

**Perfecting the Vanishing Act:  
Practical Steps to Diminish the Weight  
of the Conflict of Interest Factor Post-Glenn**

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On June 19, 2008, the Supreme Court issued its decision in *Metropolitan Life Insurance Company, et al. v. Wanda Glenn*.<sup>1</sup> The much-anticipated decision was, in the eyes of many observers and practitioners, a disappointment. Notwithstanding its perceived shortcomings, the *Glenn* decision is the law and employers, administrators and other fiduciaries must consider its impact on their claims practices and procedures. In order to understand the underlying rationale and the significance of the *Glenn* decision, one must begin with an analysis of the Supreme Court's decision in *Firestone Tire & Rubber Co., et al. v. Bruch et al.*,<sup>2</sup> and the impact that a single sentence, which some argue is mere dictum,<sup>3</sup> had on the judicial review of employee benefits claims decisions for the next two decades. Accordingly, Sections I and II of this paper examine the *Firestone* decision and subsequent circuit court interpretations. Sections III and IV then turn to the *Glenn* decision and post-*Glenn* circuit court analyses of the conflict of interest factor. Finally, this paper concludes with suggested action steps for potentially lessening the impact of a conflict of interest.

**I. The Firestone Decision**

In *Firestone*, the Supreme Court addressed the appropriate standard of judicial review for benefit determinations by plan administrators or fiduciaries under the Employee Retirement

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<sup>1</sup> 128 S.Ct. 2343 (2008).

<sup>2</sup> 489 U.S. 101 (1989).

<sup>3</sup> *Glenn*, 128 S.Ct. at 2357 (Scalia, J., dissenting).

Income Security Act of 1974, as amended ("ERISA").<sup>4</sup> The case attracted significant attention among benefits practitioners, the insurance industry and the federal government.<sup>5</sup> In a unanimous decision, the Court established the appropriate standard of judicial review but in doing so opened the door for a variety of interpretations of that standard by the circuit courts,<sup>6</sup> once again resulting in a "split" among the circuits, the elimination of which had been the stated purpose<sup>7</sup> for the Court's decision to hear the *Firestone* case.

The focal point of the *Firestone* decision was a plan administrator's interpretation of a specific provision in a severance pay plan. Firestone was the sole source of funding for the severance plan and also served as the plan's administrator.<sup>8</sup> The question presented to the plan administrator was whether certain employees were entitled to severance benefits because Firestone's sale of its plastics division to the Occidental Petroleum Company constituted a "reduction in work force" under the terms of the plan.<sup>9</sup> Firestone concluded that the sale did not constitute a reduction in work force and denied the claim for benefits.

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<sup>4</sup> 29 U.S.C. § 1001 *et seq.*

<sup>5</sup> The following entities filed briefs and/or argued as *amici curiae*: Christopher J. Wright argued the cause for the United States as *amicus curiae* urging affirmance. With him on the brief were Solicitor General Fried, Deputy Solicitor General Ayer, George R. Salem, Charles I. Hadden, and Jeffrey A. Hennemuth. Briefs of *amici curiae* urging reversal were filed for the American Council of Life Insurance et al. by Phillip E. Stano, Jack H. Blaine, and David J. Larkin, Jr.; for the Chamber of Commerce of the United States et al. by Rex E. Lee, Carter G. Phillips, Mark D. Hopson, Stephen A. Bokart, Robin S. Conrad, Jan S. Amundson, and Quentin Riegel; for the ERISA Industry Committee by John M. Vine, Harris Weinstein, and Elliott Schulder; and for the Travelers Insurance Co. by Carol H. Jewett. Briefs of *amici curiae* urging affirmance were filed for the Plaintiff Employment Lawyers Association by Paul H. Tobias; and for the Pension Rights Center by Karen W. Ferguson and Terisa E. Chaw. Christopher G. Mackaronis and Cathy Ventrell-Monsees filed a brief for the American Association of Retired Persons as *amicus curiae*. See *Firestone* 480 US at 104.

<sup>6</sup> See discussion below regarding post-*Firestone* Circuit Court interpretations.

<sup>7</sup> *Firestone* 489 US at 108.

<sup>8</sup> This "dual role" was to become the focal point of the cases discussed herein.

<sup>9</sup> *Firestone* 489 US at 105.

The employees then filed a class action on behalf of former salaried, non-union employees who worked in the plants that comprised the plastics division of Firestone under §1132(a)(1)(B) of ERISA<sup>10</sup> seeking to recover benefits due under the terms of the plan. The United States District Court for the Eastern District of Pennsylvania<sup>11</sup> granted Firestone's motion for summary judgment and held that Firestone had satisfied its fiduciary duty under ERISA because its decision not to pay severance benefits under the plan was not arbitrary and capricious.<sup>12</sup>

The United States Court of Appeals for the Third Circuit reversed the district court's grant of summary judgment.<sup>13</sup> The Court acknowledged that most federal courts<sup>14</sup> have reviewed the denial of benefits by ERISA fiduciaries and plan administrators under the arbitrary and capricious standard.<sup>15</sup> It went on to state, however, that the arbitrary and capricious standard had been "softened" in cases where the fiduciaries and administrators had some bias or adverse interest.<sup>16</sup> The Third Circuit held<sup>17</sup> 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*

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<sup>10</sup> 29 U.S.C. 1132(a)(1)(B).

<sup>11</sup> *Bruch v. Firestone Tire & Rubber Co.*, 640 F. Supp. 519 (ED Pa. 1986).

<sup>12</sup> *Bruch*, 640 F. Supp. at 521-526 .

<sup>13</sup> *Bruch v. Firestone Tire and Rubber Co.*, 828 F. 2d 134 (3d Cir. 1987).

<sup>14</sup> *Firestone*, 489 US at 107 (internal citation omitted).

<sup>15</sup> As defined in Black's Law Dictionary, "arbitrary" commonly means ". . .founded on prejudice or preference rather than on reason or fact . . . this type of decision is often termed 'arbitrary and capricious.'" BLACK'S LAW DICTIONARY 79 (7th Ed. 2000). "Capricious" is defined as "characterized by or guided by unpredictable or impulsive behavior . . . contrary to the evidence or established rules of law." BLACK'S LAW DICTIONARY 167 (7th Ed. 2000).

<sup>16</sup> *Firestone*, 489 US at 107 (internal citation omitted).

<sup>17</sup> *Firestone*, 489 US at 107.

*novus*<sup>18</sup> judicial review. It reasoned that in such situations deference to the administrator's decision is unwarranted given the lack of assurance of impartiality on the part of the employer.<sup>19</sup>

The Supreme Court began its analysis of the case by specifically stating that its analysis was limited exclusively to the appropriate standard of review in §1132(a)(1)(B) actions challenging the denial of benefits based upon plan interpretations and that it was expressing no view as to the appropriate standard of review for actions under other remedial provisions of ERISA.<sup>20</sup> It then addressed the appropriateness of the application of the arbitrary and capricious standard to the review of benefit claims denials beginning with the recognition that ERISA does not specify the appropriate standard of review for actions under §1132(a)(1)(B). The Court then pointed out that, as result of this "gap", federal courts have adopted the arbitrary and capricious standard of review under the Labor Management Relations Act ("LMRA").<sup>21</sup>

The Court concluded, however, that the "wholesale" importation of the arbitrary and capricious standard into ERISA is unwarranted because, unlike the LMRA, ERISA expressly authorizes suits against fiduciaries and plan administrators to remedy statutory violations, including breaches of fiduciary duty and lack of compliance with benefit plans.<sup>22</sup> Accordingly, the reason for the arbitrary and capricious standard in the LMRA – the need for a judicial basis in suits against trustees – is not present in ERISA and without this jurisdictional analogy, there was

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<sup>18</sup> As defined in Black's Law Dictionary, an appeal reviewed under "*de novo*" reviews means "an appeal in which the appellate court uses the trial court's record but reviews the evidence and law without deference to the trial court's rulings." BLACK'S LAW DICTIONARY 74 (7th Ed. 2000).

<sup>19</sup> *Firestone*, 489 US at 108.

<sup>20</sup> *Firestone*, 489 US at 108.

<sup>21</sup> *Firestone*, 489 US at 109.

<sup>22</sup> *Firestone*, 489 US at 109–110.

no support for the adoption of the arbitrary and capricious standard for §1132(a)(1)(B) actions.<sup>23</sup> The Court concluded that the application of the arbitrary and capricious standard of review would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted.<sup>24</sup>

The Court then turned its attention to the application of trust law to ERISA and concluded that in determining the appropriate standard of review for actions under §1132(a)(1)(B), it must be guided by the principals of trust law.<sup>25</sup> Those trust principals dictate that a deferential standard of review is appropriate when a trustee exercises discretionary powers.<sup>26</sup> Applying these principals to the situation at hand, the Court concluded that "Firestone can seek no shelter in these principals of trust law, however, for there is no evidence under Firestone's termination pay plan that the administrator has the power to construe uncertain terms or that eligibility determinations are to be given deference".<sup>27</sup>

Firestone argued, unsuccessfully, that as a matter of trust law, the interpretation of the terms of a plan is an inherently discretionary function.<sup>28</sup> The Court concluded, however, that the principals of trust law point to the application of the *de novo* standard of review in situations where the trustee does not have specifically designated discretionary powers.<sup>29</sup> The Court also rejected Firestone's contention that the application of the *de novo* standard would have the effect

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<sup>23</sup> *Firestone*, 489 US at 110.

<sup>24</sup> *Firestone*, 489 US at 110.

<sup>25</sup> *Firestone*, 489 US at 111.

<sup>26</sup> *Firestone*, 489 US at 111 *citing* Restatement (Second) of Trusts § 187 (1959).

<sup>27</sup> *Firestone*, 489 US at 111.

<sup>28</sup> *Firestone*, 489 US at 112.

<sup>29</sup> *Firestone*, 489 US at 112.

of increasing litigation, thereby increasing the costs of maintaining the plans which would in turn discourage employers from creating benefit plans.<sup>30</sup>

The Court concluded its analysis by stating, "consistent with established principals 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."<sup>31</sup> The Court went on to state, however, that since it does not rely upon the concern for impartiality that guided the Third Circuit, "we need not distinguish between types of plans or focus on the motivation of plan administrators and fiduciaries and that 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."<sup>32</sup> The Court ended its discussion with a sentence that was to become the focal point of litigation for the next two decades, culminating with the *Glenn* decision, stating, "Of course, 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.'"<sup>33</sup>

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<sup>30</sup> *Firestone*, 489 US at 115.

<sup>31</sup> *Firestone*, 489 US at 115.

<sup>32</sup> *Firestone*, 489 US at 115.

<sup>33</sup> *Firestone*, 489 US at 115 *citing* Restatement (Second) of Trusts § 187, Comment d (1959).

## II. Circuit Court Interpretations of *Firestone*

The conflict of interest statement in *Firestone* was eventually interpreted and applied by each of the circuit courts. In developing its unique interpretation, each circuit court engaged in a two-step analysis.<sup>34</sup> First, the Court determined whether the fact that the plan administrator both evaluates and pays the claims (*i.e.*, funds the plan) constitutes, in and of itself, a conflict of interest that must be taken into account in a judicial review of that administrator's benefits claims determinations. If the answer to that question is 'yes,' the inquiry then turns to the appropriate standard of judicial review.

Not surprisingly, the circuit courts developed several different approaches to answering these questions. With respect to the first inquiry, the Third, Fourth, Fifth, Ninth, Tenth and Eleventh Circuits have all concluded that a plan administrator who both evaluates and pays claims operates under a conflict of interest that must be taken into account in a judicial review of the administrator's determinations.<sup>35</sup> As one commenter has noted, however, the Third Circuit has suggested,<sup>36</sup> "that there is no conflict of interest when an employer both funds and administers the plan, but pays the benefits out of a fully funded and segregated ERISA Trust."<sup>37</sup>

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<sup>34</sup> Posting of Roy F. Harmon III to Health Plan Law, <http://healthplanlaw.com/?p=508> (Jan. 4, 2008 at 10:10 am) (last visited Oct. 12, 2008) (on file with author) (hereinafter referred to as "Harmon-Health Plan 1/4/08 Post").

<sup>35</sup> Harmon-Health Plan 1/4/08 Post, citing to *Post v. Hartford Ins. Co.*, 501 F.3d 154, 161-164 (3d Cir. 2007); *Carolina Care Plan Inc. v. McKenzie*, 467 F.3d 383, 386-387 (4th Cir. 2006), *cert. dismissed*, Nos. 06-1182 & 06-1436 (July 30, 2007); *Vega v. National Life Ins. Servs., Inc.*, 188 F.3d 287, 295-296 (5th Cir. 1999) (en banc); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 965-966 (9th Cir. 2006) (en banc); *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1003 (10th Cir. 2004), *cert. denied*, 544 U.S. 1026 (2005); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561, 1566-1567 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991).

<sup>36</sup> Harmon-Health Plan 1/4/08 Post, citing to *Post v. Hartford Ins. Co.*, 501 F.3d at 164.

<sup>37</sup> See discussion of *Burke v. Pitney Bowes Inc. Long Term Disability Plan*, 2008 WL 4276910 (9th Cir. Sept. 19, 2008) included herein below.

The First and Seventh Circuits have held that the "dual role" does not present a conflict of interest that must be taken into account in the judicial review of a benefit determination.<sup>38</sup> The Second Circuit has adopted a similar position, unless the plaintiff is able to demonstrate that the administrator was in fact influenced by the conflict of interest.<sup>39</sup> The Eighth Circuit developed a theory similar to the Second Circuit, requiring probative evidence demonstrating that a palpable conflict of interest or serious procedural irregularity existed which caused a serious breach of the plan administrator's fiduciary duty.<sup>40</sup>

With respect to the determination of the appropriate "deferential" standard of judicial review, the Third, Fourth, Fifth, Sixth and Ninth Circuits have adopted a "sliding scale" approach, where the deference afforded to the plan administrator's decision depends upon the seriousness of the conflict.<sup>41</sup> As was discussed above, the First, Seventh and Eighth Circuits do not recognize the "dual role" as a conflict of interest *per se*, but in circumstances in which a conflict of interest has been proven, those circuits will apply a sliding scale analysis.<sup>42</sup> In

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<sup>38</sup> Harmon-Health Plan 1/4/08 Post, *citing to Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005); *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999).

<sup>39</sup> Harmon-Health Plan 1/4/08 Post, *citing to Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2d Cir. 2000) (*quoting Sullivan v. LTV Aerospace & Def. Co.*, 82 F.3d 1251, 1255-1256 (2d Cir. 1996)).

<sup>40</sup> Harmon-Health Plan 1/4/08 Post, *citing to Woo v. Deluxe Corp.*, 144 F.3d 1157, 1160-1161 & n.2 (8th Cir. 1998).

<sup>41</sup> Harmon-Health Plan 1/4/08 Post, *citing to Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 87 (4th Cir. 1993); *Vega*, 188 F.3d at 297; *Borda v. Hardy, Lewis, Pollard & Page, P.C.*, 138 F.3d 1062, 1065-1069 (6th Cir. 1998) (applying abuse-of-discretion review that is "shaped by the circumstances of the inherent conflict of interest" but not calling it a "sliding scale" (internal quotation marks omitted)); *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. (rejecting the "sliding scale" metaphor but adopting an approach that is substantially similar to the sliding-scale approach)).

<sup>42</sup> Harmon-Health Plan 1/4/08 Post, *citing to Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74-75 (1st Cir. 2005); *Mers v. Marriott International Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020-1021 & n.1 (7th Cir.), *cert. denied*, 525 U.S. 947 (1998); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1162 (8th Cir.1998).

situations of egregious circumstances, the Eighth Circuit will apply the *de novo* standard.<sup>43</sup> The Second Circuit, which also does not recognize the dual role as a conflict of interest *per se*, utilizes a *de novo* standard of review when a conflict of interest is identified and it has been adequately shown that the administrator was influenced by that conflict.<sup>44</sup>

The Tenth and Eleventh Circuits have developed what has been referred to as "burden shifting"<sup>45</sup> approaches. The Tenth Circuit<sup>46</sup> shifts the burden of proof to the plan administrator to prove the reasonableness of its decision applying an arbitrary and capricious standard. In the Eleventh Circuit,<sup>47</sup> the court first determines, *de novo*, whether or not the denial of benefits was proper. If proper, the decision is affirmed. If improper, the Eleventh Circuit instructs district courts to apply a deferential standard of review. If proper under the deferential standard, then the court assesses whether there is a conflict of interest. Presuming no conflict, the decision is upheld. If there is a conflict, the burden shifts to the administrator to prove that his/her decision was not "tainted by the conflict."<sup>48</sup>

Despite the wide variety of interpretations that the circuit courts had developed with respect to the conflict of issue concept, it would be another 20 years before the Supreme Court would again address this critical issue, notwithstanding the fact that the Court had been presented

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<sup>43</sup> Harmon-Health Plan 1/4/08 Post, *citing to Woo v. Deluxe Corp.*, 144 F.3d 1157, 1162 (8th Cir.1998).

<sup>44</sup> Harmon-Health Plan 1/4/08 Post, *citing to Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2d Cir. 2000).

<sup>45</sup> Harmon-Health Plan 1/4/08 Post (generally discussing burden-shifting analysis).

<sup>46</sup> Harmon-Health Plan 1/4/08 Post, *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004), *cert. denied*, 544 U.S. 1026 (2005).

<sup>47</sup> Harmon-Health Plan 1/4/08 Post, *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1566 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991).

<sup>48</sup> *See Williams v. BellSouth Telecoms., Inc.*, 373 F.3d 1132, 1138 (11th Cir. 2004).

with numerous opportunities to do so earlier.<sup>49</sup> The case was argued before the Supreme Court on April 23, 2008,<sup>50</sup> and the decision was rendered on June 19, 2008. While many waited with baited breathe, the decision was, in many respects, less than enlightening.

### **III. Metropolitan Life Insurance Company v. Wanda Glenn**

In *Glenn*, the Supreme Court considered: (1) whether an administrator having the dual role of both paying and granting benefits under an ERISA plan was in fact an inherent conflict of interest and (2) if such an arrangement creates an inherent conflict of interest, how a reviewing court should consider the conflict of interest when an administrator has discretionary authority under the terms of the plan. The case came to the Supreme Court for review after Glenn had filed suit under ERISA to contest the administrator's termination of long-term disability benefits on the ground that Glenn was no longer totally disabled. The United States District Court for the Southern District of Ohio entered judgment for the plan, and Glenn appealed.<sup>51</sup> The Sixth Circuit Court of Appeals reversed and remanded.<sup>52</sup> The plan administrator sought *certiorari*, which was granted.

The *Glenn* court reviewed the decision of Metropolitan Life Insurance Company ("MetLife") denying Glenn continued long-term disability benefits because she was no longer "disabled" under the terms of the plan. Specifically, MetLife was the administrator and insurer

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<sup>49</sup> Discussion of panelists during *MetLife v. Glenn* teleconference. See ABA Joint Committee on Employee Benefits, *MetLife v. Glenn*, July 10, 2008 Teleconference/Live Audio Webcast featuring: Elizabeth Hopkins, Counsel for Appellate and Special Litigation, U.S. Department of Labor, Washington, DC; Bob Eccles, O'Melveny & Myers LLP, Washington, DC; and Ted Sichelman, Kauffman Foundation Research Fellow, University of California (Boalt Hall) School of Law, Berkeley, CA.

<sup>50</sup> The transcript of the oral argument before the Supreme Court is recommended reading for a better understanding of how the Justices grappled with the issues.

<sup>51</sup> *Glenn v. Metropolitan Life Insurance Co.*, 2005 WL 1364625 (S.D. OH June 8, 2005).

<sup>52</sup> *Glenn v. MetLife*, 461 F.3d 660 (6th Cir. September 1, 2006).

of the Sears, Roebuck & Company long-term disability insurance plan, a welfare benefit plan governed by ERISA. The plan gave MetLife (as administrator) discretionary authority to determine the validity of an employee's benefits claim and further stated that MetLife (as the insurer) would pay the claims.<sup>53</sup> Glenn, a Sears employee, was diagnosed with a heart condition whose symptoms included fatigue and shortness of breath. She applied for plan disability benefits in June 2000, and MetLife concluded that she met the plan's standard for an initial 24 months of benefits, specifically, that she could not "perform the material duties of her own job."<sup>54</sup>

At or around the same time as MetLife ruled Glenn eligible for 24 months of benefits, it directed her to a law firm that would assist her in applying for federal Social Security disability benefits, a portion of which MetLife would be entitled to receive as an offset to the plan benefits. In April 2002, an Administrative Law Judge ruled that Glenn's illness prevented her not only from performing her own job but also "from performing any jobs [for which she could qualify] existing in significant numbers in the national economy."<sup>55</sup> Accordingly, the Social Security Administration awarded Glenn permanent disability payments that were applied retroactively to April 2000. Despite the retroactive award, Glenn herself kept none of the Social Security benefits as three-quarters went to MetLife and the rest went to the lawyers.<sup>56</sup>

Under the terms of the Sears plan, to continue receiving disability benefits after 24 months, Glenn had to meet a higher, "Social-Security-type" standard. Specifically, she had to

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<sup>53</sup> *Glenn*, 128 S.Ct. at 2346.

<sup>54</sup> *Glenn*, 128 S.Ct. at 2346.

<sup>55</sup> *Glenn*, 128 S.Ct. at 2346.

<sup>56</sup> *Glenn*, 128 S.Ct. at 2347.

show that "her medical condition rendered her incapable of performing not only her own job but of performing the material duties of any gainful occupation for which she was reasonably qualified."<sup>57</sup> MetLife denied Glenn's claim for extension of her benefits past 24 months because it found that she was "capable of performing full time sedentary work."<sup>58</sup>

On appeal to the Sixth Circuit, the Court of Appeals reviewed the administrative record under a deferential standard because the plan granted MetLife "discretionary authority to . . . determine benefits."<sup>59</sup> In doing so, the Sixth Circuit considered the "conflict of interest" arising out of the fact that MetLife was "authorized to both decide whether an employee is eligible for benefits and to pay those benefits" as a "relevant factor."<sup>60</sup> Specifically, the Sixth Circuit set aside MetLife's denial of benefits in light of a combination of factors including:

- (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 expert; and
- (5) MetLife's failure to take into account the evidence indicating that stress aggravated Glenn's condition.<sup>61</sup>

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<sup>57</sup> *Glenn*, 128 S.Ct. at 2347.

<sup>58</sup> *Glenn*, 128 S.Ct. at 2347.

<sup>59</sup> *Glenn*, 128 S.Ct. at 2347, *citing* 461 F.3d at 666.

<sup>60</sup> *Glenn*, 128 S.Ct. at 2347, *citing* 461 F.3d at 666.

<sup>61</sup> *Glenn*, 128 S.Ct. at 2347, *citing* 461 F.3d at 674.

Writing for the majority, Justice Breyer began the *Glenn* court's analysis with a review of *Firestone*. Specifically, the Court enunciated the following four principles from *Firestone* as being relevant to *Glenn*:

- (1) To determine the appropriate standard of review, courts should be guided by principles of trust law—analagizing a plan administrator to a trustee and considering a benefits decision as a fiduciary act.
- (2) Trust law principles require *de novo* review of benefit denials unless a benefit plan provides otherwise.
- (3) Where the plan so provides, "by granting the administrator or fiduciary *discretionary authority* to determine eligibility . . . trust principles make a *deferential standard* of review appropriate."
- (4) If the administrator or fiduciary having discretion is "*operating under a conflict of interest*, that conflict must be *weighed as a factor* in determining whether there is an abuse of discretion."<sup>62</sup>

Turning first to the question of whether a plan administrator's dual role as both evaluator and payor of claims is the kind of "conflict of interest" to which *Firestone's* fourth principle refers, the Court found that it is via an examination of trust principles. Although the issue was not squarely before it and circuit courts had ruled otherwise, in dicta the Court summarily stated that "the answer is clear where it is an employer that both funds the plan and evaluates claims . . . in such a circumstance, 'every dollar provided in benefits is a dollar spent by . . . the employer, and every dollar saved . . . is a dollar in the employer's pocket.'"<sup>63</sup>

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<sup>62</sup> *Glenn*, 128 S.Ct. at 2347–2748 (internal citations omitted).

<sup>63</sup> *Glenn*, 128 S.Ct. at 2348 (internal citations omitted). *But see Colucci v. Agfa Corp. Severance Plan*, 431 F.3d 170, 179 (4th Cir. 2005) (holding that while the insurance company-administrator has a conflict, the employer-administrator does not).

In addressing the facts before it, the Court held that as a third-party administrator, MetLife's dual role as evaluator and payor presented a *Firestone* conflict of interest for numerous reasons. First, the Court recognized that an employer's own conflict may extend to its selection of an insurance company to administer its plan because an employer would be more interested in an insurance company with low rates than with accurate claims processing.<sup>64</sup> Next, the Court found that ERISA imposes "higher-than-marketplace" standards on insurers in that it sets forth the standard of care for plan administrators, specifically, that the administrator, "discharge its duties . . . solely in the interests of the participants and beneficiaries' of the plan, §1104(a)(1); [while] it simultaneously underscores the particular importance of accurate claims processing by insisting that administrators 'provide full and fair review' of claim denials."<sup>65</sup> Finally, the Court reasoned that a *Firestone* conflict exists in any situation where the benefit evaluator is also the benefit payor because "a legal rule that treats insurance company administrators and employers alike in respect to the *existence of a conflict* can nonetheless take account of the circumstances . . . as diminishing the *significance or severity* of the conflict in individual cases."<sup>66</sup>

Upon concluding that the facts presented a *Firestone* conflict of interest, the Court next considered how the conflict should "be taken into account on judicial review of a discretionary benefit determination." Although practitioners hoped that the *Glenn* court would set forth a specific test or rubric for delineating how a conflict of interest is to be evaluated under a *Firestone* deferential standard of review, the Court's opinion instead reiterated *Firestone's*

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<sup>64</sup> *Glenn*, 128 S.Ct. at 2349–2350.

<sup>65</sup> *Glenn*, 128 S.Ct. at 2350.

<sup>66</sup> *Glenn*, 128 S.Ct. at 2350.

premise that a conflict of interest should be weighed as a "factor in determining whether there is an abuse of discretion."<sup>67</sup>

Notably, the Court reasoned that weighing a conflict of interest into a factor-based analysis does not imply a change in the standard of review, say from deferential to *de novo* review. In fact, the Court expressly stated that it would not "*overturn Firestone by adopting a rule that in practice could bring about near universal review by judges de novo—i.e., without deference—of the lion's share of ERISA plan claims denials.*"<sup>68</sup>

Appearing to speak directly to the circuit courts, the Court also cautioned that it is not necessary or desirable to create special burden-of-proof rules, or other special procedural or evidentiary rules, focused narrowly on the evaluator/payor conflict.<sup>69</sup> To be sure, the *Glenn* court reiterated that a conflict of interest is to be but one factor among many that a reviewing judge should take into account. Specifically, the Court elaborated that,

Benefits 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 degree of seriousness – for us to come up with a one-size fits all procedural system that is likely to promote a fair and accurate review. Indeed special procedural rules would create further complexity, adding time and expense to a process that may already be too costly for many of those who seek redress.<sup>70</sup>

After denouncing mechanical procedural rules for evaluating a conflict of interest, the Court analogized the consideration of a conflict of interest as a "factor" in a reviewing court's determination to analyses applied in trust and administrative law, wherein the reviewing

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<sup>67</sup> *Glenn*, 128 S.Ct. at 2350.

<sup>68</sup> *Glenn*, 128 S.Ct. at 2350 (emphasis added).

<sup>69</sup> *Glenn*, 128 S.Ct. at 2351.

<sup>70</sup> *Glenn*, 128 S.Ct. at 2351.

court/agency will consider a host of factors. In such factor-based analyses the Court noted that "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."<sup>71</sup>

Most important for employers, plan administrators, and practitioners, the *Glenn* court provided some degree of insight into considerations that may heighten or lessen the importance of a conflict of interest. The Court instructed that a conflict of interest at issue should prove "more important, even perhaps of great importance, *where 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.*"<sup>72</sup> In contrast, a conflict of interest should prove "*less important, perhaps to the point of vanishing, 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.*"<sup>73</sup>

Although the *Glenn* court granted *certiorari* to determine (1) whether a conflict was presented and (2) how to evaluate the conflict under the deferential standard of review, when applying its holdings to affirm the Sixth Circuit's opinion, the Court noted that under the "combination of factors" method of review, the Sixth Circuit afforded the "conflict weight in some degree" but that other factors permeated the Sixth Circuit's analysis suggesting that the

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<sup>71</sup> *Glenn*, 128 S.Ct. at 2351.

<sup>72</sup> *Glenn*, 128 S.Ct. at 2351.

<sup>73</sup> *Glenn*, 128 S.Ct. at 2351.

"conflict alone [was not] determinative."<sup>74</sup> The other factors that were more heavily considered by the circuit court included that (1) MetLife encouraged Glenn to argue to the Social Security Administration that she could do no work, then MetLife received the bulk of the benefits of her doing so and then ignored the agency's findings to conclude that Glenn could do sedentary work;<sup>75</sup> (2) MetLife emphasized a certain medical report that favored denial or benefits, and deemphasized other reports that suggested contrary conclusions; and (3) MetLife failed to provide its independent vocational expert and medical experts with all relevant evidence.<sup>76</sup> As such, while the Court affirmed the Sixth Circuit, the egregiousness of MetLife's procedural missteps apparent in *Glenn* ultimately undermined any fruitful discussion of how reviewing courts should approach the weight afforded to conflict of interest.

Chief Justice Roberts, concurring in part and in judgment, wrote an insightful concurrence in *Glenn* wherein he discussed his reasons for disagreeing with the majority opinion regarding how a conflict should matter in a deferential review.<sup>77</sup> According to Chief Justice Roberts, "the majority would accord weight, of varying and indeterminate amount, to the existence of such a conflict in every case where it is present."<sup>78</sup> The ultimate result, then being that the level of scrutiny in every case is increased if there is a conflict, that is, in many if not

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<sup>74</sup> *Glenn*, 128 S.Ct. at 2352.

<sup>75</sup> With respect to MetLife's refusal to acknowledge the agency's determination that it had insisted Glenn apply for, the Court noted that this occurrence was not only an important factor in its own right because it suggested procedural unreasonableness, this occurrence also suggested that "*more weight could be afforded to the conflict because MetLife's seemingly inconsistent positions were both financially advantageous.*" *Glenn*, 128 S.Ct. at 2352.

<sup>76</sup> *Glenn*, 128 S.Ct. at 2352.

<sup>77</sup> *Glenn*, 128 S.Ct. at 2353 (Roberts, C.J., concurring).

<sup>78</sup> *Glenn*, 128 S.Ct. at 2353 (Roberts, C.J., concurring).

most ERISA cases—thereby undermining the deference owed to plan administrators when the plan vests discretion in them.

Akin to the dissent in *Glenn*, Chief Justice Roberts asserts that the conflict of interest should be considered on review "only where there is evidence that the benefits denial was motivated or affected by the administrator's conflict."<sup>79</sup> Noting that the conflict of interest presented in *Glenn* is a common feature of ERISA plans, Chief Justice Roberts emphasized that the majority's approach, without focusing on how a conflict of interest should be considered, "invites the substitution of judicial discretion for the discretion of the plan administrator."<sup>80</sup>

Further, Chief Justice Roberts refutes the majority's analogy to administrative law emphasizing that unlike certain administrative reviews, "certainty and predictability are important criteria under ERISA, and employers considering whether to establish ERISA plans can have no notion what it means to say that a standard feature of such plans will be one of the 'impalpable factors' involved in judicial review."<sup>81</sup> Based on its strained analogy and lack of application of the factor-based conflict of interest analysis, Chief Justice Roberts expounds that through its opinion, "the Court leaves the law more uncertain, more unpredictable than it found it."<sup>82</sup>

Justice Scalia, writing in dissent, stresses that under trust law a fiduciary with a conflict does not abuse its discretion unless the conflict *actually* and *improperly motivates* the fiduciary's

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<sup>79</sup> *Glenn*, 128 S.Ct. at 2353 (Roberts, C.J., concurring).

<sup>80</sup> *Glenn*, 128 S.Ct. at 2353 (Roberts, C.J., concurring).

<sup>81</sup> *Glenn*, 128 S.Ct. at 2354 (Roberts, C.J., concurring).

<sup>82</sup> *Glenn*, 128 S.Ct. at 2354 (Roberts, C.J., concurring).

decision.<sup>83</sup> In addition to reviewing the majority's inconsistencies with general trust law principles, Justice Scalia squarely addresses the majority's consideration of an employer acting as evaluator and payor in a administrator role. Specifically, Justice Scalia acknowledges that there is no reason "why the Court must volunteer . . . that *an employer* who administers its own ERISA-governed plan 'clearly has a conflict of interest.'"<sup>84</sup> Noting that the employer dual role circumstance was not squarely before the Court, Justice Scalia emphasized that the Court's unnecessary and uninvited resolution of that issue must be regarded as dictum.

#### **IV. Post-Glenn: Circuit Courts and the Conflict of Interest "Factor"**

Despite the concurrences and dissent in *Glenn*, the circuit courts are charged with applying the majority's factor-based conflict of interest analysis to challenged benefit denials where the administrator is given deference under the terms of the plan. Not surprisingly, circuits who have addressed conflict of interest issues in a deferential analysis under *Firestone* post-*Glenn* have evaluated how the conflict of interest will impact the analysis in varying ways, leaving plan administrators with as much, if not more, uncertainty regarding how their practices and dual roles as evaluator and payor will play out in court. Below is a review of selected opinions handed down in various circuits since the Supreme Court's June 19, 2008, *Glenn* opinion.

***Wakkinen v. Unum Life Insurance Company of America, et al.***<sup>85</sup> In *Wakkinen*, the United States Court of Appeals for the Eighth Circuit considered whether the district court erred in upholding the administrator's denial of benefits under an abuse of discretion standard where

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<sup>83</sup> *Glenn*, 128 S.Ct. at 2357 (Scalia, J., dissenting).

<sup>84</sup> *Glenn*, 128 S.Ct. at 2357 (Scalia, J., dissenting) citing *Colucci v. Agfa Corp. Severance Plan*, 431 F.3d 170, 179 (4th Cir. 2005).

<sup>85</sup> *Wakkinen*, 531 F.3d 575 (8th Cir. 2008).

the plan granted the administrator administrative discretion in determining eligibility for benefits. Implicitly recognizing that the *Glenn* decision overruled the Eighth Circuit precedent requiring probative evidence demonstrating that a palpable conflict of interest existed which caused a serious breach of the plan administrator's fiduciary duty, the Eighth Circuit recognized that UNUM's dual role of funding and evaluating eligibility for claims was an inherent conflict of interest under *Glenn*.<sup>86</sup> In an attempt to show that the conflict should be afforded substantial weight in the court's analysis, Wakkinen produced evidence that UNUM's claims practices were reviewed and found to be problematic by the United States Department of Labor and state regulators. Specifically, the examiners found several areas of concern, including excessive reliance on in-house medical professionals, unfair construction of attending physician or independent medical exam reports, failure to evaluate the totality of the claimant's medical condition, and inappropriate burdens placed on claimants to justify their eligibility for benefits.<sup>87</sup>

Despite the Department of Labor and state regulators' 2003 findings, in the Eighth Circuit's interpretation of *Glenn*, the *Wakkinen* court found that based on the procedural factors, which weighed in favor of the administrator's denial of benefits, there was not a "sufficiently close balance for the conflict of interest to act as a tiebreaker in favor of finding that UNUM abused its discretion."<sup>88</sup> Based on the extensive evidence of bias in decision making practices which may tend to show that the conflict of interest could have in fact impacted the administrator's decisions, *Wakkinen* appears to represent the Eighth Circuit's application of

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<sup>86</sup> *Wakkinen*, 531 F.3d at 581.

<sup>87</sup> *Wakkinen*, 531 F.3d at 582.

<sup>88</sup> *Wakkinen*, 531 F.3d at 582.

*Glenn* wherein the conflict of interest is relegated to being the "tiebreaker factor," looked to only in the instance where the procedural factors are sufficiently close.

**Doyle v. Liberty Life Assurance Company of Boston.**<sup>89</sup> In *Doyle*, the United State Court of Appeals for the Eleventh Circuit considered whether its "heightened standard" of review was appropriate post-*Glenn*.<sup>90</sup> In a detailed opinion, the Court reviewed its pre-*Glenn* ERISA framework, wherein after *Firestone*, the Eleventh Circuit had developed a six-step analysis to guide district courts in reviewing situations where an administrator with discretionary authority rendered a benefits decision.<sup>91</sup> Specifically, the Court noted that its prior analysis consisted of:

1. Applying the *de novo* standard to determine whether the claim administrator's benefits-denial decision is "wrong" (i.e., does the court disagree with the administrator's decision), if it is not, then end the inquiry and affirm the decision.
2. If the administrator's decision is "*de novo* wrong" then determine whether he was vested with discretion in reviewing claims, if not, end judicial inquiry and reverse decision.
3. If administrator's decision was "*de novo* wrong" and he was vested with discretion in reviewing claims, then determine whether reasonable grounds supported it (hence review his decision under the more deferential arbitrary and capricious standard).
4. If no reasonable grounds exist, then end the inquiry and reverse the administrator's decision; if reasonable grounds exist, then determine if he operated under a conflict of interest.
5. If there is no conflict, then end the inquiry and affirm the decision.

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<sup>89</sup> *Doyle*, 2008 WL 4272748 (11th Cir. Sept. 18, 2008) (WESTLAW Citation currently only available).

<sup>90</sup> *Doyle*, 2008 WL 4272748 at \*4.

<sup>91</sup> *Doyle*, 2008 WL 4272748 at \*3.

6. If there is a conflict then apply a heightened arbitrary and capricious review (where the administrator has the burden to prove that its decision was not influenced by the conflict) to the decision to affirm or deny it.<sup>92</sup>

In an attempt to resolve the inconsistencies of the Eleventh Circuit's pre-*Glenn* precedent with the *Glenn* decision, the United States District Court for the Northern District of Florida applied steps one through four of the six-step analysis, ultimately finding that Liberty Life's review of Doyle's claim for benefits was reasonable, thus necessitating the district court to consider whether Liberty Life operated under a conflict of interest.<sup>93</sup> Rather than applying the "heightened arbitrary and capricious standard," the district court modified the standard in the following way: "instead of requiring Liberty Life to prove that its decision was not influenced by the conflict – as the heightened standard requires – the court reviewed the record and concluded that 'there does not appear to be any evidence that Liberty in any way manipulated or improperly influenced Doyle's LTD benefits process in order to achieve a financially beneficial result.'"<sup>94</sup>

In reviewing the district court's decision, the Eleventh Circuit, relying on *Glenn*, found that the district court did not err in refusing to apply the Circuit's pre-*Glenn* heightened standard.<sup>95</sup> Specifically, the Court held

*Glenn* implicitly overrules our precedent to the extent that it requires district courts to review benefit determinations by a conflicted administrator under the heightened standard. We hold

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<sup>92</sup> *Doyle*, 2008 WL 4272748 at \*3 citing *Williams v. BellSouth Telecoms., Inc.*, 373 F.3d 1132, 1138 (11<sup>th</sup> Cir. 2004).

<sup>93</sup> *Doyle*, 2008 WL 4272748 at \*3–4.

<sup>94</sup> *Doyle*, 2008 WL 4272748 at \*4.

<sup>95</sup> *Doyle*, 2008 WL 4272748 at \*5.

that the existence of a conflict of interest should merely be a factor for the district court to take into account when determining whether the administrator's decision was arbitrary and capricious. And we hold that, while the reviewing court must take into account an administrator's conflict when determining whether an administrative conflict 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.<sup>96</sup>

In reviewing the district court's analysis and approval of the administrator's benefit denial, the Eleventh Circuit upheld the district court's finding that although Liberty Life's role as both "evaluator" and "payor" presented a conflict, the conflict did not influence Liberty Life's decision and was therefore consistent with *Firestone* and *Glenn*. Further, the *Doyle* court dismissed Doyle's contention that post-*Glenn* a court must give greater weight to the existence of a conflict if there is no evidence that the administrator put procedures in place to assure accurate claims assessment.<sup>97</sup> Specifically, to refute Doyle's contention, the *Doyle* court emphasized that *Glenn* held "the presence of a conflict of interest might be of little significance if the administrator can show what steps it has taken to promote accurate claim assessment, but if the record is silent on this point, it is proper to focus on other factors."<sup>98</sup> Ultimately, as there was no evidence in the record to suggest that Liberty Life was influenced by the conflict and there was no evidence which would have prompted the district court to accord more weight to the conflict, the Eleventh Circuit upheld the district court's affirmation of Liberty Life's denial of benefits.

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<sup>96</sup> *Doyle*, 2008 WL 4272748 at \*7. Notably, the Tenth Circuit's burden-shifting approach discussed in Section II, *supra*, is most likely implicitly overruled by *Glenn*.

<sup>97</sup> *Doyle*, 2008 WL 4272748 at \*9.

<sup>98</sup> *Doyle*, 2008 WL 4272748 at \*9.

**Burke v. Pitney Bowes Inc. Long Term Disability Plan.**<sup>99</sup> In *Burke*, the United States Court of Appeals for the Ninth Circuit addressed whether a trust fund structured as a Voluntary Employees' Beneficiary Association ("VEBA") Trust where both the employer and employees made contributions and the employer had a committee that rendered LTD benefit eligibility determinations under the terms of the VEBA, presented a post-*Glenn* conflict of interest.<sup>100</sup> The United States District Court for the Northern District of California, which was originally charged with addressing the issue, held that there was no structural conflict because the funds were paid from the VEBA Trust.<sup>101</sup>

Although the Ninth Circuit acknowledged that pre-*Glenn* some circuits support the proposition that no conflict of interest exists when plan benefits are paid out of trust,<sup>102</sup> the Ninth Circuit held that "even when a plan's benefits are paid out of trust, a structural conflict of interest exists that must be considered as a factor in determining whether there was an abuse of discretion."<sup>103</sup> In support of its holding, the Ninth Circuit analogized an employer's self-funded

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<sup>99</sup> *Burke*, 2008 WL 4276910 (9th Cir. Sept. 19, 2008).

<sup>100</sup> *Burke*, 2008 WL 4276910 at \*8.

<sup>101</sup> *Burke*, 2008 WL 4276910 at \*8.

<sup>102</sup> *Burke*, 2008 WL 4276910 at \*8, citing *Post v. Hartford Ins. Co.*, 501 F.3d 154, 164 n.3 (3d Cir. 2007) (stating that "when the employer both funds and administers the plan, but pays benefits out of a fully funded and segregated ERISA trust fund rather than its operating budget, no structural conflict of interest is created"); *Gilley v. Monsanto Co., Inc.*, 490 F.3d 848, 856 (11th Cir. 2007) (stating that "no conflict of interest exists where benefits are paid from a trust that is funded through periodic contributions so that the provider incurs no immediate expense as a result of paying benefits"); *Vitale v. Latrobe Area Hosp.*, 420 F.3d 278, 282-83 (3d Cir. 2005) (holding that a heightened version of abuse of discretion standard was not applicable because plan benefits were paid out of a separate trust fund); *de Nobel v. Vitro Corp.* 885 F.2d 1180, 1191-92 (4th Cir.1989) (holding that there was no conflict of interest from an employer-funded plan where plan funds were held in a trust because there is no direct and immediate expense to the employer from the payout of benefits).

<sup>103</sup> *Burke*, 2008 WL 4276910 at \*8. *But see Frankie White v. Coca-Cola Co.*, 2008 WL 4149706 \*9 (11th Cir. Sept. 10, 2008) (deciding post-*Glenn* that "our circuit law is clear that no conflict of interest exists where benefits are paid from a trust that is funded through periodic contributions so that the provider incurs no immediate expense as a result of paying benefits").

plan where "every dollar provided in benefits is a dollar spent by . . . the employer, and every dollar saved . . . is a dollar in the employer's pocket,"<sup>104</sup> to a VEBA where, "even though benefits are paid out of a trust . . . the employer has a financial incentive to deny claims because every dollar not paid in benefits is a dollar that will not need to be contributed to fund the trust."<sup>105</sup>

While the Ninth Circuit recognized that the impact of the conflict of interest is indirect, and *thus a less significant conflict compared to plans with benefits paid directly by employers*, it is still a structural conflict which must be accounted for in a district court's analysis of the administrator's benefit determination.<sup>106</sup> Moreover, the *Burke* court noted that the fact that the employees make some contribution to the VEBA lessened the structural conflict of interest, while the employer's administration of the plan tended to increase the conflict of interest as compared to the plan at issue in *Glenn*.<sup>107</sup> In conclusion, the *Burke* court found that while there were aspects of the plan that "cut both ways," the VEBA Trust created less of a structural conflict of interest than the structural conflict of interest that exists with the typical dual-role plan.<sup>108</sup>

***Young v. Walmart Stores; American General Life Companies.***<sup>109</sup> In *Young*, the United States Court of Appeals for the Fifth Circuit reviewed the district court's decision awarding full

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<sup>104</sup> *Burke*, 2008 WL 4276910 at \*8 (internal citation omitted).

<sup>105</sup> *Burke*, 2008 WL 4276910 at \*8.

<sup>106</sup> *Burke*, 2008 WL 4276910 at \*8. (emphasis added)

<sup>107</sup> *Burke*, 2008 WL 4276910 at \*9.

<sup>108</sup> *Burke*, 2008 WL 4276910 at \*9.

<sup>109</sup> *Young*, 2008 WL 4302590 (5th Cir. Sept. 22, 2008).

benefits for \$25,000 because the district court found that American General Life Company ("American Life") had abused its discretion in denying Young accidental death benefits. The Fifth Circuit reversed the district court's decision and found that American Life had not abused its discretion in denying Young accidental benefits.

In recognizing *Glenn's* impact on the consideration of an administrator's conflict of interest, the *Young* court placed emphasis on the Supreme Court's explanation that an administrator's conflict of interest should "prove more important (perhaps of greatest importance) where circumstances suggest a higher likelihood that it affected the benefits decision . . . and conversely the conflict should prove less important (perhaps to the vanishing point) where the administrator has taken active steps to reduce potential bias and promote accuracy."<sup>110</sup> In its one-paragraph analysis of American Life's inherent conflict of interest as both evaluator and payor of accidental death benefit claims, the *Young* court found that on the balance of all considerations, the conflict of interest factor was not of great importance because,

. . . there is no evidence that [American Life] has a history of biased claims administration. Nor is there any evidence that [American Life] failed to provide its independent expert with all relevant evidence. On the other hand, there is no evidence that [American Life] has "wall[ed] off claims administrators from those interested in firm finances. [American Life] did not emphasize any report over another, but its decision to deny benefits reflects that it did not accept an opinion expressed by Earl Young's treating physician."<sup>111</sup>

Ultimately, reiterating that it must consider the conflict of interest as a factor, the Fifth Circuit explained that its review of American Life's benefit denial, "while needing to be

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<sup>110</sup> *Young*, 2008 WL 4302590 at \*3.

<sup>111</sup> *Young*, 2008 WL 4302590 at \*3.

searching and careful with respect to factual issues, is narrow."<sup>112</sup> In upholding American Life's decision to deny Young accidental death benefits, the Fifth Circuit interpreted *Glenn* as not impacting its substantial evidence analysis for reviewing an administrator's decision for abuse of discretion.

**V. The "Vanishing Act" – Action Steps for Employers to Lessen the Impact of a Conflict of Interest**

As recognized by one district court, post-*Glenn*, "all conflicts are not created equal."<sup>113</sup> Accordingly, although pre-*Glenn* discovery in ERISA benefit denial cases was generally limited to the administrative record, post-*Glenn*, courts that have granted motions to compel discovery into the severity of a conflict of interest including: discovery of approval and termination rates;<sup>114</sup> discovery of the compensation paid to employees and outside consultants involved in benefit termination decisions;<sup>115</sup> and, generally, discovery outside of the administrative record aimed at assessing the weight to be accorded the conflict of interest.<sup>116</sup> To be sure, it appears that lower courts are heading the Supreme Court's explicit instruction that it is neither "necessary [n]or desirable for courts to create special burden-of-proof rules, or other special procedural or evidentiary rules, focused narrowly upon the evaluator/payor conflict."<sup>117</sup> As such, when faced with litigation over a benefit denial, employers and plan administrators should anticipate broad discovery requests relating to conflicts of interest that will both be upheld and imperative to

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<sup>112</sup> *Young*, 2008 WL 4302590 at \*4.

<sup>113</sup> *Hogan-Cross v. Metropolitan Life Insurance Company*, 568 F. Supp. 2d 410, 415 (S.D.N.Y. 2008).

<sup>114</sup> *Hogan-Cross*, 568 F. Supp. 2d at 414.

<sup>115</sup> *Hogan-Cross*, 568 F. Supp. 2d at 414.

<sup>116</sup> *Wilcox v. Wells Fargo and Company Long Term Disability Plan*, 2008 WL 2873735 \*2 (9th Cir. July 17, 2008).

<sup>117</sup> *Hogan-Cross*, 568 F. Supp. 2d at 414, citing *Glenn*, 128 S. Ct. at 2351.

future benefit denial claims. The best way to prepare for such discovery requests is to examine the current practice and procedure of a self-insured employer or plan administrator to assess how it would be viewed under the conflict of interest factor and proactively make changes as necessary.

The focus of this analysis has been the manner in which a conflict of interest impacts the standard of review utilized by a court in its consideration of the denial of a claim for benefits. It is critically important to remember, however, that the existence of a conflict of interest will only be taken into account as a factor in a court's analysis if the court is applying the deferential standard of review. In order for a court to apply the deferential standard, rather than reviewing the decision *de novo*, the administrator/fiduciary must have been specifically granted the requisite discretionary authority under the terms of the pertinent documents.

Accordingly, the first and most important action that an employer must take is to review and, as necessary, revise all pertinent documents to be certain that the administrator's discretionary authority is clearly stated. This includes not only the underlying plan documents, but also summary plan descriptions, claims procedures, claim forms and all other employee/participant communications associated with the claims process.

Having clearly established the application of the deferential standard of review, the next task is to try to "lessen" or "soften" the impact of the conflict of interest. As the Court stated in *Glenn*, "[the conflict] should prove less important (perhaps to the point of vanishing) where the administrator has taken active steps to reduce potential bias and to promote accuracy..."<sup>118</sup> The

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<sup>118</sup> *Glenn*, 128 S.Ct. at 2351.

following are suggested action steps, including those specifically identified by the Court, to lessen the weight of the conflict – "perhaps to the point of vanishing."<sup>119</sup>

#### **A. Funding Through a Trust**

- If possible, employers who have traditionally self-funded plans may wish to consider establishing a trust from which benefits will be paid.
- In the Eleventh Circuit, the funding of benefits through a trust post-*Glenn* will eliminate the conflict of interest factor in its entirety.<sup>120</sup> In the Ninth Circuit, the funding of benefits through a trust post-*Glenn* does not eliminate the conflict of interest but serves to substantially reduce the weight afforded to the conflict.<sup>121</sup> Although other circuits have not squarely addressed whether payment of benefits from a trust is a conflict of interest post-*Glenn*, prior to the *Glenn* decision, the Third and Fourth Circuits had held that funding benefits through a trust eliminates a conflict of interest.<sup>122</sup>

#### **B. Formation, Composition and Operation of Administrative Committee**

- To the extent practical, establish, through proper and well-documented corporate action, a separate committee to handle plan administration and benefits claims. Clearly separate the claims administration function from company/plan financial responsibility.
- Ideally, the claims review process should be outsourced to a completely independent third party. The delegation of this function should be by action of the committee, not the employer. Since the third party will serve as a plan fiduciary (in that it will have

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<sup>119</sup> *Glenn*, 128 S.Ct. at 2351.

<sup>120</sup> *Frankie White v. Coca-Cola Co.*, 2008 WL 4149706 \*9 (11th Cir. Sept. 10, 2008) (deciding post-*Glenn* that "our circuit law is clear that no conflict of interest exists where benefits are paid from a trust that is funded through periodic contributions so that the provider incurs no immediate expense as a result of paying benefits").

<sup>121</sup> *Burke*, 2008 WL 4276910 (9th Cir. Sept. 19, 2008), discussed in detail *supra* Section IV.

<sup>122</sup> See e.g., *Post v. Hartford Ins. Co.*, 501 F.3d 154, 164 n.3 (3d Cir. 2007) (stating that "when the employer both funds and administers the plan, but pays benefits out of a fully funded and segregated ERISA trust fund rather than its operating budget, no structural conflict of interest is created"); *Gilley v. Monsanto Co., Inc.*, 490 F.3d 848, 856 (11th Cir. 2007) (stating that "no conflict of interest exists where benefits are paid from a trust that is funded through periodic contributions so that the provider incurs no immediate expense as a result of paying benefits"); *Vitale v. Latrobe Area Hosp.*, 420 F.3d 278, 282-83 (3d Cir. 2005) (holding that a heightened version of abuse of discretion standard was not applicable because plan benefits were paid out of a separate trust fund); *de Nobel v. Vitro Corp.* 885 F.2d 1180, 1191-92 (4th Cir.1989) (holding that there was no conflict of interest from an employer-funded plan where plan funds were held in a trust because there is no direct and immediate expense to the employer from the payout of benefits).

discretionary authority over the disposition of plan assets), its services will not be inexpensive. Accordingly, the delegation of this function may be prohibitively expensive for many employers.

- Not only should the function of the committee be insulated from financial decisions, but, to the extent possible, its members should not include individuals directly involved in such matters (*e.g.*, CFO, Controller, etc.) or individuals who report to such persons. The appointment of "non-executive" personnel to the committee (who have actual decision-making responsibility) should also be considered.
- It is important to remember that the appointment of in-house (or outside) counsel to the committee, while providing the committee with ready access to legal expertise, may create a problem. Specifically, the involvement of in-house (or outside) counsel in the decision-making process may result in a loss of the attorney-client privilege. Accordingly, any involvement with the committee by counsel should be in an advisory capacity, not a decision-making capacity.
- Once established, the committee must actually operate as a "real" committee. A chair should be designated to run the meeting and a recording secretary should prepare and circulate minutes for review. The committee should meet regularly/periodically and address matters in addition to claims that may arise (*e.g.*, new legislative or regulatory guidance, judicial decisions, etc.). Consideration should be given to the creation of a charter or bylaws which articulate the functions and procedures of the committee.
- The operation and performance of the committee should be monitored and subject to management/board review. The Court in *Glenn* specifically referenced the imposition of management checks that penalized inaccurate decision-making irrespective of whom the accuracy benefits as a factor which would result in a conflict being viewed as "less important."<sup>123</sup>

### **C. Claims Procedures**

- ERISA specifically mandates that every employee benefit plan must provide for the review of claims<sup>124</sup> and there are extensive regulations governing the claims review and appeal process.<sup>125</sup> Accordingly, the administrative committee should prepare (and abide by) a specific claims review and appeal process to ensure procedural consistency and the utilization of objective criteria in the decision-making process. Of equal importance is the preparation and dissemination of information to plan participants and beneficiaries so

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<sup>123</sup> *Glenn*, 128 S.Ct. at 2351.

<sup>124</sup> 29 U.S.C. § 1133.

<sup>125</sup> 29 C.F.R. § 2560.503-1.

that they clearly understand the process and the extent to which they will be afforded access to the decision-making process as is required under ERISA.<sup>126</sup>

- Well-written procedures and employee communications are of little or no value, of course, unless they are consistently followed. Every effort should be made by the committee to document its compliance with its established procedures. Documentation of the committee's actions should also include specific references to the various factors that were taken into account by the committee in rendering a decision.
- Every effort should be made to ensure that all documents are clear, concise and free from ambiguous language. It is also important that the terms of documents conform with one another (*e.g.*, the plan and the summary plan description should mirror one another).

## **VI. Conclusion**

Ultimately, the Supreme Court's decision in *Glenn*, while not as instructive as one would hope, should not cause plan administrators and employers to panic. The circuits that have addressed conflict of interest issues post-*Glenn* have generally followed the Supreme Court's instruction that weighing a conflict of interest into a factor-based analysis does not imply a change in the standard of review, say from deferential to *de novo* review.<sup>127</sup> What the *Glenn* and post-*Glenn* opinions instruct, however, is that where a conflict exists, administrators and employers are wise to take proactive steps to assure that the conflict of interest will be afforded little weight in a court's factor-based analysis. As not all conflicts are created equal,<sup>128</sup> there can be no one-size fits all approach to implementing procedures to have a conflict's impact vanish. To that end, plan administrators, practitioners, and employers will continue to be tasked with evaluating specific plan circumstances to implement procedural safeguards, such as those

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<sup>126</sup> 29 C.F.R. § 2560.503-1.

<sup>127</sup> *Glenn*, 128 S.Ct. at 2350.

<sup>128</sup> *Hogan-Cross*, 568 F. Supp. 2d at 415.

discussed herein, to assist a plan to diminish the weight of the conflict "(perhaps to the point of vanishing)."