AMERICAN BAR ASSOCIATION
Tort Trial and Insurance Practice Section

Fall 2022

COMMITTEE NEWS

Employee Benefits Law

No Soul In The Brevity Of *Wit*[1]

In 2019, following a lengthy bench trial that included both extensive percipient and expert witness testimony, the District Court for the Northern District of California issued a detailed and expansive set of findings of fact and conclusions of law in the ERISA class action denominated *Wit v. United Behavioral Health*.[2] The decision comprised 206 numbered paragraphs of findings of fact and conclusions of law. The plaintiffs in *Wit* challenged United Behavior Health's practices of applying unwritten standards to residential treatment claims by insureds that differed from generally accepted standards of care applied by medical professionals, and violating the laws of several states as well.[3]

Notably, the plaintiffs in *Wit* were not suing for a direct award of benefits (which likely would have raised individualized issues that would have defeated commonality and typicality of the class claims under Rule 23[4]), but sought equitable and injunctive relief in the form of, inter alia, court mandated reprocessing of the claims subject to the suit using generally accepted standards of medical care.[5] The district court rejected the defendants' argument that the underlying benefits claims had not

Read more on page 13

Joseph A. Creitz, Partner
Creitz & Serebin LLP

***Joseph Creitz** is a founding partner of San Francisco's Creitz & Serebin LLP and has spent the last twenty-six years representing plaintiffs in ERISA litigation involving benefits and breaches of fiduciary duty.*

In This Issue

Chair Message

Kirsten Scott
Renaker Scott LLP
Chair, TIPS Employee Benefits Committee

Over the years I've had an opportunity to contribute several articles to the TIPS Employee Benefits Committee newsletter, so it's a real honor for me to now introduce the newsletter as Chair of the Committee for 2022-2023. Special thanks to Michelle Roberts and Dylan Rudolph, who have once again done an outstanding job of collecting and editing articles of interest to us all.

In addition to the newsletter, one of the other main benefits of involvement in TIPS is the ability to get to know and spend time with our colleagues in the Employee Benefits Committee, and in the TIPS Health & Disability, Insurance Regulation and Life Insurance Committees. Our ability to interact with and learn from each other was challenged during Covid as several in-person conferences were cancelled. But in August 2022, at long last we were able to hold a successful in-person 48th Annual Midwinter Symposium on Insurance and Life, Health and Disability Benefits at the Grand Hyatt in Nashville, Tennessee. The conference was informative and engaging, and it was great to see those of you who were able to attend! We are now looking ahead to plan our next symposium for 2023 or 2024 – stay tuned for more information. If you would like to be involved in planning the next symposium, or if you have ideas for panel topics or speakers, please contact me (kirsten@renakerscott.com) or Kelly Geloneck, Vice-Chair of the Employee Benefits Committee (kgeloneck@groom.com).

We also offer other opportunities to speak on a wide range of benefits-related topics. As one of six member Committees of the ABA's Joint Committee on Employee Benefits (JCEB), there is a wide range of speaking and discounted attendance opportunities to members with the JCEB's popular conferences and webinars.

Read more on page 3

Connect with Employee Benefits Law

website

Stay Connected with TIPS

We encourage you to stay up-to-date on important Section news, TIPS meetings and events and important topics in your area of practice by following TIPS on **Twitter** @ABATIPS, joining our groups on **LinkedIn**, following us on **Instagram**, and visiting our **YouTube** page! In addition, you can easily connect with TIPS substantive committees on these various social media outlets by clicking on any of the links.

Additionally, if you have a topic on which you would like to lead a discussion in a webinar or during a periodic Committee call, please let us know!

If you or a colleague are looking to get more involved in the Employee Benefits Committee with publishing opportunities, in addition to this newsletter, the Employee Benefits Committee provides several opportunities to get your name and articles in front of your peers and potential clients, including The Tort Trial & Insurance Practice Journal, The Brief, and TortSource. If you are interested in learning more, or if you have a junior colleague who may be interested in contributing, please contact Michelle Roberts (michelle@robertsdisability.com) or Dylan Rudolph (drudolph@truckerhuss.com).

We appreciate your involvement in the Committee, and as always welcome any thoughts on how we can improve the experience for Committee members.

Kirsten Scott
Chair, TIPS Employee Benefits Committee

Full and Fair Review of Benefit Claims and Appeals: *Cloud v. The Bert Bell/Pete Rozelle NFL Player Retirement Plan*

Nicolas Deguines, Associate
Trucker Huss, APC

Mr. Deguines counsels clients in all aspects of the design, operation, and compliance of their tax qualified retirement plans. He also advises plan sponsors and fiduciaries on how to address and resolve compliance issues, corrections under the IRS's Employee Plans Compliance Resolution System and fiduciary best practices.

Jennifer Wong, Associate
Trucker Huss, APC

Ms. Wong is an associate in the firm's health and welfare practice group. She helps clients comply with various federal and state laws applicable to health and welfare plans, including ERISA, the ACA, and HIPAA.

Administering benefit claims and appeals under large employee benefit plans can be complicated and cumbersome. Frequently, plan administrators must implement systems to process the high volume of claims and appeals under those plans. While such systems might be necessary, plan administrators must make sure that all applicable rules and regulations are followed, and that benefit claims and appeals are given a full and fair review. The need to adhere to those rules was highlighted in a recent decision issued by a district court in the Northern District of Texas in *Cloud v. The Bert Bell/Pete Rozelle NFL Player Retirement Plan*.[1]

Cloud held that the Bert Bell/Pete Rozelle NFL Player Retirement Plan (Plan) denied plaintiff Michael Cloud (Cloud) a full and fair review and abused its discretion when it denied Cloud's request for disability reclassification under the Plan, in violation of the Employee Retirement Income Security Act of 1974, as amended (ERISA). Notably, Judge Karen Gren Scholor began the opinion criticizing the Plan, stating "[t]he curtain has been pulled back as to the inner workings of [the Plan]. And what lies behind it is far from pretty with respect to how it handles disability benefit claims sought by former players…"

Background

Cloud played in the NFL as a running back from 1999 to 2005 and was a member of the New England Patriots team that won the 2004 Super Bowl. During Cloud's career, he sustained severe head trauma including seven concussions and a traumatic brain injury. As a result, prior to retiring, he experienced debilitating neurological and cognitive impairments, including various psychiatric and psychological disabilities. Since his retirement, Cloud's condition has become progressively worse.

In 2010, Cloud began receiving Inactive A benefits under the Plan. In 2014, a U.S. Social Security Administration (SSA) administrative judge found Cloud "totally and permanently" disabled. In 2016, based on the SSA determination, Cloud filed an application for reclassification to Active Football benefits with the Committee (the entity that reviews initial claims), but his application was denied at the claim level. Cloud appealed the decision in September 2016, but that too was denied by the Retirement Board (the entity that reviews appeals).

Read more on page 16

Third Circuit Rules *Thole* Does Not Require Readjustment of Article III Injury Analysis in Defined Benefit Investment Loss Case

Elizabeth Hopkins
Kantor & Kantor LLP

Elizabeth is a partner at Kantor & Kantor and head of the pension practice. She is a former Department of Labor official with over 35 years of ERISA, appellate and trial experience in both the public and private sectors.

Newton's first law of motion states that a body in motion stays in motion and a body at rest stays at rest unless acted upon by an outside force. A pendulum demonstrates this principle. So too do the court decisions in *Thole v. U.S. Bank N.A.*,[1] and in *Boley v. Universal Health Services*,[2] as Article III standing in ERISA pension cases is pulled first in one direction and then swings back in the other.

In *Thole*, the Supreme Court held that participants in a defined benefit plan lacked standing to challenge losses to their defined benefit plans when they themselves had not lost any retirement benefits. Unlike *Thole*, the *Boley* case involves a class action suit brought by participants in a defined contribution pension plan who allege that they did, in fact, suffer investment losses stemming from excessive fees associated with some of the plan's investment options.

Specifically, the class representatives in *Boley* are three current and former employees of Universal Health Services. They have challenged, as excessively costly, annual recordkeeping and administrative fees, as well as 13 target date funds—called the Fidelity Freedom Fund suite—designed to shift investment strategy as a target retirement year approaches.

The plaintiffs also challenged the method by which the plan fiduciaries selected and maintained investment options. In total, the plan offered 37 plan options, including the target date funds, which were default investments for participants who did not affirmatively elect alternatives. The class representatives were all charged the annual recordkeeping and administrative fees and collectively were invested in seven of the 37 plan options.

In an earlier phase of the case, Universal moved for partial dismissal, arguing that the named plaintiffs lacked Article III standing to challenge investment options in which they were not themselves invested, but the district court denied this motion. Undeterred, Universal renewed this argument in opposition to the plaintiffs' motion to certify a class of all current and former plan participants, arguing that because the named plaintiffs were not invested in 30 of the plan's funds, they lack constitutional standing to challenge these investments and their claims were therefore not typical of the claims of other class members. The district court again rejected this contention.

On interlocutory appeal under 29 U.S.C. §1292(e) and Federal Rule of Civil Procedure 23(f), the Third Circuit affirmed. To reach this result, the Third Circuit looked to each

Read more on page 20

Revisiting the HIPAA Proposed Rule: What Group Health Plan Sponsors Need to Know

Sarah Bowen, Associate
Trucker Huss, APC

Ms. Bowen is an associate in the firm's health and welfare and multiemployer practice groups. Sarah focuses her practice on counseling employers and multiemployer trust funds in all aspects of their employee benefit plans, including qualified retirement plans and health and welfare plans.

In late 2020, the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) proposed significant changes to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, aimed primarily at improving care coordination and data sharing. As the final rule on these changes is expected to be published this year, it's a good time for HIPAA-covered group health plans to revisit the proposed changes and consider their potential impact. While the Proposed Rule generally applies to all HIPAA-covered entities, this article focuses on the proposed changes applicable to covered group health plans. We note that the final rule may deviate from the Proposed Rule described in this article.

Background

The OCR first issued an initial request for information in December 2018 seeking feedback on how certain HIPAA rules and procedures could be streamlined to improve cooperation and data sharing among members of an individual's health care delivery team, including family members, caregivers, and community-based organizations. The OCR subsequently released the Notice of Proposed Rulemaking proposing modifications to the HIPAA Privacy Rule on December 10, 2020 and published the Proposed Rule in the Federal Register on January 21, 2021.[1] After receiving a number of comments from stakeholders on the proposed changes, the OCR extended the comment period from its original end date of March 22, 2021, to May 6, 2021. While the final rule is expected to be issued later this year, there have been no further updates from the OCR to date.

Does the Proposed Rule apply to group health plans?

The proposed modifications to the HIPAA Privacy Rule apply to HIPAA-covered entities, which include (but are not limited to) ERISA fully insured and self-funded group health plans.[2] The proposed changes also apply to "business associates" of covered entities, which generally include any person or entity that performs functions or activities involving the use or disclosure of protected health information (PHI) on behalf of the covered entity. For group health plans, common business associates include third-party administrators, claims administrators, or other service providers that respond to PHI requests or otherwise use or disclose PHI on behalf of the plan.

How do the proposed changes impact group health plans?

The Proposed Rule includes several significant changes to the HIPAA Privacy Rule aimed at improving data sharing, expanding individual access to PHI, and removing barriers to care coordination and case management. The major proposed changes which may impact group health plans and their business associates are highlighted below.

1. Notice of Privacy Practices (NPP)

- ***Revises NPP content requirements.*** The Proposed Rule modifies the content requirements of the NPP to help increase the group health plan participants' understanding of the covered entity's privacy practices, and their rights with respect to their PHI. The proposed modifications require group health plans to modify the header of the NPP that is distributed to plan participants. The header of the NPP is required to state: 1) the notice includes information regarding how a participant may access their health information; 2) how a participant may file a HIPAA complaint; and 3) that the individual has a right to receive a copy of the notice and to discuss its contents with a designated person. The header of the NPP must also specify whether the covered entity's designated contact person for questions regarding the NPP is available onsite and include their phone number and email address. Providing this information at the beginning of the NPP is meant to improve the plan participants' awareness of their Privacy Rule rights, explain what they can do if they suspect a HIPAA violation, and describe how the participant may contact a designated person to ask questions. The OCR has released model NPPs in the past and, based on the OCR's request for comments relating to how the model notice can be improved, it is anticipated the OCR will provide an updated model NPP if the proposed changes become final.

  Currently, group health plans that are HIPAA-covered entities must provide the NPP to new participants with enrollment materials, and upon request. If the proposed changes are approved, plans will need to promptly update their NPP and ensure a copy of the updated notice is distributed as required.

2. Care Coordination and Case Management

- ***Clarifies definition of "Health Care Operations" to include individual care coordination and case management.*** Under HIPAA, "health care operations" are certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its

The Proposed Rule includes several significant changes to the HIPAA Privacy Rule aimed at improving data sharing, expanding individual access to PHI, and removing barriers to care coordination and case management.

business and to support the core functions of treatment and payment.[3] The Privacy Rule allows for certain uses and disclosures of PHI without individual authorization for health care operations, including for the purpose of care coordination and case management. Guidance published in the preamble of the 2000 Privacy Rule [4] clarified that the existing definition of health care operations contemplates that health plans would, as part of such operations, conduct care coordination and case management activities on both a population-level and individual-level. However, despite this guidance, many have interpreted the current definition of health care operations to be limited to population-based care coordination and case management only. Such an interpretation excludes individual-focused care coordination and case management by health plans, limiting a health plan's ability to perform such individual-level care coordination or case management activities. The Proposed Rule addresses this issue by revising the definition of health care operations to clarify that both population-level and individual-level care coordination and case management are covered.

- ***Adds exception to minimum necessary requirement for health plan coordination and case management disclosures.*** The Privacy Rule generally requires that covered entities use, disclose, or request only the minimum PHI necessary to meet the purpose of the use, disclosure, or request. While there is a current exception from the minimum necessary standard for PHI disclosures and requests relating to care coordination and case management, it does not apply to group health plans. Because group health plans generally do not perform treatment functions, any care coordination or case management activity conducted by a health plan is considered a health care operation subject to the minimum necessary standard. As a result, a health plan is required to determine what information constitutes the minimum information necessary each time it discloses or requests PHI for an individual's care coordination or case management, which takes time and administrative resources. Additionally, plans may be disincentivized from requesting or disclosing PHI if there is any uncertainty as to whether the information meets the minimum information necessary standard for fear of triggering an impermissible use or disclosure of PHI under the Privacy Act and incurring associated penalties. The Proposed Rule changes this by adding an express exception from the minimum necessary standard for disclosures to, or requests by, a health plan for care coordination and case management at the individual level.

  If finalized, this change would promote more efficient and effective individual care coordination and case management by saving health plans

the time and resources currently required to comply with the minimum information necessary requirements for such PHI disclosures and requests. Additionally, by expressly excepting such PHI disclosures and requests, the change eliminates any potential fears plans may have regarding triggering an impermissible use or disclosure of PHI and incurring a penalty when requesting or disclosing PHI for an individual's care coordination or case management.

- ***Expressly permits disclosures to facilitate care with social and community services.*** The Proposed Rule expressly permits covered entities, including group health plans, to disclose PHI to social services agencies, community-based organizations, home and community-based service (HCBS, which are services supported by, among other payors, state Medicaid programs) providers, or similar third parties that provide or coordinate health-related services which are needed for care coordination and case management at the individual level.

3. Individuals' Right to Access PHI

- ***Access to PHI.*** The Proposed Rule allows individuals greater access to their PHI, including allowing individuals to take notes, videos and photographs and to use other personal resources to view and record PHI in person, barring unacceptable security risks. Additionally, under the proposed changes, covered entities would be prohibited from imposing unreasonable measures on an individual's right to access PHI (for example, requesting extensive or unnecessary information, requiring notarization, or accepting written requests in paper form only). If approved, group health plans should consider reviewing their policies relating to individual PHI requests to ensure they do not contain procedures that could be construed as unreasonable measures.

- ***Form of PHI.*** The Privacy Rule requires that covered entities provide individuals access to PHI in the form or format requested by the individual, if "readily producible." The Proposed Rule clarifies that "readily producible" copies of PHI include copies of electronic PHI (ePHI) requested through secure, standards-based application programming interfaces (APIs) using applications chosen by individuals, and any form or format required by applicable state or other laws. If approved, group health plans should confirm that they, or their business associates, have the ability to produce ePHI through standards-based APIs.

- ***Time period to provide PHI.*** Covered entities are currently required to provide individuals with access to their PHI upon request within 30 days, with one 30-day extension. The Proposed Rule shortens this period to 15 days, with one 15-day extension. The proposal to shorten the time for covered entities to provide individuals with access to their PHI would improve care coordination by allowing plan participants to share their records more rapidly with health care providers, informal caregivers, community-based support services, and family members – which could lead to improved health care communications and health outcomes. If approved, group health plans should ensure their written policies and operational procedures relating to PHI requests, and applicable contract language with business associates, are appropriately updated.

- ***Right to direct PHI to third parties.*** Currently, the Privacy Rule requires covered entities to transmit PHI to a third party (i.e., a family member, healthcare provider, researcher, or any other person) designated by the individual when directed by the individual. The individual's direction must be in writing, signed, and clearly identify the designated person and where to send the PHI. Among the Proposed Rule's changes relating to individual access rights, covered entities would be required to facilitate an individual's request to direct ePHI in an electronic health record (EHR) to a third party upon the individual's written request or clear, conspicuous and specific oral request, within 15 calendar days. While group health plans generally do not maintain EHRs, this proposed change would still require health plans to facilitate such a request if the individual requests that the health plan, as "Requester-Recipient," obtain ePHI in an EHR from one or more covered health care providers, the "Disclosers," on the individual's behalf. In such a case, the health plan would be required to submit the individual's request to the Discloser. If approved, group health plans will need to review and update their policies and procedures for responding to PHI requests, determining when to respond to oral requests and how to record such requests. If such requests are handled by business associates, plans should ensure business associate agreements are appropriately updated to address these changes.

- ***Clarifies fees and adds fee disclosure requirements.*** The Proposed Rule clarifies when PHI must be provided to individuals at no charge and when a covered entity is permitted to charge fees, with certain limitations, when responding to PHI access requests. The proposed changes also require covered entities to post a notice of access and authorization including a fee schedule on their website (if they maintain a website), as

well as make the notice available at "point of service" and upon request. The notice must include all types of access available free of charge and a fee schedule for copies of PHI provided to individuals, copies of PHI in an EHR directed to third parties designated by the individual, and copies of PHI sent to third parties with the individual's valid authorization. For health plans, the "point of service" could include a customer service call center that handles requests for records, or any location at which PHI is made available for individuals to inspect. The Proposed Rule also requires that, upon an individual's request, covered entities provide an individualized estimate with the approximate fees to be charged for requested copies of PHI and, if also requested, an itemization of charges constituting the total fee.

What does this mean for group health plans?

Once the proposed changes are finalized, HIPAA-covered group health plans should, at minimum, review their HIPAA policies and procedures, Notice of Privacy Practices, and contract language in business associate agreements and other potentially impacted contracts, to determine what, if any, changes are needed. Health plans' HIPAA training programs will also need to be updated to reflect any changes.

Endnotes

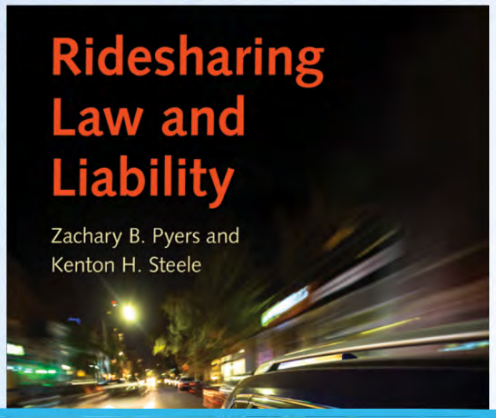
1 86 Fed. Reg. 6446 (proposed January 21, 2021) (to be codified at 45 C.F.R. pts. 160 and 164).

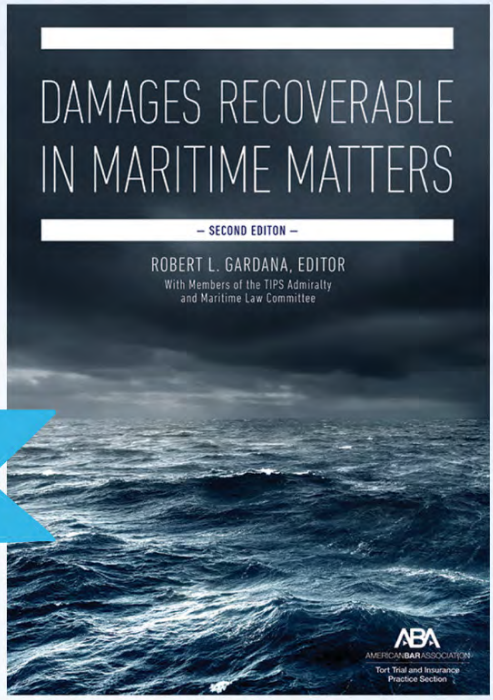
2 45 C.F.R. § 160.103. The definition of "group health plan" under HIPAA excludes self-administered group health plans with fewer than 50 participants.

3 45 C.F.R. 164.501.

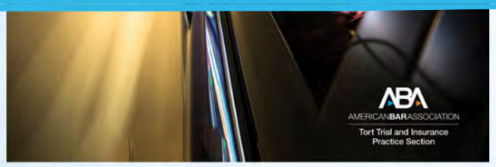
4 65 Fed. Reg. 82462, 82627 (December 28, 2000).

CHECK OUT WHAT'S NEW FROM TIPS

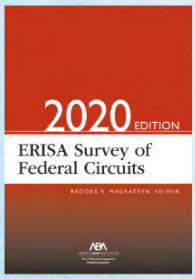


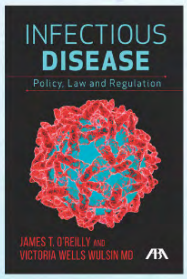


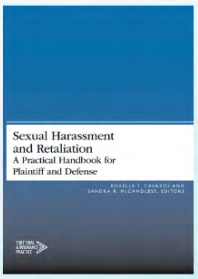
HOT OFF THE PRESSES

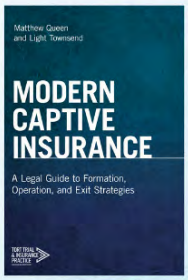


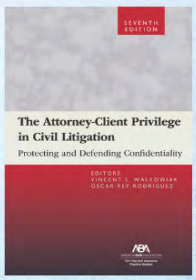
MORE NEW TITLES











WWW.SHOPABA.ORG

800-285-2221

ABA
AMERICANBARASSOCIATION
Tort Trial and Insurance
Practice Section

No Soul... continued from page 1

been fully administratively exhausted, finding that the named plaintiffs had indeed exhausted their administrative remedies and that in any event, exhaustion would have been futile for any class member who had not.[6]

In concluding that the defendant insurer had abused its discretion, the district court was mindful of the Supreme Court's guidance in *MetLife v. Glenn* that where an ERISA plan insurer operates under a structural conflict of interest, that conflict should be considered as a factor by trial courts when assessing whether an abuse of discretion is present.[7] The *Wit* court wrote: "[a]s the Court explained in *Glenn*, "where circumstances suggest a higher likelihood that [the conflict] affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration," more skepticism is warranted."[8] To bolster its conclusion that the defendant had abused its discretion, the district court's order was replete with factual findings and discussions of UBH's parsimonious claims handling and historically biased claims administration.[9]

The liability and remedies orders were widely discussed among the ERISA bar and in the press. The decisions have been cited by no fewer than thirty-five subsequent court decisions, numerous secondary sources, and six law review articles.[10]

Predictably, the insurer appealed to the Ninth Circuit. Surprisingly, the Ninth Circuit swatted down the district court's extensive and detailed findings and conclusions by way of an unpublished memorandum decision barely three pages long.[11]

Surprisingly, the Ninth Circuit swatted down the district court's extensive and detailed findings and conclusions by way of an unpublished memorandum decision barely three pages long.

First, the Ninth Circuit affirmed the district court's conclusion that the plaintiffs had standing to pursue the claims alleged.[12] The court rejected the appellant insurer's contention that the failure to seek individual contractual benefits defeated their standing, finding that the way in which the insurer allegedly misapplied its coverage guidelines materially impacted all the plaintiffs.[13] The court wrote: "Plaintiffs have shown that UBH's actions resulted in uncertainty concerning the scope of their benefits and the material risk of harm to their contractual rights."[14] The Ninth Circuit also rejected the insurer's argument that the district court should not have certified claims under Rule 23 that required individualized determinations: the court held that the plaintiff's breach of fiduciary duty claim satisfied all the elements of constitutional standing and was susceptible to resolution on a class basis.[15]

However, the Ninth Circuit declined to address the insurer's argument that the plaintiffs' class claim for reprocessing of benefit denials was improper for class treatment,[16] because it concluded that the claim failed on its merits and the district court had erred by concluding otherwise.[17] The Ninth Circuit found that the insurer's failure to apply standards and guidelines to mental health claims that were not consistent with generally accepted standards of care was reasonable. The Ninth

Circuit found that the district court had shown insufficient deference to the insurer's determinations under the abuse of discretion standard.[18]

The Ninth Circuit's order made no mention whatsoever of the district court's extensive factual findings that the insurer had acted out of economic self-interest, implicitly (and incorrectly) concluding that there was "no evidence of malice, of self-dealing, or of a parsimonious claims-granting history."[19] The determination by the Ninth Circuit cannot be reconciled with the factual findings that appear in the district court's liability decision.[20]

The upshot of the district court's rulings would have been to enforce rational, consistent, nationwide standards for reasonableness and transparency in the adjudication of ERISA-regulated mental health claims. With the stroke of a pen and a few short sentences devoid of factual support, the Ninth Circuit reversed a landmark ERISA decision that stood to benefit millions of insured Americans with mental health claims.

In May 2022 the Plaintiffs filed a petition for rehearing. That petition received amicus support from, inter alia, the National Association for Behavioral Healthcare, the American Psychological Association, The California Hospital Association, The National Health Law Program, and the states of Rhode Island, Connecticut, Illinois, and California. Both plaintiffs and the amici expressed concerns about the Ninth Circuit's apparent disregard of the insurer's parsimonious claims history, and the devastating impact that the Ninth Circuit's anemic discussion of the standard of review could have on ERISA-regulated health claims. Consideration of the petition, fully briefed since late June, now rests with the Ninth Circuit.

Time will tell whether the Ninth Circuit can be persuaded to eschew its brevity and restore the soul to *Wit*.

Endnotes

1 William Shakespeare famously wrote in Act II of Hamlet that "brevity is the soul of wit…."

2 No. 14-cv-02346-JCS, 2019 WL 1033730 (March 5, 2019).

3 *Id.* at *55.

4 Fed. R. Civ. Proc. 23.

5 *Wit.*, 2019 WL 1033730 at *5, *54; *Wit v. United Behavioral Health*, No. 14-cv-02346-JCS, 2020 WL 6479273, *23 ("Remedies Order").

6 *Wit.*, 2019 WL 1033730 at *54.

7 554 U.S. 105, 114 (2008).

8 *Wit*, 2019 WL 1033729 at *53 (citing *Glenn*, 554 U.S. at 117).

9 *See, e.g.*, *Wit*, 2019 WL 1033730 at *53.

10 *See, e.g.*, Note, *How Far We Have Not Come: An Empirical Comparison of Federal and State Mental Health Legislation*, 64 Ariz. L. Rev. 571, 618 (2022); Amy Monahan and Daniel Schwarcz, *Rules of Medical Necessity*, 107 Iowa L. Rev. 423, 452 (2022); Thomas J. Sullivan and Cathryn Johns, *Lessons About the Parity Act From Wilderness Therapy Cases*, 13 J. Health & Life Sci. L. 70, 82 (2020).

11 *Wit v. United Behavioral Health*, No. 20-17363, 2022 WL 850647 (9th Cir. March 22, 2022).

12 *Id.* at *1-*2.

13 *Id.* at *2.

14 *Id.*

15 *Id.*

16 Notably one of the three judges on the panel filed a concurrence in which he wrote that he would further have held that the district court abused its discretion by certifying the reprocessing of benefits claims under Rule 23. *Id.* at *3.

17 *Id.* at *2.

18 *Id.*

19 *Id.* (citing *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 522 F.3d 863, 868 (9th Cir. 2008)).

20 *Wit*, 2019 WL 1033730, *passim*.

Full... continued from page 4

Full and Fair Review

The district court found that the Plan's Retirement Board failed to substantially comply with ERISA procedural requirements, which in turn denied Cloud a meaningful dialogue regarding his appeal. Under § 1133 of ERISA, every plan must (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and, (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim. The court determined the Plan violated § 1133 because it (i) failed to clearly identify the specific reasons for denial, (ii) did not consider all documents and records submitted with the appeal, (iii) afforded deference to the Committee, and (iv) did not consult with the appropriate health care professional despite basing its determination on a medical judgment.

The court was displeased with the Plan's process for preparing the appeal for review and drafting decision letters. A comparison between the appeal denial letter that was provided to Cloud and the Retirement Board meeting notes, revealed that the reasons for denial in the letter were different than those contemplated by the Retirement Board. The court took issue with the fact that the Retirement Board members did not have any involvement with drafting the decision letter, which was prepared by a paralegal of the Plan's outside ERISA counsel and was not reviewed by an attorney. Further, the denial letter included incorrect citations to a different plan than the appeal was being reviewed under. The court emphasized that "the Board members did not see, discuss, edit, or review the letter before it was sent to [Cloud]," and that "the evidence clearly shows that the Board's stated bases for denial were post hoc rationalizations devised by Benefits Office staff and advisors but not discussed among the Board members."

While a Plan neutral physician determined that a neuropsychological test and MRI was essential to evaluating Cloud's injury, the Plan never referred Cloud for those examinations. The court determined that this failure denied Cloud a full and fair review.

The court also found that the Retirement Board and its advisors did not consider all documents and records submitted with the appeal. Cloud provided additional evidence to show that he had new impairments, but this evidence was not considered, and was incorrectly identified as evidence that he had already provided at the claims stage. In fact, the Retirement Board *admitted* to not reviewing all documents, explaining that they relied on advisors to review the facts of the file.

Additionally, the court found that the Retirement Board improperly relied on its advisors. One such advisor, who was also a Plan committee member, was tasked with reviewing the facts of the case, advising the Benefits Office coordinators at both the claims and appeal stages, and advising the Retirement Board. Due to the heavy involvement and influence of Plan advisors at both the claim and appeal stage, the

court determined that the Retirement Board's reliance on these advisors "creates an inherent appearance of impropriety" and "effectively forecloses the Board's ability to review the claim anew."

Finally, the court found that the Plan failed to consult with a health care professional in reviewing Cloud's claim, which required medical judgment. While a Plan neutral physician determined that a neuropsychological test and MRI was essential to evaluating Cloud's injury, the Plan never referred Cloud for those examinations. The court determined that this failure denied Cloud a full and fair review.

When analyzing procedural challenges under ERISA, courts review claims under a "substantial compliance" standard, which asks whether the Plan substantially complied with ERISA procedures, and generally excuses technical noncompliance. In light of the above failures, *Cloud* held that the Plan did not substantially comply with ERISA's requirements, and that the Retirement Board denied Cloud a full and fair review of his appeal.

Abuse of Discretion Standard

Next, the court held that the Retirement Board abused its discretion in denying Cloud's application for reclassification of his disability benefits, finding that the Board's decision was inconsistent with a fair reading of the Plan and not supported by evidence.

Key to the Board's determination of Cloud's claim and appeal was whether Cloud had experienced "changed circumstances" under the Plan. The district court found that, at times, the Retirement Board used eight different definitions for what "changed circumstances" meant, even providing no definition at all. In fact, Board members confirmed that the Plan's lawyers came up with the definition of "changed circumstances" and that the meaning of the term is "evolving." The court concluded that this was a legally incorrect interpretation of the Plan, which was an abuse of discretion.

Next, the court held that the Retirement Board abused its discretion in determining that Cloud had not "clearly and convincingly shown" that he was "totally and permanently disabled by a new or different impairment." In making this determination, the Retirement Board interpreted "changed circumstances" to mean "a new or different impairment from the one that originally qualified [Cloud] for T&P benefits." Relevant to this analysis was the fact that the Retirement Board only reviewed the SSA decisions when a player appealed the Committee's denial of reclassification.

The court held that it was difficult to conceive how the Retirement Board could determine whether Cloud's circumstances had changed in connection with his

reclassification application when there was never an assessment of what his circumstances were to begin with. Cloud was never referred to a neutral physician at the claim or appeal level. The Committee accepted the SSA decision wholesale. Then, in 2016, the Retirement Board used this wholesale acceptance as a basis for concluding that Cloud had not shown "changed circumstances." The court held that this process does not amount to a "reasonable claim procedure" as required under ERISA regulations, 29 C.F.R. § 2560.503-1(b), and is inconsistent with the Retirement Board's fiduciary obligations to participants.

Moreover, under the "Special Rules" section of the Plan, a player may be awarded Active Football benefits under the following conditions: (1) the requirements for a total and permanent disability are otherwise met, and (2) the psychological or psychiatric disorder is "caused by or relates to a head injury (or injuries) sustained by a Player arising out of League football activities," which expressly includes "repetitive concussions." The appeal denial letter acknowledged that Cloud sought benefits related to a psychological and psychiatric disorders, such as "severe mental disorder stemming from multiple concussions." However, the Retirement Board did not reference the "Special Rules" section, skipping over this requirement entirely, the Retirement Board instead based its decision in part on the finding that Cloud had not shown that he was totally and permanently disabled "shortly after" the disability first arose.

Ultimately, the court concluded that Cloud "handily" won his lawsuit, "defying the odds while facing extraordinary difficulties along the way." The court awarded Cloud retroactive disability benefits of more than $1.2 million, along with increased monthly payments going forward. Cloud was also awarded $1.2 million in attorneys' fees, plus up to $600,000 in additional fees if the case is appealed.[2] On July 25, Bert Bell/Pete Rozelle NFL Player Retirement Plan filed a notice of appeal to the Fifth Circuit.

The *Cloud* decision reinforces the importance of adhering to ERISA's claims and appeals requirements, no matter the volume or size of the plan involved. As *Cloud* shows, when benefit plans fail to provide a full and fair review of benefit claims, costly litigation may follow.

Endnotes

1 *Cloud v. Bert Bell/Pete Rozelle NFL Player Ret. Plan*, No. 3:20-CV-1277-S, 2022 WL 2237451 (N.D. Tex. June 21, 2022).

2 *Cloud v. Bert Bell/Pete Rozelle NFL Player Ret. Plan*, No. 3:20-CV-1277-S, 2022 WL 2805527, at *9 (N.D. Tex. July 18, 2022).

TIPS WEBINAR SERIES

TIPS Webinar Series offers educational, informative and instructional CLE programming for your practice.

AMERICANBARASSOCIATION

Tort Trial and Insurance Practice Section

ambar.org/tips

Third... continued from page 5

of the asserted claims. First, the court concluded, as Universal conceded, that the plaintiffs had standing to challenge the allegedly excessive recordkeeping and administrative fees, because these fees allegedly injured them and affected all plan participants in the same way.

Second, the court concluded that the plaintiffs suffered a concrete injury with respect to the challenged investments in the Fidelity Freedom Fund suite because each of the plaintiffs was invested in at least one these funds. Furthermore, the court reasoned, the plaintiffs challenged each of these target date investments on the same basis: that they were excessively expensive because they were invested in high fee actively managed funds rather than lower cost index funds.

The court reached a similar conclusion with respect to the allegedly imprudent evaluation process. Because the plaintiffs alleged that deficiencies in the process for selecting and maintaining investments (and in monitoring the other fiduciaries with respect to this process) led the plan to pay overall fees that were nearly double that of comparable plans, they adequately alleged harm for Article III purposes.

Thus, the appellate court concluded that Article III did not prevent plaintiffs from representing class members who were allegedly harmed by investments in other funds that were imprudent for the same reason, as the Third Circuit has previously held in *Sweda v. University of Pennsylvania*.[3]

In reaching what it characterized as this "straightforward conclusion," the court rejected Universal's contention that *Thole* required it to adjust its analysis. To the contrary, the court reasoned that *Thole* turned on the absence of any personal loss to the plaintiffs in that case, whereas the plaintiffs in *Boley* allege just such an injury stemming from the decisions and alleged failures of the defendant.

Having concluded that the plaintiffs surmounted the Article III hurdle, the court had little trouble affirming the district court's conclusion that their claims were sufficiently typical of the claims of the class to justify certification under Rule 23. This was not to say, the court noted, that there were no factual distinctions among the plan's 37 funds, given that some funds charged significantly higher fees than others. But these differences in degree of injury and level of recovery were not so significant as defeat class certification in the absence of potential or actual conflicts among the class members. Thus, the court recognized that, although "there may be some situations where typicality for an ERISA class would not be satisfied unless the class representatives invested in each of the challenged funds . . . that is not the case here."

The Supreme Court in *Thole* admonished that ERISA's protective purposes and broad grant of statutory standing do not vitiate the need for plan participants to establish Article III standing by showing that they have a concrete stake in the

The Supreme Court in Thole admonished that ERISA's protective purposes and broad grant of statutory standing do not vitiate the need for plan participants to establish Article III standing by showing that they have a concrete stake in the lawsuit.

lawsuit. Although *Thole* is now one of the most cited decisions in motions to dismiss ERISA fiduciary breach claims, the *Boley* case demonstrates that, despite *Thole*, the injury-in-fact requirement of Article III is still not "Mount Everest."[4]

This is consistent with the rulings of the vast majority of courts presented with motions to dismiss fiduciary breach claims in the context of defined contribution plans. With only a few exceptions, courts have had little problem since *Thole* concluding that participants in defined contributions plans possess Article III standing to challenge the management and fees associated with their plans.[5] Thus, the pendulum swings back as *Boley* and other decisions conclude that participants who allege that they have lost retirement money because of plan mismanagement have standing to sue. At least in this context, courts are correctly refusing to "make standing law more complicated than it needs to be."[6]

Endnotes

1 140 S. Ct. 1615 (2020).

2 34 F.4th 134 (3d Cir. 2022).

3 923 F.3d 320, 323 (3d Cir. 2019).

4 *Blunt v. Lower Merion School Dist.*, 767 F.3d 247, 278 (3d Cir. 2014).

5 *See, e.g.*, *In re Omnicom ERISA Litig.*, No. 20-cv-4141, 2021 WL 3292487, at *8 (S.D.N.Y. Aug. 2, 2021) (noting that courts "have held that [*Thole*] has little or no relevance when evaluating standing in cases involving defined-contribution plans"); *Mator v. Wesco Distribution, Inc.*, No. 2:21-CV-00403, 2021 WL 4523491, at *4 (W.D. Penn. Oct. 4, 2021) (collecting cases finding that defined benefit plan participants have standing even to challenge mismanagement, even with respect to funds in which they are not invested).

6 *Thole*, 140 S. Ct. at 1622.

Member Roster

Chair
Kirsten Scott
Renaker Scott LLP
505 Montgomery St, Ste 1125
San Francisco, CA 94111-6529
(415) 653-1733
Fax: (415) 727-5079
kirsten@renakerscott.com

Chair-Elect
Kelly Geloneck
Groom Law Group Chartered
1701 Pennsylvania Ave NW
Washington, DC 20006-5811
(202) 861-5418
kgeloneck@groom.com

Council Representative
Kay Hodge
Stoneman Chandler & Miller LLP
99 High St, Ste 1302
Boston, MA 02110-2375
(617) 542-6789
Fax: (617) 556-8989
khodge@scmllp.com

Diversity Vice-Chair
Angel Garrett
Trucker Huss
135 Main St, Fl 9
San Francisco, CA 94105-1815
(415) 788-3111
Fax: (415) 421-2017
agarrett@truckerhuss.com

Immediate Past Chair
Joseph Faucher
Trucker Huss
15760 Ventura Blvd, Ste 910
Encino, CA 91436-3019
(213) 537-1016
Fax: (213) 537-1020
jfaucher@truckerhuss.com

Scope Liaison
Joseph Jeffery
Chittenden Murday & Novotny LLC
303 W Madison St, Ste 2400
Chicago, IL 60606-3335
(312) 281-3600
Fax: (312) 281-3678
jjeffery@cmn-law.com

Membership Vice-Chair
Dasha Brockmeyer
Prudential Financial
dasha.brockmeyer@prudential.com

Vice-Chairs
Wilson Barmeyer
Eversheds Sutherland (US)
700 6th St NW, Ste 700
Washington, DC 20001-3980
(202) 383-0824
WilsonBarmeyer@eversheds-sutherland.com

Sarah Bowen
Trucker Huss
135 Main St, Ste 900
San Francisco, CA 94105
(415) 277-8059
sbowen@truckerhuss.com

Jonathan Braunstein
Dentons
1999 Harrison St, Ste 1300
Oakland, CA 94612-4709
(415) 882-2425
Fax: (415) 397-8549
jon.braunstein@dentons.com

Denise Clark
Clark Law Group PLLC
1100 Connecticut Ave NW, Ste 920
Washington, DC 20036
(202) 293-0015
Fax: (202) 293-0115
dmclark@benefitcounsel.com

David Cohen
Benetic, Inc.
dcohen@benetic.com

Emily Costin
Alston & Bird LLP
950 F St NW, Ste 1
Washington, DC 20004-1439
(202) 239-3695
Fax: (202) 654-4995
emily.costin@alston.com

Clarissa Kang
Trucker Huss
135 Main Street, 9th Floor
San Francisco, CA 94105-1815
(415) 788-3111
Fax: (415) 421-2017
ckang@truckerhuss.com

David Levine
Groom Law Group Chartered
1701 Pennsylvania Ave NW,
Ste 1200
Washington, DC 20006-5811
(202) 861-5436
Fax: (202) 659-4503
dlevine@groom.com

Brooks Magratten
Pierce Atwood LLP
1 Financial Plz, Ste 2600
Providence, RI 02903-2485
(401) 490-3422
Fax: (401) 588-5166
bmagratten@pierceatwood.com

Catherine Reagan
Trucker Huss
135 Main St, Fl 9
San Francisco, CA 94105-1815
(415) 788-3111
creagan@truckerhuss.com

Michelle Roberts
Roberts Disability Law, P.C.
66 Franklin St, Ste 300
Oakland, CA 94607
(510) 230-2090
Fax: (510) 230-2091
michelle@robertsdisability.com

Dylan Rudolph
Trucker Huss
135 Main St, Fl 9
San Francisco, CA 94105-1815
(415) 788-3111
drudolph@truckerhuss.com

Calendar

September 16-21, 2022	**TIPS/ABOTA National Trial Academy** Contact: Janet Hummons – 312/988-5656 Theresa Beckom – 312/988-5672	**National Judicial College** Reno, NV
October 13-16, 2022	**TIPS Fall Meeting** Contact: Janet Hummons – 312/988-5656 Theresa Beckom – 312/988-5672	**Omni Scottsdale Montelucia** Scottsdale, AZ
October 27-28, 2022	**Aviation Litigation Conference** Contact: Theresa Beckom – 312/988-5672 Cameron Witbeck – 312/988-5668	**Ritz Carlton Washington DC** Washington, DC
November 9-11, 2022	**Fidelity & Surety Law Fall Conference** Contact: Janet Hummons – 312/988-5656 Theresa Beckom – 312/988-5672	**Ritz Carlton Philadelphia** Philadelphia, PA
January 18-20, 2023	**Fidelity & Surety Law Midwinter Conference** Contact: Janet Hummons – 312/988-5656 Theresa Beckom – 312/988-5672	**JW Marriott** Washington, DC
February 1-6, 2023	**ABA Midyear Meeting** Contact: Janet Hummons – 312/988-5656 Theresa Beckom – 312/988-5672	**Marriott/Sheraton** New Orleans, LA
February 23-25, 2023	**Insurance Coverage Litigation Conference** Contact: Janet Hummons – 312/988-5656 Theresa Beckom – 312/988-5672	**Arizona Biltmore** Nashville, TN
March 1-3, 2023	**Transportation Mega Conference** Contact: Janet Hummons – 312/988-5656 Theresa Beckom – 312/988-5672	**Sheraton New Orleans** New Orleans, LA
March 3-4, 2023	**Admiralty and Maritime Law Conference** Contact: Theresa Beckom – 312/988-5672 Cameron Witbeck – 312/988-5668	**Sheraton New Orleans** New Orleans, LA
April 19-21, 2023	**Motor Vehicle Product Liability Conference** Contact: Janet Hummons – 312/988-5656 Theresa Beckom – 312/988-5672	**Omni Scottsdale Montelucia** Scottsdale, AZ