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BY JEFFREY S. KLEIN AND NICHOLAS J. PAPPAS

Effect of Conflict of Interest on Standard of Review

On June 19, 2008, in *Metropolitan Life Ins. Co. v. Glenn*, 128 S.Ct. 2343, 2346, 2350-51 (2008), the U.S. Supreme Court held that under the Employee Retirement Income Security Act (ERISA) a plan administrator that both determines eligibility for benefits and is responsible for paying benefit claims operates under an inherent conflict of interest, which must be considered by a court reviewing claim denials.

Such an inherent conflict of interest does not, however, change the standard of review applied by a reviewing court under ERISA, but is simply one factor among many for the court to take into account. The significance of the conflict depends on all the facts and circumstances applicable to the case.

The Supreme Court's opinion in *Glenn* is significant for any administrator of a self-insured or unfunded plan, as well as insurance companies administering fully insured plans. As a result of *Glenn*, such administrators are now deemed to be operating under an inherent, structural conflict of interest and will want to take special precautions to ensure that their decisions are seen as unbiased by any reviewing courts.

In this article, we analyze the *Glenn* case and offer some suggestions to plan administrators and insurers as to how they may wish to reassess their claims processes or procedures in light of the principles announced by the Supreme Court in *Glenn*.

Background

ERISA does not prescribe the standard of review for courts reviewing denials of benefits by plan administrators. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 (1989). Initially, courts applied the "arbitrary and capricious" standard of review from the Labor Management Relations Act of 1947 (LMRA) to ERISA claims for benefits, on the theory that ERISA's fiduciary-duty provisions are similar to the fiduciary provisions in the LMRA. See generally id. In *Firestone Tire & Rubber Co. v. Bruch*, however, the Supreme Court disapproved of the arbitrary and capricious standard of review as the default standard under ERISA, and held that denials of benefit claims should be reviewed de novo, unless the plan document specified otherwise. 489 U.S. 101, 115 (1989).

In *Firestone*, the Court used trust principles to hold that a denial of benefits should be reviewed by a court de novo unless the plan grants discretionary authority to the administrator to determine eligibility for benefits or construe terms of the plan. Id. at 115. If, however, the plan grants the administrator discretion to interpret and apply plan terms, the Court instructed that any conflict of interest should be "weighed as a factor in determining whether there is an abuse of discretion." Id. Yet, while the Court noted that a conflict of interest should be a factor in deciding whether an administrator abused its discretion, the Court declined to provide additional guidance regarding such inquiries.

Jeffrey S. Klein *Nicholas J. Pappas*

After *Firestone*, the circuit courts split over whether an administrator's dual roles of evaluating and paying benefit claims constitutes an inherent conflict of interest,[1] and, if a conflict of interest does exist, how such conflict should affect a court's review of the administrator's decision. The circuit courts developed three basic approaches for determining the impact of an administrator's conflict of interest on claims denials:

- sliding scale review, under which the administrator's decision is reviewed under an abuse of discretion standard, but the degree of deference afforded varies based on the severity of the conflict[2];
- de novo review, which applies if the claimant provides evidence that a conflict existed and that it in fact influenced the administrator's decision[3]; and
- burden-shifting, under which the burden of proof shifts to the administrator to prove the reasonableness of its decision under an arbitrary and capricious standard if a conflict exists.[4]

'MetLife v. Glenn'

Metropolitan Life Ins. Co. (MetLife) served as both the administrator and insurer of the Sears, Roebuck & Co. Long-Term Disability (LTD) Plan. Id. As administrator, MetLife had the discretionary authority to determine employee benefit claims, and as the insurer, MetLife also paid the claims. Id.

In June 2000, Wanda Glenn, a Sears employee, applied for LTD benefits after being diagnosed with a severe heart condition. Id. MetLife determined that Ms. Glenn was disabled within the plan's standard for an initial 24 months of benefits on the basis of her inability to perform the material duties of her own job. Id. MetLife also sent Ms. Glenn to a law firm to assist her in applying for Social Security disability benefits, some of which MetLife itself would be entitled to receive as an offset to the more generous

Jeffrey S. Klein *and* **Nicholas J. Pappas** *are partners at Weil, Gotshal & Manges, where they practice labor and employment law.* **A. Millie Warner,** *an associate at the firm, assisted in the preparation of this article.*

plan benefits. Id. In April 2002, after an administrative law judge found that Ms. Glenn was unable to perform any job for which she could qualify, the Social Security Administration (SSA) granted Ms. Glenn permanent disability payments retroactive to April 2000. Id. at 2346-47.

As a condition to continuing to receive Sears LTD plan benefits after 24 months, Ms. Glenn had to meet a stricter standard that governs entitlement to federal Social Security benefits, i.e., that her medical condition rendered her incapable of performing not only her own job, but of performing "the material duties of any gainful occupation for which she was reasonably qualified." Id. at 2347. MetLife denied Ms. Glenn's application for extended benefits, finding that she was capable of performing full-time sedentary work. Id.

After exhausting her administrative remedies, Ms. Glenn sought judicial review of MetLife's denial of extended disability benefits. Id. The district court denied relief and Ms. Glenn appealed to the U.S. Court of Appeals for the Sixth Circuit. Id.

The Sixth Circuit

Because Sears' LTD plan granted MetLife "discretionary authority to…determine benefits," the Sixth Circuit reviewed the administrative record under the deferential abuse of discretion standard. Id. In doing so, the Sixth Circuit considered as a relevant factor an inherent conflict of interest arising from MetLife's dual plan roles of benefit eligibility adjudicator and the payer of benefits. Id. The court ultimately set aside MetLife's denial of benefits in light of a combination of several circumstances, including:

(i) the conflict of interest;

(ii) MetLife's failure to reconcile its own conclusion that Ms. Glenn could work in other jobs with the conclusion of the Social Security Administration that she could not;

(iii) MetLife's reliance on one treating physician's report that suggested that Ms. Glenn could work in other jobs while giving little consideration to other, more detailed treating physician reports that indicated that she could not;

(iv) MetLife's failure to provide all of the treating physician reports to its own hired experts; and

(v) MetLife's failure to take account of evidence indicating that stress aggravated Ms. Glenn's condition. Id.

The Supreme Court

The Supreme Court first addressed the question of "whether the fact that a plan administrator both evaluates claims for benefits and pays benefit claims creates the kind of 'conflict of interest' to which *Firestone*…refers." That such a conflict exists where the "employer both funds the plan and evaluates the claims" was "clear" to the Court, as "every dollar provided in benefits is a dollar spent by…the employer; and every dollar saved…is a dollar in [the employer's] pocket." *Glenn*, 128 S.Ct. at 2348.

Less clear, however, was whether a conflict necessarily exists where the plan administrator is not the employer, but the insurance company that also pays the benefits. Id. at 2349. Despite MetLife's position that an insurer would have a greater incentive than a self-funded employer to provide accurate claims processing, because of the insurer's administrative fee structure, the fair claim processing rules under state insurance laws, and the competitive marketplace for administrative services, the Court found that a conflict existed. Id. The Court reasoned that the employer's own conflict of interest could extend to its selection of an insurance company to administer its plan, ERISA imposes higher-than-marketplace quality standards on insurers, and a legal rule that treats insurance company administrators and employers alike in respect to the existence of a conflict can nonetheless take account of the circumstances surrounding how the insurer treats those, or similar, circumstances as diminishing the significance or severity of the conflict in individual cases. Id. at 2350.

The U.S. Supreme Court held that under ERISA a plan administrator that both determines eligibility for benefits and is responsible for paying benefit claims operates under an inherent conflict of interest, which must be considered by a court reviewing claim denials.

Having found that MetLife had operated under a conflict of interest, the Court turned to the question of how the conflict should be taken into account in reviewing Ms. Glenn's claim denial. The Court refused to overturn *Firestone* by adopting a rule that in practice would bring about a near universal review de novo, without deference, of most ERISA claim denials. Id. Instead, it held that a reviewing judge should take account of the conflict when determining whether the administrator or insurer has abused its discretion. The Court also did not find it necessary to create special rules focused narrowly on the evaluator/payor conflict. Id. at 2351. The conflict is simply one factor for judges to take into account when they review the lawfulness of benefit denials. It is a factor that will be more important where circumstances suggest a higher likelihood that the conflict affected the decision, such as when the administrator has a history of biased claims administration, and less important where the administrator has taken active steps to reduce potential bias or promote accuracy, such as penalizing inaccuracy irrespective of whom the inaccuracy benefits. Id.

The Court agreed with the Sixth Circuit's earlier appraisal that the existence of the conflict was not, in itself, dispositive of the issue, but merely was a factor to be considered, and that the other aspects of MetLife's conduct of Ms. Glenn's administrative appeal, when taken into consideration alongside the conflict of interest, pointed to an abuse of discretion in denying Ms. Glenn's claim. The Court referred to this as the "combination of factors" standard. Id.

Dissent: 'Paper Bag Approach'

Although the Court was unanimous in concluding that an insurance company that both decides benefit claims and pays for benefits suffers from a structural conflict of interest, Justices Antonin Scalia and Clarence Thomas dissented from the majority's "combination of factors" or "totality-of-the-circumstances" test for weighing a conflict of interest. Id. at 2357-58. The dissent criticized the majority for taking a so-called "brown paper bag approach," where several factors are "chucked into a brown paper bag and shaken up to determine the answer." Id. at 2358. The dissent found the resulting unpredictability of the majority's position to be an unreasonable position in which to place an administrator who has been granted discretion by the settlor of the plan. Id. Moreover, in the dissent's opinion, a conflict of interest should not affect the court's review of a fiduciary's decision

unless the conflict "*actually and improperly motivate[d]* the decision." Id., (emphasis in original).

Impact of 'Glenn,' Advice

Several circuit courts likely will be affected by the Supreme Court's decision in *Glenn*, in particular, the First and Seventh circuits, which have held that the fact that an administrator pays claims and makes benefit decisions is not, by itself, a conflict of interest.[5]

Perhaps the most significant impact of *Glenn* is that it makes clear that indirect evidence may be used to establish that a conflict of interest affected a benefits decision. Accordingly, fiduciaries and plan sponsors should consider taking several steps to increase the likelihood that a reviewing court will grant deference to the fiduciary's decisions.

First, plan sponsors should consider establishing separateness between claims administrators and finance personnel. Many sponsors establish administrative committees comprised of human resources and finance employees. However, in light of the statement in *Glenn* that "walling off claims administrators from those interested in firm finances" may be viewed as an "active step[] to reduce potential bias," plan sponsors should consider creating separate committees: one to decide benefits claims and one to handle any investment or financial matters with respect to the plan(s).

To the extent practicable and cost-effective, administrators can increase the level of deference courts will give them to the extent they establish and follow procedures or guidelines for reviewing claims and document their review process. Administrators should seek to follow their own precedent and seek to avoid rendering inconsistent decisions. Administrators should be aware that plan participants may later argue that a lack of procedure or procedural irregularities evidence bias in claims processing.

Administrators increase the likelihood that their decisions will be respected if they produce thorough, well-reasoned denial letters. Administrators may seek to carefully set forth their analysis of the relevant evidence and their reasons for reaching particular decisions. Such analysis would allow the administrator to rebut any apparent inconsistency in the evidence and provide a basis which could help to avoid an inference of bias.

Plan sponsors should encourage accurate claims processing, and should avoid establishing any policies that might inappropriately incentivize claims denials. For example, in his concurrence in *Glenn* Chief Justice John G. Roberts cited a policy of providing bonuses to claims reviewers for "claims savings" as evidence that a conflict influenced an administrator's decision. Plan sponsors should, therefore, ascertain whether any claims administrators' compensation could be seen as rewarding claims denial. As the majority in *Glenn* cited the imposition of "management checks that penalize inaccurate decision-making irrespective of whom the inaccuracy benefits" as another "active step[] to reduce potential bias," plan sponsors might want to consider providing affirmative incentives for rendering accurate decisions.

Along the same lines, in adjudicating claims, administrators should not consider the financial impact of granting a claim. Administrators should not inquire about the amount of the claim, and, to the extent practical, should not access such information before a decision has been issued.

Finally, plan sponsors should perform adequate due diligence before selecting a third-party claims administrator. A history of biased claims administration, or a pattern or practice of unreasonably denying meritorious claims, was cited as adverse evidence by both the majority in *Glenn* and Chief Justice Roberts in his concurrence. Plan sponsors may, therefore, wish to ask a potential third-party administrator for its ratio of benefit claims approvals to denials. Further, sponsors may wish to check on how courts have treated claims decisions by that administrator in the past.

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1. The First and Seventh circuit courts of appeals have held that the mere fact that an administrator pays claims and makes benefit decisions does not constitute an inherent conflict of interest. See, e.g., *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005); *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999).

The Second Circuit has taken an analogous stance, holding that the mere fact of a plan administrator's dual roles does not "trigger stricter review" unless the plaintiff shows that "the administrator was in fact influenced by the conflict of interest." *Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2000) (quoting *Sullivan v. LTV Aerospace & Def. Co.*, 82 F.3d 1251, 1255-1256 (2d Cir. 1996)). Similarly, the Eighth Circuit has previously required, as a condition for heightened review, "material, probative evidence demonstrating that (1) a palpable conflict of interest or a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to her." *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160-1161 & n.2 (8th Cir. 1998).

2. See, e.g., *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 87 (4th Cir. 1993); *Vega*, 188 F.3d at 297; *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006) (en banc).

3. *Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2000) (quoting *Sullivan v. LTV Aerospace & Def. Co.*, 82 F.3d 1251, 1255-1256 (2d Cir. 1996)).

4. *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004). Under the Eleventh Circuit's version of the burden shifting approach, the court determines, de novo, whether or not the denial of benefits was "wrong." *Brown v. Blue Cross & Blue Shield of Ala. Inc.*, 898 F.2d 1556, 1566 (11th Cir. 1990). If the benefit denial was correct, the administrator's decision is affirmed; if it was wrong, "the burden shifts to the administrator to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest." Id. If the administrator meets that burden, abuse-of-discretion review applies. See *HCA Health Servs. of Ga. Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 993-995 (11th Cir. 2001). If the administrator does not meet that burden, the court reverses the administrator's decision, having already determined on de novo review that it was erroneous. Id.

5. Indeed, the First Circuit has already vacated a decision as a result of *Glenn*. On July 2, 2008, the First Circuit vacated its decision in *Denmark v. Liberty Life Assurance Co. of Boston*, No. 05-2877, in which the court addressed the standard of review to be applied in situations where an employee benefit plan insurer operates under a conflict of interest, and agreed to reexamine its holding in light of the Supreme Court's decision in *Glenn*.