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Client Advisory

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MetLife v. Glenn: Supreme Court Cautions on Conflicted Fiduciaries Deciding Claims

On June 19, 2008, the U.S. Supreme Court issued its decision in *Metropolitan Life Insurance Co. v. Glenn* ("*Glenn*").[1] Sponsors and administrators of employee benefit plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA") need to be aware of this decision and its implications for plan administration and the governance structure of plans.

Glenn involved denial of both a claim and appeal for benefits and a suit under ERISA challenging the decision maker's determination. The issue is whether, and to what extent, a court in an ERISA suit should take into account the fact that the decision maker is the same party who must pay benefits. The decision maker in *Glenn* was the insurance company through which benefits were insured, but the Court made it very clear that the issue is also present where it is an employer who funds the plan and makes claims determinations. The Court's conclusions make it imperative for plan sponsors and administrators to examine and address such conflicts of interest in their plans' claims administration process.

Background

Plans subject to ERISA must have "reasonable procedures" for the filing of claims for benefits, notice of determinations on those claims, and appeal of adverse determinations.[2] In addition, ERISA provides that a plan participant (or beneficiary) may bring a suit in court "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."[3]

With very limited exceptions, courts have consistently held that a participant must "exhaust" his or her administrative remedies under the plan before filing a suit for benefits under ERISA. The participant must have made a claim, received a denial, appealed and been denied on appeal, all as provided in the plan's claims procedures, before filing suit.

In 1989, the Court decided *Firestone Tire & Rubber Co. v. Bruch* ("*Firestone*").[4] In *Firestone*, the Court held that, where a plan provides that the decision maker has "discretionary authority to determine eligibility for benefits," a court is to review the decision maker's determination with a "deferential standard of review."[5] Absent a sufficient grant of discretionary authority to the decision maker, a court will instead review a benefits determination *de novo*, reconsidering all the evidence in the record and perhaps coming to a conclusion that differs from that of the original decision maker. Courts have applied the deferential review standard so that the plan decision maker's decision will not be overturned unless it was "arbitrary and capricious" or an "abuse of discretion." These are high hurdles for a participant to overcome, making it important to have "*Firestone*" or "discretionary review" language in plan documents.

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1 554 U.S. ___ (2008). The slip opinion may be viewed on the Supreme Court's website at http://www.supremecourtus.gov/opinions/07pdf/06-923.pdf. All cites to the Court's decision in *Glenn* are to the slip opinion.

2 The U.S. Department of Labor has issued detailed regulations describing the requirements for claims procedures under ERISA. See 29 U.S.C. § 2560.503-1.

3 ERISA § 502(a)(1)(B).

4 489 U.S. 101 (1989).

5 489 U.S. at 111.

The *Firestone* opinion also states that, where the decision maker has been granted appropriate discretion but is "operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there was an abuse of discretion."[6] The opinion did not, however, explain how a court was to do this. This was the question in *Glenn*.

The Facts and the Lower Court Decisions

Ms. Glenn was covered by an employer-sponsored long-term disability ("LTD") plan. Benefits were provided through a group disability policy with MetLife, and MetLife also administered the plan. Ms. Glenn was diagnosed with a heart condition and applied for LTD benefits. MetLife determined that Glenn could not perform her own job, which was the test for the first 24 months of LTD benefits under the plan. MetLife also encouraged Glenn to apply for Social Security disability benefits, which were granted and, the Court noted, "some of which MetLife itself would be entitled to receive as an offset to the more generous plan benefits."[7]

After the first 24 months, the LTD plan's standard for continued benefits changed to require that the participant be incapable of performing the material duties of any occupation for which he or she was reasonably qualified. (This "any occupation" test is similar to the Social Security test for disability benefits.) MetLife determined that Glenn did not meet this test and denied further benefits. Glenn followed the plan's appeal procedure, but MetLife denied her appeal. She then filed suit under ERISA, seeking to have her benefits reinstated.[8] The federal district court upheld MetLife's determination, and Glenn appealed to the Court of Appeals for the Sixth Circuit.

The Sixth Circuit reversed the district court and directed that Glenn's LTD benefits be reinstated.[9] The Sixth Circuit observed that, under the LTD plan, MetLife both decides whether a participant is eligible for benefits and pays those benefits. This was "an apparent conflict of interest" which the district court failed to discuss, so that "this factor did not receive appropriate consideration."[10]

In reaching its decision, the Sixth Circuit discussed several factors in MetLife's consideration of Glenn's claim that it found relevant: the conflict as decision maker and payor of benefits, the conflict with the Social Security Administration determination of disability, "inappropriately selective consideration of Glenn's medical record," MetLife's failure to provide full case information to its own independent experts, and failure to consider all aspects of Glenn's pathology. "Taken together," said the Court, "these factors reflect a decision by MetLife that can only be described as arbitrary and capricious."[11] MetLife sought *certiorari*, which was granted.

The Supreme Court's Opinion

The Court's majority opinion proceeds from the assumption that "where it is the employer that both funds the plan and evaluates the claims," there is a conflict of interest like that described in *Firestone*. This is "the type of conflict that judges must take into account when they review the discretionary acts of a trustee of a common-law trust."[12] So, when an employer funds a plan's benefits and is also the decision maker for benefit claims (through a committee that it appoints, or otherwise), there is a conflict of interest that a court must take into account when reviewing a denial of benefits. The Court continued that, while it might be "less clear" where the decision maker is a third party insurance company, "we nonetheless continue to believe that for ERISA purposes a conflict exists."[13]

So, the dual status of decision maker on benefits eligibility and payor (directly or indirectly) of benefits creates a conflict of interest, and that conflict must be factored into the review of a benefits determination that is entitled to arbitrary and capricious/abuse of discretion review. But how is it factored in? Anyone looking for a hard and fast rule will be disappointed. The Court said that the conflict is a factor, which, in any given case, may mean a lot, or may not mean much at all.

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6 *Id*.

7 *Glenn*, slip op. at 2.

8 *Id*. at 2-3.

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

10 461 F.3d at 666.

11 *Id*. at 674.

12 *Glenn*, slip op. at 5.

13 *Id*. at 7-8.

This conflict of interest does not by itself trigger a shift to *de novo* review.[14] Nor are courts to "create special burden-of-proof rules, or other special procedural or evidentiary rules, focused narrowly upon the evaluator/payor conflict."[15] Instead, when faced with such a conflict of interest, a court is to do what courts do: "taking account of several different, often case-specific, factors, reaching a result by weighing all together."[16] In reviewing a benefits determination for an abuse of discretion, the conflict could prove of considerable importance, such as "where an insurance company administrator has a history of biased claims administration," or where the plan sponsor was "more interested in an insurance company with low rates than in one with accurate claims processing."[17] Or, it could be less important, "perhaps to the vanishing point," where the plan implements procedures such as internal shields between claims administration and plan finance, or quality control review of claims handling.[18]

What Does This All Mean?

Glenn seems as much a rumination on judicial process as a holding on a substantive legal issue; nonetheless, the Court has spoken and "conflict of interest" is now in play as an issue in claims review and appeals under ERISA plans. Where there is a conflict of interest under *Glenn*, what can be done within the plan to seek to minimize the weight that the conflict is given by a court reviewing a benefits claim? If the potential conflict is acknowledged, and addressed by structuring and administering the claims process to provide full, fair and impartial review and appeal of claims, the less important the conflict would seem to be to a court. With that in mind, the following should be considered:

- Review all plans subject to ERISA (including "arrangements" such as severance pay and non-qualified deferred compensation that may not have been treated as plans) and confirm that they have claims procedures that conform to the ERISA regulations and a "*Firestone*" grant of discretion with respect to decisions on eligibility and amount of plan benefits. Are these clearly described in summary plan descriptions?
- Carefully review the plan's actual claims and appeal practices against the formal plan rules for consistency. Are the persons who are making decisions the persons who have that authority under the plan? There should be no variance or disconnect among the plan, summary plan description and actual practice.
- The process should be an open one: participants should be permitted to submit all relevant evidence and arguments, so that there is a full record for appeal or possible court review.
- Determine whether the persons involved in the claims procedure have the necessary knowledge, tools and information to assure accurate claims processing. Consider whether it is feasible to remove persons who make claims and appeal decisions from analysis and budgeting of plan costs.
- Outsourcing of the claims process should be considered. In doing so, the potential effect of a *Glenn* conflict of interest should be weighed, along with restructuring of the internal processes, against the costs and benefits of any outsourcing proposal.

This is an overview of *Glenn* and its possible implications. We would be pleased to discuss specific questions or issues with you at your convenience.

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[14] *Id.* at 9.

[15] *Id.* at 10.

[16] *Id.*

[17] *Id.* at 8.

[18] *Id.* at 10-11.

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