



ERISA Litigation in Focus

2026 Regulatory Shifts, Retirement
Plan Cases, and Welfare Plan
Challenges

October 2026

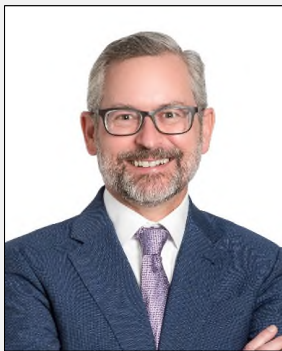
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Speakers



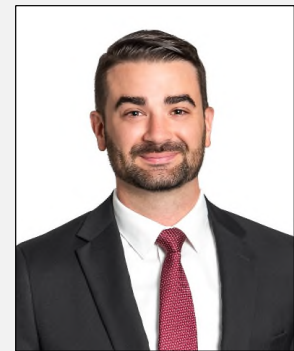
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- 4 | Impact of *Loper Bright*
- 5 | Pension Risk Transfer Litigation
- 6 | Mental Health Parity Litigation



Pleading Standards

Pace of Filings Continues Increasing 2025 and Early 2026

- 2023 saw a drop in ERISA class action filings
 - 298 cases from 2020-2023
- 2023 also saw record settlement numbers
 - 42 settlements in excessive fee class actions
 - All-time high of nearly \$353 million in settlement payments
- With decrease in 2023 filings and increase in 2023 settlements, capacity returned for plaintiffs' bar to file in 2024
 - More than 50 defined contribution cases filed in 2024
 - Emergence of new trends in forfeiture and pension risk transfer claims
- 170 ERISA class actions in 2025 and trending higher in 2026 – 2025 already surpassed year-to-date
- Over 50 settlements in ERISA class actions in 2025; at least 70 year-to-date in 2026

Pleading Standard for Fee Claims

Hughes, 142 S. Ct. 737 (2022)

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

Pleading Standards in Excessive Fee Cases

- On October 6, 2026, the Supreme Court heard argument regarding the the 9th Circuit's affirmance of dismissal with prejudice in the *Anderson* case (decision below at 137 F.4th 1015 (9th Cir. 2025))
- Key holdings below:
 - Plaintiffs asking courts to infer a fiduciary used improper methods based on investment performance of the investments, they must point to meaningfully similar investments
 - Plaintiff failed to do so because comparison was to funds with different risk-mitigation profiles
 - Plaintiff's claim that the investments were too expensive failed for similar reasons
 - The loyalty claims failed because a plaintiff must allege an *actual* (rather than potential) conflict of interest

Anderson Oral Argument

- Affirmance seems likely
 - All justices were focused on the impossibility of drawing anything meaningful from comparisons of the plan's performance to other funds that were not simple.
- Primary issue is how far the Court will go in giving guidance on the nature of benchmarks necessary to support allegations of imprudence
 - Questions to the government focused on whether to just affirm or to say more
 - Government suggested benchmark needs to hold constant at least the relevant consideration behind the fund selection (here, risk mitigation)
 - Probably will carve out cases where the imprudence claim is not based on relative performance (e.g., the lottery ticket fund)



Pleading Standards in Excessive Fee Cases

- A petition for certiorari from the 6th Circuit's decision in *Johnson v. Parker-Hannifin Corp.*, 122 F.4th 205 (6th Cir. 2024) remains pending at the Supreme Court (likely awaiting the decision in *Anderson*).
- *Johnson* reversed (over a dissent) dismissal of claims for **imprudent retention of certain investments, as well as claims that the plan should have used lower-cost share classes.**
- **Key holdings:**
 - Plaintiffs **plausibly alleged imprudent retention by pointing to high turnover and underperformance**
 - Plaintiffs plausibly alleged the share class claims by alleging that even if the plan did not meet the cheaper share class threshold, it might have been able to obtain a waiver if it requested one

Pleading Standards in Excessive Fee Cases

- On December 9, 2025, the United States filed its *amicus* brief in *Johnson*
 - The brief recommends that the Supreme Court review “[w]hether pleading an imprudent-investment claim under ERISA, ... requires allegations showing that the benchmark is a sound comparison for that investment.”
 - Substantively, it argues that plaintiffs must plausibly allege a meaningful benchmark.
 - In January, the Supreme Court granted certiorari in *Anderson* and appears to be holding *Johnson* pending the outcome in *Anderson*.

Inconsistent Results in Courts Promote More Filings

Burdens of Pleadings and Proof

- Courts inconsistent on scrutiny of benchmarks at pleading stage
 - Applies both to comparator funds for investment claims, and to bases to claim “unreasonable” RK&A fees
- Split authority on burden re causation

Standing

- *Thole* held that, without win changing the plaintiff’s benefit, the plaintiff lacks standing
- Mixed results applying that logic in DC plan context
 - Courts inconsistent on whether plaintiffs need to have invested in any/all funds they seek to challenge

Jury Trials

- Many plaintiffs continue to include jury demands, and resist efforts to strike
- So far, only courts in 2nd Circuit have accepted arguments for trial
- But others have at least allowed for possible advisory juries

Summary Judgment Standards

***In re: Quest Diagnostics*, 179 F.4th 217 (3d Cir. June 22, 2026).**

- The Third Circuit affirmed summary judgment in favor of plan fiduciaries regarding allegedly imprudent inclusion of investments in a 401(k) plan.
- The Court of Appeals held that the plan fiduciary maintained a prudent process for analyzing the plan investments and that short-term underperformance cannot demonstrate imprudence.
- It also declined to decide whether an investment policy statement is binding on fiduciaries, but held that even if it were, if the IPS has permissive language, that grants fiduciaries discretion to deviate from the terms of the statement.
- Though the case is not helpful on the pleading standard, it clarifies the burden plaintiffs have to demonstrate imprudence as to investments.

Summary Judgment Standards

Johnson v. Russell Investment Management, LLC, No. 25-10692 (11th Cir. Aug. 17, 2026)

- Participant class alleged Royal Caribbean breached ERISA's duty of prudence by replacing Vanguard TDFs with Russell TDFs.
- **The Holding**
- District court granted summary judgment, requiring an "apples-to-apples" comparator to prove objective imprudence
- Eleventh Circuit reversed and remanded
 - Focus was on loss causation – was the investment objectively imprudent
 - "An ERISA plaintiff need not identify an apples-to-apples comparison to establish objective imprudence in every case."
 - Loss causation asks whether the investment fell "outside the 'range of reasonable judgments a fiduciary may make'" such that a prudent fiduciary "would not (or could not) have made the same choice."
- Plaintiffs' theory: the Russell TDFs' *distinguishing features* — "to" glidepath, emerging-markets/real-asset bias, high fees — are themselves what made them imprudent, so a same-strategy comparator would be circular

Summary Judgment Standards

Key Takeaways from *Johnson*

- The court reaffirmed *Pizarro*'s consideration of **qualitative** (popularity, analyst ratings) and **quantitative** (fees/performance vs. peers) buckets.
- The "apples-to-apples" requirement **still governs the quantitative approach to showing imprudence**, to control for differing risk profiles/strategies and ensure underperformance reflects "real economic inferiority."
- Plaintiffs can now reach a jury on *qualitative* evidence alone.
- **Not a merits loss** — "no determination about whether the record warrants summary judgment under the appropriate standard."
- **Process documentation is the best defense**
- **Watch manager-side communications** — damaging Russell emails (client "may think they have made a bad fiduciary decision"; "hard to go with worse numbers and higher fees")
- **Arguably tied to this record** — Russell TDFs "never had more than 12 clients," lost their two largest to Vanguard, drew a Morningstar "[n]egative" rating, and underperformed by 1.51%–2.12% annualized

No Surprises Act



What is the NSA?

- The NSA is the federal statutory scheme governing those claims and the obligations arising from them.
- As the Second Circuit recently explained, Congress enacted the NSA “to address the issue of patients facing unexpected—and often exceedingly large—medical bills after they received treatment from out-of-network providers,” and codified the statute **across ERISA**, the Internal Revenue Code, and the Public Health Service Act, entrusting DOL, Treasury, and HHS with establishing and administering the federal IDR process. *E. Coast Advanced Plastic Surgery, LLC v. Cigna Health & Life Ins. Co.*, No. 25-2204, --- F.4th ----, 2026 WL 2751786, at *1–2 (2d Cir. Sept. 17, 2026) (citing *Neurological Surgery Prac. of Long Island, PLLC v. U.S. Dep’t of Health & Hum. Servs.*, 145 F.4th 212, 219(2d Cir. 2025)).

Courts have weighed in: No private right of action under the NSA

- **Text and structure**

- No express enforcement action appears in the statute. Courts look for clear congressional intent before implying a private remedy.

- **Agency enforcement**

- The statute assigns compliance authority to federal agencies. This express enforcement mechanism weighs against an additional private remedy.

How the NSA Works

1 | Patient protection

Covered patients generally owe no more than in-network cost-sharing for qualifying emergency and certain non-emergency services.

2 | Initial payment

The plan makes an initial payment or denial. The provider may then begin a 30-business-day open negotiation period.

3 | Federal IDR

If negotiation fails, a certified IDR entity selects one of the parties' offers under the statutory "baseball arbitration" process.

CARE

Qualifying out-of-network service

PAY / DENY

Initial payment determination

NEGOTIATE

30 business days

IDR

Certified entity selects an offer

The NSA separates the patient from the provider-plan reimbursement dispute and channels that dispute into negotiation and IDR.

Other key issues and arguments

FAA / state arbitration statutes	Statutory IDR is not contractual arbitration; confirmation statutes generally require a written agreement to arbitrate.
ERISA standing	A provider-assignee receives only the rights the patient possessed. Because the patient is insulated from the provider-plan payment dispute, the motion argues there is no assignable injury.
ERISA cause of action / remedy	An unpaid IDR amount is argued not to be a “benefit due” under plan terms, and equitable-relief theories cannot repackage a claim for money owed.
State-law end runs	Where a state claim exists only because of the federal IDR process, that state law cannot supply the enforcement remedy Congress omitted.
Proper parties / preclusion	Parties involved in IDR are bound by the determination; prior judgments may also foreclose renewed enforcement theories.

Potential Abuse of the Federal IDR Process

Critics argue that some out-of-network providers and intermediaries have converted a patient-protection backstop into a high-volume reimbursement strategy.

- **High-volume filings**

- Dispute volume has greatly exceeded the agencies' original projection, contributing to backlogs and eligibility-review burdens.

- **Awards far above benchmarks**

- CMS data show providers prevail in most decided disputes and prevailing offers often exceed the qualifying payment amount.

- **Ineligible or questionable claims**

- Plans allege that some submissions involve services outside the federal IDR process, duplicate or mass-filed claims, or claims routed through the wrong forum.

- **Network and cost incentives**

- Critics argue that outsized awards may reduce incentives to contract in-network and shift higher costs to employer plans and premiums.

Welfare Plan Class Actions

Health Plan Fee Suits

- Beginning in late-2022, started to see suits targeting large health insurers
 - Changes in law set transparency reporting guidelines and required plans and hospitals to post payment rate
 - Plan Administrator denied participant requests for plan information on claims payments
- Suits alleged failure to adequately respond to requests for costs of providing services to welfare plans
- New transparency guidelines mean there is more publicly available data, and lower barrier to entry for plaintiffs looking to bring suit
- There have been a significant number of cases challenging tobacco surcharges
- Even more recently, cases involving voluntary benefit programs and the so-called PPO or “financial dominance” cases

Potential Health Plan-Related Fee Claims

- As with 401(k) plans, many suits likely to be preceded by broad requests for information (both traditional plan document requests, and new transparent price information)
- Information obtained in information requests can be used to bolster claims of:
 - Breach of fiduciary duty
 - Unreasonable fees
 - Failure to monitor claims administration
 - Failure to make required disclosures
 - Prohibited transactions
 - Statutory violations

Challenges to Health Plan Fee Litigations



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

Initial H&W Fiduciary Breach Cases Struggle to Establish Standing

- In two closely watched cases, *Lewandoski* and *Navarro*, plan sponsors were sued in a putative class actions raising similar allegations of fiduciary breach related to the selection of pharmacy benefit managers (PBMs)
- The complaints alleged that failures in the selection, monitoring, and negotiation of PBM fees results in the plan (and its participants) overpaying for prescription drugs. The alleged breaches include: (i) failure to adequately consider non-traditional PBMs, (ii) failure to adequately negotiate favorable contract pricing, and (iii) improperly relying on the PBM's specialty pharmacy.
- District courts found the plaintiffs lacked standing because it was speculative to say any savings in PBM fees would have been a savings for participants, rather than employers (who could have reduced their own contributions)
- Decisions were viewed as difficult to overcome for plaintiffs pursuing this theory

Breaking the Pattern

- However, then comes the *Stern* decision out of the Southern District of New York, making similar allegations that the plan sponsor/employer breached its fiduciary duties by permitting its PBM to engage in practices that increased plan costs and inflated prices for prescription drugs.
- Court departed from the prior to decisions and denied defendant's motion to dismiss, holding that allegations of specific higher out-of-pocket costs were enough to survive a pleadings challenge.
- The court also permitted plaintiffs' prohibited transaction claim to proceed under the pleading standard set forth in *Cunningham v. Cornell University* because the complaint tracked the elements of ERISA section 406.
 - However, the court did order plaintiffs, pursuant to Federal Rule of Civil Procedure 7(a)(7), to file a reply to the employer's answer, to the extent the employer's answer invoked any ERISA section 408 exemptions to the claimed prohibited transactions.

Voluntary Benefits Litigation

- In December 2025, four putative class actions were filed alleging breaches of fiduciary duty and prohibited transactions related to pricing for voluntary benefit plans (accident, critical illness, hospital indemnity, and similar types of insurance benefits); additional filings in 2026
- The claims assert that the fiduciaries failed to adequately monitor broker compensation in these plans, and that the brokers charged excessive commissions
 - Essentially, allege premiums could have been lower
- Because employers do not contribute to these benefits, costs are paid 100% by employers, allowing plaintiffs to argue that the excessive commissions directly lead to higher than reasonable costs for them (and solving the standing problem that doomed some earlier H&W cases)
- Allege employers should have done more to monitor the benefits being offered, premiums, and commissions, and compared them to alternatives in the market. They also sue the brokers as “functional fiduciaries,” alleging they had discretionary authority to screen bids and decide what to present to employers
- Cases remain in early stages; no MTD decisions to date
- Potential threshold issue for MTD on this theory is whether plan is governed by ERISA
 - There is a DOL safe harbor that may apply where the offerings are purely voluntary and not “endorsed” by employers, but “endorsed” has been a very light standard

The New Front Line: "Financial Dominance" Theories in Group Health ERISA Litigation

- Core theories:
 - Traditional, high-premium/low-deductible PPO plan options are challenged as inherently imprudent under ERISA § 404(a)(1)(B).
 - Plaintiffs allege that when factoring in premium differentials, employer HSA contributions, and co-insurance caps, the cheaper high-deductible option is mathematically superior at **every level of medical utilization** (from zero to catastrophic)
- Key cases:
 - ***Barbich v. Northwestern University*** (N.D. Ill. 2025): The genesis case. Survived motion to dismiss
 - ***Green v. University of Rochester*** (W.D.N.Y. 2025)
 - ***New Case in S.D.N.Y.***: Introduces allegations of corporate self-interest and points to a lack of independent actuarial consultants

Tobacco Surcharge Litigation



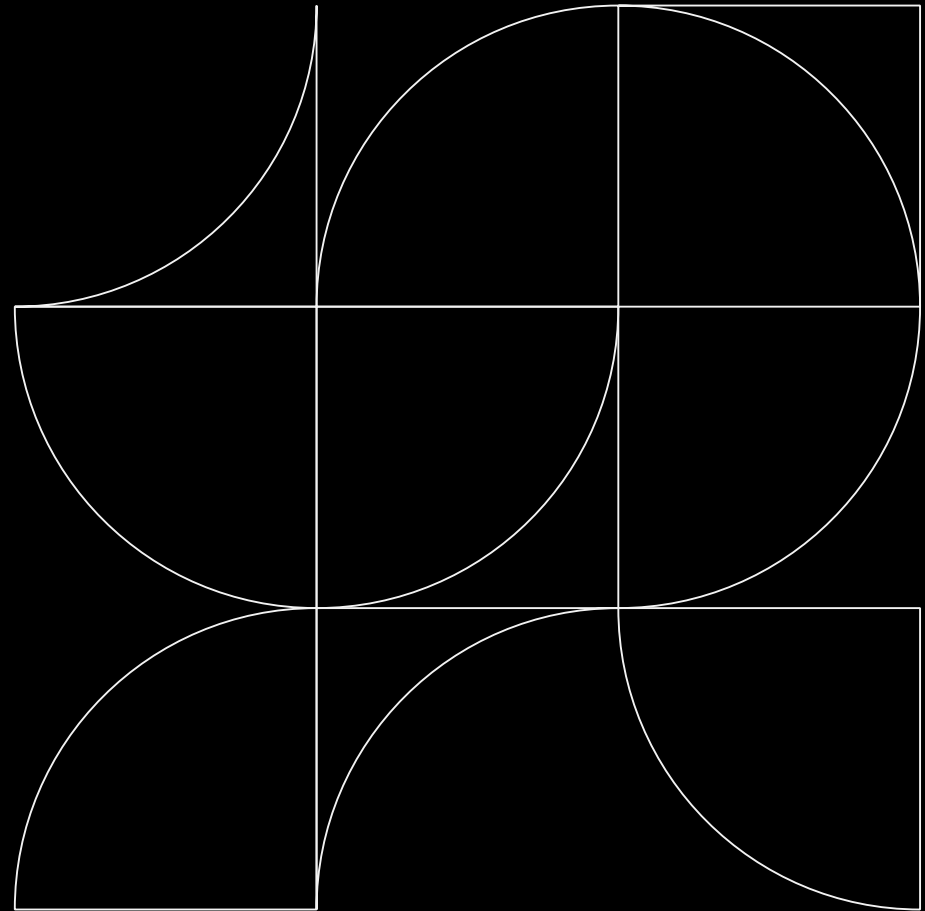
In 2024 and 2025, dozens of filings targeted health plans that had additional premium requirements for participants who use tobacco. Account for 25% of filings so far in 2026.

- Under ERISA's non-discrimination provisions, plans generally cannot discriminate in coverage provided or premiums charged based on "health status-related factors"
 - But group health plans are allowed to adjust premiums, copays, and deductibles "in return for adherence to programs of health promotion and disease prevention." 29 U.S.C. § 1182(b)(2)(B) (i.e., wellness plans)
- Many plans include a form of "tobacco-free" wellness program designed to incentivize participants to quit using tobacco to help offset the higher healthcare costs associated with participant tobacco use
 - The reward is typically avoidance of an increased insurance premium (i.e., a surcharge).
 - Plan participants who do not use tobacco products automatically obtain the reward
 - Plan participants who use tobacco products often have the opportunity to attend a tobacco cessation program to obtain the reward and either avoid the surcharge or obtain a refund

Smoking Surcharge Lawsuits, a Summary

- Generally allege violations in 4 ways:
 1. Claim the program design does not afford adequate opportunity for “full reward”
 - Many cases involve questions of extent to which “full reward” requires retroactive reimbursement
 2. Claims assert that tobacco users are charged a surcharge without a reasonable alternative to avoid the surcharge
 - Questions over reasonableness of deadlines to complete alternative standard
 3. Notice claims regarding availability of alternative standard to avoid surcharge
 - Questions of (1) when must notice be provided; and (2) what must notice say
 4. Fiduciary breach claims, most often focused on allegations of failure to act in participants’ best interests.
- Cases are mostly in early stages, but prevalence of claims provides reminder to plan sponsors and fiduciaries to consider plan design and administration, to ensure compliance with safe harbor provisions for wellness programs
- Cases likely to turn on technical elements of regulations, plan terms, and administrative practices
 - Many courts have been reluctant to dismiss claims at pleading stage
 - Because plausibility of claims turns directly on interpretation of statutory and regulatory requirements, denial of motion to dismiss has pushed several cases to settle shortly thereafter
- Employers may benefit from fulsome review, even in absence of suit

Impact of *Loper* *Bright v. Raimondo*



Loper Bright v. Raimondo

- In June 2024, the Supreme Court overturned *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 468 U.S. 837 (1984) ending 40 years of deference to administrative agencies
- *Loper Bright* directs that courts, not agencies, are best situated to interpret ambiguous statutory provisions, even in areas of agency expertise.
- The decision did not immediately change any agency regulations or actions, but has repeatedly shown up in decisions (across various topics) as an additional basis for rejecting administrative interpretations of statutes.
- Because of the extensive administrative regulations surrounding ERISA, the lowered deference may spur significant litigation
- Additionally, certain safe harbors may be in jeopardy if the relevant DOL regulations are held to conflict with the statutory language.

Tobacco Surcharge: Application of Loper Bright

- **The dispute.** In one case participants challenged Plan's s tobacco surcharge, including its failure to provide DOL's required physician-accommodation notice.
- **Independent interpretation under Loper Bright.** The court examined the statute itself and found no requirement to notify participants that the plan would accommodate their physician's recommendations.
- **General rulemaking authority was insufficient.** The court declined to defer to DOL's regulation. A general grant of rulemaking power did not authorize DOL to add notice obligations beyond those Congress specified.
- **Result.** The additional notice requirement could not support plaintiffs' claim. The court dismissed the action, separately accepting the defendant's plan interpretation on the "full reward" issue.

Pension Risk Transfer Litigation



Pleading Standards in Pension Risk Transfer Cases

Another relatively new active area of claims concerns pension risk transfers –the process of an employer limiting or eliminating its defined-benefit pension obligations by using plan assets to purchase annuities from an insurer, which assumes the responsibility of future payments

These claims assert **fiduciary breaches on the theory that the annuity is a riskier investment than the original pension plan assets**

The law in this area is underdeveloped compared to other fiduciary breach claims

Piercy, 2025 WL 2505660 (D. Mass. Aug. 29, 2025), addresses these standards in detail

Pension Risk Transfer Litigation

- **Seven tracked cases: four dismissals, one mixed ruling, two other surviving cases**
- Since March 2024, ~15 suits allege imprudent annuity-provider selection or prohibited transactions, while acknowledging PRTs are lawful. Alleged damages include transaction spread (liabilities versus assets transferred), PBGC premium savings, administrative savings, and lost federal protections.
- **Four standing dismissals**
 - Camire (D.D.C.), Bueno (N.D.N.Y.), and Dempsey (S.D.N.Y.). In Schoen (W.D. Pa.), the district court adopted the dismissal recommendation. Schoen is on appeal.
- **Piercy v. AT&T: mixed ruling on amended complaint (D. Mass. Sept. 28, 2026)**
 - Standing: receiving an allegedly riskier, less valuable annuity sufficed. Plaintiffs need not allege reduced monthly payments or imminent insurer insolvency.
 - Prudence claim against independent fiduciary survived: new comparator and affiliated-transaction allegations plausibly challenged its selection process. The court deferred disputes over metrics, available providers, and separate-account risk.
 - Other claims dismissed, including claims against defendant: plaintiffs did not sufficiently allege interference in selection, ignored red flags, or deficient monitoring after delegation to the independent fiduciary.
- **Two other cases survived dismissal and are on appeal**
 - Konya (D. Md.): Fourth Circuit appeal. DOL supports the employer. Oral argument occurred September 16, 2026.
 - Doherty v (S.D.N.Y.): Second Circuit appeal.
- These are pleading-stage outcomes, not final determinations of fiduciary liability.

Mental Health Parity Litigation

Mental Health Parity Act Litigation

- ERISA requires that most plans provide equivalent benefits for mental health as those provided for medical and surgical care 29 U.S.C. § 1185a
- Mental Health Parity Act
 - requires group health plans and insurers to cover treatments for mental health and substance use disorders in a manner that is equal to the plans' coverage of medical and surgical treatments
- 2025 has seen continued litigation regarding both plan language that appears to treat mental health benefits differently, as well as benefit decisions that appear to do so in practice
- The pace of litigation largely tracked 2024
- The single busiest jurisdiction (comprising approximately 1/4 of all parity cases filed in 2025) is the District of Utah

What the Mental Health Parity Act requires

Regulates limits on mental health and substance-use-disorder benefits when a plan also provides medical and surgical benefits.

The core rule

- Treatment limitations on mental health benefits may be no more restrictive than the predominant limitations applied to substantially all comparable medical and surgical benefits.
- NQTL Comparison
 - Mental Health / SUD
 - Processes
 - Strategies
 - Evidentiary standards
 - Other factors

Two types of limits

- Quantitative limits use numbers, such as visit caps. Nonquantitative treatment limitations, or NQTLs, restrict scope or duration without a numerical cap.
- Comparable?
 - Designed comparably and applied no more stringently

Classification matters

- The comparison is made within the same benefit classification. A plaintiff must identify an appropriate medical or surgical comparator in that classification.
- Medical / Surgical
 - Same processes
 - strategies
 - evidentiary standards
 - factors

Mental Health Parity Act Litigation

- Welfare plan fiduciaries should be cognizant of mental health provisions in plans and ensure that these provisions are applied in an equivalent manner to provisions for medical and surgical care
- Plans should be particularly careful regarding exclusions (whether in plans or on lists of providers) that can be interpreted as specifically targeting certain mental health services

The two principal parity theories

A challenge may target the written plan on its face or the way a facially neutral limitation was applied in practice.

Facial Challenge

- Question: Does the plan use comparable processes, strategies, evidentiary standards, and other factors when developing the NQTL for mental health and medical or surgical benefits?
- Focus: The terms and design of the operative plan.

As-Applied Challenge

- Question: Was the same limitation administered more stringently for the mental health benefit at issue?
- Focus: The actual claims-handling process and application.

Common NQTL examples:

- Preauthorization requirements
- Network-admission standards
- Geographic restrictions
- Provider-specialty criteria
- Facility-type restrictions

What a plaintiff must plausibly plead

Covered plan	The plan is subject to the Parity Act.
Specific limitation	Identify the quantitative limit or NQTL challenged.
Same classification	Identify a comparable medical/surgical benefit in the same classification.
Both benefit types	The plan provides medical/surgical and mental health benefits.
More restrictive treatment	Plead facts showing the limit is more restrictive for mental health.
Causal connection	Connect the alleged disparity to the denial or injury asserted.
Not enough: conclusory allegations that mental health claims are treated differently, without facts about the medical/surgical comparator or claims-handling standard.	

Example defenses at the pleading stage

- **No disparate limitation**
 - The same preauthorization rule applies to all non-emergent inpatient services, whether mental health or medical/surgical.
- **No facts showing stricter application**
 - The complaint does not identify any process, strategy, evidentiary standard, or factor applied more stringently to mental health benefits.
- **Plan terms independently defeat benefits**
 - For example, certain plans state that elective, out-of-state, out-of-network inpatient treatment is not covered absent preapproval
- **No traceability or standing**
 - The alleged network deficiency did not cause the denial where the facility was out of network and preauthorization was not obtained.
- **Relief is legal, not equitable**
 - A demand for payment from general assets cannot be repackaged as equitable relief under ERISA § 502(a)(3).

Mental Health Parity Act Litigation

- *T.E. v. Anthem Blue Cross and Blue Shield*, 165 F.4th 971 (6th Cir. 2026)
 - The Court of Appeals affirmed summary judgment in favor of a plan on a Parity Act claim.
 - The Plaintiff claimed that the insurer misapplied its mental health guidelines, but not its medical/surgical guidelines.
 - The Court of Appeals rejected the claim because even if a Parity Act cause of action exists—a question the Court did not reach—there was no evidence in the record regarding the different guidelines and how they operate.



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