STRUCTURAL CONFLICT OF INTEREST AFTER GLENN: WHAT IS THE APPROPRIATE STANDARD OF REVIEW IN DISABILITY DENIAL CASES UNDER ERISA?

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I. INTRODUCTION

Insurance is an important employee benefit that many employers offer to their employees. Insurance benefits typically include health, life, and disability insurance, both long-term and short-term, which are subject to the rules set out in the Employee Retirement Income Security Act of 1974 ("ERISA")[1]. Since the plan documents tend to be long, complicated, and filled with legalese, it is doubtful that the majority of employees are truly familiar with the particulars of their coverage. Everything changes, however, once a claim is denied and litigation is contemplated; the terms of the policy then become of paramount importance. Unfortunately for the insured, most policies give the insurer the authority to determine eligibility for benefits and to construe the terms of the plan. This paper will focus on the particularly contentious area of denial of disability claims that arise under ERISA and how the U. S. Supreme Court since 1989 has attempted to create a coherent methodology for judicial oversight of these plans when the insurer is granted such discretionary authority.

II. PLAN ADMINISTRATORS ARE FIDUCIARIES UNDER ERISA

ERISA was enacted in 1974 "to promote the interests of employees and their beneficiaries in employee benefit plans."[2] While the title of the Act refers to *retirement income security*, the law is more inclusive, covering so-called *welfare plans*, such as disability insurance.[3] The law does not require that employers provide

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[1] Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. §§ 1001-1461 (2000).

[2] Shaw v. Delta Airline, Inc., 463 U.S. 85, 90 (1983).

[3] DAWN D. BENNETT-ALEXANDER & LAURA P. HARTMAN, EMPLOYMENT LAW FOR BUSINESS 723 (5th ed., McGraw-Hill/Irwin 2007) ("A welfare plan is any plan, program, or fund that the employer maintains to provide the following: medical, surgical, or hospital care; benefits for sickness, accident, disability, or death; unemployment benefits; vacation benefits; apprenticeship and training programs; day care centers; scholarship funds; prepaid legal services; or severance pay.").

such benefits to their employees,[4] nor does the purchase of an insurance policy by an employer automatically invoke the protections of ERISA.[5] While ERISA covers most benefit plans offered in the private sector, it generally does not cover plans maintained by governmental entities.[6] Once the existence of an ERISA-covered plan is established, the statute mandates that the plan administrator perform its functions as a *fiduciary*,[7] subject to certain fiduciary duties.[8] The term *fiduciary* comes from Roman law, and means "a person holding the character of a trustee, or a character analogous of a trustee, in respect to the trust and confidence involved in it and the scrupulous good faith and candor which it requires."[9] Fiduciaries have a duty, created by undertaking certain types of acts, to act primarily for the benefit of another in matters connected with such undertaking.[10]

According to the Supreme Court in *Firestone Tire & Rubber Co. v. Bruch*,[11] "ERISA abounds with the language and terminology of trust law,"[12] and the Court has mandated that "courts are to develop 'a federal common law of rights and obligations under ERISA-regulated plans.'"[13] In *Firestone*, the Supreme Court was asked to decide on the proper standard of review under ERISA when a plan administrator's denial of benefits is challenged. In this case, Firestone sold five plants, and most of the employees were rehired by the purchaser at the same rates of pay. At the time of the sale, Firestone maintained and was fiduciary for a termination pay plan, a retirement plan, and a stock purchase plan, each of which was unfunded. Firestone admitted at trial that it had not been aware that its

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[4] *Id.* at 721.

[5] *See* Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982); *see also* Zavora v. Paul Revere Life Ins. Co., 145 F.3d 1118, 1120 (9th Cir. 1998) ("The first issue for decision is whether Paul Revere's disability insurance is, as a matter of law, an 'employee welfare benefit plan.' The answer to that question turns on whether uncontroverted evidence establishes that Decorative Carpet's role with relation to the insurance program is sufficient to render it an ERISA plan.").

[6] DAWN D. BENNETT-ALEXANDER & LAURA P. HARTMAN, EMPLOYMENT LAW FOR BUSINESS 722 (5th ed. 2007).

[7] 29 U.S.C. § 1002(21)(A). Subsection 21(A) provides:

> Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

[8] 29 U.S.C. § 1104.

[9] BLACK'S LAW DICTIONARY 563 (5th ed. 1979).

[10] *Id.*

[11] 489 U.S. 101, 110 (1989).

[12] *Id.* at 110.

[13] *Id.*

termination pay plan was governed by ERISA and, therefore, did not comply with mandated claims procedures.[14] Regardless, the trial judge granted Firestone's motion for summary judgment holding that Firestone had satisfied its fiduciary duty because its decision not to pay severance benefits to the plaintiffs was not arbitrary or capricious. The Appellate Court disagreed, as did the Supreme Court, which held that a denial of benefits under ERISA is to be reviewed under a de novo standard of review, not the more lenient arbitrary or capricious standard, "unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan."[15] Since Firestone's plan documents did not grant such authority, a de novo standard was, therefore, appropriate. In support of its view the Court turned to accepted principles of trust law.[16]

The Court of Appeals in its decision,[17] however, had based its decision to reverse on grounds of potential bias due to the inherent conflict of interest involved with Firestone's potential unfunded obligations to the plaintiffs.[18] The Supreme Court was more moderate in its view, stating that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'"[19] Courts have in other cases, however, managed to distinguish ERISA's statutory fiduciary obligations from common law fiduciary trust principles.[20]

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[14] *Id.* at 105 (citing 29 U.S.C. § 1133.)

[15] *Id.* at 115.

[16] *Id.* at 111 (citing RESTATEMENT (SECOND) OF TRUSTS § 187 (1959) and GEORGE GLEASON BOGERT & GEORGE TAYLOR BOGERT, LAW OR TRUSTS AND TRUSTEES § 560 (2d rev. ed. 1980)) ("Trust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers.").

[17] 828 F.2d 134, 143-46 (3d Cir. 1987).

[18] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 107-08 (1989) ("The Court of Appeals held that where an employer is itself the fiduciary and administrator of an unfunded benefit plan, its decision to deny benefits should be subject to *de novo* judicial review. It reasoned that in such situations deference is unwarranted given the lack of assurance of impartiality on the part of the employer.").

[19] *Id.* at 115. The court stated:

> As this case aptly demonstrates, the validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of terms in the plan at issue. Consistent with established principles of trust law, we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. Because we do not rest our decision on the concern for impartiality that guided the Court of Appeals, see 828 F.2d 143-146, we need not distinguish between types of plans or focus on the motivations of plan administrators and fiduciaries. Thus, for purposes of actions under § 1132(a)(1)(B), the *de novo* standard of review applies regardless of whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a possible or actual conflict of interest. Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a

III. ABUSE OF DISCRETION LITIGATION AFTER FIRESTONE

Firestone left several questions unanswered, a fact acknowledged in 2002 by the Supreme Court in *Rush Prudential HMO, Inc. v. Moran.*[21] The nature of these cases may have added to the difficulties in reaching consensus since they tend to tug on the heartstrings and often present very sympathetic plaintiffs and unsympathetic defendants.[22] Not surprisingly, the Circuit Courts of Appeal responded in varying ways.[23] According to judges, commentators, and practicing lawyers, the Courts of Appeal essentially split into three camps, after *Firestone*, in resolving these cases,[24] namely: a) the deferential standard (pursuant to the Restatement of Trusts § 187 based upon "reasonableness" of the administrator's actions) and which considers a conflict of interest merely as another factor to be weighed by the court, which was

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> conflict of interest, that conflict must be weighed as a "facto[r] in determining whether there is an abuse of discretion."

Id. at 115 (citing RESTATEMENT (SECOND) OF TRUSTS § 187, Cmt. d (1959)).

[20] *See, e.g.,* Ehlmann v. Kaiser Found. Health Plan of Tex., 198 F.3d 552, 554-56 (5th Cir. 2000), *cert. denied*, 530 U.S. 1291 (2000). In this case, the plaintiff had been denied disability benefits under his health maintenance organization (HMO) under ERISA and wanted access to the financial incentive arrangements between physicians and the HMO. "Ehlmann allege[d] that Kaiser violated its fiduciary duty . . . to disclose its physician compensation scheme. According to Ehlmann, this duty to disclose is broad and requires disclosure even absent specific inquiry." *Id.* According to the Fifth Circuit, "Whether ERISA imposes on HMOs a fiduciary duty to disclose physician compensation schemes is an issue of first impression in this court." *Id.* In holding that the district court correctly dismissed Ehlmann's claim for the breach of duty to disclose, the Fifth Circuit held that ERISA imposes no such duty, because by enacting specific fiduciary provisions in ERISA, Congress made modifications to the fiduciary concept and thus "this court will not add a specific disclosure requirement to those already enumerated." *Id.*

[21] 536 U.S. 355 (2002).

[22] Beverly Cohen, *Divided Loyalties: How The Metlife v. Glenn Standard Discounts ERISA Fiduciaries' Conflicts of Interest,* 3 UTAH L. REV. 956 (2009), *available at* http://www.epubs.utah.edu/index.php/ulr/article/view/247/219 ("In the recently decided Metropolitan Life Insurance Co. v. Glenn, the Supreme Court had an opportunity to revisit the deferential standard of review applied to claim denials by conflicted ERISA fiduciaries, and it opted to reaffirm the Firestone standard. As a result, substantial obstacles remain for ERISA plan members and beneficiaries challenging benefit denials. For ERISA health and disability plans in particular, this is a harsh result because an unfairly denied claim may leave a member without benefits for an expensive and urgently needed medical procedure, or without financial support after suffering a catastrophic disability.").

[23] *See id.* at 960 ("Application of the Firestone standard did not produce uniform results. When post-Firestone courts applied it, they could not agree on the extent to which fiduciaries presented a conflict situation, or how weighing the conflict as a factor should alter the review.").

[24] *See id.* ("III. Courts' Confused Application of the Firestone Standard to Conflicts of Interest"); Abatie v. Alta Health and Life Ins. Co., 458 F3d 955 (9th Cir. 2006); and Petition for Writ of Certiorari in Metropolitan Life Ins. Co. v. Peggy Hawkins-Dean, *available at* http://www.scotusblog.com/archives/05-1424.pdf.

followed by the First[25], Second,[26] and Sixth Circuit;[27] b) the sliding-scale deference approach where the degree of deference depends on the seriousness of the conflict, which was followed by the Third, Fourth, Fifth, Seventh, Eighth, Ninth[28], and Tenth Circuits;[29] and c) the so-called presumptively void standard[30] followed by the Eleventh Circuit alone,[31] where after a conflict is shown, "the burden shifts to the

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[25] In *Island View Residential Treatment Center v. Blue Cross Blue Shield of Mass.*, 548 F.3d 24, 29 (1st Cir. 2008), the First Circuit noted: "Appellants argued that in reviewing the merits of a claim disallowance, the law in the Tenth Circuit was more favorable to the claimant while the law in [the First Circuit] was more favorable to the plan administrator or other decider."

[26] The leading case in the Second Circuit in this area is *Sullivan v. LTV Areorspace & Def. Co.*, 82 F.3d 1251, 1254-57 (2d Cir. 1996), where the Court analyzed the meaning of *Firestone* in light of its own precedent and held that a mere structural conflict of interest does not affect the use of the deference standard, but if an actual conflict is shown to have affected the decision, then de novo review is appropriate.

[27] Doyle v. Liberty Life Assurance Co. of Boston, 511 F.3d 1336, 1346 (11th Cir. 2008) ("The First and Second Circuits, for example, have adopted a 'reduced deference' approach, under which a court will reduce the deference afforded under arbitrary and capricious review after the claimant shows that the administrator's decision was tainted by a conflict of interest."). Note that the Eleventh Circuit assigns the Sixth Circuit to the sliding-scale category.

[28] Abatie v. Alta Health & Life Ins., 458 F.3d 955 (9th Cir. 2006). The court stated:

> Our approach is substantially similar to that adopted by several other circuits, but with a conscious rejection of their "sliding-scale" metaphor . . . . Insofar as those cases recognize that weighing a conflict of interest as a factor in abuse of discretion review requires a case-by-case balance, we agree. A district court, when faced with all the facts and circumstances, must decide in each case how much or how little to credit the plan administrator's reason for denying insurance coverage. An egregious conflict may weigh more heavily (that is, may cause the court to find an abuse of discretion more readily) than a minor, technical conflict might. But in any given case, all the facts and circumstances must be considered and nothing "slides," so we find the metaphor unnecessary and potentially confusing.

Id. at 967-68.

[29] Doyle v. Liberty Life Assurance Co. of Boston, 511 F.3d at 1346 ("Conversely, the Third, Fourth, Fifth, Sixth, Seventh, Eighth, Ninth, and Tenth Circuits apply a 'sliding-scale' approach, under which the district court 'decrease[s] the level of deference given to the conflicted administrator's decision in proportion to the seriousness of the conflict,' (citation omitted) and then only after the claimant shows the existence of a conflict (citation omitted).") Note that the Eleventh Circuit assigns the Sixth Circuit to the sliding-scale category.

[30] *Id.* at 1346 ("Our standard is tantamount to invoking a presumption that the administrator has acted wrongly in its self-interest. This is why courts and commentators have labeled our heightened standard the 'presumptively void' standard.").

[31] *Id.* at 1344-45 ("We stand alone in our application of a standard that shifts to the administrator the burden of proving that its decision was not influenced by a conflict. Other circuits apply one of two different approaches, neither of which shifts the burden of proof to the administrator.").

fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self interest" [32] and then "de novo review is proper."[33]

IV. *METROPOLITAN LIFE INSURANCE CO. V. GLENN*

In *Metropolitan Life Insurance Co. v. Glenn*,[34] the Supreme Court granted certiorari based on two questions: 1) whether a plan administrator with discretionary authority who both evaluates and pays claims operates under a conflict of interest in making benefit determinations, and 2) if a plan administrator is operating under a conflict of interest, how should that conflict be taken into account on judicial review? The Supreme Court answered the first question with a clear and emphatic "it does" and cited traditional trust law principles in firm support.[35] It stated affirmatively that the existence of this conflict applies to insurance company administrators and self-insured employers alike.[36] As to the second question, the Supreme Court was much less clear, not at all emphatic, and freely acknowledged its own indeterminacy.[37] Here at last, after twenty years of Circuit Courts interpreting *Firestone's* "arbitrary and capricious" standard inconsistently, the Supreme Court had the opportunity to establish a bright-line standard for review of conflicted claim denials. Alas, that was not to be.

The plaintiff in this case, Wanda Glenn, was a Sears employee with a serious heart condition. She left her job after her cardiologist advised her that the physical and psychological stress associated with it were complicating her illness. She applied for disability benefits under Sears's employee insurance plan administered by MetLife. Under the terms of the plan, Glenn was eligible for two initial years of benefits if she could no longer perform the central functions of her job. Metropolitan Life Insurance Company (MetLife) approved her claim and also encouraged Glenn

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[32] *Id.* at 1340 (quoting Brown v. Blue Cross & Blue Shield of Ala., Inc., 898 F2d 1556, 1566 (11th Cir. 1990)).

[33] Brown v. Blue Cross & Blue Shield, Inc., 898 F.2d 1566, 1567 (11th Cir. 1990); *see also* Petition for Writ of Certiorari in Metropolitan Life Ins. Co. v. Peggy Hawkins-Dean, *available at* http://www.scotusblog.com/archives/05-1424.pdf ("[I]f a beneficiary of an ERISA plan provides provides 'material, probative evidence tending to show a conflict of interest, then the administrator 'must rebut the presumption by producing evidence to show that the conflict of interest did not affect its decision to deny or terminate benefits.' If the administrator fails to prove a negative – i.e., that the conflict did **not** affect its decision – its decision is void and the court reviews the benefit determination *de novo*.").

[34] Metropolitan Life Ins. Co. v. Glenn, 128 S.Ct. 2343 (2008).

[35] *Id.* at 2348 (2008). While this issue seemingly was addressed in Firestone, it was not directly before the Court; therefore, its statements in that regard can be regarded as dicta. *See* Doyle v. Liberty Life Assurance Co. of Boston, 511 F.3d 1336, 1351 (11th Cir. 2008) ("The agreement among the circuits that the decision of a conflicted ERISA administrator exercising discretion should be reviewed under a less deferential standard than the decision of an administrator not operating under a conflict is premised on the Court's dictum in *Bruch* that if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion.") (internal quotes deleted).

[36] *MetLife v. Glenn*, 128 S. Ct. at 2348 -50.

[37] *Id.* at 2350-52.

to apply for disability benefits from the Social Security Administration (SSA). The insurance company even procured an attorney to assist her. Once approved for SSA benefits, Glenn's benefits under the MetLife plan were reduced.[38]

After the initial two years, the plan required Glenn to demonstrate that she was incapable of holding any job for which she was qualified.[39] Glenn submitted additional medical reports that stated the psychological stress from even a sedentary job would cause her heart condition to worsen and so should be avoided. MetLife appointed its own medical specialist to review Glenn's file—although not to examine her physically—and ultimately denied Glenn's application on the ground that Glenn was physically capable of performing sedentary work, and that no evidence supported the contention that the psychological stress of working would exacerbate her condition. MetLife, however, withheld from its medical expert certain medical reports and the SSA's determination of disability.

Glenn brought an ERISA claim against MetLife in 2002 alleging that the company had wrongfully denied her benefits. The district court ruled against Glenn, finding that MetLife had not abused its discretion in denying her claim, and Glenn appealed to the Sixth Circuit. The court of appeals overturned the lower court and MetLife's decision. After acknowledging that MetLife's decisions were entitled to a deferential standard of review because MetLife was a plan administrator with discretionary authority, the court expressed concern that MetLife was operating under the "conflict of interest that results when . . . the plan administrator who decides whether an employee is eligible for benefits is also obligated to pay those benefits."[40] In the court's view, it was "entitled to take" that conflict "into account" when evaluating the reasonableness of MetLife's decision to deny Glenn's claim.[41] Having determined that MetLife's conflict of interest would serve as one factor weighing against affirmance of the company's decision, the court went on to find that MetLife had acted "arbitrarily and capriciously" in denying Glenn's claim.[42] While MetLife had justified the denial by referring to a report in which the doctor had deemed Glenn physically capable of performing sedentary work, the company had never addressed numerous other letters from the doctor in which he had explicitly opined that Glenn could not withstand the emotional stress of even sedentary work. The company's own medical expert, who had not examined Glenn personally, had apparently never read those letters. Furthermore, MetLife did not address, or even mention, the ruling by the Social Security Administration that Glenn was completely disabled. Those omissions, according to the court of appeals, demonstrated that MetLife's decision "was not the product of a principled and deliberative reasoning process."[43]

At issue was how an administrator's conflict of interest should factor into a court's review of a claim denial. As mentioned above, the circuits had adopted conflicting positions as to whether a single company's role as both an administrator

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[38] *Id*. at 2346-47.
[39] *Id.* at 2347.
[40] Glenn v. Metropolitan Life Ins. Co., 461 F.3d 660, 666 (6th Cir. 2006).
[41] *Id.*
[42] *Id.* at 674.
[43] *Id.*

and funder of a benefit plan creates a conflict of interest that should be weighed by a court.

The majority opinion, written by Justice Breyer held that the conflict of interest is properly weighed as a factor determining whether there was an abuse of discretion. According to the opinion, the standard of review is a deferential one and the presence of the conflict does not automatically authorize a court to apply heightened scrutiny to a claim denial. Instead, the conflict simply ranks as "but one factor among many that a reviewing judge must take into account."[44] The Court admonished against the creation of special burden-of-proof rules, or other special procedural or evidentiary rules, focused narrowly upon the evaluator/payor conflict.[45] It decided that "[b]enefits decisions arise in too many contexts, concern too many circumstances, and can relate in too many different ways to conflicts—which themselves vary in kind and in degree of seriousness—for [there to be] a one-size-fits-all procedural system."[46] The "one factor among many" test does not, as the majority forthrightly admitted, constitute "a detailed set of instructions" to lower courts.[47] Rather, the Supreme Court opted for a "tie-breaker" test: when judges review the lawfulness of benefit denials, they will take account of several different factors of which a conflict of interest is one. "In such instances, any one factor will act as a tiebreaker when the other factors are closely balanced, the degree of closeness necessary depending upon the tiebreaking factor's inherent or case-specific importance."[48] But the Supreme Court specified that a two-step process of review should be observed.

First, a court must determine the proper weight to assign to the conflict of interest. So, where an administrator has taken steps to neutralize it by walling the administrator off from firm finances or imposing management checks that penalize inaccurate decision making, the conflict might carry little or no weight at all. However, where circumstances suggest a higher likelihood that the conflict affected the benefits decision, it should be weighed more heavily. While this first step may seem amorphous and unpredictable, the Court asserted that further clarity is neither possible nor desirable: "[T]here are no talismanic words that can avoid the process of judgment. . . . [T]he [w]ant of certainty in judicial standards 'partly reflects the intractability of any formula to furnish definiteness of content for all the impalpable factors involved in judicial review.'"[49]

Step two in the analysis requires the court to examine "other factors" associated with the claim denial—such factors as, in Glenn's case, the administrator's failure to provide all medical reports to a hired expert, or its unexplained rejection of the findings of the Social Security Administration. If these "other factors," when viewed deferentially, "are closely balanced,"[50] leaving the court uncertain as to whether the claim denial was reasonable, then the conflict of

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[44] Metlife v. Glenn, 128 S. Ct. at 2351.
[45] Courts that applied such standards will be discussed in a later section.
[46] Metlife v. Glenn, 128 S. Ct. at 2351.
[47] *Id.* at 2352.
[48] *Id.* at 2351.
[49] *Id.* at 2352.
[50] *Id.* at 2351.

interest may serve as a tiebreaker. Here the relative importance of the conflict of interest in the particular case becomes relevant: if the conflict seems more important, then the court may more easily determine that the "other factors" characterizing the claim denial point toward an abuse of discretion. If the conflict seems of little or no importance, then the court's focus should remain mostly on the "other factors" involved in the administrator's decision. In this case, it was the "other factors"—MetLife's selective emphasis on medical reports that reflected poorly on Glenn's claim, its inexplicable disagreement with the Social Security Administration—that convinced the court of appeals to overrule the claim denial.[51]

In a concurring opinion, Chief Justice Roberts wrote separately to say that he would only give a conflict of interest such as MetLife's weight if circumstances demonstrated that the conflict had actually influenced the claim denial in question; only then would a court be justified in "heightening the level of scrutiny applied."[52] According to Roberts, the conflict of interest was irrelevant in MetLife's case because other factors independent of that conflict demonstrated that the claim denial was unreasonable.

Justice Kennedy wrote an opinion concurring in part and dissenting in part. Unlike Chief Justice Roberts, he did not object to either the majority's reasoning or its framework for weighing conflicts of interest. Instead, he argued that the Court had been too hasty in voting to affirm the Sixth Circuit's ruling. The Sixth Circuit had not engaged in the two-step process of deciding how much weight to accord MetLife's conflict of interest, and accordingly, the case should have been remanded to the court of appeals for further proceedings in light of the Supreme Court's opinion. [53]

V. CRITICISMS OF THE *GLENN* OPINION

Dissenting strongly to the majority's opinion, Justices Scalia and Thomas criticized the opinion as "painfully opaque, despite its promise of elucidation."[54] Justice Scalia contended that a court should not weigh an administrator's conflict of interest unless the administrator could be shown to have acted from an improper motive. In that circumstance, a court would be free to conclude that the administrator had abused its discretion, and then to review the claim denial de novo. Under this standard, the Sixth Circuit should not have considered MetLife's conflict of interest at all but should merely have reviewed the decision to deny benefits for reasonableness. According to Justice Scalia, the majority's decision amounted to "nothing but de novo review in sheep's clothing."[55]

Other criticisms can be leveled based upon "bright line" options the Court chose to forego. The Court could, for example, have ignored the existence of a mere

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[51] *Id.* at 2351-52.
[52] *Id.* at 2354-55 (Roberts, J., concurring).
[53] *Id.* at 2356 (Kennedy, J., concurring in part and dissenting in part).
[54] *Id.* at 2358 (Scalia, J., dissenting).
[55] *Id.* at 2358.

structural conflict of interest[56] adopting a pure "reasonableness test" requiring courts to use common sense in determining the substantive reasonableness of the administrator's decision. As Justice Scalia pointed out, "[a] reasonable decision is reasonable whether or not the person who makes it has a conflict."[57] Or, the Supreme Court could have called for de novo review upon evidence that the benefits denial was improperly motivated or affected by the conflict. A third bright line test would have been to acknowledge that the structural conflict of interest necessarily interferes with a plan administrator's objectivity and apply de novo review. Other bright lines can be imagined, but any bright line has the advantage of comparative certainty, which has been missing from this area for a considerable period of time. Instead, the Supreme Court adopted "a judge-liberating totality-of-the-circumstances 'test'" in which the existence of the conflict is among the factors to be considered in reviewing the claim denial.[58] This approach makes each case unique, and hence the outcome of each case unpredictable.

Several commentators point to a more fundamental problem; that *Firestone* and *Glenn* rest on a flawed interpretation of trust law. ERISA's pension plan trusts are different than traditional trusts in several important ways. While this train of thought is ultimately beyond the scope of this paper, it is still worthy of note. Most famously, Professor John H. Langbein, a Yale Professor of Law and prolific ERISA author, who is an advocate for de novo review in these cases when the administrator is operating under a conflict of interest,[59] wrote an article whose title speaks volumes: "The Supreme Court Flunks Trusts"[60] According to another pair of authors: "By framing the issue as a breach of trust, instead of a breach of contract, and by then failing to plumb the full depth of trust law, the *Firestone* Court ironically ushered in an era where plan participants are worse off under ERISA than they were before Congress enacted this trumpeted consumer protection statute."[61] Judge Posner of the Seventh Circuit, a pillar of the law and economics movement, after first noting the historical linkage of ERISA to the earlier union-related Taft-Hartley Act, which has a different contextual setting than ERISA, had this to say of the arbitrary and capricious standard authorized by *Firestone*:

> This standard was taken over for use in reviewing benefit denials under ERISA (which does not define the standard of judicial review of trustees' decisions on benefit claims), apparently without the courts' noticing that employers often held the whip hand in

[56] A conflict is structural when it is inherent in the nature of the undertaking, where, for instance, an insurance company that determines the validity of claims, economically benefits by not paying that claim.
[57] *Id*. at 2360.
[58] *Id.* at 2357.
[59] *See* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1342 (2007).
[60] John H. Langbein, *The Supreme Court Flunks Trusts*, 1990 SUP. CT. REV. 207, 207-29 (1991).
[61] Donald T. Bogan & Benjamin Fu, *ERISA: No Further Inquiry into Conflicted Plan Administrator Claim Denials*," 58 OKLA. L. REV. 637, 648-49 (2005), *available at* http://adams.law.ou.edu/olr/articles/vol58/bogan-fu584.pdf.

> ERISA trusts as they did not with the joint employer-union trust funds authorized by Taft-Hartley. . . . ERISA is paternalistic and it seems incongruous therefore to deny disappointed pension claimants a meaningful degree of judicial review on the theory that they might be said to have implicitly waived it.[62]

VI. THE IMPACT OF GLENN ON THE COURTS OF APPEAL

There was hope that the *Glenn* opinion would bring uniformity out of the jumble of *Firestone* interpretations across the circuits, but there was fear that it would prove to be as unclear as Justice Scalia had predicted. That it had the potential for both was underscored in one recent article where *Glenn* was both criticized as a continuation of *Firestone*'s deference for plan administrators[63] and yet construed as ultimately de novo review by another name,[64] which is the result invariably sought by plan beneficiaries. Given the steady stream of disability denial appeals hitting the courts, it did not take long to see reactions from the Courts of Appeal.

A. *Circuits Following the Deferential/Combination of Factors Approach*

As previously stated, the First, Second, and Sixth Circuits are generally recognized as following the deferential standard in these types of cases, a standard that is generally seen as being less amenable to unhappy insureds seeking to overturn the decisions of plan administrators with discretionary authority. Since the Supreme Court approved the actions of the Sixth Circuit, it would appear to be a reasonable

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[62] Van Boxel v. Journal Co. Employees' Pension Tr., 836 F2d 1048, 1052(7th Cir. 1987).

[63] Beverly Cohen, *Divided Loyalties: How The Metlife v. Glenn Standard Discounts ERISA Fiduciaries' Conflicts of Interest*, 3 UTAH L. REV. 956 (2009). Professor Cohen writes:

> In the recently decided Metropolitan Life Insurance Co. v. Glenn, the Supreme Court had an opportunity to revisit the deferential standard of review applied to claim denials by conflicted ERISA fiduciaries, and it opted to reaffirm the Firestone standard. As a result, substantial obstacles remain for ERISA plan members and beneficiaries challenging benefit denials. For ERISA health and disability plans in particular, this is a harsh result because an unfairly denied claim may leave a member without benefits for an expensive and urgently needed medical procedure, or without financial support after suffering a catastrophic disability.

Id. at 956.

[64] *Id.* at 991. The court noted that while the Supreme Court in MetLife rejected the de novo standard in favor of retaining Firestone's arbitrary and capricious standard coupled with weighing the conflict as a factor, application of the MetLife standard yields a result that is so close to de novo review as to be virtually indistinguishable." Id.. It continued: "By allowing the reviewing court to assign a discretionary weight to the conflict, it is uncertain how much, if any, deference will be given to the fiduciary's decision. This discretionary weighing of the conflict thereby allows the reviewing court to overturn any fiduciary decision on the stated basis that the conflict warrants greater weight in the review." *Id*.

conclusion that those three courts got it right in their interpretation of *Firestone*. According to the *Glenn* opinion:

> The Court of Appeals' opinion in the present case illustrates the combination-of-factors method of review. The record says little about MetLife's efforts to assure accurate claims assessment. The Court of Appeals gave the conflict weight to some degree; its opinion suggests that, in context, the court would not have found the conflict alone determinative . . . he court instead focused more heavily on other factors. In particular, the court found questionable the fact that MetLife had encouraged Glenn to argue to the Social Security Administration that she could do no work, received the bulk of the benefits of her success in doing so (the remainder going to the lawyers it recommended), and then (citation omitted) the agency's finding in concluding that Glenn could in fact do sedentary work. (citation omitted) This course of events was not only an important factor in its own right (because it suggested procedural unreasonableness), but also would have justified the court in giving more weight to the conflict (because MetLife's seemingly inconsistent positions were both financially advantageous). And the court furthermore observed that MetLife had emphasized a certain medical report that favored a denial of benefits, had deemphasized certain other reports that suggested a contrary conclusion, and had failed to provide its independent vocational and medical experts with all of the relevant evidence. (citation omitted) All these serious concerns, taken together with some degree of conflicting interests on MetLife's part, led the court to set aside Met-Life's discretionary decision. (citation omitted) We can find nothing improper in the way in which the court conducted its review.[65]

B. *Circuits Following the Sliding-Scale Approach*

The Estate of Schwing v. Lilly Health Plan[66] is a recent case from the Third Circuit that provides insight into how "sliding-scale" courts will implement *Glenn*.[67] The Lilly Health Plan, a plan with discretionary powers, appealed the district court's judgment in favor of an insured seeking severance benefits under an ERISA-covered plan. Applying *Glenn*, the appellate court concluded that the administrator's denial of benefits was not an abuse of discretion and reversed the trial court. The trial judge had applied a heightened standard of review based on a conflict of interest that went beyond a mere structural conflict. This conflict concerned the plan's attorney, and the court entered judgment for the plaintiff because the denial of benefits decision was tainted by the conflict. Pursuant to its understanding of the new landscape

[65] MetLife v. Glenn, 128 S.Ct. at 2351-52.
[66] 562 F.3d 522, 526 (3d Cir. 2009).
[67] *Id.* at 526 n.2.

established in *Glenn*, the Court abandoned the sliding-scale approach.[68] The Court also went on to chronicle the cases from other sliding-scale courts that had likewise seen the light after *Glenn*[69] and one Circuit, the Tenth, that had apparently decided to go its own way.[70]

That Tenth Circuit decision is *Weber v. GE Group Life Assurance. Co*.[71] where in its order granting Mr. Weber's motion for summary judgment, the court held that GE had acted arbitrarily and capriciously in denying death benefits sought

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[68] *Id.* at 525-26. The court stated:

> Prior to the Supreme Court's recent decision in *Glenn*, we interpreted the language in *Firestone* to mean that courts should consider conflicts of interest affecting plan administration when formulating the standard of review. (citation omitted) Accordingly, we adjusted the standard of review using a "sliding-scale" in which the level of deference we accorded to a plan administrator would change depending on the conflict or conflicts of interest affecting plan administration. (citation omitted) In *Glenn*, the Supreme Court interpreted the relevant language in *Firestone* in a different way, holding that courts should continue to apply a deferential abuse-of-discretion standard of review in cases where a conflict of interest is present, but that courts should take the conflict into account not in formulating the standard of review, but in determining whether the administrator or fiduciary abused its discretion . . . . Accordingly, we find that, in light of *Glenn*, our "sliding-scale" approach is no longer valid. Instead, courts reviewing the decisions of ERISA plan administrators or fiduciaries in civil enforcement actions brought pursuant to 29 U.S.C. § 1132(a)(1)(B) should apply a deferential abuse of discretion standard of review across the board and consider any conflict of interest as one of several factors in considering whether the administrator or the fiduciary abused its discretion.

Id.

[69] *Id.* at 525-26 ("Champion v. Black & Decker (U.S.) Inc., 550 F.3d 353, 359 (4th Cir. 2008) (abandoning sliding-scale approach, after *Glenn*); Burke v. Pitney Bowes Inc. Long-Term Disability Plan, 544 F.3d 1016, 1025 (9th Cir. 2008) (same); Doyle v. Liberty Life Assurance Co. of Boston, 542 F.3d 1352, 1357 (11th Cir. 2008) (same); Wakkinen v. UNUM Life Ins. Co. of Am., 531 F.3d 575, 581 (8th Cir. 2008) (same); *see also* Michaels v. The Equitable Life Assurance Soc'y of U.S. Employees, Managers, and Agents Long Term Disability Plan, 305 Fed. Appx. 896 (3d Cir. 2009) (predicting the result we now reach: that, after Glenn, we will no longer apply the sliding-scale approach). *But see* Weber v. GE Group Life Assurance Co., 541F.3d 1002, 1010-11 (10th Cir. 2008) (holding that the sliding-scale approach mirrors Glenn's approach). While no Fifth Circuit case is listed, cases in that Circuit acknowledge the demise of the sliding-scale. *See* Burtch v. Hartford Life & Accident Ins. Co., 314 Fed. Appx. 750, 757(5th Cir. 2009) ("Accordingly, we conclude that, although it was written prior to *Glenn*, the magistrate judge's report and recommendation complies with the Supreme Court's direction in Glenn to consider Hartford's conflict of interest as one factor in determining if there was an abuse of discretion. Since nothing was presented to show a greater likelihood of conflict in this case, the magistrate judge gave the conflict of interest the appropriate weight in its consideration.").

[70] *Id.* at 525. *But see* Weber v. GE Group Life Assurance Co., 541F.3d 1002, 1010-11 (10th Cir. 2008) (holding that the sliding-scale approach mirrors *Glenn*'s approach.).

[71] 541 F.3d 1002 (10th Cir. 2008).

for his wife's death, overruling the administrator's interpretation of certain policy provisions, despite the administrator's discretionary powers in that regard. According to the Court:

> However, we dial back our deference if "a benefit plan gives discretion to an administrator or fiduciary who *is operating under a conflict of interest*. (citation omitted) In such a situation, that "conflict should be weighed as a factor in determining whether there is an abuse of discretion." (citations omitted) To incorporate this factor, we have "crafted a 'sliding-scale approach' where the 'reviewing court will always apply an arbitrary and capricious standard, but [will] decrease the level of deference given . . . in proportion to the seriousness of the conflict.'" (citations omitted) This approach mirrors the *Glenn* Court's method of accounting for the conflict-of-interest factor.[72]

C. *The Eleventh Circuit's Presumptively Void Approach*

The Eleventh Circuit, which was the lone court following the presumptively void standard, addressed the effect of *Glenn* in *Doyle v. Liberty Life Assurance Company of Boston*:[73]

> We continue to adhere to Firestone's mandate that reviewing courts must consider an administrator's conflict of interest in deciding whether the decision to deny benefits was arbitrary. But we hold that Glenn implicitly overrules our precedent to the extent it requires district courts to review benefit determinations by a conflicted administrator under the heightened standard. We hold that the existence of a conflict of interest should merely be a factor for the district court to take into account when determining whether an administrator's decision was arbitrary and capricious. And we hold that, while the reviewing court must take into account an administrative conflict when determining whether an administrator's decision was arbitrary and capricious, the burden remains on the plaintiff to show the decision was arbitrary; it is not the defendant's burden to prove its decision was not tainted by self interest.[74]

[72] *Id.* at 1010-11.
[73] 542 F.3d 1352 (11th Cir. 2008).
[74] *Id.* at 1360.

VII. CONCLUSION

ERISA plan administrators with structural conflicts of interest, in the wake of *Firestone* and *Glenn*, have been given a virtual green light in denying benefit claims. Taking heed of the Supreme Court's hint in *Firestone* that a discretionary clause in an ERISA plan would only be subject to the scrutiny of an arbitrary and capricious standard, not surprisingly most plans incorporated such a clause making review of claims denials tip largely in favor of insurers and employers. Affirming the application of a deferential standard to structurally conflicted plan administrators and applying trust law rather than contract law, the Supreme Court has seemingly frustrated Congress' intention under ERISA to provide plan beneficiaries greater protection. Ironically, this entire controversy could be rendered moot by States by prohibiting discretionary clauses deemed so crucial by the Supreme Court.[75]

[75] The National Association of Insurance Commissioners adopted the Prohibition on the Use of Discretionary Clauses Model Act, also known as Model Act # 42, a brief summary and early history of which can be found at NAIC Research Quarterly, Summer 2002, www.naic.org/documents/research_RQ_2002_summer.pdf . The Model Act was adopted by the ERISA Working Group of the Health Insurance and Managed Care (B) Committee and by the Health Insurance and Managed Care (B) Committee in 2002. It provides for the prohibition of discretionary clauses in health and disability policies. *Id.* Over two years later, the NAIC approved the distribution and approval of the Model Act to the fifty states, the District of Columbia, and the U.S. Territories. Donald T. Bogan, *ERISA: State Regulation of Insured Plans After Davila*, 38 J. MARSHALL L. REV. 693, 740 (2005). A few states, such as Illinois, 50 Ill. Admin. Code § 2001.3 (2005) and California, California Insurance Code § 10291.5(f), have adopted the Model Act. Barbara C. Long, *Conflict of Interest and the Standard of Review in ERISA Cases: The Seventh Circuit's Refusal to Acknowledge What Other Circuits Already Know*, 1 SEVENTH CIR. REV. 152, 156, n.23 (2006).