Metropolitan Life Insurance Co. v. Glenn: "Conflict of Interest" is a Factor in Reviewing An ERISA Plan Administrator's Denial of Benefits

On June 19, 2008, the United States Supreme Court issued a decision in *Metropolitan Life Insurance Co.* v. *Glenn*,[1] an important case relating to the standard of judicial review for benefit claims determinations under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").[2] The majority decision held that (i) a plan administrator who both evaluates benefit claims and pays benefit claims operates under a conflict of interest and (ii) such conflict of interest is a factor in determining whether the plan administrator has abused its discretion. The Court held that it is appropriate to take the presence of such conflict into account in reviewing a determination made by an insurer in respect of a claim (as was done by the Court of Appeals in this case), but the decision does not provide clear guidance as to the precise analytic steps a court should follow in carrying out such a review. While the Court affirmed the decision of the Court of Appeals in this case, we will have to wait to see how other courts will apply this ruling in reviewing benefit claims determinations in the future. In response to the decision, claims administrators might want to consider adopting one of the structural steps suggested by the majority decision for reducing (and possibly eliminating) the significance of the conflict, such as walling off the claims administrators from those interested in firm finances or imposing management checks that penalize inaccurate decisionmaking regardless of whom the inaccuracy benefits.

I. Facts and Procedural History

Sears, Roebuck & Company ("Sears") maintained a long-term disability insurance plan, an employee benefit plan subject to ERISA.[3] Metropolitan Life Insurance Company ("MetLife") served as both plan administrator, with the authority to determine the validity of an employee's claims for benefits, and insurer of the plan, responsible for payment of valid benefit claims.[4]

Wanda Glenn, a Sears employee eligible for benefits under its long-term disability plan, was diagnosed with a severe heart condition.[5] After Glenn's application for plan disability benefits in June 2000, MetLife concluded that she satisfied the plan's standard for an initial 24 months of benefits (i.e., she could not "perform the material duties of [her] own job") and directed her to a law firm which would assist her in applying for federal Social Security benefits.[6] In April 2002, an Administrative Law Judge found that Glenn's illness prevented her not only from performing her own job (the standard for benefits under the Sears long-term disability plan), but also from "performing any jobs [for which she could qualify] existing in significant numbers in the national economy" (a federal standard more stringent than under the Sears plan), and granted her permanent disability payments retroactive to April 2000.[7] Glenn did not keep any of the backdated benefits, as three-quarters of the

[1] No. 06-923, slip op. (U.S. June 19, 2008).

[2] 29 U.S.C. 1001 *et seq.*

[3] *Metlife,* slip op. at 1.

[4] *Id.* at 2.

[5] *Id.*

[6] *Id.*

[7] *Id.*

benefits went to MetLife as an offset to the more generous Sears plan benefits and the remainder, plus additional money, went to the lawyers.[8]

In order to receive benefits under the Sears plan *after* the initial 24 month period, Glenn had to demonstrate that she was incapable of performing "the material duties of any gainful occupation for which" she was "reasonably qualified," a standard similar to that required for federal Social Security disability benefits.[9] In denying Glenn the extended benefit, MetLife determined that she was "capable of performing full time sedentary work."[10]

Glenn exhausted the administrative remedies available for review of MetLife's denial of benefits and then brought suit in federal district court pursuant to §502(a)(1)(B) of ERISA[11], which authorizes civil actions by a plan participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." After the district court denied relief, Glenn appealed to the Court of Appeals for the Sixth Circuit. The Court of Appeals applied a deferential standard in its review of the plan administrator's decision, "because the plan at issue granted the plan administrator discretionary authority to interpret the terms of the plan and to determine benefits" but concluded that MetLife's "dual function" of both deciding whether an employee is eligible for benefits and paying such benefits "creates an apparent conflict of interest."[12] The Court of Appeals further concluded that MetLife's decision to deny long-term benefits to Glenn was "arbitrary and capricious."[13] The Court of Appeals based its conclusion on a combination of several circumstances: (i) the conflict of interest, (ii) MetLife's failure to address the determination by the Social Security Administration that Glenn was totally disabled, (iii) MetLife's focus on a brief form filled out by the treating physician while ignoring his detailed reports, (iv) MetLife's failure to provide all of the treating physician reports to its own hired experts, and (v) MetLife's failure to factor in the role that stress played in aggravating Glenn's condition.[14] The Court of Appeals reversed the judgment of the district court and remanded the case with directions to reinstate Glenn's long-term disability benefits, retroactive to the date they were terminated. On appeal, the United States Supreme Court affirmed the decision of the Court of Appeals.

II. Existence of "Conflict of Interest"

Justice Breyer, writing for a majority of the Supreme Court, concluded that a plan administrator who both evaluates claims for benefits and pays benefits claims, whether an employer or a professional insurance company, operates under a "conflict of interest."[15] Justice Breyer stated that such a conclusion is clear when it is the employer that both evaluates claims and funds the plan, as "the employer's fiduciary interest may counsel in favor of granting a borderline claim while its immediate financial interest counsels to the contrary."[16] That conclusion is not altered by the fact that an employer who establishes a plan that it will both fund and administer "foresees,

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8 *Id.*

9 *Id.*

10 *Id.*

11 29 U.S.C. §1132(a)(1)(B)

12 *Glenn v. MetLife*, 461 F.3d 660, 666 (6th Cir. 2006).

13 *Id.* at 674.

14 *Id.*

15 *Metlife,* slip op. at 5.

16 *Id.*

and implicitly approves, the resulting conflict."[17] While this conclusion is less clear when the plan administrator is a professional insurance company which "likely has a much greater incentive than a self-insuring employer to provide accurate claims processing," the Court nevertheless found that a conflict also exists for ERISA purposes in such situations.[18] The Court reasoned that "ERISA imposes higher-than-marketplace quality standards on insurers" and that "an employer's own conflict may extend to its selection of an insurance company to administer its plan."[19]

III. Judicial Review of Discretionary Benefit Determinations

In determining how a conflict of interest should be taken into account on judicial review of a discretionary benefit termination, the Court looked to its prior decision in *Firestone Tire & Rubber Co. v. Bruch.*[20] In *Firestone*, the Court determined that in establishing the appropriate standard of review under 29 U.S.C. §1132(a)(1)(B), a court should be "guided by principles of trust law."[21] "Trust law continues to apply a deferential standard of review to the discretionary decisionmaking of a conflicted trustee, while at the same time requiring the reviewing judge to take account of the conflict when determining whether the trustee, substantively or procedurally, has abused his discretion."[22] Therefore, a conflict of interest should "be weighed as a 'factor in determining whether there is an abuse of discretion.'"[23] The Court clearly stated that it did not wish to change the standard of review set forth in *Firestone* (e.g., to a *de novo* standard of review) and did not deem it necessary to create special burden-of-proof or procedural rules which would add time and expense to the process. The Court emphasized that "[b]enefits decisions arise in too many contexts, concern too many circumstances, and can relate in too many different ways to conflicts" to establish such rules.[24] It is important to note that, according to the Court, a conflict is a factor to be weighed by a judge regardless of whether there is any indication that such conflict in fact influenced or affected the administrator's denial of benefits. This type of "totality of the circumstances" review is similar to the approach taken in both trust law and administrative law, where judges "determine lawfulness by taking account of several different, often case specific, factors, reaching a result by weighing all together."[25] In applying this approach, a conflict of interest "should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision" (e.g., where an insurance company administrator has a history of biased claims administration) and "should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and to promote accuracy."[26] The Court mentioned as examples of such steps "walling off claims administrators from those interested in firm finances" or "imposing management checks that penalize inaccurate decisionmaking irrespective of whom the inaccuracy benefits."[27]

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[17] *Id.* at 6.

[18] *Id.* at 7.

[19] *Id.* at 8.

[20] *Firestone Tire & Rubber Co. v Bruch*, 489 U.S. 101 (1989).

[21] *Id.* at 111.

[22] *Metlife,* slip op. at 9.

[23] *Id.* at 9 quoting *Firestone,* 489 U.S. 101 at 115 (quoting restatement §187, Comment *d*; alteration omitted).

[24] *Id.* at 10.

[25] *Id.*

[26] *Id.* at 11.

[27] *Id.*

IV. Concurring Opinions and Dissent

Chief Justice Roberts concurred in the judgment but would consider the presence of a conflict of interest "only where there is evidence that the benefits denial was motivated or affected by the administrator's conflict."[28] Justice Kennedy concurred with the Court's framework for the standard of review in ERISA cases,[29] but dissented from the Court's order affirming the judgment of the Court of Appeals as he thought that the case should have been remanded to the Court of Appeals so that the Court of Appeals could have applied the standards set forth in the Court's ruling to the applicable facts.[30] Justice Scalia, joined by Justice Thomas, dissented, arguing that "[a] trustee's conflict of interest is relevant (and *only* relevant) for determining whether he abused his discretion by acting with an improper motive," and that "the only possible basis for finding an abuse of discretion in this case would be unreasonableness of [MetLife's] determination of no disability."[31]

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If you have any questions about the issues addressed in this memorandum or if you would like a copy of any of the materials mentioned, please do not hesitate to call or email Michael Macris at 212.701.3409 or mmacris@cahill.com; Jon Mark at 212.701.3100 or jmark@cahill.com; John Schuster at 212.701.3323 or jschuster@cahill.com; Glenn Waldrip, Jr. at 212.701.3110 or gwaldrip@cahill.com; Andrew Blau at 212.701.3316 or ablau@cahill.com.

[28] *Id.* at 1 (Roberts, C.J., concurring).

[29] *Id.* at 1 (Kennedy, J., concurring).

[30] *Id.* at 3 (Kennedy, J., concurring).

[31] *Id.* at 7,8 (Scalia, J., dissenting).

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