GIBSON DUNN

2020 Year-End ERISA Disputes Update

Client Alert | February 11, 2021

With the emergence of COVID-19, 2020 was a year of significant and unprecedented change in daily life and the economy. In particular, 2020 was a busy year for Employee Retirement Income Security Act ("ERISA") lawsuits—across industries—implicating employers' retirement and healthcare plans. Not only were there significant decisions on a number of key issues impacting these lawsuits, but COVID-19 also triggered new and different legal exposure for plan sponsors and administrators. Recognizing the importance of this area of law to its clients, in 2020, Gibson Dunn launched an ERISA Disputes Practice Area, bringing together the Firm's deep knowledge base and significant experience from across a variety of its award-winning practice groups, including: Executive Compensation & Employee Benefits, Class Actions, Labor & Employment, Securities Litigation, FDA & Health Care, and Appellate & Constitutional Law.

This 2020 year-end update summarizes key legal opinions and provides helpful analysis to assist plan sponsors and administrators navigating this unprecedented time.

Section I highlights four notable opinions from the United States Supreme Court addressing ERISA's statute-of-limitations, Article III standing, and ERISA preemption. The Court also remanded a case to the Second Circuit concerning the pleading standard for alleging a breach of the duty of prudence under ERISA on the basis of a failure to act on insider information.

Section II provides a summary of hot topics in ERISA class-action litigation, including notable developments in fiduciary breach litigation and a growing trend of COBRA notice litigation.

Section III addresses evolving procedural issues, including the standard of review of benefits claim decisions, and an emerging circuit split on the arbitrability of claims brought on behalf of plans.

Section IV offers an overview of key issues in health plan litigation, including trends in behavioral health and residential treatment coverage disputes, and updates on assignments and anti-assignment clauses.

Related People

Karl G. Nelson

Geoffrey Sigler

Katherine V.A. Smith

Heather L. Richardson

Lucas C. Townsend

Jennafer M. Tryck

Matthew S. Rozen

Robert A. Batista

Brian McCarty

Jennifer H. Roges

I. Significant Activity in the Supreme Court

2020 saw a significant rise in ERISA cases reaching the United States Supreme Court. In fact, the Court decided four ERISA cases in 2020, which is more than the Court has decided in any other year of the statute's 45-year existence. These decisions provide helpful guidance to litigants on important topics in ERISA litigation. In *Intel Corp. Investment Policy Committee v. Sulyma*, 140 S. Ct. 768 (2020), the Court resolved a circuit conflict regarding when employers and plan fiduciaries can invoke the three-year statute of limitations period under Section 413(2) for an alleged breach of fiduciary duty. In

Thole v. U.S. Bank N.A., 140 S. Ct. 1615 (2020), addressing fiduciary breach claims against a defined-benefit pension plan, the Court clarified when participants in an ERISA plan have Article III standing to sue for statutory violations. In *Rutledge v. Pharmaceutical Care Management Ass'n*, 141 S. Ct. 474 (2020), the Court again addressed the scope of ERISA preemption, particularly with respect to state regulations of health care and prescription drug costs, as well as state regulations of intermediaries. Finally, in *Retirement Plans Committee of IBM v. Jander*, 140 S. Ct. 592 (2020), the Supreme Court was expected to address whether the "more harm than good" pleading standard from *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 430 (2014), can be satisfied by generalized allegations that the harm resulting from the inevitable disclosure of an alleged fraud generally increases over time, but instead, in a *per curiam* decision, declined to rule on the merits and remanded the case to the Second Circuit.

A. *Intel Corp. Investment Policy Committee, et al. v. Sulyma* Addresses Statute of Limitations

In *Intel Corp. Investment Policy Committee, et al. v. Sulyma*, 140 S. Ct. 768 (2020), the Supreme Court addressed the circumstances in which employers and plan fiduciaries can invoke ERISA's three-year statute of limitations for an alleged breach of fiduciary duty, unanimously holding that in order to trigger the three-year limitations period, an employee must have become "aware of" the plan information and that a fiduciary's disclosure of plan information alone does not meet the "actual knowledge" requirement.

The plaintiff, a former employee of Intel, sued Intel's investment committee, administrative committee and finance committee (collectively, "Intel"), alleging that his retirement plans improperly overinvested in alternative investments. *Id.* at 774. Under Section 413(1) of the Employment Retirement Income Security Act of 1974 (ERISA), breach of fiduciary duty claims may be brought within six years of the breach or violation. However, Section 413(2) of ERISA shortens the limitations period to "three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation." 29 U.S.C. § 1113(2). Plaintiff filed suit within six years of the alleged breaches but more than three years after petitioners had disclosed their investment decisions to him. *Sulyma,* 140 S. Ct. at 774. While Intel provided records showing that the plaintiff had received numerous disclosures explaining the extent to which his retirement plans were invested in alternative assets, the plaintiff testified in a deposition that he didn't remember reviewing the disclosures and also stated in a declaration that he was unaware that his account was invested in alternative investments. *Id.* at 775.

The Court unanimously affirmed the Ninth Circuit's decision holding that a plaintiff does not necessarily have "actual knowledge" based on receipt alone of information if he did not read it. *Id.* at 779. While the disclosure of information to plaintiff is "no doubt *relevant* in judging whether he gained knowledge of that information," to meet § 1113(2)'s "actual knowledge" requirement, the plaintiff must have become aware of that information. *Id.* at 777. The Court emphasized that its decision does not foreclose any of the "usual ways" to prove actual knowledge at any stage in litigation—including through proof of willful blindness—and that the decision will not prevent defendants from using circumstantial evidence to show actual knowledge. *Id.* at 779.

Gibson Dunn submitted an *amicus* brief on behalf of the National Association of Manufacturers, the American Benefits Counsel, the ERISA Industry Committee, and the American Retirement Association in support of petitioner: Intel Corp. Investment Policy Committee.

As we discussed in our Appellate Update on the *Sulyma* decision, we expect the Court's holding to lead to an uptick in lawsuits against employers and plan fiduciaries, based on allegations that the three-year limitations period is inapplicable because they did not read or cannot recall reading plan documents.

B. *Thole v. U.S. Bank N.A.* Addresses Article III Standing

As we reported in our Appellate Update, in June of last year, the Supreme Court held that participants in a fully funded defined-benefit pension plan lacked Article III standing to sue under ERISA for breach of fiduciary duties because they had no "concrete stake in the lawsuit." *Thole v. U.S. Bank N.A.*, 140 S. Ct. 1615, 1619 (2020). The plaintiffs in *Thole* alleged that the plan fiduciaries "violated ERISA's duties of loyalty and prudence by poorly investing the assets of the plan," resulting in a loss of $750 million. *Id.* at 1618. Defendants moved to dismiss for lack of standing, which the district court granted. *Id.* at 1619. The Eighth Circuit "affirmed on the ground that the plaintiffs lack[ed] statutory standing [under ERISA]." *Id.*

The Supreme Court, in a 5-4 decision authored by Justice Kavanaugh, affirmed on the ground that plaintiffs lacked Article III standing. *Id.* The Court explained that "[t]here is no ERISA exception to Article III" and that the plaintiffs lacked standing "for a simple, commonsense reason: They have received all of their vested pension benefits so far, and they are legally entitled to receive the same monthly payments for the rest of their lives." *Id.* at 1622. Accordingly, the Court reasoned that the plaintiffs did not have a "concrete stake in the lawsuit" as "[w]inning or losing [the] suit would not change the plaintiffs' monthly pension benefits." *Id.*

In so ruling, the Court rejected each of the four theories plaintiffs raised to demonstrate their standing. *Id.* at 1619–21. *First*, the Court rejected plaintiffs' argument, based on trust-law principles, that they have an equitable or property interest in the plan. *Id.* at 1619–20. The Court reasoned that "a defined-benefit plan is more in the nature of a contract" than a trust as "[t]he plan participants' benefits are fixed and will not change, regardless of how well or poorly the plan is managed." *Id.* at 1620. *Second*, the Court held that plaintiffs lacked standing to sue "as representatives of the plan itself" because they had not been "legally or contractually appointed to represent the plan." *Id. Third*, the Court found that even though ERISA affords all participants "a general cause of action to sue" it does not "affect the Article III standing analysis." *Id. Fourth*, and finally, the Court rejected plaintiffs' argument that defined-benefit plans will not be "meaningfully regulate[d]" if plan participants lack standing to sue as employers have "strong incentives" to manage plans and the Department of Labor can "enforce ERISA's fiduciary obligations." *Id.* at 1621.

In a concurring opinion, Justice Thomas, joined by Justice Gorsuch, objected to the Court's "practice of using the common law of trusts as the 'starting point' for interpreting ERISA" and recommended that the Court "reconsider our reliance on loose analogies in both our standing and ERISA jurisprudence." *Id.* at 1623. The concurrence called for the Court to return to a "simpler framework" for standing, and one in which the party must show injury to private rights. Justice Thomas stated there was no such injury in *Thole* because the private rights the petitioners alleged were violated did not belong to them; they belonged to the plan, and petitioners had no legal or equitable ownership interest in the plan assets. *Id.*

The Supreme Court's decision in *Thole* is welcome news to plan sponsors, fiduciaries, and administrators, all of whom can now rely on this decision to argue that participants of ERISA plans cannot sue for breach of fiduciary duty unless they have a "concrete stake in the lawsuit," such as a failure by the plan to make required benefits payments. *Id.* at 1619. In addition, *Thole*—and in particular Justice Kavanaugh's forceful statement that "[t]here is no ERISA exception to Article III"—provides strong support for application of Article III requirements and jurisprudence to cases brought under ERISA.

More litigation is ahead on these issues. For instance, a split among district courts has developed on the question of whether participants in defined-contribution plans have standing to bring claims challenging investments in which they did not personally invest. *Compare Cryer v. Franklin Templeton Res., Inc.*, 2017 WL 4023149, at *4 (N.D. Cal. July 26, 2017) (holding plaintiff had standing to sue for funds "in which he did not invest"

because “the lawsuit seeks to restore value to and is therefore brought on behalf of the [p]lan”); *McDonald v. Edward D. Jones & Co., L.P.*, 2017 WL 372101, at *2 (E.D. Mo. Jan. 26, 2017) (finding that “a plan participant may seek recovery for the plan even where the participant did not personally invest in every one of the funds that caused an injury to the plan”), *with Wilcox v. Georgetown Univ.*, 2019 WL 132281, at *9–10 (D.D.C. Jan. 8, 2019) (finding that plaintiffs did not have standing to challenge options in which they did not invest); *Marshall v. Northrop Grumman Corp.*, 2017 WL 2930839, at *8 (C.D. Cal. Jan. 30, 2017) (holding that plan participants lacked standing because they failed to allege that they invested in the particular fund). Since the Supreme Court made clear that injuries to the plan do not necessarily confer standing to the plan participants, *Thole* may support the argument that plaintiffs lack standing to bring suit when they did not personally invest in a challenged plan investment option. It remains to be seen whether, going forward, the courts adopt this interpretation of *Thole* to set limits on Article III standing in defined-contribution plan suits.

C. *Rutledge v. Pharmaceutical Care Management Association* Narrows ERISA Preemption

On December 10, 2020, the Supreme Court issued an 8-0 decision (Justice Barrett did not participate) in *Rutledge v. Pharmaceutical Care Management Association* holding that ERISA did not preempt an Arkansas statute regulating the rates at which pharmacy benefit managers reimburse pharmacies for prescription drug costs. Justice Sotomayor, who authored the opinion on behalf of the unanimous Court, relied on “[t]he logic of” the Court’s previous decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), to conclude that the Arkansas law “is merely a form of cost regulation . . . [that] applies equally to all PBMs and pharmacies in Arkansas,” and therefore is not subject to ERISA preemption because it did not have an impermissible connection with or reference to ERISA. 141 S. Ct. 474, 481 (2020). *Rutledge* is likely to be viewed by regulators as supporting state authority to regulate health care costs without running afoul of ERISA preemption. (Gibson Dunn’s Appellate Update discussing this case can be found here). Gibson Dunn submitted an *amicus* brief on behalf of the U.S. Chamber of Commerce in support of the Pharmaceutical Care Management Association.

In *Rutledge*, the Court ruled that “ERISA is . . . primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways,” which include those that require “payment of specific benefits,” those that bind “plan administrators to specific rules for determining beneficiary status,” and those where “acute, albeit indirect, economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage.” *Id.* at 480. The Court found that the need for regulatory uniformity—in particular, cost uniformity—is not absolute, and that it does not alone justify application of ERISA preemption: “[N]ot every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan,” which the Court noted is “especially so if a law merely affects costs.” *Id.* The following sentence from the Court’s opinion encapsulates its holding: “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.*

The *Rutledge* decision will impact future litigation regarding the scope of ERISA preemption. In particular, state regulators likely will rely on this decision in seeking to insulate state laws concerning prescription drug prices and pharmacy benefit managers from preemption. The reach of *Rutledge*, however, likely will be tested even beyond this immediate context, because state regulators can be expected also to defend other state laws and regulations on the basis that they merely impact health care costs and lack the necessary connection with ERISA plans under *Rutledge*. States may also attempt to enact new statutes and issue regulations of those health care intermediaries and other service providers to covered plans.

ERISA preemption will continue to be a hot area this year with the Ninth Circuit Court of Appeals hearing argument in *Howard Jarvis Taxpayers Association v. CA Secure Choice Retirement Savings Program* later this month, for example. In that case, the Ninth Circuit will evaluate whether ERISA preempts California's state-run auto-IRA program, which transfers portions of a person's paycheck into a retirement account.

D. *Retirement Plans Committee of IBM v. Jander* Remands Questions About *Dudenhoeffer* Pleading Standard to Second Circuit

As we discussed in a recent Securities Litigation Update, in *Retirement Plans Committee of IBM v. Jander*, 140 S. Ct. 592, 594 (2020), the Supreme Court was slated to address whether the "more harm than good" pleading standard from *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 430 (2014), "can be satisfied by generalized allegations that the harm of an inevitable disclosure of an alleged fraud generally increases over time." In *Dudenhoeffer*, the Court held that, in order to state a claim for breach of the duty of prudence under ERISA on the basis of a failure to act on insider information, a complaint must plausibly allege an alternative action that the fiduciaries could have taken that would not have violated securities laws and that a prudent fiduciary in the same circumstances would not have viewed as more likely to harm the fund than to help it. 573 U.S. at 428.

In *Jander*, plaintiffs, IBM employees who participated in an employee stock ownership plan (ESOP) sponsored by IBM, sued IBM's retirement plan fiduciary committee for breach of fiduciary duty, alleged that IBM misrepresented the value of its microelectronics division, thereby artificially inflating the value of company stock, and caused a drop in the stock price upon selling the microelectronics division. *Jander v. Ret. Plans Comm. of IBM*, 272 F. Supp. 3d 444, 446–47 (S.D.N.Y. 2017). Plaintiffs' claims were dismissed by the district court on the basis that the complaint lacked context-specific allegations as to why a prudent fiduciary couldn't have concluded that plaintiff's hypothetical alternatives were more likely to do more harm than good, failing to satisfy the *Dudenhoeffer* pleading standard. *Id.* at 449–54.

The Second Circuit reversed, holding that plaintiffs had pled a plausible claim for violation of ERISA's duty of prudence based on (1) the fiduciaries' knowledge that the stock was inflated through accounting violations; (2) their power to disclose these accounting violations; and (3) their failure to promptly disclose the true value of the microelectronics division. *Jander v. Ret. Plans Comm. of IBM*, 910 F.3d 620, 628–31 (2d Cir. 2018). Ultimately, the Second Circuit held that if the fiduciaries knew that disclosure of the insider information was inevitable, then delaying this disclosure would cause more harm than good to the ESOP. *Id.* at 630.

In a *per curiam* decision issued on January 14, 2020, the Supreme Court declined to rule on the merits in *Jander*, and vacated and remanded the case for the Second Circuit to address two unresolved issues raised by the parties: (1) whether ERISA ever imposes a duty on a fiduciary for an ESOP to act on inside information, and (2) whether ERISA requires disclosures that are not otherwise required by the securities laws. 140 S. Ct. at 594–95. Justice Kagan (joined by Justice Ginsburg) and Justice Gorsuch issued concurring opinions, articulating differing views on how these questions should be resolved on remand. *See id.* at 595–96 (Kagan, J. concurring); *id.* at 596–97 (Gorsuch, J. concurring). On remand, the Second Circuit reinstated its original opinion, again reversing the district court's decision. *Jander v. Ret. Plans Comm. of IBM*, 962 F.3d 85, 86 (2d Cir. 2020) (per curiam).

While not purporting to break new ground, the Court nevertheless noted two things. *First*, the Court explained that the *Dudenhoeffer* "more harm than good" standard is the correct standard to apply to ESOP fiduciaries. *See* 140 S. Ct. at 594. *Second*, the Court made clear that ERISA's fiduciary duty of prudence does not require fiduciaries to act in a way that violates securities laws. *See id.* However, the opinion leaves unresolved whether

there may be circumstances in which ESOP fiduciaries are required to act on the basis of inside information to benefit an ESOP, and whether the *Dudenhoeffer* standard requires ESOP fiduciaries to disclose information that is not required by federal securities laws. *See id.* at 594–95.

In recent cases following *Jander*, at least one district court has concluded that the Second Circuit's decision should be classified as an outlier because "the overwhelming majority of circuit courts to consider an imprudence claim based on inside information post-*Dudenhoeffer* [have] rejected the argument that public disclosure of negative information is a plausible alternative." *Burke v. Boeing Co.*, No. 19-cv-2203, 2020 WL 6681338, at *5 (N.D. Ill. Nov. 12, 2020). Given this circuit split, plaintiffs may be more likely to target the Second Circuit for stock-drop and similar suits. However, in a recent decision from the Second Circuit, the court affirmed dismissal of an imprudence claim brought by a plaintiff who argued that two alternative actions—earlier disclosure and closure of the fund to additional investment—were "on par with those found sufficient in *Jander*." *Varga v. Gen Elec. Co.*, No. 20-1144, --- F. App'x ----, 2021 WL 391602, at *2 (Feb. 4, 2021). The court found plaintiff's allegations insufficient, conclusory, and not consistent with those in *Jander*, concluding that she had "failed to adequately plead alternative actions that the fiduciaries could have taken." *Id.* at *2–3. Thus, while *Jander* remains good law in the Second Circuit, the *Varga* decision suggests that courts will still look closely at plaintiffs' allegations of plausible alternative actions in the context of motions to dismiss.

II. Class Actions Continued To Be a Significant Focus of ERISA Litigation in 2020

The year 2020 was again a busy period in ERISA class-action litigation, particularly fiduciary-breach litigation. While large plans continue to be the primary targets of these lawsuits, plaintiffs are also targeting smaller plans—and some cases attempting to aggregate these claims by suing administrators or service providers to multiple plans. We discuss below two important circuit splits in the field of ERISA fiduciary-breach class actions, and also an emerging area of litigation concerning the required contents of COBRA notices.

A. Hot Topics in ERISA Fiduciary Breach Litigation

We continued to see significant activity in ERISA fiduciary-breach litigation in 2020, including on issues concerning (1) whether plaintiffs can state a fiduciary-breach claim based on offering a particular mix of investment options in a plan, and (2) whether single-stock funds are per-se imprudent under ERISA. We also may see changes regarding the rules governing whether investing in environmental, social, and corporate governance ("ESG") funds could constitute a fiduciary breach under ERISA.

As to the first issue, the Seventh, Third, and Eighth Circuits have all recently addressed whether plaintiffs can state a fiduciary-breach claim by alleging that a plan offered certain underperforming investment options, as well as other unobjectionable options. In *Divane v. Northwestern University*, 953 F.3d 980 (7th Cir. 2020), the Seventh Circuit held that plaintiffs failed to allege a fiduciary breach by claiming that defendants provided

investment options that were "too numerous, too expensive, or underperforming," when the defendant also offered low-cost index funds, among other options that the plaintiffs found unobjectionable. *Id.* at 991–92. A few months after the Seventh Circuit's decision in *Divane*, the Eighth Circuit appeared to adopt a more plaintiff-friendly interpretation by holding that plaintiffs could state a claim by alleging that "fees were too high" and that the defendants "should have negotiated a better deal." *Davis v. Wash. Univ. of St. Louis*, 960 F.3d 478, 483 (8th Cir. 2020); *see also Sweda v. Univ. of Pennsylvania*, 923 F.3d 320, 330 (3d Cir. 2019) (stating that "a meaningful mix and range of investment options" does not necessarily "insulate[] plan fiduciaries from liability for breach of fiduciary duty"). These holdings may suggest to plaintiffs that the Third and Eighth Circuits will be more receptive to these types of claims, prompting an increase in fee-suit litigation in those jurisdictions.

Additionally, a circuit split may have recently developed concerning whether single-stock funds are per se imprudent plan offerings under ERISA. In May 2020, the Fifth Circuit affirmed the dismissal of a putative fiduciary breach class action in *Schweitzer v. Investment Committee of Phillips 66 Savings Plan*, 960 F.3d 190 (5th Cir. 2020). The court held that defendants satisfied their fiduciary duties to diversify and to act prudently because they provided plan participants with an array of investment options that "enable[d] participants to create diversified portfolios." *Id.* at 196–98. Accordingly, the Fifth Circuit in *Schweitzer* rejected plaintiffs' claim that "a single-stock fund is imprudent per se." *Id.* at 197–98. But only a few months later, the Fourth Circuit held the opposite, concluding that defendants breached their fiduciary duty when offering a single-stock fund. *Stegemann v. Gannett Co.*, 970 F.3d 465, 468 (4th Cir. 2020). The Fourth Circuit rejected the argument that "diversification must be judged at the plan level rather than the fund level," holding that "*each available fund* on a menu must be prudently diversified." *Id.* at 476–77 (emphasis added). In dissent, Judge Niemeyer argued that "the majority merge[d] the duties of diversification and prudence," and, in effect, made it impossible for an employer to "ever prudently offer a single-stock, non-employer fund." *Id.* at 484, 488. No other court has yet adopted the Fourth Circuit's standard. Defendants in *Stegemann* filed a petition for a writ of certiorari, and on January 4, 2021, the Supreme Court called for a response from plaintiffs, indicating that the Justices may be interested in hearing the case.

Last, in the final year of the Trump administration, the Department of Labor ("DOL") proposed and adopted a new rule that ERISA fiduciaries must make investment decisions "based solely on pecuniary factors"; and an investment intended "to promote non-pecuniary objectives" at the expense of sacrificing returns or taking on additional risk would constitute a breach of the fiduciary's duty. *Financial Factors in Selecting Plan Investments*, 85 Fed. Reg. 72,846, 72,851, 72,848 (Nov. 13, 2020). Though the final version of the rule does not explicitly reference ESG funds, the DOL's press release announcing the rule expressly stated that the rule's purpose was to provide further guidance "in light of recent trends involving [ESG] investing." U.S. Dep't of Labor, *U.S. Department of Labor Announces Final Rule to Protect Americans' Retirement Investments* (Oct. 30, 2020), https://www.dol.gov/newsroom/releases/ebsa/ebsa20201030. The new rule took effect on January 12, 2021, 85 Fed. Reg. at 72,885, and there have not yet been any cases addressing when and whether investment in an ESG fund could constitute a fiduciary breach. Notably, the new rule appears to conflict with many of the Biden administration's stated environmental goals, and the DOL rule may be a target for reversal by the new administration.[1]

B. Growing Challenges Related to COBRA Notice

The year 2020 also saw a rise in COBRA notice litigation. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows employees and their dependents the opportunity to continue to participate in their employer's group health plan when coverage would otherwise be lost due to a termination of employment or other "qualifying event[s]." 29 U.S.C. § 1163. And plan administrators are required to provide notice to employees informing them of their right to elect COBRA coverage. 29 C.F.R. § 2590.606-4. COBRA

mandates that the notice include specific information and be "written in a manner calculated to be understood by the average plan participant." *Id.* § 2590.606-4(b)(4). Plaintiffs have filed numerous class actions against employers alleging technical violations in the language of the notices, seeking statutory penalties up to $110 per day for each participant that received inadequate notice.

Many COBRA notice lawsuits have been filed in Florida, with others filed in venues that include New York and South Carolina. The number of such lawsuits has recently been spurred by COVID-19 layoffs. Plaintiffs' allegations are substantially similar across cases, and generally allege that COBRA notices were deficient for one or more of the following reasons:

1. Notice failed to identify the name, address, and telephone number of the plan administrator;
2. Notice failed to identify the qualifying event;
3. Notice failed to explain how to enroll in COBRA coverage;
4. Notice failed to provide all the required explanatory language regarding the coverage;
5. Notice was not written in a manner calculated to be understood by the average plan participant; and/or
6. Notice failed to comply with the model notice created by the Department of Labor ("DOL").

The influx of COBRA notice litigation highlights the importance for employers of reviewing their COBRA notices to assess whether any changes may be necessary to ensure compliance with statutory guidelines and regulations. To assist employers, the DOL has issued model notices on its website that employers can review against their own notices to ensure they are in compliance. Employers who have outsourced COBRA administration should also periodically check in with their third-party administrators to confirm compliance with all guidelines and regulations and may want to consider clearly assigning responsibility for compliance with notice requirements in their vendor agreements.

III. Key Decisions on Important ERISA Procedural Issues

The courts also issued important guidance this year to ERISA practitioners, plan sponsors, and plan administrators concerning ERISA procedural issues. In particular, the courts issued rulings concerning the standard of review for benefits claims, and provided further guidance on the ability to compel arbitration of claims brought by participants on behalf of a plan. Both of these topics are discussed below.

A. The Evolving Abuse of Discretion Standard of Review

In 2020, courts continued to wrestle with the degree of deference owed to benefit determinations made by plan administrators. The well-established rule is that a court reviews the plan administrator's decision *de novo* unless the terms of the benefit plan give the administrator discretion to interpret the plan and award benefits. *See Firestone Tire &*

Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). Where the plan terms grant this discretion to the administrator, courts review the administrator's determinations under a deferential "abuse of discretion" standard (or arbitrary and capricious review, as some circuits call it). *Id*. Because it is common for benefit plans to give the administrator this discretion, the deferential standard often applies, and the Supreme Court has repeatedly parried attempts by plaintiffs to strip administrators of this deference. *See Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008) (abuse of discretion standard applies even when administrator has conflict of interest); *Conkright v. Frommert*, 559 U.S. 506, 522 (2010) (abuse of discretion standard applies even when court of appeals found previous related interpretation by administrator to be invalid).

Last year, plaintiffs persisted in their efforts to curtail the deferential abuse of discretion standard, and they found success in some instances. For example, in *Lyn M. v. Premera Blue Cross*, 966 F.3d 1061 (10th Cir. 2020), even though the plan gave the administrator discretion, the court nonetheless held that a *de novo* standard applied because plan members "lacked notice" of the discretion. *Id.* at 1065. The administrator failed to disclose the document granting discretion, and the plan summary it *did* disclose "said nothing about the existence" of that document. *Id.* at 1067. To preserve plan discretion under *Lyn M.*, plan documents—including the summary plan description that plans are required to provide to their members—should disclose either the grant of discretion to the administrator or the precise document conferring that discretion.

Additionally, even when an abuse of discretion standard is found to apply, courts have developed ways to limit the degree of deference given to plan administrators. The Ninth Circuit, for example, continues to apply varying degrees of "skepticism" to the administrators' determinations—as part of abuse of discretion review—when certain factors such as a conflict of interest are present. The precise degree of skepticism applied may provide a focal point for appellate review. In *Gary v. Unum Life Insurance Co. of America*, 831 F. App'x 812 (9th Cir. 2020), the circuit held that the district court "applied the incorrect level of skepticism to its abuse-of-discretion review." *Id.* at 814. The district court had applied a "moderate degree" of skepticism because it found that the plan administrator had a structural conflict of interest (based on the district court's belief that the administrator was responsible both for assessing and paying out claims) and had failed to afford the plaintiff a "full and fair review." *Id.* at 813. But the Ninth Circuit held that, viewing the evidence in the light most favorable to the plaintiff, the circumstances in the case called for an even "higher degree of skepticism." *Id.* This heightened skepticism was warranted, in the court's view, because it found that the administrator's consultants had "cherry-picked certain observations from medical records numerous times," the administrator had not conducted an in-person examination of the plaintiff, and the administrator had reversed in part its initial decision denying benefits in full. *Id.* at 814. This decision suggests that, at least in the Ninth Circuit, courts may limit the degree of deference afforded to administrators—even under an abuse of discretion review—in particular circumstances.

However, not all circuits have been so receptive to plaintiffs' efforts. The Eighth Circuit recently clarified its case law in this area, holding that, despite what an older circuit decision may have suggested and whatever other circuits may hold, a plan administrator's delay in deciding an appeal of a benefits denial does not warrant *de novo* review. *McIntyre v. Reliance Standard Life Ins. Co.*, 972 F.3d 955, 960, 964–65 (8th Cir. 2020). As with a conflict of interest, such delay is just a factor to be considered when applying abuse of discretion review. *Id.* at 965. The First Circuit also recently reaffirmed "the importance of giving deference" to plan administrators. *Arruda v. Zurich Am. Ins. Co.*, 951 F.3d 12, 24 (1st Cir. 2020). The plaintiff in *Arruda* argued that courts can find an administrator's decision arbitrary even when the administrator "relied on several independent experts" and a record consistent with its benefits determination. *Id.* at 21–22, 24. The First Circuit disagreed, finding this proposal to be "in considerable tension with" the abuse of discretion standard. *Id.* at 24.

Last year also saw circuit courts rebuff creative attempts by plaintiffs to avoid abuse of

discretion review. For instance, in *Ellis v. Liberty Life Assurance Co. of Boston*, 958 F.3d 1271 (10th Cir. 2020), *petition for cert. filed*, (U.S. Jan. 8, 2021) (No. 20-953), all parties agreed that the plan conferred discretion on the administrator, and the plan provided that it was governed by the law of Pennsylvania, but the plaintiff sought *de novo* review on the ground that a *Colorado* statute prohibited grants of discretion in insurance policies. *Id.* at 1275. The court rejected the plaintiff's argument that Colorado law should apply, holding that the law of the state selected by a plan's choice-of-law provision normally applies, "to effectuate ERISA's goals of uniformity and ease of administration." *Id.* at 1280. Notably, the court observed that this choice-of-law question "could be avoided if ERISA preempts the Colorado statute," but it declined to resolve this preemption issue, leaving it open for future litigation. *Id.* at 1279.

Finally, in *Davis v. Hartford Life & Accident Insurance Co.*, 980 F.3d 541 (6th Cir. 2020), once again all parties agreed that the plan conferred discretion to the administrator, but the plaintiff contended that the administrator exercised no discretionary authority because a different company in the same corporate family had actually made the decision to terminate benefits. *See id.* at 545–46. But the Sixth Circuit found this argument "d[id] not add up as a factual matter." *Id.* at 546. Even though the plan's decisionmakers received their salaries from the other company, they were still adjudicating claims under the *administrator's* policies, not the other company's policies. *Id.* This precedent presents a potential obstacle for future plaintiffs who try to use the structure of a plan administrator's corporate family as a backdoor means of securing *de novo* review.

B. A Possible Split on Arbitrability of ERISA § 502(a)(2) Claims

Arbitrability of ERISA section 502(a)(2) fiduciary-breach claims brought on behalf of a plan continued to be a hot topic in 2020 as courts applied key appellate decisions in this space from 2018 and 2019. In 2018, the Ninth Circuit held that section 502(a)(2) claims belong to the Plan, not the individual employee(s), and thus individual arbitration agreements that bound plan participants to arbitrate could not be used to compel the arbitration of claims brought on behalf of the plan. *Munro v. Univ. of S. Cal.*, 896 F.3d 1088, 1092 (9th Cir. 2018). One year later, the court accordingly held that § 502(a)(2) claims are, in fact, arbitrable when *the Plan* has agreed to arbitration. *Dorman v. Charles Schwab Corp.*, 780 F. App'x 510, 513–14 (9th Cir. 2019). According to the Ninth Circuit, "[t]he relevant question is whether *the Plan* agreed to arbitrate the § 502(a)(2) claims," and when a "Plan [does] consent in the Plan document to arbitrate all ERISA claims," a mandatory arbitration agreement is enforceable. *Id.* (emphasis added). Hence, in the Ninth Circuit, even when an individual employee has "agreed to arbitrate their claims in their employment contracts," a § 502(a)(2) claim belongs to the plan and "that claim is not subject to arbitration unless *the plan itself* has consented." *Ramos v. Natures Image, Inc.*, 2020 WL 2404902, at *6–7 (C.D. Cal. Feb. 19, 2020) (emphasis added). Meanwhile, as noted in one of our recent class action updates, the Supreme Court has continued to enforce arbitration provisions in various contexts, and these decisions can be brought to bear in ERISA cases as well.

A circuit split may now be emerging on this issue. In *Smith v. Greatbanc Trust Co.*, the U.S. District Court for the Northern District of Illinois rejected the Ninth Circuit's holding in *Dorman*, even though in *Smith* (like *Dorman*) the plan documents indicated that the plan agreed to arbitrate. 2020 WL 4926560, at *3–4 (N.D. Ill. Aug. 21, 2020), *appeal docketed*, No. 20-2708 (7th Cir. Sept. 9, 2020). The court in *Smith* concluded that failure to notify a former employee (who remained a participant in the plan) of changes to the plan that compelled arbitration was inconsistent with ERISA's notice requirements, and that, to the extent the arbitration agreement served as a "waiver of a party's right to pursue statutory remedies," the agreement was unenforceable. *Id.* (quoting *Am. Express Co. v. Italian Colors Restaurant*, 570 U.S. 228, 235–36 (2013)). The case is now pending appeal.

These decisions provide important guidance for employers considering amending their plans (or other plan-related documents, such as administrative services contracts) to

include arbitration provisions. Under the Ninth Circuit's *Dorman* decision, arbitration provisions in the plan documents can be used to bind the plan and to compel arbitration of claims brought on behalf of the plan. The *Smith* decision, however, underscores the importance of providing plan participants notice of any changes to plans, such as the addition of arbitration provisions, that would potentially impact participants' rights to pursue statutory remedies.

IV. ERISA Health Plan Litigation

Finally, litigation concerning health plans remains a substantial part of the ERISA litigation landscape. In 2020, the federal courts of appeals addressed a significant number of disputes over behavioral-health coverage and issued a wide range of decisions addressing plan participants' ability to assign their rights to providers.

A. Behavioral Health and Residential Treatment

ERISA disputes over behavioral-health coverage and residential treatment remained a significant source of litigation and appeals in 2020. Appellate decisions in this area mainly involved individual claims by patients challenging coverage determinations. Last year the courts of appeals decided at least 9 cases involving the denial of coverage for behavioral-health treatment, each of which involved individual claims by patients.

In disputes over individual coverage, the appellate courts in 2020 tended to afford significant deference to plan administrators' determinations that behavioral-health treatment—and in particular residential treatment—was not medically necessary or did not qualify as emergency care. For example:

- In *Doe v. Harvard Pilgrim Health Care, Inc.*, the First Circuit affirmed a district judge's application of *de novo* review when she found that a patient's residential treatment for psychological illness was medically unnecessary because medical experts had concluded that the patient did not require 24-hour supervision, her condition could be managed at a lower level of care, and medication had improved her condition before treatment. 974 F.3d 69, 72–74 (1st Cir. 2020).
- In *Tracy O. v. Anthem Blue Cross Life & Health Insurance*, the Tenth Circuit concluded that Anthem did not act arbitrarily and capriciously in denying coverage for a residential stay at a psychiatric facility because Anthem reasonably relied on four doctors' conclusions that the patient's condition had not significantly deteriorated and that her behavior could be managed in an outpatient setting. 807 F. App'x 845, 853–55 (10th Cir. 2020).
- In *Brian H. v. Blue Shield of California*, the Ninth Circuit affirmed a district judge's determination that Blue Shield had not abused its discretion because it reasonably relied on expert opinions that a patient's stay at a residential-treatment facility was not medically necessary because he would not have posed a danger to himself or others if treated in a less intensive setting. 830 F. App'x 536, 537 (9th Cir. 2020).
- In *Meyers v. Kaiser Foundation Health Plan, Inc.*, the Ninth Circuit affirmed a district judge's conclusion that Kaiser (regardless of whether *de novo* or abuse-of-discretion review applied) properly denied coverage for a patient's out-of-network residential treatment because it did not meet the plan's requirements for out-of-network coverage: It did not qualify as emergency services and, even if the treatment was unavailable in-network, the patient did not obtain Kaiser's

permission prior to treatment. 807 F. App'x 651, 653–54 (9th Cir. 2020).

- In *Todd R. v. Premera Blue Cross Blue Shield of Alaska*, 825 F. App'x 440, 441–42 (9th Cir. 2020), the Ninth Circuit, vacating the district court's *de novo* judgment for the plaintiffs, held that a plan administrator correctly determined that a medical policy's criteria for residential treatment were not met but remanded for the district court to consider in the first instance the plaintiff's argument that those criteria were improper.

In each of these decisions, the court of appeals accorded deference to individual denials of coverage by administrators. By contrast, in *Katherine P. v. Humana Health Plan, Inc.*, 959 F.3d 206, 209 (5th Cir. 2020), the Fifth Circuit determined that the district judge improperly granted summary judgment to the plan administrator. The Fifth Circuit reaffirmed prior precedent holding that when review of a coverage determination is *de novo*, the ordinary summary-judgment standard applies and a material dispute of fact should be decided by a bench trial. *Id.* The panel thus vacated the district judge's grant of summary judgment to a plan administrator and remanded for the district judge to decide a dispute of material fact about whether treatment at a level of care less intense than partial hospitalization had been unsuccessful in controlling the plaintiff's eating, purging, and compulsive exercise. *Id.* at 209–10; *see also Lyn*, 966 F.3d at 1064 (remanding for district court to apply *de novo* review to residential treatment claim rather than abuse of discretion standard).

Given the broad judicial deference ordinarily accorded to plan administrators' medical determinations, plaintiffs have sought other grounds for challenging denials of coverage for behavioral healthcare. One common strategy is to invoke the federal Mental Health Parity and Addiction Equity Act, and related state parity acts, which require that health plans provide equal coverage for mental illnesses and physical illnesses. In *Stone v. UnitedHealthcare Insurance Co.*, for instance, the plaintiff alleged that the health plan and its administrator violated the federal and California mental health parity acts when they refused to cover her daughter's out-of-state residential-care treatment, but the Ninth Circuit affirmed the judgment for the defendants. 979 F.3d 770, 774–77 (9th Cir. 2020). Because the plan imposed the same limitations on out-of-state mental- and physical-health treatments, the plaintiff had not shown that the defendant treated mental health less favorably than physical health. *Id.* at 777.

More novel theories have met skepticism in the courts of appeals. In *I.M. v. Kaiser Foundation Health Plan, Inc.*, for example, the plaintiff alleged that Kaiser breached its fiduciary duty to him by excluding coverage for residential treatment for eating disorders from its plans and inhibiting physicians from referring him to a residential-treatment facility. 2020 WL 7624925, at *2 (9th Cir. Dec. 22, 2020). The Ninth Circuit disagreed, finding no evidence in the record that Kaiser had erected barriers to residential treatment. *Id.*

B. Assignments and Anti-Assignment Clauses

The assignment of benefits remains a critical issue in ERISA health plan litigation. Under ERISA § 502(a), only "a participant or beneficiary" may sue an insurer to recover benefits owed to her or to enforce her rights under her plan. 29 U.S.C. § 1132(a)(1)(B). Ordinarily, this would mean that a patient herself would have to sue an insurer under § 502(a). However, courts have deemed it permissible for participants to "assign" their benefits to healthcare providers. *See, e.g.*, *Plastic Surgery Ctr. v. Aetna Life Ins. Co.*, 967 F.3d 218, 228 (3d Cir. 2020). Once a participant has validly assigned her benefits to a healthcare provider, that provider can stand in the shoes of the participant and bring suit against an insurer for non-payment under § 502(a). *Id.* The appellate courts in 2020 addressed a variety of issues related to the assignment of benefits

1. Scope of the Rights Conveyed

Appellate courts continue to grapple with the scope of the rights conveyed by an assignment. Decisions in 2020 reflect at least two distinct approaches. In *American Colleges of Emergency Physicians v. Blue Cross & Blue Shield of Georgia*, the Eleventh Circuit took a blanket approach, holding categorically that "the assignment of the right to payment includes the right to seek equitable relief." 833 F. App'x 235, 240 (11th Cir. 2020). The Sixth and Ninth Circuits, in contrast, held that the scope of an assignment of benefits depends on the specific language used; where an assignment's language appears to encompass only causes of actions *for benefits*, then additional potential causes of action under ERISA are not included. *See DaVita Inc v. Amy's Kitchen, Inc.*, 981 F.3d 664, 678–79 (9th Cir. 2020) (holding that assignment of "any cause of action . . . for purposes of creating an assignment of benefits" did not include the right to seek equitable relief); *DaVita, Inc. v. Marietta Mem'l Hosp. Emp. Health Benefit Plan*, 978 F.3d 326, 344 (6th Cir. 2020) (concluding that identical language did not include the right to bring breach-of-fiduciary-duty claims under § 1104(a)(1)(B)); *see also McKennan v. Meadowvale Dairy Emp. Benefit Plan*, 973 F.3d 805, 808–09 (8th Cir. 2020) (holding that an assignment of "any and all causes of action" did not include the right to challenge the rescission of the assignor's coverage, at least where deceased assignor failed to comply with plan provisions as to third-party representatives). These decisions can be a mixed bag for plans, insurers, and administrators. The Eleventh Circuit's approach allows providers to bundle benefits claims with equitable claims, while protecting insurers against having to litigate separate claims by patients and providers as to the same underlying treatment. The opposite is true for the Sixth and Ninth Circuit decisions: Where the assignment excludes equitable relief, providers have fewer arrows in their quiver to use against insurers, but insurers could face multiple lawsuits for the same treatment.

2. Waivability of Assignment Issues

Courts sometimes treat the existence and scope of an assignment as a jurisdictional question—going to the existence of Article III standing—that therefore cannot be waived. *Cell Sci. Sys. Corp. v. La. Health Serv.*, 804 F. App'x 260, 264 (5th Cir. 2020) (stating that the existence "of valid and enforceable assignments of benefits" is necessary for Article III standing). In the Sixth Circuit's *DaVita* decision, however, the court held that a defendant had waived the argument that one of the plaintiff's claims fell outside of the scope of the assignment. 978 F.3d at 345. The panel explained that "[t]he question of whether [a patient] has transferred their interest to [a provider] . . . deals not with Article III standing" but with Federal Rule of Civil Procedure 17's requirement that an action "'must be prosecuted in the name of the real party in interest.'" *Id.* The court thus found Article III standing without deciding the dispute about the scope of the assignment. *Id.* at 341 n.8.

3. Anti-Assignment Clauses

In recent years, ERISA health plans have increasingly elected to include "anti-assignment" clauses. *See Plastic Surgery Ctr.*, 967 F.3d at 228. These clauses bar patients from assigning their benefits to providers, or place certain limits on the scope of what claims can be assigned (or in what circumstances), putting providers back in the position of having to bill patients directly. *Id.* Should the patient prove unable or unwilling to pay, providers must then either rely on the patient to bring an ERISA suit or sue the patient directly. *Id.*

Many circuits have addressed these clauses, and they have unanimously determined that the clauses are, in general, permissible and enforceable. *See Am. Orthopedic & Sports Med. v. Indep. Blue Cross Blue Shield*, 890 F.3d 445, 453 (3d Cir. 2018). Still, appellate decisions in 2020 reflect multiple strategies through which providers have attempted to avoid the effect of anti-assignment clauses, with varying degrees of success:

- In *Beverly Oaks Physicians Surgical Center, LLC v. Blue Cross & Blue Shield of Illinois*, the Ninth Circuit held that an insurer had waived its right to invoke an anti-assignment clause by failing to raise it during the administrative claim process. 983

F.3d 435, 440–42 (9th Cir. 2020). The court also held that the plaintiff had pleaded sufficient facts to adequately allege that insurer was "equitably estopped from raising" the anti-assignment clause because the insurer had promised the provider that it was eligible to receive payment under plan. *Id.* at 442–43.

- In *Cell Science*, by contrast, the Fifth Circuit rejected an argument that an insurer was estopped from invoking anti-assignment clause. 804 F. App'x at 264–66. The court emphasized that there was "no indication from the record that [the insurer] either misrepresented or misled [the provider] with respect to its intention to enforce the anti-assignment clause in its plan." *Id.* at 265.
- In *King v. Community Insurance Co.,* the Ninth Circuit held that an assignment fell outside of the scope of the plan's anti-assignment clause. 829 F. App'x 156, 159–60 (9th Cir. 2020). The plan expressly allowed payments to "providers" and forbade beneficiaries from assigning benefits to "anyone else." *Id.* at 159. The Ninth Circuit rejected the insurer's argument that the phrase "anyone else" meant anyone other than the beneficiary. *Id.* at 160. The court also held that the anti-assignment clause was unenforceable because it was not properly included in any plan document. *Id.* at 160–62.

---

[1] Congress may also attempt to take action against the rule. The Congressional Review Act provides a procedure for Congress to pass a Joint Resolution of Disapproval within 60 legislative working days that, if signed by the President, deems recent administrative rulemaking to not have had any effect. The DOL's new rule is still within that 60-day timeframe.

The following Gibson Dunn lawyers assisted in the preparation of this alert: Karl Nelson, Geoffrey Sigler, Katherine Smith, Heather Richardson, Lucas Townsend, Jennafer Tryck, Matthew Rozen, Jennifer Roges, Luke Zaro, Daniel Weiss, Jialin Yang, Christopher Wang, Robert Batista, Zachary Copeland, and Brian McCarty.

Gibson Dunn lawyers are available to assist in addressing any questions you may have about these developments. Please contact the Gibson Dunn lawyer with whom you usually work, or any of the following:

Karl G. Nelson – Dallas (+1 214-698-3203, knelson@gibsondunn.com)
Geoffrey Sigler – Washington, D.C. (+1 202-887-3752, gsigler@gibsondunn.com)
Katherine V.A. Smith – Los Angeles (+1 213-229-7107, ksmith@gibsondunn.com)
Heather L. Richardson – Los Angeles (+1 213-229-7409,hrichardson@gibsondunn.com)
Lucas C. Townsend – Washington, D.C. (+1 202-887-3731, ltownsend@gibsondunn.com)
Jennafer M. Tryck – Orange County (+1 949-451-4089, jtryck@gibsondunn.com)
Matthew S. Rozen – Washington, D.C. (+1 202-887-3596, mrozen@gibsondunn.com)

Related Capabilities

Executive Compensation and Employee Benefits

Labor and Employment

Insurance and Reinsurance