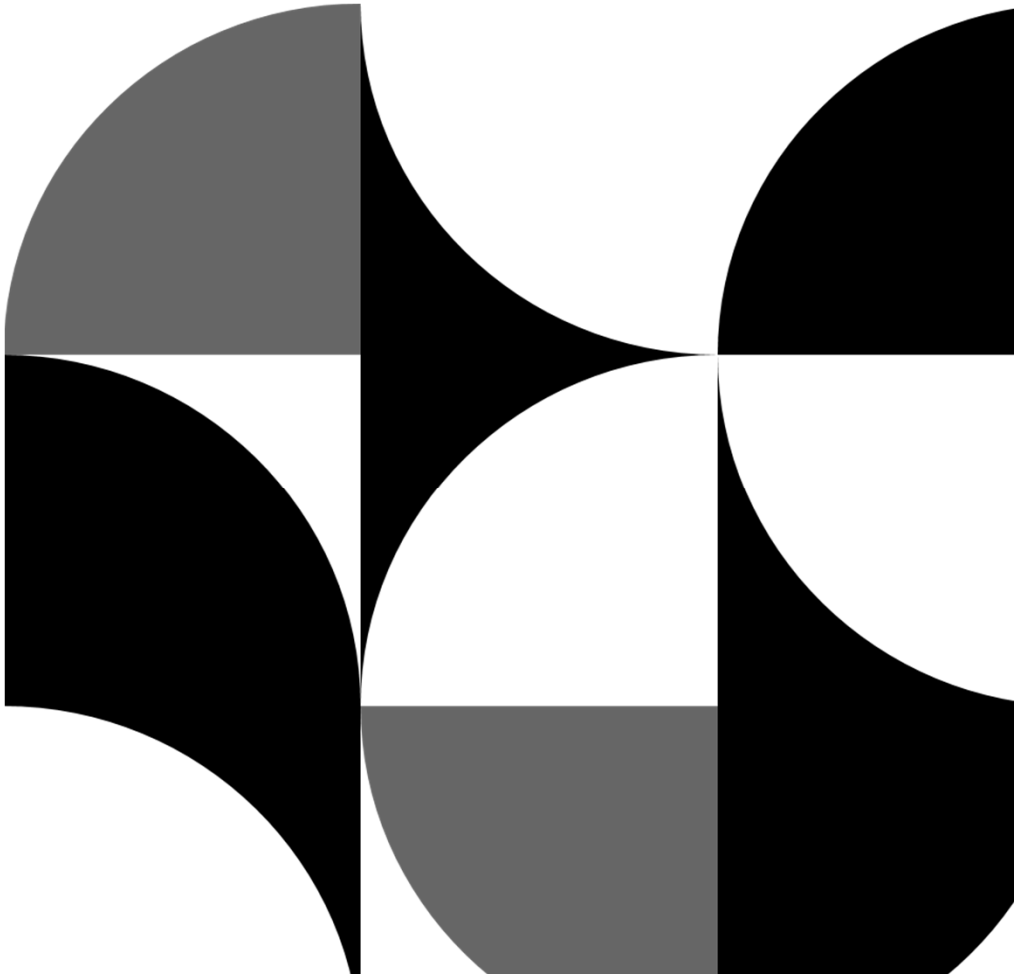
Seyfarth

ERISA Updates for July 2024:

Trends We're Watching (So You Don't Have To)

July 15, 2024



Seyfarth Shaw LLP

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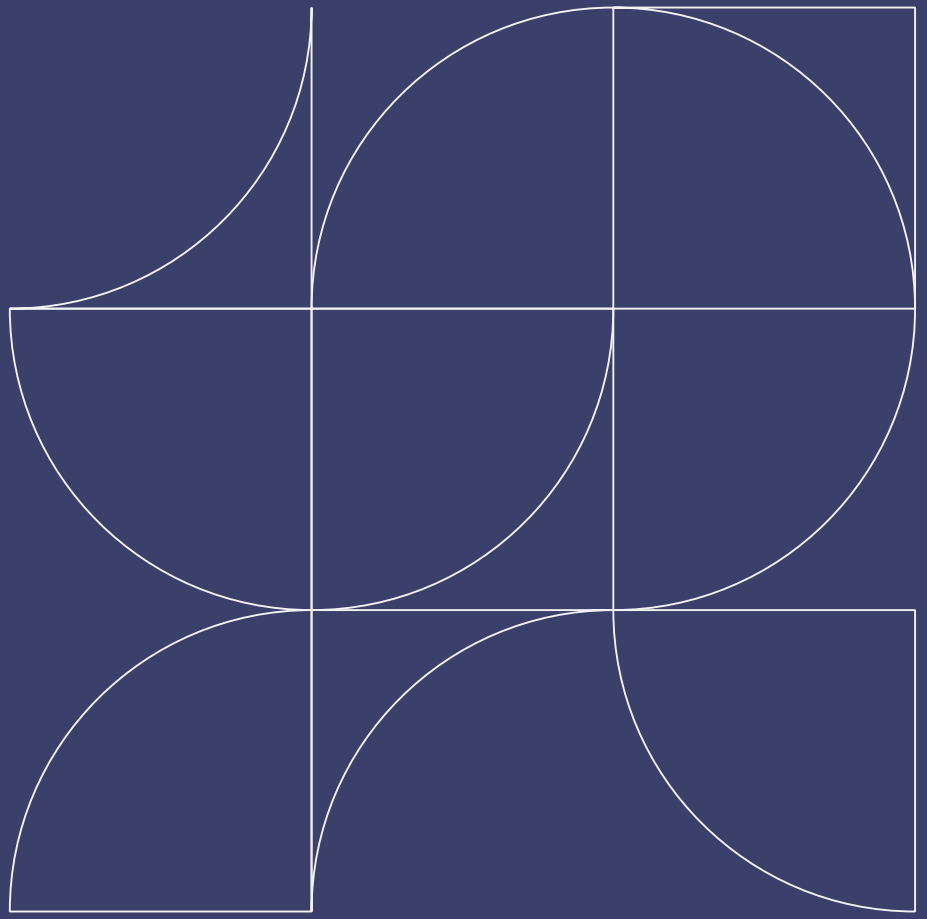
ERISA Preemption



Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co.

- Two opinions issued:
  - *Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co.,* No. 23-55019, __ F.4th __, 2024 WL 2789835 (9th Cir. May 31, 2024) (state law claims)
  - *Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co.*, No. 23-55019, __ F. App'x __, 2024 WL 2801531 (9th Cir. May 31, 2024) (ERISA claims)

Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co.

- Plaintiff Bristol SL Holdings, Inc., is a holding company owned by three former shareholders of Sure Haven Inc., a now-defunct drug rehabilitation and mental health treatment center.
- Sure Haven had a practice of having patients sign an assignment of rights that gave Sure Haven the right to seek reimbursement from Cigna.
- Cigna reimbursed Sure Haven for its services for several years, but Cigna began to suspect that Sure Haven was engaging in “fee forgiveness”
- “Fee forgiveness” is a practice where a provider waives or does not collect deductibles and copays from patients.
- Cigna alleged that this practice was not permitted under the respective benefit plans and “inflates insurance costs at an insurer’s expense by eliminating the financial incentive for patients to seek cheaper in-network care.”

Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co.

- Cigna began denying Sure Haven's claims unless it provided proof of payment by its patients.
- Cigna refused to pay claims for 106 patients, totaling $8.6 million.
- Sure Haven filed for bankruptcy and its successor-in-interested Bristol filed a lawsuit in California federal court alleging claims for benefits under **both** state law and ERISA.

Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co. State Law Claims

- Cigna first argued that Bristol lacked standing to bring ERISA claims against it, arguing that Bristol was not the party “assigned” the claim to reimbursement.
- This argument initially succeeded in district court, but was reversed in 2022, with the Ninth Circuit concluding that the successor-in-interest (Bristol) had “derivative” standing under ERISA.
- In the second round at the district court level, Cigna argued that Bristol’s state law claims for breach of contract and promissory estoppel were preempted by ERISA. The district court ruled in favor of Cigna for a second time, and Bristol appealed to the Ninth Circuit.
- The Ninth reiterated ERISA’s broad preemption provision providing that a state law is preempted by ERISA if it has a “reference to” or a “connection with” an ERISA plan. Under the “reference to” prong, a claim must be either “premised on the existence of an ERISA plan” or “the existence of the plan is essential to the claim’s survival.”

Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co. State Law Claims

- The Ninth Circuit concluded that Bristol's state law claims satisfied this test, because they had an "impermissible 'reference to' ERISA plans.
- The Ninth Circuit noted the references:
  - The basis for Sure Haven to request reimbursement from Cigna was whether reimbursements were available to participants under the Plan.
  - The services Sure Haven was providing were services covered by the Plan.
  - Sure Haven's claims were denied because the Plan prohibited "fee forgiveness."

Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co. State Law Claims

- The Ninth Circuit also analyzed whether the claims were preempted under the "connection with" prong of the preemption provision.
- The Ninth Circuit reiterated the familiar standard that a state law "has an impermissible connection with an ERISA plan if it **governs a central matter of plan administration or interferes with nationally uniform plan administration,** or if it bears on an ERISA-regulated relationship."
- The court ruled that Bristol's claims governed **a central matter of plan administration**:
  - Bristol's breach of contract claims depended on the verification of plan coverage in calls with Sure Haven creating a contract to pay for the claims.
  - Finding this interaction was sufficient to create a contract "would be at odds with the way ERISA plans operate, because reimbursement under a plan is ultimately contingent on information and events beyond the initial verification and preauthorization communications."
- The Ninth Circuit concluded that this is "the kind of intrusion on plan administration that ERISA's preemption provision seeks to prevent."

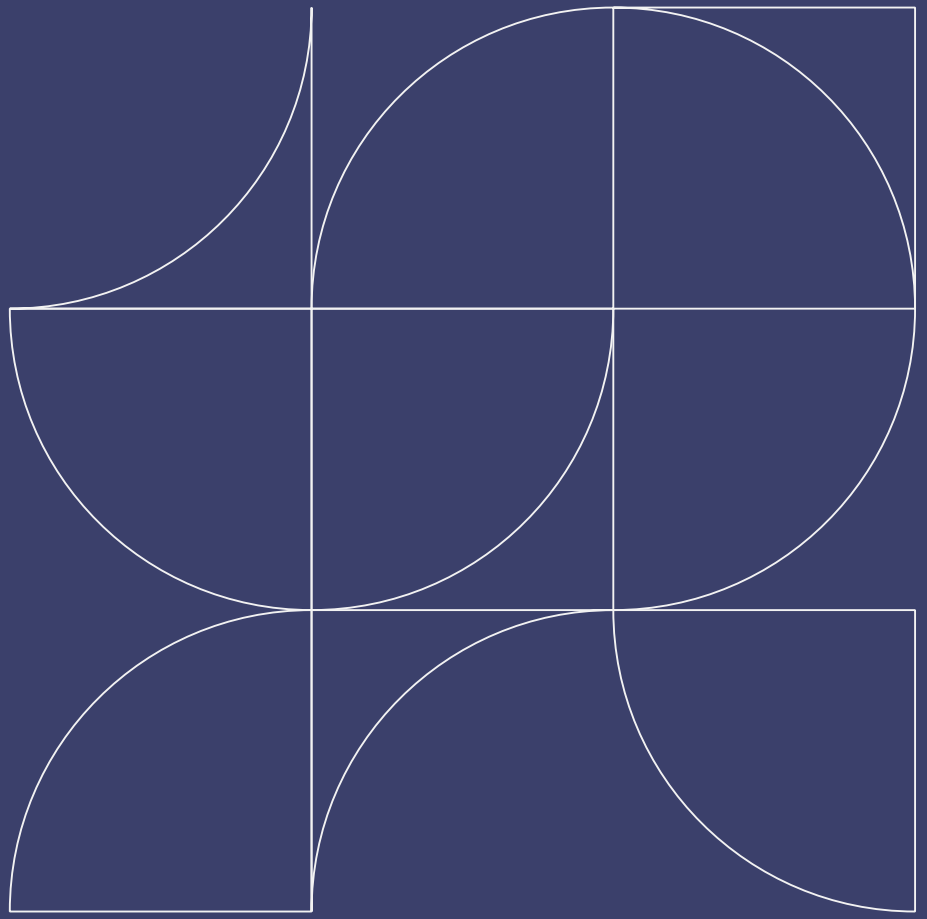
Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co. State Law Claims

- The Ninth Circuit held that Bristol's claims also **interfered with nationally uniform plan administration:**
- The Ninth Circuit stated that "if providers could use state contract law to bind insurers to their representations on verification and authorization calls regardless of plan rules on billing practices, benefits would be governed not by ERISA and the plan terms, but by innumerable phone calls and their variable treatment under state law."
- ERISA was designed to prevent this type of "discordant regime."

Bristol SL Holdings, Inc. v. Cigna Health & Life Ins. Co. ERISA Claims

- As for the ERISA claims that Bristol had brought originally, the Ninth Circuit also affirmed the district court's dismissal of those claims, finding that Cigna did not abuse its discretion in determining that Bristol's claims were not payable because of the plans' prohibition on fee-forgiveness.
- Bristol challenged both the standard of review and the merits of Cigna's decisions, but the Ninth Circuit affirmed the district court's ruling on both.
- Cigna had discretionary authority in making its decisions, even if that power was found only in SPDs, because they were valid plan documents and there was no formal benefit plan to the contrary in evidence.
- On the merits, Cigna had (1) engaged in "meaningful dialogue" with Sure Haven regarding the reasons for denial, (2) Cigna's interpretation of the plan provisions barring fee-forgiveness was reasonable; and (3) Cigna's conclusion that fee-forgiveness was occurring was well supported by Cigna's internal investigation, letters to Sure Haven patients, an undercover inquiry into Sure Haven's rates, and its audits of patient records.

Prohibited Transactions



Prohibited Transactions

- ERISA § 406 broadly outlines a series of “prohibited” transactions that fiduciaries are restricted from engaging in (or causing a plan to engage in)
- Two recent cases (reaching divergent results) deepen a circuit split as to plaintiffs’ burden to plead prohibited transaction claims
    - Some speculation that the Supreme Court could soon look to resolve the divergent standards
- Increased attention to these claims could lead to increase in filings in this space

Prohibited Transactions

- *Bugielski v. AT&T Servs, Inc*., 76 F.4th 894 (9th Cir. 2023)
  - In reversing summary judgment for the defendants, 9th Circuit took a very broad view of prohibited transactions, and set a low bar for plaintiffs to clear
    - The AT&T plan at issue has used the same recordkeeper since 2005
    - In the mid-2010s, AT&T and the recordkeeper amended their contract to allow the recordkeeper to receive compensation from "additional services from new vendors"
    - The Court of Appeals held that the amended contract was a prohibited transaction under 29 U.S.C. § 1106(a)(1)(c) (furnishing of services) because the recordkeeper was already a party in interest
    - It further held the record was not clear as to whether the recordkeeper received only "reasonable compensation" – a key fact in assessing whether the transaction was "exempt"
  - The holding suggests that any subsequent contract or amendment entered into after a service provider is originally hired gives rise to almost a *per se* prohibited transaction claim

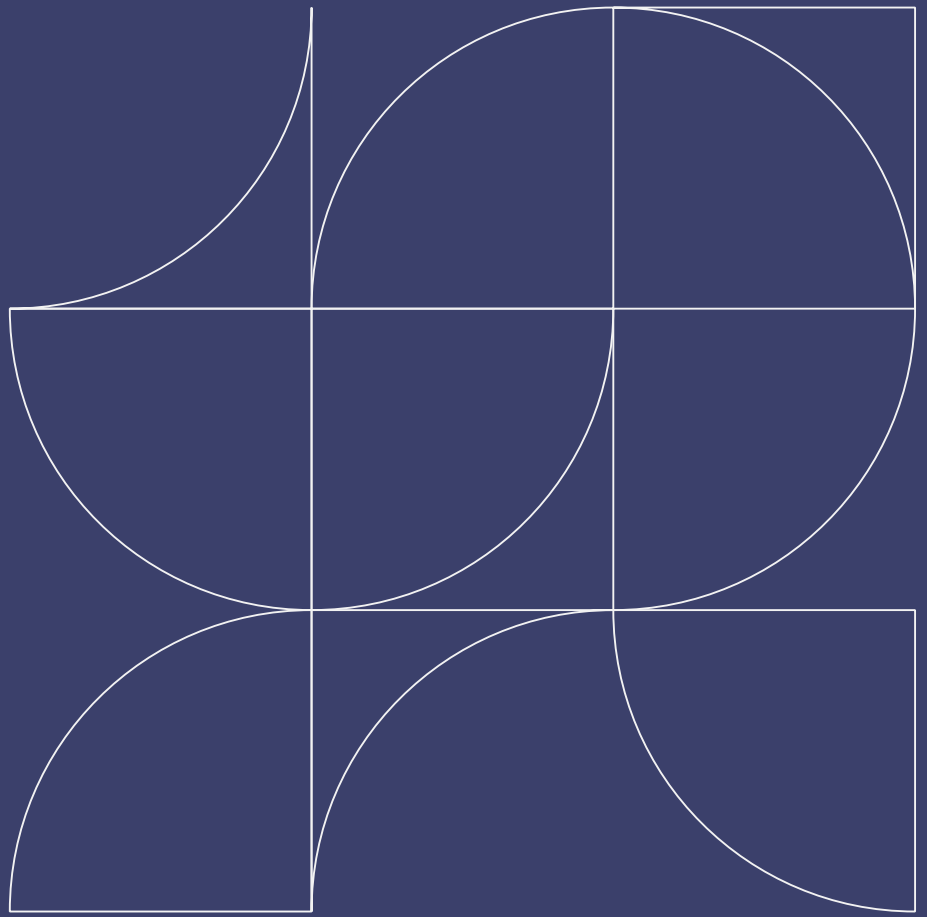
Prohibited Transactions

- *Bugielski v. AT&T Servs, Inc*., 76 F.4th 894 (9th Cir. 2023) – Key Takeaways
  - Because courts have held that the prohibited transaction exceptions in 29 U.S.C. § 1108 are affirmative defenses, the pleading standard to get past a motion to dismiss could be very low (simply alleging that an existing service provider renegotiated its contract)
    - This holding is in some tension with the 9th Circuit's decision in *Santomenno v. Transamerica Life Ins. Co*., 883 F.3d 833 (9th Cir. 2018) (holding that negotiating a service provider contract is not a fiduciary action).
    - It also presents something of a catch-22 from the point of view of the plaintiff-side bar:
      - If there is no RFP/new contract for a service provider, there is a possible prudence claim
      - If there is a new contract, that's a possible prohibited transaction
  - If broadly adopted, the 9th Circuit's opinion would significantly undo progress on pleading standards as to 401(k) fee claims, by reducing plaintiff's burden to show compensation was unreasonable, and shifting burden to defendants as an affirmative defense

Prohibited Transactions

- *Cunningham v. Cornell University*, 86 F.4th 961 (2d Cir. 2023)
  - Like the *AT&T* case, complaint alleged that defendants caused the plan to pay recordkeepers more than reasonable compensation, and alleged a prohibited transaction
    - District court dismissed, holding plaintiff failed to plead the lack of an applicable exemption
    - Second circuit affirmed
  - In contrast to the 9th Circuit's opinion, the 2nd Circuit held that "to plead a violation of [Section 406(a)(1)(C)], a complaint must plausibly allege that a fiduciary has caused the plan to engage in a transaction that constitutes the 'furnishing of . . . services . . . between the plan and a party in interest' *where that transaction was unnecessary or involved unreasonable compensation*."
    - Holding was rooted in text of ERISA, and conclusion that the statute incorporates the exemptions into the recitation of what is "prohibited," such that they are an element of claims, not affirmative defenses
- *Cunningham* better aligns pleading burdens for prohibited transaction and post-*Hughes* fiduciary breach claims
  - Protects against risk of frivolous PT lawsuits using discovery to explore other potential claims

ERISA 401(k) Fee Litigation



A “Fever Pitch” of Litigation

- ERISA class actions have been filed at record rates in recent years
  - 298 cases from 2020-2023
  - All-time high of 101 in 2020; 89 more in 2022
  - 48 in 2023
  - 43 related to retirement plans alone in 2024 so far
- Typical allegations are that the plan fiduciaries failed to select prudent investments, overpaid service providers, utilized an incorrect mortality table not in the interest of participants
  - But novel theories have emerged
- Law firms representing plaintiffs have proliferated
- Even medium-sized and small plans now targeted (as small as $4.5M)
- Costs of increase in filing have been staggering
  - From 2020-2023, $911 million in settlements; $353 million in 2023 alone.

Pleading Standard for Fee Claims

- *Hughes,* 595 U.S. 170 (2022)
  - Participants in two 403(b) defined contribution plans alleged that they were charged excessive record-keeping fees and high investment option fees
  - The District Court granted a motion to dismiss and the decision was upheld by the 7th Circuit Court of Appeals
  - Supreme Court rejected that 7th Circuit law, clarifying that fiduciary has duty to assess prudence of each investment option, not just lineup as a whole
  - On remand from the Supreme Court, the 7th Circuit allowed two claims to proceed:
    - Recordkeeping & Share Class
    - For recordkeeping, Plaintiffs must plausibly allege fiduciary actions outside range of reasonable actions
    - For share class, Plaintiffs must show that comparator share class was plausibly available

Hughes – Aftermath

- Courts continue to grapple with ERISA pleading standard questions
  - Cases decided by Second, Third, Fifth, Sixth, Seventh, Eighth, Ninth, Tenth Circuit Courts of Appeals
  - Given the heavy volume of class action filings, there have also been a large number of district court decisions
- Cases vary in their interpretations/approaches, but it has generally been the case that more cases are surviving dismissal
- At least some Plaintiff firms seem to be narrowing their complaints
  - For example, limiting to recordkeeping claim and pointing to “comparable plans with a similar number of participants, similar net assets, and that utilize the same recordkeeper,” and alleging those plans paid less

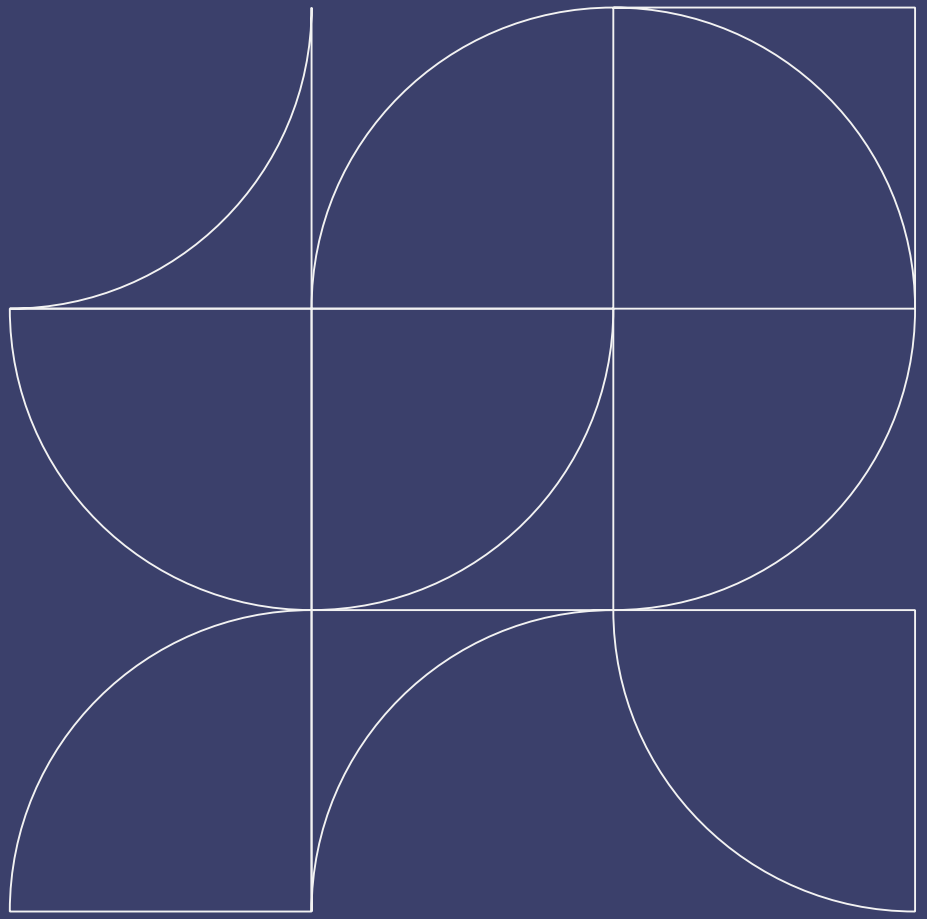
Beyond the Pleading Stages

- Favorable trends for Plaintiffs at the pleading stage have not carried through to merits rulings
- Several defense victories at summary judgment, will helpful reasoning:
  - “It is a mathematical reality that some subset of a given class of 401(k) plans will have smaller recordkeeping fees than all the others . . . . It does not follow, however, that all fiduciaries of 401(k) plans that are not in that subset have arguably breached their fiduciary duties to a sufficient degree that requires a trial.”
- Courts – both at SJ and at trial – have also been critical of certain expert witnesses
- Trials – including a jury trial – have produced favorable outcomes for defendants
- While allegations of “meaningful benchmarks” have been enough at the pleading stage, evidence to support those comparisons has been harder for plaintiffs to come by

Key Takeaways

- 401(k) Plan fee litigation is not going away anytime soon
- Motions to dismiss have become more difficult on balance since *Hughes*
  - Success at the motion-to-dismiss stage has hinged on how closely a court is willing to scrutinize alleged facts about a plan and putative comparators
  - Courts appear to be allowing a relatively general level of comparison to proceed beyond motions to dismiss
  - Because of the relatively lower pleading standard post *Hughes*, recordkeeping claims in particular have a better likelihood of surviving a motion to dismiss
- Process matters

401(k) Litigation Flavor of the Month: Forfeitures



Forfeiture Litigation

- Beginning in September 2023, at least 7 cases have been filed related to the use of “forfeiture” assets in 401(k) plans
  - Forfeitures are typically the money left behind when an employee leaves the company before all of their benefits are vested
  - The money usually came from employer contributions
- Plan terms (under applicable regulations) often specify that forfeitures can be used to satisfy employer contribution requirements or offset plan expenses
- These new lawsuits challenge the decision, under those arrangements, to use forfeiture assets to reduce employer expenses, rather than defray costs to participants
- These cases highlight the practice of plaintiffs’ firms targeting historically “routine” plan practices, in hopes of identifying next “trend” in 401(k) litigation
- Viability of these claims against any particular plan is likely to turn significantly on language in individual plan documents

Forfeiture Litigation – Key Defenses

- How much an employer contributes is non-fiduciary. Employer decided to contribute less thereby forcing the fiduciaries to use forfeitures to make up the shortfall.
- No harm to the plan; it is no worse off as a result than it would otherwise have been.
- No anti-inurement issue or PT because plan assets are not going back to the employer. The money stays in the plan.
- Allocation within the plan is not a “commercial bargain” so it’s not covered by the PT rules at all.
- Paying benefits, which is what happened here, is not a PT.

Forfeiture Litigation – Conflicting Court Decisions

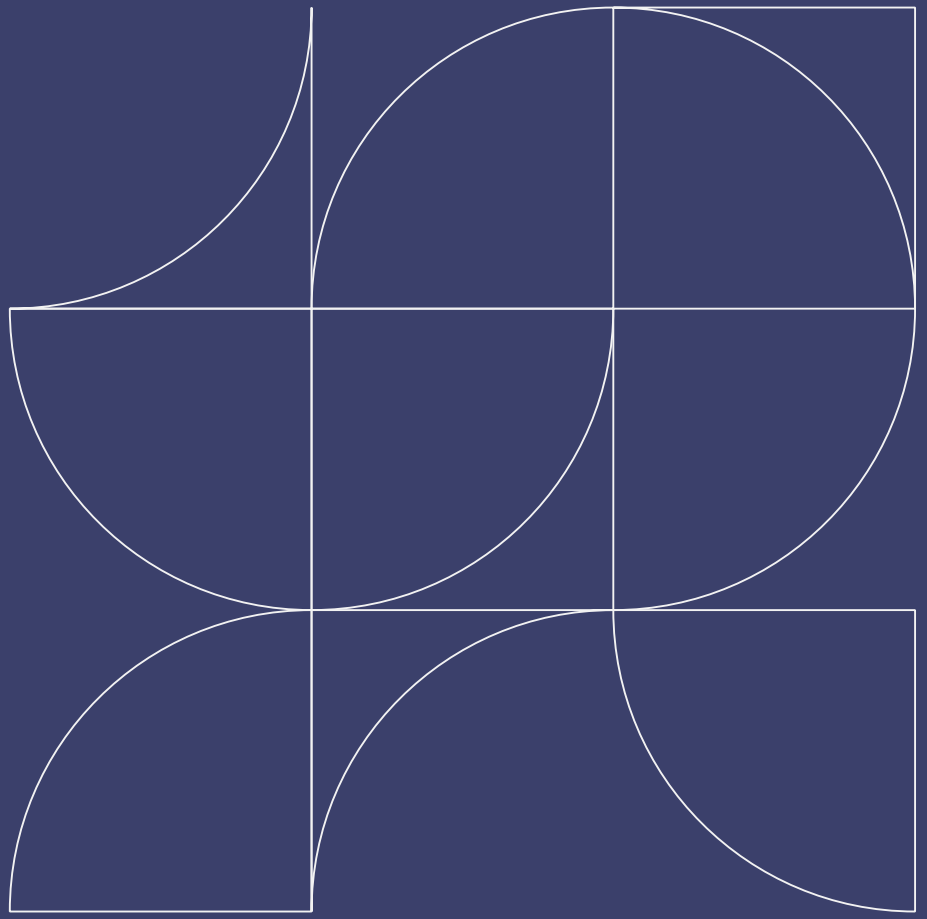
Southern District of California denied motion to dismiss:

- Plaintiffs plausibly alleged harm by showing that had forfeitures been used for expenses, the participants would have paid no admin fees.
- ON the inurement issue, he said that while these might be treated as mistaken contributions, the law was not clear that they could be, and they were not defined as such in the plan.
- The court said that facially, these could be PTs (though it says the 406(a) claim is a close question).

Northern District of California granted motion to dismiss without prejudice:

- Fiduciary duty theory was novel and implausible; purported categorical rule that did not account for factors a fiduciary may consider
- No “transaction” so no anti-inurement violation or PT

The End of *Chevron* Deference



Loper Bright v. Raimondo

- In June 2024, the Supreme Court overturned *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 468 U.S. 837 (1984) ending 40 years of deference to administrative agencies
- *Loper Bright* directs that courts, not agencies, are best situated to interpret ambiguous statutory provisions, even in areas of agency expertise.
- Going forward, as a first step, courts will evaluate whether Congress gave discretion to the agency.
- Agency action will be evaluated for persuasiveness, with emphasis on consistent, long-term interpretations that are contemporaneous with adoption of the statute.

Impact of *Loper Bright* for ERISA Practitioners

- Supreme Court stated its new rule applied going forward only – prior rulings under *Chevron* remain in place, for now.
- The decision does not immediately change any agency regulations or actions, but may spur far reaching challenges to a wide variety of administrative rules.
- Because of the extensive administrative regulations surrounding ERISA, the lowered deference may spur significant litigation.
- Additionally, certain safe harbors may be in jeopardy if the relevant DOL regulations are held to conflict with the statutory language.
- Immediate areas of challenge: fiduciary rule, “ESG” rule, ACA 1557 regulations.
- Supreme Court’s subsequent *Corner Post* decision also makes it easier to challenge agency action

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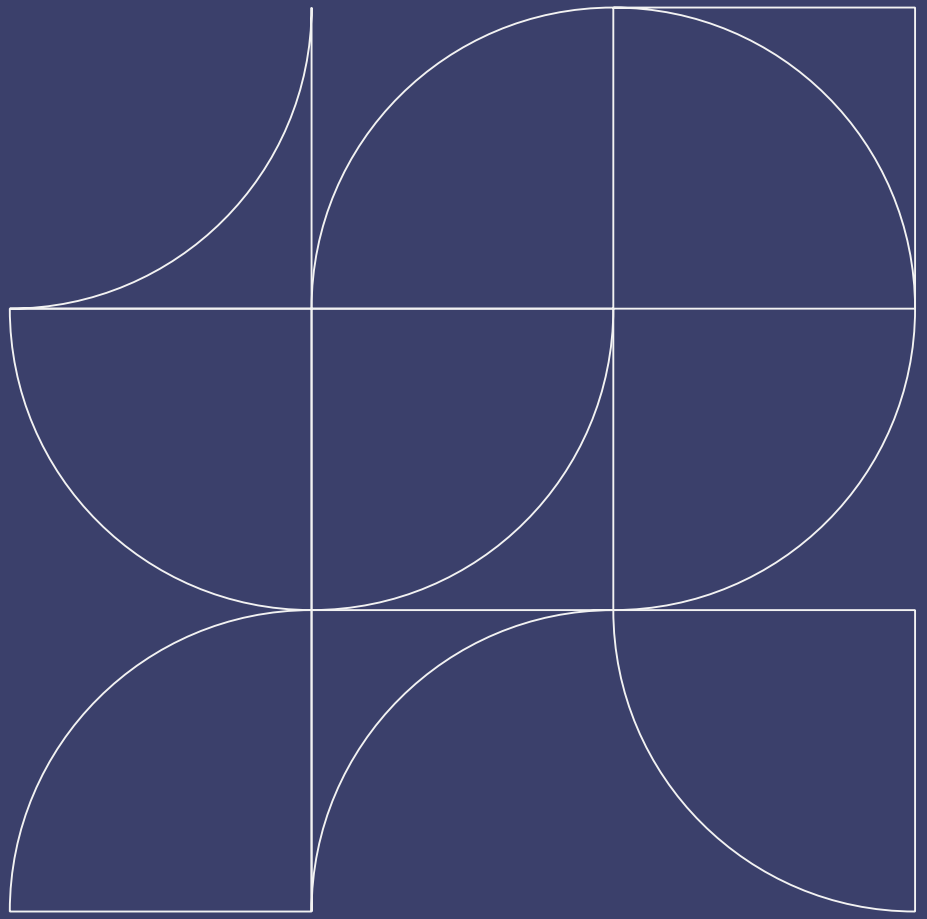
Is Fee Litigation Coming for Health Plans?



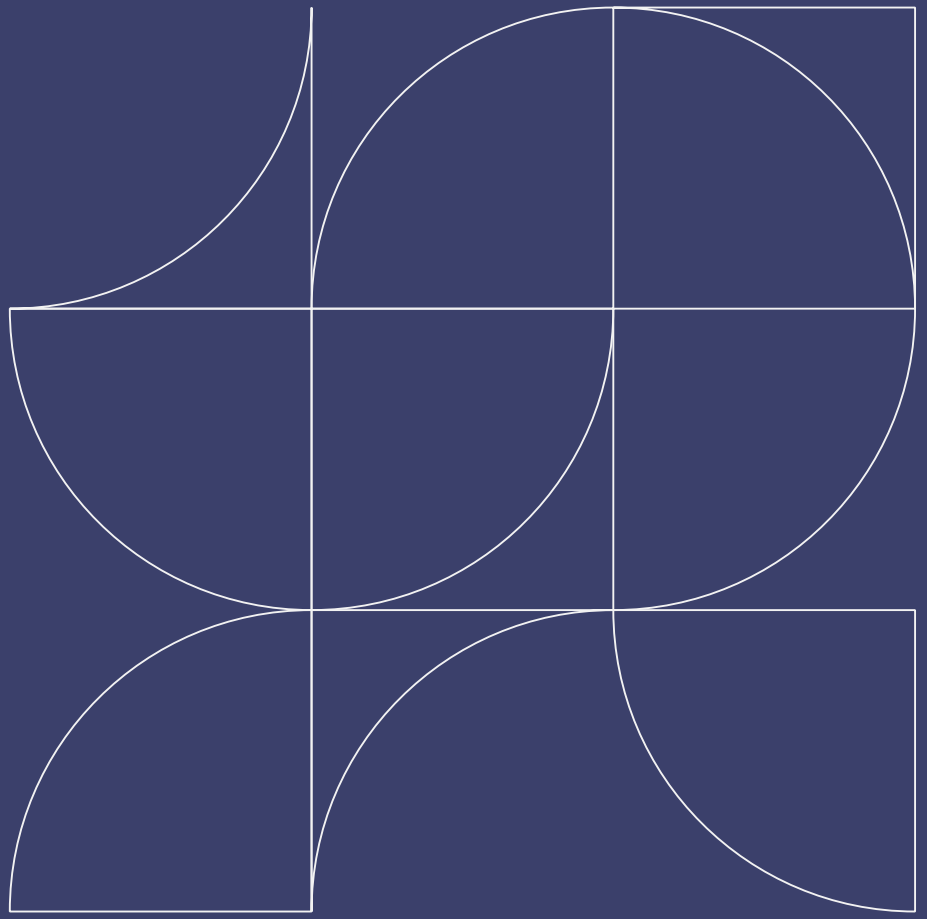
Lewandowski v. Johnson & Johnson, et al. No. 24-cv-00671 (D.N.J.)

- In February 2024, Johnson & Johnson (J&J) and its benefit plan committee were sued in a putative class action alleging the company breached its fiduciary duty in its selection of its pharmacy benefit manager (PBM), its reliance on a biased consultant in the selection process, and its failure to negotiate more participant-friendly contract terms in implementing the services.
- The complaint alleged that J&J breached its fiduciary duties through a series of actions resulting in the plan (and its participants) overpaying for prescription drugs. The alleged breaches include: (i) failure to adequately consider non-traditional PBMs, (ii) failure to adequately negotiate favorable contract pricing, and (iii) improperly relying on the PBM's specialty pharmacy (rather than a third-party vendor).
- Though there are potentially distinguishing factors between the J&J plan and other welfare plans (particularly that the J&J plan is funded by a trust), this case may be the prelude to a coming wave of similar suits.
- The initial complaint sparked a motion to dismiss and an amended complaint. The motion to dismiss the amended complaint was filed on June 28, 2024 and is pending.

Challenges to Health Plan Fee Litigations

- Standing
  - Plaintiffs may need to show benefits were at risk on fiduciary breach claims
- Stating a claim
  - Difficulty in finding suitable benchmark/ “meaningful comparator”
  - Separating plan design and fiduciary functions
- Class certification
  - Treatment under health plans likely lacks uniformity found in retirement plans; increased individualization in circumstances/impact on benefits could make certification more challenging

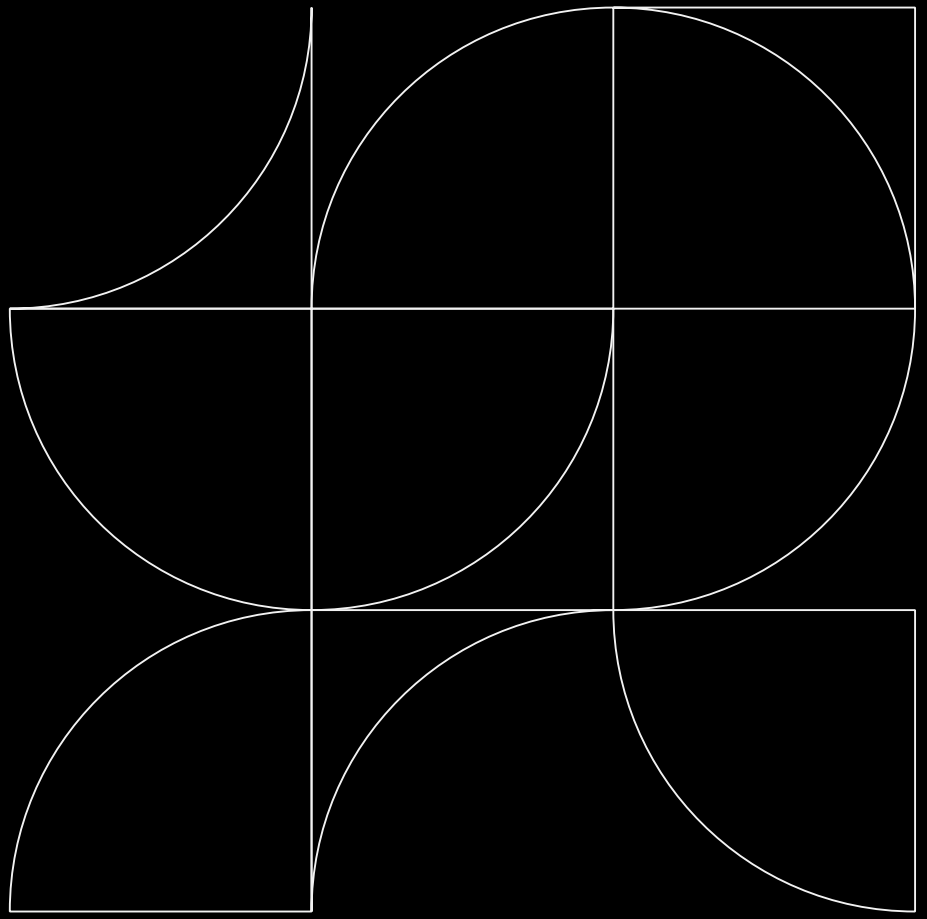
Pension Risk Transfer Litigation



Pension Risk Transfer Litigation

- Since March 2024, 5 lawsuits have been filed (against 4 companies) asserting claims for breach of duty of prudence related to pension risk transfers.
  - All relate to transactions with Athene
  - All are still at initial pleading stage
- Plaintiffs in these cases acknowledge that PRTs are lawful, but allege Athene was an imprudently risky provider to select
  - Plaintiffs raise concerns about private equity control over Athene, use of captive, offshore reinsurers, and attacks on “risky” investment philosophies
- Reference to DOL IB 95-1: “safest available annuity provider”
- Cases are focused on transfers of retirees, not plan terminations
- Plaintiffs face some pleading hurdles, including as to standing
- If claims survive MTD, likely to see additional filings, including other annuity providers, additional transactions, and potentially plan terminations

Questions?



thank you!

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