GIBSON DUNN

2021 ERISA Litigation Update

Client Alert | February 22, 2022

Click for PDF

This past year was another busy one for Employee Retirement Income Security Act ("ERISA") litigation, including significant decisions from the United States Supreme Court and the federal courts of appeals on issues impacting retirement and healthcare plans, coupled with the change in presidential administrations that resulted in new rules affecting ERISA plan sponsors and administrators.

Last year, Gibson Dunn also welcomed back Eugene Scalia as a partner to the Firm's Washington, DC office after he served as the 28th U.S. Secretary of Labor from September 2019 to January 2021. Scalia's return adds further depth to Gibson Dunn's bench of elite ERISA litigators, who take an interdisciplinary approach to their work resolving complex matters for our clients, and bring 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 year's Annual ERISA Litigation Update summarizes key legal opinions and developments to assist plan sponsors and administrators navigating the rapidly changing ERISA litigation landscape.

Section I highlights two notable opinions from the United States Supreme Court rejecting a challenge to the individual mandate in the Affordable Care Act on standing grounds, and addressing the pleading standard in ERISA "excessive fee" fiduciary-breach cases. We are also watching pending petitions for certiorari concerning the application of ERISA's fiduciary requirements to business transactions between plan administrators and third-party service providers, and ERISA preemption of state-run IRA programs for private-sector workers.

Section II delves into how the federal courts have applied the Supreme Court's decision in *Thole v. U.S. Bank*, 140 S. Ct. 1615 (2020), addressing Article III standing in ERISA cases. We also discuss the implications for ERISA litigants of the Court's recent decision on Article III standing in *TransUnion LLC v. Ramirez*, 141 S. Ct. 2190 (2021).

Section III addresses the continuing impact of the Supreme Court's decision in *Rutledge v. Pharmaceutical Management Association*, 141 S. Ct. 474 (2020), on the issue of ERISA preemption.

Section IV provides an analysis of how the federal courts are assessing the enforceability of arbitration agreements in ERISA plans.

Section V discusses how the courts continue to grapple with the standard of review for ERISA benefits claims.

Section VI offers an overview of the Department of Labor's rule changes concerning environmental, social, and governmental ("ESG") investing, and the implications of those changes for ERISA plan fiduciaries.

Related People

Eugene Scalia

Karl G. Nelson

Geoffrey Sigler

Heather L. Richardson

Matthew S. Rozen

Jennafer M. Tryck

Lana Habib El-Farra

Alex Ogren

Clare F. Steinberg

Yan Zhao

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

I. Key 2021 Supreme Court Decisions & Cases to Watch

The United States Supreme Court decided two cases in 2021 with significant implications for ERISA plans and their sponsors and administrators. In *California v. Texas*, 141 S. Ct. 2104 (2021), the Court dismissed a challenge to the Affordable Care Act ("ACA") by holding that the plaintiffs lacked Article III standing to bring the suit. In *Hughes v. Northwestern University*, the Court held that allegations that a defined-contribution retirement plan breached ERISA's duty of prudence by offering high-cost investment options may be actionable even if the plan also offers lower-cost options. But the Court declined to adopt an ERISA-specific pleading standard for these fiduciary-breach claims.

The Court has also ordered further briefing on pending petitions for certiorari in ERISA cases concerning the application of ERISA's fiduciary requirements to arms-length contracts between a plan administrator and third-party service providers, and the scope of ERISA preemption over state-run programs that enroll private sector employees in retirement savings programs.

A. *California et al. v. Texas et al*. and *Texas et al. v. California et al.* Uphold the Affordable Care Act

In *California v. Texas*, 141 S. Ct. 2104 (2021) (consolidated with *Texas v. California*), the Supreme Court rejected on Article III standing grounds the latest challenge to the constitutionality of the ACA. In 2012, the Court rejected constitutional challenges under the Commerce Clause to the requirement in the ACA that individuals must maintain health insurance coverage, also known as the individual mandate. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012). The Court reasoned that the ACA was not a command to buy health insurance—which Congress would lack the power to enact—but merely a tax for not doing so. *Id.* at 574–75.

In December 2017, Congress amended the ACA to eliminate the penalty for not buying health insurance, but did not eliminate the ACA's individual mandate. Two individuals and several states, including Texas, then challenged the individual mandate as unconstitutional, arguing that because it no longer carried a penalty, it no longer qualified as a tax. They also argued that because the individual mandate is essential to the ACA, the entire statute must be struck down. When the Trump Administration declined to defend the ACA's constitutionality, several states, including California, intervened to defend the statute and challenge the plaintiffs' Article III standing. The Fifth Circuit held that the plaintiffs possessed standing and held that the individual mandate is unconstitutional. *Texas v. United States*, 945 F.3d 355, 377–93 (5th Cir. 2019), *as revised* (Dec. 20, 2019), *as revised* (Jan. 9, 2020), *rev'd and remanded sub nom. California v. Texas*, 141 S. Ct. 2104 (2021).

The Supreme Court reversed, holding that neither the individual plaintiffs nor the plaintiff states had Article III standing to challenge the individual mandate. *See California*, 141 S. Ct. at 2114–2116. The individual plaintiffs claimed that they satisfied the standing requirements because of the payments they have made and will continue to make to carry the minimum essential coverage that the ACA requires. But the Court reasoned that even if payments necessary to hold the insurance coverage required by the ACA were an injury, that injury would not be traceable to the government, because without any penalty for noncompliance, the statute is unenforceable against the individual plaintiffs. *Id.*

The Court likewise concluded that the states did not have Article III standing because they failed to show that their injuries were fairly traceable to unlawful government conduct. *Id.* at 2116. The states claimed they were indirectly injured by the mandate because it would cause more people to enroll in Medicaid or state employee health insurance programs. But the states failed to demonstrate "that an unenforceable mandate will cause their residents to enroll in valuable benefits programs that they would otherwise forgo." *Id.* at 2119. Texas also asserted that it would bear increased direct costs because of ACA reporting and administrative requirements, but the Court found that these costs were not

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

caused by the mandate and would remain even if it were struck down. *Id.* at 2119–20.

Justice Alito, joined by Justice Gorsuch, dissented, concluding instead that (1) the state plaintiffs possess standing in light of the increased regulatory and financial burdens from complying with the ACA, and they did not forfeit these claims, and (2) the individual mandate is unconstitutional and not severable from the rest of the ACA. *Id.* at 2124 (Alito, J., dissenting).

The decision is a significant one for ERISA because it eliminates, for now, some of the uncertainty around the validity of the ACA, including the ACA's ERISA-specific requirements such as the large employer health insurance mandate. But the decision leaves unresolved the merits questions presented in the case—*i.e.*, whether the individual mandate is constitutional or whether it is severable from the rest of the ACA—which the Court may be asked to revisit in future cases.

B. *Hughes v. Northwestern University* Addresses Pleading Standard in ERISA Fiduciary-Breach Suits

In *Hughes v. Northwestern University*, the Supreme Court reiterated in an unanimous decision that a district court's review of a pleading challenge in an ERISA "excessive fees" fiduciary breach suit is a context-specific inquiry that requires courts to assess whether plaintiffs plausibly allege—under *Ashcroft v. Iqbal*, 556 U.S. 662 (2009) and *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007)—that plan fiduciaries failed to monitor all plan investments and remove imprudent ones.

Northwestern University offered its employees defined-contribution retirement plans, in which the employees maintain individual investment accounts and choose how to invest their contributions. *Hughes v. Nw. Univ.*, 142 S. Ct. 737, 740 (2022). Former and current employees of Northwestern alleged that the plans' fiduciaries violated the duty of prudence under ERISA by providing employees with a menu of investment options that included allegedly high cost and poorly performing options that caused plan participants to incur excessive fees. *Id.* at 741. The plans also included the types of low-fee options that plaintiffs preferred. *Id.* at 741–42.

The Seventh Circuit affirmed the dismissal of petitioners' claims for failure to plausibly allege a breach of fiduciary duty. *Divane v. Nw. Univ.*, 953 F.3d 980, 993 (7th Cir. 2020). The court held in relevant part that Northwestern had complied with its duty of prudence by offering a menu of investment options that included low-cost funds, along with the other higher-cost options challenged in the complaint. *Id.* at 991–92.

Relying on *Tibble v. Edison Int'l*, 575 U.S. 523 (2015), the Supreme Court reversed, holding that the Seventh Circuit erred in dismissing the plaintiffs' claims without making a "context-specific inquiry" that "take[s] into account [a fiduciary's] duty to monitor all plan investments and remove any imprudent ones." *Hughes*, 142 S. Ct. at 740. The Supreme Court reasoned:

> [E]ven in a defined-contribution plan where participants choose their investments, plan fiduciaries are required to conduct their own independent evaluation to determine which investments may be prudently included in the plan's menu of options. . . . If the fiduciaries fail to remove an imprudent investment from the plan within a reasonable time, they breach their duty.

Id. at 742 (citing *Tibble*, 575 U.S. at 529–30). The Court remanded the case to the Seventh Circuit so that it could "reevaluate the allegations as a whole" and "consider whether petitioners have plausibly alleged a violation of the duty of prudence as articulated in *Tibble*, applying the pleading standard discussed" in *Iqbal* and *Twombly*. *Id.* Under that standard, plaintiffs must plead "enough facts to state a claim to relief that is plausible on its face." *Twombly*, 550 U.S. at 570; *see also Iqbal*, 556 U.S. at 679 (allegations must

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

"permit the court to infer more than the mere possibility of misconduct"). The Court concluded its opinion by addressing the importance of affording deference to plan fiduciaries, stating: "At times, the circumstances facing an ERISA fiduciary will implicate difficult tradeoffs, and courts must give due regard to the range of reasonable judgments a fiduciary may make based on her experience and expertise." *Hughes*, 142 S. Ct. at 742.

Ultimately, the Court's decision in *Hughes* was narrow. It did not establish a new pleading standard for ERISA fiduciary-breach claims, as petitioners had sought, nor did it set out the specific allegations that would be sufficient to plead a claim under plaintiffs' fiduciary-breach theories. It is thus left to be seen whether this decision will pave the way for more "excessive fee" suits, whether the district courts will rely on *Hughes* to permit more cases to proceed to discovery, or whether the Supreme Court's guidance concerning deference to plan fiduciaries will prompt courts to find that allegations that other investment options were theoretically available at a lower cost are not alone enough to withstand a pleading challenge.

C. Supreme Court Petitions to Watch

We are also monitoring three pending petitions for certiorari implicating ERISA issues. *John Doe 1 v. Express Scripts Inc.* (No. 21-471) and *OptumHealth Care Solutions LLC v. Peters* (No. 21-761) address the application of ERISA's fiduciary requirements to arms-length transactions between a plan administrator and a third-party that provides services to a plan. *Howard Jarvis Taxpayers Association v. CA Secure Choice Retirement Program* (No. 21-558), concerns whether California's auto-IRA program, which enrolls private-sector employees in a state-run retirement savings program, is preempted by ERISA.

1. *John Doe 1 v. Express Scripts Inc.* (No. 21-471)

In *John Doe 1 v. Express Scripts Inc.*, health insurance policyholders seek to revive a proposed class action accusing Anthem and Express Scripts of violating fiduciary duties under ERISA by entering into a self-interested contractual arrangement that resulted in the plans and participants paying above-market prices for prescription drugs. The case arose from Anthem's decision, as administrator of self-insured ERISA health plans, to sell its in-house pharmacy benefit management business to Express Scripts. Plaintiffs allege that in exchange for a substantially higher purchase price for the business, Anthem agreed to delegate to Express Scripts discretion to set the drug prices charged to Anthem customers, including prices that plaintiffs claim far exceeded industry standards.

Plaintiffs petitioned the Supreme Court to hear the case after the Second Circuit affirmed dismissal, holding that Anthem and Express Scripts were not acting as fiduciaries under ERISA when executing and acting upon the drug pricing contract. *See Doe 1 v. Express Scripts, Inc.*, 837 F. App'x 44 (2d Cir. 2020). The Second Circuit relied in part on the Sixth Circuit's decision in *DeLuca v. Blue Cross Blue Shield of Mich*., which held that an insurer did "not act[ ] as a fiduciary when it negotiated" rate changes for certain medical services, "principally because those business dealings were not directly associated with the benefits plan at issue but were generally applicable to a broad range of health-care consumers." 628 F.3d 743, 747 (6th Cir. 2010). As to Anthem, the court explained that even if Anthem's decisions "may ultimately affect how much plan participants pay for drug prices," they were business dealings not directly associated with the plans they may ultimately have affected. *Doe 1*, 837 F. App'x at 49. The Second Circuit also agreed with the district court that Express Scripts did not act as a fiduciary when it set prices for prescription drugs, even though it had "extraordinarily broad discretion," because "at bottom the ability to set such prices is a contractual term, not an ability to exercise authority over plan assets." *Id.*

Plaintiffs petitioned for certiorari, contending that the Second and Sixth Circuit decisions had established an invalid, extra-statutory "business decisions" exemption from ERISA's definition of "fiduciary," causing a split with the Fourth, Fifth, Seventh, Eighth, and Ninth

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

Circuits, which do not apply such an exemption. On December 13, 2021, the Supreme Court invited the Solicitor General to file a brief expressing the views of the United States. If the Court takes up this case, it could impact whether plan administrators and their contractors may face liability as plan fiduciaries when making business decisions, such as executing service-provider contracts, that affect prices paid by the plan or its participants.

2. *OptumHealth Care Solutions, LLC v. Peters* (No. 21-761)

In *OptumHealth Care Solutions, LLC v. Peters*, the Supreme Court has called for a response to a petition for a writ of certiorari by OptumHealth Care Solutions LLC addressing ERISA section 406(a)'s prohibition against certain "transactions" by plan fiduciaries involving a "party in interest." The petition challenges a Fourth Circuit decision holding that a non-fiduciary service provider, with no preexisting relationship to a plan, may qualify as a "party in interest" by contracting with a plan fiduciary and getting paid under those contracts.

The case arises from an agreement by Aetna to pay OptumHealth Care Solutions, Inc. ("Optum") to provide access to Optum's networks of chiropractors and physical therapists for members of a self-funded health plan administered by Aetna. *Peters v. Aetna Inc.*, 2 F.4th 199, 210 (4th Cir. 2021). Plaintiff alleges that instead of paying Optum out of the fees Aetna received from the plan, Aetna requested that Optum add its administrative fee to the claims submitted by Optum's downstream health care providers. *Id.* This arrangement allegedly caused Optum's fees to be passed on to plan members, instead of being paid by Aetna, as the plan allegedly required. *Id.* Among other theories, plaintiff claimed that Aetna's contract with Optum violated ERISA's prohibition on transactions with parties in interest. *Id.* at 213. The district court disagreed, concluding that Optum could not be liable as a party in interest because it had no preexisting relationships with either the plan or Aetna. *Id.*

The Fourth Circuit reversed, holding that Optum could be held liable "based on its apparent participation in and knowledge of Aetna's administrative fee billing model." *Id.* at 240. Because Optum lacked a prior relationship with the plan, the Fourth Circuit concluded that it was not a party in interest at the time it entered into the service agreement with Aetna. But the Fourth Circuit nonetheless held that a reasonable factfinder could find Optum liable as a party in interest when it *performed* the contract by providing services to the plan allegedly with knowledge of circumstances that rendered the billing arrangement with Aetna unlawful. *Id.*

Optum filed a cert petition, asking the Supreme Court to resolve the question of whether a service provider can qualify as a party in interest under ERISA section 406(a) if the provider lacks a preexisting relationship with the plan that is independent of the relationship created by the allegedly prohibited transaction. In its petition, Optum contends that the Fourth Circuit's decision exposes plan fiduciaries and non-fiduciary service providers to litigation simply by engaging in and being paid under an arms-length services agreement, and thereby creates a split with the Tenth Circuit, which held in *Ramos v. Banner Health*, 1 F.4th 769, 784, 787 (10th Cir. 2021), that ERISA does not categorically prohibit plan fiduciaries from contracting with third-party service providers, and that such an interpretation of the statute would lead to "absurd result[s]" that would extend to "run-of-the-mill service agreements, opening plan fiduciaries up to litigation merely because they engaged in an arm's length deal with a service provider." In *Ramos*, the Tenth Circuit concluded that "some prior relationship must exist between the fiduciary and the service provider to make the provider a party in interest" under ERISA. *Id.* at 787. The Fourth Circuit's decision in *Peters* would appear not to require evidence of a "prior relationship" to trigger prohibited transaction liability.

The Supreme Court sought a response from respondent on Optum's petition for a writ of certiorari, suggesting the Court may want to weigh in on whether a "preexisting relationship" is required before a third-party contractor providing administrative services to a plan may qualify as a "party in interest."

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

3. *Howard Jarvis Taxpayers Association v. CA Secure Choice Retirement Program* (No. 21-558)

We are also monitoring a pending petition for a writ of certiorari that asks the Supreme Court to review a preemption challenge to CalSavers, California's state-run auto-enrollment IRA program. CalSavers is one of a handful state-run IRA programs for private sector workers. It applies to eligible employees of certain private employers in California that do not provide their employees with a tax-qualified retirement savings plan. Eligible employees are automatically enrolled in CalSavers, but may opt out. If they do not opt out, their employers must remit certain payroll deductions to CalSavers, which then funds the employees' IRAs. California manages and administers the IRAs and acts as the program fiduciary.

Howard Jarvis Taxpayers Association challenged the CalSavers program, arguing that it is preempted by ERISA. The Ninth Circuit rejected this argument, concluding that ERISA does not preempt CalSavers, and relying in part on the Supreme Court's decision in *Rutledge v. Pharmaceutical Care Management Association*, 141 S. Ct. 474 (2020). *See Howard Jarvis Taxpayers Ass'n v. California Secure Choice Ret. Sav. Program*, 997 F.3d 848, 863 (9th Cir. 2021). As we discussed in last year's ERISA update, the Supreme Court held in *Rutledge* that ERISA did not preempt an Arkansas statute regulating the rates at which pharmacy benefit managers ("PBMs") reimburse pharmacies for prescription drug costs because the 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. *Rutledge*, 141 S. Ct. at 481. In *Howard Jarvis*, the Ninth Circuit relied on the Supreme Court's reasoning in *Rutledge* to hold that ERISA did not preempt CalSavers, reasoning that:

> CalSavers is not an ERISA plan because it is established and maintained by the State, not employers; it does not require employers to operate their own ERISA plans; and it does not have an impermissible reference to or connection with ERISA. Nor does CalSavers interfere with ERISA's core purposes.

997 F.3d at 852–53. In so holding, the Ninth Circuit rejected plaintiff's argument that CalSavers is preempted because it "competes with" ERISA plans and will "frustrate, not encourage the formation of" ERISA plans. *Id.* at 864. The court concluded that the Supreme Court's decision in *Rutledge* made clear that "'ERISA does not pre-empt' state laws that 'merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme or substantive coverage.'" *Id.* (quoting *Rutledge*, 141 S. Ct. at 480).

The Supreme Court requested the CalSavers program to respond to a petition for a writ of certiorari filed by Howard Jarvis Taxpayers Association. A decision by the Court in this case may have far-reaching impact for the viability of state-run auto-IRA programs that are proliferating throughout the country, including in Colorado, Connecticut, Illinois, Maryland, New Jersey, and Oregon. For further discussion of how courts of appeals have applied *Rutledge*, including further discussion of the Ninth Circuit's decision in *Howard Jarvis Taxpayers Association v. CA Secure Choice Retirement Program*, *see infra* **Section III**.

II. Article III Standing in ERISA Cases Under *Thole v. U.S. Bank* and *TransUnion LLC v. Ramirez*

As we addressed in our update last year, Article III standing continues to be a key issue for ERISA litigants. Here we analyze how the federal courts are implementing the Supreme Court's Article III standing decisions in *Thole v. U.S. Bank*, 140 S. Ct. 1615 (2020), and *TransUnion LLC v. Ramirez*, 141 S. Ct. 2190 (2021), in the ERISA context.

In *Thole*, the Supreme Court held that participants in a fully funded defined-benefit pension

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

plan lacked Article III standing to sue under ERISA for breach of fiduciary duties because, while the plan lost $750 million due to the fiduciaries' alleged breach, the participants had no "concrete stake in the lawsuit." *Thole*, 140 S. Ct. at 1618–19. Plaintiffs continued to receive all of their vested benefits to which they were legally entitled, and those "benefits are fixed and will not change, regardless of how well or poorly the plan is managed." *Id.* at 1620, 1622. The Court's decision in *Thole* means that plaintiffs do not have standing to bring a breach of fiduciary duty claim against a defined-benefit plan unless they have suffered a concrete injury such as the plan's failure to make the required benefit payments. *Id.* at 1619.

In the year and a half since *Thole* came down, the courts of appeals have generally declined to extend *Thole* outside the defined-benefit plan context. However, at least one district court has taken a broader view and applied *Thole* in the context of employer-sponsored health plans, finding plaintiffs lacked standing because they could not allege that their own claims for benefits were impaired by cross-plan offsetting.

In *Ortiz v. American Airlines, Inc.*, the Fifth Circuit declined to extend *Thole* to claims of breach of fiduciary duty brought by plan participants in a defined-contribution retirement plan. 5 F.4th 622, 629 n.9 (5th Cir. 2021). In relevant part, plaintiffs alleged that defendants should have offered a stable-value investment option in their plan, and that plaintiffs lost investment income by investing in the lower return option in their plan. *Id.* at 629. Defendants argued that *Thole* should preclude Article III standing because the plaintiffs did not have a cognizable injury giving them a concrete stake in the lawsuit. *Id.* The Fifth Circuit disagreed, explaining that *Thole* "explicitly drew a distinction between a defined-benefit plan and a defined contribution plan, such as a 401(k), in which the retirees' benefits are typically tied to the value of their accounts, and the benefits can turn on the plan fiduciaries' particular investment decisions." *Id.* (quotation markss omitted). Here, however, the court noted that plaintiffs had presented evidence that the plan fiduciaries' decisions, although affecting the plan as a whole, resulted in "lost investment income" to their individual accounts that was concrete and redressable for purposes of standing. *Id.* at 629.

The Third Circuit will have the opportunity to decide an appeal raising a similar issue in the near future. In *Boley v. Universal Health Services, Inc.*, 498 F. Supp. 3d 715 (E.D. Pa. 2020), plaintiffs allege that fiduciaries for their defined-contribution retirement plan imprudently offered high-fee investment options in the plan, resulting in the plan and its participants paying excessive fees. *Id.* at 718. Plaintiffs alleged that they invested in only seven of the plan's many fund offerings during the putative class period, and defendants argued that under *Thole*, plaintiffs lacked standing to bring claims as to the remaining funds, because plaintiffs could not show a personal injury to their individual account balances due to the performance of the funds in which they did not invest. *Id.* at 719. The district court disagreed, concluding that plaintiffs had standing to challenge funds in which they did not invest because, unlike in *Thole*, plaintiffs' claims alleged, among other things, a "[p]lan-wide breach as to process," and this "imprudent process forced [plaintiffs], and all Plan participants, to choose from an expensive menu of investment options" that injured all plan participants, including plaintiffs. *Id.* at 719, 721, 723–24 (quotation marks omitted). Defendants have appealed this decision, with argument held on February 11, 2022. *See generally Boley v. Universal Health Svcs., Inc.*, No. 21-2014 (3d Cir.). Thus, like the Fifth Circuit in *Ortiz*, the Third Circuit will have to decide whether allegations of injury stemming from fiduciaries' alleged retention of imprudent investment options—thereby causing a plan to generate less investment income for its participants—are sufficient to satisfy Article III standing even where the named plaintiffs do not allege they invested in the challenged funds.

Last year, the Second Circuit also had the opportunity to weigh in on the breadth of *Thole*. In *Gonzales de Fuente v. Preferred Home Care of New York LLC*, the court affirmed dismissal of plaintiffs' complaint on standing grounds where plaintiffs were participants in a defined-benefit health plan who claimed breach of ERISA fiduciary duties due to alleged misappropriation of employer contributions to the plan, which plaintiffs contended should

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

have been used to provide them a superior plan. 858 F. App'x. 432 (2d Cir. 2021). The case implicated New York's wage parity law, which forbids employers from retaining any "portion of the dollars spent or to be spent to satisfy the wage or benefit portion" of employee compensation. *Id.* at 434 (quoting N.Y. Pub. Health Law § 3614-c(5)(a)). Plaintiffs argued that the New York law made their status under ERISA more like that of *defined contribution* plan participants, and they argued they suffered "concrete injuries in the form of increased out-of-pocket costs and reduced coverage." *Id.* at 433. In rejecting this argument, the Second Circuit relied on *Thole* to hold that plaintiffs lacked standing to bring their ERISA claims because they had received, and would receive, all promised benefits under their health plan, and any compensation plaintiffs may have been entitled to under the New York law was separate from their ERISA claim. *Id.* at 434.

The United States District Court for the District of Minnesota reached a similar result in *Scott v. UnitedHealth Group, Inc.*, 540 F. Supp. 3d 857, 859 (D. Minn. 2021). The court rejected plaintiffs' argument that they had standing to challenge their employers' health plans' practice of cross-plan offsetting because their plans are funded in part by their payroll contributions. *Id.* at 862. The court found that, as in *Thole*, the "plaintiffs do not have any claim to the plans' assets; instead, their only claim is to receive the benefits to which they are entitled" under the plans. *Id.* at 863. Thus, the court found that rather than being a defined contribution plan, an employer-sponsored health plan is "closely analogous" to a defined-benefit plan. *Id.* at 864. Applying *Thole*, the court held that plaintiffs did not have standing because they could not allege that any of their own claims for benefits had been denied due to the alleged cross-plan offsetting. *Id.* at 865.

The Supreme Court further clarified the requirements for Article III standing last year in *TransUnion LLC v. Ramirez*, 141 S. Ct. 2190 (2021), limiting the size of a putative class action alleging violations of the Fair Credit Reporting Act ("FCRA") for failing to ensure that information on TransUnion's credit reports is accurate before disseminating them. *Id.* at 2200. Even though most class members did not suffer an injury from the disclosure of their credit reports to third parties, the Ninth Circuit affirmed certification of the class and concluded that all class members had Article III standing to recover damages because of the mere "*risk* of harm to their concrete privacy, reputational, and informational interests protected by the FCRA." *Id.* at 2202; *id.* at 2216 (Thomas, J., dissenting) (emphasis added).

The Supreme Court reversed in part, narrowing the class to plaintiffs who could establish Article III standing, reasoning that "Article III does not give federal courts the power to order relief to any uninjured plaintiff" regardless of whether they are part of a class. *Id.* at 2208 (Kavanaugh, J.) (quoting *Tyson Foods, Inc. v. Bouaphakeo*, 577 U.S. 442, 466 (2016) (Roberts, C.J., concurring)). The Court explained that the violation of a federal statute is not, alone, sufficient to confer standing under Article III, *id.* at 2206, but may be sufficient if the harm alleged has a "'close relationship' to a harm traditionally recognized as providing a basis for a lawsuit," *id.* at 2200. Here, the Court explained, plaintiffs whose credit reports bearing misleading information had been disclosed to third parties could establish Article III standing based on reputational harm analogous to the traditional tort of defamation. *Id.* at 2205, 2209. But the Court held that the rest of the plaintiffs—whose credit reports were not disseminated to third parties—lacked standing to seek damages because they merely faced, at most, a "risk of future harm." *Id.* at 2210. Although "a person exposed to a risk of future harm may pursue forward-looking, injunctive relief to prevent the harm from occurring, at least so long as the risk of harm is sufficiently imminent and substantial," the Court held that "in a suit for damages, the mere risk of future harm, standing alone, cannot qualify as a concrete harm—at least unless the exposure to the risk of future harm itself causes a *separate* concrete harm." *Id.* at 2210–11.

These holdings may have significant consequences in ERISA cases. In ERISA class actions, *TransUnion* appears to require Plaintiffs to establish that *each* class member suffered an Article III injury, potentially raising individualized inquiries that could impede class certification. Further, *TransUnion* clarifies the standard for establishing Article III

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

standing, potentially limiting ERISA claims premised on purely procedural injuries or risk of future harm in actions seeking damages or other retrospective relief. Taken together, the *Thole* and *TransUnion* decisions give ERISA defendants paths to argue (1) that plan participants lack concrete harm sufficient to confer Article III standing, and (2) for limits on available remedies.

III. Impact of the Supreme Court's Decision in *Rutledge v. Pharmaceutical Care Management Association* on ERISA Preemption

As we anticipated in our 2020 ERISA Update, the Supreme Court's decision in *Rutledge v. Pharmaceutical Care Management Association*, 141 S. Ct. 474 (2020) has played a significant role over the last year-and-a-half in litigation concerning ERISA preemption of state laws. Subject to certain exceptions, ERISA preempts any state law that "relate[s] to" an ERISA plan, 29 U.S.C. § 1144(a), meaning that the law has either a "connection with" or a "reference to" ERISA plans, *Egelhoff v. Egelhoff ex rel. Breiner*, 532 U.S. 141, 147 (2001) (citation omitted). A state law has an impermissible connection with ERISA plans if it "governs … a central matter of plan administration or interferes with nationally uniform plan administration." *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 320 (2016) (internal quotation marks and citation omitted). And a state law impermissibly refers to ERISA plans if it "acts immediately and exclusively upon ERISA plans" or "the existence of ERISA plans is essential to the law's operation." *Id.* at 319–20 (citation omitted).

In *Rutledge*, the Court applied these principles to an Arkansas statute regulating the rates at which pharmacy benefit managers (PBMs), acting as middlemen between ERISA plans and pharmacies, reimburse pharmacies for prescription drug coverage. 141 S. Ct. at 478. Although PBMs generally pass drug prices on to plans, the Court held that "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 480. The Court explained that the statute in question did not have an impermissible connection with ERISA plans because it merely regulated the cost of covered prescription drugs, not plan choices about which drugs to cover. *Id.* at 481. The Court also explained that the statute did not "refer to" ERISA plans because it affected plans only indirectly and it "regulate[d] PBMs whether or not the plans they service fall within ERISA's coverage." *Id.*

Last year, the Eighth, Seventh, and Ninth Circuits, as well as a number of district courts, had the opportunity to apply *Rutledge*, and these decisions suggest the courts are taking a narrower view of ERISA preemption.

In *Pharmaceutical Care Management Association v. Wehbi*, 18 F.4th 956, 964 (8th Cir. 2021), the Supreme Court vacated an earlier Eighth Circuit decision and directed the court to reconsider the case in light of *Rutledge*. As in *Rutledge*, *Wehbi* involved a preemption challenge to a state statute regulating in various ways the relationship between PBMs and pharmacies. *Id.* Most notably, the law "limit[ed] the accreditation requirements that a PBM may impose on pharmacies as a condition for participation in its network." *Id*. at 968. The Eighth Circuit had initially held that the statute was preempted because it had an impermissible "reference to" ERISA, in that the statute's "definitions of and references to 'pharmacy benefits manager,' 'third-party payer,' and 'plan sponsor'" either referenced ERISA plans or were "taken verbatim" from ERISA. *Pharm. Care Mgmt. Ass'n v. Tufte*, 968 F.3d 901, 905 (8th Cir. 2020). But on remand neither party disputed that *Rutledge* had undercut any argument for "reference to" preemption. 18 F.4th at 969–70. The Eighth Circuit recognized this shift in the law, explaining that while "[p]reviously, circuit precedent held that the existence of ERISA plans is essential to a law's operation if the law *can apply to an ERISA plan*," now "the existence of ERISA plans is essential to a law's operation only if the law *cannot apply to a non-ERISA plan*." *Id.* at 969 (emphases added).

The briefing on remand focused on "connection with" preemption. The Eighth Circuit held, however, that the statute was not preempted on that basis. *Id.* at 970. Addressing a

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

recurring issue, the panel explained that "the challenged provisions do not escape preemption" simply because "they regulate PBMs rather than plans." *Id.* at 966. But the panel nonetheless concluded that the statute—including its limited accreditation requirements—was not preempted because it "constitute[d], at most, regulation of a noncentral 'matter of plan administration' with *de minimis* economic effects and impact on the uniformity of plan administration across states." *Id.* at 968–69 (citation omitted). In upholding North Dakota's authority to restrict the accreditation requirements a PBM may impose on pharmacies as a condition of participation in its network, the decision raises important questions about the ability of states to regulate membership in plan networks in both the pharmacy and medical treatment contexts.

Courts have also applied *Rutledge* in other contexts. For instance, in *Halperin v. Richards*, 7 F.4th 534 (7th Cir. 2021), the Seventh Circuit considered whether ERISA preempts state law claims against a company's "directors and officers who serve[d] dual roles as both corporate and ERISA fiduciaries." *Id.* at 539. The plaintiffs—creditors of a company undergoing bankruptcy proceedings—alleged that the company's directors and officers had conspired with the trustee for the company's ERISA-covered employee stock ownership plan to inflate the valuations of the company's stock to drive up their own pay, which was tied to the stock ownership plan valuations. *Id.* The defendants argued that the claims were preempted because the company's "valuations were governed by ERISA" and they acted solely in their ERISA roles when evaluating the company's stock. *Id.* at 540. The Seventh Circuit concluded, however, that ERISA did not preempt these claims against the directors and officers, explaining that *Rutledge* stands for the proposition that "[s]ome parallel state rules … are not preempted," *id.* at 541, and holding that "ERISA contemplates parallel state-law liability against directors and officers serving dual roles as both corporate and ERISA fiduciaries," *id.* at 542. The court nonetheless held that ERISA preempted the claims against the trustee and its non-fiduciary contractor, as claims against those individuals "would interfere with the cornerstone of ERISA's fiduciary duties." *Id.* at 539.

The Ninth Circuit also relied on *Rutledge* in the decision at issue in the petition for a certiorari in *Howard Jarvis Taxpayers Association v. CA Secure Choice Retirement Program*, which is discussed *supra* in **Section 1.C.2**. *See* Petition for Writ of Certiorari, *Howard Jarvis Taxpayers Ass'n v. CA Secure Choice Ret. Program* (No. 20-15591).

A number of district court decisions have also applied *Rutledge* to find that ERISA does not preempt various state laws and claims. *See, e.g., ACS Primary Care Physicians Sw., P.A. v. UnitedHealthcare Ins. Co.*, 514 F. Supp. 3d 927, 941–42 (S.D. Tex. 2021) (emergency care statutes); *Emergency Physician Servs. of New York v. UnitedHealth Grp., Inc.*, 2021 WL 4437166, at *2, 8–9 (S.D.N.Y. Sep. 28, 2021) (breach of implied-in-fact contract and unjust enrichment claims for failing to reimburse emergency services at a reasonable rate); *Emergency Servs. of Oklahoma, PC v. Aetna Health, Inc.*, 2021 WL 3914255, at *1–3 (W.D. Okla. Aug. 24, 2021) (same); *Elena v. Reliance Standard Life Ins. Co.*, 2021 WL 2072373, at *2–4 (S.D. Cal. May 24, 2021) (intentional infliction of emotional distress claim based on post-traumatic stress disorder intensified by "ridicule" suffered from third-party claim administrator's agent with regards to disability coverage claim); *Sarasota Cnty. Pub. Hosp. Bd. v. Blue Cross & Blue Shield of Florida, Inc.*, 511 F. Supp. 3d 1240, 1243–44, 1249 (M.D. Fla. 2021) (breach of preferred provider agreement); *Florida Emergency Physicians Kang & Assocs., M.D., Inc. v. United Healthcare of Florida, Inc.*, 526 F. Supp. 3d 1282, 1289, 1298–99 (S.D. Fla. 2021) (conspiracy to "manipulate and depress the usual or customary reimbursement rate" for medical services).

We expect ERISA preemption will continue to be a highly litigated area this year, with courts being asked to apply *Rutledge* to a broad array of state regulations and common law claims. And should the Supreme Court grant the pending petition in *Howard Jarvis Taxpayers Association v. CA Secure Choice Retirement Program*, it would have the opportunity to further define the parameters of ERISA preemption.

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

IV. Arbitrability of ERISA Fiduciary-Breach Claims

The arbitrability of ERISA section 502(a)(2) fiduciary-breach claims continued to generate contentious litigation in 2021. As we detailed in our 2020 ERISA Update, the Ninth Circuit's 2019 decision in *Dorman v. Charles Schwab Corp.*, 934 F.3d 1107, 1111–12 (9th Cir. 2019) struck down decades of case law holding that fiduciary-breach lawsuits under ERISA could not be arbitrated. This in turn led many companies to write new arbitration language into their plans. We can now shed more light on the enforceability of these arbitration terms as additional courts of appeal have weigh in, including the Seventh and Second Circuits, as well as district courts in Ohio and Florida. As these cases suggest, federal courts continue to struggle with whether and how to enforce arbitration agreements in ERISA plans, and we expect arbitrability to continue to be a hotly litigated issue this year.

In September, the Seventh Circuit decided *Smith v. Board of Directors of Triad Manufacturing, Inc.*, 13 F.4th 613, 615 (7th Cir. 2021), a case brought by an individual on his own behalf, and on behalf of a putative class, alleging a claim for fiduciary breach under ERISA section 502(a)(2) for mismanagement of his retirement plan and seeking removal of the plan fiduciaries. However, plaintiff's suit ran headlong into his plan's arbitration provision, which in relevant part, provided that plaintiff could not "seek or receive any remedy which has the purpose or effect of providing additional benefits or monetary or other relief to any Eligible, Employee, Participant or Beneficiary other than the Claimant." *Id.* at 616. The district court denied defendants' motion to compel arbitration, and the Seventh Circuit affirmed. The appellate court "[j]oin[ed] every other circuit to consider the issue" in holding that "ERISA claims are generally arbitrable." *Id.* at 620. But the court concluded that the particular arbitration provision at issue ran afoul of the effective vindication doctrine, which holds that an arbitration provision may be held unenforceable on public policy grounds when it "operate[s] … as a prospective waiver of a party's right to pursue statutory remedies." *Id.* at 620–21 (citing *Am. Exp. Co. v. Italian Colors Rest.*, 570 U.S. 228, 235 (2013)). Deploying the doctrine—which "rare[ly]" applies—the Seventh Circuit reasoned that the plan's arbitration provision precluded certain remedies that ERISA "expressly permit[s]." *Id.* at 623. Specifically, the provision precluded plaintiff from seeking relief that extended beyond himself, even though ERISA expressly contemplates "such other equitable or remedial relief as the court may deem appropriate." *Id.* at 621. Because the provision would preclude plaintiff from pursuing the remedy of removing the plan fiduciary, which "would go beyond just [plaintiff] and extend to the entire plan," the provision operated as a waiver of statutory remedies and could not be enforced. *Id.* at 621–623. However, the court was careful to explain that "the problem with the plan's arbitration provision is its prohibition on certain plan-wide remedies, not plan-wide representation," signaling that the court took no issue with the provision's class action waiver. *Id.* at 622. The Seventh Circuit also saw "no conflict" between its decision and the Ninth Circuit's decision in *Dorman* because the *Dorman* arbitration provision "lacked the problematic language present here." *Id.* at 623.

The Second Circuit's recent decision in *Cooper v. Ruane Cunniff & Goldfarb Inc.*, 990 F.3d 173 (2d Cir. 2021), provides yet another example of the emerging and divergent approaches to assessing the arbitrability of section 502(a)(2) fiduciary-breach claims. There, a split panel reversed a district court order compelling arbitration. *Id.* at 175–76. Rather than taking issue with the enforceability of the clause itself (as in *Smith*) the court noted that the plaintiff's claims did not fall within the scope of the arbitration provision. *Id.* at 179. The provision covered "all legal claims arising out of or relating to employment," but the defendant had not argued that plaintiff's claim for fiduciary breach arose out of his employment, so the question before the Court was limited: did plaintiff's fiduciary breach claim "relat[e] to [his] employment"? *Id.* at 180. The majority answered in the negative, reasoning that arbitration was only required when the "merits of th[e] claim involve facts particular to an individual plaintiff's own employment." *Id.* at 184. Writing in dissent, Judge Sullivan articulated a more expansive view of the arbitrability of fiduciary-breach claims. He argued that "[w]here, as here, an arbitration agreement uses broad language that is ambiguous about whether an issue in dispute is arbitrable, we must resolve that ambiguity

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

in favor of arbitration." *Id.* at 186 (Sullivan, J., dissenting).

This year, the Sixth Circuit will also hear an appeal in *Hawkins v. Cintas Corp.*, No. 19-1062, 2021 WL 274341 (S.D. Ohio Jan. 27, 2021), wherein the district court declined to compel arbitration of breach of fiduciary duty claims brought on behalf of the plaintiffs' plan. *Id.* at *7. The district court reasoned that the claims were not arbitrable because they were brought on behalf of the plan and there was "no agreement" between the plan and the defendant to arbitrate plan disputes. *Id.* at *3–4. Specifically, while the plaintiffs' participant agreements stated that "'the rights and claims of Employee' will be arbitrated," that language bound only the individual employee, not the plan. *Id.* at *6. The court explicitly distinguished *Dorman*, emphasizing that the defendant had provided no evidence that any plan document actually bound the plan to arbitration. *Id.* Separately, the court rejected defendant's argument that, as sponsor of the plan, it could either consent to arbitration via the filing of a motion to compel, or otherwise "modify Plan documents to require Plan claims to proceed to arbitration." *Id.* at *5, 7. Because the court found no valid agreement to arbitrate existed between the plan and the defendant, it ruled that the claims must proceed in federal court absent intervention by the Sixth Circuit.

These approaches to the arbitrability of section 502(a)(2) claims may be sowing seeds for a potential circuit split. By way of example, a Florida district court recently rejected the Seventh Circuit's reasoning in *Smith* and enforced the arbitrability of fiduciary-breach claims over an effective vindication challenge. *See Holmes et al. v. Baptist Health So. Florida*, No. 21-22986, 2022 WL 180638 (S.D. Fla. Jan. 20, 2022). The *Holmes* plaintiffs brought fiduciary breach claims on their own behalf, and on behalf of the plan, and a putative class of those similarly situated. Plaintiffs' plans contained an arbitration clause providing that "[a]ny claim … which arises out of, or relates to, or concerns the Plan … shall be resolved exclusively by binding arbitration." *Id.* at *1. Relying on *Smith*, plaintiffs argued that the provision was unenforceable under the effective vindication doctrine because it forbade "Plan-wide relief—such as removal of the plan's fiduciaries and appointment of new fiduciaries, which is authorized under § 1109(a)," but precluded by the arbitration clause. *Id.* at *2. The district court disagreed. It pointed to the absence of any Eleventh Circuit authority applying the effective vindication doctrine to void an arbitration clause and reasoned that unlike the provision in *Smith* which "completely denied some types of statute-authorized relief to the Plan, the clause here does not, as individual claimants can each recover the harm to their defined contribution accounts, and they can recover Plan-wide relief that does not provide additional benefits or monetary relief to others." *Id.* at *3.

We expect to see more litigation over the arbitrability of section 502(a)(2) claims as courts continue to flesh out the enforceability, scope, and application of plan arbitration provisions.

V. The Standard of Review of ERISA Benefits Claims

As we discussed last year, federal courts continue to examine the scope and standard of review for ERISA benefits claims. In general, courts review a plan administrator's benefits decision *de novo* unless the terms of the plan grant the administrator discretion to interpret the plan and award benefits, in which case courts review the claims decisions under a deferential "abuse of discretion" standard (sometimes called "arbitrary and capricious" review). *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). Benefit plans commonly grant this discretion to their administrators, so the deferential standard often applies to ERISA benefits claims, with the Supreme Court repeatedly parrying attempts by plaintiffs to strip administrators of this deference. *See, e.g.*, *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 115 (2008); *Conkright v. Frommert*, 559 U.S. 506, 522 (2010). Nonetheless, lower courts continue to grapple with how to apply these standards of review at different stages of litigation and the appropriate burden on each party under each standard.

A recent appellate decision confronted this issue and provided potentially helpful guidance

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

while deepening a circuit split and leaving questions concerning whether courts may make factual determinations at summary judgment, and the standard of review when there is evidence that a plan administrator acted under a conflict of interest.

A. Circuits Appear Split Over the Permissibility of Factual Determinations at Summary Judgment

The Eighth Circuit's recent decision in *Avenoso v. Reliance Standard Life Ins. Co.*, 19 F.4th 1020 (8th Cir. 2021), deepens a circuit split over the role of summary judgment in ERISA benefits disputes. Because there is no right to a jury trial in ERISA cases and review of benefits determinations is generally limited to the administrative record, *see id.* at 1025, benefits cases are often decided on cross-motions for summary judgment without need for a trial. The First Circuit has thus held that summary judgment in ERISA cases "is simply a vehicle for teeing up the case for decision on the administrative record," allowing the court to "weigh the facts, resolve conflicts in evidence, and draw reasonable inferences." *Doe v. Harvard Pilgrim Health Care, Inc.*, 974 F.3d 69, 72 (1st Cir. 2020) (citations omitted). In *Avenoso*, however, the Eighth Circuit joined the Second, Sixth, Seventh, Ninth, and Eleventh Circuits in rejecting this approach and holding that district courts are not permitted to make factual determinations when reviewing ERISA benefits claims at the summary judgment stage, under either the *de novo* or abuse of discretion standards. *See* 19 F.4th at 1025–26; *O'Hara v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 642 F.3d 110, 116 (2d Cir. 2011); *Patton v. MFS/Sun Life Fin. Distribs., Inc.*, 480 F.3d 478, 484 n.3 (7th Cir. 2007); *Shaw v. Conn. Gen. Life Ins*., 353 F.3d 1276, 1282, 1286 (11th Cir. 2003); *Kearney v. Standard Ins.*, 175 F.3d 1084, 1095–96 (9th Cir. 1999) (en banc); *Wilkins v. Baptist Healthcare Sys., Inc.*, 150 F.3d 609, 619 (6th Cir. 1998). The court explained that when considering these claims at summary judgment, "weigh[ing] the evidence, mak[ing] credibility determinations, or attempt[ing] to discern the truth of any factual issue" is improper. *Avenoso*, 19 F.4d at 1024.

Avenoso preserves an important but limited role for bench trials in ERISA benefits cases. The Eight Circuit explained that a bench trial may be necessary when the district court needs to review evidence from outside the administrative record to determine, for example, the degree of deference owed to the administrator's decision, or to resolve a dispute over whether a piece of information was part of the administrative record. *Id.* at 1026. Because such instances could involve "new evidence, including witness testimony[,] [s]ummary judgment . . . serve[s] the important function of sparing the court, the parties, and the witnesses the time and expense of a bench trial in the event that the case can be resolved without one." *Id.*; *see also Wilkins*, 150 F.3d at 619 ("The district court may consider evidence outside of the administrative record only if that evidence is offered in support of a procedural challenge to the administrator's decision, such as an alleged lack of due process afforded by the administrator or alleged bias on its part."). Other circuits have also agreed that a bench trial may sometimes be necessary to resolve factual disputes—such as choosing between competing physician reports—when a plan does not grant discretion to the administrator and the district court therefore reviews the administrator's decisions *de novo*. *See Avenoso*, 19 F.4d at 1026–28; *Shaw*, 353 F.3d at 1282, 1286; *see also, e.g.*, *Kearney*, 175 F.3d at 1095.

B. Plaintiffs Have Achieved Mixed Results Challenging Decisions Based on Alleged Conflicts of Interest of Plan Administrators

This past year courts also continued to grapple with how to handle deference to an administrator's benefits decision when there is evidence of a conflict of interest—*i.e.*, where the administrator both makes eligibility determinations and pays benefits. Courts generally agree that the mere existence of a conflict of interest does not establish an abuse of discretion, and the effect of a conflict of interest depends on a case-specific inquiry. Several decisions in the past year nonetheless provide guidance as to the circumstances in which a conflict of interest may prove to be a key driver of the outcome.

As a general matter, recent decisions have described the impact of a conflict of interest in

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

various ways. In *Boyer v. Schneider Elec. Holdings, Inc.*, 993 F.3d 578 (8th Cir. 2021), for example, the Eight Circuit stated that "a tie . . . might be resolved against a conflicted administrator," but it ultimately upheld the decision at issue because the administrator's interpretation of the plan was reasonable, its fact findings were "supported by substantial evidence," and there was no evidence that the company "permit[ted] outcomes on claims decisions to influence the company's evaluation and compensation of those who make the decisions." *Id*. at 581–84. In *Weiss v. Banner Health*, 846 F. App'x 636 (10th Cir. 2021), meanwhile, the Tenth Circuit stated that an administrator's conflict may "decrease[] the level of deference to which its decision is entitled," but it upheld the administrator's decision even "[t]aking the conflict of interest into account" because the administrator could reasonably rely on the medical guidelines used to interpret the plan and the decision was supported by both internal and external reviewers who considered all of the relevant evidence. *Id.* at 640–41.

Other notable decisions suggest circumstances in which a plaintiff may overcome deference to the plan fiduciary based in part on the presence of a conflict of interest. In *Noga v. Fulton Financial Corp. Employee Benefit Plan*, 19 F.4th 264 (3d Cir. 2021), the plaintiff had twice been determined eligible for disability benefits by insurer-affiliated medical professionals, and each time the insurer had engaged a third-party consultant to review the claim, leading the plan to overturn its initial favorable determination. *Id.* at 277–78. In finding an abuse of discretion, the Third Circuit emphasized the "unusual timing of, impetus for, and scope of requests for outside review." The first request occurred more than a year after the insurer learned of the facts that supposedly prompted the request, and less than a month after a nurse employed by the insurer recertified that the plaintiff remained totally disabled. *Id.* at 268–69, 277. The other occurred during plaintiff's administrative appeal of this initial denial, a day after a benefits analyst *overturned* the termination of benefits relying on records from both his physicians and a different insurer-employed nurse, who determined plaintiff lacked "consistent work function at any level." *Id.* at 269, 278. Because these facts suggested that the review requests were "tied" to the insurer's "structural" conflict of interest, and the record otherwise "favor[ed] the continued award of benefits," the Third Circuit held that the insurer had abused its discretion, and it affirmed the order that plaintiffs' benefits be reinstated. *Id.* at 278–29.

In *Roehr v. Sun Life Assurance Co. of Canada*, meanwhile, the Eighth Circuit held that, while an administrator can mitigate the effect of a conflict of interest with outside review of the record, it cannot solely "rel[y] on the same evidence to both find a disability and later discredit that disability." 21 F.4th 519, 525–26 (8th Cir. 2021). There, plaintiff's physicians had diagnosed no specific cause for plaintiff's tremors and also noted that these tremors were intermittent, and the plan administrator relied on these evaluations to provide benefits for ten years. *Id.* at 521–24. With no particular triggering medical reason, the plan administrator, seeking "to reduce any potential conflict of interest or bias," then had third-party physicians review the plaintiff's file, who determined that the lack of a diagnosis and the absence of references to tremors in periodic medical evaluations showed that plaintiff was able to work, which the plan administrator relied upon to deny benefits. *Id.* 523–25. The court found this reversal of course to be an abuse of discretion because the new, non-physical evaluations' medical findings were entirely consistent with the diagnosis the defendant had relied upon to provide benefits for a decade (intermittent tremors with no known cause), and the defendant "pointed to no information available to it that altered in some significant way its previous decision to pay benefits." *Id.* at 525–26. Specifically, although the court held that third-party medical review of the record can preserve deferential review despite a conceded conflict of interest, it noted that "'the previous payment of benefits is a circumstance' weighing against the termination of benefits." *Id.* at 525 (quoting *McOsker v. Paul Revere Life Ins.*, 279 F.3d 586, 589 (8th Cir. 2002)). A plan administrator should therefore not wait "almost a decade" to use such review to support a "change in decision," especially when the decision is not supported by new medical evidence, such as an "independent medical exam." *Id.* at 526

Nonetheless, as in *Boyer* and *Weiss*, circuit courts continue to be unreceptive to

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

overturning discretionary decisions by plan administrators even in the face of a conflict of interest if the plaintiff cannot point to evidence that the conflict played a role in the eligibility determination. As the Sixth Circuit emphasized in *Lloyd v. Procter & Gamble Disability Benefit Plan, Plan #501*, the mere presence of a conflict of interest typically is insufficient to overturn an administrator's determination absent "'significant evidence' that the conflict actually affected or motivated the decision at issue." No. 20-4329, 2021 WL 4026683, at *11 (6th Cir. Sept. 3, 2021). Thus, the presence of a conflict of interest and conflicting medical opinions can be insufficient to support a finding of an abuse of discretion where a plan and administrator justifiably relied on at least some medical evaluations, and that decision did not appear to be specifically tainted. *See id.* at *6–11.

In the absence of a conflict of interest, plaintiffs continue to face steep obstacles to recovery, particularly when a plan vests its administrator with discretion in resolving contested claims issues. In *Michael J. P. v. Blue Cross & Blue Shield of Texas*, for example, the Fifth Circuit reversed summary judgment in favor of the plaintiff, concluding that the denial of benefits was supported by substantial evidence. No. 20-30361, 2021 WL 4314316, at *6 (5th Cir. Sept. 22, 2021). The court stated that "even if an ERISA plaintiff supports his claim with substantial evidence, or even with a preponderance, he will not prevail" as long as defendants can support their decision with "more than a scintilla" of evidence with "a rational connection between the known facts and the decision or between the found facts and the evidence." *Id.* at *2 2 (quoting *Foster v. Principal Life Ins. Co.*, 920 F.3d 298, 304 (5th Cir. 2019)). Finding that defendants met this burden by proffering physicians and reports demonstrating the lack of need for the sought medical treatment, *id.* at *4–6, it was "beside the point" what evidence plaintiffs had to the contrary, *id.* at *7.

Notably, *Michael J. P.* featured a significant concurrence by Judge Oldham, who agreed that the majority had correctly applied the circuit's "substantial evidence" standard, but questioned the ultimate validity of that standard. *See id.* at *8 (Oldham, J., concurring). He first suggested that "substantial evidence" review was derived from practice under the Labor Management Relations Act of 1947 ("LMRA"), but the Supreme Court in *Firestone* had questioned importing the LMRA's review standard into ERISA. *Michael J. P.*, 2021 WL 4314316, at *8–9 (citing *Firestone*, 489 U.S. at 109–10); *see also Glenn*, 554 U.S. at 121 (Roberts, C.J., concurring in part and concurring in the judgment). He also suggested that the Fifth Circuit's version of substantial evidence review in ERISA cases—requiring only more than a "scintilla" of evidence supporting the decision—is radically different from substantial evidence review conducted elsewhere, including administrative law challenges, which ordinarily entail a more "holistic" analysis of the record, "taking into account contradictory evidence . . . ." *Id.* at *9–10 (quoting *Universal Camera Corp. v. NLRB*, 340 U.S. 474 (1951); citing *Dish Network Corp. v. Nat'l Lab. Rels. Bd.*, 953 F.3d 370, 377 (5th Cir. 2020), *as revised* (Mar. 24, 2020)). Ultimately, Judge Oldham expressed concern that the current form of substantial evidence review used in ERISA cases to assess whether an administrator has abused its discretion in making benefits determinations, adopted through legal, logical, and historical errors, may "make[] it particularly difficult for ERISA beneficiaries to vindicate their rights under the cause of action created by Congress." *Id.* at *10. While it is unclear whether Judge Oldham's views will gain traction in the Fifth Circuit or elsewhere, it is indicative of the kind of skepticism that courts sometimes exhibit towards deferential review of decisions by administrators exercising discretionary authority over ERISA plans.

VI. Changing Department of Labor Rules for ESG Investing

In closing, we highlight an important rule change proposed in 2021 by the Department of Labor ("DOL") concerning environmental, social, and governance ("ESG") investing. As we predicted last year, a new rule proposed and adopted by the DOL late in the Trump administration was targeted for significant revisions by the Biden administration. The new proposed rule purports to provide guidance to plan fiduciaries on the factors they must consider when assessing whether to add or retain investment options in ERISA retirement plans, and states that ESG factors "often" should be among those considerations.

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

As we discussed last year, in the final days of the Trump administration, the DOL proposed and adopted a 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 fiduciary duty under ERISA. *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 did 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.

On October 14, 2021, the DOL published a new proposed rule, entitled "Prudence and Loyalty in Selecting Plan Investments and Exercising Shareholder Rights," which specifies that a fiduciary's assessment of whether an investment option or decision is prudent "may often" require "an evaluation of the economic effects of climate change and other ESG factors on the particular investment or investment course of action." 85 Fed. Reg. 57,272, 57,276 (Oct. 14, 2021). The proposed rule explains that "this provision is intended to counteract negative perception of the use of climate change and other ESG factors in investment decisions caused by the 2020 Rules." 85 Fed. Reg. 57,276.

While some fiduciaries and plan beneficiaries have welcomed the proposed rule and the opportunity to consider ESG factors in the investment selection process, others have expressed concern that the proposed rule may go too far and require fiduciaries to show why ESG were *not* considered in the selection of investments, and thus may open fiduciaries to yet another avenue of litigation. *See*, *e.g.*, Ellen Meyers, *Retirement advisers group, AARP wary of Labor Department's ESG proposal*, Roll Call (Jan. 6, 2022), https://rollcall.com/2022/01/06/retirement-advisers-group-aarp-wary-of-labor-departments-esg-proposal/.

In a December 2021 letter to Labor Secretary Marty Walsh, several Senate Republicans emphasized the potential "traps for plan fiduciaries" and "increased litigation risk" that the new rule would create, stating that the rule establishes "a *de facto* mandate on fiduciaries of retirement plans, requiring them to consider ESG factors." Pat Toomey, Mike Crapo, Richard Burr & Tim Scott, Re: Prudence and Loyalty in Selecting Plan Investments and Exercising Shareholder Rights [RIN 1210-AC03] (Dec. 10, 2021), https://www.scott.senate.gov/imo/media/doc/2021-12-10%20Ranking%20Members%20Letter%20to%20DOL.pdf. In their letter, the Senators asked the DOL to withdraw the proposed rule, but this would appear to be an unlikely outcome under the current democratic administration. *Id.*

The period for commenting on the proposed rule closed on December 13, 2021. We will continue to track developments in the rule as it goes into effect.

The following Gibson Dunn lawyers assisted in the preparation of this alert: Eugene Scalia, Karl Nelson, Geoffrey Sigler, Heather Richardson, Matthew Rozen, Jennafer Tryck, Lana El-Farra, Tessa Gellerson, Alex Ogren, Amanda Sansone, Clare Steinberg, Luke Zaro, and Yan Zhao.

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:

Eugene Scalia – Washington, D.C. (+1 202-955-8543, escalia@gibsondunn.com) 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) Matthew S. Rozen –

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**

Washington, D.C. (+1 202-887-3596, mrozen@gibsondunn.com) Jennafer M. Tryck – Orange County (+1 949-451-4089, jtryck@gibsondunn.com)

© 2022 Gibson, Dunn & Crutcher LLP Attorney Advertising: The enclosed materials have been prepared for general informational purposes only and are not intended as legal advice.

Related Capabilities

Executive Compensation and Employee Benefits

Labor and Employment

Class Actions

Insurance and Reinsurance

Securities Litigation

FDA and Health Care

© 2026 Gibson, Dunn & Crutcher LLP. All rights reserved. For contact and other information, please visit us at www.gibsondunn.com. | **www.gibsondunn.com**