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## Conflicted Plan Administrators Face A Slightly More Rigorous Judicial Review of Benefit Determinations

Many ERISA plans allow insurers to act as plan administrators. As administrators, insurers have the dual obligation to determine the validity of employee benefit claims and to pay valid claims. This dual role is not prohibited. In fact, ERISA authorizes companies to fulfill both fiduciary and nonfiduciary functions as long as they do not in actuality commingle those functions. See 29 U.S.C. § 1108(c)(3). ERISA permits dual roles because ERISA's protections in combination with judicial scrutiny, provide adequate structural safeguards to ensure the just administration of employee benefit plans.

In the recent case *Metropolitan Life Ins. Co. et al. v. Glenn*, 461 F. 3d 660 (2008), the United States Supreme Court tackled the question of whether a court should more critically review a denial of benefits by a plan sponsor when that sponsor has dual roles. The Court noted the importance of the case because the "lion's share" of ERISA plan claim denials are made by plan administrators that both assess and pay claims.

MetLife served as an administrator and insurer of an ERISA-governed, long-term disability plan which granted MetLife authority to determine the validity of employee benefit claims and also permitted MetLife to pay claims. Plan participant Wanda Glenn was diagnosed with a heart disorder. She applied for and began receiving an initial 24 months of disability benefits under the plan. MetLife instructed Glenn to apply for permanent Social Security disability benefits which she began receiving based on a determination by an administrative law judge that she was unable to perform any job for which she was qualified. The judge's decision was based in part on information submitted by MetLife. MetLife's financial obligation to Glenn was diminished by her Social Security disability benefits.

When the 24 month period concluded, Glenn applied for extended plan benefits. The application had a stricter standard that resembled the Social

Security standard. In parting with the agency determination, MetLife terminated Glenn's benefits and denied her extended coverage finding that she was capable of engaging in sedentary work.

Glenn eventually brought a lawsuit in federal court against MetLife arguing that her benefit denial was arbitrary and capricious and in violation to ERISA. The district court disagreed with Glenn and denied relief. The Sixth Circuit reversed the district court's decision specifically noting that MetLife operated under a conflict of interest because it evaluated benefit claims and paid them out of its own pocket. Due to this conflict, the Sixth Circuit determined that greater scrutiny of MetLife's decision was warranted.

The appeals court overturned MetLife's denial of benefits based on the following factors: 1) The conflict of interest, 2) MetLife's and the administrative law judge's incongruent determinations, 3) MetLife's reliance on a single physician's report suggesting Glenn's ability to perform sedentary jobs rather than other detailed physician reports suggesting she could not perform any job, 4) MetLife's role in supporting Glenn with her permanent disability request.

In Glenn, the Supreme Court found no errors in the Sixth Circuit's approach. The Court held that the dual roles of administrator and insurer create a conflict of interest that courts may consider with other factors when reviewing benefits determinations for abuse of discretion. The Court took steps to limit its holding by refusing to adopt a rule which would require automatic de novo review of benefits denials by conflicted plan sponsors. Had the Court failed to limit its holding, it could have been interpreted as requiring judges not to grant any deference to conflicted plan sponsor benefits determinations.

The Glenn Court further limited its holding by explaining that a conflict of interest can become an unimportant judicial review factor "where the administrator has taken active steps to reduce potential bias and to promote accuracy, for example, by walling off claims administrators from those interested in firm finances, or by imposing management checks that penalize inaccurate decision-making irrespective of whom the inaccuracy benefits."

However, the Court noted that a conflict of interest should give judges more pause when “circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to, cases where an insurance company administrator has a history of biased claims administration.”

Glenn is significant because in instances where other factors are closely balanced, a conflict of interest will now act as a tiebreaker requiring judges to give less deference to benefits decisions by conflicted plan administrators. In his concurring opinion Chief Justice Roberts points out that “[j]udicial review under the majority’s opinion is less constrained, because courts can look to the bare presence of a conflict as authorizing more exacting scrutiny.” In other words, the Glenn decision has—to some degree—universally raised judicial scrutiny of decisions by plan sponsors with a conflict of interest.

The impact of the Glenn decision is far from certain. Some argue that this case embodies a victory for employees because employees will now receive more meaningful judicial protection. With that protection, employees will, on average, enjoy greater benefits. Others argue that claims will be more likely to settle for more money and go to trial more often. If one follows that line of reasoning to its logical conclusion, Glenn is a victory for no one. If employers incur additional claims defense costs, they will likely pass those costs onto employees in the form of higher premiums and less generous benefits. In any case, Glenn will likely cause some difficulties for conflicted plan sponsors of ERISA-governed plans—at least in the short-run.

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