No. 06-923

IN THE
Supreme Court of the United States

METROPOLITAN LIFE INSURANCE COMPANY AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

v.

WANDA GLENN,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Sixth Circuit

BRIEF FOR PETITIONERS

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QUESTIONS PRESENTED

I. Whether the fact that the claim administrator of an ERISA plan also funds the plan benefits, without more, constitutes a "conflict of interest" that must be weighed in a judicial review of the administrator's benefit determination.

II. If an administrator that both determines and pays claims under an ERISA plan is deemed to be operating under a conflict of interest, how should that conflict be taken into account on judicial review of a discretionary benefit determination?

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

The caption contains the names of all the parties to the proceeding below.

The corporate disclosure statement included in the petition for a writ of certiorari remains accurate.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES

STATUTES

REGULATIONS

OTHER AUTHORITIES

BRIEF FOR PETITIONERS

OPINIONS BELOW

The court of appeals' opinion is reported at 461 F.3d 660. Pet. App. 1a. The opinion of the United States District Court for the Southern District of Ohio is unpublished but is electronically reported at 2005 WL 1364625. *Id.* at 27a.

JURISDICTION

The judgment of the court of appeals was entered on September 1, 2006. On November 22, 2006, Justice Stevens extended the time within which to file a petition for a writ of certiorari to January 2, 2007 (a Court holiday). No. 06A524. The petition for a writ of certiorari was filed on January 3, 2007, and granted on January 18, 2008. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Relevant provisions of the Employee Retirement Income Security Act of 1974 (ERISA) and the Department of Labor's implementing regulations are set forth in the appendix to this brief.

STATEMENT

1. After a decade of congressional study, Congress enacted ERISA "to provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208 (2004). ERISA did not "require[ ] employers to establish employee benefits plans" or "mandate[ ] what kind of benefits employers must provide if they choose to have such a plan." *Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996). It instead "encourag[ed] the formation" of such plans by establishing a legal framework

that facilitates cost-effective plan administration (*Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)) and that "minimize[s] the administrative and financial burden of complying with conflicting [state-law] directives." *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 656 (1995) (internal quotation marks omitted). ERISA was thus carefully designed "to strike an appropriate balance" between "the need of the workers for a level of protection which will adequately protect their rights" and the "interests of employers . . . in maintaining flexibility in the design and operation of their pension programs." S. Rep. No. 93-127, at 13 (1973).

The procedural framework that ERISA established for challenging plans' benefit determinations reflects Congress's "careful balancing" between the dual statutory objectives of protecting plan participants and promoting plan formation. *Pilot Life*, 481 U.S. at 54. For example, ERISA authorizes a plan participant to bring a civil action "to recover benefits due to him under the terms of the plan" (29 U.S.C. § 1132(a)(1)(B)), but restricts the availability of individualized monetary relief. *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985). ERISA also expressly preempts all state-law claims that "relate to any employee benefit plan" (29 U.S.C. § 1144(a))—thereby restricting plan participants to the remedies afforded by ERISA itself—while expressly saving state laws that regulate insurance from preemption. *Id.* § 1144(b)(2)(A); *see also Davila*, 542 U.S. at 209 ("the ERISA civil enforcement remedy" is "exclusive"). Together, these provisions create a uniform federal regulatory framework that facilitates the fair and efficient administration of employee benefit plans and that preserves state regulation of the in-

surance business. *Egelhoff v. Egelhoff*, 532 U.S. 141, 148, 149 n.3 (2001).

2. Petitioner Metropolitan Life Insurance Company (MetLife) administers benefit claims for petitioner Sears Long Term Disability Plan (Plan), an employee welfare benefit plan sponsored by Sears, Roebuck and Company (Sears). J.A. 181a. MetLife "has the responsibility of Claim Fiduciary for the provision of full and fair review of claim denials." *Id*. MetLife is also the issuer of the insurance policy that funds the Plan's benefits. *Id*. The terms of the Plan expressly afford MetLife, as Claim Fiduciary, "discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan." *Id*.

Under the Plan, participants are entitled to receive sixty percent of their salary if they become "totally disabled." J.A. 165a-66a. During the first 24 months of disability payments (and during the initial 140-day elimination period that must precede the payment of any benefits), a participant is totally disabled if she "cannot perform the material duties of [her] own job." *Id.* at 159a-60a. After 24 months, the Plan provides that a "Total Disability" exists only if the participant is "totally incapable of performing the material duties of *any gainful occupation* for which [she is] reasonably qualified." *Id.* at 160a (emphasis added). If a participant who is receiving benefits ceases to be totally disabled under the operative Plan definition, the payment of disability benefits is terminated. *Id*. at 161a.

3. Respondent Wanda Glenn worked as a Sears sales manager between 1994 and 2000. J.A. 100a. She worked forty to fifty hours per week, and directly

supervised twenty to thirty sales associates. *Id*. at 115a, 117a. Her responsibilities involved some climbing, reaching, stooping, and lifting, and required standing 20-60% of the workday and walking 61-100% of the workday. *Id*. at 116a.

On March 3, 2000, Glenn visited her treating physician, Rajendra Patel, complaining of chest tightness. J.A. 92a. Dr. Patel diagnosed her as suffering from dilated cardiomyopathy, a condition associated with an enlarged heart and a thinned and weakened heart muscle. *Id*. at 91a. Tests indicated that Glenn's left ventricle ejection fraction—which measures the efficiency with which the heart delivers blood to the body—was only 22%. *Id.* at 89a. An ejection fraction below 35% is considered poor.[1]

In light of this diagnosis and Glenn's reports of fatigue, Dr. Patel advised Glenn to stop working and to begin claiming disability benefits. J.A. 82a-83a. He explained that, "[c]onsidering her low ejection fraction, I feel that she may not be able to continue to work in any kind of environment that would cause significant physical or psychological stress and demands." *Id*. at 82a.

Glenn submitted her long-term disability claim to Sears on June 20, 2000. C.A. App. 288. The claim was supported by an "Attending Physician Statement" from Dr. Patel, which stated that Glenn was disabled from performing her job at Sears. J.A. 109a. Dr. Patel also initially checked a box indicating that Glenn was not totally disabled "For Any Occupation." *Id*. It appears that Dr. Patel then crossed this out, and checked that he "Cannot Determine"

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[1] *See* Medtronic, Inc., Ejection Fraction and Its Importance, *at* http://www.hearthelp.com/sca/ejection-fraction.html.

whether Glenn was totally disabled for any occupation. *Id*.

Sears transmitted Glenn's claim to MetLife for a determination. MetLife concluded that Glenn could not "perform the material duties of [her] own job" (J.A. 159a-60a) and that she was therefore totally disabled within the meaning of the Plan. Glenn began receiving long-term disability benefits in September 2000 following completion of the 140-day elimination period.

After submitting her claim, Glenn began to respond well to new medication prescribed by Dr. Patel. Indeed, by July 2000, Glenn told Dr. Patel that she "felt much better." J.A. 84a. Dr. Patel reported at that time that she was doing "clinically well," and another cardiologist to whom she was referred also stated that she showed "good functional capacity and tolerance." *Id*. at 84a-85a.

Glenn's health continued to improve after her implantable cardiac defibrillator (ICD)—which she had received when she first experienced heart problems in the late 1980s—was replaced in October 2000 with a device that included both a defibrillator and a pacemaker with "biventricular pacing," a newly developed technique for treating cardiomyopathy. J.A. 71a, 75a. Unlike an ICD device, which is only designed to prevent death should cardiac arrest occur, a device with biventricular pacing actually helps "enhance cardiac function," causing a reduction in heart enlargement and increasing the ejection fraction and cardiac output.[2] Indeed, by December

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[2] *See* Cheuk-Man Yu, *New Insight into Left Ventricular Reverse Remodeling After Biventricular Pacing Therapy for Heart Failure*, 9 Congestive Heart Failure 279, 279-83 (2003); Cleve-

2000, Dr. Patel reported that Glenn was doing "clinically well," and by April 2001, her ejection fraction had improved to 40-50%. J.A. 72a, 74a. Dr. Patel noted at that time that Glenn was walking four or more laps around the mall four or five times a week, as compared to two laps two or three times per week previously. In November 2001, Dr. Patel reported that Glenn continued to have "better exercise tolerance than before" and that she was "clinically stable." *Id.* at 62a-63a.

4. Under the Plan, benefit payments are reduced if a participant is receiving or is eligible for (but not actually receiving) other benefits, such as social security disability benefits (SSDB). J.A. 166a-68a. The Plan also provides that estimated SSDB will not be deducted if the participant has applied for such benefits and agrees to repay the Plan for all overpayments resulting from an SSDB award. *Id.* at 168a.

When MetLife determined that Glenn might be eligible for SSDB, it did not reduce her benefit payments by the amount of SSDB for which she was eligible, but instead referred her to a law firm that assisted her in submitting an application for SSDB in August 2000. J.A. 145a-46a. In addition to avoiding the estimated reduction, obtaining SSDB was beneficial to Glenn in two significant ways: (1) a recipient of SSDB accrues covered quarters of work for social security retirement benefit purposes (20 C.F.R.

[Footnote continued from previous page]

land Clinic, Cardiac Resynchronization Therapy: The Biventricular Pacemaker Implant Procedure, *at* http://www.clevelandclinic.org/heartcenter/pub/guide/tests/procedures/biventricular_pm.htm.

§ 404.115(c)), and (2) the Plan does not reduce benefits by the SSDB cost-of-living increases. C.A. App. 144. The Social Security Administration (SSA) initially denied Glenn's claim. J.A. 132a. Following a hearing, however, an administrative law judge (ALJ) concluded that, under the relevant Social Security regulations, Glenn was "disabled" effective April 30, 2000. Pet. App. 41a-42a (citing 20 C.F.R. § 404.1520 and 20 C.F.R. § 416.920).

In his April 22, 2002 decision, the ALJ found that, although Glenn was impaired, her impairments were not severe enough to warrant a finding of disability without an inquiry into her ability to perform her prior work and other gainful employment. Pet. App. 44a-45a. Adopting the testimony of a vocational expert, the ALJ concluded that Glenn's medical condition prevented her from performing any of her prior jobs. The burden then "shift[ed] to the Commissioner to show that there are other jobs that the claimant can perform which exist in significant numbers in the economy." *Id.* at 46a. The ALJ found that the Commissioner had not met that burden. *Id*. at 47a.[3]

5. MetLife periodically reevaluated Glenn's eligibility for benefits by sending requests for medical information to Dr. Patel. As Glenn approached the beginning of her third year of benefits, MetLife started to evaluate whether she was eligible to continue to receive benefits under the stricter definition of "Total Disability" operative after the first two

[3] As provided by the Plan, MetLife thereafter reduced its monthly benefits payments to Glenn by the amount that she was receiving from the SSA, and Glenn reimbursed MetLife for the amount of benefits that she had been overpaid as a result of the retroactive SSDB award.

years of benefits, which requires the claimant to be "totally incapable of performing the material duties of any gainful occupation for which [she is] reasonably qualified." J.A. 160a.

Accordingly, in March 2002, MetLife requested Dr. Patel's opinion on Glenn's ability to return to some form of full-time work. J.A. 57a. Dr. Patel completed a physical capacity evaluation in which he opined that, in an eight-hour workday, Glenn could sit eight hours, stand four hours, and walk two hours. *Id*. at 58a. The evaluation asked whether Glenn was able to work full-time at a sedentary physical exertion level occupation, and Dr. Patel answered "yes." *Id*. Consistent with this answer, when asked to list any physical barriers preventing Glenn from returning to full-time work, Dr. Patel answered "NA." *Id*.

In June 2002, Dr. Patel completed another physical capacity evaluation. J.A. 54a. At that time, he repeated that, in an eight-hour workday, Glenn could sit eight hours and stand four hours. He further indicated that Glenn could now walk from two to four hours per day. *Id*. He also stated that Glenn could lift and carry up to ten pounds occasionally, and that she could use her hands for grasping, pushing, and fine manipulation. *Id*. at 54a-55a. Dr. Patel restricted Glenn from heavy exertion and emotional stress. *Id*. at 55a.

In July 2002, MetLife sent Glenn's records to Dr. Mark Moyer, an independent physician consultant, who concurred with Dr. Patel that Glenn could perform sedentary work. C.A. App. 170. Glenn's file was then referred to a Certified Rehabilitation Coordinator for a transferable skills and labor market analysis (TSA). Taking into account Glenn's educa-

tion, background, and training, and Dr. Patel's physical capacity evaluations and instructions to limit heavy exertion and emotional stress, the Rehabilitation Coordinator found that there were sedentary occupations available in Glenn's geographic area that she was capable of performing and that met her salary requirements, including account information clerk, attendance clerk, and classified ad clerk. J.A. 100a-03a; *see also id.* at 113a.

Based on Dr. Patel's conclusion in the two most-recent physical capacity evaluations, Dr. Moyer's review of Glenn's file, and the results of the vocational TSA, MetLife concluded that Glenn could perform alternative occupations that, unlike her position as a Sears sales manager, were sedentary in nature. Thus, because Glenn was not "totally incapable of performing the material duties of any gainful occupation for which [she was] reasonably qualified," MetLife advised Glenn by letter on July 13, 2002, that she did not meet the stricter definition of "Total Disability" that applies after 24 months, and that her last day of benefits would be September 16, 2002. J.A. 14a-15a.[4]

Glenn requested that MetLife reconsider its decision. J.A. 35a. In support of her reconsideration request, she submitted a letter from Dr. Patel, dated nine days after MetLife's decision, in which he asserted that Glenn continued to have shortness of breath with "moderate exertion" and "continue[d] to have significant difficulty in returning to even any kind of sedentary job because any kind of psychological stress at work causes significant problems with

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[4] Although a file copy of this letter was not retained, there is no dispute that Glenn received it. J.A. 14a-15a, 35a.

her cardiovascular condition." *Id.* at 44a. Dr. Patel further stated (erroneously, as MetLife later learned) that "the patient has tried to return to work in the past with exacerbation of her symptoms," and concluded that Glenn "should not be forced to return to . . . even sedentary work." *Id*. Dr. Patel's letter did not identify any changes in Glenn's medical condition that had caused him to alter his recent opinions that Glenn was fit for sedentary work with low exertion.

Before MetLife fully reevaluated Glenn's eligibility for continued long-term disability benefits, the case management specialist sent her a letter dated August 28, 2002, updating the decision to discontinue her benefits and specifying her review rights. J.A. 29a-33a. Consistent with the conclusion of a nurse consultant that had reviewed Glenn's file (*id.* at 17a-20a), MetLife explained that the new "information submitted" by Glenn did "not change the previous finding" because Glenn's medical records supported Dr. Patel's earlier conclusion that her condition was stable and that she could perform sedentary work. *Id*. at 29a-32a.

Glenn appealed this decision through counsel on February 12, 2003. C.A. App. 191. In support of her appeal, Glenn submitted yet another letter from Dr. Patel, in which he asserted that, even though he had previously reported that Glenn was fit for sedentary work, there was "never a time" when he felt Glenn "would be able to return to full-time employment." J.A. 42a. He also maintained that her new cardiac device had no role in "improving her cardiac function" and was only meant to provide defibrillation in the event of sudden cardiac death (*id*.)—a perplexing statement given that Dr. Patel himself had previously noted that Glenn's new cardiac device also included biventricular pacing (*id*. at 71a, 75a),

which can significantly improve heart function. *See supra* pg. 5 n.2.

MetLife then referred Glenn's records to Dr. Chandrakant Pujara, an independent board-certified cardiologist. Dr. Pujara observed that, as a result of "appropriate medical management and biventricular pacing, the patient has achieved a relatively stable cardiac status." J.A. 39a. He also stated that Glenn "has been relatively free of any significant cardiac decompensation as documented by Dr. Patel's follow up notes." *Id*. at 38a. Given these factors, Dr. Pujara concluded that, although the impact of emotional stress on Glenn was difficult to gauge, Glenn was "a reasonable candidate to try one of the sedentary job classes at least on a trial basis" and that her work capacity should continue to improve with the use of biventricular pacing. *Id*. at 39a.

Based on the entirety of the medical and vocational record before it, MetLife rejected Glenn's appeal. In a letter dated May 20, 2003, detailing Glenn's objective medical records, MetLife explained that "the documentation currently in the file"—including, specifically, Dr. Patel's letter of February 12, 2003—did not support a disability as defined in the Plan. J.A. 25a-26a.

6. Having exhausted her administrative remedies, Glenn filed suit in the United States District Court for the Southern District of Ohio seeking benefits under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

The district court granted MetLife's motion for summary judgment. As required by binding Sixth Circuit precedent, the district court first ruled that the fact that MetLife both evaluated and paid claims constituted a "conflict of interest" that had to be

"considered as a factor when applying the abuse of discretion standard." Pet. App. 34a. "[C]onsider[ing] and weigh[ing] this factor throughout" its analysis (*id.*), the district court nevertheless upheld MetLife's determination that Glenn is not eligible for benefits under the stricter Plan standard for "Total Disability" applicable after 24 months. In light of Dr. Patel's conclusion in his physical capacity evaluations that Glenn was capable of performing sedentary work, the similar findings of Drs. Moyer and Pujara, and the vocational TSA, the court concluded that there was "substantial evidence supporting MetLife's determination that [Glenn] was no longer totally disabled as the Plan defines that term." *Id.* at 40a. The court explained that, because "Dr. Patel expressly acknowledged that he had stated that plaintiff was fit for sedentary work" in his February 12, 2003 letter, "MetLife did not abuse its discretion by viewing Dr. Patel's recantation with skepticism." *Id.* at 39a. The court also concluded that the SSA decision awarding benefits to Glenn did not undermine MetLife's reasoning because "the records before the ALJ and MetLife were materially different." *Id.* at 36a.

7. The Sixth Circuit reversed. Like the district court, the court of appeals held that the fact that MetLife both evaluated and paid claims constituted a "conflict of interest" that was a "relevant factor in determining whether an abuse of discretion had taken place." Pet. App. 10a. According to the court of appeals, however, the district court had given insufficient "weight" to that conflict in reviewing MetLife's decision to terminate Glenn's benefits. *Id.*

Although it purported to apply an abuse-of-discretion standard of review, the court of appeals then conducted an in-depth review of Glenn's history,

highlighting and emphasizing information favorable to Glenn while minimizing or ignoring contrary evidence. Among other things, the court faulted MetLife for "fail[ing] to address Social Security's contrary determination of Glenn's status." Pet. App. 11a. The court of appeals also criticized MetLife for crediting the two physical capacity evaluations in which Dr. Patel stated that Glenn could return to work in a sedentary capacity, and "fail[ing] to give any weight to Dr. Patel's letters of July 22, 2002, and February 12, 2003, in which he clearly stated that he did not believe Glenn was capable of returning to work." *Id.* at 15a. Conceding that "Dr. Patel's opinion of Glenn's ability to perform sedentary work has not been consistently expressed" (*id.* at 23a)—but failing to acknowledge that Dr. Patel had changed his opinion only after MetLife had terminated Glenn's benefits and without identifying any change in Glenn's medical condition—the court of appeals found that "the only fair inference from the record would undercut" the "aberrational" evaluations in which Dr. Patel indicated that Glenn was able to undertake sedentary work. *Id.* at 16a, 20a.

The court of appeals concluded, "Taken together, these factors reflect a decision by MetLife that can only be described as arbitrary and capricious," and it therefore ordered the reinstatement of Glenn's disability benefits. Pet. App. 25a.

SUMMARY OF ARGUMENT

I. The language, history, and purpose of ERISA establish that an entity that acts as a fiduciary when evaluating claims does not act under a conflict of interest that must be considered on judicial review merely because it has separately agreed in a nonfi-

duciary capacity to fund the benefits paid by the Plan by issuing a group insurance policy.

A. ERISA explicitly authorizes plan fiduciaries to evaluate and pay claims (29 U.S.C. § 1108(c)(3)) and thereby establishes that this consolidation of functions within a single entity, standing alone, does not place fiduciaries in the prohibited position of "deal[ing] with the assets of the plan in [their] own interest." *Id.* § 1106(b)(1). Weighing the fact that the same entity both evaluates and pays claims on judicial review in the absence of any evidence in the administrative record that the fiduciary acted improperly would conflict with these provisions of ERISA and with this Court's conclusion that a fiduciary may have "financial interests adverse to beneficiaries" as long as it does not act upon those interests when making fiduciary decisions. *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000).

This conclusion is confirmed by the trust-law principles that served as the backdrop for ERISA's enactment. Where a conflict of interest is contemplated in the trust documents, trust law does not generally weigh that conflict on judicial review. Such a conflict is relevant, if at all, only if the plaintiff is able to make a showing that the fiduciary's decision was actually infected by self-dealing.

Changing the plan settlor's intended arbitrary-and-capricious standard of review merely because—as Congress also contemplated—the entity that determines eligibility also pays the claims would undermine ERISA's objectives of promoting prompt, efficient, and cost-effective plan administration. It is far more efficient to have a single company that issued the funding mechanism based on the plan design evaluate a benefit claim under those plan terms

than to divide those functions between two separate companies. Moreover, changing the standard of judicial review merely because entities in MetLife's position separately perform these two functions will encourage participants with dubious claims to file suit in the hope that a heightened standard of review and the burdens of conflict-of-interest discovery will produce a settlement, or that the diluted standard will persuade a court to second-guess a plan's reasonable benefit determination. The costs associated with this administrative inefficiency and increased litigation will increase premiums or diminish the generosity of plan designs, as well as deter employers from forming new, or continuing existing, benefit plans.

B. The realities of benefit plan administration confirm that companies that act as fiduciaries and separately fund claims through group insurance policies do not operate under a conflict of interest that should affect the standard of judicial review. As several circuits have recognized, insurance companies and the employers who sponsor ERISA-regulated plans share strong commercial incentives to treat claimants fairly and to pay meritorious claims. Moreover, the claims reviewers making benefit determinations do not have financial interests adverse to claimants because they are salaried employees whose income does not vary based upon denials, and because, in making such determinations, they are bound by their fiduciary obligation under ERISA to act "solely in the interest" of plan participants. 29 U.S.C. § 1104(a)(1). Indeed, such potential, theoretical conflicts abound in other areas of the law, but this Court has nonetheless determined that employees should not be presumed to be biased in favor of their employer (*Richardson v. Perales*, 402 U.S. 389, 410 (1971) (administrative law)) and that the plain-

tiff must make a threshold showing of improper motive (*United States v. Armstrong*, 517 U.S. 456, 468 (1996) (criminal prosecutions)). These standards should also apply in the ERISA setting.

C. Participants' interests are adequately protected even without a heightened standard of review. Improperly motivated decisions will almost invariably be reversed under the usual abuse-of-discretion standard because ERISA's requirement that a fiduciary document the basis for its claims determinations makes it exceedingly difficult to conceal self-interested decision-making. Moreover, the fiduciary obligations imposed by ERISA are in addition to, and do not displace, regulation by various state departments of insurance. *See*, *e.g.*, 29 U.S.C. § 1144(b)(2)(A); *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342 (2003). State regulation and Department of Labor procedural safeguards provide participants with strong protection against improperly-motivated benefit determinations.

Because the provisions of the Sears Long Term Disability Plan contemplate that MetLife will both evaluate and pay claims, and Glenn produced no evidence that MetLife was motivated by its own self-interest when terminating her benefits, the decision below should be reversed.

II. If the Court concludes that the fact that a company both evaluates and pays claims should affect the standard for judicial review, that conflict should be weighed as only one factor in determining whether the company abused its discretion.

A. This Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), indicates that a conflict of interest, if a cognizable conflict exists, is merely one factor to be considered in deter-

mining whether a fiduciary abused its discretion. That approach is more consistent with ERISA's trust-law underpinnings and the objectives that animate the statute than the alternative approaches sometimes employed by the courts of appeals. If the Court concludes that the fact that a company both evaluates and pays claims must be weighed on judicial review, it should also make clear that such an arrangement warrants *de minimis* weight on judicial review in all but the most egregious factual circumstances.

B. Although the Sixth Circuit purported to apply the abuse-of-discretion standard that this Court endorsed in *Firestone*, it actually undertook a *de novo* review of MetLife's determination when it reweighed the evidence, emphasized the factors that favored Glenn, and accorded no weight to compelling contrary evidence, much less any deference to MetLife's decision. The Sixth Circuit's decision should therefore be reversed even if the fact that MetLife both evaluated and paid claims is relevant on judicial review.

As an initial matter, even if some weight were appropriate, the court of appeals gave undue weight to the fact that MetLife both evaluates and pays claims. There is no evidence that this purported conflict of interest in any way affected MetLife when it concluded that Glenn was not eligible for long-term disability benefits under the strict standard set forth in the Plan. Indeed, that decision was fully substantiated by the medical file, which included five assessments in which her own treating physician and independent physicians concluded that Glenn was capable of performing sedentary work.

The court of appeals also erred by requiring MetLife to provide a written refutation of the SSA disability determination. That requirement contravenes this Court's holding in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003), that courts may not impose a discrete "burden of explanation" when claim administrators reject a claimant's evidence. *Id.* at 834. Moreover, the SSA determination was based on different medical evidence than MetLife's decision to terminate Glenn's benefits, and was fully consistent with that decision.

The court of appeals also impermissibly second-guessed MetLife's resolution of the "conflict" between Dr. Patel's physical capacity evaluations and the revised assessments he submitted after MetLife terminated Glenn's benefits. In fact, the court of appeals completely ignored the crucial timing of the treating physician's changed conclusion. MetLife reasonably concluded that the medical evidence established that Glenn was not disabled, despite Dr. Patel's revised assessment, because that assessment contradicted his prior consistent physical capacity evaluations and the opinions of three other physicians.

ARGUMENT

In the wake of this Court's holding in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), that ERISA plan fiduciaries' discretionary benefit determinations should be reviewed for an abuse of discretion, lower courts have struggled with whether an entity that both evaluates and pays claims should be deemed to operate under a "conflict of interest" that should alter, or otherwise be factored into, the standard for judicial review. Some courts—such as the Sixth Circuit in the decision below—have held that these fiduciaries always operate under a conflict

of interest that should be weighed on judicial review (Pet. App. 10a); others have held that this fact is generally irrelevant on judicial review (*see*, *e.g.*, *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)); and a third group has held that the factor should be considered on judicial review only if the plaintiff is able to demonstrate that the conflict of interest actually influenced the benefit determination (*see*, *e.g.*, *Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 92 (2d Cir. 2000); *Sahulka v. Lucent Techs., Inc.*, 206 F.3d 763, 768 (8th Cir. 2000)).

Where a fiduciary is found to be operating under a conflict of interest, the lower courts have also adopted differing means of weighing that conflict on judicial review. Most lower courts have adopted variations of the so-called "sliding scale" standard, under which the degree of deference afforded to the fiduciary depends on the seriousness of the conflict. *See*, *e.g.*, *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006) (en banc) (disclaiming the "sliding scale" label but advocating a "similar" approach in some cases); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 392 (3d Cir. 2000); *Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 587 (8th Cir. 1999). Other courts, however, shift the burden of proof to a conflicted fiduciary to establish the reasonableness of its decision. *See Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004); *HCA Health Servs. of Ga., Inc. v. Employers Health Ins. Co.*, 240 F.3d 982, 993-95 (11th Cir. 2001). And at least one court utilizes *de novo* review to examine a decision by a conflicted fiduciary. *See Pulvers*, 210 F.3d at 91. *But see Abatie*, 458 F.3d at

973 (court may consider new evidence under abuse-of-discretion review).

The circuits' consideration of these questions since *Firestone* has produced several useful insights. First, as recognized by the Seventh and Eighth Circuits, among others, the standard of review required by the plan's delegation of discretionary authority should not change merely because a *potential* conflict exists that was also contemplated by ERISA. Second, as suggested by the majority view, an actual conflict (as distinguished from the potential conflict here) should be weighed as part of abuse-of-discretion review; it should not shift the burden of proof or produce *de novo* review.

I. A COMPANY THAT BOTH EVALUATES AND PAYS CLAIMS, WITHOUT MORE, DOES NOT OPERATE UNDER A CONFLICT OF INTEREST THAT MUST BE WEIGHED ON JUDICIAL REVIEW.

The Sixth Circuit held that the fact that the same entity both evaluates and pays claims should *always* be weighed on judicial review of a fiduciary's benefit determination. That conclusion cannot be reconciled with the language or purpose of ERISA, its trust-law underpinnings, or the realities of benefit plan administration. Each of these interpretive guideposts establishes that, where a company both evaluates and pays claims, this fact, standing alone, should only affect judicial review where the plan settlor does not contemplate this consolidation of functions or where the plaintiff is able to make a substantial showing from the administrative record or public sources that the fiduciary's benefit determination was actually infected by a conflict of interest.

A. The Language, Structure, And Purpose Of ERISA Establish That A Company That Evaluates And Pays Claims Does Not For That Reason Alone Operate Under A Conflict Of Interest That Must Be Weighed On Judicial Review.

1. As this Court has repeatedly noted, ERISA establishes a "comprehensive and reticulated" legal framework governing employee benefit plans. *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 251 (1993) (internal quotation marks omitted). ERISA addresses in detail the subject of prohibited transactions by fiduciaries, and expressly prohibits a fiduciary from "deal[ing] with the assets of the plan in his own interest." 29 U.S.C. § 1106(b)(1). ERISA also expressly *authorizes* an employer—or any agent of the employer—responsible for funding a benefit plan to serve in a fiduciary capacity as claim administrator. *See id.* § 1108(c)(3); *see also id.* § 1002(14)(C). ERISA even requires employers to serve as default plan administrators in certain circumstances. *See id.* § 1002(16)(A)(ii). Congress therefore made clear that it did not consider a fiduciary that is separately responsible for paying the claims that it reviews to be acting "in [its] own interest." In the case of fiduciaries that are also insurance providers, Congress carefully preserved the existing state regulatory schemes (*id.* § 1144(b)(2)(A)), adding to that oversight the heavy obligations of a fiduciary.

It cannot be the case that an arrangement that was expressly contemplated—and authorized—by Congress, without more, changes the standard of review for discretionary benefit determinations. Congress's decision to provide express authorization for employers to fund and administer pension plans—a

common-place arrangement of which Congress was well-aware when it enacted ERISA—reflects its judgment that a fiduciary's theoretical financial interest in a benefit determination does not, standing alone, constitute a conflict of interest that should affect the standard of review. *See* Staff of Senate Comm. on Labor and Public Welfare, 92d Cong., 2d Sess., Statistical Analysis of Major Characteristics of Private Pension Plans 31-32 (Comm. Print 1972) (finding that sixty percent of participants in private pension plans belonged to employer-administered plans and that some of these plans were unfunded). It defies logic to suggest that, when "enact[ing] ERISA to protect . . . the interests of participants in employee benefit plans" (*Davila*, 542 U.S. at 208 (internal quotation marks omitted; ellipsis in original)), Congress would have expressly permitted the same entity to evaluate and pay claims if it believed that vesting both responsibilities in a single body would create a conflict of interest detrimental to plan participants.

This conclusion is confirmed by *Pegram v. Herdrich*, 530 U.S. 211 (2000), which acknowledged that ERISA authorizes a fiduciary to "have financial interests adverse to beneficiaries." *Id.* at 225. The Court explained that ERISA does not prohibit a fiduciary from owning "two hats"—such as that of plan fiduciary and plan funding source. ERISA instead requires that a "fiduciary with two hats wear *only one at a time*, and wear the fiduciary hat when making fiduciary decisions." *Id.* (emphasis added). Based on these statutory principles, the Court held that a health maintenance organization could not have breached its fiduciary duty to act solely in the interest of plan beneficiaries when its physician owners made medical treatment decisions under a

framework that enabled the physicians to profit from a decision to minimize medical care, because the physicians were not acting in a fiduciary capacity when making such decisions.

Because ERISA permits a fiduciary to have "financial interests adverse to beneficiaries" (*Pegram*, 530 U.S. at 225) and expressly authorizes the consolidation of claim administration and funding responsibilities within the same entity, the fact that the same company has employees who sell group insurance policies that fund plans and others who determine eligibility—and may therefore derive a financial benefit from a claim denial—cannot be weighed on judicial review unless the plaintiff makes a showing that the fiduciary in fact acted on the basis of its own financial interests when carrying out its fiduciary responsibilities.

2. The trust-law principles that served as the backdrop for the enactment of ERISA confirm that, without more, the fact that the same entity both evaluates and pays claims does not create a conflict of interest that must be weighed on judicial review. *See Firestone*, 489 U.S. at 110-11 (because "ERISA abounds with the language and terminology of trust law," the Court must look to "principles of trust law" "[i]n determining the appropriate standard" for reviewing benefit determinations); *see also Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996); *Cent. States, Se. & Sw. Areas Pension Fund v. Cent. Transp., Inc.*, 472 U.S. 559, 570 (1985).

Under traditional trust-law principles, trustees may serve in settings where their decisions could *potentially* further their own interests, as long as that arrangement is contemplated in the trust documents. *See*, *e.g.*, Restatement (Second) of Trusts (1959) § 170

cmt. t ("By the terms of the trust the trustee may be permitted to sell trust property to himself individually, or as trustee to purchase property from himself individually, or to lend to himself money held by him in trust, or otherwise to deal with the trust property on his own account.").[5] Where such a potential conflict was contemplated by the settlor, courts do not weigh that conflict in reviewing trustees' decisions because it is "the administration of the trust, not potential conflicts, [that] determine[s] if the trustees have acted in the best interests of the trust beneficiaries." *Delaware v. Belin*, 456 So. 2d 1237, 1241 (Fla. Dist. Ct. App. 1984). Indeed, this Court has explained that "it is a settled principle that trustees having the power to exercise discretion will not be interfered with so long as they are acting bona fide. To do so would be to substitute the discretion of the court for that of the trustee." *Shelton v. King*, 229 U.S. 90, 94-95 (1913). Courts thus continue to "presume[ ] that a trustee" "has acted in good faith" despite such a potential conflict, unless there is some

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[5] *See also* G.G. Bogert & G.T. Bogert, *The Law of Trusts and Trustees* § 543(U), at 373 (rev. 2d ed. 1978) (most commonly recognized exception to application of rule against conflicts of interest is where the settlor has approved the self-dealing transaction or conflict-of-interest position); Mark L. Ascher et al., *Scott and Ascher on Trusts* § 17.2 (5th ed. 2007) (if trust authorizes trustee to undertake certain transaction, trustee may ordinarily do so without fear of liability, notwithstanding that the transaction involves self-dealing or a conflict of interest); *Estate of Fruehauf v. Comm'r*, 427 F.2d 80, 86 (6th Cir. 1970) (holding that a widower who served as both executor and trustee of his deceased wife's estate could convert trust property into his personal property because the trust document allowed him to do so); *In re Estate of Thompson*, 328 P.2d 1, 3 (Cal. 1958); *Rosencrans v. Fry*, 95 A.2d 905, 913 (N.J. 1953).

affirmative evidence to the contrary. *Gregory v. Moose*, 590 S.W.2d 665, 670 (Ark. Ct. App. 1979).[6]

Trust law therefore confirms what is apparent from ERISA's own provisions: The fact that a plan fiduciary has a potential conflict of interest contemplated in the plan documents should only be weighed on judicial review if a plaintiff is able to make a showing that the fiduciary was actually infected by self-dealing when making the challenged decision.

This conclusion is consistent with the Court's decision in *Firestone*.[7] Relying on the Restatement (Second) of Trusts, the Court observed that, if an administrator "is *operating*" under a conflict of interest, then such a "conflict must be weighed as a 'facto[r] in determining whether there is an abuse of

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[6] *See also Goldman v. Rubin*, 441 A.2d 713, 725 (Md. 1982) (reversing a trial court's decision because, "[b]y emphasizing the conflict of interests, which we have concluded was intended and authorized, the trial court did not reach an analysis of the fiduciaries' position under a standard of discretionary action"); *Estate of Gilliland*, 140 Cal. Rptr. 795, 802 (Ct. App. 1977); *In re Estate of Alexander*, 171 S.W.3d 794, 796-97 (Mo. Ct. App. 2005); *In re Pincus' Estate*, 105 A.2d 82, 86 (Pa. 1954); *In re Estate of Halas*, 568 N.E.2d 170, 178 (Ill. App. Ct. 1991); *Huntington Nat'l Bank v. Wolfe*, 651 N.E.2d 458, 465-66 (Ohio Ct. App. 1994).

[7] In *Firestone*, this Court reviewed the Third Circuit's holding that a benefit determination by a fiduciary that both evaluates and pays claims should be subject to *de novo* review "given the lack of assurance of impartiality on the part of the employer." 489 U.S. at 107-08 (citing 828 F.2d 134, 137-45 (3d Cir. 1987)). The Court did "not rest [its] decision on the concern for impartiality that guided the Court of Appeals," but instead concluded that *de novo* review was appropriate for all benefit determinations "unless," as here, "the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id.* at 115.

discretion.'" 489 U.S. at 115 (quoting Restatement (Second) of Trusts § 187 cmt. d) (alteration in original; emphasis added). In making this statement, the Court did not purport to determine which categories of conflicts of interest should be taken into account on judicial review. Indeed, the illustrations provided by the Restatement suggest that the Court was referring to conflicts of interest that have actually infected the trustee's determination. *See* Restatement (Second) of Trusts § 187 cmt. g illus. 2-4 (an action is motivated by an improper purpose such as a conflict of interest or a religious bias where the trustee's decision was based "solely on the [improper] ground"). Whatever role an *actual* conflict such as that described in the Restatement should play in judicial review, ERISA and its trust-law underpinnings establish that a *potential* conflict contemplated by the plan settlor when delegating discretion should not change the abuse-of-discretion standard where there is no affirmative evidence that the fiduciary acted upon that conflict.

3. Any change in the intended standard of review based on the mere fact that the same entity reviews and pays claims—as contemplated by the plan—would also contradict the dual policies underlying ERISA.

Congress designed ERISA to protect the interests of plan participants and to facilitate the formation of employee benefit plans by "minimizing the administrative and financial burdens on plan administrators." *Egelhoff*, 532 U.S. at 150 (internal quotation marks omitted). The consolidation of claims administration and funding responsibilities within a single company promotes both of these objectives because allocating multiple administrative responsibilities to a single entity facilitates the development of an effi-

cient claims-processing and payment procedure. The cost-savings associated with the consolidation of claims processing and payment responsibilities in a single company preserve finite resources for stabilizing premiums or providing more generous benefit plans, and may encourage the formation of more employee benefit plans. As the United States correctly argued in *Pegram*, "ERISA . . . tolerates the level of divided loyalty that is intrinsic to those common arrangements [under which insurers make benefit determinations], so that ERISA plans will be created and insurance companies and others will find it practical to work for them." Br. for the United States as *Amicus Curiae* at 28, *Pegram* (No. 98-1949); *see also* 120 Cong. Rec. H8702 (daily ed. Aug. 20, 1974) (statement of Rep. Ullman upon introducing the conference report) (it is "axiomatic" that "plans cannot be expected to develop if costs are made overly burdensome").

On the other hand, treating such common-place arrangements, without more, as a "conflict" that dilutes the standard of review intended by the plan settlor will inevitably encourage participants with dubious claims to file suit in the hope of convincing a court to second-guess the plan's claim determination.[8]

The undiluted abuse-of-discretion standard of review that is intended by plan documents deters ques-

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[8] If the fact that the same entity both evaluates and pays claims is sufficient, without more, to heighten the standard of review, fiduciaries may shade their claim determinations in favor of individual claimants who would otherwise not qualify for benefits in order to avoid expensive and protracted litigation, thereby reducing the funds available for the payment of meritorious benefits claims.

tionable filings—and shields plans from the costs of unwarranted litigation—by preventing a plan's reasonable claim determination from being overturned simply because record evidence supports both sides of the issue. *See Gall v. United States*, 128 S. Ct. 586, 597 (2007). Application of this deferential standard of review makes eminent sense in the context of discretionary claim determinations because plan fiduciaries have much more extensive experience reviewing the merits of such claims than do federal courts. *Cf. Koon v. United States*, 518 U.S. 81, 98 (1996). This Court has acknowledged, however, that "[i]t is a fair question just how deferential the review can be when the judicial eye is peeled for conflict of interest." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n.15 (2002). If courts are required to dilute the applicable deferential standard merely because the same entity both evaluates and pays claims, they may use this purported conflict of interest—either knowingly or unknowingly—as a basis for substituting their own evaluation of the medical evidence for plan fiduciaries' reasonable benefit determinations.

ERISA reflects Congress's "desire not to create a system that is so complex that . . . litigation expenses[ ] unduly discourage employers from offering welfare benefit plans." *Varity Corp*, 516 U.S. at 497. Indeed, ERISA seeks to facilitate cost-effective dispute resolution through internal administrative review rather than litigation. *See* 29 U.S.C. § 1133(2); 29 C.F.R. § 2560.503-1(h)(1). Increasing the litigation burdens on ERISA plans will drain their limited financial resources and discourage employers from establishing benefit plans—to the substantial detriment of existing and prospective plan participants and beneficiaries. This Court should not lightly re-

write the deferential standard that the plan settlor envisioned when it delegated discretionary authority to the claim fiduciary, solely on the basis of a potential conflict that was also contemplated by the plan, and thus invite wasteful litigation that can only diminish the assets that are ultimately available to provide and fund benefits.

B. The Realities Of The Insurance Business Confirm That A Company That Evaluates And Pays Claims Does Not Operate Under A Conflict Of Interest That Must Be Weighed On Judicial Review.

Congress's decision to provide express authorization for ERISA plan fiduciaries to evaluate and pay claims also reflects its understanding that the practical realities of the insurance business impose significant checks upon fiduciaries that simultaneously perform these functions.

Any potential conflict inherent in an insurance company's evaluation and payment of claims is counterbalanced by the fact that insurers have powerful long-term business incentives to treat claimants fairly. Employers are not required to provide welfare benefits to their employees (*Spink*, 517 U.S. at 887), but many employers do so to attract talent and boost employee morale. Insurers who routinely deny meritorious claims will inevitably anger participants and, in turn, alienate their employers, who—having made the decision to fund a welfare benefit plan—want to ensure that their financial investment has the intended effect of increasing employees' job satisfaction. *See Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1021 (7th Cir. 1998) ("employers want to see their employ-

ees' claims granted because they want their employees satisfied with their fringe benefits"). Indeed, as several courts have noted, individual claims are often quite minute when compared with the profitability of the supposedly conflicted decision-makers (*see Chalmers v. Quaker Oats Co.*, 61 F.3d 1340, 1344 (7th Cir. 1995)), who are unlikely to risk their goodwill—and endanger their prospects of securing repeat business—by not treating claimants fairly (*Wright*, 402 F.3d at 75); *see also Group Insurance* 24 (William F. Bluhm et al. eds., 4th ed. 2003) ("Organizations cannot survive if they must focus their sales efforts on replacing dissatisfied customers."). These long-run reputational incentives for insurance companies to review benefit claims in an equitable manner counteract the purely theoretical short-term interest that a company may have to minimize payouts by denying meritorious claims.

Moreover, it is overly simplistic to think that, where an insurance company is responsible for evaluating and paying claims, every dollar that the insurance company pays in benefits comes directly out of its profits. Ordinarily, the premium that a plan sponsor or the participants pay is calculated using actuarial assumptions that allow the insurance company to pay meritorious claims while still earning a profit considered to be reasonable by state regulators. *See generally* S. Haberman & E. Pitacco, Actuarial Models for Disability Insurance (1999). *See also* Cal. Code Regs. tit. 10, § 2214; N.Y. Comp. Codes R. & Regs. tit. 11, § 52.40. If those assumptions prove incorrect, the insurance company will adjust the premium in future years to reflect more accurately the cost of paying benefit claims. Various underwriting approaches, rate-setting mechanisms, and reserving and investment practices, all of which

involve actuaries, underwriters, investment specialists and regulatory oversight, make the business of insurance significantly more complex than may appear at first blush. *See*, *e.g.*, *Group Insurance*, *supra*, at 655-712. The assumption of the United States that "every exercise of discretion impacts [the fiduciary] financially, filling or depleting its coffers" (U.S. Cert. Br. 13 (internal quotation marks omitted)) is thus overly simplistic.

Furthermore, the insurance company employees who actually make benefit determinations do not have direct personal stakes in the outcome of their decisions. Indeed, this Court has recognized that a person's interests are not defined simply by the source of his paycheck. *See Polk County v. Dodson*, 454 U.S. 312, 319 (1981) (holding that a public defender is not a state actor simply because he is paid by the State). Administrative law judges, for example—who are often salaried employees of the agencies appearing before them—are not considered to be operating under a conflict of interest when presiding over adversarial proceedings between their agency-employer and a third party. In *Richardson v. Perales*, 402 U.S. 389 (1971), the Court concluded that a social security hearing examiner is not biased against a claimant simply because he is a government employee "charged with developing the facts." *Id.* at 410. The Court emphasized that the allegations of bias "assume[d] too much" because, without any evidentiary substantiation, they ascribed improper motives to a hearing examiner based on a procedural structure that was common throughout many government programs. *Id.*; *see also Withrow v. Larkin*, 421 U.S. 35, 52 (1975) ("our cases . . . offer no support for the bald proposition . . . that agency

members who participate in an investigation are disqualified from adjudicating").

Like a social security examiner, an insurance company claims administrator is not an advocate on behalf of his employer; rather, "[h]e acts as an examiner charged with developing the facts" and making a benefit determination on the basis of those facts. *Perales*, 402 U.S. at 410. In reaching a decision, the claims administrator is bound by his fiduciary obligation to discharge his responsibilities "solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104(a)(1).

Accordingly, as at trust law, a claims fiduciary operating under a contemplated conflict of interest must be "presumed" to act in accordance with this fiduciary obligation, even if his employer also pays a participant's benefits. *Gregory*, 590 S.W.2d at 670 ("it is presumed that a trustee has acted in good faith and the burden of proof rests upon those who question his actions"). Indeed, as this Court has recognized in other settings, courts should not presume that decision-makers are motivated by improper considerations without a substantial evidentiary showing to that effect. *United States v. Chem. Found., Inc.*, 272 U.S. 1, 14-15 (1926). In *United States v. Armstrong*, 517 U.S. 456 (1996), for example, the Court refused to allow discovery into whether a prosecutor's decisions were improperly motivated by race where the defendant had failed to make an "appropriate threshold showing" that the prosecutor declined to prosecute similarly-situated persons of other races. *Id.* at 463. The Court emphasized that prosecutors' charging decisions are inherently discretionary, and that discovery into the prosecutor's motives would "divert . . . resources" and impose significant constraints on charging discretion. *Id.* at 468.

A threshold showing of probative evidence was necessary to "adequately balance[ ]" the prosecutor's interest in exercising his discretion and the defendant's interest in race-neutral prosecutorial decisions. *Id.* at 470.

A similar rule is appropriate in the ERISA context. A claim that a company was conflicted because it both evaluated and paid claims should fail in the absence of a showing that the company's decision was actually infected by that potential "conflict." Indeed, this Court has made clear that "any conflict of interest on the plan fiduciary's part" is relevant on judicial review *only* where the "conflict was plausibly raised." *Rush Prudential*, 536 U.S. at 384 n.15.

Fiduciaries should therefore be presumed to faithfully discharge their obligations in the absence of an appropriate showing from the administrative file indicating that the fiduciary's decision was actually based on an improper motive. Restatement (Second) of Trusts § 187 cmt. g ("Although ordinarily the court will not inquire into the motives of the trustee, yet if it is shown that his motives were improper or that he could not have acted from a proper motive, the court will interpose.").[9]

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[9] *See also Jarvis v. Boatmen's Nat'l Bank,* 478 S.W.2d 266, 273 (Mo. 1972) ("The presumption is that a trustee has acted in good faith and the burden is on the one questioning his actions and seeking to establish a breach of trust to prove the contrary."); *Rice v. Peoples Sav. Bank*, 247 P. 1009, 1011 (Wash. 1926) ("The presumption is that a trustee will faithfully administer his trust . . . .") (internal quotation marks omitted).

C. Participants' Interests Are Fully Protected When Their Claims Are Reviewed By Insurers That Both Evaluate And Pay Claims.

This conclusion finds further support in the extensive protections available under federal and state law for participants whose benefit determinations are made by insurers that both evaluate and pay claims.

1. Under the usual abuse-of-discretion standard, an ERISA fiduciary's discretionary benefit determination may be reversed if it is "arbitrary, capricious, or made in bad faith, not supported by substantial evidence, or erroneous on a question of law." *Music v. W. Conference of Teamsters Pension Trust Fund*, 712 F.2d 413, 418 (9th Cir. 1983) (internal quotation marks omitted). This standard—whether termed "abuse of discretion" review or "arbitrary and capricious" review—closely resembles the standard articulated in the Administrative Procedure Act for review of agency determinations. 5 U.S.C. § 706(2); *see also Block v. Pitney Bowes Inc.*, 952 F.2d 1450, 1454 (D.C. Cir. 1992) (R.B. Ginsburg, J.). Although that standard is "deferential," it does not require a court merely to "rubber-stamp[ ] the result." *Torres v. UNUM Life Ins. Co. of Am.*, 405 F.3d 670, 680 (8th Cir. 2005); *see also Hackett v. Xerox Corp. Long-Term Disability Income Plan*, 315 F.3d 771, 774 (7th Cir. 2003) (even under a deferential standard of review, "deference need not be abject").

The abuse-of-discretion standard is sufficient to identify virtually all improperly motivated claim determinations because those decisions invariably rest

on faulty reasoning and inadequate support.[10] Whenever a claim for benefits is denied, the claim administrator must set forth in writing the specific reasons for the denial, describe any additional material or information necessary for the employee to perfect the claim, and explain why that material or information is necessary. 29 U.S.C. § 1133(1). These documentation requirements make it exceedingly difficult for administrators to conceal an arbitrary or capricious decision, and thus significantly reduce the likelihood that administrators will act on the basis of their own financial interests. *Cf. Wolff v. McDonnell*, 418 U.S. 539, 565 (1974) ("the provision for a written record helps to insure that administrators, faced with possible scrutiny by state officials and the public, and perhaps even the courts . . . will act fairly"). Accordingly, even without weighing a potential "conflict of interest," the faulty reasoning offered in an attempt to justify an inappropriate denial of a meritorious claim will inevitably result in a finding that

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[10] *See, e.g.*, *Morgan v. UNUM Life Ins. Co. of Am.*, 346 F.3d 1173, 1177-78 (8th Cir. 2003) (insurer knew before awarding benefits that the claimant routinely engaged in the type of activities the insurer later used as the basis for discontinuing his benefits and insurer's physician lacked experience with respect to claimant's condition); *Zuckerbrod v. Phoenix Mut. Life Ins. Co.*, 78 F.3d 46, 50 (2d Cir. 1996) (denial of partial benefits reversed because it was not supported by substantial evidence); *Hawkins v. First Union Corp. Long-Term Disability Plan*, 326 F.3d 914, 919 (7th Cir. 2003) (overturning a plan's benefit determination because there were "mere scraps" of evidence supporting its denial of benefits); *Marecek v. BellSouth Servs., Inc.*, 49 F.3d 702, 706-07 (11th Cir. 1995) (denial of benefits was erroneously based on unsustainable "factual findings and *post hoc* explanations"); *Buffonge v. Prudential Ins. Co. of Am.*, 426 F.3d 20, 22 (1st Cir. 2005) (claims process was so tainted as to be arbitrary and capricious).

the decision is arbitrary and capricious on judicial review.

The protection afforded to participants by abuse-of-discretion review is reinforced by the Department of Labor's extensive procedural regulations governing ERISA benefit determinations. 29 C.F.R. § 2560.503-1. Those regulations require that a benefit plan "provide a claimant with a reasonable opportunity for a full and fair review of . . . [an] adverse benefit determination." *Id.* § 2560.503-1(h)(2). That review must be performed by someone other than the individual who conducted the initial benefit determination and may not afford deference to that initial decision. *Id.* § 2560.503-1(h)(3)(ii). As part of that review, the fiduciary *must* "consult with a health care professional who has appropriate training and experience in the [relevant] field of medicine" (*id.* § 2560.503-1(h)(3)(iii); *id.* § 2560.503-1(h)(4)), "take[ ] into account all comments, documents, records, and other information submitted by the claimant" (*id.* § 2560.503-1(h)(2)(iv)), and, when upholding a denial of benefits, provide the "specific reason or reasons for the adverse determination" (*id.* § 2650.503-1(j)(1)). These procedural measures provide additional safeguards against biased decision-making by fiduciaries and ensure that self-interested claims determinations will be apparent from the face of the decision itself.[11]

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[11] Where a fiduciary has failed to adhere to the Department of Labor's procedural requirements—or to other procedural standards imposed by ERISA or the terms of the plan itself—a court should require the fiduciary to reconsider its benefit determination in accordance with the full panoply of procedures to which it is required to adhere. *Cf. Fla. Power & Light Co. v. Lorion*, 470 U.S. 729, 744 (1985) ("if the agency has not considered all

2. State and federal regulation of insurers provides another layer of protection for plan participants.

ERISA expressly saves state laws that regulate insurance from preemption. 29 U.S.C. § 1144(b)(2)(A); *see also Ky. Ass'n of Health Plans, Inc.*, 538 U.S. at 341-42. In enacting this savings clause, Congress signaled that it is the province of state insurance departments—not federal courts applying ERISA—to oversee and systematically examine insurance practices, including claims processing. Where necessary, these state departments are free to impose extensive remedial measures to correct insurers' wrongdoing. In 2003 and 2004, for example, three state insurance regulators, acting on behalf of their own States and a number of other States, conducted a coordinated investigation of an insurance company based on complaints of biased and irregular decision-making in the company's processing of disability claims.[12] In a settlement with the States, the company agreed to make changes to its claims reviewing procedures and its corporate governance structure, to reassess more than 200,000 claims, and to pay a $15 million fine. Specifically, the company agreed to increase the number of experienced claims

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relevant factors, . . . the proper course, except in rare circumstances, is to remand to the agency for additional investigation or explanation"); *INS v. Ventura*, 537 U.S. 12, 17 (2002) (same). Indeed, courts are much better equipped to police fiduciaries' compliance with procedural requirements than to make benefit determinations themselves.

12 *See* Me. Bureau of Ins., Report of the Targeted Multistate Market Conduct Examination, *at* http://www.maine.gov/pfr/insurance/unum/Unum_Multistate_ExamReport.htm.

professionals; involve upper management more heavily in the approval of claims denials; modify its policies regarding medical information, including guidelines for the use of independent medical evaluations; and add a position of quality compliance consultant to assess the totality of its claims decisions and focus on issues of compliance and documentation.[13]

As this settlement illustrates, state insurance regulators have the ability to take action when an insurer is suspected of denying meritorious claims, whether because it is acting under a conflict of interest or otherwise. Moreover, because state regulators have broader exposure to the insurance business than federal courts, they are better equipped to detect when an ERISA plan fiduciary is systematically denying claims based on improper motives. Indeed, even absent consumer complaints, state regulators routinely conduct market examinations designed to detect any improprieties in claims decisions. *See*, *e.g.*, Me. Rev. Stat. Ann. tit. 24-A, § 221; Mo. Rev. Stat. § 374.205.1(1); N.M. Stat. § 59A-4-5. Thus, unlike federal courts, specialized state regulators have the resources, expertise, and authority to impose systemic corrective action in response to any insurer misconduct. And, to the extent that any close calls involve public policy choices, state regulators are better situated than courts to make them.

State regulatory oversight is complemented by federal regulation by the Department of Labor, which possesses a full range of enforcement mechanisms to regulate ERISA plan fiduciaries, including

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[13] *See* UnumProvident Announces Settlement of Multistate Market Conduct Examination, *at* http://www.unum.com/newsroom/news/corporate/111804_Settlement.pdf.

the authority to intervene in plan proceedings on a participant's behalf, to initiate administrative enforcement actions, and to file suit against fiduciaries that have breached their obligations to plan participants. *See* 29 U.S.C. §§ 1132(a)(2), 1132(a)(5); *see also* Dep't of Labor, ERISA Enforcement, *at* http://www.dol.gov/ebsa/erisa_enforcement.html. The threat of federal regulatory action further deters plan fiduciaries from making claims determinations based on their own financial interests.

In light of the extensive state and federal regulation of insurers that serve as ERISA plan fiduciaries, it is both contrary to one of ERISA's primary goals and simply unnecessary for courts to weigh the mere fact that a company both evaluates and pays claims on judicial review to provide adequate protection for participants. Ordinary abuse-of-discretion review—together with state and federal enforcement measures—provide highly effective means of identifying, and remedying, biased decision-making by claim fiduciaries that are also insurance companies.[14]

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The resolution of this case under ERISA's conflict-of-interest principles is straightforward. The terms of the Sears Long Term Disability Plan expressly contemplate that MetLife will both evaluate and pay claims, and respondent has not come forward with any evidence indicating that MetLife's

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[14] Moreover, as illustrated by the circuits' divergent approaches, "weighing" a conflict of interest in the application of an abuse-of-discretion standard poses serious problems of judicial administration and makes it difficult for parties to predict the outcome of litigation challenging an administrator's decision.

termination of her benefits was based on financial considerations, rather than on its dispassionate evaluation of her medical record. Under the express provisions of ERISA, and the traditional trust-law principles that underpin the statute, the Sixth Circuit therefore erred when it relied on the mere potentiality of conflict to alter the abuse-of-discretion standard intended by the Plan. That benefit determination should have been reviewed for an abuse of discretion without regard to the existence of a potential conflict of interest.

II. IF THE FACT THAT A COMPANY BOTH EVALUATES AND PAYS CLAIMS, WITHOUT MORE, MUST BE WEIGHED ON JUDICIAL REVIEW, IT SHOULD BE ONLY ONE FACTOR CONSIDERED IN DETERMINING WHETHER THERE WAS AN ABUSE OF DISCRETION.

The lower courts have adopted three principal standards for reviewing benefit determinations by fiduciaries acting under an actual conflict of interest: abuse-of-discretion review that weighs the conflict of interest as one relevant factor (*see*, *e.g.*, *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006) (en banc) (disclaiming "sliding scale" label); *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 (5th Cir. 1999)); a burden-shifting approach that requires the fiduciary to establish that its decision was reasonable (*Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (10th Cir. 2004)); and *de novo* review (*Pulvers v. First UNUM Life Ins. Co.*, 210 F.3d 89, 91 (2d Cir. 2000)). Application of either the burden-shifting or *de novo* standard of review is inconsistent with this Court's decision in *Firestone*, ERISA's trust-law underpinnings, and the objectives that animate the statute. If

a fiduciary is deemed to operate under an actual conflict of interest solely because it separately provides the funding mechanism for the benefits at issue (or is found to be operating under any other category of actual conflict), that conflict should merely be weighed as one factor in determining whether the fiduciary abused its discretion. In the absence of evidence that the claim administrator's decision was infected by self-dealing, however, such a conflict should be given only *de minimis* weight.

Although the Sixth Circuit purported to apply the abuse-of-discretion standard, its wholesale re-evaluation of Glenn's medical file indicates that it actually undertook a *de novo* review of the evidence. Thus, even if the fact that MetLife was both deciding and paying claims should be weighed on judicial review, the decision below should be reversed because the court of appeals gave that conflict undue weight and applied the wrong standard of review.

A. Abuse-Of-Discretion Review Is Compelled By *Firestone*, Trust Law, And ERISA's Statutory Objectives.

1. In *Firestone*, this Court held that, under ERISA, a "deferential standard of review [is] appropriate when a [fiduciary] exercises discretionary powers." 489 U.S. at 111; *see also LaRue v. DeWolff, Boberg & Assocs., Inc.*, 552 U.S. _ (2008) (Roberts, C.J., concurring) (slip op. at 3) ("this Court has held that ERISA plans may grant administrators and fiduciaries discretion in determining benefit eligibility and the meaning of plan terms, decisions that courts may review only for an abuse of discretion"). In contrast, if the plan does *not* afford the fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan, a benefit deter-

mination is reviewed *de novo*. *Firestone*, 489 U.S. at 115; *see*, *e.g.*, *Mullaney v. Aetna U.S. Healthcare*, 103 F. Supp. 2d 486, 490 (D.R.I. 2000) (applying *de novo* review).

The *Firestone* Court also considered the appropriate standard for reviewing discretionary benefit determinations by conflicted plan fiduciaries. Although the lower court in *Firestone* had concluded that the fact that the same entity both evaluates and pays claims requires *de novo* review, this Court declined to "rest [its] decision on the concern for impartiality that guided the Court of Appeals." 489 U.S. at 115. The Court expressly noted that any "concern for impartial decisionmaking" would not "foreclose[ ] parties from agreeing upon a narrower standard" than *de novo*. *Id*. Because there was no delegation of discretionary authority and *de novo* review applied, the Court did not decide whether the particular fact pattern before it *was* a "conflict" that should affect the standard of review. The Court instead stated, "[I]f 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.'" *Id.* (quoting Restatement (Second) of Trusts § 187 cmt. d) (second alteration in original). Later decisions confirm that *Firestone* requires abuse-of-discretion review of decisions by conflicted fiduciaries. *See Rush Prudential*, 536 U.S. at 384 n.15 ("In *Firestone Tire* itself, we noted that review for abuse of discretion would home in on any conflict of interest on the plan fiduciary's part, if a conflict was plausibly raised.").

Firestone therefore authoritatively forecloses application of a *de novo* standard of review or a burden-shifting approach to evaluate a decision by a con-

flicted plan fiduciary, and instead suggests that courts may weigh a conflict of interest as one factor in determining whether there was an abuse of discretion. There is no reason to revisit that conclusion here. *See* Br. in Opp. to Pet. for Cert. 24 (endorsing *Firestone*'s approach); U.S. Cert. Br. 16 (same).

2. *Firestone*'s rejection of the burden-shifting and *de novo* approaches is confirmed by traditional trust-law principles and ERISA's statutory objectives.

As *Firestone* recognized, trust law provides for abuse-of-discretion review where a trustee is given a discretionary power, even when the trustee operates under an *actual* conflict of interest. In applying this abuse-of-discretion standard, "the burden of proof remains on the party challenging the fiduciary's conduct as there is no presumption against the fiduciary despite the divided loyalty." *In re Estate of Halas*, 568 N.E.2d 170, 178 (Ill. App. Ct. 1991).[15] The *de novo* and burden-shifting approaches are therefore also squarely at odds with ERISA's trust-law underpinnings.

Thus, if this Court concludes that the deferential standard of review intended by the plan must be modified to take into account the type of potential, theoretical conflict at issue here, it should nonetheless reaffirm that abuse-of-discretion review remains the rule when the plan gives fiduciaries discretionary power, and should direct, as *Firestone* suggested,

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[15] *See also Gregory*, 590 S.W.2d at 670-71 (even in the presence of an actual conflict of interest, it must be "presumed that a trustee has acted in good faith and the burden of proof rests upon those who question his actions and seek to establish a breach of trust"); *Wolfe*, 651 N.E.2d at 466; *Rosencrans*, 95 A.2d at 913; *Bank of Nev. v. Speirs*, 603 P.2d 1074, 1077 (Nev. 1979).

that any such conflict simply be considered as part of the required deferential review. If any modification of the abuse-of-discretion standard is appropriate at all, this one, as the United States has recognized, "best balances" ERISA's employee protections "with the statutory authorization for fiduciaries to serve in dual roles . . . and for employers generally to set up plans as they see fit." U.S. Cert. Br. 17.

Although the majority of courts of appeals is therefore correct to reject the *de novo* and burden-shifting approaches, there is wide variation among those courts in the application of the weighing approach that they apply instead. There are especially large variations regarding the amount of weight (if any) courts give to the fact that a company both evaluates and pays claims. For that reason, if the Court concludes that some weight should be given to the fact that a company evaluates and pays claims, it should clarify that—in the absence of a showing that the determination was infected by self-dealing so as to bias the decision-maker against the claim—courts should give *de minimis* weight to the fact that a company both evaluates and pays claims. Giving this arrangement anything more than the most minimal weight on judicial review would be inconsistent with the fact that Congress expressly contemplated—and endorsed—such arrangements. Moreover, the existence of significant procedural protections for plan participants under federal and state law also effectively prevents companies from acting upon any theoretical conflict of interest they may have under such circumstances.

B. The Court Of Appeals Did Not Apply An Abuse-Of-Discretion Standard Of Review.

Although the Sixth Circuit professed to apply an abuse-of-discretion standard of review, in reality, it undertook a *de novo* review of MetLife's benefit determination in which it reweighed the evidence in Glenn's file without according any deference to MetLife's decision and faulted MetLife for failing to discuss each piece of evidence in that file, including the SSA's benefit determination. A faithful application of the abuse-of-discretion standard of review—even one that treats as a "conflict" the mere fact that MetLife both evaluated and paid claims—establishes that MetLife's decision to terminate Glenn's benefits was reasonable and should have been upheld.

1. The Court Of Appeals Gave Undue Weight To The Fact That MetLife Both Evaluated And Paid Claims.

As an initial matter, the fact that MetLife both evaluates and funds benefits warrants *de minimis* weight, if any, in review of its termination of Glenn's benefits. Glenn was provided with a number of procedural protections—including an opportunity to submit evidence of cardiac insufficiency that would support her treating physician's attempt to retract his pre-denial statements that Glenn could perform full-time sedentary work, a right to administrative review of the determination, and review by a nurse consultant and two independent medical examiners—that limited any opportunity MetLife had to act in a biased manner. These procedural protections are even more rigorous than those required by the Department of Labor regulations, which do not require the physician consulted by a plan during ad-

ministrative review to be independent of the plan. 29 C.F.R. § 2560.503-1(h)(3)(v); *cf. Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161 (8th Cir. 1998) (holding that less deferential review is triggered where a fiduciary denies a claim "without seeking any independent medical review").

Moreover, there was no evidence that MetLife's benefit determination was in fact infected by self-dealing. There were no procedural irregularities in MetLife's disposition of Glenn's claim, which was thoroughly reviewed on three different occasions by MetLife's claims administrators. Nor was the evidence so inconsistent with MetLife's determination that the only possible inference is that MetLife acted to further some improper motive.

On the contrary, the record demonstrates that MetLife's conclusion that Glenn was not disabled from performing any job was completely reasonable. The medical records establish that, as a result of "appropriate medical management and biventricular pacing, [Glenn] has achieved a relatively stable cardiac status." J.A. 39a. Glenn's ejection fraction—a critical indicator of her heart condition—had improved from 22% in March 2000 to 40-50% after medical treatment (*id*. at 72a, 74a), the same rate she had throughout the 1990s (*id*. at 41a), when she was able to perform her demanding job at Sears, which required walking and standing for 60% to 100% of the workday (*id*. at 115a). Most significantly, Dr. Patel, her treating physician, twice indicated in physical capacity evaluations submitted to MetLife that, in an eight-hour workday, Glenn could sit eight hours, stand four hours, and walk two hours. *Id*. at 54a, 58a. Dr. Patel was specifically asked whether Glenn was able to work full-time at a sedentary physical exertion level occupation, and he

checked "yes." *Id.* at 58a. Dr. Moyer, an independent physician, concurred with Dr. Patel's conclusion after reviewing Glenn's records. C.A. App. 170. Based on these evaluations and Glenn's vocational background, a Certified Rehabilitation Coordinator found that there were alternative sedentary occupations available for which Glenn had transferable skills, namely account information clerk, attendance clerk, and classified ad clerk. J.A. 100a-03a. In light of this evidence, MetLife concluded on July 13, 2002, that Glenn was not disabled from performing *any* gainful occupation. *Id.* at 14a-15a.

In the administrative appeal that ensued, MetLife reasonably determined that Dr. Patel's revised conclusion that Glenn could not even perform sedentary work—issued nine days after MetLife made the decision to terminate Glenn's benefits—did not outweigh the contrary medical evidence. Although that evidence established that Glenn could not work in the high stress position of Sears sales manager, which required extensive lifting, standing, and walking, there were five medical assessments in the record—two from Dr. Patel and one each from Drs. Moyer, Pujara, and Snider—that concluded that Glenn could perform sedentary work. Dr. Pujara, for example, concluded that the available medical records indicated that Glenn was "capable of sedentary activity as per the U.S. Department of Labor Guidelines." J.A. 39a. And Dr. Snider, an independent examiner who testified during the SSA hearing and who was found to be credible by the ALJ, also concluded that Glenn was able to perform sedentary activity as long as it involved a "low stress work environment" and light exertion. Pet. App. 45a.

It was therefore well within the bounds of MetLife's discretion to credit this evidence over Dr.

Patel's conveniently-timed change of heart, particularly in the absence of any change in the underlying medical records. Indeed, this Court has acknowledged that claim fiduciaries need only "credit a claimant's *reliable* evidence." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834 (2003) (emphasis added); *see also Barnhart*, 179 F.3d at 589 (the fact that a fiduciary "reached a decision contrary to [plaintiff's] medical evaluators, when it based this decision on substantial evidence in the record, reports of outside medical reviewers, and conflicting evidence in [plaintiff's] own submissions to the record," did not render the decision arbitrary or capricious).[16]

2. MetLife Was Not Required To Address The SSA Decision In Its Written Benefit Determination.

Relying on its decision in *Darland v. Fortis Benefits Insurance Co.*, 317 F.3d 516 (6th Cir. 2003), *overruled in part by Nord*, 538 U.S. 822, the court of ap-

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[16] MetLife's skepticism about the medical opinion offered by Dr. Patel after MetLife had determined that Glenn was no longer eligible to receive disability benefits is consistent with this Court's recognition that "a treating physician, in a close case, may favor a finding of 'disabled.'" *Nord*, 538 U.S. at 832. Indeed, according to one survey, 64.3% of treating physicians believe that it is necessary to manipulate insurance plan rules to obtain insurance payments, including exaggerating the severity of the patient's condition. *See* Matthew K. Wynia, *Physician Manipulation of Reimbursement Rules for Patients*, 283 J. Am. Med. Ass'n 1858 (2000); *see also* Victor G. Freeman, *Lying for Patients—Physician Deception of Third-Party Payers*, 159 Archives of Internal Med. 2263 (1999) (reporting a survey in which 57.7% of treating physicians self-reported that they would give a false diagnosis to obtain insurance payments for a patient).

peals also faulted MetLife for "act[ing] . . . in unacknowledged conflict with the determination of disability by the Social Security Administration." Pet. App. 25a. In so doing, it directly contradicted this Court's decision in *Black & Decker Disability Plan v. Nord* and misconstrued the record before the SSA.

a. In *Nord*, this Court refused to extend the so-called "treating physician" rule, developed in the social security context, to ERISA. The Court held that, unlike social security ALJs, ERISA claims administrators are not required to give "special weight to the opinions of a claimant's physician" or to provide a written explanation for disagreeing with the opinion expressed by a claimant's physician. 538 U.S. at 834. The Court acknowledged that "ERISA and the Secretary of Labor's regulations under the Act require 'full and fair' assessment of claims and clear communication to the claimant of the 'specific reasons' for benefit denials" (*id.* at 825), but concluded that nothing in this statutory or regulatory framework "command[s] plan administrators to credit the opinions of treating physicians over other evidence" (*id.*), or "impose[s] on plan administrators a discrete burden of explanation" in writing when they "credit reliable evidence that conflicts" with a treating physician's conclusion. *Id.* at 834. The Court emphasized that the "treating physician" rule is inapplicable in the ERISA context in both its "procedural" form—which "requires a hearing officer to explain why she rejected the opinions of a treating physician"—and its "substantive" form—which "requires that 'more weight' be given to the medical opinions of a treating physician." *Id.* at 834 n.4.

The Sixth Circuit's requirement that MetLife provide a written refutation of an SSA disability determination is flatly inconsistent with *Nord*'s conclu-

sion that courts may not impose a discrete "burden of explanation" on plan administrators. Although Department of Labor regulations prohibit plan administrators from refusing to consider evidence presented by a participant, *Nord* makes clear that they are not required to discuss such evidence or mention it in writing because ERISA's objectives are best served by "preserv[ing] the greatest flexibility possible for . . . operating claims processing systems." 538 U.S. at 833 (internal quotation marks omitted; ellipsis in original). Moreover, because a social security ALJ—unlike an ERISA claim administrator—is required to give special weight to a treating physician's opinion (20 C.F.R. § 404.1527(d)(2)), the court of appeals' written refutation requirement gives a treating physician's opinion, even if credible, a degree of weight that this Court explicitly rejected in *Nord*.

b. Contrary to the Sixth Circuit's contention that MetLife acted in "conflict" with the SSA decision (Pet. App. 25a), the SSA proceedings actually corroborate MetLife's benefit determination.

The ALJ who presided over the SSA proceedings did not conclude that Glenn was physically unable to perform any sedentary occupation. Indeed, the ALJ credited the opinion of Dr. Snider, who testified that Glenn "could sit throughout the day with normal breaks," could "stand and walk for three to four hours total during the workday," and was "limited to [a] low stress work environment." Pet. App. 44a-45a.

The SSA found Glenn to be disabled because she lacked vocational skills to perform the type of jobs available to someone with her physical limitations. The transferable skills assessment before the SSA found that Glenn had no skills that were "transferable" to sedentary jobs within her physical capacity.

Pet. App. 47a. Under SSA regulations, the Commissioner had the burden of disproving this vocational assessment, but he introduced no contrary evidence. *Id.* at 46a; *see also Bowen v. Yuckert*, 482 U.S. 137, 146 n.5 (1987) ("the Secretary bears the burden of proof at step five, which determines whether the claimant is able to perform work available in the national economy."). It was solely because the Commissioner wholly defaulted on his obligation to meet this burden that the SSA found Glenn to be totally disabled.[17]

The burden of proof for Glenn's ERISA claim, however, was different than that for her SSA claim because, under the terms of the Plan, it was Glenn who bore the burden of establishing that she could not perform sedentary work. J.A. 161a. She failed to meet that burden because the vocational TSA—which was not before the ALJ—established that there were several jobs in her geographic area for which she was qualified and physically fit. Glenn was under no such burden in the SSA proceedings, where the Commissioner was required to affirmatively establish that she could perform sedentary work. In light of these divergent burdens of proof and factual records, it was reasonable that MetLife would reach a conclusion that was different than the one reached by the SSA, but unreasonable to expect claims examiners to be able to articulate these substantive and procedural differences.

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[17] Moreover, it does not appear that the SSA had Dr. Patel's March 2002 and June 2002 assessments that Glenn had regained the capacity to do full-time sedentary work. J.A. 128a-30a; *see also Block*, 952 F.2d at 1455 (acknowledging the significance of different records considered by the SSA and ERISA claims fiduciaries).

c. The fact that MetLife encouraged Glenn to apply for social security benefits was consistent with its fiduciary obligation and does not change this analysis.

In order to reduce the employer's cost of providing benefits, the Plan provides that disability benefits will be reduced by the amount of social security and other benefits for which the participant is eligible. J.A. 166a-68a.[18] Because the terms of the Plan authorize MetLife to implement this deduction even if the participant does not actually apply for social security benefits, MetLife derives no financial advantage from encouraging a participant to apply for benefits and then requesting that the participant reimburse it for any overpayment of benefits. After it is reimbursed for the overpayment, MetLife is in no better position than it would have been had it remained silent and reduced the participant's benefits based on estimated SSDB. Indeed, it would be inconsistent with ERISA's objectives and MetLife's fiduciary obligations to penalize MetLife for administering the Plan in accordance with its terms and for encouraging participants to apply for government benefits to which they may be entitled, particularly when the Plan requires benefits be reduced by estimated SSDB if beneficiaries fail to apply for them. *See also supra* pg. 6-7 (detailing other ways the SSDB award directly benefited Glenn).

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[18] This is a common provision of long-term disability plans for the additional reason that it is not in the public interest for disabled individuals to receive more income than they did while in the workforce.

3. MetLife's Evaluation Of The Medical Evidence Was Reasonable.

Finally, the court of appeals criticized MetLife for "reject[ing] Dr. Patel's more detailed reports" of Glenn's health while crediting the "check-off forms" in which he indicated that Glenn was capable of performing sedentary work. Pet. App. 20a. The court of appeals' criticism is both legally and factually flawed.

Determining whether Dr. Patel's physical capacity evaluations were more credible than his other evaluations of Glenn's health required resolution of a disputed issue of fact. Under abuse-of-discretion review, "The fact that the . . . court might reasonably have concluded that a different [determination] was appropriate is insufficient to justify reversal of" a fiduciary's benefit determination. *Gall*, 128 S. Ct. at 597; *see also* Br. for the United States as *Amicus Curiae* at 13, *Nord* (No. 02-469) ("A plan that confers discretion on the administrator to determine whether a claimant is disabled necessarily leaves to the administrator the discretion to resolve factual disputes, such as the nature and extent of the claimant's medical condition and physical limitations."). A court must therefore defer to a fiduciary's reasonable resolution of a disputed issue of fact, even if the court would have resolved the dispute in a different manner.

This is not what the court of appeals did here. It improperly substituted its own evaluation of the medical evidence for MetLife's. Indeed, MetLife's decision to reject Dr. Patel's revised conclusion regarding Glenn's work capacity is well-supported by the extensive record evidence demonstrating that Glenn could perform a sedentary job, including evidence

from Dr. Patel himself. J.A. 54a, 58a. Three other independent physicians who reviewed Glenn's medical records concluded that Glenn was capable of performing sedentary activity in a "low stress work environment." Pet. App. 45a; J.A. 39a; C.A. App. 170. These medical opinions flatly contradicted Dr. Patel's revised conclusion—reached only after MetLife had decided to terminate Glenn's benefits—that she could not work in a low-stress setting, and they are consistent with the objective medical evidence, which demonstrates that, with drug treatments and biventricular pacing, Glenn's ejection fraction had greatly improved and her heart function was normal or within the "lower limits of normal." J.A. 74a.

The court of appeals also faulted MetLife for offering "no explanation for its resolution of the conflict [between Dr. Patel's revised conclusion and the conclusions of other physicians] or, for that matter, whether it was given any consideration at all." Pet. App. 20a. By detailing the medical information in the file that undermined the reliability of Dr. Patel's change of heart, however, MetLife did just that. J.A. 24a-26a. Moreover, as this Court concluded in *Nord*, a fiduciary's conclusion must be upheld if supported by reliable evidence (such as the two physical capacity evaluations completed by Dr. Patel before the denial and the independent medical assessments of Drs. Pujura and Snider), regardless of whether the fiduciary provides a written basis for rejecting conflicting evidence.[19]

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[19] Moreover, although MetLife did not explicitly question his credibility, Dr. Patel made several misleading statements in his reassessment of Glenn's condition. In his February 12, 2003 letter, Dr. Patel stated that Glenn's ICD device had "no rol[e]" in "improving her cardiac function" and was only meant to pro-

Finally, the fact that Dr. Patel's physical capacity evaluations of March and June 2002 were completed on "check-off forms" does not diminish their significance. In fact, the physical capacity evaluations deserve more weight than Dr. Patel's generalized reports on Glenn's condition because they are the only pre-termination documents in which Dr. Patel was specifically asked to evaluate Glenn's ability to perform full-time work. *Cf. D. Ginsberg & Sons, Inc. v. Popkin*, 285 U.S. 204, 208 (1932) ("Specific terms prevail over the general."). Those forms made clear to Dr. Patel that MetLife sought his opinion for the specific purpose of evaluating Glenn's ability to return to work. *See* J.A. 57a ("We are evaluating [Glenn's] ability . . . to return to fulltime work within her capabilities. To complete our assessment we need your input.").[20]

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vide defibrillation if needed (J.A. 42a)—an assertion that is contradicted by Dr. Patel's earlier acknowledgment that Glenn's ICD device also included biventricular pacing (*id.* at 71a, 75a), which is capable of significantly improving cardiac function. Indeed, Dr. Pujara had previously stated that, as a result of "appropriate medical management and biventricular pacing, the patient has achieved a relatively stable cardiac status," and predicted that Glenn's "work capacity should improve" even further with biventricular pacing. *Id.* at 39a. Similarly, in his July 22, 2002 letter, Dr. Patel stated that Glenn "has tried to return to work in the past with exacerbation of her symptoms." *Id.* at 44a. MetLife learned, however, that Glenn had not in fact tried to return to work at any time after April 2000. *Id.* at 58a.

[20] The manner in which Dr. Patel completed the physical capacity evaluations also demonstrates that he did not check the boxes thoughtlessly. For example, Dr. Patel was instructed, in the event he answered "no" to the question whether the patient could work in a sedentary occupation, to list or describe any

In light of the substantial record evidence contradicting Dr. Patel's July 2002 and February 2003 assessments, MetLife's decision to terminate Glenn's benefits was reasonable and did not remotely constitute an abuse of discretion.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

Respectfully submitted.

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physical barriers preventing Glenn from returning to work full-time. Dr. Patel responded "NA." J.A. 58a.

APPENDIX

Title 29 U.S.C. § 1002 provides, in relevant part:

§ 1002. Definitions

* * *

(14) The term "party in interest" means, as to an employee benefit plan—

(A) any fiduciary (including, but not limited to, any administrator, officer, trustee, or custodian), counsel, or employee of such employee benefit plan;

(B) a person providing services to such plan;

(C) an employer any of whose employees are covered by such plan;

(D) an employee organization any of whose members are covered by such plan;

(E) an owner, direct or indirect, of 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of a corporation,

(ii) the capital interest or the profits interest of a partnership, or

(iii) the beneficial interest of a trust or unincorporated enterprise,

which is an employer or an employee organization described in subparagraph (C) or (D);

(F) a relative (as defined in paragraph (15)) of any individual described in subparagraph (A), (B), (C), or (E);

(G) a corporation, partnership, or trust or estate of which (or in which) 50 percent or more of—

(i) the combined voting power of all classes of stock entitled to vote or the total value of shares of all classes of stock of such corporation,

(ii) the capital interest or profits interest of such partnership, or

(iii) the beneficial interest of such trust or estate,

is owned directly or indirectly, or held by persons described in subparagraph (A), (B), (C), (D), or (E);

(H) an employee, officer, director (or an individual having powers or responsibilities similar to those of officers or directors), or a 10 percent or more shareholder directly or indirectly, of a person described in subparagraph (B), (C), (D), (E), or (G), or of the employee benefit plan; or

(I) a 10 percent or more (directly or indirectly in capital or profits) partner or joint venturer of a person described in subparagraph (B), (C), (D), (E), or (G).

* * *

(16)(A) The term "administrator" means—

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

* * *

Title 29 U.S.C. § 1106 provides, in relevant part:

§ 1106. Prohibited transactions

(a) Transactions between plan and party in interest. Except as provided in section 408:

(1) A fiduciary with respect to a plan shall not cause the plan to engage in a transaction, if he knows or should know that such transaction constitutes a direct or indirect—

(A) sale or exchange, or leasing, of any property between the plan and a party in interest;

(B) lending of money or other extension of credit between the plan and a party in interest;

(C) furnishing of goods, services, or facilities between the plan and a party in interest;

(D) transfer to, or use by or for the benefit of, a party in interest, of any assets of the plan; or

(E) acquisition, on behalf of the plan, of any employer security or employer real property in violation of section 407(a).

(2) No fiduciary who has authority or discretion to control or manage the assets of a plan shall permit the plan to hold any employer security or employer real property if he knows or should know that holding such security or real property violates section 407(a).

(b) Transactions between plan and fiduciary. A fiduciary with respect to a plan shall not—

(1) deal with the assets of the plan in his own interest or for his own account,

(2) in his individual or in any other capacity act in any transaction involving the plan on behalf of a

party (or represent a party) whose interests are adverse to the interests of the plan or the interests of its participants or beneficiaries, or

(3) receive any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan.

(c) Transfer of real or personal property to plan by party in interest. A transfer of real or personal property by a party in interest to a plan shall be treated as a sale or exchange if the property is subject to a mortgage or similar lien which the plan assumes or if it is subject to a mortgage or similar lien which a party-in-interest placed on the property within the 10-year period ending on the date of the transfer.

Title 29 U.S.C. § 1108 provides, in relevant part:

§ 1108. Exemptions from prohibited transactions

* * *

(c) Fiduciary benefits and compensation not prohibited by 29 U.S.C. § 1106. Nothing in section 406 shall be construed to prohibit any fiduciary from—

(1) receiving any benefit to which he may be entitled as a participant or beneficiary in the plan, so long as the benefit is computed and paid on a basis which is consistent with the terms of the plan as applied to all other participants and beneficiaries;

(2) receiving any reasonable compensation for services rendered, or for the reimbursement of expenses properly and actually incurred, in the performance of his duties with the plan; except that no person so serving who already receives full-time pay from an

employer or an association of employers, whose employees are participants in the plan, or from an employee organization whose members are participants in such plan shall receive compensation from such plan, except for reimbursement of expenses properly and actually incurred; or

(3) serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest.

* * *

Title 29 C.F.R. § 2560.503-1 provides, in relevant part:

§ 2560.503-1 Claims procedure.

(a) Scope and purpose. In accordance with the authority of sections 503 and 505 of the Employee Retirement Income Security Act of 1974 (ERISA or the Act), 29 U.S.C. 1133, 1135, this section sets forth minimum requirements for employee benefit plan procedures pertaining to claims for benefits by participants and beneficiaries (hereinafter referred to as claimants). Except as otherwise specifically provided in this section, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Act.

(b) Obligation to establish and maintain reasonable claims procedures. Every employee benefit plan shall establish and maintain reasonable procedures governing the filing of benefit claims, notification of benefit determinations, and appeal of adverse benefit determinations (hereinafter collectively referred to as claims procedures). The claims procedures for a plan will be deemed to be reasonable only if—

(1) The claims procedures comply with the requirements of paragraphs (c), (d), (e), (f), (g), (h), (i), and (j) of this section, as appropriate, except to the extent that the claims procedures are deemed to comply with some or all of such provisions pursuant to paragraph (b)(6) of this section;

* * *

(g) Manner and content of notification of benefit determination.

(1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. Any electronic notification shall comply with the standards imposed by 29 C.F.R. 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the claimant—

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;

(v) In the case of an adverse benefit determination by a group health plan or a plan providing disability benefits,

(A) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

(B) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

(2) In the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, the information described in paragraph (g)(1) of this section may be provided to the claimant orally within the time frame prescribed in paragraph (f)(2)(i) of this section, provided that a written or electronic notification in accordance with paragraph (g)(1) of this section is furnished to the claimant not later than 3 days after the oral notification.

(h) Appeal of adverse benefit determinations.

(1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures—

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such informa-

tion was submitted or considered in the initial benefit determination.

(3) Group health plans. The claims procedures of a group health plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless, in addition to complying with the requirements of paragraphs (h)(2)(ii) through (iv) of this section, the claims procedures—

(i) Provide claimants at least 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(iii) Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(iv) Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to

whether the advice was relied upon in making the benefit determination;

(v) Provide that the health care professional engaged for purposes of a consultation under paragraph (h)(3)(iii) of this section shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

(vi) Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which—

(A) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

(B) All necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

(4) Plans providing disability benefits. The claims procedures of a plan providing disability benefits will not, with respect to claims for such benefits, be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures comply with the requirements of paragraphs (h)(2)(ii) through (iv) and (h)(3)(i) through (v) of this section.

* * *

(j) Manner and content of notification of benefit determination on review. The plan administrator shall provide a claimant with written or electronic notifi-

cation of a plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 C.F.R. 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—

(1) The specific reason or reasons for the adverse determination;

(2) Reference to the specific plan provisions on which the benefit determination is based;

(3) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(4) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about such procedures described in paragraph (c)(3)(iv) of this section, and a statement of the claimant's right to bring an action under section 502(a) of the Act; and

(5) In the case of a group health plan or a plan providing disability benefits—

(i) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule,

guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(ii) If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."

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