable where they "prohibit[] a litigant from pursuing his statutory rights in the arbitral forum." *Id.* at 506. And because the class waiver was not severable from the arbitration provision itself due to a non-severability clause, the court held that "the entire arbitration provision must fall with the class action waiver," and affirmed the district court's order declining to enforce the provision. *Id.* at 508.

Second, in *Berkelhammer v. ADP TotalSource Group, Inc.*, 74 F.4th 115 (3d Cir. 2023), the Third Circuit addressed whether participants must consent to arbitrate claims brought on a plan's behalf under ERISA § 502(a)(2) and held that the plan (not participants) must consent. *Id.* at 120. Plaintiffs in *Berkelhammer* brought claims against a plan fiduciary committee, among others, for fiduciary breach "on behalf of the plan" under ERISA § 502(a)(2), claiming poor investment performance caused monetary losses to their retirement plan. *Id.* at 117. In response, the committee sought to enforce an arbitration clause in the plan's service contract with a third-party investment advisor that provided advice on the plan's investment strategy. *Id.* Plaintiffs argued that their claims could not be compelled into arbitration because they had not consented to arbitrate. *Id.* But the district court rejected this argument, concluding that arbitration was required because the plan had already consented to arbitrate. *Id.* The Third Circuit affirmed, holding that under ERISA § 502(a)(2), which authorizes plan participants to bring claims "on behalf of a plan," plaintiffs' claims "belong to the Plan, [so] the Plan's consent to arbitrate controls." *Id.* at 119–20. Notably, because the dispute in *Berkelhammer* did not implicate any class waiver, the case did not reach the issue that was ultimately dispositive in *Henry*.

Third, in *Cedeno v. Sasson*, No. 21-2891, 2024 WL 1895053 (2d Cir. May 1, 2024), the Second Circuit ruled that a plan arbitration provision limiting the relief available in an arbitration proceeding to remedies impacting only the participant's own account and forbidding any relief that would benefit any other employee, participant, or plan beneficiary was unenforceable. *Id.* at *1. The plaintiff in *Cedeno* brought claims "on behalf of the plan" against the company, its trustee, and other defendants under ERISA § 502(a)(2). *Id.*. Defendants moved to compel arbitration, pointing to the plan's arbitration provision. *Id.* at *4. The district court concluded that the arbitration agreement was unenforceable because it prevented participants from pursuing plan-wide remedies under § 502(a)(2). *Id.* The Second Circuit affirmed, holding that "[b]ecause [plaintiff's] avenue for relief under ERISA is to seek a plan-wide remedy, and the specific terms of the arbitration agreement seek to prevent [plaintiff] from doing so, the agreement is unenforceable." *Id.* at *5. In reaching its conclusion, the Second Circuit pointed to recent decisions from other courts of appeal—including, among others, the Third Circuit's *Henry*

opinion—as support for its conclusion "that the challenged provisions in the arbitration agreement operate as an impermissible prospective waiver of the plaintiff's statutory rights." *Id.* at *15–*17.

As *Henry*, *Berkelhammer*, and *Cedeno* illustrate, a plan must consent to arbitrate claims brought on its behalf under ERISA § 502(a), but limiting the relief available in arbitration to remedies impacting only a plaintiff's own account may risk invalidation of the arbitration clause in its entirety absent language making clear that the challenged provisions are severable. Thus, plan administrators should closely evaluate the implications of express severability clauses in plan arbitration provisions.

III. Further Important Developments Concerning ERISA-Governed Retirement Plans

In addition to litigation concerning *Chevron* deference and arbitrability, other legal and regulatory changes in 2023 had significant impact on ERISA-governed retirement plans.

A. How Courts Interpret the Pleading Standard Post-*Hughes*

As we addressed in our 2022 update, the Supreme Court reiterated in *Hughes v. Northwestern Univ.*, 595 U.S. 170, 177 (2022) ("*Hughes*") that "excessive fees" fiduciary breach suits under ERISA must satisfy the pleading standard set out in *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007) and *Ashcroft v. Iqbal*, 556 U.S. 662 (2009). The Supreme Court also reiterated that because an ERISA duty of prudence claim "'turns on the circumstances . . . prevailing at the time the fiduciary acts,'" any inquiry into the sufficiency of the pleadings "'will necessarily be context specific.'" *Id.* (quoting *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 425 (2014)). Recent decisions from the Seventh and Tenth Circuits help to illustrate what "context" a plaintiff must show to survive a Federal Rule 12(b)(6) pleading challenge.

On remand, the Seventh Circuit in *Hughes v. Northwestern Univ.*, 63 F.4th 615 (7th Cir. 2023), held that "to plead a breach of the duty of prudence under ERISA, a plaintiff must plausibly allege fiduciary decisions outside a range of reasonableness." *Id.* at 630. This standard, the Seventh Circuit explained, requires plaintiffs to "provide enough facts to show that a prudent alternative action was plausibly available" but not that the prudent alternative action was "actually available." *Id.* Applying this standard, the Seventh Circuit found the plaintiffs in *Hughes* to have adequately pled their imprudence claims by alleging that materially similar but lower cost investment options and recordkeeping services were available in the marketplace but not adopted by plaintiffs' plan. *Id.* at 633–34. However, the Court cautioned that the inquiry was context specific and claims "in a future case may or may not survive dismissal based on different pleadings and the specific circumstances facing the ERISA fiduciary." *Id.* at 634.

Likewise, in *Matney v. Barrick Gold of North America*, 80 F.4th 1136 (10th Cir. 2023), the Tenth Circuit relied on the Supreme Court's guidance in *Hughes* and held that to establish that investment or recordkeeping fees are plausibly excessive, a "meaningful benchmark" is required, and whether a benchmark is "meaningful" will "depend on context because 'the content of the duty of prudence' is necessarily 'context specific.'" *Id.* at 1148 (citing *Hughes*, 595 U.S. at 177). Specifically, in the context of an excessive investment fees claim, the Tenth Circuit explained that a plaintiff must allege that "the alternative investment options have similar investment strategies, . . . objectives, or . . . risk profiles." *Id.* In the context of an excessive

recordkeeping fees claim, a plaintiff must allege "that the recordkeeping services rendered by the [benchmark plans] are similar to the services offered by the plaintiff's plan." *Id.* Because plaintiffs' complaint in *Matney* lacked this level of factual detail, it failed to state a claim, and was therefore properly dismissed. *Id.* at 1149.

At bottom, the *Hughes* decision directs courts that there is no ERISA-specific pleading standard for fiduciary-breach claims and plaintiffs must satisfy the plausibility requirements set forth in *Twombly* and *Iqbal*. But, as the *Hughes* and *Matney* decisions make clear, defendants have a path for challenging the sufficiency of plaintiffs' pleadings where plaintiffs have failed to allege facts showing meaningfully similar, but lower cost, alternatives were plausibly available in the marketplace.

B. Potential Circuit Split in How Courts Are Applying *TransUnion* in Assessing Class-Member Standing

In our 2021 update, we addressed how federal courts were implementing the Supreme Court's decision in *TransUnion LLC v. Ramirez*, 594 U.S. 413, 431 (2021), which held that "Article III does not give federal courts the power to order relief to any uninjured plaintiff, class action or not." This year, the Fifth Circuit in *Chavez v. Plan Benefits Servs., Inc.*, 77 F.4th 370 (5th Cir. 2023), identified a potential circuit split regarding how this holding should be applied to class member standing challenges in ERISA fiduciary breach suits.

The issue in *Chavez* was whether a class could be certified of participants in benefit plans administered by defendant where the named plaintiffs did not participate in some of those plans. *Id.* at 378. Defendants argued that certification in that context was improper because it allowed the plaintiffs "to challenge fees that they were never subjected to, in plans that they never participated in, relating to services that they never received, from employers for whom they never worked." *Id.* at 378. The Fifth Circuit noted that "whether a class representative may seek to litigate harms not precisely analogous to the ones she suffered but harms that were nonetheless suffered by other class members" is a point of disagreement among the circuits and summarized the differing approaches. *Id.* at 379 (citation omitted).

Under the "class certification approach" adopted by the First, Third, Sixth, and Ninth Circuits, if a "class representative has standing to pursue her own claims," then the standing inquiry is settled and any remaining concerns regarding disjuncture between the representative and putative class members (including dissimilarity in injuries suffered) are approached "as an issue of class certification"—*e.g.*, as part of the Rule 23(a) commonality analysis. *Id.* at 380 (citation omitted). In contrast, the Second and Eleventh Circuits have adopted different variations of the "standing approach," and hold that if a class representative did not "possess the same interest and suffer the same injury as the class members," then "the class representative lacks standing to pursue [such] claims," and the claims should be dismissed on Article III grounds. *Id.* at 380, 383 (citation omitted).

Ultimately, the Fifth Circuit declined to take a position in *Chavez* because, there, the court concluded that plaintiffs' claims "wholly implicate the same concerns with respect to each

member of the class that [p]laintiffs seek to represent," so certification could be supported under either of the competing approaches. *Id.* at 386 (citation omitted).

A recent example of how courts analyze Article III standing in ERISA fiduciary breach suits after *TransUnion* can be seen in *Lucero v. Credit Union Retirement Board*, 2024 WL 95327 (W.D. Wisc. Jan 9, 2024), where the court concluded that plaintiffs' failure to demonstrate concrete injury across the putative class doomed their certification bid. There, plaintiffs brought claims on behalf of their plan under ERISA §§ 502(a)(2) and 409, alleging that they were charged excessive recordkeeping fees. *Id.* at *1. But the record in the case showed that three of the four named plaintiffs in fact paid recordkeeping fees in a range that plaintiffs themselves alleged was reasonable. *Id.* at *2. Relying on *TransUnion*, the court found the three plaintiffs lacked Article III standing, ruling that "'[o]nly those plaintiffs who have been concretely harmed by a defendant's statutory violation may sue that private defendant over that violation in federal court.'" *Id.* (quoting *TransUnion*, 594 U.S. at 427). Defendants also argued that the remaining plaintiff could not satisfy Rule 23(a)'s adequacy and typicality requirements because she paid different fees than other putative class members. *Id.* at *3–*4. The court agreed, finding that the class lacked the necessary "congruence between the investments held by the named plaintiff and those held by members of the class[] she wishes to represent." *Id.* at *5, *6 (citation omitted).

We will continue to monitor this potential circuit split as the law continues to develop. For now, the Supreme Court's *TransUnion* opinion, and the decisions interpreting it, give ERISA defendants paths for challenging Article III standing and class certification where named plaintiffs have not suffered the same injury as the putative class.

C. Growing Split on the Scope of ERISA's Prohibited Transaction Clause

Late last year, the Ninth and Second Circuits issued published decisions addressing the scope and application of ERISA's prohibited transaction provisions. As the Second Circuit recognized, there appears to be a growing split between the Third, Seventh, and Tenth Circuits on the one hand, and the Eighth and Ninth Circuits on the other hand, concerning whether a plan fiduciary engages in a prohibited transaction under ERISA § 406(a)(1)(C) simply by entering into a routine, arm's-length agreement with a third party for plan services such as recordkeeping or investment consulting. Litigants in both cases have filed petitions for writs of certiorari with the Supreme Court. If the Court takes up one or both cases, it will have the opportunity to provide meaningful guidance to plan sponsors and administrators concerning what ERISA requires when a plan contracts with third party service providers.

As background, ERISA § 406(a)(1)(C) prohibits plan fiduciaries from involving plans and assets in certain kinds of business deals, including a prohibition against the "furnishing of goods, services, or facilities" between a plan and a "party in interest." 29 U.S.C. § 1106(a)(1)(C). A "party in interest" of an employee benefit plan is defined to include "a person providing services to such plan." 29 U.S.C. § 1002(14)(B). ERISA § 408(b)(2) exempts certain transactions between a plan and a "party in interest" from § 406's prohibitions if: (1) the contract or arrangement is reasonable, (2) the services are necessary for the establishment or operation of the plan, and (3) no more than reasonable compensation is paid for the services. 29 U.S.C. § 1108(b)(2).

In *Bugielski v. AT&T Services, Inc.*, 76 F.4th 894(9th Cir. 2023), the Ninth Circuit held that contract amendments executed between defendants and a service provider to provide investment advising services and access to a brokerage window were prohibited transactions under section 406(a)(1)(C) because defendants "cause[d] the plan to engage in [] transaction[s]" that constituted "furnishing of goods, services, or facilities between the plan and a party in interest." *Id.* at 900–01. In so ruling, the court rejected the reasoning of other courts of appeal—including *Sweda v. Univ. of Penn.*, 923 F.3d 320 (3d Cir. 2019) and *Albert v. Oshkosh Corp.*, 47 F.4th 570 (7th Cir. 2022)—which more narrowly construe the prohibition against "furnishing services" based on concerns that a broad construction of the statute would hinder fiduciaries' ability to contract with third parties for essential plan services. *Id.* at 906–07. The Ninth Circuit concluded that remand was necessary for the district court to consider whether the prohibited transactions satisfied the exemption in ERISA § 408(b)(2) that a "party in interest"—here, the third-party service provider—received no more than "reasonable compensation" from all sources for its services to the plan. *Id.*

Subsequently, in *Cunningham v. Cornell University*, 86 F.4th 961, 973–74 (2d Cir. 2023), the Second Circuit acknowledged the split that the Ninth Circuit deepened in *Bugielski* and took a different approach entirely. The Court held that to plead a violation of § 406(a)(1)(C), a "complaint must plausibly allege that a fiduciary has caused the plan to engage in a transaction that constitutes the 'furnishing of . . . services . . . between the plan and a party in interest' *where that transaction was unnecessary or involved unreasonable compensation*." *Id.* at 975 (quoting 29 U.S.C. §§ 1106(a)(1)(C), 1108(b)(2)(A)) (original emphasis). The court explained that this interpretation of ERISA's prohibited transaction provisions as "incorporate[ing]" the exemptions, and "flow[ing] directly from the text and structure of the statute." *Id.* The court then affirmed dismissal of plaintiffs' prohibited transaction claims because plaintiffs had not alleged that the transactions were unnecessary or that the compensation tendered was unreasonable. *Id.* at 978.

We expect ERISA's prohibited transaction rules will continue to be a highly litigated area this year, and the developing circuit split may pave the way to a Supreme Court decision in this area. Indeed, plaintiffs filed a petition for certiorari in the *Cunningham* case, and the Supreme Court requested briefing from defendant, suggesting it may be interested in taking up that case. Defendants also filed a petition in the *Bugielski* case on April 9, 2024. Should the Court grant either or both of these petitions, it would have the opportunity to further define and clarify ERISA's requirements for plans contracting with third parties for routine plan services.

D. An Update on the Department of Labor's ESG Rulemaking

As addressed above in **Section I**, and as discussed in our 2021 and 2022 updates, the Department of Labor ("DOL") has been actively engaged in rulemaking concerning environmental, social, and governance ("ESG") investing for the better part of a decade. Specifically, our update last year focused on the final rule released by the DOL on November 22, 2022 (the "2022 Rule"). Last year's update also highlighted two lawsuits that challenge the 2022 Rule, *Utah v. Walsh* and *Braun v. Walsh*.

In *Utah v. Walsh*, the 2022 Rule was upheld, and an appeal is now pending. In that case, attorneys general from 25 states filed sued to prevent the 2022 Rule from taking effect. *Utah v.*

Walsh, 2023 WL 6205926, at *1 (N.D. Tex. Sept. 21, 2023). In denying the challenge and ruling for the DOL, the district court applied the two-step framework outlined in *Chevron USA Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984),and held that the 2022 Rule did not violate ERISA. The court first analyzed "whether Congress has directly spoken to the precise question at issue," and found that it had not. 2023 WL 6205926, at *4 (quotation omitted). The court then concluded that the 2022 Rule was a reasonable interpretation of ERISA and "the reasonableness of DOL's interpretation [wa]s supported by its prior rulemakings." *Id.* at *4-*5. The court also held that the 2022 Rule was not arbitrary or capricious under the Administrative Procedure Act because, among other reasons, the DOL reasonably concluded, based on the rulemaking record, that the prior rule could have "a chilling effect on fiduciaries' consideration of pertinent information when making investment decisions." *Id.* at *6. On October 26, 2023, the plaintiffs filed a notice of appeal to the Fifth Circuit, and the appeal is now fully briefed. The Fifth Circuit has tentatively scheduled oral argument for the week of July 8, 2024.

Additionally, as we reported last year, a group of participants in ERISA-regulated retirement plans filed suit in the Eastern district of Wisconsin claiming that the 2022 Rule violates ERISA and exceeds the statutory authority granted to the Secretary of Labor and DOL. *See Braun v. Walsh*, No. 23-cv-234 (E.D. Wisc.). Since our last report, plaintiffs filed a motion for preliminary injunction and temporary restraining order. No. 23-cv-234, Dkt. 8. As of the time of this publication, the motion is fully briefed and awaiting decision by the court.

We will continue to monitor the legal and regulatory landscape surrounding the 2022 Rule and the changing role of ESG factors in plan sponsor and fiduciary decision making.

IV. Key Developments for Health & Welfare Plans

ERISA-governed health benefit plans remain an active source of litigation. This year, the Tenth Circuit issued a significant decision applying *Rutledge v. Pharmaceutical Care Management Association*, 141 S. Ct. 474 (2020), to hold that ERISA preempts an Oklahoma law regulating pharmacy benefit managers. The federal courts of appeals also continued to grapple with whether "reprocessing" is an appropriate remedy under ERISA, and whether monetary relief is available for claims brought under ERISA § 502(a)(3). Litigation over the Mental Health Parity and Addiction Equity Act also continued to be active this year, particularly in the Tenth Circuit. And, finally, proposed and final regulations implementing the No Surprises Act are likely to have significant implications for ERISA health plans moving forward.

A. Tenth Circuit Holds That ERISA Preempts Oklahoma Law Regulating Pharmacy Benefit Managers

In recent years, litigation involving pharmacy benefit managers ("PBM") has become a fertile area for development of case law regarding ERISA preemption. PBMs act as third-party intermediaries between health plans and various entities in the prescription drug supply chain, including manufacturers and pharmacies. As states increasing seek to regulate PBMs, a number of recent decisions involving PBMs have addressed ERISA preemption.

The Supreme Court addressed this issue four years ago in *Rutledge v. Pharmaceutical Care Management Association*, 141 S. Ct. 474 (2020), holding that ERISA did not preempt a state law regulating the maximum allowable cost ("MAC") lists that PBMs use to determine the rate at which PBMs reimburse pharmacies for covered prescription drugs. Since then, lower courts have struggled with the implications of *Rutledge* for other state laws, including other laws regulating PBMs' interactions with pharmacies.

This year, the Tenth Circuit addressed that issue in *Pharmaceutical Care Management Association v. Mulready*, 78 F.4th 1183 (10th Cir. 2023), holding that ERISA preempts certain provisions of the Oklahoma Patient's Right to Pharmacy Choice Act ("the Act"). Enacted in 2019, the Act sought to regulate the network of pharmacies with which PBMs contract by requiring PBMs "to admit every pharmacy that is willing to accept the PBM's preferred-network terms into that preferred network," ("network restrictions"), *id.* at 1183, and by preventing PBMs from denying or terminating "a pharmacy's contract because one of its pharmacists is on probation with the Oklahoma State Board of Pharmacy" ("probation prohibition"), among other things, *id.* at 1201–02.

The Pharmaceutical Care Management Association ("PCMA"), a trade association representing PBMs, challenged these provisions, arguing that they were preempted by ERISA because they effectively regulated plans' decisions about the structure of their coverage networks, and thus effectively prevented plan administrators from administering their plans in a uniform manner. *Id.* at 1197. The Tenth Circuit agreed, holding that the Act's network restrictions "have an impermissible connection with ERISA plans"—and are therefore preempted—because they "effectively abolish the two-tiered network structure, eliminate any reason for plans to employ mail-order or specialty pharmacies, and oblige PBMs to embrace every pharmacy into the fold." *Id*. at 1196, 1199. The court likewise concluded that ERISA preempted the Act's probation prohibition because "limiting the accreditation requirements that a PBM may impose on pharmacies as a condition for participation in its network . . . affect[s] the benefits available by increasing the potential providers" and "eliminates the choice of one method of structuring benefits." *Id*. at 1203–04. The Tenth Circuit distinguished *Rutledge* on the grounds that the Arkansas law there—governing MAC pricing—was a "mere cost regulation" and "ERISA does not pre-empt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage." *Id*. at 1199–00.

In reaching these holdings, the Tenth Circuit also rejected Oklahoma's argument that the Act is not preempted because "it regulates PBMs, not health plans," and plans are not required to contract with PBMs. *Id*. at 1194. Instead, the Tenth Circuit held that a "state law can affect ERISA plans even if it does not nominally regulate them," and that "state laws can relate to ERISA plans even if they regulate only third parties." *Id.* at 1194. The application of ERISA preemption to state laws that nominally regulate plan-affiliated entities such as PBMs and claims administrators is a recurring issue in a variety of settings, so the Tenth Circuit's holding on this issue is likely to be relevant beyond the PBM context.

Finally, the Tenth Circuit contrasted its holding with the Eighth Circuit's decision in *Pharmaceutical Care Management. Association v. Wehbi*, 18 F.4th 956 (8th Cir. 2021), which upheld a North Dakota that "resemble[d]" the probation prohibition in Oklahoma. *Mulready*, 78 F.4th at 1203. The Tenth Circuit found "*Wehbi's* limited reasoning unhelpful" because *Wehbi* had

failed to "assess the law's effects on the structure of the provider network and connected effect on plan design." *Id*. at 1203. In light of the Tenth Circuit's disagreement with *Wehbi*, it is reasonably likely that Oklahoma will seek Supreme Court review of the *Mulready* decision. The deadline for to seek certiorari has now been extended to May 10, 2024.

B. Courts of Appeal Continue to Grapple With Reprocessing as a Remedy

In last year's update, we reported on the Ninth Circuit's January 2023 decision in *Wit v. United Behavioral Health*, 58 F.4th 1080 (9th Cir. 2023), a significant decision of the increasingly litigated topic of "reprocessing" class actions—a strategy that gained steam over the past years as a way to challenge ERISA benefits decisions on a class-wide basis. Since that update, on August 22, 2023, the Ninth Circuit issued an amended decision that preserved the January decision's bottom-line holding largely reversing the judgment in favor of the class, while providing further nuance regarding the law of reprocessing in the Ninth Circuit. *See* 79 F.4th 1068 (9th Cir. 2023).

The plaintiffs in *Wit* were beneficiaries of several ERISA-governed health benefit plans who filed suit on behalf of three putative classes, representing nearly 70,000 coverage determinations under as many as 3,000 different plans. 58 F.4th at 1088. Defendant United Behavioral Health ("UBH") acted as the claims administrator for these plans, and for a subset of plans, also as the insurer. *Id*. The plaintiffs had all submitted coverage requests that UBH denied after applying certain "guidelines" that UBH had developed to implement the governing plans' coverage criteria—including, among other things, a requirement that treatment be consistent with generally accepted standards of care ("GASC"), and that treatment not fall into other exclusions from coverage. *See id.* at 1088–89. The plaintiffs alleged that UBH breached fiduciary duties and improperly denied benefits by applying guidelines that were more restrictive than GASC. *Id.* at 1089. To avoid individualized fact questions that otherwise would have precluded class certification, the plaintiffs framed the relevant injury as the use of an unfair "process," and disclaimed any attempt to prove that the use of that guidelines-based process actually *caused* the improper denial of benefits—seeking instead only "reprocessing" under new guidelines as relief. *See id.*

Over the course of several years, the district court certified the plaintiffs' requested class, held a bench trial, and entered judgment for the plaintiffs. 58 F.4th at 1090–91. The court concluded that UBH had violated ERISA by employing guidelines that impermissibly deviated from GASC, and it ordered prospective injunctive relief for up to ten years—requiring the use of new guidelines going forward—and "reprocessing" of class members' tens of thousands of past claims under those new guidelines. *Id*.

As addressed in last year's publication, the Ninth Circuit reversed in large part in January 2023. It held first that the district court erred in certifying claims seeking "reprocessing" because "reprocessing" is not a remedy available under either of the provisions of ERISA on which the plaintiffs relied—29 U.S.C. §§ 1132(a)(1)(B) and 1132(a)(3). *See* 58 F.4th at 1094. As the court explained, "[a] plaintiff asserting a claim for denial of benefits must [] show that she may be entitled to a positive benefits determination if outstanding factual determinations were resolved in her favor." *Id.* By certifying the class without requiring such a showing, the district court impermissibly used Rule 23 to enlarge or modify the plaintiffs' substantive rights, in violation of the Rules Enabling Act, 28 U.S.C. § 2072(b). *Id*. Plaintiffs' requested "reprocessing" also fell

outside the scope of § 502(a)(3), which provides a cause of action for "'appropriate equitable relief'"—meaning the type of "relief that, traditionally speaking (*i.e.*, prior to the merger of law and equity) were *typically* available in equity." *Id.* (internal citations omitted) (emphasis in original). The panel explained that plaintiffs offered no basis for concluding that reprocessing was relief "typically" available in equity. *Id.*

Finally, the Ninth Circuit held that, contrary to the district court's ruling, absent class members cannot be excused from complying with the plans' administrative exhaustion requirements. 58 F.4th at 1097. The court explained that when an ERISA plan specifies that beneficiaries must exhaust administrative remedies before seeking relief in court, courts are required to enforce those contractual requirements, and cannot create judicial exceptions to compliance. *See id.* at 1098.

The plaintiffs subsequently sought rehearing, and the Ninth Circuit replaced its January opinion with a new one in August. 79 F.4th at 1086. As it had previously, the court held that the district court abused its discretion by concluding that reprocessing is a remedy available under § 502(a)(3), explaining that reprocessing is not "appropriate equitable relief" for fiduciary breach claims brought under that provision because it was not "typically available in equity." *Id*. at 1086.

Moreover, the Ninth Circuit again held that class certification was improper regarding the plaintiffs' denial of benefits claims because the proposed classes included participants whose claims were denied based on UBH guidelines that the plaintiffs had not challenged or based on reasons other than the UBH guidelines. *See id*. at 1085–86. As the Ninth Circuit explained, "[a]n individual plaintiff who demonstrated an error in the Guidelines would not be eligible for reprocessing without at least some showing that UBH employed an errant portion of the Guidelines that related to his or her claim." *Id*. at 1086.

Applying an abuse of discretion standard, the Ninth Circuit found that UBH's interpretation that the plans did not require coverage for all care "consistent with GASC" did not conflict with the plans' language, and thus reversed the district court's judgment to the extent it relied on the conclusion that the plans required coverage for all care consistent with GASC. *Id*. at 1088. The court also remanded the case back to the district court regarding whether plaintiffs' fiduciary duty claim was subject to the plans' administrative exhaustion requirement and, if so, whether unnamed claim members satisfied that requirement. *Id*. at 1089.

The implications of *Wit* for reprocessing class actions remains a live issue even in the Ninth Circuit—and even in *Wit* itself, where the district court has permitted the plaintiffs to file a renewed motion for class certification in light of the Ninth Circuit's decision. *See* No. 3:14-cv-2346, Dkt. 625, at 46-49 (N.D. Cal. Dec. 18, 2023). The plaintiffs have indicated that they intend in that motion to seek certification of a slightly narrow class seeking reprocessing for nearly all of the class that the Ninth Circuit ordered decertified in *Wit*. *See id.*, Dkt. 617, at 10 (N.D. Cal. Nov. 20, 2023); *id.*, Dkt. 626, at 26 (N.D. Cal. Dec. 15, 2023). In response, UBH has filed a petition for writ of mandamus asking the Ninth Circuit to hold that its August 2023 decision bars the plaintiffs from seeking to revive their reprocessing class action through a renewed motion for class certification. *See United Behavioral Health v. U.S. Dist. Ct.*, No. 24-242, Dkt. 1.1 (9th Cir. Jan. 12, 2024). On April 26, 2024, the same panel that decided UBH's original appeal (and thus the same panel that issued the August 2023 decision) ordered the plaintiffs to respond to UBH's

mandamus petition by May 17, 2024. *See id.*, Dkt. 12.1 (9th Cir. Apr. 26, 2024). Plaintiffs have filed their response, and UBH filed their reply on May 22, 2024. As of this publication, the Ninth Circuit has not yet ruled on UBH's mandamus petition.

The Tenth Circuit also weighed in on reprocessing in a pair of decisions last year, ruling on August 15, 2023 that reprocessing was appropriate for an individual plaintiff in *David P. v. United Healthcare Insurance Co.*, 77 F.4th 1293, 1299 (10th Cir. 2023). The Tenth Circuit agreed with the district court that the Defendants' claims processing procedure was deficient because it failed to "engage with the opinions of" the patient's treating providers. *Id*. at 1309–10. But it rejected the Plaintiffs' argument that in light to this asserted defect, the district court should simply "outright gran[t] Plaintiffs their claimed benefits." *Id.* at 1315. Instead, the court agreed with the Defendants that the district court should remand "Plaintiffs' claims for benefits" to the plan administrator "for proper consideration." *Id*.

This decision adds further clarity to the standard articulated by the Tenth Circuit in *D.K. v. United Behav. Health*, 67 F.4th 1224, 1229 (10th Cir. 2023). In *D.K.*, the court held that it was not an abuse of discretion for a district court to award benefits directly to the plaintiffs instead of remanding the claim decision to the plan administrator for reprocessing. *Id*. at 1244. The court explained that awarding benefits directly may be appropriate "when the record shows that benefits should clearly have been awarded by the administrator" or when the administrator's actions were "clearly arbitrary and capricious." *Id*. at 1243. Applying that standard, the Tenth Circuit held that remand was unnecessary because the Defendant had committed too many "repeated procedural errors" to warrant "an additional 'bite at the apple.'" *Id.* at 1244. In contrast, in *David P.*, the Tenth Circuit held that remand was the appropriate remedy because the record was insufficient to clearly establish that plaintiffs were entitled to the benefits they sought. 77 F.4th at 1315. These cases illustrate the ongoing challenge of determining when remand is appropriate in an individual denial of benefits case.

C. Fourth Circuit Addresses Whether Monetary Relief Is Available Under § 502(a)(3)

Plaintiffs seeking monetary relief following a denial of benefits received a mixed ruling from the Fourth Circuit in *Rose v. PSA Airlines, Inc.*, 80 F.4th 488 (4th Cir. 2023). There, the Fourth Circuit held that an unjust enrichment claim for monetary relief may proceed only if the plaintiff can allege specific traceable profits retained as a result of the wrongful act. In *Rose*, the administrator of a deceased beneficiary's estate brought a wrongful denial of benefits claim under ERISA § 502(a)(1)(B) and a breach of fiduciary duty claim under § 502(a)(3), alleging that plan administrators wrongfully refused to cover a heart transplant and seeking monetary relief under both claims. *See id.* at 492–94. According to the complaint, the plan administrators first denied coverage on the basis that the treatment was experimental and later on the basis that an alcohol-abuse exception precluded coverage, but an external review ultimately determined that the transplant should have been covered. *See id.* at 493–94. The district court granted the plan administrators' motion to dismiss, concluding that monetary compensation is not a benefit "due" "under the terms of [the] plan" and ERISA does not provide generally for compensatory, "make-whole" monetary relief under § 502(a)(3). *Id.* at 493.

On appeal, the Fourth Circuit affirmed the dismissal of the § 502(a)(1)(B) denial of benefits claim, explaining that the only benefit "due" under the plan was the transplant itself. *See id.* at 495. Therefore, the beneficiary was limited to seeking either an injunction requiring the plan to cover the surgery beforehand or reimbursement for out-of-pocket expenses had he obtained the transplant and paid for it out of pocket, not the "*monetary cost* of the benefit that was never provided." *See id.* (emphasis in original).

The bulk of the court's analysis focused on the § 502(a)(3) claim, which it remanded. That section allows a beneficiary to seek "other appropriate equitable relief" to "redress" a violation of the plan's terms. 29 U.S.C. § 1132(a)(3). The court explained that the Supreme Court has construed this provision to only allow for relief that would be "*typically* available in equity." *Rose*, 80 F.4th at 498–500 (emphasis in original) (quoting *Montanile v. Bd. of Trustees of Nat. Elevator Indus. Health Benefit Plan*, 577 U.S. 136, 142 (2016)). As it pertains to monetary relief, the court determined that equity would allow a plaintiff who can "point[] to specific funds that he rightfully owned but that the defendant possessed as a result of unjust enrichment" to recover, *id.* at 500, whereas a plaintiff claiming broader "relief that amounts to personal liability paid from the defendant's general assets" cannot, *id.* at 502. In reaching that conclusion, the court determined that the Supreme Court's guidance in *CIGNA Corp. v. Amara*, 563 U.S. 421 (2011), that ERISA might allow for more general "'make-whole,' loss-based, monetary relief under § 502(a)(3)," was mere dicta that had been later disavowed by the Supreme Court, and the court declined to follow prior Fourth Circuit decisions that could potentially permit the broader claim for relief. *Rose*, 80 F.4th at 502–03 (citing *Montanile*, 577 U.S. at 148 n.3). Thus, the court held that only a plaintiff who can point to "specifically identified funds that remain in the defendant's possession or . . . traceable items that the defendant purchased with the funds" can possibly recover those "unjust gains." *Id.* at 504. In this case, because the plaintiff had alleged that "the defendants have been unjustly enriched by keeping the money they should have paid [the beneficiary]'s doctors," *id.* at 496, the court remanded to the district court to consider whether the plaintiff had plausibly alleged that the "defendant was unjustly enriched by interfering with [the beneficiary]'s rights and (2) that the fruits of that unjust enrichment remain in the defendant's possession or can be traced to other assets." *Id.* at 504–05 (footnote omitted).

Judge Heytens wrote a separate opinion agreeing with the majority's treatment of the § 502(a)(1)(B) claim and its ruling that the "502(a)(3) claim should be remanded for further proceedings." *Id.* at 505 (Heytens, J., concurring in part and dissenting in part). But he disagreed with the majority's treatment of the law of the circuit, explaining that the Supreme Court's statements in *Montanile* did not undermine the dicta in *Amara* that the Fourth Circuit had previously adopted on the merits. *Id.* at 507. Thus, he would not have required the beneficiary to "show traceability" in order to obtain relief. *Id.*

Following this opinion, the plaintiff petitioned for certiorari, which the Supreme Court denied. Minute Entry, *Rose v. PSA Airlines Inc.*, No. 23-734 (U.S. Apr. 15, 2024).

Ultimately, the Fourth Circuit's ruling suggests a fairly narrow and perhaps difficult path for financial recovery for such claims. We will continue to follow related developments in lower courts following this decision.

D. Courts of Appeal Address the Scope of the Parity Act

The Mental Health Parity and Addiction Equity Act (the "Parity Act") is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. Recent litigation regarding the scope of the Parity Act reflects an increased focus by the plaintiffs' bar on seeking access to behavioral health treatment, mental health treatment, and substance use disorder treatment through Parity Act claims.

In *E.W. v. Health Net Life Insurance Co.*, the Tenth Circuit partially reopened a suit by a plan participant who accused his insurer of wrongfully refusing coverage for his daughter's in-patient care. 86 F.4th 1265 (10th Cir. 2023). The plaintiff alleged that the insurer unlawfully treated mental health treatment differently from medical and surgical care, in violation of the Parity Act. *Id.* at 1278–79, 1289. Defendants argued that they did not provide unequal coverage for mental health care in comparison to other types of treatment and instead plaintiffs had failed to identify the medical necessity criteria, dooming their claim. *Id.* at 1289. The district court agreed, resulting in dismissal of the complaint. *Id.* at 1280.

The Tenth Circuit reversed, concluding that the plaintiffs stated a claim under the Parity Act. The court reasoned that while a plaintiff must allege a disparity between mental health or substance use disorder benefits and medical/surgical benefits, defendants' decision to not provide the criteria plaintiffs requested prevented plaintiffs from knowing the criteria used by the insurer when determining coverage sufficed to establish a disparity. *Id.* at 1290–91. The Tenth Circuit declined to decide whether the Parity Act provides for a private right of action because the issue was not contested by the parties, but nonetheless laid out the elements of a Parity Act claim. *Id.* at 1281.

Also argued in 2023 was a Ninth Circuit case concerning claims processing under the Parity Act. *Ryan S. v. UnitedHealth Grp., Inc. et al.*, 9th Cir. Case No. 22-5761. In *Ryan S.*, a proposed class of patients accused a health plan administrator of wrongly denying coverage for substance use disorder treatment in violation of ERISA and the Parity Act. On remand from a prior appeal, the district court noted that there is "no clear law on how to state a claim for a Parity Act violation," dismissed plaintiffs' Parity Act claim, and concluded that plaintiff had not plausibly alleged that his (or the class's) injuries stemmed from a breach of ERISA fiduciary duties. *Ryan S. v. UnitedHealth Grp., Inc.*, 2022 WL 2813110, at *2, *5 (C.D. Cal. July 14, 2022).

The Ninth Circuit reversed the dismissal of the Parity Act and fiduciary duty claims. *Ryan S. v. UnitedHealth Grp., Inc.*, 98 F.4th 965 (9th Cir. 2024). The court first reasoned that a plaintiff must allege "the existence of a procedure used in assessing [mental health or substance use disorder benefits claims] that is more restrictive than those used in assessing some other claims under the same classification" to state a Parity Act claim. *Id.* at 969. When that challenge is to a particular internal process, the plaintiff must "provide some reason to believe that the denial of [mental health or substance use disorder benefits] claims was impacted by a process that does not apply to" analogous medical and surgical claims. *Id*. at 973. The Ninth Circuit reasoned that the plaintiff met that pleading standard because he alleged that his claims were denied and he cited to a 2018 agency report that concluded that the defendant processed mental health and substance use disorder claims using an algorithmic process that, depending on a patient's

progress, can cause the claim to be referred to peer review that could result in a denial of services. *Id.* Because there was “no comparable additional review process” for medical and surgical claims, the alleged use “algorithmic process” that could “trigger additional levels of review” and denial of claims was sufficient to allege a violation of the Parity Act. *Id.* at 973–74. Finally, because plaintiff alleged that a more rigid review process applied to his mental health and substance use disorder benefits claims, the Ninth Circuit reasoned that the fiduciary duty claim survived as well. *Id.* at 974.

These decisions, particularly the Tenth Circuit’s decision in *E.W.*, still leave open whether a defendant could successfully challenge a Parity Act claim based on a lack of a private right of action. But notwithstanding this open question of law, both *E.W.* and *Ryan S.* propose similar elements for such a claim, requiring that plaintiffs prove or allege the relevant plan is subject to the Parity Act; that the plan provides for both medical/surgical benefits and mental health/substance use disorder benefits; that there are medical/surgical benefits that are analogous to the mental health/substance use disorder benefits; and a disparity between those benefits.

E. New Developments Regarding the No Surprises Act

Recent litigation regarding the No Surprises Act (“NSA” or “Act”), 42 U.S.C. § 300gg-111, is also likely to have significant implications for ERISA health plans moving forward. The NSA responds to concerns that patients sometimes face unexpected bills from out-of-network providers. It does so by limiting patients’ cost-sharing payments for most surprise out-of-network services, and establishing an independent dispute resolution (“IDR”) process to resolve payment disputes between providers and insurers. Patients’ cost share is calculated based on the “qualifying payment amount” (“QPA”)—an amount that approximates what the provider would be paid for providing the relevant services in-network. Health care providers and insurers then engage in the IDR process to determine the insurer’s payment either through negotiation or through arbitration before a private entity (the “IDR entity”) certified by the Departments of Health and Human Services, Treasury, and Labor. The IDR entity’s determination of the reimbursement rate is based on the QPA and other factors enumerated in the NSA.

Over the past several years, the Biden Administration has promulgated a series of regulations and guidance establishing the IDR process, the method for calculating the QPA, the administrative fee for IDR disputes, and batching criteria for those disputes. In the past year, however, Judge Kernodle in the Eastern District of Texas—in lawsuits brought by a provider organization, the Texas Medical Association (“TMA”)—has issued three decisions vacating these regulations and guidance.

First, TMA challenged the regulations establishing the IDR process, arguing that they “unlawfully ‘pu[t] a substantial thumb on the scale in favor of the QPA’” and forced the IDR entity to disregard other factors enumerated in the statute that might warrant payment above the QPA amount. *Tex. Med. Ass’n v. HHS* (“*TMA II*”), 654 F. Supp. 3d 575, 587 (E.D. Tex. 2023). The regulations purportedly did this by instructing IDR entities to consider the QPA first and to disregard information regarding the other factors if it found that information to be non-credible, irrelevant, or duplicative of information already accounted for by the QPA. The government argued that these aspects of the regulations were supported by its statutory authority to establish the IDR process,

see 42 U.S.C. § 300gg-111(c)(2)(A), and to "fil[l] … 'gap[s]' in the statute 'concerning how to evaluate the various pieces of information that go into selecting payment amounts,'" *TMA II*, 654 F. Supp. 3d at 592. But Judge Kernodle disagreed, concluding that "there is no 'gap'" to fill because the NSA "vests discretion in the arbitrators—not the Departments" to decide how to evaluate this information "based on their expertise as set forth in the statute." *Id.* at 591-92. The court thus vacated the regulations in a February 2023 decision. *Id.* at 595.

The government's appeal from that decision is fully briefed in the Fifth Circuit, which held oral argument in February 2024 before Judges King, Jones, and Oldham. At the argument, a majority of the panel appeared skeptical of the challenged regulations, with Judge Jones suggesting that the IDR process would have worked "perfectly well" without the challenged regulations, and Judge Oldham suggesting that the approach reflected in the regulations was "not the statute Congress wrote here." As of this publication, however, the panel has yet to issue its decision.

Second, TMA successfully challenged the regulations establishing the methodology for calculating the QPA. The QPA for a service is calculated by identifying all "contracted rates recognized by the plan or issuer" and taking the median of those rates. 42 U.S.C. § 300gg-111(a)(3)(E)(i). In *Texas Medical Ass'n v. HHS* ("*TMA III*"), 2023 WL 5489028 (E.D. Tex. Aug. 24, 2023), Judge Kernodle held that several provisions of the regulations were inconsistent with the statute's definition of the QPA. That included provisions directing insurers, in calculating the QPA, to: (1) include contracts with an in-network provider that list rates for a service that the provider does not actually provide (so-called "ghost rates"); (2) exclude agreements governing only a single case; (3) exclude incentive and bonus payments; and (4) calculate a single QPA for different specialties when the insurer does not vary its in-network rates by specialty; and that (5) allowed self-funded plans to include contracts with other plans administered by the plan's third-party administrator. The court also vacated a separate regulation directing insurers to transmit their initial payment or notice of denial of payment to the provider within 30 days after the insurer "receives the information necessary" to make its payment determination, as opposed to 30 days after the provider submits a claim (even if lacking the necessary information). The court nonetheless upheld regulations specifying the information that insurers must disclose to providers about their QPA calculations. Several of these rulings—the rulings on ghost rates, single-case agreements, incentive and bonus payments, timing of payment, and disclosure—have been appealed to the Fifth Circuit. As of this publication, briefing in that appeal is still underway.

Third, Judge Kernodle also vacated regulations and guidance that set the administrative fee for each IDR dispute at $350 and permitted providers to batch IDR disputes together only if they concerned services billed under the same service code. *Tex. Med. Ass'n v. HHS* ("*TMA IV*"), 2023 WL 4977746, at *6-15 (E.D. Tex. Aug. 3, 2023). The Biden Administration has since promulgated an amended regulation setting the administrative fee at $115, but has yet to finalize amended batching criteria.

As a result of this litigation, IDR operations were paused several times throughout 2022 and 2023, but the IDR process has been fully reopened since December 15, 2023.

The Second Circuit also recently reaffirmed a decision rejecting a constitutional challenge to the NSA brought by a small group of providers. The providers had argued that the IDR process: (1) violates the Takings Clause by depriving them of their common-law right to payment of the fair

value of their services; (2) violates the Seventh Amendment by depriving them of the right to a jury trial that they would otherwise enjoy in suits against patients; and (3) deprives them of due process by allowing insurers to calculate the QPA unilaterally and to thereby dictate the amount of payment. In an August 2022 decision, a district court dismissed the Takings and Seventh Amendment claims on the merits and dismissed the due process claims as premature due to the ongoing litigation regarding the regulations establishing the IDR process. *Haller v. HHS*, 621 F. Supp. 3d 343, 352-62 (E.D.N.Y. 2022). The providers appealed the rulings on the Takings Clause and Seventh Amendment. But on appeal, they modified their Seventh Amendment theory. Rather than relying on their right to a jury trial in claims against *patients*, the providers asserted for the first time that they had direct claims against *insurers* on which they were entitled to a jury trial. The Second Circuit affirmed the dismissal of their original theories, but remanded for the district court to consider their new theory in the first instance. *Haller v. HHS*, 2024 WL 290440, at *1-2 (2d Cir. Jan. 23, 2024). As of this publication, the providers have indicated that they intend to file an amended complaint in July 2024.

V. ERISA Litigation Issues on the Horizon

The world of ERISA litigation will continue to evolve in 2024 and beyond. Among other emerging trends, fiduciaries should be aware of an uptick in suits challenging (1) actuarial equivalence in pension benefits, (2) how fiduciaries use plan forfeiture accounts, and (3) pension risk transfer transactions.

Growing Prevalence of "Actuarial Equivalence" Suits

We continue to see class actions brought against sponsors of defined benefit pension plans claiming that the plans violate ERISA because they fail to provide joint and survivor annuity ("JSA") and other forms of benefit that are "actuarially equivalent" to a single life annuity ("SLA"). Relevant here, ERISA requires defined benefit plans to offer married participants a JSA that is the "actuarial equivalent" of a SLA for the life of the participant. 29 U.S.C. § 1055(d); *see also* 29 U.S.C. § 1054(c)(3). But the statute does not define the phrase "actuarial equivalent," nor does it dictate what assumptions a plan must use to determine actuarial equivalence. In these lawsuits, plaintiffs challenge under ERISA the reasonableness of the assumptions their plans use to calculate JSA benefits—*i.e.*, the interest rates and mortality tables—arguing that defendants use inapt or out-of-date actuarial assumptions. Plaintiffs seek to reform their plans to require the use of assumptions that would, in their view, result in greater JSA benefits. The issues involved in these cases are complex, and to date, no court of appeals has weighed in on the merits of plaintiffs' theories. But as the cases proceed through resolution and appeal, the federal courts will have opportunities to provide guidance to plan sponsors concerning ERISA's requirements for calculating JSA benefits.

Plaintiffs first started bringing claims under this theory in late 2018, and they have thus far had mixed results on the merits. At least two courts recently rejected plaintiffs' theories as a matter of law on the basis that the text of ERISA does not require that interest rates and mortality tables used to calculate JSA benefits be "reasonable." *See Belknap v. Partners Healthcare Sys., Inc.*, 588 F. Supp. 3d 161, 175 (D. Mass. 2022); *Reichert v. Kellogg Co.*, No. 2:23-cv-12343 (E.D. Mich Apr. 17, 2024), ECF No. 36. And another court recently held that plaintiffs had failed to plead breach of fiduciary duty claims that the calculation methods used by their plan were

unreasonable simply because a different set of assumptions could have yielded higher benefits, but allowed other statutory claims to proceed. *Skrtich v. Pinnacle West Capital Corp.*, No. 2:22-cv-1753 (D. Ariz. Aug. 7, 2023), ECF. No. 29.

A number of other recently filed cases are awaiting decisions on motions to dismiss or are proceeding through discovery and summary judgment. *See, e.g.*, *Franklin v. Duke University*, No. 1:23-cv-833 (M.D.N.C.) (motion to dismiss denied, pending appeal); *Hamrick v. E.I. Du Pont de Nemours and Company*, No. 1:23-cv-238 (D. Del.) (motion to dismiss granted in part and denied in part); *Whetstone v. Howard University*, No. 1:23-cv-2409 (D.D.C.) (motion to dismiss pending); *Watt v. FedEx Corp.*, No. 2:23-cv-2593 (W.D. Tenn.) (motion to dismiss pending); *Bennet v. Ecolab*, 0:24-cv-546 (D. Minn.) (no response to amended complaint yet filed). We will continue to monitor this rapidly evolving area of law as cases are filed and move toward resolution.

New Wave of Fiduciary-Breach Suits Concerning Plan Forfeiture Accounts

Plan fiduciaries can expect to continue to see an influx of suits alleging claims for breach of fiduciary duty through the use of forfeitures in retirement plans. In these cases, plaintiffs claim that plans violate ERISA by using forfeitures to reduce company contribution costs instead of using the funds to defray plan administrative expenses. The IRS permits plans to use forfeitures to reduce company contributions under certain circumstances, but the Department of Labor has not yet weighed in on whether this is permissible under ERISA.

As one example, in *McManus v. Clorox Co.*, No. 4:23-cv-05325 (N.D. Cal.), the plaintiff alleged that defendant violated ERISA by using 401(k) forfeitures to reduce company contribution costs instead of to pay plan administrative expenses that are otherwise paid from participant accounts. Plaintiffs also separately raised claims under ERISA's anti-inurement and prohibited transaction provisions. Defendants recently filed a motion to dismiss, which is pending, arguing that the plan permits the fiduciaries to use forfeitures in this way, the fiduciaries properly disclosed how they apply forfeitures, and the fiduciaries did not otherwise violate any duties under ERISA.

The Southern District and Northern District of California have each recently weighed in on this issue. The Southern District of California denied defendants' motion to dismiss in *Perez-Cruet v. Qualcomm Inc.*, No. 3:23-cv-1890 (S.D. Cal.), allowing plaintiff's forfeiture claims to proceed. The court reasoned that because the plan sponsor used forfeitures to offset its own future contributions, instead of offsetting administrative expenses that were otherwise paid by plan participants, plaintiff had plausibly alleged a breach of the duty of loyalty under ERISA. The court also held that plaintiff stated a claim for breach of ERISA's duty of prudence because defendants allegedly "harmed the participants" by "letting the administrative expense charge fall on the participants rather than the employer" despite the plan documents expressly providing that the sponsor could use the forfeitures in this way. Applying similar reasoning, the court concluded that plaintiff had adequately pleaded claims for violations of ERISA's anti-inurement and prohibited transaction provisions.

However, the Northern District of California recently issued a decision granting defendant's motion to dismiss in *Hutchins v. HP Inc.*, 5:23-cv-05875 (N.D. Cal.). There, the court reasoned

that the plan did not require the sponsor to pay administrative costs, and plaintiff was not otherwise entitled to them under ERISA. Thus, the plan sponsor did not breach any fiduciary duty under ERISA by declining to use forfeited funds to pay administrative costs that would otherwise be paid by participants. The court likewise concluded that plaintiff's prohibited transaction claims were implausible because they fell outside of "the types of commercial transactions contemplated by Congress." Thus, the court held that plaintiff's claims were implausible and must be dismissed, but granted him the opportunity to replead.

Nearly identical complaints have also been filed against other plan sponsors over the past six months. *See, e.g.*, *Rodriguez v. Intuit, Inc.*, No. 5:23-cv-5053 (N.D. Cal.); *Barragan v. Honeywell Intl., Inc.*, No. 2:24-cv-1194 (C.D. Cal.); *Prattico v. Mattel, Inc.*, No. 2:24-cv-2624 (C.D. Cal.). It remains to be seen whether the DOL or other courts will follow the lead of the Southern District of California in *Perez-Cruet*, or the reasoning of the Northern District of California in *Hutchins.* We will continue to monitor these cases.

String of New Lawsuits Concerning Pension Risk Transfer Transactions

Early this year, we also saw a series of lawsuits challenging how fiduciaries managed pension risk transfer transactions. In the practice of pension de-risking, a plan sponsor may purchase an annuity contract with an insurer to satisfy benefit obligations under the plan for some or all of the plan participants, thereby shifting pension liability risk to the insurer. While plaintiffs acknowledge that these arrangements are permissible under federal benefits law, they argue that fiduciaries nevertheless breach their duties if they fail to engage in a monitoring process that results in the selection of the safest annuity provider available to assume these obligations. The cases challenging pension risk transfers, which are still in their early stages, are pending in Maryland, Washington, DC, and Massachusetts. *See Camire et al v. Alcoa USA Corp.*, No. 1:24-cv-01062 (D. D.C.); *Konya et al v. Lockheed Martin Corp.*, No. 8:24-cv-750 (D. Md.); *Schloss et al. v. AT&T, Inc. et al.*, No. 1:24-cv-10656 (D. Mass.); *Piercy et al. v. AT&T Inc. et al.*, No. 1:24-cv-10608 (D. Mass.). Pension risk transfers have been growing in popularity in recent years, and these cases warrant a close watch by plan sponsors and fiduciaries considering pension de-risking.

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