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Where an insurance company both determines an appeal for ERISA benefits and also pays that claim, a conflict of interest is present. The U.S. Supreme Court in *Metropolitan Life v. Glenn*, holds that where the language of a plan grants the administrator discretionary review of claims, this conflict will be taken into account as a "factor" to be weighed in determining whether judicial deference should be given to the administrator's decision.

The Supreme Court Considers Conflicts of Interest in Benefit Claims Procedures

By Russell D. Chapman

On June 19, 2008, the Supreme Court issued an opinion in *Metropolitan Life Insurance Co. v. Glenn*, holding that where an insurance company both determines an appeal for ERISA benefits and pays that claim, a conflict of interest as described in *Firestone v. Bruch* is presented. Where the language of a plan grants the administrator discretionary review of claims, this conflict must be taken into account as a "factor" to be weighed in determining whether judicial deference should still be accorded to the administrator's decision.

Facts of the Case

Wanda Glenn was a participant in the Sears long-term disability plan that was insured and administered by MetLife. The plan's disability standard required the participant to be unable, due to the disability, to engage in any gainful occupation or employment - a standard similar to the "Social Security" disability standard. Glenn suffered from a heart condition, and at MetLife's suggestion, applied for and obtained a ruling from the Social Security Administration that she was completely disabled. Later, MetLife concluded that she could engage in sedentary occupations, and the company denied her claim. The district court upheld MetLife's denial of the claim, but the Sixth Circuit Court of Appeals reversed. The Supreme Court granted *certiorari* to determine whether the fact that MetLife both insured the plan and determined the claim was a conflict of interest as described in *Firestone*, and if so, what effect it would have in reducing the level of deference to be granted to MetLife's decision to deny benefits.

Justice Breyer, writing for a 7-2 Court, held for Ms. Glenn, and affirmed the Sixth Circuit's decision.

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Court set out four principles for judicial review of ERISA administrator decisions on benefit claims.

1. The courts are to be guided by trust principles.
2. The appropriate standard of review is de novo, unless language in the plan documents grant the administrator discretion in making the decision. This language has come to be known as "*Firestone* language."
3. Where discretion is granted to the administrator - that is, Firestone language is present - the courts must honor that grant by according the administrator's decision deferential review, *i.e.*, overturning the decision only if the administrator abused its discretion.
4. Even where the plan includes *Firestone* language, if the administrator is operating under a conflict of interest, that conflict is weighed as a factor in determining whether there has been an abuse of discretion.

The Court held that where the administrator with the authority to make the claim determination also has the obligation to pay that claim, it is operating under a conflict of interest as described in the fourth *Firestone* principle. MetLife argued that market forces require insurers to determine claims fairly and accurately, rendering mitigation of *Firestone* deference unnecessary. The Court rejected this argument, noting that ERISA places "higher-than-marketplace quality standards" on insurance companies who act as ERISA fiduciaries, since they must act in that capacity "solely in the interests of par-

ticipants and beneficiaries." MetLife's "marketplace" arguments, the Court held, go to the "significance or severity" of the conflict, not to its existence.

In analyzing the extent to which the conflict would be taken into account in the review process, the Court noted that where the *Firestone* language is present, *de novo* review is not appropriate, and the standard remains deferential review. The Court also cautioned that it is not necessary for the lower courts to fashion special burden-of-proof or other procedural or evidentiary rules regarding the administrator-as-payor conflict. Rather, the language used in *Firestone* remains the standard, but where the administrator is conflicted, the degree of the conflict is a "factor" to be weighed according to the facts of the case. Where the issue is a close one, the conflict may serve as a "tiebreaker," and will weigh more heavily if it appears the conflict actually affected the administrator's decision.

The Court noted that this was apparently what happened in the Sixth Circuit's review. The Sixth Circuit noted that MetLife suggested that Glenn obtain Social Security disability benefits, then ignored that finding of disability, emphasized one medical report that favored denial, while rejecting others that favored granting benefits, and failed to provide all of the medical evidence to its own experts.

Finally, the Court noted a connection between ERISA's deferential standard and that employed by the courts in the context of reviewing agency rulings, noting that it would not provide a "detailed set of instructions" for use in weighing the factors to be considered in evaluating such decisions, indicating that the analysis of conflict situations would be on a case-by-case basis.

What Should Plan Sponsors and Administrators Do?

Because this case may well result in more lawsuits over denied benefit appeals, plan sponsors and administrators must become more attuned to the necessity of fully documenting their claims review processes, ensuring that all relevant materials (particularly those submitted by the claimant) are addressed in the denial letter, and avoiding inconsistent or irreverent comments in e-mails and other correspondence relating to benefit claims.

Also, to the extent this factor can be addressed as a practical matter, plan sponsors should separate the claims administrative function from the source of benefit payment to the extent possible. For a self-insured plan, this may mean appointing an independent claims review administrator, or appointing employees to a claims review committee who are not associated with the financial performance of the company and who were not responsible for the original claim decision.

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