MetLife V. Glenn: The Court Addresses a Conflict over Conflicts in ERISA Benefit Administration

A case concerning disability benefits could have important ramifications for how health benefits are administered as well – by Timothy Stoltzfus Jost

ABSTRACT:

In its June 2008 decision in MetLife v. Glenn, the Supreme Court held that federal courts reviewing claim denials by Employee Retirement Income Security Act (ERISA) employee benefit plan administrators should take into account the fact that plan administrators (insurers or self-insured plans) face a conflict of interest because they pay claims out of their own pockets and arguably stand to profit by denying claims. This paper analyzes the history of the conflict in the courts over this issue; the Supreme Court’s resolution of it in MetLife; and the implications of this decision for plans, beneficiaries, and health policy. [Health Affairs 27, no. 5 (2008): w430-w440 (published online 3 September 2008; 10.1377/hlthaff.27.5.w430)]

On 19 June 2008 the United States Supreme Court handed down Metropolitan Life Insurance (MetLife) v. Glenn (128 S. Ct. 2343), its latest decision interpreting the Employee Retirement Income Security Act (ERISA) of 1974. Most Americans, including many health care professionals, either have never heard of ERISA nor have only the vaguest notion of what it is. Yet no other statute so profoundly affects employment-related health insurance, which covers 60 percent of Americans and pays for 30 percent of American health care. 1 ERISA establishes the rules under which employee benefit plans, including health benefit plans, must be operated. Although MetLife itself involved a disability claim, the decision applies equally to health care claims.

On its face, MetLife involves technical issues of legal procedure. More fundamentally, the decision struggles with, and may indeed affect, the nature of employment-related health insurance, the foundation of health care financing in the United States. Although most Americans are insured through their place of employment, employers have no legal obligation to provide health benefits. Indeed, many employers have dropped health coverage in recent years. The continued willingness of employers to offer health benefits ultimately depends on the predictability and manageability of benefit costs. But employees count on their benefit plans to assure that when they actually need medical care, they will not be abandoned to face financial disaster or worse--death or disability.

As a practical matter, the cost of health benefits to employers and their value to employees are first determined when the employer settles on a benefit, cost-sharing, and premium package for a benefit year. But it is also determined daily as plan administrators (insurers, self-insured plans, or third-party administrators) make benefit determinations. Although plan coverage is sometimes clear, claims adjudication often involves application of vague terms such as "medically necessary" or "experimental" care to specific situations. Approximately 1.9 million claims are denied by employee benefit plans each year. 2 Each denial potentially decreases the cost of coverage--immediately for self-insured and prospectively for insured employers (which usually pay an experience-rated premium). But denials also potentially decrease the value of coverage to the individual employee.
Claim determinations are ultimately reviewable in the federal courts. The courts' approach to reviewing these determinations could, therefore, affect the cost of employee benefits. If, on the one hand, courts routinely overturn claim denials, the cost of coverage will increase, not just because plans will lose more appeals, but also because plans will have to litigate more appeals of adverse determinations as members see their chances of appeal improve. Moreover, plans will likely approve more claims initially instead of risking litigation. An increase in the cost of coverage may in turn lead to more employers' abandoning coverage. On the other hand, if courts routinely defer to plan determinations, upholding most, plans will in all likelihood be more aggressive and confident in denying claims. This could make coverage more affordable but also put employees at risk. Much of the backlash against managed care has been related to coverage denials.

The approach that courts take to reviewing the legal and factual conclusions of a plan administrator when a claim determination is appealed referred to as the "standard of review," is thus very important. MetLife addressed the standard that the federal courts must apply in reviewing challenges to ERISA claims denials. Interpreting an earlier ERISA decision, the Court articulated the question as to what extent courts should defer to the decision of the plan administrator when the administrator faces a conflict of interest because it is essentially paying the claim out of its own pocket and stands to profit if the claim is denied. The Court decided that this conflict must be taken into account as a "factor" in judicial review. This paper analyzes the Court's decision, the background of the decision, and its potential effect on American health policy.

**ERISA Plan Benefit Determinations**

As is suggested by its name, ERISA was adopted by Congress in 1974 to address serious problems in the administration of employee pension programs.4 ERISA was not limited to pension reform, however; it also covers employee welfare programs, including health benefits. Health insurance has traditionally been, and continues to be, extensively regulated by the states. ERISA expressly preempts (that is, displaces and takes precedence over) all state laws that "relate to any employee benefit plan."5 But ERISA's preemption provision is subject to a sweeping exception: it expressly does not preempt state laws that regulate insurance.6 This exception, however, is subject to a further exception: states cannot regulate self-insured employee benefit plans; they can only regulate insurance companies that insure plans.7 More than half of covered employees in the United States are in self-insured plans, not subject to state regulation.8

ERISA also preempts state laws in a second way. It replaces all state law remedies for challenging adverse benefit plan claim decisions with a single remedy: a lawsuit "to recover benefits due...under the terms of [the] plan, to enforce...rights under the terms of the plan, or to clarify...rights to future benefits under the terms of the plan."9 This form of preemption requires further explanation. Most states offer a variety of remedies for denial or limitation of insurance benefits--certainly a claim for breach of the insurance contract, but often also statutory claims and possibly a claim for punitive damages for egregious cases. All of these remedies are displaced by ERISA. What ERISA offers plan beneficiaries instead of state remedies is the opportunity for an internal "full and fair review" by the
The process by which ERISA claims are determined is largely governed by regulations that went into effect in 2002. A claim for services must first be presented to an ERISA plan administrator, which must make an initial decision within specified time limits. Plans must provide a process for an internal review. If the plan is provided through an insurance company (that is, not self-insured) and the denial is ultimately upheld internally, more than forty states offer an external review procedure, which the ERISA regulations permit plan members to pursue if they choose. In 2002 the Supreme Court specifically permitted state external review for ERISA cases. A claimant who remains dissatisfied can sue in federal court.

Judicial Review of ERISA Claim Denials: A History of Conflict

Traditionally, lawsuits brought by insured people against insurance companies in state court were tried as breach-of-contract actions. The courts received evidence, decided factual disputes, and interpreted the contracts themselves. Moreover, a special body of contract law developed around insurance cases under which the courts construed contractual ambiguities in favor of the insured and tried to honor the insured person's "reasonable expectations," recognizing that insurance contracts were usually "adhesion contracts"--long, dense contracts drafted by insurers to protect their interest with little input from insured people. This is how non-ERISA health insurance claim cases are still generally handled.

It is arguable that Congress intended that challenges to adverse ERISA claim determinations be tried in the same way. Early drafts of the legislation that became ERISA provided that these cases would be tried under state insurance law. Although the final legislation preempted state law governing claims, ERISA itself states that the courts are to interpret ERISA plans and enforce rights under them.

From the beginning, however, the courts interpreted ERISA as establishing a different approach to reviews of benefit claim denials. ERISA describes plan administrators as fiduciaries and throughout treats them as though they were administering a trust. This approach makes sense for pension plans, which, like classic trusts, usually have an identifiable fund administered by trustees. The trust concept applies less comfortably to health plans, which rarely accumulate or invest funds and are usually administered by an insurance company or third-party administrator chosen by the employer.

Courts interpreting ERISA, however, took its trust language very literally. Courts traditionally review the decisions of trustees exercising discretion granted by the creator of the trust using an "abuse of discretion" standard. The trustee is primarily responsible for managing the trust, and courts will not second-guess reasonable decisions. This was the standard that courts initially applied to coverage decisions by ERISA plan administrators.

Although the trust language of ERISA certainly led courts in this direction, other factors played a role as well. First, the courts interpreting ERISA looked to precedents applying the Labor Management Relations Act (LMRA), under which courts had routinely deferred to pension plan administrators.
This deference made sense for LMRA pension plans, administered by neutral bodies representing both employers and employees, but the courts tended not to notice that ERISA plan administrators were not neutral but, rather, were appointed by employers.

The courts were also concerned about the burden that would be imposed on the federal courts if all ERISA claimants were granted a full trial. Although ERISA allows state courts to hear ERISA claims, the Supreme Court held quite early that any ERISA plan could demand that a case against it be tried in federal court.23 If all ERISA claims could result in a fully litigated federal court case, the burden would be staggering.

But perhaps the most important factor driving judicial deference was the courts' basic understanding of the nature of employee benefits.24 Historically, employee benefits--initially primarily pensions--were understood to exist for the business purposes of employers, granted at the employer's discretion.25 Over time, an alternative understanding emerged of benefits as creating contract rights.

If benefits are understood to exist solely for the business purposes of employers, very limited judicial review of employer benefit decisions is appropriate--questioning only determinations that are completely arbitrary or discriminatory. If benefits are contractual compensation, on the other hand, a more searching review to protect the rights of the employee is warranted.

Support for both approaches can be found in ERISA and its legislative history.26 On the one hand, it is clear that Congress intended to create a supportive environment that would encourage employers voluntarily to offer benefits to their employees. On the other, Congress also intended ERISA as a regulatory statute to improve the protection of employees' rights. But early court decisions were more concerned with encouraging plan creation than protecting claimants, and they generally deferred to plan administrators.

By the late 1980s some courts were beginning to question whether plan claimants deserved more protection.27 In 1989 the issue finally reached the Supreme Court in Firestone Tire and Rubber Company v. Bruch.28 Firestone concerned the interpretation of Firestone's plan for termination pay as it affected a group of employees. The Court rejected the deferential standard, concluding that "de novo" review was the proper standard for judicial review of ERISA fiduciary decisions. Applying de novo review, a court reviews the facts of a claim and the law applied to it afresh, giving no particular deference to the plan's determination. The court may even take additional evidence, although it usually sticks to the claims record.

Firestone recognized a sweeping exception to the de novo standard. Where the plan afforded discretion to the administrator in construing the terms of the plan or in making benefit decisions, plan decisions should be reviewed deferentially, reversed only for abuse of discretion.29 The Court further recognized an exception to the exception: "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 'facto[r] in determining whether there is an abuse of discretion.'"30
The Problem of Conflicts Of Interest in ERISA Determinations

An immediate effect of Firestone was that plans were almost universally rewritten to award discretion to plan trustees making benefit decisions. Abuse of discretion remained the general standard of review. Most of the federal courts equated abuse of discretion with the administrative law "arbitrary and capricious" standard, rejecting only decisions that were "totally unreasonable," "whimsical, random, or unreasoned," or, as one prominent federal judge said, "off the wall."31

The "conflict of interest" exception, however, puzzled the lower courts. In fact, benefit plans are almost always administered by someone with a conflict of interest. Insurers make money only if they collect more in premiums than they pay in benefits, and thus they profit from denying claims. The more benefit claims a self-insured employer or its independent administrator approves, the less goes to the employer's bottom line. Only fully funded plans with neutral administrators face no conflict, but health plans are rarely administered this way.

The question the courts struggled with is the extent to which these conflicts are a cause for concern. ERISA plans and insurers argued that conflicts are just not a problem. Approval of any one claim has a trivial effect on an insurer's bottom line. Insurers that routinely deny claims risk loss of business, because employers offer benefits to secure employees' good will and will not remain with an insurer that generates constant employee dissatisfaction. ERISA, moreover, explicitly authorizes conflicts of interest, allowing employers to both fund and administer ERISA plans. And the fiduciary obligations of an administrator are not just to single plan members, but to the entire group covered by the plan. Administrators must review individual claims with an eye to preserving plan assets for all. Finally, plan administrators possess special expertise in interpreting and applying plan provisions; thus, their decisions should be given deference despite concern about conflicted interests.32

Claimants' representatives, on the other hand, argued that however trivial any single claim may be, the aggregate financial effect of claim denials is significant. It is by no means obvious, moreover, that markets will punish excessive claim denials. Employers will welcome lower insurance rates, and employees might not become aware of unfair claims practices, particularly if denials are focused on a few high-cost claims or on disabled employees, who are not part of the active workforce. Although ERISA tolerates structural conflicts, it also requires that plans be administered "solely in the interest of the participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries."33

The federal appellate courts were divided in their response to these arguments.34 Most were willing to assume that insurers or self-insured plans faced a conflict of interest. Some courts, however, viewed the issue as a red herring, believing that the competitive market for insurance would punish insurers that stinted on benefits.35 Even courts willing to accept that plans faced conflicts, moreover, did not necessarily see this as a problem. A handful of courts scrutinized conflicted decisions carefully or required a plan administrator to prove that its decision was not affected by a conflict.36 However, many courts applied a "sliding scale" standard, giving deference to plan administrators but scrutinizing their decisions more carefully if the court saw a serious conflict.37 In effect, most courts required the
claimant to show that a plan’s decision was in some way tainted by a conflict. Because courts generally limited their review to the claim record, however, refusing discovery probing plan decision making, it was very difficult for claimants to prove that plan decisions were actually affected by conflicts.

The sanguine position of the courts with respect to the effect of conflicts of interest was challenged in the early 2000s, when investigative news reports revealed that Unum-Provident, the largest U.S. disability insurer, had set denial quotas and pressured claims examiners to deny claims. Unum had offered medical advisors bonuses, based in part on company earnings, and company stock options. An internal memorandum established that Unum’s management had been aware of the “enormous” advantages that ERISA offered them in benefit denials, including deferential review. Unum was fined millions of dollars by state regulators and required to reconsider hundreds of thousands of claims denials.

The MetLife V. Glenn Decision

This was the situation when the Sixth Circuit Court of Appeals decided MetLife v. Glenn. Glenn was a Sears employee, disabled by a heart condition. MetLife initially accepted her disability claim, even assisting her in applying for Social Security disability. After two years, however, MetLife concluded that Glenn did not qualify for continued disability benefits, even though Social Security had in the interim found her permanently and totally disabled and her treating physician continued to consider her disabled. Glenn sued under ERISA, but the district court ruled for MetLife. The Court of Appeals, however, reversed, noting that MetLife faced a conflict of interest.

MetLife sought review by the Supreme Court, which agreed to address the question of how federal courts should take into account conflicts of interest in reviewing ERISA benefit determinations. Although the case involved a disability determination, the health benefit ramifications of the decision were obvious, and amicus briefs were filed by America’s Health Insurance Plans (AHIP), the Blue Cross Blue Shield Association, and the American Dental Association.

The Supreme Court affirmed the Court of Appeals, ruling for Glenn. Five members of the Court joined in the majority opinion written by Justice Stephen Breyer. Chief Justice John Roberts wrote an opinion concurring in the result but rejecting the majority’s reasoning in part. Justice Anthony Kennedy wrote an opinion largely accepting the majority’s approach but arguing that the case should be sent back to the Court of Appeals for redetermination. Justice Antonin Scalia wrote a scathing dissent, joined by Justice Clarence Thomas, ridiculing the Court’s decision as “painfully opaque” and as establishing a “gobbledygook” solution to what Scalia deemed a simple problem with an obvious solution.

Anyone hoping that the Court would set out a straightforward roadmap for deciding ERISA benefits cases will find MetLife disappointing. Indeed, the majority exulted in the imprecision of the standard it created, asserting that "want of certainty" in review standards "reflects the intractability of any formula to furnish definiteness of content for all the impalpable factors involved in judicial review." In fact, however, the Court’s decision clarifies a number of important issues and provides useful guidance to lower courts.
First, the Court reaffirmed Firestone, which it interpreted as establishing four principles: (1) the courts should be guided by trust law in ERISA appeals, (2) trust law generally calls for de novo review, (3) deferential review is appropriate where the plan grants discretionary authority to an administrator, and (4) a conflict of interest must be "weighed as a factor" in determining whether there is an abuse of discretion.

Second, the Court conclusively determined that insurers face a conflict of interest in deciding ERISA claims. The Court began with what it considered an easier question: whether an employer that both funds and administers an ERISA plan has a conflict of interest. It concluded that an employer obviously does, since it has to pay itself any claims it approves. The Court also gave short shrift to MetLife's arguments that conflicts are not a problem under ERISA because ERISA allows employers to administer plans and was intended to encourage employers to establish plans and to avoid complex review procedures. All of these considerations, it concluded, were outweighed by congressional intent to protect ERISA beneficiaries.

The Court further determined that insurers also face a conflict in administering ERISA plans. It noted that insurers might deny claims to be able to offer lower rates to employers, and that in any event, "ERISA imposes higher-than-marketplace quality standards on insurers." Indeed, all of the justices agreed that insurers are conflicted in deciding ERISA benefit claims.

The Court next reached the most difficult issue: how these conflicts should be taken into account in reviewing discretionary benefit determinations. Here the majority parted ways with Justices Roberts, Scalia, and Thomas. First, the Court decisively rejected changing the standard of review from deferential to de novo in cases involving conflicts. One concern driving the Court's decision here was the workload of the federal courts. If each of the 1.9 million ERISA beneficiaries who receive claim denials each year filed a federal court case, the Court noted, the federal court caseload would increase nearly eightfold. The Court was not about to allow this to happen.

The Court rather decided to retain deferential review but held that the existence of a conflict should be one of several "case-specific factors" that courts should take into account in applying deferential review to ERISA benefit denials. In close cases, the existence of a conflict could serve as a "tie-breaker." In situations "where circumstances suggest that [a conflict] affected the benefits decision," it would be a more important factor. Where the administrator had "taken active steps to reduce potential bias and 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," a conflict would receive less consideration. The Court held up as a model of this approach the Court of Appeals decision below.

In sum, the Court devised a practical if somewhat indefinite approach. The courts should still defer to the administrator's decision--and not re-decide the case--but also keep in mind that the administrator has a conflict, and if there is evidence of improper motivation, the absence of fair procedures, or any other evidence that the conflict distorted the decision, the court should look more closely.
Justices Roberts, Scalia, and Thomas rejected the Court's approach as vague and incoherent and as substituting judicial for administrator discretion. All three concluded that the existence of a conflict of interest was only relevant if the plaintiff could prove that it directly motivated the adverse decision. The Court, however, rejected this position, concluding that conflict is a relevant factor in reviewing "the lawfulness of benefit denials," regardless of whether it was a sole motivation.

The Policy Implications of MetLife

What, then, is the importance of MetLife? First, it clarifies issues that have divided the lower federal courts. Insured and self-insured ERISA plans are indeed conflicted, and although their determinations are not to be retried by the federal courts de novo, the lower courts should not uphold determinations simply because they are not "off the wall." This is good news for ERISA beneficiaries, who not only will receive a more thorough review of their claims, but also will have a right to discovery to probe an administrator's decision-making processes. The Court specifically referred to "a history of biased claims administration," which will not appear on the face of a claims record, as a factor relevant to judicial review. The decision also sends a clear message to ERISA administrators: get your house in order. Create procedural safeguards and incentive systems that assure unbiased decisions, and be prepared to prove that they are operative. This will not require a radical change for administrators in compliance with current ERISA claims regulations, but companies that follow the path Unum-Provident took in the late 1990s are asking for trouble.

What is the larger meaning of MetLife for health policy? Increased scrutiny of plans' decisions likely portends more approvals of ERISA benefit claims and more lawsuits challenging claims denials. This may raise the cost of some ERISA plans, which may mean that additional employers will drop health coverage or increase employee cost sharing or premiums, causing additional employees to forgo coverage. But if the only way we can keep employment-related coverage functioning is by improperly denying workers benefits, is the system worth preserving? Tellingly, the dissenters did not contend that the decision would bring down our employment-based insurance system, an argument made in past ERISA cases.46

The demise of employment-based health insurance system would not, moreover, be universally mourned. Critics on the right advocate a larger role for individual insurance; on the left, for public insurance. But neither individual nor public insurance avoids conflicts of interest. Conflicts are, if anything, greater with individual insurance, where the insurer has an incentive not only to reject coverage for individual services, but also of the insured, as evidenced by recent "post-claims underwriting" scandals. Public insurers, on the other hand, have long been accused of denying or delaying services to save money. Any system that relies on third-party payers must find a way to reconcile their interests with those of individual beneficiaries.

If conflicts cannot be eliminated, however, they can be managed, even minimized. Transparent decision-making procedures that are balanced and incentivize fair rather than cost-saving determinations are a start, as noted by MetLife. State external review procedures of insurance plan decisions can also help. But MetLife itself devises a further practical, if still frustratingly vague, approach:
independent judicial review, deferential to the initial decision maker so as to discourage frivolous appeals, yet attentive to procedural imbalance and improper motivation and open to considering, case by case, other ways in which a conflict may distort a determination. How exactly this will work now needs to be fleshed out by the lower courts. But it is an approach adaptable to any third-party payer-based system, and thus of continued interest no matter how health policy debates play out in the future.

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NOTES:


3. Whether claim denials in fact decrease costs or value depends on complex questions regarding the value of health services that are beyond the scope of this paper.

4. See 29 U.S. Code, Sec. 1001.

5. 29 U.S. Code, sec. 1144(a).


10. 29 U.S. Code, secs. 1132(a)(1)(B), 1133(2).

11. 29 U.S. Code, sec. 1001(b).

12. 29 CFR, sec. 2560.503-1(f)(2)

13. 29 CFR, secs. 2560.503-1(h)(3)(ii) and (iii).

14. 29 CFR, sec. 2560.503-1(k).


18. Ibid., 16.

19. See, for example, 29 U.S. Code, secs. 1102(a), 1103, 1104.


21. See, for example, Bueneman v. Central States, Southeast and Southwest Areas Pension Fund, 572 F.2d 1208 (8th Cir. 1978).


27. Van Boxel v. Journal Co. Employees' Pension Trust, 836 F.2d 1048 (7th Cir. 1987); and Bruch v. Firestone Tire and Rubber Co., 828 F.2d 134 (3rd Cir. 1987).


29. Ibid., 115.

30. Ibid., citing the Restatement (Second) of Trusts, Sec. 187, Comment d (Philadelphia: ALI, 1959).