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COMMITTEE NEWS

Employee Benefits Law

The Winds Of Change Are Blowing In ERISA Litigation

Mr. DeBofsky is the founding member of his law firm in Chicago, IL. He represents claimants and plaintiffs in employee benefit claim disputes involving disability insurance, life, health, retirement, long-term care, and other employee benefit-related matters.

The winds of change are blowing in ERISA litigation. Beginning in 2020, when Judge Amul Thapar questioned the basis for the administrative exhaustion doctrine in ERISA claims litigation, writing, "[i]t is troubling to have no better reason for a rule of law than that the courts made it up for policy reasons,"[1]it is becoming increasingly clear that unique features of ERISA litigation that deviate from the Federal Rules of Civil Procedure may be coming to an end. An even more recent ruling, also out of the Sixth Circuit, has openly questioned "remands" of ERISA cases to private litigants as "rest[ing] on paper-thin reasoning."[2] The most recent ruling even cited an article I wrote several years ago that broadly addressed anomalies in ERISA civil procedure.[3]

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Mark D. Debofsky
DeBofsky Sherman Casciari Reynolds P.C.

***Mr. DeBofsky** is the founding member of his law firm in Chicago, IL. He represents claimants and plaintiffs in employee benefit claim disputes involving disability insurance, life, health, retirement, long-term care, and other employee benefit-related matters.*

In This Issue

Chair Message

Joe Faucher
Trucker Huss, APC
Chair, TIPS Employee Benefits Committee

Welcome once again to the TIPS Employee Benefit Committee newsletter. Some of the best and brightest in the ERISA litigation world have contributed to this most recent edition. Mark DeBofsky offers us a thought-provoking look at how ERISA litigation relating to the standard of review in benefit claims may be changing and evolving before our eyes—and suggests that it should. Defense attorneys may disagree but would be wise to take heed.

Dylan Rudolph provides an excellent synopsis of the Department of Labor's recent guidance to plan sponsors and service providers on the topic of cybersecurity, as well as increasingly common litigation springing from cybersecurity concerns. It is a must-read for plan sponsors and fiduciaries.

Ross McSweeney discusses the Supreme Court's recent decision in *Hughes v. Northwestern University,* a case that was on the top of almost every ERISA litigator's mind this past year. He concludes with an interesting and unique take on a potential unintended impact of the decision. (Intrigued? Read the article!)

And finally, Peter Sessions explores how different courts of appeals handle the tricky question of whether and when to remand benefit claims to plan administrators for a "second bite of the apple." Every ERISA litigator who has practiced in this area knows how important the issue is. Peter does an excellent job of breaking it down.

The TIPS Employee Benefit Committee Mid-Winter Symposium was recently postponed from January to this coming August 18-20. The symposium will take place at the Grand Hyatt in Nashville, Tennessee. I'm looking forward to seeing all of you there, in person, after a long winter of Covid discontent. As always, if you would like to participate in TIPS, we welcome you—and articles of interest—with open arms.

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Litigation And Government Investigation Risk Following The Department Of Labor's Cybersecurity Guidance

Dylan D. Rudolph, Director
Trucker Huss, APC

***Mr. Rudolph** represents plans and plan fiduciaries in complex ERISA litigation, including fiduciary breach claims involving plan investments and fees, and counsels plan sponsors on fiduciary compliance.*

The U.S. Department of Labor ("Department") estimates that there are roughly $9.3 trillion of retirement assets that need protection from potential cybersecurity threats.[1] Internet based cyber-attacks are expected to double by 2025 and to cost companies an estimated $10.5 trillion annually. Studies show that as few as .05% of cyber-attacks are detected in the United States, even though reports also indicate that cybercrime is up nearly 600% since the onset of the COVID-19 pandemic.[2] Plan sponsors and fiduciaries must be aware of these threats and take the necessary steps to protect themselves and their participants from this ever-present cyber risk. Failure to do so may subject them to litigation and the risk of government investigation and enforcement.

Cyber Claims in ERISA Litigation

We have seen claims involving cybercrime asserted in recent lawsuits filed under the Employee Retirement Income Security Act of 1974 ("ERISA"). Those claims often involve allegations that plans sponsors or service providers did not adequately protect plan assets from fraudulent activity that resulted in those assets being misappropriated. In these cases, courts have grappled with the intersection between ERISA's fiduciary duties and cyber-related claims.

For example, in *Leventhal v. The MandMarblestone Group*[3], a participant, the plan, and the plan's sponsor sued the plan's third-party administrator and asset custodian after cyber criminals stole money from a participant's plan account. After the participant made a legitimate withdrawal, cyber criminals obtained a copy of the withdrawal forms and impersonated the participant to take money from his plan account. The electronic impersonators made additional withdrawal requests from the same account at a high frequency, reducing the account balance from $400,000 to $0. The participant, plan, and plan sponsor alleged that the plan's third-party administrator should have been alerted by the peculiar nature of the withdrawals, and that the plan's asset custodian should not have distributed the funds. They further alleged that the defendants failed to use common safeguards and procedures to protect the participant's assets. In response to an early motion by the defendants, the court concluded that the plaintiffs stated viable claims for breach of fiduciary duty under ERISA against both the administrator and asset custodian. Those claims, however, were never fully tested because the case settled after some discovery.

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A Huge Deal Or Ho-Hum? Measuring The Likely Impact Of *Hughes v. Northwestern University*

Ross P. McSweeney
Groom Law Group

***Mr. McSweeney** is a senior associate at Groom Law Group, Chartered, in Washington, D.C. Mr. McSweeney represents plan sponsors, trustees, and other fiduciaries, along with plan service providers, in a wide range of litigation matters arising under ERISA.*

For a case that the employee benefits community followed with all the anticipation of a new Marvel movie, the Supreme Court's decision in *Hughes v. Northwestern University* was surprisingly terse. Justice Sotomayor's opinion for a unanimous court ran only five pages and change long; excluding the summary of the dispute, the opinion devoted just six paragraphs to substantive legal reasoning. Of course, length can be a misleading indicator of significance. After all, John Marshall's opinion in *United States v. Barker* was only six words—"The United States never pay costs."—yet it resolved forever whether the common law allowed private citizens to recover legal costs from the government. Still, there may be reason to question whether *Hughes* signals the seismic shift in benefits law that many observers expected.

As background, *Hughes* is one in a litany of class actions alleging that retirement plan administrators violated ERISA's duty of prudence by failing either to reduce the fees the plans paid for administrative services such as recordkeeping or to ensure that the investment choices the plans offered participants had reasonably low fees. The plaintiff in *Hughes* alleged that, among other things, Northwestern included high-cost "retail" investment options in its defined-contribution employee benefits plan despite the availability of identical, lower-cost "institutional" options. Northwestern prevailed on a motion to dismiss by arguing that it could not be liable for having expensive options because its menu also allowed participants to pick some number of cheap options.

During oral argument, the Justices cleaved into opposing camps. On one side was the liberal wing, which read the complaint as plainly alleging that Northwestern did not exercise the same level of care as comparable administrators when selecting the plan's investment options. Indeed, Justice Sotomayor complimented the employees' counsel for making what she described as the "strongest argument"—that, for pleading purposes, all participants have to do is "say that others have offered institutional shares, and [that Northwestern] could have done this [too]."

The conservative wing occupied the opposite position, worrying that class actions in which participants nitpick well-intentioned investment decisions were simply extortive devices to extract a settlement on even the flimsiest allegations. After noting the many "questions about judicial competence and administration and realms of reasonable judgment" raised in the employees' complaint, Justice Gorsuch

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Fifth Circuit Rules That Insurer Gets a "Second Bite at the Apple" After Making Faulty Coverage Determination

Peter Sessions
Kantor & Kantor, LLP

Peter has been practicing in the insurance and ERISA-related fields of law for more than 20 years and has special expertise in appellate litigation.

When an ERISA administrator denies a benefit claim because the claimant is not an eligible plan participant, what happens when a court later rules that this decision was wrong? Does the court order that benefits be approved? Or does the court give the administrator a second chance to deny the claim by allowing it to determine whether the now-covered participant met the plan benefit criteria? In *Newsom v. Reliance Standard Life Ins. Co.*,[1] the Fifth Circuit decided that an administrator should get another chance to decide the merits of the claim.

James Newsom was a software architect for Lereta, LLC where he had been employed for 23 years. Unfortunately, he had a long history of health problems, including chronic fatigue syndrome, fibromyalgia, depression, and attention deficit hyperactivity disorder. Because of these issues, in September of 2017 he could no longer work a 40-hour work week, so Lereta reduced his hours to 32 per week, which was still considered full-time. However, this still proved too much, so Lereta reduced Newsom's hours further to part-time status in October of 2017. By January of 2018, he was unable to work at all.

Newsom submitted a claim for short-term disability (STD) benefits under Lereta's ERISA-governed disability plan, which was ultimately approved by Defendant Reliance Standard Life Insurance Company ("Reliance"), the plan's insurer. However, Newsom's claim for long-term disability (LTD) benefits received a chillier reception from Reliance. Reliance noted that the plan only covers "active, Full-time employees," and "Full-time" meant "working for [the employer] for a minimum of 30 hours during a person's regular work week." Reliance further determined that Newsom's date of disability was in January of 2018, and thus, because he was not working full-time in the weeks prior to that date, he was not covered under Lereta's LTD plan and was ineligible for LTD benefits.

Having exhausted his appeals with Reliance, Newsom filed suit. At trial, the district court agreed that Reliance had erroneously denied his LTD claim. The district court found that Newsom was a "full-time employee," eligible for benefits in October of 2017, regardless of whether he was actually working 32 hours per week, because he was scheduled to work those hours by Lereta. The court further found that Newsom became disabled in October of 2017. As a result, the court overturned Reliance's decision and ordered it to pay Newsom benefits through the date of judgment.

Reliance appealed, arguing that the district court (1) incorrectly interpreted the "full-time" and "regular work week" plan provisions, (2) erred in finding that Newsom became disabled in October of 2017, and (3) should have remanded the case to Reliance instead of awarding benefits.

The Fifth Circuit quickly rejected Reliance's first argument. The court noted that it was foreclosed by the court's prior decision in *Miller v. Reliance Standard Life Ins. Co.*,[2] in which it had agreed with the Sixth Circuit that the term "full time" and its reference to a "regular work week" was "ambiguous and should thus be interpreted in favor of the insured pursuant to the rule of *contra proferentem.*" Thus, the district court "did not err by interpreting the term 'full time' and its reference to a 'regular work week' to mean the 'scheduled work week' set by Lereta for Newsom."

Reliance's second argument fared no better. Noting that factual findings are only reversible for clear error, the Fifth Circuit upheld the district court's determination that Newsom became disabled in October of 2017. Both courts found it probative that Reliance had previously found that this date was Newsom's effective date of disability for the purpose of his claim for STD benefits.

Reliance's third argument was that because it denied Newsom's claim on coverage grounds, it had never had a chance to determine whether Newsom was disabled for the purposes of the LTD policy. Thus, Reliance argued that the district court should not have awarded benefits, but remanded Newsom's claim to Reliance to make that determination in the first place. Newsom objected, contending that "remand would amount to an impermissible 'second bite at the denial apple,'" and pointing out that the district court had already found under *de novo* review that Newsom was entitled to benefits, so a remand was pointless.

Reliance should have had an opportunity to address the question of disability in the first instance.

However, the Fifth Circuit agreed with Reliance. Citing its prior decision in *Schadler v. Anthem Life Insurance Co.*,[3] and the Seventh Circuit's decision in *Pakovich v. Broadspire Services, Inc.*,[4] the court determined that the district court erred in not remanding the case to Reliance. The Fifth Circuit noted that the district court appeared to have "conflated the issues of eligibility and disability," and evidence in the record suggested that Newsom might have been able to return to work by August of 2018. Thus, Reliance should have had an opportunity to address the question of disability in the first instance.

As for Newsom's argument regarding the district court's *de novo* review, "an administrative record answering these questions was simply not before the district court, irrespective of its *de novo* review. Once it determined that Newsom was not eligible for LTD benefits, Reliance stopped. Once the district court determined that Newsom was in fact eligible for LTD benefits, and the date on which his eligibility

began, it should have stopped as well and remanded the case for Reliance to make the separate disability determination."

Finally, the Fifth Circuit addressed the issue of attorney's fees. The district court had awarded fees to Newsom, and Reliance appealed that decision. However, it failed to file any briefing regarding the issue, and the clerk dismissed Reliance's appeal. Reliance filed a motion to reinstate the appeal, which the court granted, consolidated with the merits appeal, and remanded both to the district court "with instructions to remand Newsom's claim to the administrator for further proceedings consistent with this opinion."

The Fifth Circuit's first two rulings in this decision are uncontroversial. As noted above, the first issue had already been decided in a previous case, and the second issue is an unremarkable application of the clear error rule. However, the third issue regarding the proper remedy deserves closer attention.

Newsom's "second bite at the denial apple" argument is reminiscent of Ninth Circuit decisions that have used similar language. *In Grosz-Salomon v. Paul Revere Life Ins. Co.,*[5] *the court explained that* "a plan administrator will not get a second bite at the apple when its first decision was simply contrary to the facts".[6] In fact, in 2012 the Ninth Circuit explicitly stated that "the general rule…in this circuit and in others, is that a court will not allow an ERISA plan administrator to assert a reason for denial of benefits that it had not given during the administrative process."[7] As Harlick, 686 F.3d 699 explained, "ERISA and its implementing regulations are undermined 'where plan administrators have available sufficient information to assert a basis for denial of benefits, but choose to hold that basis in reserve rather than communicate it to the beneficiary.'"[8]

As a result, the Fifth Circuit's decision in this case seems to be starkly at odds with the Ninth Circuit's approach, as it gives Reliance the proverbial second bite at the apple disfavored by *Harlick*. Interestingly, the Fifth Circuit did not cite, let alone discuss, *Harlick* (or any of the cases cited by *Harlick*) in reaching its decision. Because of this apparent conflict, the "second bite" issue may be one for the Supreme Court to sort out in the future.

Endnotes

1 *Newsom v. Reliance Standard Life Ins. Co.*, 26 F.4th 329 (5th Cir. 2022).
2 *Miller v. Reliance Standard Life Ins. Co.*, 999 F.3d 280 (5th Cir. 2021).
3 *Schadler v. Anthem Life Ins. Co.*, 147 F.3d 388 (5th Cir. 1998).
4 *Pakovich v. Broadspire Servs., Inc.*, 535 F.3d 601 (7th Cir. 2008).
5 Grosz-Salomon v. Paul Revere Life Ins. Co., 237 F.3d 1154 (9th Cir. 2001).
6 *Id.* at 1163.
7 *Harlick v. Blue Shield of California*, 686 F.3d 699, 719–20 (9th Cir. 2012).
8 *Id.* at 70 (quoting *Glista v. Unum Life Ins. Co. of Am.*, 378 F.3d 113, 129 (1st Cir. 2004)).

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Another recent case of note has also questioned the application of deferential review of ERISA cases and the meaning of "substantial evidence." In *Michael J.P. v. Blue Cross and Blue Shield of Texas,*[4] a concurrence authored by Judge Andrew Oldham questioned the manner in which courts examine records for substantial evidence and deemed the current practice of seeing if there is any evidence in the record is a deviation from the directive given by the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch.*[5] The *Michael J.P.* case involved a claim for health insurance benefits—after her fifth attempted suicide, the plaintiff's daughter was psychiatrically hospitalized but the benefit plan covered only a few days of treatment and deemed ongoing residential treatment unnecessary, asserting the patient was no longer at imminent risk of suicide or self-harm.

A district court upheld the insurer's determination, which was based on the Milliman Care guidelines to determine the appropriate level of care, finding the insurer's determination was based on substantial evidence. The court of appeals affirmed. However, Judge Oldham issued a concurring opinion in which he wrote the substantial evidence standard used in ERISA cases "is notably more deferential than ordinary substantial-evidence review" in cases arising under administrative law. He questioned whether the substantial evidence standard's application in such a manner was "justifiable" since the standard as applied permitted affirmance of a claim decision so long as there is some reliable evidence supporting the determination.

Retracing the history of the use of the substantial evidence standard, Judge Oldham maintained that what the courts have been doing is inconsistent with *Firestone,* which distinguished ERISA cases from pre-ERISA cases brought under the Labor Management Relations Act, in which court review examined whether the plan trustees "have acted arbitrarily, capriciously or in bad faith; that is, is the decision of the Trustees supported by substantial evidence or have they made an erroneous decision on a question of law."[6] *Firestone* found, however:

> Unlike the LMRA, ERISA explicitly authorizes suits against fiduciaries and plan administrators to remedy statutory violations, including breaches of fiduciary duty and lack of compliance with benefit plans. Thus, the *raison d'être* for the LMRA arbitrary and capricious standard—the need for a jurisdictional basis in suits against trustees—is not present in ERISA. Without this jurisdictional analogy, LMRA principles offer no support for the adoption of the arbitrary and capricious standard insofar as § 1132(a)(1)(B) is concerned.[7]

Although *Firestone* permitted plans to reserve discretion, in such cases, review should be the same as under trust law, i.e., for "abuse of discretion."[8] Judge Oldham

complained that courts have instead used an "arbitrary and capricious" standard of review, upholding the plan's determination so long as it is supported by substantial evidence. But as the concurrence noted, ERISA's "'substantial evidence' is radically different from 'substantial evidence' elsewhere in law."

To discern the meaning of the term "substantial evidence," Judge Oldham turned to the Supreme Court's seminal case defining "substantial evidence," *Universal Camera Corp. v. NLRB*.[9] There, the Court cast doubt on whether it was proper for a federal court to affirm an administrative agency determination so long as there was some evidence in the record that supported the outcome. Instead, the Court ruled that a "holistic" assessment is required – one that necessitates giving "consideration to 'the record as a whole,' 'taking into account contradictory evidence or evidence from which conflicting inferences could be drawn.'"[10]

Judge Oldham observed that the current regime of substantial evidence is inconsistent with that standard and defective because courts do not "engage in a holistic review of the evidence," and once a court finds there is some evidence supporting the claim decision, courts do not "consider how substantial the plaintiff's evidence is, because it doesn't matter—the administrator has carried their burden."[11] In other words, courts "quickly approve the administrator's decision as supported by substantial evidence, without taking into account contradictory evidence or evidence from which conflicting inferences could be drawn."[12] As a result, Judge Oldham acknowledged that such a minimalist view of substantial evidence makes "it particularly difficult for ERISA beneficiaries to vindicate their rights under the cause of action created by Congress. And it does so with no apparent support in law, logic, or history."[13]

"...such a minimalist view of substantial evidence makes "it particularly difficult for ERISA beneficiaries to vindicate their rights under the cause of action created by Congress."

What makes this concurrence even more interesting though is a detail Judge Oldham omitted. The majority opinion authored by Justice Stephen Breyer in *Metro. Life Ins. Co. v. Glenn,*[14] reiterated *Firestone*'s holding and then cited *Universal Camera* as a roadmap for how courts should review benefit denials "by taking account of several different, often case-specific, factors, reaching a result by weighing all together."[15] By citing *Universal Camera,* Justice Breyer was echoing what Justice Felix Frankfurter wrote in *Universal Camera:*

> [C]ourts must now assume more responsibility for the reasonableness and fairness of Labor Board decisions than some courts have shown in the past. Reviewing courts must be influenced by a feeling that they are not to abdicate the conventional judicial function. Congress has imposed on them responsibility for assuring that the Board keeps within reasonable grounds. That responsibility is not less real because it is limited to enforcing the requirement that evidence appear substantial when viewed, on the record as a whole, by courts invested with the

> authority and enjoying the prestige of the Courts of Appeals. The Board's findings are entitled to respect; but they must nonetheless be set aside when the record before a Court of Appeals clearly precludes the Board's decision from being justified by a fair estimate of the worth of the testimony of witnesses or its informed judgment on matters within its special competence or both.

Judge Oldham's concurrence is a reminder that judges adjudicating ERISA benefit disputes need to examine the evidence presented by both parties and view that evidence in the context of the entire record. He also presented a powerful argument for the need for courts to reassess how they decide claim disputes and avoid the tendency to simply check off boxes in finding the plan administrator's evidence sufficient. Just because the plan administrator's decision has support from a specialist physician is not a guarantee that the evidence is sufficient when viewed in comparison to the plaintiff's submission and as part of an examination of the record as a whole.

As *Universal Camera* teaches, courts are not to abdicate their judicial responsibilities and rubber stamp claim decisions just because the plan administrator has discretionary authority. ERISA is a paternalistic statute that was enacted for the protection of plan participants and their beneficiaries. Courts need to go about their duty in adjudicating cases with that principal in mind and insure the record shows the claim was fully and fairly assessed. Judge Oldham's opinion should be read and taken to heart by every federal judge because he convincingly argues that courts have deviated from their proper role without any authority or basis for doing so.

Endnotes

1 Wallace v. Oakwood Healthcare, Inc., 954 F.3d 879, 900 (6th Cir. 2020) (Thapar, J., concurring); *see,* DeBofsky, "6th Circ. Ruling Offers Fresh Look at ERISA Exhaustion," Law 360 (April 24, 2020); available at https://www.law360.com/articles/1264985

2 *Card v. Principal Life Ins. Co.*, 17 F.4th 620 (6th Cir. 2021).

3 Mark D. DeBofsky, *A Critical Appraisal of the Current State of ERISA Civil Procedure*, 18 Emp. Rts. & Emp. Pol'y J. 203, 233–34 (2014).

4 *Michael. J. P. v. Blue Cross Blue Shield*, No. 21-1041, 2022 WL 585912 (U.S. Feb. 28, 2022) (non-precedential).

5 *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989).

6 *Danti v. Lewis*, 312 F.2d 345, 348 (D.C. Cir. 1962); *see also Giler v. Bd. of Trustees of Sheet Metal Workers Pension Plan of S. California*, 509 F.2d 848, 849 (9th Cir. 1974); *Brune v. Morse*, 475 F.2d 858, 860 n.2 (8th Cir. 1973); *Miniard v. Lewis*, 387 F.2d 864, 865 (D.C. Cir. 1967); *Kosty v. Lewis*, 319 F.2d 744, 747 (D.C. Cir. 1963).

7 *Firestone Tire and Rubber Co.*, 489 U.S. at 110 (citations omitted).

8 *Id.* at 957; *see also* Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 Am. U. L. Rev. 1083, 1096–1107 (2001) (discussing the various standards of review applied to ERISA claims).

9 *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 71 S. Ct. 456, 95 L. Ed. 456 (1951).

10 *Michael J. P. v. Blue Cross & Blue Shield of Texas*, No. 20-30361, 2021 WL 4314316, at *10 (5th Cir. Sept. 22, 2021), *cert. denied sub nom. J. P. v. Blue Cross Blue Shield*, No. 21-1041, 2022 WL 585912 (U.S. Feb. 28, 2022), *citing Universal Camera Corp.*, 340 U.S. at 487, 490; *accord Dish Network Corp. v. Nat'l Lab. Rels. Bd.*, 953 F.3d 370, 377–78 (5th Cir. 2020), *as revised* (Mar. 24, 2020).

11 *Id.* at *10.

12 *Id.*

13 *Id.*

14 *Metro. Life Ins. Co. v. Glenn*, 554 U.S. 105, 128 S. Ct. 2343, 171 L. Ed. 2d 299 (2008).

15 *A Metropolitan Life Ins. Co.*, 554 U.S. at 117.

Litigation... continued from page 3

Likewise, in *Bartnett v. Abbott Laboratories*[4], a participant sued the plan's sponsor, administrator, and recordkeeper, alleging that an impersonator had accessed the participant's plan account online, added a new bank account, and requested a $245,000 distribution. The participant alleged that the plan's sponsor, administrator, and recordkeeper failed to identify the suspicious distribution requests and recognize that the impersonator was using a phone number not previously linked to the account. The participant further alleged that one of the plan's agents had inadvertently provided the participant's contact information to the impersonator. Unlike in *Leventhal,* the court in *Bartnett* dismissed the claims against the plan sponsor and administrator, finding that ERISA's duty of prudence did not extend to safeguarding participant data or preventing scams. The court allowed the claims against the plan's recordkeeper to proceed, but those claims were not fully tested either because the case settled.

The Department of Labor's Cybersecurity Guidance

On April 14, 2021, the Department's Employee Benefit Security Administration ("EBSA") issued its first official cybersecurity guidance.[5] The guidance was organized into three parts, as follows:

First, EBSA provided guidance to plan sponsors and fiduciaries regarding steps that should be taken to prudently hire and monitor service providers. This guidance states that plan sponsors and fiduciaries should: (1) compare the service provider's security standards to industry standards and review security audit results; (2) consider contract provisions in service provider agreements that give sponsors and fiduciaries the right to review audit results demonstrating compliance with industry standards; (3) evaluate the service provider's track record in the industry; (4) inquire whether the service provider has experienced past security breaches; (5) find out if the service provider has any insurance policies and the scope of that coverage; and (6) beware of any contract provisions that limit the service provider's responsibility for cybersecurity breaches.

EBSA outlined "Best Practices" for plan fiduciaries and recordkeepers responsible for maintaining plan-related IT systems.

Second, EBSA outlined "Best Practices" for plan fiduciaries and recordkeepers responsible for maintaining plan-related IT systems. EBSA stated that fiduciaries and recordkeepers should: (1) have a formal, well-documented cybersecurity program; (2) conduct prudent annual risk assessments; (3) have a reliable annual third-party audit of security controls; (4) clearly define and assign information security roles and responsibilities; (5) have strong access control procedures; (6) conduct periodic cybersecurity awareness training; (7) implement and manage a secure system development life cycle program; (8) have an effective business resiliency program addressing business continuity, disaster recovery, and incident

response; (9) encrypt sensitive data, stored and in transit; (10) implement strong technical controls in accordance with best practices; and (11) appropriately respond to any past cybersecurity incidents.

Third, EBSA's guidance provided tips for plan participants and beneficiaries who access their retirement accounts online. Those tips included to: (1) register, set up, and routinely monitor their online plan account; (2) use strong and unique passwords; (3) use multi-factor authentication; (4) keep personal contact information current; (5) close or delete unused accounts; (6) be wary of free Wi-Fi; (7) beware of phishing attacks; (8) use antivirus software and keep apps and software current; and (9) know how to report identity theft and cybersecurity incidents.

The Department's cybersecurity guidance has been met with both relief and concern among plan sponsors and fiduciaries. Relief because the guidance directly addressed what the Department believes are the necessary steps and "best practices" that plan sponsors and fiduciaries should take to protect their plans and participants from cybersecurity threats. Concern because this guidance may prove to be a high bar for plan sponsors and fiduciaries to meet.

Litigation and Government Investigation Risk

Since the Department issued its cybersecurity guidance in April 2021, EBSA has begun including a set of cybersecurity-related requests during plan audits and investigations. EBSA is now requesting a series of documents reflecting the plan's cybersecurity programs and procedures, the identity and responsibilities of persons who have oversight of the plan's cybersecurity systems and controls, and the plan's risk assessments, internal audits, and cybersecurity awareness training programs. EBSA has also begun including questions about cybersecurity controls and programs in its investigative interviews. Plan sponsors and fiduciaries now need to be prepared for these types of questions during Department investigations and audits, including by ensuring proper programs and procedures are in place before government action is initiated.

Moreover, we anticipate an increased risk to plan sponsors and fiduciaries of private litigation. Claims against fiduciaries who fail to implement the Department's cybersecurity guidance may be low-hanging fruit for plaintiff's attorneys. Notably, the Department's guidance arguably contradicts holdings like the one in *Bartnett*, where the court dismissed claims against the plan's sponsor and fiduciaries on the basis that ERISA's duty of prudence did not require the safeguarding of participant data or prevention of scams. Now that the Department's formal guidance provides that sponsors and fiduciaries should have formal cybersecurity programs, risk

assessments, and controls in place, courts may be more ready to find that ERISA's duty of prudence requires adherence to those best practices. And, consequently, adherence to those best practices may work like a safe harbor for plan sponsors and fiduciaries to shield them from potential liability if the best practices are followed. Nevertheless, this guidance is not law, and even where plan sponsors and fiduciaries have allegedly failed to meet the Department's best practices, their actions may still satisfy ERISA's duty of prudence.

In order to mitigate investigative and litigation risks, plan sponsors and fiduciaries should review the Department's guidance and use it as a guide for evaluating and monitoring their cybersecurity programs and procedures, and those of their service providers. Plan sponsors and fiduciaries should review service provider agreements consistent with the Department's guidance, negotiate changes as necessary, and heed the Department's guidance when conducting requests for proposals for new providers. They should also review their fiduciary and cybersecurity insurance to make sure they have appropriate coverage for potential claims in the event that a cybersecurity breach occurs. And, importantly, plan sponsors and fiduciaries should educate their participants about the steps they should take to protect online information and to avoid cybercrime.

Endnotes

1 News Release, *US DEPARTMENT OF LABOR ANNOUNCES NEW CYBERSECURITY GUIDANCE FOR PLAN SPONSORS, PLAN FIDUCIARIES, RECORD-KEEPERS, PLAN PARTICIPANTS*, https://www.dol.gov/newsroom/releases/ebsa/ebsa20210414 (April 14, 2021).

2 Embroker, *2022 Must-Know Cyber Attack Statistics and Trends*, https://www.embroker.com/blog/cyber-attack-statistics/ (January 31, 2022).

3 *Leventhal v. MandMarblestone Grp. LLC*, No. 18-CV-2727, 2020 WL 2745740 (E.D. Pa. May 27, 2020).

4 *Bartnett v. Abbott Lab'ys*, 492 F. Supp. 3d 787, 793 (N.D. Ill. 2020).

5 *See* endnote 1, *supra*; https://www.dol.gov/sites/dolgov/files/ebsa/key-topics/retirement-benefits/cybersecurity/tips-for-hiring-a-service-provider-with-strong-security-practices.pdf; https://www.dol.gov/sites/dolgov/files/ebsa/key-topics/retirement-benefits/cybersecurity/best-practices.pdf; https://www.dol.gov/sites/dolgov/files/ebsa/key-topics/retirement-benefits/cybersecurity/online-security-tips.pdf.

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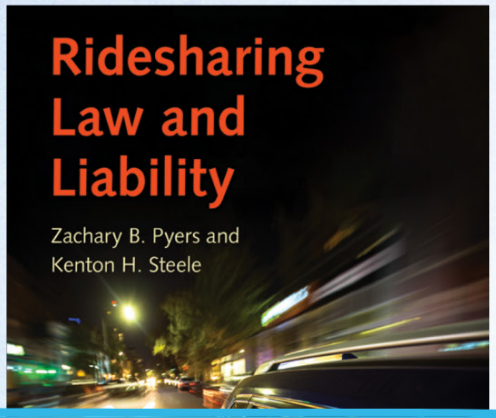

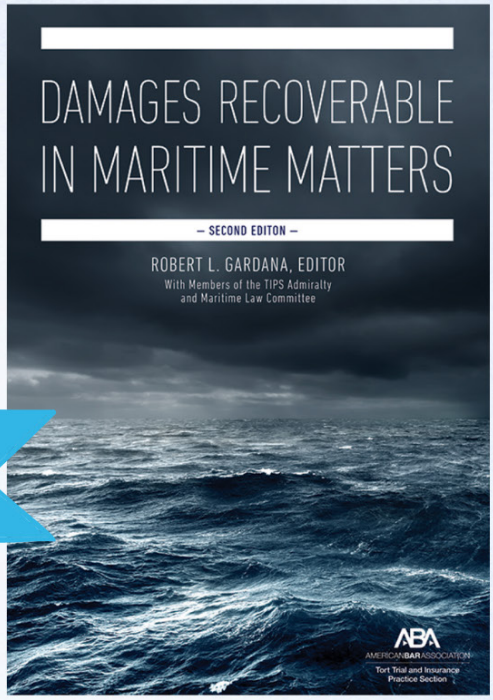

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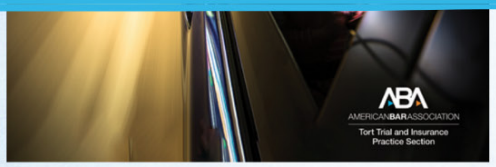
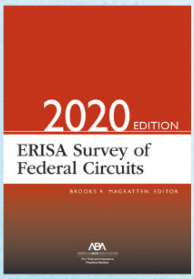
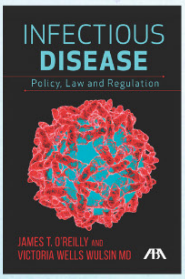
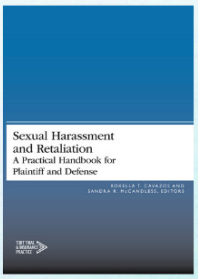
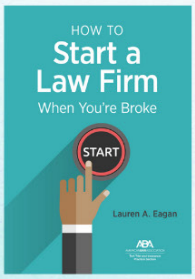


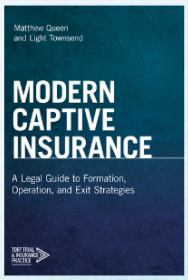
MORE NEW TITLES

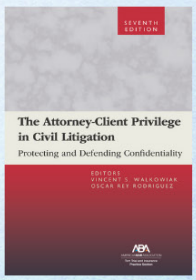












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A Huge... continued from page 4

rebutted the common platitude that "it can all be worked out at trial" by observing that excessive-fee cases rarely, if ever, reach trial.

Given the Justices' evident—and seemingly irreconcilable—disagreements, it is somewhat surprising that the opinion was unanimous. But its unanimity, along with its brevity, may offer a clue about the decision's likely impact.

Justice Sotomayor's opinion begins by reaffirming a fiduciary's "continuing duty . . . to monitor investments and improve imprudent ones." For Sotomayor, that obligation eliminates the possibility that that Northwestern could evade responsibility by offering "an adequate array of choices." Because fiduciaries "are required to conduct their own independent evaluation to determine which investments may be prudently included in the plan's menu of options," the fiduciaries fall short if they "fail to remove an imprudent investment from the plan within a reasonable time." Thus, identifying prudent options that employees *could* have chosen is not enough to insulate administrators from liability for including subpar investment options. Rather, administrators have an ongoing duty to protect employees from making poor investment choices by monitoring and removing those choices from the plan's menu.

So far, the opinion reads as a straightforward extension of the views Justice Sotomayor expressed during oral argument. Yet Justice Sotomayor concludes with a curious caveat:

> 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.

Justice Sotomayor likely included this coda as a conciliatory gesture aimed at winning the support of the conservative Justices who doubted excessive-fee class actions at oral argument. It tempers the effect of the Court's principal holding that administrators cannot shirk their duty to monitor the prudence of an individual investment choice simply by offering participants a wide array of options. In other words, the conservative Justices may have joined Justice Sotomayor's opinion in the belief that, despite the apparent victory it handed participants, it offered plan administrators a safe haven to make difficult decisions between competing considerations.

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Indeed, that may still be the outcome when the case returns to the Seventh Circuit on remand. Justice Sotomayor faulted the Seventh Circuit for its "exclusive focus on investor choice" without considering whether Northwestern had regularly reviewed

those investments. The Seventh Circuit did not mention Northwestern's efforts to monitor the investments at all, instead concluding that the sheer number of options the plan offered—over 400 in all—rendered an imprudence claim implausible. *Hughes* leaves open the possibility that the Seventh Circuit will once again affirm dismissal, this time by expressly weighing the "difficult tradeoff" Northwestern may have made between maximizing overall investment choices and monitoring individual investment options, goals both served by the duty of prudence.

Conscientious plan fiduciaries reading *Hughes* now know that they cannot rely exclusively on the many choices available to participants to defend failure-to-monitor claims. What else can they glean? The Supreme Court emphasized that ERISA requires plan fiduciaries "to conduct their own independent evaluation to determine which investments may be prudently included in the plan's menu of options." But this was already the case, as established in *Tibble v. Edison Int'l*, 575 U.S. 523, 135 S. Ct. 1823, 191 L. Ed. 2d 795 (2015). So, *Hughes* eliminated one strategy for fulfilling the duty to monitor, but it offered administrators no guidance about how else they may go about this task except that the inquiry is "context specific." Again, however, that was already the case, as established in *Fifth Third Bancorp v. Dudenhoeffer*, 573 U.S. 409, 134 S. Ct. 2459, 189 L. Ed. 2d 457 (2014). It is thus difficult to say whether *Hughes* lowered the hurdle plaintiffs must clear in pleading an excessive-fee suit, raised it, or left it untouched at the same height.

Finally, *Hughes* suggests an unintended consequence that might make the plaintiffs' bar rue its "victory." The essence of the Supreme Court's holding is that plan fiduciaries must evaluate the prudence of each investment option separately, rather than relying on the overall prudence of the investment lineup as a whole. Recent decisions have shown courts increasingly probing during class certification whether each participant seeking relief suffered a personal harm, and whether participants share that harm in a way that would allow the definition of an adequate class. Thus, by training courts' focus on *individual* investment options, *Hughes* may have made it harder for plaintiffs to bring claims on behalf of all plan participants. After all, the more investment options a plan offers, the more possible combinations there are for participants to select, and the less likely it is that any two participants selected the same investment options.

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Member Roster

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

Chair-Elect
Kirsten Scott
Renaker Hasselman Scott LLP
505 Montgomery St,
San Francisco, CA 94111-6529
(415) 653-1733
Fax: (510) 839-7839
kirsten@renakerhasselman.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
1 Embarcadero Ctr, Fl 12
San Francisco, CA 94111-3617
(415) 788-3111
Fax: (415) 421-2017
agarrett@truckerhuss.com

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

Membership Vice-Chair
Dasha Brockmeyer
Saul Ewing Arnstein & Lehr
1 Ppg Place
Pittsburgh, PA 15222
(412) 209-2538
dasha.brockmeyer@saul.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

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

Mark Boyko
Bailey & Glasser LLP
34 N Gore Ave Ste 102,
Saint Louis, MO 63119-2343
(314) 863-5446
Fax: (314) 621-7151
mboyko@baileyglasser.com

Jonathan Braunstein
Seyfarth Shaw LLP
560 Mission St, Ste 3100
San Francisco, CA 94105-2930
(415) 544-1057
Fax: (415) 397-8549
jbraunstein@seyfarth.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
1080 Pipestem Pl,
Potomac, MD 20854
(202) 744-1880
Fax: (202) 471-3510
david_a_cohen@yahoo.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
1 Embarcadero Ctr, Fl 12
San Francisco, CA 94111-3617
(415) 788-3111
Fax: (415) 421-2017
ckang@truckerhuss.com

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

Sarah Mysiewicz Gill
Groom Law Group Chartered
3702 Exaclibur Ct, Apt 203
Bowie, MD 20716
sgill@groom.com

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

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