Dual-role Benefit Plan Administrator Conflicts: Proceed With Caution

16

The Supreme Court's ruling in Metropolitan Life Ins. Co. v. Glenn *increases the likelihood of the courts overturning certain benefits decisions. Understanding the ruling and what steps to take in its wake can help companies limit that risk.*

Patrick W. Spangler

In *Metropolitan Life Ins. Co. v. Glenn* (128 S.Ct. 2343, June 19, 2008), the U.S. Supreme Court held that employee benefit plan administrators who both evaluate and pay claims suffer from a conflict of interest and courts should weigh this factor when reviewing benefit claims brought under ERISA. This decision changes the law in several jurisdictions and increases the likelihood that participants will now be able to obtain discovery when the employer or insurance company both pays claims and makes benefits determinations. Not only does this decision increase the likelihood of costly discovery, it could increase the risk to the plan that a benefits decision could be overturned in court. As a result, dual-role administrators should review their claims administration structure to determine whether they can reduce the risk that a conflict will compromise a decision to deny benefits and throw them into litigation.

Review of Employee Benefits Claims Before *Glenn*

In 1989, the Supreme Court decided *Firestone Tire & Rubber Co. v. Bruch* (489 U.S. 101) and laid the modern framework for judicial review of ERISA benefit claims. The Court held that a deferential abuse of discretion standard applies if the plan language allows the fiduciary to interpret the plan. Almost all employee benefits plans now include this language to afford an administrator's decision limited review in court if a participant files suit. This deferential standard generally limits the scope of evidence the plan administrator should consider, thus precluding additional discovery and limiting the cost of litigating benefits claims in federal court. The deference afforded under this standard also insulates the administrators' decision from being overturned in most cases. Most federal courts equate abuse of discretion with the administrative law "arbitrary and capricious" standard, rejecting only decisions that are "totally unreasonable," "whimsical, random, or unreasoned," or, as one federal appellate judge said, "off the wall."

However, in the 19 years following the Court's decision in *Bruch*, many participants' attorneys have attempted to alter this deferential standard of review and obtain discovery

Patrick Spangler is an attorney at the Chicago office of Vedder Price P.C., where he is a member of the firm's Labor and Employment group and ERISA Litigation subpractice. He can be contacted at pspangler@vedderprice.com.

on the ground that the administrator had a conflict of interest. *Bruch* lends some support for this approach, 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 'factor' in determining whether there is an abuse of discretion."

Before *Glenn*, federal appeals courts struggled with this language in *Bruch* when confronted with dual-role administrators. Some courts found that a dual role, by itself, did not create a conflict. Others held that a dual role always creates a conflict. When courts did recognize a conflict, the courts' review on the results of that diverged in several jurisdictions. Some held that the conflict resulted in a *de novo* standard of review when no deference was afforded to the administrator and discovery was sometimes permitted. Other courts applied a burden-shifting approach. Yet a third group of courts applied a sliding-scale review whereby the court's standard of review became progressively more stringent depending on the conflict's significance.

Faced with this split of authority in the appeals courts, the Supreme Court granted review in *Glenn* to address: (1) whether dual-role administrators operate under an inherent conflict of interest; and (2) if a conflict does exist, how it affects the court's review of the administrator's denial of benefits.

Metropolitan Life Insurance Co. v. Glenn

In *Glenn*, the Supreme Court held that dual-role administrators – including insurers making claims decisions under group insurance policies and employers making claims decisions under a self-funded plan – have an inherent conflict that the reviewing court must consider on a case-by-case basis.

In *Glenn*, the participant was a Sears employee who filed for disability benefits after a heart condition impaired her ability to work. MetLife, which served as the administrator and insurer of Sears' long-term disability (LTD) plan, rejected Glenn's claim for extended benefits, and said she was able to continue performing full-time work after her condition improved following medical treatment. Glenn sued MetLife under Section 502(a)(1)(B) of ERISA, which allows federal courts to review a plan administrator's denial of a participant's claim for benefits under an ERISA plan.

The district court ruled for MetLife, but the 6th U.S. Circuit Court of Appeals reversed, holding that MetLife had abused its discretion in denying Glenn's claim. Because the plan granted MetLife discretionary authority, the 6th Circuit reviewed the claim under an abuse of discretion standard, but ultimately set aside the claim due to five factors (see box).

Factors Relevant to Abuse of Discretion Review in *Glenn*

Here are the five factors the 6th Circuit cited under the abuse of discretion review in *Glenn*:

1) the conflict of interest;
2) MetLife's failure to reconcile its own conclusion that Glenn could work in other jobs with the Social Security Administration's conclusion that she could not;
3) MetLife's focus upon one treating physician report suggesting that Glenn could work in other jobs at the expense of other, more detailed treating physician reports indicating that she could not;
4) MetLife's failure to provide all of the treating physician reports to its own hired experts; and
5) MetLife's failure to take account of evidence indicating that stress aggravated Glenn's condition.

The Supreme Court affirmed the 6th Circuit's ruling in a 5-4 decision. The Court held that a conflict will always exist when an administrator is responsible for making benefit eligibility determinations and paying claims. In so holding, the Court rejected MetLife's attempt to argue that an insurance company stands in a materially different position compared to an employer-sponsor of a self-funded plan because insurers pass the cost of claims onto the insured. On the question of what standard of review should be applied, the Court expressly rejected the invitation to adopt a *de novo* or lesser standard of review for conflict cases, and instead held that – even when presented with a conflict – the courts review claims under a deferential standard of review and the conflict simply ranks as "but one factor among many that a reviewing judge must take into account." Accordingly, the Court held that the 6th Circuit properly "weighed" the conflict of interest "as a factor determining whether there [was] an abuse of discretion."

Acknowledging the vague and ad hoc nature of its "one factor among many" test, the Court admitted that its analysis does not provide a "detailed set of instructions" for reviewing courts. The Court did provide a loose, two-step approach, through which the reviewing court first identifies whether a conflict exists and determines how much weight to give the conflict when reviewing the claims record. The Court explained that little weight should be assigned where the administrator acts to minimize the conflict by "walling off claims administrators from those interested in firm finances, or imposing management checks that penalize inaccurate decision making irrespective of whom the inaccuracy benefits." However, "where circumstances suggest a higher likelihood that" the conflict "affected the benefits decision," the Court explained that the reviewing court must weigh the conflict more heavily.

After identifying the conflict and the weight to assign, the reviewing courts should look to "other factors" associated with the claim denial, the Court instructed. If the other factors are closely balanced, any factor (including the conflict) can act as a tie-breaker. If the weight assigned to the conflict is minimal, however, the Court reasoned that the reviewing court's focus should remain on the other factors.

Who Is at Risk?

This decision mainly affects claims administrators that fund and decide benefit claims. This includes insurance companies that perform this dual-role function. Many employers purchase insurance for medical, dental, vision, disability and life insurance benefits, including business travel accident and accidental death and disability. In this scenario, it is the insurer, as claims administrator, that would be sued and therefore has a direct stake in the conflict analysis. The insurer runs the risk under *Glenn* of having its conflict weighed upon review and the risk of a participant's lawyer obtaining discovery on the extent of that conflict. This is particularly burdensome for insurance companies because of the volume of claims processed. For example, the Supreme Court noted that courts should give more weight to the conflict when the administrator has a "history of biased decisiomaking," which has many insurance companies wondering whether they will now routinely face discovery requests when defending litigated claims.

More indirectly, the overall impact of this case on insurance companies may be to increase the cost of benefit claims litigation, which may be passed on to employers in the form of higher premiums. Therefore, companies may see increased plan administration costs in the future depending on how the federal courts interpret *Glenn*.

The *Glenn* decision also affects self-funded plans that employees of plan sponsors administer. This dual role appears most often in severance, retirement and some LTD plans when a benefits committee made up of plan sponsor employees is responsible for deciding benefits claims and appeals. In *Glenn*, the Court stated in dicta (commentary extraneous to the ruling) that employers may have an even greater conflict than an insurance company because "every dollar provided in benefits" is a dollar the employer spent and "every dollar saved" is a dollar in the employer's pocket.

Finally, some self-funded employee benefit plans hire outside third-party administrators (TPAs) to handle claims processing. This arrangement typically insulates the employer from the conflict-of-interest analysis because – although the employer funds the benefits – the TPA makes decisions on benefits. However, some claims structures allow for claims appeals to come back to an employer committee for a decision on review and, under those circumstances, the conflict-of-interest analysis comes into play.

At-risk Parties After *Glenn*

- Claims administrators that both fund and decide benefit claims.
- Self-funded plans that the plan sponsor employees administer.
- Self-funded employee benefit plans and their third-party administrators.

How Companies Can Reduce Risk

With minimal effort, employers can reduce risk in a conflict-of-interest benefit determination. Reviewing how claims are decided and by whom is an essential first step.

Review Third-party Claims Administrator Opportunities

In some self-funded welfare plans, employers make benefits determinations though in-house benefits committees. This is typical in the severance plan context, for example, and can be the case for some LTD plans. Depending on whether it is cost-effective to do so, employers should review the financial viability of outsourcing claims procedures for these plans to limit the risk that a conflict could jeopardize judicial review. Furthermore, if your plan uses a TPA to decide initial benefit claims, but allows an employer committee to decide appeals, you should consider changing this process to allow your TPA to complete both steps of this review. This will insulate the company from getting dragged into litigation if a participant alleges a conflict of interest.

Reform Benefits Committee Composition and Procedures

If an in-house committee makes benefits decisions, companies should consider revising its structure and membership. Originally, many plans named the employer or the corporation as the plan administrator, which led courts to allow participants to bring claims against the corporation and its board of directors. As a way to limit director liability, companies began to create employee benefits committees, which are often composed of a mix of employees from the human resources (HR), finance or accounting, and operations departments.

In *Glenn*, the Court recognized that the weight of the conflict will depend on the facts and circumstances of each case. Although it failed to provide any bright-line guidance, the Court noted that an administrator may take steps to reduce the importance of the conflict ("perhaps to the vanishing point") through a reduction in potential bias and promote accuracy. As an example, the court noted that the administrator could wall off claims administrators from those interested in firm finances, or impose management checks that promote accuracy.

It is not uncommon for benefits committees that decide claims to include high-level executives from finance or accounting departments or operations executives in charge of major business units. The reason for this is that these committees often have additional responsibilities for plan design and other settlor functions, and many companies want higher-level executives involved in those decisions. However, given that these individuals may now be seen as too concerned about the company's bottom line, companies should consider creating a separate committee to only deal with benefits claims, which would ideally include employees from only the HR department. HR employees are typically not engaged in firm finances, do not have significant equity ownership, and do not have incentive-based compensation tied to the company's financial performance. If a committee is made up of all or mostly HR employees, a court will likely downplay the significance of the conflict of interest.

Review Claims Procedures to Make Sure They Comply With ERISA

For dual-role administrators, one way to reduce the impact of a conflict is to make sure the plan's current administration complies with ERISA's claims procedures. Participants often cite procedural mishaps as evidence that a conflict of interest has influenced the claims decision, even if the decision has support in the record. This can lead to a costly remand. Many self-funded plans that review claims in-house do so because of the low volume of claims for that particular plan. However, the fact that the committee does not review a large volume of claims can often result in errors in the administrative claims process simply because the committee does not have to perform this function very often.

ERISA's claims procedures provide detailed guidelines for the timeframes, procedures and content of initial claim denials and appeal decisions. A self-audit of your employee benefit plans can ensure compliance with the claims regulations, thus eliminating the procedural mishaps that could be used against you to exacerbate a conflict-in-review litigation. Benefits committees should also notify and continue to work with in-house and outside counsel when a claim is filed to ensure that timelines are met and benefit denials contain the proper content.

For More Information

This article is one of 25 chapters on the most recent HR developments published in *Human Resources 2009: Answers to Your 25 Top Questions, Winter Edition*.